REACHING ADOLESCENTS IN RURAL AREAS: EXPLORATORY STUDY ON FACTORS CONTRIBUTING TO LOW UTILISATION OF FAMILY PLANNING SERVICES AMONG ADOLESCENTS IN MANGOCHI DISTRICT- MALAWI

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LIST OF ACRONMYS

ABC	Abstain Be faithful and Condom use
AIDS	Acquired Immunodeficiency Syndrome
BLM	Banja La Mtsogolo
CBC	Community Based Distributor Agents
CDC	Community Development Committee
CPR	Contraceptive Prevalence Rate
FGDs	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HAS	Health Surveillance Assistant
ICPD	International Conference on Population and Development
KI	Key Informant
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MDHS	Malawi Demographic Health Surveys
MHRC	Malawi Human Rights Commission
NGO	Non Governmental Organizations
PSI	Population Services International
STIs	Sexually Transmitted Infections
YCBDA	Youth Community Based Distributor Agents
YDIC	Youth Drop In Centers
YFS	Youth Friendly Services
YONECO	Youth Net and Counseling
TBA	Traditional Birth Attendant
TRA	Theory of Reasoned Action
UNICEF	United Nations Children's Emergency Fund
UNFPA	United States Agency for International Development
WHO	World Health Organization

DEFINITION OF TERMS

Adolescence: It is a period of transition from childhood to adulthood (UNFPA, WHO, 2003).

Adolescents: defined as those people aged from 10-19. (Early adolescence characterize those aged from 10 – 14, late adolescence characterize those aged from 15-19) (UNFPA, WHO 2003).

Adolescent fertility rate*:* the number of live births among girls aged 15-19 divided by the number of girls in that age group. It is expressed per 1,000 populations. (WHO, 2002).

Youths: Characterize those aged from 14 - 24 (UNFPA, WHO, 2003)

Young people: Young people encompasses both adolescents and youths as it applies to those aged from 10-24 (UNFPA, WHO, 2003).

Menarche: Age when one attains puberty.

Reproductive health: A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. (Defined in the Programme of Action of the International Conference on Population and Development (ICPD), held in Cairo, Egypt, in September 1994)

Sexual health: Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity (WHO, 2006).

Sex: Sex refers to the biological characteristics that define humans as female or male (WHO, 2002).

Sexuality: Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (UN, 1995).

Comprehensive sexuality education: a life long process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy.

Abortion

Induced: the voluntary termination of pregnancy which is used to end an already established pregnancy (i.e. a method that acts after nidation has been completed). (WHO, 2006)

Unsafe abortion: is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both. (Division of Family Health and Special Programme of Research and Research Training in Human Reproduction. International Conference on Population and Development, Cairo, Egypt, 5-13 September 1995.)

Eclampsia: Convulsions and coma occurring in a pregnant or puerperal woman and associated with pre-eclampsia that is a condition in pregnancy manifested by hypertension, oedema and/or proteinuria. (WHO, FHI, 2002)

Family Planning: Implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. Family planning is achieved through contraception defined as any means capable of preventing pregnancy – and through the treatment of involuntary infertility. (Working definition used by the Special Programme of Research and Research Training in Human Reproduction, and the Division of Family Health).

Family planning services: Includes family planning counseling, information, education, communication, choice of family planning methods and other services on reproductive health issues.

Gender: It is used to define those characteristics of women and men that are socially constructed. The learned behaviour makes up gender identity and determines gender roles (WHO, 2002).

Culture: Generally refers to patterns of human activity and the symbolic structures that give such activities significance and importance (Online Etymology Dictionary).

Norms: Standards of behavior that are accepted in a particular society. Norms derive from values that identify what should be judged as good or bad (Macmillan English Dictionary for Advanced learners).

Morals: Used interchangeably with norms implying principals of right or wrong behavior that is generally accepted by a society.

ABSTRACT

It is widely acknowledged that providing family planning services to adolescents would not encourage them to indulge in sexual behaviors but would rather help them with information on how to protect themselves if sexually active from unwanted pregnancies and sexually transmitted infections including HIV/AIDS. Despite the universal knowledge of at least one modern method of family planning among adolescents in Malawi, use of these methods remains negligible and virtually no in-depth studies have targeted adolescents to explore the situation.

The purpose of this study was to explore the contributing factors to low utilization of family planning services among adolescents in Lungwena area of Mangochi District in Southern Region of Malawi.

Qualitative methods using focus group discussions, individual interviews, key informant interviews plus some general participant observations and limited discourse analysis were used to obtain data for this study.

The study found that adolescents' utilization of family planning services in Lungwena area is mainly affected by lack of community acceptance to acknowledge adolescents sexual activity. However, norms of the society and messages adolescents are exposed to, through some cultural practices, peers and parents confuse adolescents in the understanding of family planning services in general. As such adolescents are challenged with numerous reproductive health problems in this society. In addition, lack of proper knowledge pertaining to family planning methods, individual perceived barriers and barriers associated with delivery of services inhibit adolescents' to use the available family planning services.

This is the first study that has used qualitative methods to explore adolescents' low utilization of family planning services in Mangochi District. Findings suggest that equipping adolescents with proper knowledge and sensitizing the community on unmarried adolescents reproductive health needs would help adolescents to utilize the available family planning services hence protect them from the sexual health problems found by this study.

Chapter 1: Introduction

Today adolescents' sexual activity is a public health concern. This is because it brings with it serious consequences such as pregnancy complications, sexually transmitted infections (STIs), including HIV/AIDS, early school dropout among girls and emotional stress just to mention a few. Apart from HIV/AIDS and other STIs, unmarried adolescent pregnancy is one of the serious consequences of early initiation of sexual activity.

Since the International Conference on Population and Development in Cairo (ICPD) in 1994, recognition of adolescents' specific sexual and reproductive health needs have gradually increased(1). Attempts are now tendered to focus on prevention, education and counseling for those who are not sexually active but provisions of messages to those who are already sexually active are lagging behind (ibid). Unmarried adolescents' are told to abstain from sex which for some is however, more unrealistic and ineffective than using family planning methods. Complete abstinence requires strong motivation, self control, maturity, determination, self-efficacy and empowerment among other things. It is well known that using barrier methods of family planning services provides a dual purpose in preventing unwanted pregnancies and STIs including HIV/AIDS(1-2). However, studies in Malawi have not included unmarried adolescents' on use of family planning services.

Having worked and stayed in Lungwena community for a period of two years, I observed that adolescent girls were having children out of wedlock, which could be assumed that many of these pregnancies were unwanted. The focus of this study is on lack of prevention of unwanted pregnancies, STIs including HIV/AIDS through utilization of family planning services among adolescents'. Use of family planning services among adolescents' would provide them with relevant information on preventive measures from the consequences of unprotected sex even before they are sexually active. It would also help sexually active adolescents' to make informed choices of contraceptive methods that suit their special needs, which would protect them from unwanted pregnancies as well as STIs including HIV/AIDS.

1.2 Malawi Country Profile

1.2.1 Geography

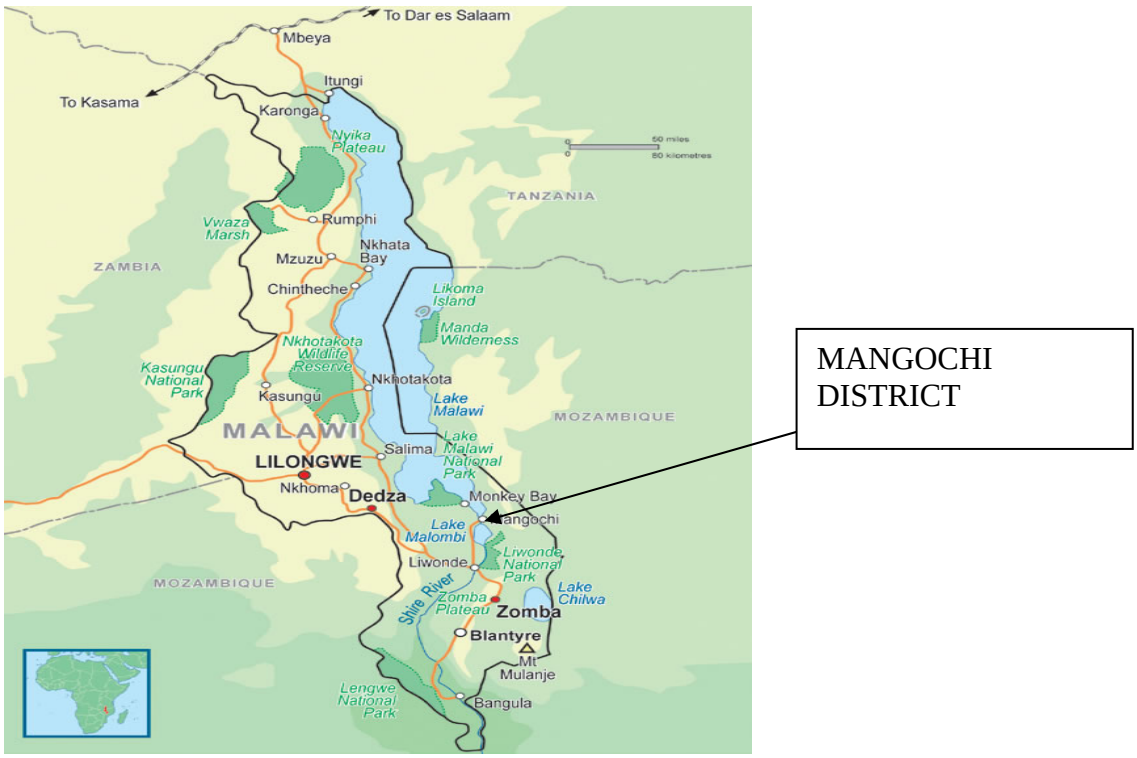

Fig 1: Map of Malawi

Malawi is a landlocked country which is long and narrow situated in the southern region of the African Continent. The country shares its border with Zambia in the north-western region, Tanzania in the northern region, Mozambique in the eastern, southern and western regions. It has a total area of 118,480 square kilometers of which 94,276 square kilometers is occupied by land. The most striking topographic feature on the face of Malawi is the Great Rift Valley which is drawn from the very north to the extreme south passing through the 580km Lake Malawi which forms the eastern boundary of the country with Tanzania and Mozambique (3).

The country is divided into three regions namely; Southern region, Central region and Northern region. The capital city is Lilongwe situated in the central region of the country. The country is made up of 28 districts. Six districts are in the Northern Region, nine are in the Central Region and thirteen in the Southern Region. Administratively, the districts are subdivided into traditional authorities (TAs), presided over by chiefs. Each TA is composed of villages, which are the smallest administrative units and are presided over by village headman.

Malawi has a tropical, continental climate with maritime influences. Rainfall and temperature vary depending on latitude and proximity to the lake. From May to August, the weather is cool and dry. From September to November, the weather becomes hot. The rainy season begins in October or November and continues until April.

1.2.2 Economy

Malawi ranks among the worlds least developed countries, with most of the population involved in subsistence agriculture. Its Gross Domestic Product (GDP) is US$ 2 billion and its average income per capita is approximately around U$160. Income inequality is also relatively high with a Gin Coefficient of 0.38. The economy is highly reliant on agriculture accounting for 70 percent of exports in 2004, tobacco, tea, and sugar being the major export cash crops. Agriculture involves over 85 percent of the population which accounts for 35 percent of GDP. The common food crops are corn, millet, rice, peanuts, cassava, and potatoes. The economy further relies on substantial inflows of economic assistance from the International Monetary Fund (IMF), the World Bank and Individual donor nations. The country is largely self-sufficient with regard to food, but due to high cost of fertilizer, coupled with erratic rains for the past three years, Malawi is experiencing food insecurity, making it largely dependent on imported food from South Africa. Currently, the country is expecting another year of food insecurity because of floods. Moreover in 2005, it was reported that 52% of the population of Malawi was living below the poverty line, an improvement from 64% in the 2001(3-4).

1.2.3 Population growth and demographic information

The population of Malawi has grown from 12.5 million in 2005 to approximately 13,166 million in 2008 (5). The majority (90%) of its population live in the rural areas where the population density is one of the highest in Africa and only 10% live in the urban areas. Malawi's total fertility rate (TFR), is still high (6.9%) per woman of childbearing age mainly exacerbated by early child bearing and a low contraceptive prevalence rate (3).

Malawi has a diverse culture consisting of a number of related ethnic groups namely; Chewa, Nyanja, Tumbuka, Tonga, Lomwe, Yao, Ngoni and a number of other smaller groups including Asian and European groups. English is the official language while Chichewa is the national local language and other languages have regional importance. The largest religious populations of Malawi are Christians (75%, mostly Presbyterian and Roman Catholic), followed by Muslim (20%), indigenous beliefs (3%) and other (2%). (4)

Malawi's health indicators are among the worst in the world. Its maternal mortality ratio remains one of the highest in the world influenced by a number of interrelated factors. It was at 1120 in 2000 and has slightly decreased to 984 in 2004 (3). Infant mortality rate (IMR) and under-five mortality rate (U5MR) have improved from 104 and 189 per 1000 live births in 2000 to 69 and 118 in 2004. Life expectancy at birth is estimated to have dropped from 39.8 in 1998 to 37.7 years in 2000. The downward trend of life expectancy is due to the HIV/AIDS epidemic with an estimated prevalence rate of 14 % among adults aged 15 to 49 years being infected in 2005. The prevalence is higher among women than men (13 and 10 percent respectively) (3; 5-6).

Chapter 2. Background Information

WHO (2003) defines adolescents' as persons between 10 and 19 years of age and today they make up 20% of the world's population, of whom 85% live in developing countries (3-4; 7). For many millions of young people, adolescence is a critical passage in which they gain life experiences through schooling, job training, work experiences, community activities, youth groups and relationships. Also major physical, cognitive, emotional, sexual and social changes that affect adolescent behavior occur during this time. Contrary to the early development theorists notion that youth is a healthy period of growth with no major physical illness, there is now substantial literature that adolescents' face unique reproductive health challenges of early sexual debut, HIV/AIDS and other STIs, unplanned pregnancies and illegal abortions (1-2;7-8). As reported by UNFPA (2005) everyday more than a quarter of a million young people become infected with an STI, and more than half of all new infections occur in these young people aged 15-24 (9). These challenges threaten their health and survival.

Although all adolescents' are prone to unprotected sexual behaviors; adolescent girls face a dual challenge in most cases. In addition to HIV/AIDS and other STIs, Heather et al (2007) asserts that mortality and morbidity related to pregnancy, delivery and unsafe abortion remain among the most significant risks to adolescents' girls' health (10). For instance, adolescent pregnancy in high risk contexts is associated with increased risks of miscarriage, pre-mature labour, blood pressure problems (pre-eclampsia) and perinatal mortality. Also the reproductive tract of girls under the age of 14 is more susceptible to obstructed labour and fistula because they are not yet fully matured. Furthermore, unintended pregnancy among adolescent girls can lead to social stigmatization, loss of educational opportunities and physical harm, either from attempting an unsafe abortion or from giving birth before reaching

physical maturity (1-2;10). Moreover, UNICEF (2003) states that pregnancy is the leading cause of death among young women aged 15 to 19 worldwide, with complications of childbirth and unsafe abortions being major factors (11). These complications become even a greater challenge in developing countries where obstetric facilities are limited.

According to Ryan et al (1996) adolescence is a period when adolescents' make the transition from parent-directed use to self-determined use of health services (12). Thus access to health services during this period can modify risky behaviors, promote healthy habits, and improve adolescents' health (13). It is estimated that 10 million young people are living with HIV/AIDS with the vast majority (62%) living in sub-Saharan Africa (1; 9; 11). Even though this is the situation, literature documents that adolescents' have particular difficulties in accessing healthcare information about protective measures and treatment in many parts of the world (9; 11; 14). In addition, adolescents' are poorly informed about how to protect themselves from pregnancies and STIs.

Although evidence has shown that family planning drastically reduces the rate of unwanted pregnancies (20), many adolescents still face problems in getting family planning services they need. Access to information and use of the reproductive health services are major ways adolescents' could be protected from the consequences of the sexual health threats. Unfortunately, use of reproductive health services, specifically family planning, has only been associated with adult women in most African countries. The underlying factor to these barriers is the belief that unmarried adolescents' are too young, do not have sex and therefore do not need the services. Therefore unmarried adolescents' find it difficult to obtain the contraceptives they need. For instance, Marie Klingberg et al carried out a qualitative study in Vietnam to identify barriers and needs for appropriate reproductive health services for young people, including health care providers towards adolescent sexuality. They found that health care providers and midwifery students have an overall negative attitude towards pre-marital sex, abortion and use of contraceptives among adolescents (15). Similar findings were noted in qualitative studies in South Africa and Senegal where youths were hired to seek services at clinics and observed the treatment they received (16-17). In South Africa, providers resisted requests for condoms and gave no instructions on use (16). In Senegal, none of the youths who requested for contraceptives received them (17). However, many countries in sub-Saharan Africa have documented that unmarried adolescents' are sexually active and first sex

in some boys and girls in peri-urban areas in Zimbabwe and Zambia occur as early as the age of nine (18-19).

A study on Sex, Contraception and Childbearing before Marriage in Sub-Saharan Africa, found that there was universal knowledge levels of at least one modern method of contraceptives among sexually experienced adolescents in Kenya, Botswana, Zimbabwe and Malawi. However less than 30% of respondents who had never married but sexually experienced, used a modern contraception (20). Similar studies in Senegal, Tanzania, Zambia, Lesotho, Namibia and Nigeria found that adolescents' had difficulties in accessing family planning services due to unsupported health providers, lack of family planning information, marital status, embarrassment, lack of knowledge of specific methods and lack of parental support (17; 21-25). These findings are in contrast to Mwaba's study (2000) in South Africa where it was found that 23% of the adolescents' indicated that pregnancy was caused by girls themselves seeking to prove their fertility (26). The findings further inform that one third of adolescent girls in South Africa become pregnant before the age of 20, despite contraceptives being free and mostly accessible. Another qualitative study was undertaken in Limpopo Province on the barriers to adolescent girls accessing clinic services for contraception. In this study, lack of contraceptive use among girls was related to pressure from male partners and family members to have a baby or prove their fertility (27). These studies show that there may be other factors that may encourage adolescents to engage in unprotected sexual intercourse – for example to prove fertility - hence influencing low utilization of family planning services. Caldwell and Caldwell (1987) also emphasized the cultural imperatives of African communities that are important in maintaining high levels of fertility (28). Hence, use of family planning services among adolescents can be determined by many factors that can be considered obstacles to actual use of the services.

WHO (2002) states that adolescents' prefer services that offer them confidentiality, with non-judgmental health providers, accessibility and affordability; and autonomy where they can use services without parental consent, just to mention a few (29). In some instances, adolescents' have complained about inconvenient locations, opening times and high costs of treatment for STIs. Further, adolescents' who seek family planning services either for treatment of STIs or contraceptives have expressed fear, embarrassment and judgmental attitudes on the part of some health workers (19; 29). Even in developed countries, adolescents' failure to use family planning services was associated with health providers because they did not observe

confidentiality in their service provision (30). Further, in developed countries, studies that reported a high utilization of family planning services among adolescents indicated that the style with which health care providers interact with adolescents is a significant determinant of adolescents' satisfaction with health care services in reproductive health (ibid). It can therefore be argued that despite the resources in developed countries, adolescents' views towards using family planning services are not that different from the African setting.

In general, promoting use of family planning services among adolescents can lead to decreases in morbidity and mortality due to unsafe pregnancy, abortion, STIs including HIV/AIDS, and can slow population growth. In Malawi, like in many other sub-Saharan countries, adolescents' are not spared from the consequences of premarital sexual activity and early child bearing manifested in the number of sexual reproductive health problems such as unintended pregnancies, hospital admissions due to attempted abortions, and STIs just to mention a few. Therefore understanding adolescents' perceptions on family planning services was imperative because it has provided some significant information on what adolescents' think regarding their low uptake of family planning services despite wanting the services.

2.1 Overview of Adolescents in Malawi

Corresponding to WHO definition, in this study, adolescents are also defined as the period spanning from 10 to 19 years. This is also the definition that National Family Planning Council of Malawi (NFPCM) uses (31).

Despite various consequences of unprotected sex among adolescents, premarital sex is still a controversial issue in Malawi as many people still hold to the belief that adolescents are not supposed to have sex. However, literature in Malawi has shown that premarital and unprotected sex is very common among adolescents. MDHS report of (2004) indicates that 50% of adolescents had initiated sexual intercourse before they had reached the age of 15 (3). Further, Phiri et al (1997) found that the majority of young boys and girls (60%) had their first sexual encounter between the ages of 10 and 15 and the majority (72% of females and 81% of males) did not use contraceptives (32).

Clinic-based studies have further documented the consequences of unprotected sex among adolescents in Malawi. In a cross-sectional descriptive study conducted by Lema et al (2003) at Queen Elizabeth Hospital, Blantyre, Malawi, adolescents' aged 13 to 19 comprised 27.6% of admissions with complications of abortions, with 45.1% reporting that the pregnancy was

unwanted. Further, unwanted pregnancies were reported commonly among single adolescents than married adolescents' (88.8% versus 12.2% respectively) (33). Throughout Malawi, abortion cases are also high among 15 to 19 years of which complications of unsafe abortions in school aged girls account for between 16 and 40 percent of admissions to gynaecological wards in public hospitals (34). Issues of STIs though based on scanty data also pose significant risk to many adolescents' in Malawi. Furthermore, the epidemic of HIV/AIDS has not spared Malawian adolescents, because currently many infected people out of the general population are adolescents' who fall into the young ages of 15 to 24 years. Prevalence rate is estimated at 17.9% among this group (3). The sad point of it is that the majority of the population in Malawi, about 6.3 million (48%) of Malawi's 13 million people are younger than 15 years of which 91,000 of this group are suspected to be infected with HIV (35). However these problems are preventable through correct and consistent use contraception and safe sexual practices.

Although early child bearing is associated with high maternal mortality in Malawi, childbearing among adolescents' is very common, as reflected in the data found in the MDHS (2004) report. Among the 15 to 19 years age group of adolescent girls, one in three adolescents had begun child bearing; one in four had already had a child and a further 9 percent were pregnant at the time of the survey (3). In addition, adolescent pregnancy has increased from 330 per 1,000 in 2000 to 336 per 1,000 in 2004 (3; 36). Further, in a study conducted by Chimbiri (2003) in Mchinji district of Malawi, it was reported that 590 per 1000 maternity admissions at Mchinji district hospital were adolescents (36). However, unmarried pregnant adolescents' are psychologically tortured in many parts of Malawi. For instance, a qualitative study by Munthali (et al) found that the consequences of unmarried girls being pregnant were more serious than boys and that in some cases girls may be disowned by their parents because of bringing shame and disgrace to the family (37). Within the over-sampled district of Mangochi, where the present study took place, adolescents are reported to have the highest proportion of female who have started childbearing (48%). Moreover, the district reported the lowest contraceptive prevalence, lowest mean age at first sexual intercourse, marriage, and birth among young people below the age of twenty compared to national average figures (3).

Currently, the Malawi Demographic Health Surveys (MDHS) are the main source of data on adolescents in Malawi as such there is more quantitative data pertaining to adolescent

reproductive health as opposed to in-depth qualitative data. It was therefore, of great importance to understand adolescents' views on this topic, considering that they attribute a significant number of the total population of Malawi. For instance, the 1998 census indicated that adolescents comprise 23% of the total population of Malawi and that the adolescent population is estimated to have increased from 1.86 million in 1987 to 3.01 million in 2002 and is still increasing (38). Therefore such a considerable number can not be neglected in Malawi in terms of health issues. The overview of adolescents' described in this section forms the foundation on which the current study was built.

2.2 Overview of family planning Program in Malawi

Around the 1980s the Malawi government, was reluctant to implement family planning policy. Malawi government adoption of family planning was mainly a reaction to the acute expanding population and food crisis which was noted in 1987 (39). This was the impetus for promoting child spacing. The other reasons for introducing child spacing were health-related problems that women were facing when pregnancies were too early, too many, too late (associated with old age), and too frequent. Thus child spacing was officially integrated into maternal and child health system in 1982, and implemented in 1984 for the purpose of reducing child and maternal mortality. Due to the value attached to children in Malawi, men did not want women to use family planning and to avoid suspicions from other people that some women were using contraceptives; child spacing clinics were attached to hospitals. By then, Malawi had 141 child spacing clinics attached to hospitals and health centers. Since then, a lot of initiatives have taken place to sensitize the community on the importance of child spacing. Government agencies like Community Development Committee (CDC) conducted a workshop with chiefs and parliamentarians to discuss health, social and economic advantages of small families and embarked on an exploration of traditional cultural methods of birth spacing (39-40). The revamping of child spacing into family planning resulted in the change in political system from one government to multiparty democracy government (39).

As of late, family planning has been remarkably successful in Malawi with contraceptive prevalence rate (CPR) for modern methods being increased from 7.4% to 26.1% from1992 to 2000 and to 28% in 2004 with 97% knowledge levels among married women (3; 6; 41). Furthermore, family planning services are free and almost universally available through all government health facilities. In addition, to reach those in rural areas, community based distributor agents (CBDAs) were trained and they have been a key contributor in the success of family planning in Malawi. They raise awareness in their respective communities on using

family planning methods and they provide the population with pills, condoms and referring or even escorting them to hospitals for other methods such as injections, Norplant, tubal ligation and vasectomy[1]. Further, there are multiple channels of communication in multiple languages through posters, media programs, theatre, health talks just to mention a few. In addition, private clinics like Banja la Mtsogolo (BLM) offers family planning services in an integrated system in all the 29 districts.

To some extent family planning services have been biased in design and approach. For instance, Malawi family planning services and reproductive health programs have tended to focus on adult women since family planning programmes are often channeled through maternal and child health (MCH) services with direct responsibility to females. This might have probably influenced men and unmarried adolescents' to view family planning as not suitable for them.

2.3 Response to include adolescents in family planning services in Malawi

With adolescents' reproductive health problems of early and unwanted pregnancies, STIs including HIV/AIDS, Malawi started to raise awareness of adolescents sexual and reproductive health needs. Malawi, being a signatory to the 1994 Cairo ICPD meeting, revised its family planning policy and contraceptive guidelines in 1996 to include adolescents' into reproductive health services (42). Therefore, Malawi Reproductive Health Policy emphasizes special risks of adolescent pregnancy and advocates provision of family planning methods to adolescents without the consent of relatives, spouses or partners. Since then, many interventions have taken place to address adolescents sexual and reproductive health needs to protect them from HIV/AIDS, unwanted pregnancies, early pregnancies, early sex and other reproductive health needs. Interventions were designed to cater both in and out of school adolescents. However, Malawi family planning use among adolescents' is still low leaving a substantial unmet need for contraception.

2.3.1 In-School Curriculum and Extra Curricular Activities

In 1997, the government implemented in the school curriculum a life skills education subject to be taught in primary schools from standard four through secondary schools[2]. The curriculum is developed with simple messages and knowledge about human body, sexual

[1] Injections, Norplant, tubal ligation and vasectomy are family planning methods that are clinically based and can not be offered by a CBDA but only a medically trained person.

[2] In the Education system of Malawi, primary education covers those aged from six years which begins in standard one and in most cases when they reach standard four, they are between nine and ten years. Primary education runs up to standard eight then those who are qualified go to different secondary schools for four years before they go for university education for more four years.

behavior, violence and exploitation among many topics (43). According to UNICEF, they found out that 48% of the marriages in Malawi involve adolescents aged from 15 to 18 years and hence started supporting the programme by training teachers on how to deliver the information and interact with children (12). The subject has successfully reached all children who do not drop out of school before standard four (43). However, no proper evaluation has been done to find out the impact of the subject on adolescents change of behavior as regards to early marriages and pregnancies, early sex, spread of STIs including HIV/AIDS which are the major emphasis of the subject.

The in-school curricular activities include the introduction of numerous clubs namely; *Anti-AIDS/Edzi-Toto and Why-Wait*[3]. All the clubs aim at reducing HIV and STI transmission among youths. In addition, there is *Youth Alert! 'My Life, My Future'* which is another HIV/AIDS education programme that visits school aged adolescents. Apart from visiting schools, it also futures a radio programme specifically for adolescents on issues related to early sex and prevention of HIV/AIDS. The programme is operated under an NGO called Population Services International (PSI) in Malawi. The Youth Alert club was introduced in 2002 after analyzing the existing HIV/AIDS prevalence in secondary schools (44). Specifically, Youth Alert has overcome critics by focusing on abstinence while also addressing the core messages of safe sex with the use of Abstinence, Be faithful and Condom (ABC) approach. These youth's clubs have the same objectives, namely (44-45):

- Delaying sexual debut.
- Promoting primary and secondary abstinence.
- Promoting safe sex among those who are sexually active.
- Promoting a decrease in the number of sexual partners.

The major challenge to the aforementioned programs and clubs is that they do not include adolescents who are out of school. Many children in Malawi, especially in the rural areas, do not go to school and sometimes they stop early. In the rural areas, this stems from poverty at household level that affects many children which results in their getting involved in child labor to support their families and themselves.

[3] Anti- Aids, Edzi Toto and why Wait are in – school clubs aimed at imparting knowledge to adolescents in behaviour change in reaction to HIV/AIDS and other STIs including pregnancy prevention.

2.3.2 The out of school youth clubs

Different non governmental organizations (NGO's) have introduced a number of Youth Friendly Services (YFS) in almost all districts in Malawi. The aim is to involve young people in information transfer to fellow youths in their respective communities on sexual and reproductive health issues. In the beginning, membership was limited to a particular age group, 15 to 24 years, but recently, everybody is free to join. Apart from the information, the clubs involve the participants by playing indoor and outdoor games. In some of these YFSs, adolescents are further provided with free access to STI treatment (45).

2.3.3 Youth Clubs in the Study area

In Lungwena area of Mangochi District, adolescents who go to school get information on sexual and reproduction health from life skills education which is offered as one of the subjects and also through joining Anti-AIDS club. Those who are out of school have limited information due to the fact that there are still few YFS clubs and they are not well established because they lack physical structures. However, adolescents just meet on specific days in different points where they go and share information on reproductive health issues. NGOs such as Save the Children and Youth Net and Counseling (YONECO)[4] usually visit the adolescents in the area with theatre, and other activities that disseminate information that target the adolescent sexual behavior. The district hospital also visits the area with sensitization messages. Findings on sex education (through youth clubs and school curricula) and contraceptive behavior show an association with improved contraceptive use (46). However, Piet Reijer et al suggest that there is need to assess the impact of these programs and clubs in terms of how adolescents' sexual behaviors have changed through being members of these clubs (43). He further observed that according to their evaluation study, the impact of the school clubs were difficult to asses because of their diversity in membership and purpose as some were doing behavior change activities while others were doing skills training.

2.4 Current knowledge on adolescent's utilization of family planning services

After reviewing a number of related studies and reports globally and internally on the topic at hand, it was found that there are many factors that would influence use and non-use of family planning services among adolescents. Despite the international consensus and commitment to addressing adolescents' access to reproductive health services, there are both individual and

[4] YONECO- a non governmental organization that pays school fees, buys school uniforms and books for young girls who were pregnant before and would like to continue with their primary or secondary education.

program level barriers to adolescents' use of family planning services. Individual barriers relate to adolescents' attitudes, assumptions, and social norms that family planning is for married people to reduce family size. Increased costs, knowledge of the contraceptives and where to find them are other hindrances for adolescents' to use family planning services. Programmatic level barriers relate to biases by the service providers, and lack of total acceptance that adolescents equally need family planning services as adults. Other barriers include location and opening hours which in most cases are not convenient for adolescents.

The first step in developing this study was to compose a literature review which was submitted to the department in the early months of May 2007. The studies reviewed indicate that some empirical research has been done on adolescents' reproductive health problems in Malawi but with limited research on the current study topic. Therefore a proposal was developed to address the situation.

2.5 Research gap

Results from earlier research in the study areas pointed to gaps in knowledge needed to better understand adolescents' perceptions on family planning services. In Malawi as well as in Lungwena area of Mangochi district (study area), family planning services including contraceptives are available and free of charge in all government health facilities (hospitals, clinics and through CBDAs). Again NGOs have implemented youth community based distribution agents (YCBDA) for family planning, but still usage is low. Although, current reports show that contraception use has shifted from 7% to 15% and 21% since 1992 to 2000 and 2004 among sexually active unmarried young people, still this is quite low considering that knowledge of at least one family planning method is almost universal (3; 6;45). However, the findings from MDHSs and other studies reviewed provides no detailed information to understand adolescents' utilization of family planning services in Malawi. Therefore, it was important that a detailed study exploring reasons on adolescents' utilization of family planning services in a rural setting be conducted, in attempting to fill the current identified research gap.

2.6 Research Question

The main question that the study attempted to answer was: What are the contributing factors to adolescents' low utilization of family planning services that can help them to be protected from STIs and unwanted pregnancies?

2.7 Broad and Specific objectives of the study

The overall objective of the study was to explore the contributing factors to low utilization of family planning services among adolescents in Lungwena community of Mangochi district in Malawi.

2.7.1 Specific objectives

Specific objectives were to:

1. Identify adolescents' reproductive health concerns in the community.
2. Explore adolescents' perceptions on utilization of family planning services.
3. Investigate the perceptions of the community members towards utilization of family planning services by adolescents.
4. Identify barriers faced by adolescents on utilization of family planning services.
5. Identify adolescents' sexual and reproductive health care services available in the district.

2.8 Rationale and justification of the present study

As already indicated in section 2.1, maternal mortality still poses as a major public health threat in Malawi, especially young girls between 15 and 19 years. Consequently, this puts Malawi very behind in trying to attain the Millennium Development Goals (MDGs) numbers two, four and five[5].

Evidence has shown that providing information and family planning services to adolescents result in their improved health (averting both births and pregnancies that would result into abortions and miscarriages) (31). Sadly, previous studies in Malawi have shown that contraceptive use among adolescents' is not common though many adolescents' are sexually active (3; 6). Also the high knowledge of at least one modern family planning method among adolescents' in Malawi has not translated into protective behaviors. Therefore, better knowledge of adolescents' perceptions and practices on family planning services was needed in order to understand the inhibiting factors so as to develop public health strategies that would encourage adolescents' to utilize the available family planning services. By providing family planning services to adolescents' they are also afforded counseling and proper individual information on their reproductive health status which would in turn protect them from the consequences of unprotected sex.

[5] MDG number two; achieve universal education (all boys and girls complete a full course of primary education); number three; reduce child mortality (reduce the mortality rate among children under five); number five; improve maternal mortality (reduce by three quarters the maternal mortality ratio)

2.9 Theoretical Perspectives

Chinn and Kramer (1999) define a theory as an "expression of knowledge….a creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of phenomena" (47). Literature reviewed in relation to the current study, enlightened on a number of theoretical perspectives that would help in contextualizing adolescents' low utilization of the available family planning services in Lungwena area. Burns and Grove (1997) asserts that research as a form of inquiry, either generates new knowledge where little exists or tests existing theories to see whether they are supported by evidence (48). However, within the literature search, it was found that there were limited qualitative studies which were guided by theories on this topic. In addition, few studies that were guided by theoretical perspectives were also limited to include social, economic, and cultural factors which may have an influence in shaping the sexual behaviors of adolescents' including their decision making on use of family planning services.

However, in attempting to understand adolescents' low utilization of the available family planning services in Lungwena area, a number of theories are discussed in this section in relation to one outstanding 'Initial Behavior' model depicted in fig 2. The model provides a framework for understanding the potential influences on an individual's decision to make use of the available health services. The model suggests that people's use of health services is a function of their predisposition to using services, factors that enable or impede use, and their need for the services. Contextualizing behavior model in this study, use of health services implies adolescents' use of preventive services which are family planning services.

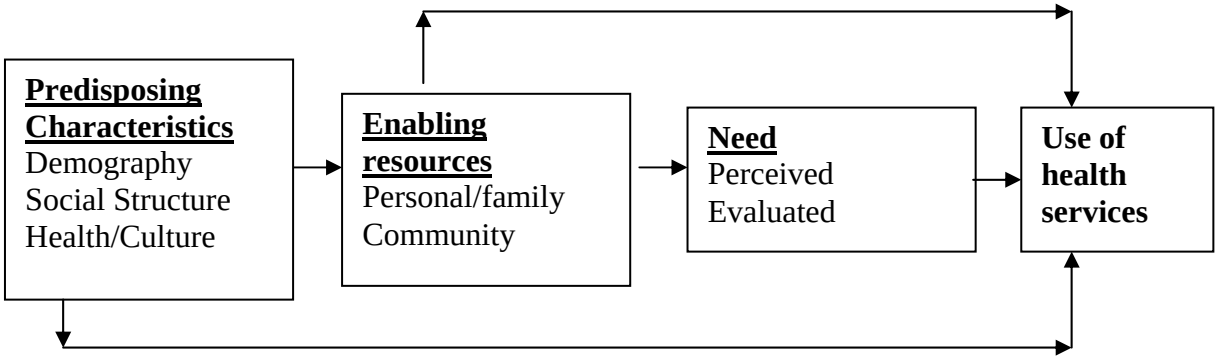

Fig 2. Initial Behavior Model 1960
Source: Anderson, R.M

The purpose of the Initial Behavior Model is to help in discovering conditions that either facilitate or impede utilization of services (49). The model points to health beliefs such as attitudes, values and knowledge that might influence people's subsequent perceptions of need and use of health services. Therefore, in this study, the health beliefs can be adolescents' and community perceptions on adolescents' use of family planning services which may have an impact on their decision to use the services. For instance, other reports reviewed have shown that common concerns of adolescents to use family planning services includes confidentiality, convenience of clinic hours, location and providers attitude towards adolescents' sexual activity (1-2; 8-11). Therefore, such attitudes can be impeding factors among adolescents' to use the available family planning services in their respective communities.

The health belief further points to age and gender as examples of demographic factors that can influence use of family planning services among adolescents. The feeling of being young among adolescents' can influence them not to use the available family planning services despite engaging into risky sexual behaviors. Studies in adolescents' sexual and reproductive health have documented this (22; 50- 51). It further provides one means of explaining how social structure might influence use of services. Adolescents' lack of parental control, socio economic status of parents and their educational level may further have an influence on adolescents' sexual behavior and use of family planning services. It can therefore be argued that adolescents' who have educated parents and that are economically stable may likely live a positive life with opportunities which may probably influence them to delay sexual activity. On the other hand, educated parents may possibly advise their children to use family planning services if they are sexually active. The cultural influences could refer to health beliefs and attitudes of adolescents' and the community towards unmarried adolescents' using family planning methods in relation to morals.

From gender perspective, gender role stereotypes increase the probability of adolescent girls' failure to protect themselves from unprotected sex. Lipps (1999) cited in Christine Varga (2003) argued that a large part of sexual expectations, decisions and behaviors are shaped by our societally-ascribed gender roles (52). Gender role socialization involves learning, in part, the expectations of how men and women should relate to one another. These expectations can influence sexual decisions and behaviors. Since gender roles include scripts on how sexual interactions should take place, men tend to take the leading role in sex and may decide whether to use a condom or not. In such situations, gender can be a predisposing, enabling as

well as an impeding factor to adolescents' utilization of family planning services. Doyle (2001) argues that gender norms and unequal power relations comprise young women's sexual health by limiting their ability to negotiate safer sexual practices (53). Therefore adolescent girls need empowerment to be assertive in decision making as regards to their sexual life and use of family planning services. Further, the gender norms within a society may encourage high risk sexual practices such as multiple sexual partners among boys. In this way, it is important that adolescents engaging in such behaviours should use family planning services so as to get protected. Varga et al (1997) confirms that masculine ideologies encourage multiple sexual partners and more sexual activity, and promote beliefs that lead to negative attitudes toward condom use and inconsistent condom use (54).

According to the sex role theory, it explains that we humans learn from society's institutions to behave in ways appropriate to our sex. Thus men are aggressive, rational, dominant and objective while women are passive, intuitive, submissive and subjective (55). However, this can have a negative impact on adolescents' sexual behavior and the passivity of women may influence girls to accept unsafe sex. This may also have an influence on adolescent girls' decision making on use of family planning services in the sense that they can easily get discouraged.

Ajzen's theory of Reasoned Action (TRA) has also a potential value in explaining adolescents' use of family planning services. In this theory the central variable is the intention to perform a behavior and it is the immediate determinant of the behavior (56). The TRA contextualizes that adolescents sexual and contraceptive behavior is a result of adolescents attitudes toward performing that behavior (e.g., having protected sex), beliefs about what others think one should do (normative beliefs), and his/her motivation to comply with those norms (ibid). Therefore, perceived attitudes and values of other significant people have important effect on shaping intention of adolescents in their sexual behaviour as well as use of the services. Studies contextualizing TRA reported that adolescents are more influenced by attitudes of their peers about pre-marital sex, contraception and safer sex practices (57-58). For example, it was found that if adolescents believe that their peers express norms favouring condom use and actually use condoms, then they themselves are more likely to use condoms (58). Brown et al (1999) asserts that adolescents are typically concerned with gaining acceptance from peers, of which dating and sexual relationships appear to be an important

means of establishing and maintaining peer group status (57). As such, use of family planning services could also depend on whether peers value and supports the idea of using the services.

In summary, there are many theories which can provide some insights to holistically understand adolescents' predisposition and impeding factors to use the available family planning services. However, theories discussed and presented in this section have merely provided us with some empirical understanding on some of the potential contributing factors to adolescents' use and non-use of the available family planning services. Exploring these factors would help to better understand how programs can be designed to encourage and get adolescents to use family planning services more effectively. Inherent in each theory are limitations. Depending on the research question, theories were combined so as to complement each other to help us consider a broader perspective in understanding the research question.

Chapter 3: Research Design and Methodology

3.1 Introduction

This chapter presents the study design and the methodology on which the results of this thesis are based. It starts by presenting the study design, setting, study population, study period, sample size, sampling procedure, and the tools that were used for data collection, data handling and analysis, ethical considerations and challenges met during the study period.

3.2 Study Design

Relevant literature reviewed helped in the selection of the current study design. Literature has shown studies that aim at proving a hypothesis use quantitative approach and those that seek to explore the phenomenon, go for qualitative design. Therefore the ideal method depends on the kind of questions that need to be answered and what kind of data is most useful for that purpose. The focus of the current study was to explore the perceptions of a particular group of people in their natural setting, specifically to understand adolescents' low utilization of family planning services in a specific community. With the focus of the study, an exploratory qualitative method using ethnographic approach was ideal in attempting to address the phenomenon, because the topic is exploratory and focused on particular opinions, beliefs and experiences. Quantitative study design falls out of scope to collect such information.

Denzin and Lincoln (1994) define qualitative research as multi-method in focus, involving an interpretive, naturalistic approach to its subject matter (59). This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret

phenomena in terms of the meanings people bring to them. This is what was done in the current study where by I stayed in the community for a period of one month trying to understand adolescents in their natural setting as regards to use of family planning services. Emerging theories in adolescent reproductive health have shown that there are a lot of issues underground that need to be understood before concluding adolescents' behavior and non-use of family planning services (49; 56). Bryman (2001) opens it up that in ethnographic studies the researcher is immersed in a social setting for a period of time, observing behaviors, listening to what people say in conversations, asking questions, collection of documents of interest and relevance to the study and conducting interviews (60). Despite being a Malawian, there were certain things which I was unfamiliar with as regards to the setting and required me to understand them fully by getting immersed into the society.

Within qualitative methodologies, triangulation of methods was further employed so as to have rich data from different approaches which was compared during analysis. Triangulation is most often thought of as referring to obtaining information from multiple sources and it is usually based on the researchers wish to obtain multiple perspectives on a phenomena (61). The study therefore, used two data sources, adolescents and key informants (KIs). I used focus group discussions (FGDs), KIs, individual interviews, general participant observations and some limited discourse analysis to study the phenomenon. According to Jick (1979), triangulation within a single method addresses internal consistency and reliability issues (62).

3.3 Study Setting

The study was conducted in Mangochi District southern part of Malawi. Apart from the researcher's familiarity and working in the district for a period of time, the district has a number of programs targeting adolescent sexual and reproductive health issues. The study specifically took place in Lungwena Community in the catchment area of Lungwena health centre within Mangochi District where a number of studies in the Norway /Malawi NUFU collaboration take place.

3.2.1 Lungwena Community Profile

Lungwena community is located approximately 40 kilometers away from the main district town of Mangochi. It has a total population of approximately 23,100 and 26 villages from the two Traditional authorities (TAs) namely Makanjira and Chowe. In Lungwena, 18.3% of the population is under age 5, while 49% is below age 15. The population has more females, noted at sex ratio of 93 per 100. The area is 20 kilometers long and roughly 5 km wide rural

area in the Rift Valley between the escarpment and the south-eastern shore of Lake Malawi (63).

The area is dominated by *Yao* ethnicity (94.4%), however other tribes also exists in minority such *Chewa, Tumbuka, Tonga, Lomwe* and *Sena*. The population is predominantly of *Yao* in origin and followers of Sufi Muslim, thus the main language is *Chi-Yao* (mother tongue) even though *Chi-Chewa* an official national language is understood by many. Family organization is matrilineal and land is also inherited by women (63). However, men are normally considered heads of households because they have a stronger influence on important family decisions. Farming and fishing form the main occupation, although the main sources of income are fishing, farming, petty trade and migrant labour. The health centre in the community provides normal preventive and curative modern health services like family planning, ante-natal and delivery care, growth monitoring, vaccinations, and treatment of common illnesses. The health centre is staffed by nurses and medical assistants, but no doctors.

3.4 Study Period

The study was carried through a period of 12 months. The first three months from March to May was for proposal development that includes writing a research plan, literature review and writing a methodology paper. In May, the study protocol was first submitted to ethical research committee in Norway. From June, the researcher underwent the process of submitting the proposal of the study to ethical committee in Malawi, the country where data was collected. Reviewing the proposal took several months, and actual data collection took one month. The period of waiting for approval from the ethics committee was devoted to general interactions in the study area to gain familiarity, attending to cultural cerebrations in the community and reading through news papers which had related topics to this study. Because I was not new in this community, it was easy for me to follow the cultural events happening and I was able to attend.

3.5 Study Population

Adolescents and KIs in Lungwena community were the study population. The core participants were both married and unmarried adolescents from both sexes. Adolescent boys were specifically involved to find out if gender has an impact on negotiation skills on using family planning services and to explore their perceptions as well on the study topic. In total I had 11 KIs from different backgrounds. Their background characteristics were as follows;

four were parents, one traditional birth attendant (TBA), one female initiator, two teachers, one health surveillance assistant (HSA), one community based distributor agent (CBDA) and one nurse midwife in the family planning clinic. The KIs were considered at three levels as follows;

Community level- One traditional birth attendant (TBA), one female initiator[6] (*nankungwi*), and one health surveillance assistant (HSA).The TBA was included purposely to understand her views on how she perceives the adolescents pregnancies and deliveries because in this community literature has shown that many women deliver through TBAs (64). Therefore, it was important to understand whether she encounters a lot of problems with adolescents who seek assistance during the time of delivery. The HSA was included because HSAs are involved in primary health care prevention which includes distribution of family planning methods and conducting health talks. The female initiator was specifically included because she counsels adolescent girls during initiation ceremonies on moral behaviours including sex education. As a result, it was important to learn from her on how she perceives adolescents' behaviors and if use of family planning services is ideal for them. Views were further explored from four parents (equally divided according to sex), who were currently having children of the adolescent age. These gave me opportunity to explore the community's perceptions from parental point of view as regards to adolescents' sexual behaviors and use of family planning services. Also parents are in constant contact with adolescents' and therefore can easily advise them about their sexual behaviors and encourage them to protect themselves by using the services.

Service provider's level - One nurse midwife who works in the family planning clinic was considered and one Community based distributor agent (CBDA). Because of their experience in family planning delivery, they were considered important to understand how they perceive adolescents sexual behaviors in this community and the reality of using family planning services among adolescents.

School level – Two teachers in command of teaching life skills subject in primary education were involved. Other studies have shown that life skills education have proved a positive

[6] The initiator is the one who stays with the initiates during the initiation ceremony and is the one responsible for all lessons especially among the girls. For the boys, the initiator is primarily responsible for circumcising the boys but in terms of lessons, other selected people who are known to be good counselors in the society perform the job of counseling the initiates

change in adolescent sexual behaviors such as empowering girls to make decisions on the type of sex (65). Consequently, it was found that girls had made informed decisions of using contraceptives in those studies (ibid). In addition, the school becomes a second home for adolescents who go to school as they spend most of their time at school with the teachers than parents or guardians. Therefore, it was important to investigate how teachers perceived the behavior of school going adolescents' in relation to the phenomenon.

3.6 Sample Size

As an exploratory study, there was no need to draw a probability sample because no hypothesis was to be tested. Thus a purposeful sampling was used and in Patton's view (1990), all types of sampling in qualitative research may be encompassed under the broad term of 'purposeful' sampling (66). This implies that the sample is intentionally selected according to the needs of the study. Miles & Huberman (1994) further justifies that purposeful sampling permits the selection of interviewers whose qualities or experiences permit an understanding of the phenomena in question and therefore variable (67). Homogeneous sampling was specifically used aimed at understanding and describing the adolescents in the community. In addition, snowballing approach was used to identify adolescents for individual interviews. However the actual sample size depended on the number of the adolescents who accepted to take part in the study and reaching data saturation[7].

For the purpose of planning, there was a target sample for individual interviews in all three selected villages which was 24. In each village, 8 adolescents were targeted and the break down was two unmarried and married adolescent boys and girls in one village and in three villages, it came to a total of 24 adolescents. However, this plan was achieved as 24 individual interviews were conducted. Out of the 26 villages in Lungwena catchment area, three villages namely *Chapola*, *Ng'ombe* and *Biti-kalanje* were also purposely selected based on the fact that they were big villages and had more households with adolescents comparing to the rest of the villages. For instance, the total population in the 3 selected villages was as follows; *Chapola* village has 2,344 people and 218 households with adolescents, *Ng'ombe* village has 4,117 people and 231 households with adolescents, and *Biti-Kalanje* village has 1,621 people with 162 adolescents' households (63). Secondly, all the three villages were at least in the same direction and considering the limited time and resources during the study period, it was easy to move from one village to the next. For FGDs, 40 adolescents were planned for, to take

[7] Data saturation in qualitative studies implies reaching a point at which no new information or themes are observed in the data.

part in the study and were to be divided into a group of six people in each session. Therefore, with two sessions in each village, it added up to 36 participants who actually took part in the FGDs.

However the sampling process was not fixed. It was flexible and evolved as the study progressed until the point of redundancy in emerging themes was achieved.

3.7 Sample Recruitment and Procedure

All adolescent participants who took part in this study were assumed to be potential users of family planning services. As an exploratory study this was important because recruiting only adolescents who already use the family planning services would have not given the data about those who had wanted to use but could not use the services. As such, it was open to every adolescent but with the target sample in mind. The initial plan was to randomly select participants from the households with adolescents. However, during data collection it was not a reality because, many adolescents' in those households were no longer available. Through consultations, it was found that some had gotten married, moved to stay with relatives somewhere, and many reasons were reported. As such the recruitment procedure changed and I recruited the participants by working hand in hand with the management team of the community. Field guide report on qualitative research methods informs that recruitment strategies are typically flexible and can be modified if new topics, research questions, or subpopulations emerge as important to the study (68).

In order, to meet the management team, I consulted the clinician at Lungwena health centre (Mr Pondani) to inform those who were in the management team in the three selected villages. Two members of the management team were found and one was working for both two villages selected so he made the work easier on this part. I informed the management team[8] about the scope of the study and how I wanted them to help me. Through them, I wrote letters to inform the village leaders about the study and further explained that adolescents' and some KIs will be consulted for interviews.

I booked an appointment with the village leaders two days in advance before the day of starting interviews in each village to talk to them face to face about the purpose and the scope

[8] Management team- In Lungwena catchment area, there is a management team committee that was established to help in the village with many issues pertaining to the health centre. Lungwena is a training health centre for students within and outside Malawi for community health, therefore all people who go there to carry out a study, they go through the management team.

of the study. I further discussed with them about the length of time I would spend in the village, when and where to meet the participants for FGDs and individual interviews. A day prior to the interviews, the management team consulted a number of adolescents' for FGDs whom I met at the village headman's house. I explained to them about the scope of the study and those who agreed, I sought consent from their guardians. KIs within the village were also contacted through the help of the two management team members. I worked hand in hand with the management team until I finished data collection.

During the day of the interviews, I reminded the gathered adolescents about the scope of the study, and divided the group according to gender for the FGDs. The male research assistant conducted the FGDs with boys and I took the girls. All the meetings for FGDs were scheduled for the afternoon, from 3 o'clock to 4 o'clock. The discussions took approximately one hour.

I recruited participants for individual interviews through snowballing approach. Individual interviews were conducted in the morning however with snowballing approach, some days I had two interviews only instead of four and kept on varying depending on availability of the respondents. The management team members, local traditional leaders and all participants in the study were given tablets of soap in appreciation of their time.

3.8 Data Collection Techniques and Tools

All interviews were conducted in local languages namely *Chi-Chewa* and *Chi-Yao*. Variation of the language depended on the type of respondents, For instance, adolescents preferred *Chi-Chewa* while some KIs with exception of the two teachers and mid-wife nurse, interviews were conducted in *Chi-Yao.* The main tools employed were content interview guides through FGDs, individual adolescents' and KIs (see appendix 1, 2&3). General participant observations and some limited public discourse analysis were also done.

3.8.1 Interviews

Rogers and Bouey (1996) asserts that the most utilized data collection method in qualitative studies is the interview (69). As an exploratory study, semi-structured interviews also known as guided interviews were used to collect data. I developed two content guides (one for adolescent participants and one for KIs) which were used to collect data (see appendix 1, 2&3). With an open approach, the content guide opened up to many discoveries that helped us to find complex issues to probe on. Flick (1998) acknowledges that the guides allow researchers to generate their own questions to develop interesting areas of inquiry during interviews (70). The interview guide included questions on the following:

- *Reproductive health problems facing adolescents in the community.*
- *Adolescents and community perceptions on adolescents using family planning services (contraceptives and family planning programs)*
- *Socio cultural factors affecting adolescents accessibility to family planning services*
- *Reasons why adolescents do not use contraceptives at first sexual intercourse*
- *Barriers faced by adolescents towards utilization of family planning services*
- *Existing sexual and reproductive health care services for adolescents* (see appendix 4 & 5).

Themes to be elaborated were sexual coercion, contraception, norms for girls and boys, adolescents' attitude, parental attitude and community attitude among others. Technical terms like reproductive health problems were defined and simplified in simple terms such as pregnancies, sexual activity and STIs so as to provide a common understanding between the interviewer and the interviewee.

3.8.2 Pre-testing

In the words of De Vaus (1993), "Do not take the risk. Pilot test first". These are important reasons for undertaking a pilot study (71). In this study, it was important to pre-test the guides before actual data collection so as to revise the tools for actual data collection. During pre-testing, a number of issues were noted such as how questions were accepted by the respondents, willingness to respond to some questions and availability of respondents. Further, the exercise looked at how much time was approximately required per interview guide and whether the tools were collecting the information needed. In addition, this was also the time to pre-test the research assistants to examine the success of training. Data from pre-testing was transcribed and translated within two days. Finally, the guides were revised to be used for actual data collection. According to Baker (1994) one of the advantages of conducting a pilot study is that it might give advance warning about where the main research project could fail, where research protocols may not be followed, or whether proposed methods or instruments are inappropriate or too complicated (72). This is the reason I attempted to do pre-testing during my study.

3.8.3 Individual Depth Interviews with adolescents

The researcher conducted repeated individual interviews with adolescent girls and the male hired research assistant conducted the interviews with adolescent boys. In total 24 individual interviews were conducted with adolescents. This was the major method of data collection from adolescents which was supplemented with data from FGDs and observations. Probing was done whenever it was necessary. For instance, if some of the issues were unclear or were communicated in jargon, probing was done so as to capture the main idea. Although some

participants were going much further in the discussion but with the help of the guide, all important themes were uncovered and probed for.

It was a good plan to triangulate methods in the current study because most of the issues discussed were sensitive and variations were noted that in individual interviews, more sensitive issues were uncovered than in FGDs. For instance, some participants gave their own experiences in relation to the themes discussed. Patton (1999) justifies that the aim of qualitative research is to go below the surface of the topic being discussed, explore people in much detail and uncover new ideas that were not anticipated at the outset of the research (73).

Kvale (1996) asserts that qualitative research interviews attempts to understand the world from the subject's point of view… and to unfold the meaning of people's experiences (74). By just introducing the study topic, participants were more concerned about the adolescents' reproductive health problems in the community and discussed them in detail. As such, I included the objective that addressed the major adolescents' reproductive health problems in the area.

Patton (1990) points out that any face-to-face interview is also an observation. Thus non-verbal messages were noted during interviews and this gave the researcher an insight to ensure an in-depth detailed understanding of the participants (66).

To respect issues of confidentiality, interviews were conducted at a desired place chosen by the respondent, but at the same time the interviewer and interviewee helped each other in identifying a place which was conducive to use a tape recorder.

3.8.4 Focus Group Discussions (FGDs)

FGD is a very flexible tool useful for exploring topics about which little is known (66; 74). The aim of using FGDs was to explore the participant's views about adolescents' using family planning services from a group point of view. Kreuger (1988) argues that FGDs taps into human tendencies where attitudes and perceptions are developed through interaction with other people (75). A total number of six FGDs were conducted. FGDs were further considered to take care of the social desirability bias[9] which is more common in one to one

[9] Social desirability bias is where respondents have a tendency to "adjust the truth" so that they sound nicer, richer and more desirable to the researchers.

interviews. Babbie (1983) also noted that whenever people are asked for information, they answer through a filter of what will make them look good (76).

According to Morse G (1995) FGDs refer to a qualitative method that gathers people with similar background or experiences to discuss a specific topic of interest in research (77). Therefore, to facilitate a free discussion, sex composition was considered such that we conducted separate sessions for boys and girls. Hence, a total of six FGDs were conducted as follows; two FGDs for unmarried girls and three FGDs for unmarried boys. In one village, I conducted a mixed FGD for married and unmarried adolescent girls because, I could hardly find unmarried adolescents to form a group of at least five participants. Most of the unmarried adolescent girls were already interviewed during individual interviews hence limiting the participants in the FGD. However, the information from the mixed group was very relevant considering the fact that many girls in this community marry early and their opinions on the phenomenon were ideal. Tape recorders were used to record the discussions and were labeled with date of the interview, type of the group and name of village. Discussions were conducted in a natural setting and we tried as much as possible to find a place which was free from any disturbances. Communication and interaction was encouraged during discussions and probing was done where necessarily. During discussions, attention was given to both verbal and non-verbal communication and short notes were taken which were later expanded on after the interview. Each discussion lasted for approximately one hour.

Any FGD requires a good knowledge of local conditions implying that communities are never the same. As such in this Muslim community, gender was considered as boys FGDs were conducted by a male interviewer and I conducted the girls' discussions. To ensure consistency of the interviews, the research team was meeting every evening to discuss how some questions were phrased and enlightened each other on the themes. We could also exchange the tape recorders to listen how the interview was conducted.

3.8.5 Key Informant Interviews (KI)

KI interviews were conducted with people in the study area that are known to have good command of the social and cultural norms on their community and a particular position in it. A total of 11 interviews were conducted with KIs from different backgrounds so as to capture varying perspectives and underlying issues pertaining to the phenomena. As an exploratory study, ideas generated from different angles helped to create a more complex understanding on the phenomena.

Interviews with KIs took a period of one week because I had to make appointments with them on their specific time to conduct the interview. All the interviews were done in their respective homes except for the two; teachers and the nurse working in the family planning clinic of which I interviewed them at their work places. I interviewed eight KIs namely; two teachers, nurse midwife, HSA, and four parents. The female research assistant interviewed the TBA, female initiator and the female CBDA. The male assistant took the role of transcribing the KIs interviews. Using face to face interviews with the KIs allowed a free exchange of ideas and it led to more complex questions and getting more detailed information. Probing was done to allow clarity on interesting and relevant issues. On each interview, option was given at first to choose the language they had wanted because despite *Chi-Yao* being mother tongue language, *Chi-Chewa* (national language) is also spoken largely.

3.8.6 Participant Observation

Participant observation was done from the very first day I entered into the community. Since I became part of the community, I had chance to observe a variety of things including their traditional dances for initiation ceremonies. According to DeMUNCK and SOBO (1998) use of participant observation affords access to the 'backstage culture'[10] (78). For instance, through socialization, I was able to chat with the adolescents' especially during the late afternoons and weekends when most of them went to the lake. As such, I managed to observe their interactions and behaviors as well. I had a diary for observation notes and in some interviews; I brought up interesting issues I had observed for clarity. DeWALT and DeWALT (2002) suggests that participant observation can be used as a way to increase the validity of the study, as observations may help the researcher to have a better understanding of the context and phenomenon under study (79). I further paid particular attention to the health centre and observed two family planning sessions. Integrating myself into the community helped me to understand the contextual background of the participants through recording their cultural activities.

3.8.7 Discourse analysis

It was important to listen to different radio stations in the country, watch television and read daily news papers to gain information on diverse socio-cultural context on how adolescents are perceived in Malawi. Prior to my knowledge, different news papers helped to advance my

[10] Back stage culture- According to DeMUNCK and SOBO (1998), provides opportunities for viewing in unscheduled events.

level of understanding on the socio economic factors in Malawi, the cultural practices in different districts and health problems in the country. In addition, radio programs on HIV/AIDS had provided some background understanding in relation to the study topic. For instance, there were many radio programs targeting adolescents' behavior in the current world of HIV/AIDS. This helped me to have a good overview of how adolescents are understood in Malawi in general.

3.9 Research Assistants and Training

Two research assistants were hired through consultations to find local young people aged from 19 to 24 to help in data collection, transcribing and typing. I enquired about the local research assistants who had a good experience in the in-depth interviewing skills. Moser & Kalton (1986) informs that the success of good semi-structured interviews depends on the interviewing skills of the interviewer (80). The 19 to 24 age range was considered for research assistants because I wanted to take care of the age gap of the adolescents and at the same time I wanted assistants that had finished the secondary education in Malawi. The two research assistants hired had completed their secondary education, were recommended to have good experience of interviewing skills and had a good command of the local language.

The female research assistant was hired to assist in transcribing and typing which was running concurrently with data collection. In addition she was hired to interview women KIs to justify how different interviewers would generate data on the same phenomenon. The male assistant was hired to conduct interviews with male adolescents'. Although I did not find studies that presented information documenting the importance of the researcher's gender in conducting the in-depth interviews, other authors have tried to explain the relevance of it. For example, Misher (1986) cited in Williams et al (1993) has shown that a successful interview involves the active participation of both interviewer and respondent in a joint construction of meaning which could be the same gender (81). DeVault (1990) further describes how this process of developing shared understandings is thoroughly gendered. She argues that individuals in the same sex pairs usually assume that they share certain background experiences (82).

Thorough training of the research assistants was done for two days and to maximize the time both of them were trained on interviewing and transcribing. During training, they attempted mock interviews to see if they had understood the guides and the scope of the study before

pre-testing the guides[11]. After pre-testing, we helped each other in revising the guides and on how we could approach important themes. Moser & Kalton (1986) asserts that to obtain accurate and complete data yet maintaining sufficient standardization to secure the validity and reliability of data is a major challenge to interviewers and depends upon thorough training (80).

3.10 Researchers Role

Deborah et al (1998) asserts that qualitative research involves the "researcher as instrument", wherein the researcher's use of self is a primary tool for data collection (83). With a background as a research assistant working in the reproductive health area, and especially in the same community where the study took place, I had a particular advantage because I was aware about the contextual background of the population in the area. For instance, knowledge about their culture and their socio economic status helped me in planning and approach of the current study. However, my previous experience as an interviewer and supervisor in qualitative reproductive health studies helped me to understand the importance of not concluding issues based on assumptions but finding out from the people themselves always gives concrete solution to the assumptions. As such while collecting data, I acted as somebody naive of what could be the underlying factors to adolescents' low utilization of family planning services because I wanted to explore their perceptions. Therefore, analysis is also towards reporting what the participants said. However, communicating with adolescents' was not a problem to me because I was aware of how to approach them as regards to this community and where to observe them. For instance, the lake is the best place in this community because many adolescents' like chatting by the lake in the afternoon as boys go fishing while girls go washing and cleaning plates.

My assumptions were that adolescents did not use family planning services probably because they did not want them or probably other factors were limiting their use if they had wanted them. My interest in working with adolescents grew further after previously staying in the community understudy and observing the problems of early pregnancies among adolescent girls assuming that they were problems to them. I linked the early pregnancies to unprotected sex and indeed the consequences of early and unprotected sex among adolescents' poses a threat to an adolescent life.

[11] Mock interviews are those interviews that research assistants perform among themselves like a role play whereby they take the field scenario.

3.11 Data Handling and Analysis

I conducted all the interviews with female adolescents' and the male assistant conducted the interviews with the male adolescents'. The female research assistant helped in interviewing some female KIs. Upon completion of each interview, the cassette was labeled by date of interview, name of interviewer, village, and respondent category (FGD, KI or individual).[12] Summary notes were written on each interview. Transcribing started right away in the field so that we could see where the data was limited and needed supplementation or further understanding. Two call backs were made on individual interviews after discovering that there were important issues raised but were not probed on. Due to limited time, the three of us were all involved in transcribing the recorded data straight into English. However, to ensure validity, we exchanged the cassettes. I and the female assistant transcribed the data of the male assistant and he transcribed my data and those done by the female assistant. Since the cassettes were many, I had to help in transcribing my own data as well but in the end I asked one of them to listen from the cassette and go through my transcripts. Data was transcribed in verbatim.

Immediately after transcription, all the transcripts were typed and kept in a secured place. The hired female assistant could not finish typing all the transcripts in the limited time so I typed the rest of the transcripts.

Data analysis started together with planning of data collection. In the process of collecting data several issues related to the study topic were taken into consideration and documented which formed part of the analysis. In addition, I synthesized a number of themes during the planning of data collection and together with the research question and objectives of the study formed a background to start with analysis.

From theoretical perspectives, flexible and open grounded theory approach was incorporated to help in identifying main themes during analysis and formulation of categories and patterns in the data (84). Therefore, notes from observations, discourse analysis and transcribed data were brought together. Transcripts were read several times to understand what the data was communicating in the first place. Then, main themes were highlighted and identified by using multiple colored highlighters. These themes were grounded into categories which were

[12] Respondent category, in addition to whether it was an FGD, key informant or individual interview also looked at whether the FGD was for boys or girls, the individual interviews were with a boy or girl and the position of the key informant.

matched with the objectives and a pattern was formed. A thematic table was drawn in which the themes and sub themes were placed with relevant quotes.

Main themes and sub themes were coded in the following identified thematic areas; adolescents perceptions on using family planning methods, community perceptions on adolescent using family planning services, adolescents accessibility to family planning services, reasons for not utilizing the family planning methods and availability of adolescent health care services. Data was analyzed manually.

3.13 Dissemination of Findings

According to Malawi College of Medicine Research Ethics Committee, a final report of the thesis with an abstract will be submitted to the College of Medicine Library. Presentation of the findings will be done at the International Dissemination Conference which falls in the month of November every year at Malawi College of Medicine.

Again a copy of the report will be given to Mangochi District hospital office and Lungwena health centre for documentation. In addition, an article will be written with an aim of publishing in peer reviewed journals and presenting at the conferences. The final report in form of a thesis will be handed to the Department of International Community Health as a partial fulfillment of the Master of Philosophy in International Health Programme. In addition, the thesis will act as a reference material for future students undertaking the same programme at Oslo University.

3.14 Ethical Considerations

3.14.1 Informed Consent

Declaration of Helsinki (1964) states that informed consent is a prerequisite for all research involving human beings and that a signatory of the research subject demonstrates that an informed decision was made (85). Therefore in this study, written and verbal consent was sort for all participants who took part in the study. The research assistants were well trained on the importance of obtaining consent and before starting each interview, the scope of the study was narrated and research subjects were further told about how the interview was going to be conducted. Emphasis was further drawn on how the results would be used and their freedom of participation (see appendix 4). They were also informed why tape recorders were going to be used through out the study. The research assistants were aware of informing the study participants about any changes that would arise in the course of the interview due to

unforeseen circumstances. Giving them such information was based on the fundamental moral duty that the principal investigator was not acting against the participants wishes and that the person's human dignity was respected.

According to Data Collectors Field Guide report, it was not necessary to obtain consent for participant observations (68). The permission granted to conduct the study in the community was justifiable to carry out observations as well because our research team became part of the community. However, I made a personal commitment to protect the identities of the people I observed. I only asked for consent when I was observing the family planning sessions from the in-charge of the health centre and the volunteer on duty who conducted the sessions.

3.14.2 Assent Form

In Malawi, special ethical and regulatory considerations apply when conducting research with persons under the age of 18 years. Since this study had involved study subjects from the age of 12 years, an assent was sort from the adolescents falling in this age which was confirmed in signing. For those who were not married, their parents or guardians were asked for the consent and this was explained to the adolescents' participants during introduction of the study but adolescents were required to consent as well. Before the research subjects approved and signed on the assent form, I was very honest to tell them about what we wanted to learn from them using the referred appendix in section 3.14.1. For those who were married, their husbands were just informed for reasons of politeness and no parental consent was sought because some of them had their own homes and were living their own life. The issues of how to obtain assent from parents were discussed with the Research Ethics Approval in Malawi (see appendix 5).

3.14.3 Confidentiality

I addressed the issues of privacy and confidentiality to all participants who took part in the study. I trained the research assistants on how to respect confidentiality of the respondents and their opinions and I kept reminding them throughout the course of the study. As a general rule from Declaration on Ethics Considerations regarding Health Database, the information was de-identified. In face to face interviews, the first thing before the start of interview is stabling and building rapport so that the respondent(s) builds trust in the interviewer. Eventually, the major emphasis in the process of building rapport was to explain issues of confidentiality. Therefore all adolescents who took part in the study were not asked to give their names. Only some demographic characteristics were sought such as gender, age, level of education and

religious affiliations. Participants involved in FGDs were therefore given nick names such as *P1* to denote their names (see appendix 1).

Maintaining confidentiality implies ensuring that particular individuals can never be linked to the data they provide. However, in interviews with KIs it was a challenge on how to make the information de-identified because these were the key people and each of them had a title in the society. In this situation, data was to be analyzed according to individual perspectives. However, I discussed with them that data would not be disclosed to any other people but it will be analyzed and the report will be written according to how the data was collected. We agreed based on the fact that the report will be potentially attributable to them. Among the KIs, it was only possible to analyze the data from parents anonymously because the demographic characteristics incorporated only their gender and the gender of their adolescent child/children. Lack of clear qualitative guidelines limited the researcher on how to maintain the analysis of the KIs de-identified.

To ensure maximum confidentiality, all the interviews were conducted at a place where other people who were not involved had no access to the discussion. Repeatedly during probing, issues of confidentiality were communicated to the participants. We made it open that signing the consent and assent forms implies that the respondents have also abided to the rules of confidentiality in the study. Signing was optional whether in writing or thumb print. All the interview guides, consent and assent forms were translated into their local language for transparency.

3.14.4 Ethical Clearance and Approval

Data upon which I had presented the results today would have not been done if the ethical committees in Norway and Malawi had not approved and recommended the Principal Investigator to carry on data collection. Before leaving Norway for field work in Malawi, the protocol was handed in to the Research Ethics Committee in Norway to seek approval in the month of May 1997 and the protocol was approved (see appendix 6). In Malawi, where the study took place, the protocol was submitted in August and the approval was obtained in December giving limited time of data collection as the Principal Investigator had to return back to Norway in mid January for the spring semester (see appendix 7)

3.15 Field Challenges

Late approval of the protocol by the Research Ethics Committee in Malawi was a big challenge as data collection started late and a lot of work was also supposed to be completed

before I came back to Norway. As such I did not observe the clinic set up of Malindi Private Hospital and Mangochi District hospitals of which the adolescents' recommended and I felt I had observed them. Secondly, finding unmarried adolescent girls was not an easy task and it led into changing of initial plans in which unmarried girls were supposed to have their own FGDs in all the three villages but it resulted into mixing them with the married adolescents in one village. Therefore among the girls, two FDGs were purely conducted as planned but one was mixed having both married and unmarried adolescents.

Chapter 4. Contextual Background

4.1 Introduction

The aim of the study was to explore contributing factors to low utilization of family planning services among adolescents. The core part were identification of adolescents' to participate in the study and people holding key positions that gave them knowledge in the study topic. To achieve the study's main objective, data was generated through individual interviews, FGDs, observations and some limited discourse analysis as explained in chapter 3 of methodology. This chapter therefore takes us to understand the contextual background of the adolescents' living in Lungwena area by presenting a case study from one of the KIs. The case study has formed the foundation of the results and discussions that are presented in chapter 5 because it leads to emerging themes that are discussed to give an overview of adolescents' living in Lungwena area.

4.2 Contextualization of Family Planning

Triangulation of methodologies used in this study was an important tool to understand opinions from adolescents and KIs on how family planning is perceived by adolescents' and the community in general in this society. To understand a broader view of contributing factors to low utilization of family planning services, a case is presented in this chapter based on in-depth discussion with one of the KIs. This case is chosen because it is interesting to me and it unfolds common issues which came out from all participants in the study topic. Pettigre (1988) noted that it makes sense to choose cases such as extreme situations and polar types in which the process of interest is "transparently observable" (86). According to David Silverman (1993) when a pattern from one data source is corroborated by the evidence from another, the finding is stronger and better grounded (87). I started my discussion by asking him the major reproductive health problems facing adolescents' in that community. A KI teaching life skills education subject at one of the primary schools in the community explained as illustrated below:

Here our girls get pregnant at early ages of not more than fifteen years and they marry men who are much older than them. These men usually stay in South Africa where they get employed and when coming back they bring, or carry materials like cell phones, screens and money which they give to these young girls and their parents as well. Due to financial problems, these girls get attracted and as a result they marry men who have two to three wives. After being impregnated, they get abandoned and by then, they are already with a baby. The other problem is cultural practices. In this society, when young people come back from initiation ceremonies, especially girls do not fear men sexually. Whether a man is old they do not care. Also the cultural practices encourage them to have sex at a young age, as a result most of the girls get used to such a behavior and they get pregnant at a very tender age, sometimes they do not even realize that they have become pregnant. Since they do not fear men and go out with different men, sometimes they get infected with STIs or even HIV and feel shy to go to the health centre to seek medical help. Those who are known to have STIs stop coming to school because their friends laugh at them. Also here most people are very poor and if they find that they have a kid especially a girl, they saw themselves getting relieved from poverty soon and also to get rid of their responsibility in looking after their kid, parents look for a man to marry their young girl without her knowledge and consent.

The reproductive health problems presented in the above narration are more centralized on the girl child than on the boy child. For instance, issues of early pregnancies, early marriages and having older sexual partners in this context are all related to girls. This prompted me to understand and observe more of the family structure in this society and how gender roles are ascribed. In the process of our discussion, I asked him about his perceptions on adolescents' using family planning services. He explained that it was very important and gave a detailed explanation as indicated below;

It is very important that adolescents should be using family planning services so that they can be prevented from the unwanted early pregnancies and STIs. Already here at school we have Edzi Toto[13] club that sensitizes our students about the consequences of having unprotected sexual intercourse. This group is also assisted by the health centre which supplies them with condoms.

Despite acknowledging the importance of adolescents' using family planning services, it was noted that there was a clash with their customs which indirectly discourages adolescents' from using the family planning services. I noted as he said,

But as teachers our emphasis is that adolescents should refrain from sex (abstain), because a condom is not hundred percent perfect. As teachers we also discourage them to use pills because it is involving, that means every day they have to use the pills which we do not

[13]Edzi Toto literal translation implies (HIV/AIDS NO) it is a club which is found in primary schools, secondary schools and in tertiary education to sensitize young people in issues of HIV/AIDs and reproductive health issues.

think our young girls can manage. For married adolescents we also encourage the ABC approach that they should be faithful to their partners[14]

Although the condom is not one hundred percent perfect but when used correctly the probability of protecting a pregnancy and STIs including HIV/AIDS outweighs the risk of having unprotected sex. Adolescents use of family planning is a complex issue in this society as the cultural norms indirectly discourage the practice of using the services especially among unmarried adolescents'. I captured this when I had asked him the possible reasons on non-use of the services among the adolescents. He said as illustrated in the quote below:

All of them are influenced by culture as I have already told you that parents resist their daughters to use family planning, it is better they marry if they find a boyfriend. Parents think that if their children marry, the husbands whom they marry will assist the whole family. Some do not use the services because they are afraid of the health providers whom they think will shout at them. They prefer buying condoms but it is also expensive. Boys believe that if they use a condom, girls will not trust them."[15]

This narrative part influenced me to understand what happens in their everyday life in this society and it led me to look into main themes that give the background of the adolescents' living in this society. The themes emerged are (a) culture and sexuality, (b) gender roles and sexuality, (c) religion (d) family structure, and (e) social economic factors and sexuality. Going through these themes will give a complete background and an understanding of the adolescents living in the study area and whether using family planning is ideal to them. Michael Huberman (1994) says the holistic approach must give attention to both the individual's unique phenomenology and the larger social context in which these subjective meanings for experience are acted out (88).

4.3 Culture and Sexuality

The word culture is difficult to define, but it is hard to avoid in a discussion of ethnography. Borofsky (1983) defines that culture constitutes the very matrix within which people formulate their ideas and in which they carry out their activities (89). In our study, adolescents' are caught in a situation whereby they seem to be victims of cultural change. Due to modernization they receive conflicting messages within the society in which they are growing. For instance, with the pandemic of HIV/AIDS, there are messages from media, government and non governmental organizations (NGOs) which are against the cultural

[14] ABC approach implies that people should either abstain, or be faithful to one another as sexual partners and the two fails they should use a condom.
[15] The reasons indicated in this quote of why adolescents do not use family planning are also the ones which many adolescents' participants in this study said.

practices which are considered high risk to the life of adolescents. On the other hand, culture demands them to undergo some rites of passage[16] which is a right to social integration. Like other societies in different regions of Malawi, the Lungwena society has its own rites of passage that are carried out in form of a cycle, from birth to death. For instance, special cultural practices are performed when a woman is expecting a baby, after delivery, during the pre-adolescent, after puberty, entering into marriage, infertility in the family, and when a person dies. Some of these cultural practices have a strong bearing on shaping the behaviors of adolescents in Malawi. For the sake of this study, I will concentrate on the initiation ceremonies which are performed among the pre-adolescents' and adolescents' because they are mentioned in the case presented as one of the underlying contributing factor to adolescents' low use of family planning services.

4.3.1 Initiation ceremonies

Initiation ceremonies are traditional forms of sex education. Historically, sexual initiation was part of initiation rituals performed in most of sub-Saharan countries (90). In many rural context these are still practiced, though to a lesser extent or in changed forms. According to Malawi Human Rights Commission (MHRC) report, the fact that these practices have existed for many years, means that they may have served an important role in the survival of the group (91). In Malawi, young people undergo some initiation rites before and after they have reached puberty. The procedures vary according to the culture found in the region. For instance, in the Northern region of Malawi, initiation rites are not conducted in a formal way as they are in the Southern region and some parts in Central region. In the Northern region, when the girl attains puberty the elderly[17] people sits down with her to explain what has happened and how she should live her life after puberty. Additional lessons are given with emphasis on avoidance of premarital sex, respect of parents and close attention to her body during menses. Little is known to what happens when the boy attains puberty in the northern region. In the Central region, the main emphasis is also to teach girls to wait for sex until marriage. In the Southern region, the primary lesson is the same but in this society it is found that they have additional lessons on sexuality that is to prepare the girl and the boy for marriage life (91-92).

[16] Rites of passage are numerous ceremonial events, existing in all societies that mark the passage of an individual from one social or religious status to another.

[17] Adults are people like grandmothers from both sides of the parents and auntie that are a sister to the girl's father. These are the ones who hold responsibility of telling the girl about what she is supposed to especially taking care of herself when having menses and general respect of adults including parents.

Initially the initiation ceremonies for girls in the southern region and especially in Lungwena area of Mangochi district (the area under study) were carried out in two phases. First, during pre-adolescent and secondly when the girl has reached puberty. In all these stages, girls were educated on how they could please a man sexually (92). With external pressures from school timetables, HIV/AIDS epidemic and change of government in Malawi, now the practice is only done once during the pre-adolescent. Girls undergo the *nsondo* initiation while boys undergo *jando* initiation[18] and it targets young people who have not reached puberty (approximately between nine and twelve years). The main aim is to mould the young people into acceptable human beings inculcated with the norms of the society. Respect for parents, all adults in the society and helping in household chores is also emphasized. As a form of respect, the initiates[19] stop entering their parents bedrooms and sometimes the boys move out from their parents' houses and sleep in the kitchen or either build their small hut just close to their parents' house.

In addition to moral lessons, research found that *Yao* culture further tells the initiates to practice sex (101). Khaila et al (1999) also observed that in some parts of the Southern Region of Malawi, both female and male initiates are considered unclean soon after initiation (93). They are, therefore, expected, and sometimes forced, to engage in sex to cleanse[20] themselves as a final rite. Failing to fulfill the requirement, the new initiates are warned that one of their parents will die. The process is called *kutsatsa fumbi* (removing dust) among girls and *kutaya mafuta* (spilling oil) among boys. In the past, to achieve the process of cleansing the initiates, a man was hired to have sex with all the girls in the initiation camp and the same was done with boys. Although now the process has changed that no sex should happen in the initiation camps but still some initiates are reported to be told to practice sex after the initiation ceremonies. Already this is contradicting information to adolescents' as at the same ceremony they are told to abstain and yet are expected to practice sex. Furthermore, telling adolescents' to practice sex at such early ages may expose them to sex when they are not psychologically mature to make informed decisions. In Kenya, Tanzania and Botswana, rituals associated with the transition from childhood to adulthood which included sex education have also been documented (94)

[18] Nsondo is intiation ceremony for girls and Jando is for boys only
[19] Initiates are those boys and girls who are going or have just graduated from the initiation ceremonies.
[20] Cleanse – when initiates are still in the camp, they are viewed as unclean and are therefore told to have sex so as to become clean. Traditionally, sex with a protection does not clean a person and this implies that they are supposed not to use a condom. Moreover, in the initiation ceremonies nothing like a condom is mentioned to the initiates because the intention is not to encourage them to be having sex, bit just to practice what they were told and it should be only once.

In Lungwena area, the initiation ceremonies are well organized. Boys and girls undergoing initiation ceremonies stay in the initiation camps away from their homes for a period of one month. The key person for the initiation ceremonies is the initiator, and among the female initiates is *nankungwi* (female initiator), while for male initiates is *ngaliba* (male initiator) who is also assisted by other people. The female initiator was one of the KIs in my study because of the particular role she plays during this time. These ceremonies always happen during the harvesting time so that parents can have enough food for the cerebrations and have sold some produce as well to buy new clothes for the new initiates. The initiation ceremonies are marked by the celebrations[21] to welcome the new initiates in their parents' homes and people in the community have overnight dances. I observed the cerebrations and the newly initiates were looking beautiful in new attires as the relatives were dancing and giving them money. As I was watching the dances, I asked one of the spectators (middle aged lady, of over thirty years), why people were so excited. She told me that this was the happiest moment especially to parents of newly initiated boys because sometimes boys die in the initiation camp if the circumcision was not properly done.

In this study, I did not recruit any of the newly initiates because they had not reached the adolescent age, which was the inclusion criteria for the respondents. However, many of those who were initiated in the previous years were among the respondents. In this study, some of the adolescents' through individual interviews confirmed to have practiced sex, immediately after graduating from the initiation ceremonies due to fear that one of their parents may die. At first, probing proved no results on the issue of practicing sex but when I asked their opinions on adolescents' using family planning methods, many recommended, both from FGDs and individual interviews citing that initiation ceremonies puts them at high risk of contracting STIs as they engage in sex with people whom they do not know properly. Like other participants, a fifteen years girl who had practiced sex after her initiation ceremony responded as shown in the following excerpt:

> *I think it is important that we adolescents learn how to use family planning services*. Why? *hmm... like me I had sex soon after I came out from initiation ceremony because we are told if we do not clean ourselves, our mothers will die so I did not want my mother to die just because of me. And if the man had HIV, he would have infected me*. How old were you then? *I was about seven or eight*. Do you know the man you had sex to and did you keep

[21] Initiation celebrations are well organized and relatives of the initiated child start preparing in advance that this year our child will be initiated and will need a new material to wear on the graduation day of the initiation. They also prepare for food as they invite other relatives to attend and usually the function is a big event.

on having sex afterwards? *I was lucky enough because he was a boy also young like myself and had just come from jando (boy's initiation) as well, because others have sex with older people.* I further probed. Did you keep on having sex with the boy you have just mentioned or may be any other man? *No, I had never had sex again with any other boy, it was once and I did not see him again, but I heard that he moved out from this village long time ago and I don't even know where he went.*

Whether having sex with a fellow young person or not, but such practices are risky because some young people have HIV as well through mother to child transmission. Other studies also indicated that the initiation syllabus in the elaborate ceremonies encourages adolescents' to experiment sex after the initiation (93-94). This further confirms Van Gennep's argument cited in Munthali et al (2006) that initiation rites denote entry from an asexual world to a sexual one (37). Some adolescents' further reported that using family planning services would help them to be protected especially during the overnight dances related to initiation celebrations. One adolescent boy said *"we dance the whole night and a lot of people engage in sex because most of them are very happy"*. Therefore, one can argue that having sex is another form of expressing happiness in this context.

Interviews with some KIs revealed that such practices have empowered the girls not to fear men sexually and have contributed to the increase of major reproductive health problems among adolescents' in the community.

4.4 Religion

In Malawi, a majority (55%) are Protestants, (20%) Moslems, Roman Catholics (20%) and traditional indigenous beliefs and other minor religion constitutes (5%) (4-5). Protestants and Roman Catholics are widely spread through out the whole country in all three regions but Moslems are more concentrated in some few districts of the Southern region. As indicated in the methodology chapter, the society in our study area is dominated by Moslems and by looking at the number of mosques in the area, one could easily conclude that the *Yao's* are Moslems. Religious groups in Malawi are very influential in any change starting from politics through behavioral change. With the pandemic of HIV and AIDS, different religious groups have played a leading role on preaching against harmful cultural practices in the different communities. For instance, practices of wife inheritance, polygamy, death cleansing rituals and high risk traditional initiation ceremonies. It further preaches against premarital sex, multiple sexual relationships and encouraging couples to be faithful to each other.

Furthermore, religion plays an important role in shaping the sexual behavior of adolescents' in Malawi. Consequently, different religious groups have taken over the role of initiation ceremonies from traditional ones and encourage parents to have their children initiated through the organized religious groups. Boys are further encouraged to go to the hospital for circumcision.

Religiosity is negatively related to premarital sexual behavior. As such, religious groups in Malawi are currently going through a challenging time whereby it seems to be contradicting self on issues of premarital sex and having safe sex especially among the unmarried people. Caldwell (1994) cited in Chimbiri (2007) asserts that religious beliefs have been considered to be barriers to HIV prevention (95). For instance, from the biblical point of view, premarital sex is condoned and telling adolescents' to use condoms if they want to have sex is immoral, as people are supposed to abstain until in marriage. Catholics do not allow the use of modern family planning methods among married couples and the unmarried as well. Moslems too value procreation and using protective measures is not taken as a priority but it preaches that it is better people get married and have sex while in marriage. Similarly, in our study, adolescents' reported that parents told them to get married and have children rather than using family planning methods. This is supported by Munthali et al, who noted that teenage pregnancy and childbearing are generally accepted so long as it is done within marriage, otherwise it is strongly condemned when out-of-wedlock (37). In the Malawi weekend Nation newspaper, one featured article conceptualized the stand of church leaders in regards to unmarried people: *"we think the use of condoms among unmarried adolescents has contributed to the rise of HIV/AIDs among young people in Malawi because condoms make them confident that they can not become pregnant or impregnate a woman, as such many tend to use them only at first time and stop as the relationship grows"*. Similar statements were mentioned in this study by some KIs and some adolescents' as well.

4.5 Culture and adolescent sexuality

Malawi generally has a secretive culture on sexual issues. One article featured in Malawi newspapers conceptualized the secretive culture of adolescents' in the pandemic of adverse reproductive health problems including HIV/AIDs that has hardly hit most young people in the region. In the article, current master students call for legalizing sex in the country. The article further informs that, because talking about sex with unmarried young people is regarded as taboo; many adolescents' have sex in hiding which in most cases is unprotected. Therefore legalizing sex in Malawi will imply young unmarried people having permanent

sexual partners with whom to have sex and in that way can be protected. Therefore, if adolescents' missed the opportunity of undergoing through any initiation ceremony or their elderly relatives did not properly educate them during the time they reached puberty; adolescents' grow with vague information concerning sexuality. Parents in Malawi are not free to talk about sex with their children. For instance, some parents turn off the radio or television when issues concerning sex education and condom use are discussed in the presence of their children. Parents think that discussing sex related topics with their children is encouraging them to be promiscuous. Similarly, a study in Brazil by Vanconcelos et al (1997) shows that discussions of sex and related topics with adolescents' may be discouraged for girls because of common belief that to inform them about sex is to encourage sexual activity (96). Studies in sub Saharan Africa have also documented that parents discussing sex with their children is regarded as a taboo (20; 46). However, evidence has shown that comprehensive sexuality education can effectively delay the initiation of sexual activity and unprotected intercourse, decrease the number of sexual partners and also increase the use of modern methods of contraception (97).

It was noted that parents shift the responsibility of teaching their children about sexual issues to other people. In our study, a teacher complained "*parents think we are the ones supposed to teach their children on sexual life but we also think that it is their responsibility to sit down with their children and tell them about such issues."* John Alube et al argues that many parents expect service providers including teachers to take the role of discussing issues pertaining to adolescents' growth and sexuality, and to give the adolescents' answers (51). In the mist of our conversation pertaining to this issue, one parent (father to an adolescent girl) said "*if the culture is preventing us from talking about these things (talking about sex) with our children, then we must change the culture, otherwise our children will continue to die with HIV"*. The expectation is that unmarried adolescents' are not supposed to have sex and that sex is something that has to be discussed in the context of marriage. In this study, adolescents' expressed that one of the contributing factors they had failed to use family planning services is the negative attitude parents had displayed towards premarital sex.

4.5 Family structure, Gender roles and Sexuality

In Malawi, there are extended family structures that include any relatives other than members of a nuclear family living together in a household. The marriage system is either matrilineal or patrilineal. The *Yao* in the southern region follow matrilineal practices, *Tumbuka* in the northern region follow patrilineal and the *Chewa* in the central region, their system is

transforming from a matrilineal to a patrilineal type (98). Under a matriliny, a family is an integral part of the wife's lineage rather than the husbands. As such among the *Yao* in Lungwena area, this involves the husband moving over from his parents to live with his wife and her relatives. The uncle of the wife is the one who has more powers over the children other than the father to his own children. In terms of divorce, the man moves away and becomes no longer responsible for his own children. Despite being a matrilineal culture, polygamy is also practiced and the man can have more than two wives in different villages. In such situations, the man just moves from one wife to the other in their respective villages. In addition, when a married woman is infertile, the husband is granted to marry another woman while maintaining the infertile one. However if the man is infertile, then another cultural event is conducted. For instance, the marriage counselor[22] in collaboration with some relatives arranges for another man to have sex with the wife without the husbands' knowledge so that a child can be born in the family. This man is chosen on the basis that he has proved to be fertile through having a child (ren) and is paid some money if he has really managed to impregnate the woman. This man is traditionally called *fisi* (hyena)[23]. The aim behind this practice is that the family should not be disgraced in the community for not having children and that children are important in the family to help their parents when they are growing old. Although matrilineal culture values girls because they are the ones who retain the lineage, Reiniers (2003) cited in Michelle P (2007) informs that one implication of this matrilineal characteristic are high levels of divorce, with over 50% of first marriages ending rapidly (99). This was also found in our present study.

In Malawian society the gender roles are ascribed in such a way that children learn the distinction between men and women's roles at an early age. As girls grow, they are taught to take the role of their mothers such as cooking for the family and caring for patients in the family while boys do not have much to do, they usually spend their time fishing, playing and some migrate to Johannesburg for part time jobs. With the HIV/AIDs pandemic, many studies in Malawi have cited that high school drop out rate among girls is due to the fact that

[17] Marriage counselor- Usually they are two from both sides of the family. They are the ones who are initially involved in the planning of marriage and keep on to be a pillar for a particular family in terms of problems that may arise in the family. Sometimes they just observe on how the family they entitled to is progressing. Therefore, any problems found in the family, they are the ones who settles them down and sometimes can permit divorce as well.

[23] Hyena- this is a man who is hired to have sex with the woman in the family after the marriage counselors have realized that the family is failing to produce children. The assumption is that, it is the man who is infertile and this is planned without the husband's knowledge and consent so as to avoid disgracing him. However, the hired hyena is paid for after successfully impregnating the woman.

they take over the responsibility of caring for their infected relatives (32; 44-45). When the mother is away, the girl does everything that the mother is supposed to do in the home. Orphaned girls are even at more disadvantages because some male guardians sexually abuse them. Incest was noted in our study, as girls FGD reported a great concern that some of their friends were impregnated by their fathers, brothers and uncles. Probing them for reasons, participants were mute and some said did not know the reason. Adolescents' could not talk about it openly probably because of stigma attached to it since it is considered a taboo for parents or any relative to have sex with their young relation. It is a common belief today in Malawi that having sex with a virgin heals the HIV virus and that might probably be the reason male relatives are doing this. A previous study in Malawi, documented that incest was common in Mangochi and Mulanje districts, but isolated cases were also reported all over the country (91). Studies in the city of Zimbabwe similarly found that girls less than 15 years of age were most vulnerable to sexual abuse by male relatives, neighbors and school teachers (100). Usually such type of behaviors put girls at high risk of unwanted pregnancies and STIs as girls are likely to become powerless to negotiate for safe sex with their elderly relatives. Again, there is not much that is done when cases of incest have been known because they are often dealt with as family issues.

4.6 Socio economic factors and sexuality

The main source of income in Lungwena community is primarily biased towards men because it is fishing and migrating to Republic of South Africa for piece work jobs which are all masculine related. Therefore, most of the households are female headed because husbands had migrated to South Africa. Despite being a matrilineal society, men are still decision makers since they have more access to income than females and generally in Malawian culture, men are regarded as decision makers whether in marriage or not. In Malawian cultural history, labour migrating has for generations been associated with masculinity and with the passage to manhood, as young men seek their fortune in the outside world and, ideally, return with their spoils to the envy of their rural relatives (101). In our study, young girls are fond of getting attracted to such men and many of them are reported to be impregnated by them because the men from abroad have money and everything. In this study, KIs reported that female parents were having tough time to bring up their children alone, especially daughters because they become stubborn once they get into relationships with men who go to South Africa. This is in contrast with a study which took place in Cameroon, in which women were reported to have a very good relationship and were given more attention from their children than their husbands (102). Therefore, in this study, parents attributed

adolescents' early pregnancies and marriages as a result of stubbornness among their female children.

In Lungwena area, some men were reported to have forgotten their families once they landed in South Africa. For instance, they could not send any form of help and stopped communicating with their families or girlfriends. As such wives and girlfriends resorted into multiple sexual partners for economic support. Multiple sexual partners are a method many poor single women use to better their economic standing. Yet in our study, this has resulted into adverse consequences of unwanted pregnancies such as death due to abortions because such women and girls could not publicly seek family planning services in fear of terminating their original relationships. Because of economical stress, some female parents were reported to encourage their unmarried adolescent girls to batter sex and usually in these affairs protective sex is not common because sex is paid for. In such situations, Khaila et al asserts that there is nothing else that these people can do because they need money for clothes and food (93). However, I observed that these modes of behaviors are dangerous; as the relationships are temporary and that some girls' contract diseases and unwanted pregnancies of which doubles their poverty.

4.7 Conclusion

With complete background information presented, a lot of issues have been highlighted that will make us understand the results and discussions presented in the next chapter. As such the presentations of findings and discussions have a close reference to the information presented in this chapter.

Chapter 5: Findings and Discussions

5.1 Introduction

This chapter presents the findings and discussions of the exploratory study on factors contributing to adolescents' low utilization of family planning services in Lungwena community. The objectives of the study were to; identify adolescents' reproductive health concerns in the community, explore adolescents' perceptions on utilization of family planning services, investigate the perceptions of the community members towards utilization of family planning services by adolescents, identify barriers faced by adolescents' on utilization of family planning services and identify the available adolescents' reproductive health care services in the area**.** The emerging themes that gave the overview background of the

adolescents in Lungwena area are (a) culture and sexuality, (b) gender roles and sexuality, (c) religion (d) family structure, and (e) social economic factors and sexuality. Going through the objectives and these themes gave the main pattern on how the results could be presented and discussed. The results are therefore presented in five main themes as follows; (1) Cultural factors (2) Socio economic factors, (3) Lack of proper knowledge, (4) Individual related problems (5) Reasons associated with delivery of services (6) Other factors and the last objective is treated separately.

5.2 Cultural factors

Our findings locate that cultural factors have a great impact on an adolescent reproductive health life in Lungwena area. Major reproductive health problems and low utilization of family planning services among adolescents' are mainly influenced by cultural factors. Participants reported a number of problems affecting adolescents' in the community such as early marriages, early sex and pregnancies, planned marriages, sexual harassment and community attitudes to adolescent sexual activity and use of family planning services, which were all cultural related.

5.2.1 Early marriages

Although a host of literature has argued that in the recent years, adolescents are postponing marriage in African countries as it is in the (western countries), in our study many adolescents still marry when they are still very young. Kavinya A. (2001) asserts that there is an encouragement for reproduction and marriage especially in rural areas (103). Discussions with adolescents and KIs reported that reaching menarche was a criterion for most adolescent girls to get married. There were arguments to show that the district is associated with early marriages as one adolescent reported:

> *Most of the girls here drop out from school and get married just after puberty as you know Mangochi district, those who go to school are very few. At the age of fifteen most of the girls have a baby who is able to run*. (Individual interview, 16 years, adolescent boy)

All 11 KIs acknowledged the problem of early marriages and that it was more prominent among adolescent girls. The remarks from some KIs were as follows:

> *Most girls here marry early and when they reach the age of twenty one, they have five children of which they even fail to look after.* (Female, CBDA)

> *Most girls here marry at the age of 15. For instance, look at that girl, she is already married and they marry to old people not of their age. Young girls here are confident enough to marry older people. Married women here know how it is when a woman goes*

in labour but they do not sit down to counsel their daughters on dangers of early pregnancies and early child bearing. (Male Parent of an adolescent girl)

Some teachers here have also married some adolescent school girls but nothing had happened. If it were in other places, parents would have questioned and taken the matter further and usually the teacher looses the job but here parents become happy that the daughter is married without thinking of her future. (Primary school life skills education teacher*)*

Culturally, marriage is associated with child bearing. Hence it becomes difficult for married adolescents to postpone child bearing because the community expects the family to have a child so as prove its fertility. In such situations, use of family planning services may easily get discouraged. For instance, a married adolescent boy aged 17 said, *"Once you marry and fail to have a child in the first year, parents go to traditional doctors to help the family so that a child can be born".* Another study in the same area documented that when a family is failing to have a child, a *(fisi) hyena*[24] is hired to help (104). Munthali et al (2006) asserts that a person's marital status may increase chances of fertility because the very fact of being in a marital union entails greater exposure to the risk of pregnancy (37). Similarly, Mujahid and Kachikopa cited in Munthali et al indicated that variations in the age at which a woman enters into marriage can have a substantial influence on the total number of children she has at the end of her reproductive cycle (ibid). This was further observed in other two districts of Malawi where MHRC study established that some girls had as many as four children by the time they were 20 years old (91).

5.2.1.1 Marriage influenced by tradition

Although it is no longer acceptable for parents to plan marriages for their children due to HIV/AIDS epidemic, KIs reported that some parents were still practicing such a tradition. The process is called '*chitomero*'- (early engagement) whereby a man proposes a girl when she is very young at the age of four or above and sometimes it is the parents who propose that my daughter or son will get married to a particular family. As the girl grows, she is told that she has a husband who is waiting on her and the man is free to have her at any time he decides to marry. Often in such situations, girls marry older partners in which they have little control over sexual decision making due to unequal power relations. For instance, in a South African study, girls who were marrying older partners reported that it would be easier to try to refuse sex than negotiate condom use (27). Asking the adolescents' to see if they were aware of such

[24] The assumption is that, it is the man who is infertile and this is planned without the husband's knowledge and consent so as to avoid disgracing him. If the woman has failed again to conceive after having sex with this fisi (hyena) then the husband in the family is advised to marry a second wife.

practices, they consented but were not sure if such practices were still happening but said sometimes parents could "*just open your eyes that there is a well mannered unmarried boy in a particular family*". This is like helping them to find a suitable life partner. Such situations are often complex as they may put girls at increased risk of unprotected sex, because girls get exposed to sex at young ages whereby they might probably have little information on protective sex. Meekers et al, argues that, certain traditional practices may elevate the likelihood of STI transmission among adolescent girls as they often get married early to older polygamous men (105).

The life skills education teacher at one of the primary schools in the study area further complained of high drop out rate of girls at his school due to early marriages and blamed the society whereby innocent girls were arranged for marriage without their knowledge. According to him, this was a major adolescent reproductive health problem in this community, especially among girls because they were getting married at a young age. He further questioned the initiation ceremonies as many girls stopped schooling after being initiated. He emphasized as illustrated in the quote below:

> *Culture has influenced the behavior of girls a lot, because here at my school, young girls after being initiated do not respect any male teacher and even me, they just look at me in my eyes without any fear as if we are age mates.*(Primary school teacher, aged 42)

In Malawian setting, male teachers expect some social distance from girls and vice versa. Therefore in this context, the assumption from teachers is that such girls are no longer observing rules of respect which they are supposed to have towards male teachers. Since initiation ceremonies are believed to influence the sexual behaviour of initiated girls, this may also imply that teachers perceive such girls who are not respecting them as sexually active. Adolescent girls reiterated that the period they were kept in the initiation camps were too long (one month) and were taught several things in relation to sex. Whether it is tradition or other reasons, UNICEF cites that child marriage remain entrenched in rural parts through sub Saharan Africa from Ghana, Kenya to Zambia (11). Furthermore, research has indicated that onset of regular and unprotected sex at an early age of less than twenty years puts the girls at an increased risk of cervical[25] cancer (1).

[25] Cervical cancer refers to malignant condition of the cervix (the mouth of the uterus/womb)

5.3.1 Early pregnancies and sex

Due to early marriages, many adolescents' were reported to have early pregnancies and this was reported as a major adolescent reproductive health concern by many participants. In addition, some of the pregnancies reported were out-of-wedlock. The issue of early sex was very thrilling as participants reported that some adolescent girls have sex at early ages of nine. Hickey (1997) also observed that age at first sex is declining in Malawi but Maluwa Banda et al (2001) argued that adolescents' in the southern region of Malawi initiate sex earlier than their counterparts in central and northern regions (106-107). With deep concern expressed by a low tone, one KI said,

> *In this community, most girls fall pregnant before they are married and when they are still very young. This is because most of them become active in sexual affairs at a very young age of nine or ten. When they become pregnant at this young age they do not go to hospital because they fear the doctors will shout at them because at the hospital they say young people can easily die with a pregnancy. So they go to anzamba (traditional birth attendant) and when fails to deliver it, is when they take the girl to the hospital but it is already late. At the hospital, they deliver through operation* (Female initiator)

KIs were more worried because the outcomes of early pregnancies were not always good. Individual interviews and KIs reported names of adolescent girls who died due to complications of abortions because the pregnancy was unwanted. Section 5.1.3.1 below elaborates more on abortions. FGDs did not mention the names of any individuals who died due to abortions, therefore without individual interviews this information would have not been captured. To emphasize the degree of early pregnancies, a nurse midwife working in the family planning clinic reported that among the deliveries at the hospital, three quarters of them were among young people of below 25 years. She explained as illustrated in the quote:

> *….Also most of these adolescents were delivering through operation, had birth complications which results into high infant and maternal mortality. For instance, here a lot of girls give birth when they are just too young, from ages of twelve some are already pregnant and most of them have problems during delivery. For example, last year we registered twenty five maternal deaths and sixteen of them were young people of below the age of 25 years.* (Nurse Midwife)

Her emphasis was on maternal deaths due to early pregnancies and little on infant mortality. Mangochi district hospital is on third position as regards to maternal death in Malawi and since health workers are blamed at this hospital for negligence to expectant mothers, probably she wanted to inform that the society too has to be blamed. A further study is needed to document the number of normal deliveries among adolescents' at this hospital. A previous

study in Malawi evidenced that early pregnancies is characterized by high maternal death and problems of fistula[26] among girls of less than 20 years (34).

One KI attributed the problems of early sex and early pregnancies to the initiation ceremonies. He said that the initiation ceremonies had empowered the girls not to fear men sexually because after coming out from initiation ceremonies, many girls did not stay longer before they had gotten a pregnancy. In this context, initiation ceremonies seem to have many consequences on adolescent girls than boys. In FGDs, participants reported that the consequences of early sex and pregnancies were grave as in most cases, sex was unprotected. Abortions, infant and maternal deaths were the major outcomes reported due to unsafe and early sex and these were all mentioned as adolescent reproductive health concerns in this community.

5.3.1.1 Consequences of early pregnancies

Although adolescent girls argued by calling the out-of-wedlock pregnancies to be 'accidental ones,' it was quite interesting to note that adolescents' were overwhelmingly aware of the consequences of early pregnancies and explained a number of them like; some die because they resort to abortions, are not physically mature, have birth complications, fail to have a normal delivery, loose a lot of blood during labour, infants became ill or born prematurely and died due malnutrition. Interestingly, one adolescent girl further elaborated like in the quote below:

> *Guardians fear to take the pregnant adolescent girl to the hospital because they fear the nurses and as a result they take her to a TBA, but it very dangerous because a person dies due to poor services and that TBAs are not trained.* (Individual interview, unmarried adolescent girl, aged 16)

This shows that adolescents are generally knowledgeable about the importance of going to the hospital. Although not mentioned, for adolescent girls being pregnant means possible resentment of being dropped from school. The head teacher at one of the primary schools illustrated this point:

> *Last year I expelled a twelve year old girl who was pregnant and was just in standard three but I told her that she was free to come back to continue schooling after delivery. But I understand she had problems to deliver at this health centre so she was transferred to Mangochi district hospital where she was operated on.*

[26] Obstetric fistula is a hole in the birth canal caused by prolonged labour without prompt medical intervention, usually a caesarean section.

He further said it was difficult for such girls to come back to school because they feel ashamed among their friends and they fail to socialize. I asked him why adolescents' who were mothers were ashamed in school. He explained that according to this society, being a single mother is stigmatized but getting married early is not stigmatized and often time's girls who are single mothers are the ones willing to go back to school. In many African countries, pregnant students are required to drop out of school and in Malawi up to 11,000 female students in 2006 were dropped out from primary schools due to pregnancies (108). Theoretically it is possible for adolescents' who are mothers to go back to school but many do not do so. Although all participants mentioned an NGO working in the area called 'youth net and counseling' (YONECO) which was helping those adolescents' who are mothers to re-continue with their education, most of them did not go back to school. This is probably surrounded by stigma within the society to single mothers, and as a result adolescents' who are mothers felt that their friends would make fun of them.

5.3.1.2 Abortions

In this study, abortion was widely mentioned as an adolescent reproductive health problem. All participants stated that an out-of-wedlock pregnancy brings shame to the family. As such, some female parents were reported to have assisted their daughters to abort. In Malawi abortion is illegal except for some medical cases to save mothers life. Therefore some adolescents' were reported to be going to traditional doctors for assistance. Numerous studies in developing countries have documented that many girls and women die due to unsafe abortions (Bangladesh, Zambia, Malawi and Cameroon), (10) but Berer (2004) evidenced that in countries where legislation allows abortion on broad indications, there is much lower incidence of unsafe abortion and much lower mortality from unsafe abortions, as compared to legislation that greatly restricts abortion (109). Further, my assumption was that abortion would not occur in this society because the Moslem culture encourages procreation and prohibit abortion so as to protect the mother's life. By contrast to my assumptions, FGDs and individual interviews confirmed that abortions were common in the community only that it happens in secrete. However, I asked them why, since some girls in the FGDs had reported to admire friends who were having children. The common response was the pregnancy was unwanted and the practice of abortion was further reported to be common among those who had boyfriends or husbands in South Africa for fear of loosing their partners.

> *Most abortions here occur amongst girls who are engaged or married to men who went to Johannesburg (South Africa). When these men go to South Africa they stay there for along period of time without coming back home. As a result girls and even married*

women start having other sexual relationships and sometimes they fall pregnant and also they fail to go to the hospital for contraceptives because they fear that people will question them since their husbands or fiancés are far away. When such girls and women hear that their fiancés or husbands are now coming ….. laughs, what can they do? They abort so that they can maintain their original relationships. In a very low tone; last year a woman, very young died in our neighboring village because she was trying to abort when she heard from the husband's relatives that her husband was coming to pick her to South Africa". (In-depth conversation, CBDA)[27]

These are the challenges that some adolescent girls and young women are facing in this community because probably they are not even taken to the hospital as abortion is illegal in Malawi. The gap that men creates by going to South Africa puts girls and young wives in a dilemma of having other sexual relationships because they are not too sure if the men will come back. However, discussions with a nurse midwife revealed that issues of abortions were not very common at the hospital and said probably because the '*Yao'* culture values children a lot or because they fear to come to the hospital.

Since the main reasons for abortions were that the pregnancy was unwanted, I asked them why they did not use family planning services. Participants in FGDs and individual interviews reported that it was difficult for unmarried girls to seek family planning services because culturally, it is not accepted for unmarried adolescents' to indulge in sex. Premarital sex is regarded as immoral according to Malawian culture and in many African societies as well. Even those who were already married, they feared the society would report the news to their husbands abroad because seeking family planning services implies that one is having sex. As such, unmarried adolescents' who are sexually active find it difficult to openly come out on the public for any services as regards to their sexual activity. Subsequently, in our study, all unmarried adolescents' reported that they felt shy and young to go to the hospital for contraceptives despite wanting them. I asked them why. Many responded as illustrated below:

We are afraid of the relatives and like some of us who are not yet married, we are very shy and if you go to the hospital many people sees you and also we meet a lot of people even though there is privacy between you and the doctor, but people would ask you why you are there, they want to know if you are sick or not. The best place to go is the CBDA because one can go there even at night" (unmarried adolescent girl, 15 yrs, standard 6, in-depth interview)

[27] Adolescents participants both boys and girls had also mentioned abortions to happen because of the men's who go to south Africa and live their girlfriends and wives behind for a long period of time without communicating to them. As a result many wives and girls friends were deceived by other men that their partners were married again in South Africa and will not come back.

Moreover boys said they were even shy to buy condoms from the shops during the day. Even though family planning services can be available, but stigma attached to premarital sex discourage many adolescents to access the services. Adolescent participants stated that they were even shy to go to Lungwena health centre for the services.

> *We feel shy especially at lungwena health centre because we know that everbody knows us and we become afraid that they will ask us if we are sick or not. Some people instead of asking you if you are sick, they ask the provider why you are there and the providers tells them that she wanted kulera (family planning) and these people go in the village telling everybody that you have started using kulera yet you are not married..*[28] (Individual interview, unmarried adolescent girl, 15 years)

In this way, confidentiality is compromised. Some adolescents' expressed that they were even constrained just to ask anybody or their parents about where they could find contraceptives. George et al (1995) asserts that parents and families across a wide variety of cultures sought to deny young people information about sex and reproduction because adults hold ambivalent attitudes towards young people, viewing them as simultaneously young (110). Because of their willing to use family planning, I asked them what would be the best way for them to have access to family planning services. School going adolescents' preferred contraceptives to be distributed in school either by one of their teachers. Married adolescents' especially girls said if they had changed the setting at the hospital and if the CBDA had a number of family planning methods[29].

A CBDA reported that due to shyness, most adolescents' were visiting her at night for different family planning methods and boys were reported to visit her often for condoms and girls for pills. This probably shows that girls have low preference for condoms. Consequently girls might be at high risk to STIs including HIV as pills only prevent a pregnancy.

5.1.3 Gender roles and Power imbalance

Stereotypical gender roles place adolescent girls at heightened risk of sexual abuse. Socio cultural perspectives of male and female sexuality also define different expectations of adolescent girls and boys in relation to sexual conduct. For instance, some gender norms contribute to men being sexually aggressive. In our study, girls FGDs reported sexual abuse such as rape and violence to be one of the reproductive health problems adolescent girls were

[28] Participant's preferred Mangochi district hospital and Malindi private hospital because the family planning was integrated that other people did not know whether one was at the hospital for family planning or other diseases.

[29] The CBDA was allowed to give condoms and pills only but for the rest of the methods, she was writing a letter for the clients to be attended at the health centre or the district hospital.

facing in the area. Unmarried girl's participants reported that often boys were forcing them to have sexual relationships and because of this many of their friends were reported to have stopped schooling because they were impregnated. They further reported that boys were sexually harassing them by touching their sexual organs as one girl said *"Boys sexually harass us. They touch our breasts and we can not report that to our parents because they can not understand and instead they accuse us that it was us who started to seduce them, so we do not tell them."* These are some of the challenges adolescent girls are facing. They might be willing to tell parents about their sexual health concerns but they fear the reaction of their parents. It further probably shows that parents are not supportive and open to discuss sexual related problems with their children. Although it seems difficult for many parents to have an open sex discussion with their children, but listening to their reproductive health concerns would still be important, as they can know how to properly advise them. In Amuyunzu (1997) study, specific areas of improvement were suggested such as change the attitude towards adolescent parent discussion on sexual matters and the need for basic sexual and reproductive health education to parents themselves (111).

Studies from various parts of the world have shown how masculine identities are based on sex to prove their masculinity (53-54; 112). Such gender norms can place girls at high risk of sexual violence, including rape or domestic violence in which use of family planning methods such as condoms during sexual initiation might be difficult. For instance, in the same interview girls also mentioned rape as a reproductive health concern as one girl said, "*last year, a certain girl was raped and was taken to the hospital, but she was told that the man who raped her was HIV positive, so was put on treatment"*. In this context, use of family planning services among adolescents' can also enlighten them on the importance of emergency contraception[30] which can be used when sex occurs unexpectedly and without contraception. Lloyd and Emery (2001) argues from a feminist perspective that male sexual coercion and violence are about power and control, embedded with the prevailing traditional power structures of male dominance and female subordination (113). Doyle et al (1995) asserts that gender norms and unequal power relations compromise young women's sexual health by limiting their ability to negotiate safer sex practices such as condom use or fidelity (53). Similarly, in our study, both unmarried and married girls attributed low utilization of family planning services to gender imbalances because unmarried girls could not negotiate for safe sex and married adolescents feared their husbands.

[30] Emergency contraception provides a back up method for women who suffer from contraception failure, women who have been raped and miss the dead line for contraceptive injection.

5.1.3.1 Failure to negotiate for safe sex

The effect of gender relations and power issues in Malawi are embedded within the culture that women are not supposed to make decisions. This has made women not to have autonomy and became increasingly dependent on men for any decisions whether regarding their sexual feelings or other. Consequently, girls informed relatively lack of negotiation skills for safer sex with their sexual partners as it is not expected of them to argue with their husbands or boyfriends. Probably this is the reason girls had mentioned pills, injections and abstinence as methods of family planning to avoid confronting sexual partners rather than boys who frequently mentioned condoms. Knowledge on family planning methods is more elaborated in section 6.1. Even those girls who acknowledged multiple sexual partners did not report condom use since some were using pills. In one study, it was found that young women prefer oral contraceptives because they have difficulties in insisting on, or negotiating condom use (114). I asked the girls if they had ever tried to tell their sexual partners to have safe sex. Two girls reported that they tried but were not successful and the rest (12) were of the view that it did not make any difference whether to try it or not because "*boys can not allow that a girl should tell them to use a condom, otherwise he will just end up the relationship and tell you that your friends also would like to have me*". In many cases, male sexual partners have warned to terminate the relationship if girls insist in using condoms. This becomes more challenging to girls if the relationship is in a form of a 'safety net'[31] and as a result girls end up giving in to unprotected sex in fear of loosing the supplier. Holland et al (1992) 'passive feminity' can also be illustrated by the behavior of girls in our study who felt unable to negotiate condom use and instead resorted to leaving it to the responsibility of their male partners (115). Among the two who tried and failed to negotiate condom use, one of them said,

> *He told me to choose between him and a condom, and he said if you don't believe me we can go to the hospital for an HIV test if you are afraid of AIDS, and I got convinced that we can have unprotected sex because he assured me that he was ready to go to the hospital and I believed that he was not infected* (Individual interview, adolescent girl, 16 years).

This probably shows the weakness of girls in decision making when it comes to sex. Zekya et al in Gupta (2003) informs that girls have little influence over decision making or the use of contraceptives because they are commonly socialized to be submissive to men (116). Coleman in sexual script theory suggests that males are socialized to be more directive and assertive about their sexual needs and the initiators of sexual intimacy, where as females are

[31] Safety net is when the relationship is merely based on money and other materials that a male partner provides to the girl. The girl also provides sex because she is in need of support which can be either material or money.

expected to be sexually naïve (55). Boys said they deliberately refused to use condoms because some girls don't like condoms and they were afraid to loose the relationship. One unmarried boy said, "*Girls terminate the relationship with you and go to their friends telling them not to allow you because you have condoms so it means you also have a lot of girls"*. Talking to girls why they did not like condoms when having sex, they argued that often boys who use condoms are also believed to have other girlfriends of which they had sex to and refusing sex with a condom was one way of finding out if that was true. However, this is risky especially if boys really have sex with other partners because HIV/AIDS and other STIs can easily be spread. This also informs how strong the bond between promiscuity and condom use is perceived in this society which may further discourage use of family planning services among adolescents.

5.1.3.2 Fear of husbands.

Chimbiri (2006) observed that use of condom within marriage appears to contradict views of marriage as an institution created by God for procreation as well as satisfaction of sexual desires (95). Similarly, in our study, married adolescents' reported that their husbands did not allow the wives to use family planning methods because the intention of marriage is to have children. Holland and Dickson et al reported inequalities of power including male pressure and violence (115). The example cited through girls FGD in which a married girl reported that some husbands threats to physically beat the women or ends the marriage when found with contraceptives reflects these imbalances to some degree. The excerpt below illustrates it:

> *Interviewer (I): You said men are the ones who are against the idea of kulera (family planning). Why is that so?*
> *Participant (P) 3: Because all they want are children*
> *P 6: These men are after children that is why they discourage or not authorize the use of kulera (family planning)*
> *P1: others do abuse their wives physically until the marriage ends. All they say is about bearing children and as a result most of the women do kulera without the consent of their husband. All women do pretend to go to under five clinics with their children for vaccinations while in actual sense, they go for family planning services.*
> *P4: And even the service providers do not keep the secret. So when they spill the beans, the husband feels cheated and fights with you at the end the marriage breaks up"* (married and unmarried girls, FGD, 6 participants)

Although these findings can not be generalized to all married adolescents in Malawi, other detailed studies need to be carried out to see how gender has influenced the use of family planning services among married adolescents.

Further, married adolescent girls said that husbands discouraged them saying that if women use injections (Depo-Provera), they did not stop having monthly periods as a result husbands failed to have sex with them. Although some women may encounter some changes in their menstrual cycle in their first days of using family planning methods, but this could be just a myth that some husbands use for discouraging their wives in using family planning services. Therefore, women who were really desperate for the services would go in secret to the CBDA to take pills and if they needed an injection, they were escorted to the hospital by the CBDA. Participants reported that suggesting a condom was even worse as the husbands were not even ready to hear about it. This confirms many other findings that signify the negative view associated with condom use within marriage as condom is widely believed to be associated with extra-marital sex and asking for it …, brings all sorts of tensions that many spouses are not prepared to deal with (117). This was commonly reported to happen among the recent marriages that had two to three children and participants mentioned that some of the women who got married sometime back were able to use family planning[32] without problems with their husbands. I asked them what can be done for such men to understand the importance of *kulera* (family planning). The responses were as illustrated in the quotes below:

> *P5: They should be given information on the importance of kulera. That is the only way because they are the ones who are fending for the families. Even the children sleep without blankets, (laughs).*
> *P4: In our society there are no family issues being discussed between the spouses. If you dare to share the information or piece of advice given from family planning clinic, he rebukes you and threatens to beat you even to the extent of breaking up the marriage. All we can ask the government is to help us by educating the husbands individually so that we can be helped because even the diseases (HIV/AIDS) are spread by them."* (FGD, married and unmarried adolescents)[33]

Married adolescents' seem to have difficulties in convincing their husbands because the men do not have proper knowledge on family planning and it shows that there is no spousal communication as regards to sex. At the same time, it might also show that men have limited access to information on family planning services in general. A further study is needed to explore the extent of male involvement in family planning services in this area.

[32] Family planning implies using family methods to the participants in this study which in literal translation to the local language is *Kulera* and family planning services implies both information and family planning methods.
[33] This shows that people in the village trust government for effective changes to take place. Also it shows that men do not escort their wives to antenatal clinic which is true according to many Malawian men.

5.1.3.4 Attitudes about gender roles and sexual relationships

Gender norms within a society can also shape the sexual behavior of adolescents'. In this study, gender norms have contributed both to low utilization of family planning services and adolescents' reproductive health problems. Crawford and Popp (2003) illustrated about how young girls are judged negatively for showing interest in sex and having sex with many partners (118). In this study, adolescent boys having a number of sexual partners was justifiable while girls having many sexual partners was reported as a reproductive health problem. This was found during boys FGDs as they reported to have two to three girl friends depending on their physical strength if they can manage all of them sexually. Further, boys did not blame themselves for having more sexual partners because it gives them a wide sample to choose on whom to take for marriage. The excerpt below summarizes the whole situation.

> *Interviewer (I): How many sexual partners do the adolescents have at a time in this community?*
> *Participant (P) 3: Some do have two or three sexual partners at a time.*
> *P6: Some do have up to five sexual partners while those who are arrogant do have six partners at a time*
> *P 4: I have three girlfriends, and the sexual partners are like this, some are permanent partners so that I can choose one from them to marry in future, while others are for hit and run*[34]. (Boys FGD, 6 participants)

This probably shows how gender roles are divided in this society, that they are certain things that men are justifiable to do and women not. In this case it seems acceptable for a boy to have multiple sexual partners and probably it shows masculinity. Pateman (1991) also observed that within the traditional sexual script, young men are socialized to define their masculinity in terms of the number of female partners and to consider the quality of the relationship in their decision to have sex (55). Similarly, interviews with high school students in Zimbabwe indicated that while boys can have (and indeed should have), many girlfriends, girls should stick to one (119). This was also reported in South Africa (120). Boys FGDs further reported that girls were also having multiple sexual partners and that they were having sex with them without any protection. Moreover girls with multiple sexual partners were labeled "*atsikana wosakhazikika*" not stable girls in literal local language translation. To justify the degree of multiple sexual partners among girls, in boys FGD one participant illustrated, "*there was a certain girl who was pregnant here last year and when asked to mention the one responsible, she mentioned more than ten men*". Young women's fear of

[34] Hit and run are casual sexual partners that are not considered as permanent girlfriends or boyfriends but short time sexual partners.

being labeled contributes to their silence around sexual desire and their silenced engagement in sex with men (ibid).

5.1.3.5 Trust and a feeling of respect

Francine argues that condom use is thought to reflect mistrust, lack of faithfulness, and promiscuity and that it is associated with sexual activity outside the context of a relationship (102). In many studies, trust was mentioned as a reason for not using condoms (26; 102). Similarly, in our study adolescents' reported that if sex was with a 'stable partner' then a condom was not important.[35] Participants' reported that they believed in (trust), "*sitimakayikirana and timadziwana"* (we don't doubt ourselves and we know each other). More than half of adolescents' reported that using a condom implies that you are not trusting ones partner and any attempt to propose condom use can destroy the relationship. A standard six unmarried adolescent boy informed that he had stopped using a condom with his girlfriend because their affair would have ended as he explains in this quote:

> *When a condom is introduced in a relationship which you know each other well, it means one of you is not moving well, cheating with other men or women. For example, my first sex with my girlfriend, I bought a condom and the time when we wanted to have sex, I put on it and she asked me to stop having sex with her. I asked her why, she said that I did not love her and just wanted to use her like the way I sleep with other girls. I told her that I love her too much and I will marry her. She said then why is it that I wanted to use a condom if I trusted her as a good girl fit to be a future wife."*[36] (In-depth interview, 17yrs boy)

Girls also mentioned that boyfriends have told them to have trust. According to a fifteen year's school going adolescent girl, *"boys have sweet talk and they tell you not to worry about pregnancy and HIV but just enjoy the game (sex)."* Other participants mentioned that one loses self respect from the other partner because the condom is associated with prostitutes. It can therefore be argued that some adolescents would prefer respect from their partners rather than to be protected.

[35] Stable partner refers to a relationship in which both partners are determined in the relationship, and plans for marriage are likely to develop in a relationship which is considered stable. Therefore use of condoms when having sex with a stable partner contradicts with the intention of the relationship which is viewed to prepare both partners for marriage and as a result partners need to have trust in each other as they now that they will soon get married.

[36] Not moving well in this society implies having multiple sexual partners.

5.1.4. Influence of tradition and cultural norms on adolescent use of family planning.

The belief that sexuality is only accepted through the social institution of marriage automatically excludes unmarried adolescents' as eligible clients for family planning services. The name 'family planning' in literal translation conveys a similar message that family planning is for those people who are married and have a family. This pre-conceived idea in most adolescents' makes them feel out-of-place in accessing family planning services. Similar findings were reported from Zambia and South Africa where adolescents' perceived family planning services to be reserved for married people (18; 23-24). Similarly in our study, some of the reasons unmarried girls did not use family planning is the belief that it is only for married people. One girl illustrated as in quote below.

> *Family planning is for married people because they want to have few children and not us because this can cause us not to have children in future and our future husbands will divorce us if we fail to have children".* (Individual interview, unmarried adolescent girl, aged 16).

Such beliefs discourage unmarried adolescents' to use the available family planning services. This calls for information education campaigns (IEC) in Lungwena community to equip adolescents' with right information. The belief that use of family planning services can enhance promiscuity among unmarried adolescents' is also reflected in our study as a fifteen year's school going unmarried adolescent girl strongly said,

> *As far as I am concerned, kulera (family planning) is not proper for adolescents, this should only be for adults because whenever boys and girls hear of kulera (family planning) he decides to have chibwenzi (boy or girl friend) and they start sleeping together, so there is need to hide, only adults should receive. This medication for kulera (family planning) has also encouraged girls to drop from school since after they heard of kulera, they started moving around (having sex) with different people as a result they are now pregnant*[37] (Individual interview, adolescent girl, aged 15)

The knowledge that family planning can also prevent STIs including HIV/AIDS is not displayed in the above quote. Although unmarried adolescents' had mixed perceptions on utilization of family planning services, married adolescents' had only one view. Married adolescent girls reported that all adolescents who are sexually active are supposed to use the recommended adolescents' family planning methods so as to be prevented from STIs, HIV and early pregnancies which were affecting many adolescents in the area.

[37] Kulera (FP) is cited as a form of treatment to a disease which girls suffer from. Although, there is a form of knowledge displayed in this quote about family planning but it is a poor knowledge because family planning is not medicine but just a preventive measure.

> *Adolescent girls are more at disadvantage because they are the ones who carry the burden of the pregnancy alone. The other thing is that the boys of these days when they impregnate you, they do leave you and start shouting at you, now to avoid such incidents, it is better to use family planning* (16 years, married and mother of one)

The common fear displayed for preventing a pregnancy among girls is its visibility and related negative consequences when a man denies responsibility. However, in our study girls realized the importance of using family planning after experiencing the negative consequences of the unprotected sex. For instance, an adolescent mother who was once pregnant at the age of fourteen emotionally reported that it was better to use family planning methods during any sexual intercourse because "*you never know what will happen next after sex"*. Talking from her experience, she further said,

> *I did not know that I would become pregnant because I met this man once (had sex once) and for all, and now I feel very bad because he denied me and my mother sometimes tells me that it is too much on her to look after me and my baby, but I have got no choice."* [38]
> (In-depth conversation, adolescent girl 16 years)

I further asked her if the man was a boyfriend (*chibwenzi*)[39] or if they had any plans to get married. She blushed and said "*he was my boy friend (chibwenzi) but we had not started making plans for marriage, even our parents did not know about the relationship and of course am lucky now because YONECO is taking care of my education.* Although YONECO is taking care for her education but such remarks from parents risks their daughters life as the probability to force her into another disastrous relationship can outweigh their anger. In Uganda, Atuyambe et al evidenced that pregnant adolescents' were psychologically violated by parents and the community within which they lived (121).

5.1.5 Community opinions on adolescent's use of family planning

Almost all KIs (8 out of 11) strongly reported that adolescents' should use family planning services so as to be prevented from STIs, early pregnancies, infant and maternal deaths. Although the KIs on the other hand stated that it would be like encouraging them not to abstain, but also strongly said that the reality was that adolescents' were exposed to sex at very young ages and some as young as ten years. KIs felt that even married adolescents' should use family planning services because most of them were reported too young to start

[38] The girl in now back in school and she in standard seven. YONECO is paying school fees for her and other related school material like uniform and note books.

[39] Chibwenzi is a local name in Chichewa which refers to both a boyfriend and girlfriend whom one can also start making plans of marriage. Of course some of the girl/boyfriends are not for marriage purposes.

child bearing and mentioned a number of girls who were very young (between ages 13 and 15) and were already married in the community. As we were discussing, sitting under a big shade of a mango tree, a TBA directed me with her eyes to a girl who was passing by and had carried a bucket of water on her head – *"look, she got married last month to an adult man with an age difference of ten probably."* She further said, *"If this girl gets pregnant, do you think she will manage to deliver normally? … may be, by the grace of god."* The major concern was that many adolescent girls if pregnant were afraid to go to the hospital and delivered through the TBA, and some of them were dying afterwards due to shortage of blood and other complications. Although any pregnancy carries a risk, in many respects our findings are similar to several studies that acknowledge an early pregnancy having a higher risk because the body is not physically mature (1; 11; 24; 108; 120).

With exception to what many KIs said, the female initiator *(nankungwi*) was against the view that unmarried adolescents' should be using family planning services. She further argued that she noted with great concern that unmarried girls were publicly told about family planning and sex, *"which is very bad because they don't know what a pregnancy is"*. She emphasized that *"Girls are supposed to be told about family planning when they are in marriage."* Culturally, many elderly people do not like it when explicit language related to sex is talked publicly. The assumption is that unmarried adolescents' do not have sex and public talking on sexual issues is like telling them what happens in marriage which they are not supposed to know until they get married. In this way unmarried adolescents' may be discouraged to use the available family planning services. Costos cited in Munthali et al (2007) asserts that sex is another taboo issue in most societies (including the west) (122). However, this may lead to denial of important information to sexually active adolescents' as they may get involved into high risk sexual activities[40] without actually knowing how to protect themselves and that may accelerate the spread of STIs including HIV/AIDs and unwanted pregnancies. Although elderly people have a negative feeling towards open sex language, research has shown that greater openness and acceptance of adolescents' sexuality can increase young people's ability to negotiate their sexual and contraceptive decision-making (97).

5.1.5.1 Cultural related barriers

Although many KIs in this study acknowledged that adolescents' should use family planning services, some participants reported that it was difficult for unmarried girls to use family

[40] High risk sexual activities imply having unprotected sex which partners who are infected with STDs including HIV and that may eventually cause death if not treated.

planning services, because their parents did not allow them to do so. Adolescents reported that their parents are against premarital sex and had told them negative stories about using family planning when one is not married. A recent study has shown that for fear of encouraging sexual activity, mothers withhold vital information about sexuality and reproduction from their daughters – imparting instead messages of danger, fear and shame (123). Similarly, in our study, parents told their daughters that family planning will destroy their wombs and their reproductive health system and would become permanently infertile. In an individual interview, an unmarried adolescent girl said, *"Parents tell us false stories concerning those who pursued higher education and do not have children because were using family planning methods."* As such girls complained that pills were difficult to keep away from their parents and sometimes could forget to take them as prescribed because some of them were hiding the pills to their friend's houses. Even in developed countries, such as United States, adolescents' fear of parental notification has been cited as one explanation for the substantial delay in adolescents' obtaining family planning services. The only difference to our study is that in United States, they require a parental consent from clients younger than 16 years (124), while in Malawi this is not required. In an in-depth conversation with an unmarried girl she informed that parents shout if they hear one is using family planning.

> *Parents start accusing you that you are unfaithful, you want to become a prostitute and they tell you that you are young and have not given birth to any child. So if you take family planning you will just destroy your chiberekero (uterus) and will not have children until you get old. If you want to get married just get married and stay at your house so that you should have children. (*16 years, school going, standard 7)

This situation is challenging to adolescents' because they have ambivalent views towards family planning. As such, it can really become difficult for them to make decisions about whether to use family planning services, because they are not told the truth. To parents, family planning is associated with prostitution. This was also told in girls FGD, where a parent had warned her daughter not to touch the methods of the prostitutes. Adolescent boys reported that their parents told them not to use family planning unless they are married and have enough children. Talking to one parent, he agreed and explained as illustrated in the quote below:

> *As parents we want grandchildren because we are growing old and we want somebody whom can stay with us and help us in collecting firewood and a lot of things. For instance if the child reaches the age of twenty one (21) without getting married or having a baby, the child is taken to a herbalist to consult and help so that our child can marry and have children as well* (Male parent).

In this way, adolescents' may be discouraged to use family planning services. At the same time, the negative attitude displayed by parents towards adolescents' using family planning services in marriage shows that parents are only against the idea of adolescents' having children when they are not married. However in marriage, regardless of age, adolescents' are expected to have children. During an individual interview an adolescent girl reported that some of the parents did not understand the importance of using family planning and to such parents' one can not even ask for permission or discuss something concerning using family planning services because they are always furious. This was further noted during girls FGD.

> *Interviewer (I): why is it that most adolescents' do not use family planning?*
> *Participant (P) 2: Our parents do not agree*
> *I: Why*
> *P 3: They say don't take family planning, what are you going to space? Do you have a child? You are going to be spacing a stone?*
> *P6: If you are schooling, they say are you going to space the books?*
> *P5: Others say a young child taking family planning, that's encouraging her to be promiscuous because when doing that she is not going to get the pregnancy then they will be just saying family planning- family planning, that's teaching her promiscuity.*[41](Unmarried girls FGD, six participants)

The general picture is that parents seem to contribute a lot towards unmarried adolescent girls to low utilization of family planning services in this community. According to these findings, unmarried girls are easily tracked and questioned by their parents if using family planning methods than boys who seem to be only questioned when they are married in which parents do not allow them to use family planning methods. Further reports from adolescents' were that they feared the society in general to openly go to the hospital for family planning services and indicated that even buying condoms from shops was not easy for them since some of the shop owners were relatives and could tell their parents. The only option reported was to go to the CBDA at night to collect condoms even though some of them were not trusted as well. According to the social norms, unmarried people are supposed to wait for sex but the CBDA reported that the reality is that more than half of unmarried adolescents' have sex and equally need the services in Lungwena community. I further probed for reasons they face when want to use family planning services. One adolescent girl said *"kunyozedwa, kutsekedwa (intimidation and being laughed at) we are not loved by other people because they think what we are doing is crazy."* The other obstacle revealed during FGDs was lack of interaction and communication with parents on utilization of family planning services as parents did not want

[41] Participants were very active and from my observation it seemed like every body was concerned and none of the participants through out the discussion mentioned that parents had allowed them.

their unmarried children to start using the methods. One adolescent boy said, *"When we go for family planning services, we don't wait for them to agree and in fact we do not go to ask for their permission, you just have to go and take them*." Even influential actors such as religious groups, teachers and some health providers have found difficulties to acknowledge adolescents' premarital sexual activity in Malawi. Therefore unmarried adolescents' can have difficulties in accessing the services because of the community attitude and may end up facing numerous consequences of unprotected sex. To a large extent, our findings are similar to Chikovore (2004) in Zimbabwe and Warenius et al (2006) in Zambia who found that young people grow up in a context where sexuality is silenced and surrounded by prohibitions (125-126).

5.3 Socio economic factors

In our study, socio economic factors have contributed to adolescents' experiencing major reproductive health problems of multiple sexual partners and engaging in unsafe sexual practices which have eventually resulted into unwanted pregnancies and STIs including HIV/AIDS. Multiple sexual partners influenced by poverty are also associated with non use of family planning services because girls become powerless to negotiate for safe sex in such instances. In our study poverty is further portrayed as an underlying factor to low utilization of family planning services among adolescents' because they could not go to their preferred places for treatment of STIs and family planning services in general. This is because some of their preferred places were private hospitals which they could not afford paying the bills and transport costs. The next five sections discuss the impact of socio economic factors on the study phenomena.

5.3.1 Early pregnancies

Apart from culture, participants attributed early pregnancies among adolescent girls to socio economic status. In general, participants mentioned poverty as the driving force to early pregnancies among girls because they have sex in exchange of their material needs like soap, lotion and money. A fifteen year's school going adolescent girl in an individual interview reported *"You know, we are very poor and because of this, some of the girls are easily taken up by fishermen because they always have money."* In such situations, adolescent girls fail to decide on the type of sex because they need support. It was further reported that some girls thought that by being impregnated, the men would probably marry them so as to have continued support from the men. However, it was informed that many young girls were abandoned after being impregnated and had to bear the responsibility of raising the child alone. In both FGDs and individual interviews, adolescents' reiterated that pregnant

unmarried adolescent girls were worse poorer than unmarried adolescent boys who impregnated the girl. This is because the girl had to take care of the child and sometimes parents would deny her a home and that she is primarily responsible for the pregnancy. Although it is the duty of parents to take care of their children but when parents have nothing to offer, sometimes it becomes a big challenge to raise their daughters in such circumstances. Our findings confirm several studies in Africa that have documented the association of poverty and early unwanted pregnancies among adolescents (Uganda, Botswana, Zambia, and Kenya) (127). However, Zelizer (2005) argues that material exchange is coercive in so far as women are poor and have limited opportunities (128). Therefore, in this case, money or material changing hands with sexual partners could be "nothing but" female exploitation. According to our findings, it can be further argued that adolescent girls are being exploited in this community since men take advantage of the girls' economic status.

5.3.2 Forced marriages

Forced marriages were one of the reproductive health concerns that many participants mentioned in this community. Both adolescents' and KIs reported that some parents were forcing their daughters into early marriages because of poverty at household level.

> *Once girls grow they are forced by their parents to marry, they call it Durban, they stop going to school and get married to the one who goes to Durban…..…instead the girls are being disturbed from schooling"* [42] (Unmarried boys FGD, six participants)

During the girls FGDs adolescents' confirmed that parents were forcing them to marry whilst they were still young. I asked them to explain in detail what really happens and the following segment covers what different participants said:

> *Participant (P) 4; You know here most of our parents are poor and if you ask them of something like soap, they tell you, why don't you get married and find your needs? Get married and you no longer become poor.*
> *P 2;(laughs) I got married at the age of thirteen, my mother told me to marry my husband who is now in south Africa so that I can help her to raise my younger brothers and sisters.*
> *Moderator (M); So do you help the mother?*
> *P 2: ….not very much because I told you that my husband went to South Africa so there is nothing much I can do.*
> *P 6; Here it is impossible for a girl to reach sixteen years without getting married … all participants' laughs …*
> *P 5: It is true, poverty is not good, we are forced to get married when our time is not ready while we want to continue with school* (Married and unmarried girls FGD)

[42] Durban is a city in the Republic of South Africa where men from Mangochi migrate to look for part time employment and these men usually have a lot of money and some even bring cars when coming home. So these parents force their daughters to get married to such men because they believe that they will financially help them since this is a matrilineal culture which implies that the husband will come to stay to his wife's home.

Adolescent girls said that their female parents were the ones who were exerting pressure on them to get married unlike the male parents and in an FGD, girls explained the behavior of their female parents as a form of gender based violence. One girl said *"we the girls are at a disadvantage, because our parents force us to marry before the time is ripe (not ready for marriage) while the boys are not forced to get married."* Six out of eleven KIs mentioned that many parents were poor and that some even fail to feed their children. For instance, one KI said "*therefore if the family has a girl child, they told her to go and find her own means"*. In this way, adolescent girls are compelled to have unprotected sex and use of family planning services is indirectly discouraged because sex is expected and allowed in marriage. Also, chances are high for adolescents' to be sexually abused in such marriages and this may leave a permanent scar of psychological torture in their lives. In (2005) Sharon published that in other districts of Malawi; some girls were forced to marry men five times older than them to settle the family's debts (129). Similar findings were observed in studies conducted in the villages of Ghana and rural northern areas of Ethiopia (130). However, participants were concerned that even though girls were being forced into marriage, many of them were getting divorced and that the numbers of single adolescent mothers were increasing in the community. I also encountered difficulties to find adolescent girls who were single and had no child to be respondents during our study. However, MHRC tries to protect people below the age of 15 years from entering into marriage (91). Further more, UNICEF states that no girl should become pregnant before the age of 18 because she is not physically ready to bear a child (11). These could be viewed as just theoretical ideas which are in contrast with what was found in the present study.

5.3.3 Multiple sexual partners

In section 5.1.3.4 multiple sexual partners is a major adolescents' reproductive health problem especially among girls in relation to gender attitudes embedded in the community. However, in this section, multiple sexual partners in Lungwena area is a major reproductive health problem among adolescent girls because it is associated with abduct poverty at house hold level as reported by almost all participants in our study. Many respondents had mentioned poverty as one of the main underlying factor to the major reproductive health problems especially among adolescent girls. In this study, girls were reported to have older multiple sexual partners in search of money. However, sex with older partners is likely to be unprotected because of the girls' inability to insist on condom use. Therefore use of family planning services would help adolescents' who can not negotiate for condom use with other methods that can be used secretly such as pills and injections. The only disadvantage is that

girls would not be protected from STIs including HIV/AIDS. A qualitative study in Nairobi slums similarly found that dire economic conditions contribute to sex –for –money exchanges and that these conditions normalize early sexual behavior and unhealthy sexual practices (131). KIs blamed the tendency of married young boys leaving their wives back home in search of jobs in South Africa as the underlying factor for young wives to start having multiple sexual partners. The thoughts of a KI were a true representation of what a married adolescent girl said in this quote;

> *Here married or not married one has to have another man to assist her in times of emergency because when these husbands or boyfriends go to south Africa, they took time to start sending money home, some totally forget you and you just hear that he got married to another woman.* (In-depth interview, 16yrs, married girl)

This demonstrates a situation whereby girls and young women rely on other men not necessarily because of love but for economic support. Cornwall asserts that money can buy love and a similar argument was made by Zelizer 2005 (128). Boys accused girls as 'money lovers', as a main reason for having more than one boyfriend so as to receive money from all of them. Khaila et al, write that some wicked women resort to prostitution together with their girl children to sustain their families (93). Even though the girls in our study acknowledged that their parents had forced them into marriage or that they have multiple sexual partners to find their needs, they did not perceive themselves as prostitutes. These perceptions correspond to Ankomah (1992); Ankomah and Ford, (1994) cited in Ankomah (1999) who noted that the practice of sexual exchange is quite different from prostitution as it is understood in western societies (130). Where as sexual exchange is generally acceptable, formal prostitution is not and is considered an infraction on socio sexual morals.

Chatting with an adolescent boy one afternoon when I found him along the lake, he boastfully said, "*there is a network here of relationships and laughs.*"[43] This was also noted by Hans Peter Kohler in his study in Likoma island of Malawi who observed social networking of sexual relationships (132). Asking him why there was such a network, the response was attributed to poverty which was forcing adolescent girls to have multiple sexual partners and indulging in unprotected sex in exchange of money with business people who were coming to buy fish at the lake. He kept on talking; "*Girls have two or more boyfriends so that they can have money to support their families and themselves, and they do not use condoms because*

[43] Network of relationships implies that if one girl had sex with one man and that man had a wife or another sexual partner and that sexual partner had also another sexual partner the network goes on and on. If among the network one is infected, that means a lot of people will be infected if that person did not go to the hospital.

they want money. After all beggars should not be choosers if the man wants a condom he can be the one to propose it." Caldwel in Nigeria asserts that social networking is also economic networking (133). Francine van den Borne (2005) further comments that poverty or the economic discourse seems an adequate enough justification for most young girls to have sex with men (102). Studies in Nigeria and Uganda found that money plays an important role in the negotiation of sexual relationships among adolescents' because male sexual partners have higher bargaining power when they have more money (132).

5.3.4 Sexually transmitted infections

Due to a number of multiple sexual partners, participants reported a number of problems concerning sexual activity which they defined as STIs that were affecting adolescents' in the area. The commonly mentioned ones in almost all interviews were *chindoko* (syphilis), *chizonono* (gonorrhea), *mauka* (genital warts), *zibomu* (chancroid), tuberculosis and *kanyela* (feeling cold in absence of an opposite sexual partner). According to adolescents' participants, *kanyela*[44] was also included as one of the STIs and to some extent this may justify the degree of sexual activity among adolescents' because they may think that if they do not have a sexual partner, they would suffer from *kanyela*. It may further show lack of proper knowledge on the STIs in general among the adolescents. Despite being infected with different STIs, going to the hospital was not a priority for adolescents' as they feared to be tested for HIV/AIDS.

> *Here adolescents suffer from STIs such as gonorrhea, syphilis and many do not go to the hospital to receive treatment even if they get infected. Many fail to go to the hospital because they think that they will be tested for HIV. As a result many go to the traditional healer thinking that they are bewitched and if the traditional healer fails, then they go to the hospital but very late*[45]*"*. (In-depth interview, 16 year's boy)

Therefore, adolescents' low utilization of family planning services is influenced by a number of concerns. Informants further reported that some adults were also infected with STIs because some married male adults were having extra marital relationships with the unmarried adolescent girls who were having multiple sexual partners.

5.3.5 Promiscuity

A majority of KIs (9 out of 11) had reported positive opinions towards adolescents' using family planning services. KIs had wanted adolescents' especially girls to start using family

[44] *Kanyela* has been reported as a positive reproductive health problem because in this context, it becomes a problem because one is feeling cold just because the opposite partner in not around. If the opposite partner is around, the disease is not there.

[45] The fear of being tested HIV positive is still common among adolescents and many adolescents still lack knowledge that HIV testing is voluntarily in Malawi.

planning services because many girls were caught sleeping with fishermen. For instance, a parent of six children, three of them adolescents' said, "*the lake attracts different people, some come for business to buy fish, some are just tourists and some we do not even know hopefully are prostitutes."* Because of poverty, many girls had become promiscuous as one KI reported,

> *Due to poverty our young girls have sex with men who come to buy fish here in exchange of money to buy their needs such as lotion and clothes. Sometimes they even sleep with the men within the village yet they already know that this man is married and have children but they don't fear the consequences of having sex with men who are already married. Married men can deny them responsibility if they impregnate them since they are already married and sometimes they can infect them with HIV/AIDS. Even the wives to these married men can beat them* (CBDA).

This is a challenging situation as it may put girls at risk of unwanted pregnancies and STIs because in such cases sex is often unprotected. Similar trends were observed in Uganda and Tanzania, documenting a high association of promiscuity among girls and women along Lake Victoria and fishermen (127). By contrast, MHRC study, in Nkhotakota district (along Lake Malawi), observed that girls and women were sleeping with fishermen in exchange of fish but not money as revealed in our study (91). However, Hallman argues that the practice of transactional sex where women and girls engage in sex for material gain –is the oft-mechanism by which women are said to be placed at increased risk of infection (134).

6.1 Lack of proper knowledge

All adolescents in our study knew a number of family planning methods and commonly mentioned ones were injections (Depo-Provera), pills, male condoms and abstinence. This concurs with (2004) MDHS which indicates high knowledge levels of modern family planning methods among adolescents' (3). Only few boys (4 out of 12) mentioned withdrawal and male sterilization as family planning methods. Married adolescents' mentioned the Interurine Contraceptive Device (IUD) method. However, boys FGDs displayed lack of proper knowledge by reporting other natural methods which they believed can prevent pregnancy. Other participants were nodding their heads to show their agreement as participant six explained:

> *There are other methods as well that does not require going to the hospital (laughs…)* I encouraged him to keep on…..…and he proceeded, *when one is having sex whilst standing, because sperms fall backwards. Also when having sex in water because the sperms get washed away and when a girl is menstruating because the sperm meets with the rotten blood and no fertilization occurs."* (Boys FGD, six participants)

This is a big challenge and if many adolescents' still believe and hold on to such type of non-effective methods then a lot need to be done in order to change their thinking towards the right information as regards to how they can protect themselves from STIs and unwanted pregnancies. Further adolescents' with such beliefs may not value the importance of using modern family planning methods and eventually it might also affect their decision making of using family planning services in general. Another natural method reported by both girls and boys was following the dates of the menstrual cycle. This is also dangerous as probably many adolescents' really do not understand how the menstrual cycle works. Therefore adolescents' need thorough education and insight before deciding to use this method. Further, in girls FGD, one participant reported that family planning should be used when one has encountered a problem during delivery. However, participants knew that pills, injections, condoms and male sterilization were available at the hospital and that condoms were also available at CBDAs, HSA, and could be bought from shops. The other source mentioned was at a youth club office called 'NCANDA *ndi* NCANDA'[46] located at the core of the district and it was preferred by all adolescents' who had visited it because of its good services. Like all other adolescents', the nineteen year's school going unmarried boy who had once visited the place said "*it is a good place because they do everything, in my case the time I went there for the methods, they explained to me the advantages and disadvantages of all methods and told me to choose which I want."* This probably informs that adolescents' have preferences about where they could go for family planning services.

6.1.1 Lack of knowledge about occurrence of a pregnancy

Adolescent mothers further argued that unmarried adolescents' do not use family planning services because they think they cannot become pregnant since they are young even though they engage in sexual behaviors.

> *Because she regards herself as a young girl who cannot have pregnancy since have just started menses and says I will be having sex and will start using family planning when I grow older. They also take what their parents tell them about family planning that you are young, so you can not use family planning then without knowing, immediately the result of having unprotected sex is pregnancy."* (Married adolescent mother of two, 18 years, no school)

To those adolescents' who are sexually active, the feeling of being young is dangerous because it want exempt them from the consequences of unprotected sex. Probably this

[46] NCANDA *ndi* NCANDA is an organization under save the children and operates in the study area with its staff from Save the children offices based at Mangochi District hospital.

informs that adolescents' in general, lack correct information about when one can become pregnant or impregnate a woman which calls for more education through use of family planning services. Further, our findings corresponds with studies in South Africa which also found that many adolescent girls had not used contraceptives on their first sex because they felt young and that they could not become pregnant (18; 23). From the above quote, it can further be assumed that the feeling of being young is probably associated with marital status in many adolescents' implying that unmarried adolescents' would feel young while married adolescents' would possibly consider themselves adults.

In FGDs, adolescent girls said that they knew friends and classmates who had gotten pregnant while they were very young. According to girls, an early pregnancy was a result of ignorance because they were not sure that they would become pregnant on their first sex. For instance, a single adolescent mother with a one year old baby boy in her hands narrated,

> *I did not know that I can become pregnant; because I had sex only once with this man and it was my first day to have sex in my life. I started having malaria now and then and my mother took me to the hospital where I was told that I was pregnant and I will have a child, I got disappointed*. (In-depth interview aged 16)

Lack of proper knowledge concerning basic aspects of human reproduction were further noted in Warenius et al study in which adolescent girls aged 20 years did not know how one becomes pregnant (135). Therefore, ignorance about the general consequences of unprotected sex can be one of the reasons adolescents' do not use family planning methods during their first sex.

The unexpected finding was noted in discussions with adolescent boys in which they informed that sometimes girls were forcing their boy friends to have unprotected sex because the girls were admiring their friends with children. In life, people get inspired by role models and in this society probably being a mother is a great achievement to adolescent girls. My interpretation corresponds with other authors that have argued that within the Afro-American black community, motherhood is seen as a woman's fashion in society. Like in our study, high regard for motherhood among adolescents' is reflected to some extent in the results of a 1980 study by Thompson in which Black teenagers stated that they believed the greatest satisfaction in marriage would be the conception of a child (136). In such situations, adolescents' use of family planning services aiming at preventing a pregnancy can not be an enabling factor.

6.1.2 Negligence due to lack of proper knowledge to consequences of unsafe sex.

In contrast to my assumption, adolescents' and KIs reported that adolescents' did not use the services deliberately because of negligence which consistently came out in all FGDs and individual interviews. The health surveillance assistant (HSA) informed that sexually active adolescents' choose deliberately not use family planning services because they are well knowledgeable about where to find family planning services. He further said that some, who were reported to be suffering from STIs, were members of the youth friendly service (YFS) in the community which usually discuss prevention of STIs and pregnancies. This calls for an evaluation of the YFSs in behavior change of its members. According to boys FGDs, the emphasis of using safe sex was to prevent the unwanted pregnancies and it was the responsibility of girls to check how they could prevent themselves from the unwanted pregnancies. As such, boys blamed girls for lack of responsibility to protect themselves. The common saying was:

> *Girls here take this for granted, those who use pills or injections are not many because even when other girls hear about family planning methods, they decide not to use the services"*. (In-depth interview, adolescent boy, sixteen years, not married).

The girls also thought it was men who were supposed to decide on how sex should be. These conflicting views put adolescent girls in a double bind, making me wonder if they can ever win the battle of decision making on how sex should be to their sexual partners. Boys FGD revealed that some of their friends were boasting that they did not care about having a protective sex because they rely on fishing which implies money. Our friends say "*even though I bare a child, I will fish, sell and then have money which I can give to my girlfriend to support the kid"*. These findings informs that boys are possibly not more concerned about the consequences of unprotected sex, in terms of HIV/AIDS and other STIs, but are more concerned with the implications of impregnating a girl which they can get away with, if they have access to money.

In general adolescents', both during FGDs and individual conversations, displayed a lack of concern about the STIs including HIV/AIDS which was noted from their common phrase '*timakaika*'- (we are not certain) that we can contract the diseases as one participant said "*we say this can not happen to me."* I acknowledge that within my search, there was no literature as regards to negligence and adolescents' use of family planning services.

6.1.3 Beliefs about first sex

Due to poor knowledge, adolescent boys in our study believed that they were not supposed to use any protection such as condom on their first sex. In an FGD with unmarried boys, they concurred that first sex should be bare (without condom), so that a man should test the girl if she is sexually good or not, without interference of a condom. Boys stated that having first sex with a condom will not enable them as partners to discover and appreciate each other sexually and as a result one could not make future decisions about marriage. Further, one participant said, *"it also it gives chance for both of you to see each others private parts"*. Asking girls why protection is not used during their first sex, they reported that it was due to ignorance since first sex happens when they are too young and not yet exposed to *kulera* (family planning) information. Similar findings were noted by MHRC study which suggested that sex education including use of contraceptives should be introduced to children when they are still young because some get exposed to sex at very tender ages even before puberty (100). Despite adolescents' having beliefs about first sex, they should also take caution that each unprotected sex is a high risk sex. The famous Malawi daily times newspaper of Monday, December (2007) featured Dr Malewezi who observed that use of condom at last high risk sex remains low in rural areas and especially in southern region of Malawi, which has the highest population, compared to the other two regions.

6.1.4 Negative beliefs about family planning methods

Adolescents' in our study had a lot of negative beliefs pertaining to different family planning methods which are probably due to poor knowledge they have on the methods in general. According to them, such beliefs have influenced their low utilization of the available family planning services. Similarly, a couple of qualitative studies in many African countries have overwhelmingly documented adolescents' negative beliefs and misconceptions that are associated with family planning methods and how they had limited the use of the methods among the intended users (130;133;137). The results of those studies echo the findings presented here. For instance, in our study, various negative beliefs specifically about injections and condoms were also reported from both individual interviews and FGDs as follows, *"Condoms have viruses of HIV so that many people should die because it was a deliberate move by the government to control the population"*. Some said, *"Condoms causes sores in the female genital track and the men's gentalia, condoms can burst during sexual intercourse as a result a woman can die"*. Other participants believed that with injections, the abdomen and the legs becomes permanently swollen. With prevailing norms that emphasize on the importance of children, adolescents' have acquired transverse rumours from both

friends and parents about how using family planning methods would make them infertile hence limiting their actual use. In girls FGDs, statements like "*sometimes injections can burn your womb"* had made unmarried adolescent girls fear for their future life in case they get married and do not have a child. Consequently, this would discourage adolescent girls to use family planning services. These findings fit well in the initial behaviour model featured in chapter 2, in which beliefs about the services can influence low utilization of the available services (49).

However, a nurse midwife in a family planning clinic had argued that no client had come to the hospital with complications of using family planning methods. Among the KIs, only a significant majority (2 out of 11), a TBA and a female initiator (*nankungwi*) argued that pills do not dissolve, can cause wounds in the stomach as you take them every day and as a result (*zimazaza pa chinena*) they just pile up between the upper part of the vagina and the stomach. In general, adolescents' presented a number of myths about family planning methods such as they cause cancer, maternal death and that one becomes barren if uses the methods before having a child first. Wrong perceptions about different family planning methods are likely to de-motivate adolescents' to use the methods even if they can be sexually active.

Both unmarried adolescent girls and boys believed that sex with a condom was never sweet. It was interesting to note that sessions with girls were blaming boys to be refusing condoms by saying that, "*sweet in a wrapper is never sweet".* This was mentioned by all adolescent participants in the study. With boys' sessions, they also accused girls that they had always refused sex with condom based on the same reasons of sweetness. To understand them better I probed them as highlighted in the excerpt below:

> *Interviewer (I): Tell me what do really girls say if you boys introduce a condom during the time you want to have sex with your girlfriends.*
> *Participant(P)2: Girls always deny to use condoms they say one can not eat sweet while it is in the paper (all laughs) so once we hear them saying this we throw away the condom saying yes let us do it without a condom.*
> *P5: One does not reach peni peni (orgasm) when having sex because you can not combine sweet with a paper, it is better you first remove the paper so that you can enjoy the sweet.*
> *P 3: It also becomes hard on our part to tell them that we will use a condom* (Boys focus group, six members).

This probably shows that both boys and girls had preferred unprotected sex because no failure of sexual intercourse had been reported based on the fact that the opposite sexual partner had insisted on protected sex. The general consensus was sex should be *nyama kwa nyama* (fresh to fresh) implying plain sex. Boys and girls want to enjoy sex the natural way. "Natural" sex

has been reported in several countries like Tanzania, South Africa, Uganda as far as cote d Ivoire (127). Plain sex was reported to make both partners sexually satisfied. Similar findings were noted in Francine study, who reported that the strong symbolic value of semen also discourage condom use (102). However, participants had reported correct knowledge of condoms as they mentioned that it prevents both a pregnancy and STIs. This becomes a complex issue as adolescents' have their own values attached to unprotected sex and calls for intensive civic education to change such attitudes towards having safe sex. Therefore, encouraging adolescents' to use family planning services would them help acquire such information.

The new finding was that some boys acknowledged failure to use condoms because they were attracted by the physical appearance of girls and would totally forget about the condom and remembered it later after engaging in unprotected sexual intercourse. Lack of knowledge was further noted in contradicting information which boys and girls reported in all FGDs and individual interviews. When unmarried girls acknowledged condom use, they cited pregnancy as the main reason while boys acknowledged condom use on the type of the girl they were having sex with.

> *Some of us we use a condom depending on the type of the girl, if you know that she is fine, no problem, just go ahead…laughs".* (Out of school married adolescent boy, aged 17)

Therefore physical appearance among adolescent boys can determine the health status of a person because in this context use of safe sex is probably due to fear of HIV/AIDS which is associated with the looks of a person. This contradicts with *chishango* [47] brand which warns condom users not to be taken up by physical appearance. *Chishango* (condom) adverts are found almost everywhere in Malawi even on buses. On the other hand, it implies that adolescents' who know each other better or have been in a sexual relationship for a longer period of time are less cautious about having unprotected sex leading to greater risk of pregnancies and STIs.

7.1 Individual related barriers

Adolescents' in both FGDs and individual interviews had reported a number of reasons that discouraged them using the available family planning services. Most of them were individualistic.

[47] Chishango (condom) brand is a Population Services International non-governmental organization that distributes and sells condoms throughout Malawi and has its adverts everywhere from billboards, charts in schools, hospitals and even in public drinking places. Their posters are very simple and communicate messages on condom as a protective measure.

7.1.1 Peer pressure

School going adolescent girls acknowledged being constrained to use the available family planning services because of their friends who were laughing at them if found with family planning methods.

> *At school there is Edzi Toto club which educates all pupils on the dangers of STDs and HIV/AIDs, dangers of early pregnancies and consequences of early marriages and the club offers condoms and writes referrals for those who want pills and injections at the hospital. However, if other pupils discovers that so and so is using the methods, they laugh at her especially the girls and they spread the news even to her parents".* (In-depth interview, adolescent girl, standard six, aged 16)

Influence of peers in decision making is more prevalent among adolescents' and has influenced many to fall into problems either it be sexually or not. Several studies have demonstrated that peers are important in shaping attitudes towards sexual behavior among young people which can either be positive as well as negative (58). Even in Jamaica where adolescent pregnancy is highest in the Caribbean region, peers would react when they learned that a young female was sexually active (137). Similarly, in our study it was also commonly reported that girls' decisions on whether to use family planning services were influenced by peers. The quote below explains this situation.

> *Sometimes whenever your friends have seen that someone is looking for kulera (family planning), they say, you why do you want to use kulera (family planning)? Don't you know that you have a lot of babies in your body? Do you want to die? That is why we make sure that at the age of 20 we have at least children"* (Adolescent mother of one, not married, 17 years)

Non verbal peer pressure was also noted as some adolescents' stated," *there is competition among us, if you see your friend is married and have children, you ask yourself, what I am doing?."* Qualitative studies in Sub-Saharan Africa also show that peer pressure has a strong influence in encouraging premarital sexual activity and that young people gain social acceptance from their peers for having sex before marriage (57-58). This is further reflected in Ajzen theory of reasoned action presented in chapter 2, in which values of significant others have an effect in shaping adolescents' sexual behaviours (56).

7.1.2 Abstinence

Some adolescents' reported that they did not use family planning services because they were abstaining. However, many mentioned that it was hard to maintain because there is need to fulfill sexual feelings and desires. According to some girls' respondents, the best way was to avoid having a boyfriend so that they can easily wait on sex until in marriage. They said that by waiting, they would get protected from HIV/AIDs and unwanted pregnancies.

Interestingly, in our study, abstinence was used after having sex and getting exposed to consequences of unsafe sex. One adolescent girl stated, "*In the past I used to have plain sex*[48] *but now I do not use contraceptives because I am abstaining, there is HIV*". However, abstinence is a very good way of protecting one self if one can manage. In Burkina Faso and Ghana, adolescents' also acknowledged abstinence as way of protecting themselves from HIV, other STIs and pregnancy (137). Adolescents' mentioned an NGO called YONECO to have made them realize the importance of abstinence in the community. Because almost all adolescents' mentioned YONECO, I asked YONECO reproductive health coordinator on how they were progressing with their activities in the area. She mentioned that they were trying but culture had influenced reproductive health behaviors of many adolescents' in the area, "*as such, there is still a lot to be done as we can not concentrate on preventive measures but rather on the causes of such behaviors among adolescents"*. This finding points to the importance of considering culture in designing of interventions towards addressing adolescents' reproductive health needs in this community.

7.1.3 Side effects

In both FGDs and individual conversations, adolescents' presented a number of side effects pertaining to different family planning methods. Among the participants, non users reported that the information on side effects which they hear from users of family planning methods propagate fear in them that they fail to make decisions on whether to start using family planning or not. Those who were using had also reported their experiences. The discussion is illustrated in the excerpt below;

> *Interviewer (I): some of you said that you experienced side effects from using family planning, could you explain to me what were they and if you heard from your friends what did they say?*
> *Participant (P)2: Yes the injections are painful; now my boyfriend buys condoms from the groceries and am not quite sure of what will happen after wards, may be one can die.*
> *P 6: I use injections and I do fall sick regularly and I feel that it is very bad to us the adolescents. So we should get helped in a way that if we use it, we should not fall sick every month.*
> *P 4: for me I use kulera (pills) but the time I want to start menses, I just have heavy bleeding as if I am flushing out water. Continuous menses also cause me to have headache.*
> *P1: Others say they do menstruate the whole month without stopping, become thin and their skin become pale even if they apply oil. So these are the bad things that prompt people not to use injections (Depo-Provera)*
> *P2**:** I want to start using family planning methods, but when I hear all these things I become afraid. Because others become fat but others become thin as if they have contracted kachirombo (HIV virus)* (FGD, married and unmarried girls, 6 participants)

[48] Plain sex refers to sex without any protection. In recommended English it implies unsafe sex.

Although injections were reported to have more side effects, some married adolescent informants acknowledged that there were on injections and also some wanted to go for injections than using pills. Pills were not preferred because they could raise conflicts when discovered by husbands. Specific complaints about condoms were that participants felt itchy in their gentalia after using them. Condoms have a lubricant and some people might be allergic to it and that may be applicable to the participants who experienced some itching of private parts in our study. Other studies have also reported the same, concerning condoms (101-102; 116; 123). This calls for proper counseling to clients so that they should be aware of both advantages and disadvantages of the methods before they start using them.

8.1 Reasons associated with delivery of services

There is ample evidence that adolescents' who need the services do not use them. For instance, many reasons concerning delivery of services were discussed in detail as the major factors adolescents' were discouraged to use the available family planning services despite wanting them.

8.1.1 Clinic set up

I observed some family planning sessions at the health centre and the setting of the health centre in general. My attention was drawn to the place where antenatal clinic is done because of the posters which were pinned on the walls. The posters in the clinic communicate messages about family planning. They were very simple as some did not contain any or few words but just pictures of a pregnant woman with a toddler and a husband carrying a baby while the other two children walking with them. In simple translation the picture was communicating the dangers of un-spaced pregnancies to women. Patients were entering one by one in the consultation room and would come out with a prescription to collect medicine through a window on an open space. Besides this line, was another cue for those who wanted to collect family planning methods. Family planning clinic was conducted everyday depending on the turn up of women and availability of the nurse. However, each person was free to visit the health centre at any time for family planning services as long as the hospital was open because one volunteer was always around to help them. During antenatal session, women sang songs praising family planning and the message was like it enables them to have manageable families and gave them time to do businesses. During the three days I stayed at the health centre, no unmarried adolescent girl or boy had come to the clinic for family planning services, only married adolescent girls were coming. Discussions with adolescents' reported that they were limited to utilize the available family planning services which were

especially offered at Lungwena health centre because of the clinic set up and in turn is a brief discussion of how the set up has affected some adolescents to use family planning services in this community.

8.1.2 Lack of Privacy

According to adolescents', the main drawback was the setting of the health centre. They reported that the bench for people to sit who wanted to collect family planning methods was just next to the one people were sitting as they were waiting to go into the consultation room. In an individual interview, one unmarried girl said,

> *When you are sitting on this bench, everybody sees you and just know that the message has already reached your parents before you are there.* (School going adolescent girl, aged 14)

Some participants indicated dissatisfaction with how they are handled at the health centre. One participant explained that he felt bad when he went to collect condoms because he did not expect other people to know why he was there.

> *I wasn't satisfied, when she was giving me condoms, she just brought a carton and said take it and that time adults and children were around, and I failed to hide because they had already seen the condoms".* (In-depth interview, unmarried adolescent boy, 17 years, stopped school)

Adolescents' informed that the privacy was only in the consultation room because it was only two of you and the door was closed. During my observation at the health centre, there was another room where counseling for family planning was conducted. However, this room was also a through road to the maternity ward. Pregnant women who were on waiting and their guardians were passing through in and out several times while the counseling session was in progress. Other health workers would also come in to pick up files and other things. To those who are not married, it is indeed a challenging situation because of the negative attitude the society has towards premarital sex. However, I observed that in terms of privacy as to where the clients could collect the methods would probably be a challenge at this health centre because they have few rooms.

8.1.3 Confidentiality

Adolescents' said that they were reluctant to collect family planning methods at the health centre because they did not trust some of the health providers. It was reported that most of the service providers at the health centre were friends of their parents and as a result could report to parents that their daughters came for family planning methods. Sometimes the providers

could ask the girls if their parents knew that they had come to the hospital for contraceptives. For instance, during FGD with unmarried girls one participant said,

> *Other service providers do tell people who use family planning more especially names of school girls and women whom their husbands are in Johannesburg, and when you are there everybody looks at you.* (14 years, school going adolescent girl)

Some of the providers would also tell the relations of the husband that their daughter in-law came to take family planning methods yet the husband was not living with her. This was common among the married adolescent girls who had husbands in South Africa. Adolescents' felt that it was unfortunate because most of the providers at the health centre were not helping them properly and mentioned that the two private hospitals (Malindi and Banja la Mtsogolo), and Mangochi district hospital were much better in dealing with unmarried people in issues concerning family planning and other reproductive health needs. However, they informed that the two private hospitals and the district hospital were far and needed transport money which was difficult for them to find. Similar findings were found in Zambia where adolescent clients believed that staff workers could not be trusted to maintain their confidentiality (126).

8.1.4 Provider's negative attitude and work load

Adolescents' reported that they were afraid of service providers because some of the doctors were reported to be proud and they did not treat the adolescents' well when they had approached them for family planning and treatment of STIs. During an individual conversation, one adolescent boy said "*some doctors amazigomera (are too proud) they take their positions from home and use it at work*". However, this might not only apply to doctors working in family planning clinic but to other departments as well. Clients are also likely to confuse between a doctor, nurse, clinician and other health personnel for they think anyone in the hospital is called doctor.

Some participants complained of priority being given to pregnant women even when we are the first ones to come.

> *When we go to the hospital, doctors say family planning is not a disease so you can wait until I finish attending those who are in the maternity ward who wants to deliver. Sometimes the doctor can have patients the whole day and you just sit waiting and in the end you just go home, that is why we go to take the methods from the CBDA*[49] (sixteen years unmarried adolescent girl, stopped schooling)

[49] Anyone at the hospital was called a doctor by the participants. They could not differentiate between a doctor, nurse or volunteers. At this health centre, FP counseling and provision of some methods that does not require

Due to shortage of health personnel and burn out, the preference of assisting adolescents' seeking family planning seemed not a priority as compared to other physical illnesses. To understand their experiences, I asked them if they had ever gone to the hospital for family planning services, and one participant stated,

> *Sometimes we think of going to the hospital but when you think of treatment there, you just say I will not go. For me I went but service providers were busy and told me to wait because they were working in the maternity ward and they had other patients somewhere as well. As a result I thought of going back home because I was there for a long time and I was thinking that may be people from my village can find me and will ask me what I was doing yet I was not sick.* (Unmarried adolescent boy, 16 years, no school)

These problems were relatively reported from clients who were attending Lungwena health centre for services. This might probably be true because my observation was that, there are less than five health professionals working in the health centre and the health centre receives a lot of people with different needs. Some participants explained that sometimes they were given such bad reactions from the doctors because of the time they had gone to the hospital. One participant said "*the best time to go is in the afternoon when doctors have few patients unlike in the morning hours when long cues wait for one doctor to attend"*. Therefore, efforts must be made to improve the capacity of health workers to deliver family planning services in order to achieve the desired results.

Those who had visited the District hospital had special health personnel in their minds that they preferred unlike those who would start advising them to abstain. Commenting on some providers, adolescents' reported that some were very friendly but some could act like parents scolding them for using the methods that are meant for married people. For instance, one adolescent boy elaborated in an FGD that if you meet Nurse *X*, she will explain to you properly as he explained in the quote below:

> *I went to Mangochi district hospital to collect condoms, when offering the condoms, she explained to me that even though she was giving me condoms that does not mean that we can not get HIV/AIDs and she said the best way was always to abstain* (Boys FGD, six participants)

It can therefore be argued that adolescents' need health personnel who are ready to accept that adolescents' too indulge in sex, and who can listen to what they want as regards to their

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clinical expertise are done by volunteers. Even at Mangochi district hospital, family planning clinic is conducted by nurses not doctors.

sexual life. This corresponds with Fred et al in Ginsburg (1995) who noted that provider's attitude and not the content of discussion was the major determinant of adolescents' satisfaction with their health care (138). Further, in the same quote, still the attitude of health providers is that adolescents should abstain. Although many adolescents' disliked the attitude of some health providers, some school going adolescents' said if the hospital had enough health personnel whom could attend to their needs, it was better if they had gone to the hospital because the medical people explains properly how each method has to be used, and one has a wider choice of methods unlike the CBDA's who have little knowledge. This is in contrast with FGDs conducted in (2002) among married women in Malawi which highly praised CBDAs for giving clear explanations and for helping them to overcome difficulties with hospital providers (139).

Two unmarried adolescent girls on pills reported that some nurses were good because they did not mind where one is coming from and doing. But some nurses were reported to ask and if they find that you go to school, they would say "*so you will stop schooling*" and if you want pills they would say "*you want to spread the STIs"*. This could be viewed as a bad attitude towards unmarried adolescent clients and would likely influence low utilization of family planning services among many adolescents'. The general picture displayed in our findings is that nurses and other health professionals in the reproductive health area seem to be caught in unethical dilemma between the norms and values of the community and the reality of unmarried adolescents' engaging in premarital sex. In Zambia, Kenya, South Africa and Tanzania, nurses also found it difficult to give family planning methods to adolescents' on the basis of their age, parity and marital status (17-18; 23;126).

Some health providers were reported to have denied providing treatment to adolescents' who had contracted STIs on the grounds that they should go back home to pick up the person they had sex with so as to be treated together. Not all adolescents' in our study had the same experience but many of them (10 out of 26) had reported similar experiences. In an FGD with boys, one participant narrated how they are treated and presents his hospital experience as expressed in this quote:

> *At the hospital, they shout and ask that do you have a sexual partner? If you say yes, they demand you to pick up the partner and get treated together, and then you go and inform the partner that I have been found with an STI so they are demanding both of us for treatment at the hospital. For instance, last year I had contracted chinzonono (syphilis), and I first went to traditional doctor but after failing I decided to go to the hospital and I was sent back to get the one I had sex with so that they should treat both of us. I did not*

want to tell her so I did not go back to that hospital but I went to Banja la Mtsogolo, a private clinic and I was healed and they advised me not to have unsafe sex a gain. They gave me condoms to be using if I want to have sex."[50] (In-depth conversation, unmarried boy, 17 years, no school)

Probably the service providers insisted on treating both partners to avoid further spreading of the infections in case there is a chain of sexual partners and that would mean everybody in that chain will be infected. However, this complicates the situation as many infected adolescents' do not go back to the hospital for treatment. I noted this when many unmarried adolescents' (both boys and girls) expressed that this becomes a major problem especially when;

You do not know really the person who infected you if you slept with more than one person. Also, some times you just have fear to tell the boyfriend you had sex with because he can start thinking and accusing you that you have other boyfriends. As a result you do not go back to the hospital and just try traditional medicine". (In-depth conversation, unmarried adolescent girl, aged 15, standard 5)

Adolescent girls expressed that even if one can have one boyfriend, *"he some times refuse to go with you to the hospital saying you have to mention another boy you slept with, not him"*. Other adolescents' disliked the hospital on treatment of STIs because health providers associated STIs with promiscuity. For instance, during an individual interview with unmarried school going adolescent girl, she said, *"They shout at you that instead of concentrating on your education, you are busy with men".* She was told this when she went to the health centre to seek treatment, the time she had contracted an STI. Such fear inculcated in the clients may likely put infected adolescents at high risk of spreading the disease further and, at the same time worsening their health situation due to lack of access to treatment in good time. Despite the unfriendly service providers, some were recommended for treating STIs among adolescents' and in a boys FGD one participant said "*some are good, if you go there, they treat you, and they will not go on the market and say you have got a certain disease and have given such and such a medicine."* In an individual interview, another adolescent boy further commented that he was properly welcomed and said "*they receive us properly, but the only problem is when you are telling them, they do ask us how you got it plus shouting*". However, if some service providers really happen to spread results of their patients, then they act against

[50] The quote may be understood in three different ways. Firstly, services providers may shout just because of their negative attitude towards adolescent sexual behaviors. Secondly, because the client came to the hospital late after the disease has reached an advanced stage and thirdly because STDs can be prevented if one had used a protection during sexual intercourse.

the medical ethics.[51] Further, this would discourage adolescents' from using family planning services. However, talking with a nurse midwife in the family planning clinic, she stated that they were very open to help adolescents' with family planning services including other issues on reproductive health in general, but many adolescents' often do not want to use the services because they prefer getting married so as to have children than schooling.

9.1 Other Factors

9.1.1 Lack of role models

Despite the early pregnancies, KIs said that it was difficult for adolescents' to fully utilize family planning services due to lack of role models in the community. According to one KI, "*Adolescents' here admire that my friend is having a baby."* This could probably be the reason some adolescents' marry early so that they can be like their friends. My interpretation is that if this syndrome is common in many girls, then family planning to them is not ideal. This study therefore, points out to the importance of having role models in the society to which adolescents' would emulate good things like being educated, being economically stable either through business or getting married at a good age when they are physically and psychologically mature.

9.1.2 Lack of parental control

KIs reported that lack of parental control has forced many adolescent girls into early marriages since most of the girls were growing up with a single parent (female parents only) because men were staying in South Africa for part time jobs. Although, our findings points to early marriages among adolescent girls, KIs argued that some parents were not happy with the practice of early marriages. Among the KIs, one parent gave an example of how he reacted after his daughter willingly got married whilst he was working in South Africa.

> *My daughter got married at the age of thirteen and by then I was working in South Africa, when I got the message; I came back the same week to terminate the marriage. Lucky enough, she was not pregnant. Since then, I did not go back to South Africa so that I could monitor her and now she got married but at a good age of twenty one*. (Male parent of three adolescents)

The general concern was adolescents' (both boys and girls) who were growing in female headed households were difficult to control. In Botswana, diminished control of adolescents' sexual behavior was also associated with female headed households (ibid).

[51]The medical ethics manual emphasizes that 'all identifiable information about a patients health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind, must be kept confidential, even after death.'

9.1.3 Stubbornness

KIs complained that many adolescents' were stubborn and as a result, they fail to take their parents advice even when it means advising them about using contraceptives. Although adolescents' in this study complained that parents discouraged them to use family planning services and that parents do not discuss anything related to sex, one parent had argued that the adolescents' are not always ready to take parents advice. One parent illustrated and expressed in the quote below:

> *The problem with our children is that they are stubborn, that is why they are landing in all sorts of problems of pregnancies and diseases. For example, I have my daughter and to tell you that my daughter is this one and have three children, you can not accept it because of her size, she is too young. I advised her that she should be using family planning because doctors are not stupid to tell you to be using family planning but she does not listen to me"* (female initiator and also parent to two adolescents)

These are some of the complex issues parents of adolescents' are facing. The CBDA had also argued that the village headman was trying his best to counsel the adolescents' about the dangers of early pregnancies but adolescents' did not listen to him either. A female parent said *"They don't listen to what we are advising them, so what can we do?"*

10.1 Available adolescent reproductive health care services.

This section address objective number five which looked at the available adolescents' reproductive health care services in the area that adolescents' were aware of and have access to when in need of different reproductive health services. On this objective, I wanted to find out if they knew where they could go if they had any reproductive health needs. Many participants had mentioned Mangochi District hospital, Lungwena health centre and NCHANDA *ndi* NCHANDA as the places where would always go for reproductive health services. However, girls argued that the district hospital was quite far and for someone to go there it needed a lot of time and transport money. The well known health care reported by almost all adolescents' was Lungwena health centre which was within the community where this study was conducted.

> *It is the only health centre which is available for both youths and adults. Edzi Toto club is available for school going adolescents only. There is no youth friendly service at the moment in the community which has physical structures but some youths just meet in special days under a mango tree to discuss such issues. Also here in the village, we have YONECO youth club and there is another here at Chiwaya (name of a place) where we go*

to have access to information but others don't go due to stubbornness"[52] (In-depth conversation, married adolescent boy, 16 years, no school)

Respondents had also mentioned some more youth friendly services like MOVIMONDO and YONECO and reported that the YFSs were helping adolescents' who were only members of the club particularly with information on HIV, dangers of early pregnancies and prevention of STIs. Some of the boys among the participants were members of the youth friendly clubs and expressed that youth friendly clubs were open to everybody but *"even if when girls become members, they do not participate fully and they become shy in front of us boys"*. Although adolescents' had mentioned a number of health care services for their reproductive health needs, their main concern was where to go for treatment when they had contracted STIs as one boy who once suffered from STIs said,

We know that we are supposed to go to the CBDA, or TBA in our community because sometimes they also have some condoms, but if I forgot to use the condom in the first place and contract an STI, then I do not know really if the hospital would treat me, Last time I got sick I was in problems after they demanded me to take my sexual partner and by then the traditional medicine had already failed. (Unmarried adolescent boy, 17 years, no school)

The TBA was commonly mentioned by married adolescents' in terms of pregnancies, and they reported that she always have more patients than the health centre. KIs acknowledged that many adolescents' who were pregnant did not go to the hospital in the first place, but rather to the TBA and could go to hospital later after the TBA had failed. Even those who had contracted STIs, their first option were traditional doctors because in the first place they did not know that it was an STI. One boy informed, "*We realize that it is an STI later and may be after you have applied traditional medicine and failed because we do not know the signs in the first place"*. However, such situations may contribute to the perceived bad attitude of health personnel towards treating STIs among adolescents' because they probably go to the hospital late after the condition is already worsened since they first consult TBAs or other traditional doctors. On the other hand, it depicts lack of knowledge among adolescents' to signs and symptoms of STIs.

In contrast to their expectations, adolescents' reported that these health care services were not specifically for adolescents' but for other people as well. Asked them about those who were

[52] This illustrates that adolescents had wanted services that were special for adolescents where they could get information and treatment. In Malawi, the health care services available like hospitals, private clinics and health centers, carter for all age group and my intention was to know if these young people had knowledge of that and what they thought about the services.

found in their community, Malindi private hospital was repeatedly mentioned and adolescents' recommended it for the good services on STIs treatment, antenatal clinic and family planning services in general. They said the only draw back was that it was a private hospital and required some fee for STIs treatment but some family planning methods were offered free of charge. Norplant was charged for. This illustrates that adolescents' know where they can go if they are in problems concerning their reproductive health needs only that they have priorities of where to go based on their individual feelings. However, for treatment of STIs, it is still a challenge to them because of the providers' negative attitude in public hospitals and that a private hospital requires some small fee which adolescents' can not afford.

In general many adolescents' recommended that government should help them with more information on adolescent reproductive health issues, and formulation of youth clubs within the community so that they can be educating each other on dangers of unprotected sex. Adolescent boys further asked for civic education on their parents on dangers of early pregnancies and marriages. Interestingly, girls recommended that they needed their own hospital where only adolescents' would go if they become pregnant, had contracted STIs and for family planning services. They emphasized the hospital should be written 'adolescents' only'. In girls FGD, one participant elaborated, "*We mean we want a place where we can be free to go at any time without fearing people"*. In general, this illustration points to how lack of community support makes it impossible for adolescents' to use the available family planning services freely, that could protect them from various reproductive health problems that adolescents' encounter. Individual interviews and FGDs helped to understand what adolescents' really want in their life as regards to family planning services and their reproductive health needs in general.

10.2 Summary

The chapter has presented the main findings and general discussion focusing on the broader issues that emerged from the study. The findings and discussion merged the data obtained from all sources namely KIs, FGDs, individual interviews, and some limited discourse analysis and general observations performed during the study period. A number of important findings have emerged from this study. Firstly the results points to numerous reproductive health concerns facing adolescents' in this community, namely; early exposure to sex, early unwanted pregnancies and marriages, multiple sexual partners and STIs. Further, our findings locate adolescents' utilization of family planning services at a critical intersection between

norms and the values of the community – which challenges premarital sex - the reality of adolescent premarital sex and adolescents need for family planning services. While adolescents' had wanted to use the family planning services, the norms of the society were against it unless adolescents' get married and also in marriage after they had produced some children. Further, unmarried adolescents' encounter difficulties in accessing family planning services, because the society and the health providers view such adolescents' as promiscuous. In our study, the reluctance of health personnel to give family planning methods and proper information on method use revolves around the conflicting ideas embedded in the culture that premarital sex is immoral. In addition to norms and values of the society, socio- economic factors and poor knowledge of different family planning methods among adolescents' are further acknowledged to have contributed to adolescents' low utilization of family planning services in Lungwena area.

10.3 Strengths of the study

As an exploratory study, the triangulation of methods helped to complement the findings in this study. For instance, real examples of those adolescents' who underwent the ritual of sex cleansing soon after initiation ceremony were not reported in FGDs but were uncovered during individual interviews. On the other hand use of FGDs allowed some participants to influence others to talk of sensitive issues as well which were later probed by following up in individual interviews. For instance, issues of incest and abortion were revealed in FGDs and were confirmed in individual interviews.

Since the focus of this study was on adolescents', KIs acted as a reference point on what was being discussed by adolescents' and hearing the KIs views helped the researcher on how to probe further on certain issues in adolescents' interviews. For instance, the way KIs viewed adolescents' premarital sex and what adolescents' said as regards to premarital sex and use of family planning was very important to this study. Use of these multiple techniques accounted for validity of our findings as some issues could cut across the three techniques used. Further, employing these different techniques accounted for new findings that are not found in MDHSs, which according to the reviewed literature, acts as the main data source on adolescents' and use of family planning services in Malawi. The MDHSs only account for the number of adolescents' using family planning methods and their knowledge levels but understanding reasons for use and non use are not accounted for. Again, the site where the study was conducted has also enabled to the new findings in the present study. For instance, issues of how cultural practices have contributed to low utilization of family planning services

and to major reproductive health problems in general are deeply rooted from the type of culture embedded in this society.

10.4 Key methodological issues

I acknowledge that it was challenging to analyze the vast amounts of data generated from the multiple data collection techniques employed in the study namely FGDs, KIs, individual interviews with adolescents', some discourse analysis and general observations.

Initially it was planned to hold FGDs with unmarried adolescents' only (boys and girls) and married adolescents' were planned to be among some of the respondents in individual interviews. However, during field work it was observed that it was difficult to find unmarried adolescent girls in one of the chosen village, as most of them were married. This has also been highlighted in section 3.8.4. In this situation, the only alternative was to conduct a mixed FGD of married and unmarried adolescent girls. This probably affected the response of the unmarried girls because it is possible that they felt low in the presence of their married counterparts considering the sensitive topic and the belief that sex is discussed within the context of marriage in this society. Unmarried participants who were noted to be shy and did not contribute much despite being probed, were further followed up during individual interviews for more clarifications, although call back interviews have high probability of changing information as participants become aware of the topic discussed.

It is pointed in section 3.8.3 of the methodology chapter that during proposal development, four objectives were identified on which data was to be collected but during the time of data collection, one objective was added, namely; 'identify adolescents' reproductive health concerns in the area'. The additional objective came in after piloting of the study tools. It was discovered that multiple responses came out emphasizing the major adolescents' reproductive health problems in the community and this influenced the researcher to include a new objective which looked at the major reproductive health concerns/problems affecting adolescents' in the area. Consequently, this objective generated more data and leaving out this objective would have made the study incomplete. This is because the reproductive health problems identified were well linked to the perceptions on low utilization of family planning services among adolescents' which is the focus of this study. Denzin and Lincoln (1994) asserts that flexibility is one of the major strengths of inductive approaches to research and as qualitative researchers; we go where the data take us, using whatever strategies, methods, or empirical materials at hand (60). These authors further argues that as we begin to make sense

of the phenomenon under investigation, we might change our approach, change our focus, add research sites, and even develop new strategies or tools.

During the interviews, it would have been more appropriate to target adolescents' who are sexually active and yet have never used family planning services or were using but had stopped. However, it would have been difficult to find adolescents' that would have acknowledged their sexual behavior.

Some of the interviews were conducted by the help of research assistants. Probably some biases occurred as to how the interviewers rephrased the questions and some of the issues were not intensely probed. However, I further acknowledge that conducting good interviews in qualitative research is not easy and it is an art that one can develop.

As an exploratory study, the results can not be generalized to all adolescents' in Malawi because the sample was small; it depended on the number of adolescents' found in the selected villages in this community. Also the study was conducted in a rural setting which has a different culture. Therefore the findings can only be representative to this community, but has provided insights which can further be compared to other districts in different regions of Malawi.

The study methodology was biased in selection of KIs. For instance only the female initiator was included and the male initiator was not included because from consultations, he does the role of circumcising only and not counseling. However, it would have been important to find out from him about the person who does counseling of the male initiates during male initiation ceremonies. It would have been further important to have views of a KI from religion side. The top most key person in this Moslem community such as the 'Sheikh' is likely to be more knowledgeable and would have added in some different views on the phenomena.

Late approval of the protocol by the research ethics in Malawi did not provide the gap to give the preliminary findings to the participants who took part in the study so as to cross check with information they gave during the interviews after transcribing. Only the pilot interviews were transcribed in time and went back to the respondent to inform them what they said. This would have been helpful because like in the feedback of the pilot results, some respondents

had some additional points to what they already said, making the data richer than before. However, analyzed data from pilot study is not included in this thesis; it was for testing the guides. Earlier transcription would have also provided chance to make queries in some points which required more probing.

Transcribing and translating of KIs data was done by the help of the local research assistants, but due to limited time, the transcripts were not discussed back with the one who actually conducted the interviews to see if it was transcribed according to how the interviews were conducted.

Lastly, the study did not adequately investigate views of parents. The four parents included were part of the KIs. It would have been better to conduct one FGD with parents as well so as to hear their perceptions on a broader perspective.

Chapter 6: Conclusions and Recommendations

6.1 Conclusion

Adolescents' in this society get confusing messages, i.e. from tradition, parents, teachers, peers and it becomes challenging for them to make proper decisions about what to take and leave out concerning use of family planning services. As such, adolescents' are challenged with numerous reproductive health problems, and their lack of support from the community to use the available family planning services has even complicated the situation. If only the community can acknowledge unmarried adolescents' sexual activity, then use of family planning services in Lungwena area would be ideal to many adolescents'. However, adolescents' need empowerment to deal with their sexual activity. Otherwise, the grave consequences of unprotected sex among adolescents' will remain a public health challenge. Much as we do not want to exaggerate the generalizability of our results, we do feel that they have some importance in increasing our general understanding of adolescents' and utilization of the available family planning services in this part of the world.

6.2 Recommendations

It remains challenging to give a recommendation on how to deal with poverty in this community despite the numerous problems it has influenced pertaining to our current study. Thus recommendations presented in turn do not include how to deal with poverty. However, interventions should acknowledge adolescents' utilization of family planning services and reproductive health problems in Lungwena area as issues that are affected by numerous social

and economic factors. Since our findings show that there are a lot of female headed households in this area, it calls for proper investigation of how single women and adolescent girls manage. Currently, there is a host of literature on poverty in Malawi but none is conducted on how poor single women and girls manage in such situations.

Expand on the already existing interventions to reach more adolescents and the community with proper information on adolescents' reproductive health needs- Our findings locate that the NGOs such as YONECO, NCANDA *ndi* NCANDA, and other theatre groups who sensitize the community on reproductive health issues are playing a great role in educating the community. In our study adolescents' recommended that theater should be visiting the community more frequently than they do because it helps adolescents' to understand more on reproductive health issues and parents too understand the adolescents' reproductive health needs. Although many adolescents' correctly reported the consequences of unprotected sex, some recommended that they wanted more information on how they could sexually protect themselves. Therefore, more interventions through these already established organizations would help in educating adolescents' in sexual protective behaviors, the whole community on adolescents' major reproductive health problems highlighted in our findings and the importance of adolescents' using family planning services. Since our findings show that adolescents' have strange beliefs about first sex and how natural methods can prevent a pregnancy, through these already established channels, additional lessons should specifically address myths related to family planning methods and first sex. Furthermore, adolescents' need right information, on their sexual life at very young ages and possibly in the pre-adolescent. In our study many girls proved lack of knowledge as regards to when one can become pregnant. They thought having sex once and for the first time excludes them from pregnancy. Another study in Botswana which looked into adolescents' sexual behavior also suggested the same recommendation (138).

Work in a joined effort to protect adolescents from the reproductive health problems –In this study, adolescents' hear different messages about using family planning services and sexual activity in general. Therefore, the Ministry of health should coordinate all key partners in this community such as health personnel, parents, teachers, and religious leaders on how to deal with adolescents' reproductive health problems. Adolescents' should also be involved in planning. Working in an organized way can help in developing similar messages that would be imparted to adolescents' at different levels and this could probably help adolescents' to be

focused in decision making as regards to their sexual activity and use of family planning services.

Increase training on CBDAs -Our findings revealed that CBDAs had few family planning methods as compared to those found at the hospital. Participants further stated that CBDAs were not experts because they could not explain the advantages and disadvantages of each method. Despite such remarks, surprisingly all adolescents' recommended the CBDAs especially on their good attitude towards them, their privacy in the sense that one could even visit them at night without been seen. Moreover, adolescents' liked CBDAs because they were found within the community, so it was not difficult to get help. Therefore, there is need for more training on CBDAs on how to deal with adolescents' reproductive health needs and communication skills on how they could explain to adolescents' the reasons why they (CBDAs), do not readily have other methods such as injections. The training should further emphasize confidentiality and privacy which are major concerns for adolescents' to use family planning services. Similarly, previous research on family planning in Malawi observed that many women had preferred CBDAs other than the hospital because they could not wait for more hours without getting helped as they expressed -"people would rather have a child than queue for hours" (139). The study also recommended empowerment of CBDAs through refresher courses.

Deal with cultural barriers- A number of barriers in utilization of family planning services in this study are related to negative attitudes the community have towards adolescents' pre-marital sex. This has made adolescents' in our study feel young and thinks that they are not eligible for the services unless they get married despite their sexual activity. Therefore, interventions should aim at changing the cultural beliefs of the community towards adolescents' premarital sexual activity. The community can be sensitized through the entry point of KIs who acknowledged the importance of adolescents' using family planning services. For instance, one parent had recommended that a committee should be formulated in the community to look into problems of early marriages and pregnancies.

Disseminate the findings of the study to the community- The principal investigator of this study should go back to the community and disseminate the findings about the current situation of adolescents' in the community where the study took place. This can be done through school meetings and village meetings in which adolescents' should also be involved. In such a way, joined efforts can be put forward on how to deal with adolescents'

reproductive health needs and concerns, and if adolescents' who are sexually active can be encouraged to use family planning services. Further, interventions should aim at sensitizing chiefs, teachers, parents and other prominent leaders like religious leaders on the importance of open sex discussion with adolescents'. The major problem noted in this study is that adolescents' are hidden from proper sex education. While parents and the community give negative information on sex to adolescents', media and peers display positive and desirable information on sex. Telling adolescents' the truth about sex would save them from the many dangers of unprotected sex and this can be done in a joined effort of stake holders. Research has increasingly shown that involving adolescents' in making free, informed choices about contraception does not lead to increases in risky sexual behaviour, or to initiating adolescents' sexual activity (96). However, adolescents' who are well informed about sex, delay in the sexual intercourse and in number of sexual partners (ibid).

***Target both unmarried boys and men in increasing knowledge level as regards to use of family planning services*-**Many adolescent girls in this study complained that they could not propose use of condoms during sex to their boyfriends because boys[53] could not accept. Married adolescents' also expressed the same feeling. However, both unmarried and married adolescent girls explained that the alternative was to use pills and injections which some of them had also problems to keep away from parents and husbands. At the same time, pills and injections would only protect them from pregnancies but other STIs including HIV/AIDS will remain unprotected. Therefore, interventions aiming at adolescents' utilization of family planning services in Lungwena community should further target both married men and unmarried boys. For instance, programs should be designed on how men and boys can be integrated in family planning services. This would probably help adolescent boys and men in general to understand the importance of using family planning services and specifically having safe sex practices. Dodoo and van Landewijk cited in Jeremy et al theorized that the reason sub-Saharan Africa has been slow to adopt family planning is that programs fail to target men (140).

Work with traditional initiators to include a family planning lesson in their initiation syllabus. In our study, participants were concerned about the initiation ceremonies because adolescents' were becoming sexually active soon after graduating from initiations. Although the government and NGOs have intervened by campaigning against the initiation practices

[53]Boys in this study are young men who are not yet married. While men are those who are not falling in the young ages of 10 to 24 and married.

that are considered high risk to the spread of HIV/AIDS, still more efforts need to be done as regards to these traditional initiation ceremonies. Since our study have found that many adolescents' engage in sex at early ages, introducing use of family planning services during the period of initiation ceremonies would probably help to reach adolescents' with right information before some of them are exposed to sex, as many are initiated at early ages before 12. However, the initiators also need some education on the importance of adolescents' using family planning services and the dangers of adolescents' having early and unprotected sex.

Provide more training opportunities to health providers- Providing training and more refresher courses to those working in family planning clinics on how to deal with adolescents' would help to end the gap that is created because of the attitude health personnel have towards sexual activity among unmarried adolescents'. There is need for better training of health providers on how to view and understand adolescents' reproductive health needs, taking into consideration that they too have rights and therefore require equal treatment in terms of confidentiality, privacy and positive interpersonal communication skills. In our study adolescents' had complained about lack of confidentiality and judgmental attitudes from some health personnel.

Improve the clinic set up – One of the major barriers to low utilization of family planning services mentioned by many adolescents' was the clinic set up. Many unmarried adolescents' and married adolescents' who had husbands in South Africa complained about lack of privacy as every body would see them on the cue of family planning methods. An evaluation study conducted in the same area had also recommended on improving the clinic set up (141).

Work on abortion policies: Interventions should work towards improving the current policies on abortions which stipulates that abortions can be legally performed in Malawi to save the life of the pregnant woman. Many participants reported that some girls had died in the community because of abortions which were carried out by traditional doctors. However, to avoid abortions, there is need for increased dissemination of information on contraception through use of family planning services among adolescents'.

Further Research

1. How gender has influenced the use of family planning services among adolescents'.

2. Identify the number of adolescents' who have normal deliveries at the hospital and those with complications.
3. To what extent has initiations ceremonies influenced the sexual behaviour of adolescents in this community?
4. Why are men reluctant to get involved in family planning?
5. How do health care providers communicate with adolescents' in general?
6. There is need to find out the acceptability of a female condom among adolescents' and if girls can protect themselves in that way.
7. There is need to carry out an in-depth research to understand what motivates those unmarried adolescent girls who are using family planning methods and if they use them consistently and with whom.
8. A further study is needed to investigate adolescents' understanding of family planning methods.
9. Another exploratory study is needed to explore the perceptions of urban adolescents' to utilization of family planning services.
10. There is need to find out to what extent has poverty contributed to low utilization of family planning services among adolescents' in this era of HIV/AIDs.
11. In-depth study is needed to explore the consequences of abortions in the area.
12. A detailed study is needed to understand parents' perceptions on adolescents' utilization of family planning services.

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APPENDICES

Appendix 1: Participants Demographic Capture Sheet for FGDs

Group type:
FGD number:
Date of discussion:
Venue:
Time start:
Time stop:
No of participants at start:
No of participants at end:

Participants' personal details (recorded at end)					
Participant	Gender (m/f)	Marital Status	Age	Education (Years)	Religion

Comments on the discussion

Appendix 2: Interview guide for Adolescents

Bio data
Gender:
Age:
Marital status:
Education (number of years):
Religion:

Introduction
Adolescents like you experience body and emotional changes as they grow up. They also have needs and concerns about their reproductive health (pregnancies, sexual activity, menstrual cycle, reproduction, sexual relationships etc) and they sometimes wish that they can get someone to talk to and share these concerns. In this discussion, I want to learn from you about the main adolescents' health concerns/problems in this community and how they cope and deal with them. I am also interested to learn much about adolescents family planning services in this community, as I already told you about the main focus of my study which is to explore the contributing factors to low utilization of family planning services by adolescents in this community. Please feel free to ask any questions or seek clarifications. The information that you provide will be treated with utmost confidentiality and will not be used for any other purpose other than this study. Participation in this research is voluntary and you are free to withdraw your participation at any time you feel like doing so and be assured that withdrawing to participate at anytime will not affect the services that you receive at clinic. Just to remind you again, in this discussion I will use this recorder to record our discussion so that I should not miss any point. You are free to listen to the recorded discussion after we get finished.

- Ask for explanations on the major reproductive health concerns facing adolescents in their community today? By adolescents reproductive health concerns, I imply those issues such as indulging in sex, pregnancies, STIs, and anything related to sexual activity. (Probe for early pregnancies and sexually transmitted infections, early sexual debut, multiple sexual partners and early marriages, etc)
- Enquire about how adolescents get helped to address the problems just discussed. Please explain (probe for community, school and church if they provide them with help or information)
- Ask them about their views on providing family planning services to unmarried adolescents whether in the community, school, clinics and public places? (Probe on family planning methods and information on prevention of STIs and pregnancies.)
- Ask them about the reproductive health services they feel should be provided for adolescents and they should explain why?
- Ask them to explain about the organizations, hospitals or any places they know of which offer family planning services in the community. Also find out from them about their preference on where they would go for reproductive health services from the places they have just mentioned and why they would choose those places. (probe on how the services are offered)
- Find out if they have ever gone to the mentioned places for any reproductive health services? (probe for STIs treatment, information on family planning methods and accessing family planning methods) If Yes or No, explain why or why not?

- Ask them if they were satisfied with the services they received? (Probe on the quality of care given to adolescents in general who seek family planning services, contraceptives and any information concerning their reproductive health needs. Also probe on, affordability, accessibility, opening hours and etc).
- Ask them about how free they would visit the services if given chance to visit such services? (Probe from on their opinions on the common constraints).
- Enquire if they got any other additional information besides the services discussed above. (Probe for protective measures on sexually transmitted illness, pregnancy and HIV/AIDS).
- Ask why adolescents do not use family planning methods at first sex. (probe for community attitudes, knowledge of family planning methods, accessibility, availability and service providers attitudes)
- Explore their attitude about unmarried adolescents using family planning services and why? (probe for reasons for use and non use and ask them to mention the family planning methods they know)
- Find out about their perceptions on what they think are the barriers facing adolescents to use the available family planning services in their community?
- Ask them about how they feel about the Youth Friendly Services which are in the area and what differences they are making in terms of behaviour change as regards to early marriages, pregnancies and spread of STIs among adolescents in the community. (probe on how these youth friendly services have made a difference if any)
- Ask them about their knowledge on the implications of early pregnancies among the adolescents? (Probe on community attitudes, parents, and health problems associated with early pregnancies and social life)
- Ask them about their knowledge on adolescent reproductive health care services that are offered, at this hospital, district, community etc. (Probe for family planning services, including treatment of STIs and family planning methods)

NEVER USED FAMILY PLANNING SERVICES

- Ask why is it that they have never used family planning services? (Probe for more explanations as regards to knowledge of the services, accessibility, need for the services, affordability, community attitude, and personal attitude.
- Ask if probably they know someone else who has used the services mentioned above and ask their views about the services they received? (probe on satisfaction of the services from providers view and personal satisfaction on using the services)
- Ask if there was a time when they had a sexual health need but did not know where to get information, advice or services? (Ask for more explanations on the type of sexual health need)
- Enquire about any additional information that they would like to share about other services or information that are necessary for adolescents in the community?
- Thank them for their information and time.

Appendix 3: Interview guide for Key Informants

Bio-data
Marital status:
Position:
Gender:
Age:
Education (number in years):

- Ask them the major reproductive health problems adolescents are facing in their area in general? (reproductive health problems such as adolescent marriages, sexual activity, STIs, pregnancies and any other relating to adolescent sexual activity) (probe for early marriages, STIs, unwanted pregnancies, and multiple sexual partners)
- Ask them to explain about adolescent reproductive health services that are offered, at the health centre, within the community and in the district etc. (Probe for adolescents' access to family planning services).
- Ask them to explain in detail which services are particularly offered for adolescents from those they have mentioned (Probe on how adolescent services differ from general services).
- Find out from them in detail about their perceptions on adolescents (married and unmarried) using family planning services in Malawi, and particularly in their community. (Probe on cultural norms, religious issues and social norms).
- Ask them to explain the barriers faced by adolescents in utilizing the available family planning services found in the community and in the district. (Probe on cultural barriers, social norms, community attitudes, knowledge of the available services)
- ***Parents***- In addition, ask them to explain if they do face any challenges discussing about family planning services with their adolescents and whether it is proper to do so.

Additional questions for the service providers

- Ask them to explain the reproductive health services that are most sought by adolescents at the health facility (probe for family planning services and pregnancy care).
- Ask them to explain in terms of family planning services, how they look at the turn up for unmarried and married adolescents (Probe for reasons based on culture, social norms and health care system, knowledge of family planning services). Also probe for explanations on the difference.
- Find out if services for family planning to adolescents are offered in the same setting as those of adults? (Probe on the nature of the setting).
- Ask them to explain if they face any challenges offering family planning services to the adolescents (whether married or not).
- Ask them to describe the characteristics of reproductive health problems that frequently cause admission of adolescents at their facility.(probe on pregnancy related problems).
- Enquire of any additional information and thank them for their time and their information.

Appendix 4: Consent Form

My name is *Austrida Gondwe* and I am a researcher as well as a student from the University of Oslo in Norway. I am conducting research on family planning services and adolescents in this community. I am interested to learn more about the family planning services in your community; what really happens; where the family planning services are; how do you have access to them; what barriers and challenges do adolescents face in utilizing them, how the

services are perceived in this community and what changes you wish could be done on these services. I am also interested to know about your personal experiences, practices, attitudes and other issues as well that may arise in the course of our discussion.

The interview will last approximately for one hour. I will ask you a series of questions and I will record everything that we are going to discuss so that I should not forget. After we finish the discussion, no body will have access or listen to what we are going to discuss here apart for myself.

I also wish to assure you that information gathered during this interview is confidential. To ensure confidentiality, I will not ask you, your names but rather we can give each other nicknames and I will not ask you so many characteristics about yourself, it will be just age , religious affiliation and level of education. I will reduce the possibility of recognition as much as possible. Immediately after retrieving the information from the tapes, all the tapes will be destroyed, transcripts will be anonymous as possible, they will only be accessed by the research team and they will be kept in the drawer under lock and key.

Having said this, I would like to inform you that participation in this study is voluntarily. Whether you agree to participate or not, this will not affect you in all aspects of your life in this community and country. If you will participate, you are also allowed to withdraw from the discussion if you feel to do so. This again will not affect your normal daily life and activities even access to the services.

Do you agree to participate in the study?

I agree…… No I don't agree……..

Signature_____ Date: _____

Appendix 5: Assent form for unmarried adolescents under 18 years

My parent/guardian knows about this study and wants me to be in the study if I want to. I do want to be in the study, but I know that I can stop being in the study any time I want to. I know that my study researcher can talk about the study with my parent/guardian, but will not talk about it with anyone else who is not working on this study unless I and my parent/guardian say it is OK. I can call the study researcher any time I have any questions.

Signature of Child _____ Date

I have solicited the assent of the child.
Signature of Person Obtaining Assent/Consent _____ Date

Consent of Parent or Guardian _____ Date

I agree with the manner in which assent was solicited and given by my child and I agree to have my child participate in the study.

Although my child did or could not give his/her assent, I agree to have my child participate in the study.

I will be given a signed copy of this Consent Form.

Print Name of Parent(s) _____ Date

Signature of Parent(s) _____ Date

Appendix 6: Ethical clearance from Norway

UNIVERSITETET I OSLO
DET MEDISINSKE FAKULTET

Professor Johanne Sundby
Institutt for allmenn- og samfunnsmedisin
Universitetet i Oslo

Regional Committee for Medical Research Ethics
Southern Norway, Section A
PO Box 1130 Blindern
NO-0318 Oslo

Phone: 228 44 666
Fax: 228 44 661
E-mail: rek-2@medisin.uio.no
Homepage: www.etikkom.no

Date: 3 April 2008
Your ref.:
Our ref.: S-07257

S-07257a Title: Factors contributing to low utilisation of family planning services among young people in Mangochi District, Malawi [2.2007.1465]
Project Manager: Professor Johanne Sundby, International Health, University of Oslo
M.Phil Student Austrida Gondwe
Sponsor: Norad, Lynn Josephson

We refer to your letter received 18 March 2008.

The committee has the following comments to your answer:

- A lateat date must be set for the deletion of the data.
- Information shall be given to the participants about the date of deletion

The project is approved subject to the condition that the above comments are incorporated before the project is commenced.

Best wishes for the project!

Yours sincerely

Kristian Hagestad
Chief County Medical Officer, Spec. of Public Health
Chairperson

Jørgen Hardang
Secretary

Copy to: M.Phil Student Austrida Gondwe, Institutt for allmenn- og samfunnsmedisin, UIO
NORAD, Lynn Josephson, Postboks 8034 Dep. 0030 Oslo

Appendix 7: Ethical clearance from Malawi

UNIVERSITY OF MALAWI

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 877 245
877 291
Fax: 874 700
Telex: 43744

Prof. R.L. Broadhead, MBBS, FRCP, FRCPCH, DCH

Our Ref.:

Your Ref.: P.04/07/506

13th December, 2007

Austrida Gondwe
Centre for Reproductive Health
P/Bag 360
Blantyre 3

Dear Austrida Gondwe,

P.09/07/582 – Factors contributing to low utilization of family planning

I write to inform you that COMREC reviewed your resubmission of the above-mentioned proposal and I am pleased to inform you that your proposal was approved on 13th December, 2007 after considering that you addressed all the issues which were raised in an earlier review.

As you proceed with the implementation of your study I would like you to take note that all requirements by the college are followed as indicated on the attached page.

Please note that the ICH guideline 3.2.1 had been followed during the voting process.

Sincerely,

Prof E. Borgstein
CHAIRMAN - COMREC

EB/tck

Approved by
College of Medicine
13 DEC 2007
(COMREC)
Research and Ethics Committee