Community understanding of sexual and reproductive health matters in Malawi, case study of Mangochi District

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Olivia Jelenje

Abstract

Whilst the existing literature uncovers the association between contraceptive behaviour and social, cultural and economic context, little is known on the mechanisms within the context that shape contraceptive behaviour. This study aims at exploring the mechanisms through which the context in which men and women of reproductive age groups from Mangochi, shape their contraceptive behaviour. The study was guided by the theory of planned behaviour (Azjen & Fishbein, 1980) and the process context approach (de Bruijn, 1999). The study includes description of the study area, stories and ideas from men and women to describe contraceptive behaviour. The information was collected through 18 in-depth interviews, three focus group discussions, three key informant interviews, literature review and observation. The findings reveal that apart from economical, social and emotional reasons men and women are motivated to use contraceptives because of the prevalence of maternal mortality and morbidity and child illnesses within the Mangochi context. There is a belief in Mangochi that contraceptive use prevents future wanted contraception. The concepts contraception and family planning are defined using cultural schemas. The individual's life course presents a platform for imparting messages on sexuality and reproduction. In a matrilineal system, the family is important in forming intentions to use contraceptives. The findings suggest that the social, cultural, economic and ecological context help to explain contraceptive behaviour in Mangochi. In addition to describing the context in which contraceptive use takes place, the study also gives an indication of the health problems that exist in the study population and that need attention.

Keywords: **contraceptive use, sexual and reproductive health, contraceptive behaviour, context**

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1 Introduction

Sexual and reproductive health is defined as "a holistic concept that encompasses physical, mental and social well-being of individuals in all matters relating to sexuality and reproduction'' (WHO, 2008 p.2). The concept of sexual and reproductive health was introduced because of the paradigm shift in addressing population growth and development. For the past decades, scholars' approach to fertility was by linking *individuals'* development with demographic objectives while overlooking the wellbeing of *individuals* (Tremayne, 2001 italics author's words). The International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994 acknowledged that the wellbeing of individuals was being overlooked in the countries' approach to fertility. In trying to address this problem, the ICPD introduced sexual and reproductive health as new approach to encompass the wellbeing of individuals, replacing earlier approaches of family planning and population control (Petchesky & Judd, 1998 p.9 cited from Tremayne, 2001). Sexual and reproductive health is a broad concept that covers a wide range of topics like maternal mortality and morbidity, infant mortality, unsafe abortion, unwanted pregnancies, family planning infertility, child health, domestic violence among other things (Francisco et al., 2007).

1.1 Background of the study

This study focuses on family planning because it forms an important aspect in sexual and reproductive health. Family planning enables individuals to have a responsible, satisfying and safe sex life (Glasier et al., 2006). In November 2009, The International Conference on Family Planning in Kampala, Uganda, described family planning as a link to achieving all the eight Millennium Development Goals. The goals include eradication of hunger, achievement of universal education, promotion of gender equality and women empowerment, reduction of child mortality, improvement of maternal health, combating of HIV/AIDS and other diseases, environmental sustainability and development of global partnership (UN, 2011). Using the sexual and reproductive health approach, family planning has proven to have an impact on population growth and at the same time contribute to the well being of individuals by controlling fertility and enabling individuals to have satisfying and safe sex and reproductive life respectively (Cleland et al., 2006; Cates, 2009; WHO, 2011).

Even though family planning has been known to have social, economic and health benefits to individuals and countries, the concept has not been widely adopted across the globe. It is estimated that 200 million couples in developing countries would like to delay or stop child bearing but are not using any family planning method. The reasons for not using any family planning are largely attributed to lack of access, limited choice of methods, fear of side effects, religious beliefs, cultural reasons, and gender based barriers, illiteracy and lack of quality family planning services among other factors (WHO, 2011). Empirical evidence suggests that sexual and reproductive health is affected by people's experiences, relationships and broader context in which they live. The broader context includes the social, cultural and economic context (Francisco et al., 2007).

Malawi is one of the developing countries in Sub-Saharan region that has been affected by low use of family planning methods despite having family planning programmes in place. There have been several studies done in the past in Malawi and elsewhere that have suggested that contraceptive use is associated with social cultural and economic context (Stephson, et al., 2006, 2008; Munthali, 2004; Yeatman et al., 2008). In general, demographers acknowledge the role of the social cultural and economic context in understanding demographic behaviour. Some researchers have tried to explain demographic behaviour by linking it with economic context and others have linked it with social cultural context (Becker, 1960 cited from Bruijn, 1999; Caldwell and Caldwell, 1987; Caldwell and Caldwell, 1990b). Whilst the existing literature uncovers the association between contraceptive use and social, cultural and economic context, little is known on how specific mechanisms within the social cultural and economic context shape

individuals' contraceptive behaviour. The available literature focuses on the statistical correlation between contraceptive use and social cultural and economic factors. The processes and stories behind such statistical relationships are missing. This research study aims at exploring the mechanisms through which the social, cultural and economic context in which men and women of the reproductive age groups in Mangochi are embedded in, shape their contraceptive behaviour. The study uses description of the context, stories and ideas on contraceptive use from men and women as situated in the social, cultural and economic context. The outcome of this study is a master thesis and it is anticipated that findings would inform policy makers and role players in sexual and reproductive health on the importance of social , cultural and economic context in coming up with community relevant family programs such that contraceptive use is widely adopted by individuals.

1.1.1 The current contraceptive situation in Malawi

Malawi´s population is estimated at 13.1 million people with a population growth rate of 2.8 percent (NSO, 2008). On a global Human Development Index, Malawi is ranked number 153 out of 169 countries with two thirds of the population living below poverty line of less than 2 US Dollars per day (UNDP, 2011). The population mainly relies on subsistence farming for their livelihood. Adult literacy rate in Malawi is estimated at 75 percent (UNICEF, 2010).

The Malawi Government adopted Family Planning Policy in 1992 (Solo et al, 2004). The policy was reviewed five years later to incorporate and support the programme of action of International Conference and Population Development (ICPD) that was developed in Cairo in 1994. The policy was reviewed to incorporate issues addressing population growth and health. The adoption of Family Planning Policy led to the implementation of family planning programmes throughout Malawi. It has been observed that with the introduction of family planning programmes and child spacing policy, Malawi has registered contraceptive prevalence increase from 7.4 percent in 1992 to 46 percent in 2010. The Total Fertility Rate had decreased from 6.7 children per woman in 1992 to 5.7 children per woman in 2010 (NSO, 2011). Apparently, the decrease could have been substantial if it were not for contextual factors like poverty, high illiteracy levels, cultural and religious barriers, shortage of health personnel, drought and HIV and AIDS (Solo et al., 2005).

Additionally, the introduction of family planning programs in Malawi led to an increase in the use of modern contraceptive methods over the traditional practices. The National Statistical Office classifies modern contraceptive methods to comprise injectables, implants, pills, intrauterine devices, male and female condoms and male and female sterilisation while the traditional contraceptive methods comprise periodic abstinence also called rhythm methods, withdrawal methods and other folk methods (NSO, 2008). In the recent Malawi Demographic Health Survey conducted in 2010, it was noted that among the reproductive age groups for people who are married, 52 percent (almost half of the married population) were not using any type of contraceptive method, 46 percent were using modern contraceptives and only 2 percent were using traditional methods. Table 1.1 below shows the distribution of modern contraceptive methods in 2010 among married men and women. The most commonly used contraceptive methods are injectables and the least practised are male sterilisation and female condoms while traditional contraceptive methods account for only 4 percent of the current contraceptive prevalence rate (NSO, 2011). The modern contraceptive methods are available from government health facilities, private medical facilities and community based distribution agents.

Table 1.1: Percent distribution of contraceptive use among married men and women in Malawi

Contraceptive use	Percent
Not using any method	52
Injectables	26
Female Sterilisation (Tubal Ligation)	10
Traditional Methods	4
Traditional methods	4
Pills	3
Male Condoms	2
Other Methods	1

Source: NSO, 2011

1.1.2 Mangochi District

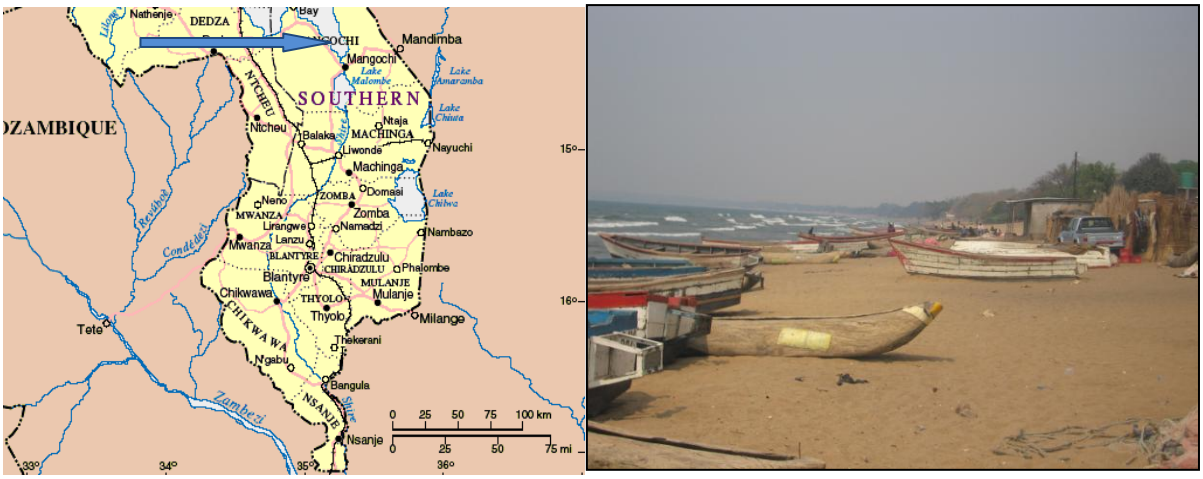


Figure 1.1: Map of Malawi and fishing boats on the docking area

The study is positioned in Mangochi District, located the in southern region of Malawi. The district lies along Lake Malawi. Because of its location, it is the most active fishing district in Malawi and has high tourism industry. Administratively, a district council manages the district and it is divided into traditional areas. The traditional areas are further divided into villages. Traditional Authorities (TA) manage the traditional areas while Village Headmen (VH) manage villages. The district council acknowledges the traditional system hence Traditional Authorities are considered part of the district council.

In terms of population, Mangochi District is one of the districts that have a relatively high population, estimated at about 800,000 as compared to other districts in Malawi. The district has the lowest contraceptive use and higher TFR estimates as compared to the general Malawi estimates (see Table 1.2) (NSO, 2011).

Table 1. 2: Mangochi population estimates relative to the country estimates

Population estimates	Malawi	Mangochi
Population	13,077160	797,061
Total Fertility Rate	5.7 children per woman	7.0 children per woman
Contraceptive Use	46 percent	29 percent
Modern Contraceptive Methods	42 percent	27 percent
Traditional Methods	4 percent	2 percent
No Method	54 percent	71 percent

Source: NSO, 2011: NSO, 2008

In terms of the inhabitants, tribes like *Chewa*, *Tumbuka*, *Tonga*, *Lomwe* and *Sena* occupy the district but the most predominant tribe is *Yao*. The *Yao* tribe comprises 90 percent of the population in the district. Since The *Yao* are the predominant tribe in the district and most traditional rituals are done according to *Yao* traditions, for example chieftaincy in the district is of matrilineal descent typical *Yao* traditions. Within family institutions, men exercise authority over their sisters and their sisters' children (nieces and nephews) (Mtika & Doctor, 2002). Even though men wield such authority over their sisters, the village head can be either a woman or a man depending on who is the first in lineage but preference is given to nephews. People of Mangochi observe traditional practises like traditional songs and dances in events like weddings, initiation ceremonies and when they are installing a new chief. The most widely known rituals among the *Yaos* in Mangochi are the initiation for boys known as *Jando* and the initiation for girls (*nsondo*) as they progress from childhood to adulthood. Initiation ceremonies are rituals that mark the transition from childhood to adulthood. During these ceremonies, among other things, children are groomed on sex life and marriage (Gama, 2009).

The Mangochi population is characterised by a high numbers of Moslems and a few Christians, hence the *Yao* tribe is associated with Islam. The socialisation of people within the district is influenced by opinion leaders, religious groups, village headmen, traditional counsellors, families, friends, people who come for fishing or tourists, political leaders, health workers and teachers (Munthali et al, 2004). Thus, men and women learn their norms, values, culture and behaviours through interaction with afore mentioned group of people. The people in Mangochi earn their living through subsistence agriculture and fishing. They also generate alternate income through small-scale businesses (CSR, 2004).

1.2 Objectives and research questions

The main objectives of the study are to gain a detailed understanding on the social, cultural and economic context in which contraceptive behaviour for men and women of the reproductive age groups in Mangochi takes place. And to describe how men and women's motivations, beliefs, understanding of sexual and reproductive health and life course form their intentions to use contraceptives in Mangochi. The study answers the following research questions in order to achieve the main objectives.

1. *What motivates men and women to use contraceptives in Mangochi?*
2. *What are the individual's attitudes, subjective norms and perceived behaviour control that form intentions to use contraceptives in Mangochi?*
3. *How are the intentions to use contraceptives embedded in the socio-cultural and economic context in which men and women live in Mangochi?*
4. *What is the role of life course in forming men and women's intentions to use contraceptives in Mangochi?*
5. *What is the social cultural and economic context in which contraceptive use take place in Mangochi?*

6. *What role does the understanding of sexual and reproductive health matters among men and women in Mangochi play in forming their intentions to use contraceptive?*

1.3 Description of chapters

The thesis starts by describing the context of the sexual and reproductive health, the aim of the study, brief descriptions of the country and district where the study is situated. The chapter ends with an outline of the study objectives and research questions. *Chapter two* illustrates theory of planned behaviour and the process context approach as the theoretical framework underpinning the study. This is followed by the definition of concepts and the conceptual framework proposed for the conduct of the study. The chapter ends with the description of how the concepts used in the study are operationalised. *Chapter three* describes the context in which the study is situated. Then it describes approaches used in conducting the study. The research methods and data analysis are described in the mid section. The chapter ends by describing the ethical considerations and the reflection of the data collection and analysis. *Chapter four* presents the findings of the research study and the inductive model generated from the findings. *Chapter five* discusses the study findings, implications of the findings and finally chapter six concludes the thesis and suggests recommendations for further research.

2 Introduction to theoretical framework

In order to explore men and women's intentions to use contraceptives, careful consideration of individual behaviour is important. According to Ajzen, "the general rule is; the stronger the intentions *in individuals* to engage in behaviour, the more likely should be its performance" (Ajzen, 1991 p.181, italics author's words). Different scholars approach individual behaviour differently. As indicated by de Bruijn, social scientists approach individual behaviour as being influenced by the society as a human being is considered a social being. Psychologist considers individual behaviour as driven by individual's needs, impulses and drives. Biologists consider individual behaviours as driven by biological limitation and capabilities. Economists consider individual behaviour as driven by motivations and rationality in decision making while others consider individual behaviour as being time dependent and the list is endless (de Bruijn, 1999). The study uses the combination of theory of planned behaviour and the process context approach; both guide the conceptual framework for this study. These theories have been specifically chosen for this study because they incorporate different elements from distinguished scholars to try to explain individual behaviour. In addition, the theories link individual behaviour with the social, cultural economic context, which is an important aspect in this study.

2.1 The theory of planned behaviour

The theory of planned behaviour of Azjen (1991) situates behaviour as an outcome of individuals' intentions to perform behaviour. Subsequently, intentions to perform behaviour are seen as a combination of individuals' attitudes towards the behaviour, subjective norms on the behaviour and perceived behavioural control over the behaviour of interest. The theory is applicable to individual behaviours that are under volitional control (Ajzen, 1991).Within the theoretical framework (Figure1); intentions capture individual motivations for performing behaviour. According to Ajzen (1991), empirical evidence supports the theorised relationship between intentions to perform behaviour and the actual performance of the behaviour. He gathered findings on the researches that investigated different types of behaviours and the outcomes indicated that there is indeed a relationship between the intentions to perform behaviour and the actual performance of the behaviour (Ajzen, 1991).

The theory of planned behaviour also theorises that *attitudes towards behaviour of interest* is one of antecedents to formation of individuals' intentions to perform behaviour. Attitudes towards behaviour of interest are regarded as the personal evaluation of behaviour. These are individual's thoughts of the likely consequences on the contemplated course of action (Ajzen, 2007 p.5). Attitudes are said to emerge from the personal experience, formal education, media, and social interaction. Literature suggests that attitudes vary among individuals due to individual differences like demographic characteristics and personality.

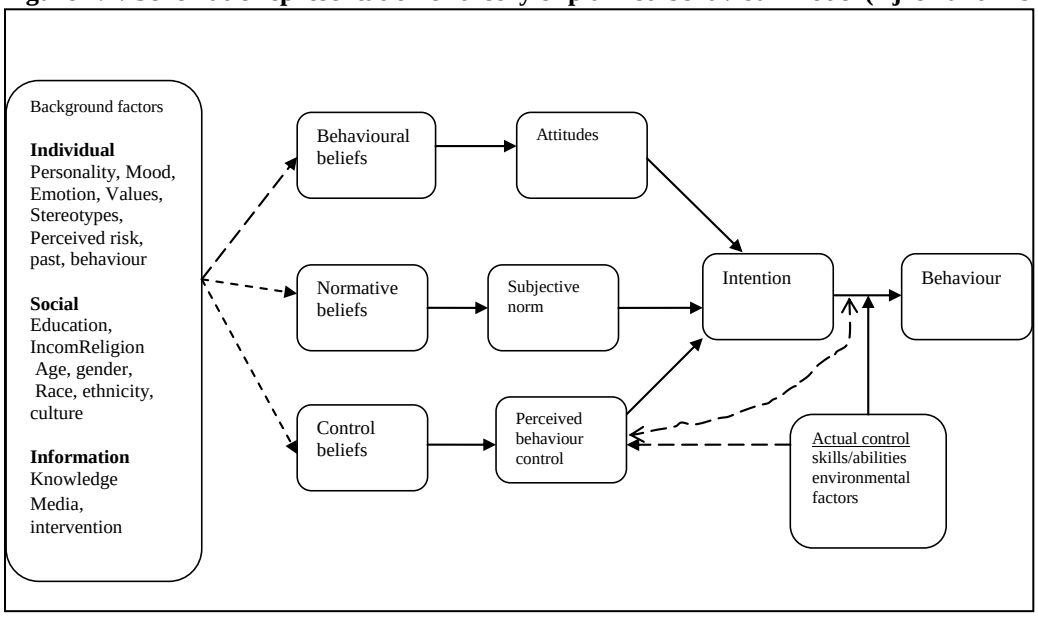
Individual differences account for personal experiences, exposure to information and how individuals remember and interpret information (Ajzen & Fishbein 2010). According to the proposed theoretical framework of planned behaviour, individual's attitudes are shaped by *behavioural beliefs*; these are the positive or negative individual evaluation of performing behaviour.

Another antecedent to formation of individual's intentions to perform behaviour of interest are individual's *subjective norms*. Subjective norms are defined as "perceived social pressure to perform or not to perform the behaviour" (Ajzen 1991 p.188). In other words, subjective norms are regarded as individual's socially expected modes of conduct. Beliefs that form subjective norms are called *normative beliefs* and these are beliefs that individuals approve or disapprove of individual's performance of behaviour. Thus, the theory postulates that individual's would intend to perform certain behaviour when they perceive that people who are important to them think they should engage in certain behaviour (Ajzen 2007).

The last antecedent that forms individual's intentions to perform behaviour of interest is the perceived behavioural control. Perceived behavioural control is defined as "people's perception of the ease or difficulty of performing the behaviour of interest" (Ajzen, 1991 p.183). Perceived behaviour control is important when individuals have a motive to succeed at a given task, have confidence in their ability to perform the behaviour and have self-efficacy (Ajzen, 1991). In this case, self-efficacy is "judgment of how well one can execute courses of action required dealing with prospective situations" (Bandura, 1982, p.122 cited from Ajzen, 1991p.184). Beliefs that form perceived behavioural control are called control beliefs. Control beliefs are defined as the perceived capability of performing the behaviour (Ajzen, 2007).

The theory of planned behaviour model is as shown in Figure 2.1 below. The model shows the relationship between intention to perform behaviour and the predicting the behaviour of interest. It is should be noted that in addition to the attitudes, perceived norms and perceived behavioural control individuals must have the knowledge, skills and capabilities to perform the behaviour of interest.

Figure 2.1: Schematic representation of theory of planned behaviour model (Ajzen and Fishbein 2007)



2.2 The process context approach

Since the theory of planned behaviour does not elaborately consider context, the process –context approach is used to explain the individual intention to perform the behaviour. The process context

approach postulates individual behaviour as embedded in the context. The process context approach states that individual's behaviour and status at a given moment in time is seen as an outcome of a *process* that involves series of individual decisions and actions over a lifetime, which takes place in social economic, demographic, ecological, cultural and political context (Hutter, 1998 p.8; de Bruijn, 1999). Different theorists describe the process that leads to individual behaviour as specified in the approach, differently. One such theory is the *Life Course theory*; this approach recognises that individual behaviour is related to one's biological age, psychological age and social age norms (de Bruijn, 1999). In addition, individual behaviour is influenced by the physical and social environment in which an individual is situated in. (Hutchson, 2010). In another investigation, Giele & Elder (1998) noted that the general and unique aspects of individual location (which has been referred by Hutchson 2010 as physical and environment) affect personal experiences, which are said to be socially and individually patterned in ways that carry through time. The stages of development in individuals are characterised by infancy, childhood, adolescence and adulthood. *Processes* in individuals occur at each of the development stages biologically, mentally (psychologically) and socially. Hence, it is important that individuals' decision-making and behaviour should be examined in the light of individual's experiences at different stages and expectations from the society in which they are situated. (D'Andrade, 1992 cited from Hutter, 1998).

The process context approach is also used to explain the relationship between understanding of sexual and reproductive health and behaviour. As it happens, the approach gives a framework for acquisition of knowledge and understanding that forms individual's behaviour. In fact, social cognitive theory that explains how learning and knowledge take place is embedded within the process context approach. In this theory, individual behaviour is explained as circumstances in which a pattern of behaviour of interest is developed; in this way, behaviour and learning are linked (de Bruijn, 1999). People are said to learn through observing, imitating and modelling behaviour of others. When people observe, they retain the observation in their minds and later they reproduce the observation or they are motivated to perform the behaviour in future (Bandura, 1977 cited from de Bruijn 1999).

In addition to the theory of planned behaviour and the process context approach, empirical evidence of Bulatao (1981) suggests that motivation is one of the most important aspects in forming individual's behaviour. Motivation has been greatly discussed by Abraham Maslow (1970) as one of the determinants of individual behaviour. Motivation empowers individuals with a sense of belonging, self-actualisation and realisation of goals (Maslow, 1970). Ajzen (1991) acknowledges that motivations form intentions to perform behaviour of interest in individuals hence, motivation is also considered as an antecedent that forms behavioural intentions.

2.3 Conceptual framework

The integration of the theory of planned behaviour, Maslow's motivation theory and the process context approach form a guideline in explaining the individual's intention to adopt contraceptive use in Mangochi. The population of interest are men and women in reproductive age groups whose partner or themselves are at risk of unintended pregnancy respectively.

2.3.1 Contraceptive use

Within the conceptual framework, the behaviour of interest is contraceptive use. The term is used when any method of contraceptives is used to prevent pregnancy regardless of the method (adopted from WHO definition of contraceptive prevalence rate (2011)).

2.3.2 Intentions to use contraceptives

Intentions to use contraceptives are regarded as the individual's willingness to use contraceptive to prevent pregnancy. This concept is adopted from the Ajzen's definition of intention to perform the behaviour of interest (Ajzen, 1991). For example if an individual considers using contraceptives in future to avoid births then she or he is likely to use any contraceptive method to prevent pregnancy.

2.3.3 Attitudes towards contraceptive use

Attitudes towards adoption of contraceptives are considered as perceived advantages and disadvantages of using contraceptives. According to the theory of planned behaviour, it is postulated that if an individual believes that using contraceptives has more advantages than not using, it is likely that he or she would form strong intentions to use contraceptives.

2.3.4 Subjective norms on contraceptive use

Subjective norms are defined as what others perceive should be done or not done regarding the behaviour of interest (Ajzen, 2010). In the current study, the descriptive beliefs are perception that individuals have due to social pressure. According to the theory of planned behaviour, individuals who value the approval of their peers, believe that they should perform the behaviour of interest. Social researchers have found influence from local networks, religious leaders, friends, neighbours and peers to be important in determining an intention to perform behaviour. (Caldwell et al., 1987b; Khan, 1987; Bashar, 1993 cited from de Bruijn, 1999*).*

2.3.5 Perceived behaviour control over contraceptive use

Perceived behavioural control is defined as the extent to which individuals feel they are capable of using contraceptives successfully. This definition of perceived behavioural control is adopted from Ajzen (1991).

2.3.6 Life course of an individual

This study situates, individual's intention to use contraceptive within the life course of an individual. Usually life course is studied in terms of life history but in this context life course is studied in terms of life experiences thus individuals, background, life experiences and future expectations as they growing up. The existing literature on individual's life course define life course as transition from childhood to adulthood and entry into marriage (de Bruijn, 1999). This study defines life course as stages in individual life that individuals undergo different ceremonies within their life course.

2.3.7 Understanding of sexual and reproductive health

Understanding of sexual and reproductive health is conceptualised as how men and women understand the concept of contraception and family planning. Explanation of contraception and family are considered as proxies to understanding of sexual and reproductive health matters.

2.3.8 Motivation to use contraceptive

According to de Bruijn (1999), motivations to human behaviour are multidimensional. Motivations to human behaviour encompass goals to achieve physical wellbeing, material wellbeing, safety, affiliation, social status, power, self-esteem, pleasurable inner states and creativity (de Bruijn, 1999 p.92). In the current study, motivation is conceptualised as goals that individuals aim to achieve by using contraceptive method.

2.3.9 Social context

Social context in this study is defined as the social environment in which individuals are situated in that could influence individual's intentions to use contraceptives. The social environment includes religious affiliation, social networks, family, friends, schools and health facilities (de Bruijn, 1999).

2.3.10 Economic context

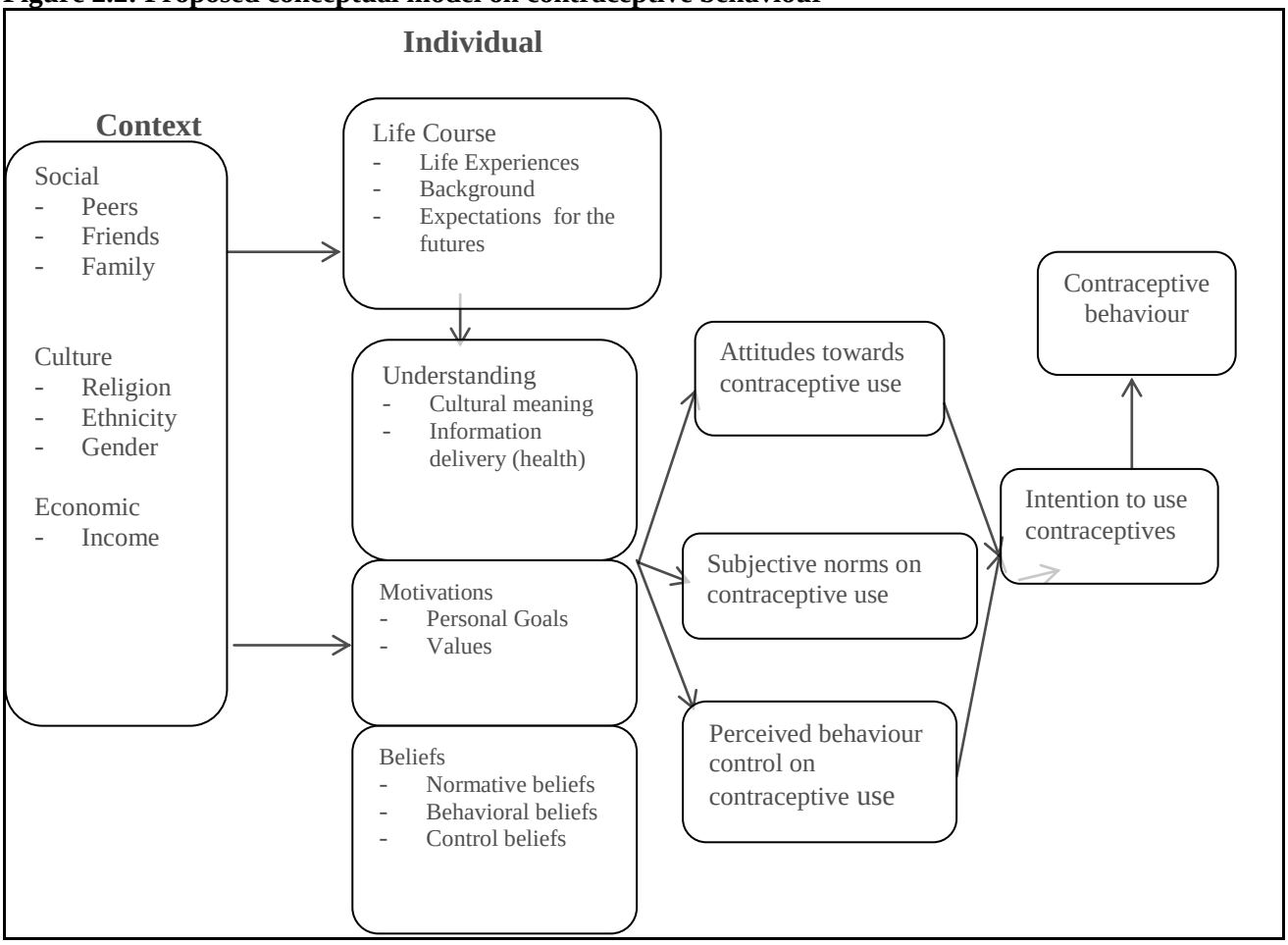
Economic context is defined as the economic environment in which individuals are situated in that could influence individual's intentions to use contraceptives. The economic environment includes source of income, cost and benefits associated with contraceptive use and distribution of wealth (de Bruijn, 1999).

2.3.11 Cultural context

Cultural context is defined as an environment in which individuals are situated that could influence intentions to use contraceptives. The cultural context includes traditional beliefs, culture affiliation and ceremonies (de Bruijn, 1999).

Figure 2.2 indicates a conceptual model that has been adapted to guide this research. The figure illustrates contraceptive behaviour as an outcome of an individual's intention to use contraceptive. As suggested by Ajzen (2007), three conceptually independent considerations that individuals are likely to make before performing any particular form of behaviour are placed as the most likely causes that would form an intention to use contraceptives. The three causes are conceptualised as *attitudes towards contraceptive use*, *subjective norms on contraceptive use* and *perceived behaviour control over* contraceptive behaviour in the model. Secondly, individual's understanding of sexual and reproductive health, motivations and beliefs as situated in their life course, form origins on one's attitudes towards contraceptive use, subjective norms on contraceptive use and perceived behaviour control over contraceptive use. Finally, the understanding of sexual and reproductive, motivations for contraceptive use, and beliefs on contraceptive use are situated in social cultural and economic context.

Figure 2.2: Proposed conceptual model on contraceptive behaviour



2.4 Operationalisation of concepts

The following paragraphs illustrate how the concepts are operationalised in the study. The concepts are operationalised based on research questions that the study aims to address.

The first research question; "*What motivates men and women to use contraceptives?"* is answered by asking individuals the following question, "*If they would make a choice to use contraceptives what would be the reason?"* The responses and ideas from individuals are synthesized and presented as motivations for contraceptive use. In-depth interviews are used to collect this information.

In order to answer the second research question; "*What are individual's attitudes, subjective norms and perceived behaviour control which form intentions to use contraceptives in Mangochi?"* In-depth interviews and focus group discussions are used to collect the information using the following concepts; *Attitude towards contraceptive use*, *subjective norms on contraceptives use* and *Perceived behaviour control over contraceptive use*.

Attitudes towards contraceptives use: These are attitudinal beliefs towards contraceptive use. These are the expected consequences of using contraceptives for family planning purposes. Individuals are asked about their opinions on contraceptive use and their perceptions on advantages and disadvantages of using contraceptives. The responses are synthesised and presented as attitudes that form intentions to use contraceptives among men and women in the study population.

Subjective norms on contraceptives use: This is the perceived social pressure whether to use contraceptives or not. The idea is to find out if individuals' intention to use contraceptives could be influenced by other people. The questions asked in in-depth interviews include, "*Who are the people whom individuals usually discuss regarding contraceptive use* and "*If they would decide to use contraceptives, who do they think would object to individuals decision to use contraceptive and why*?" The responses are synthesised and presented as subjective norms that form intentions to use contraceptives among men and women in the study population.

Perceived behaviour control over contraceptive use: This is the extent to which individuals feel are capable of using contraceptives successfully. The concept is operationalised by the asking individuals *"How easy is it for individuals to use contraceptives*" through in-depth interviews and focus group discussions. The responses are synthesised and presented as perceived behavioural control that form intentions to use contraceptives among men and women in the study population.

The third research question; "*How are the intentions to use contraceptives embedded in the socio-cultural and economic context in which individuals live?"* In-depth interviews are used to collect information on ***intentions to use contraceptives***. The concept is operationalised by asking individuals following question, "*If you intend to use contraceptives to prevent pregnancy given the social, cultural and economic context, how confident are that you would succeed and why*?" The responses are synthesised and presented as intentions to use contraceptives among men and women in the study population.

The fourth research question; "*What is the role life course in forming men and women's intentions to use contraceptives?"* The concept is operationalised using the following questions;

- How would you describe the environment in which you grew up?
- Can you remember the time you become an adult, what happened (for women started menstruating)?
- Can you remember the time you became married, what happened?

The research question is answered through in-depth interviews, key informant interviews and focus group discussions. The findings are synthesised and presented the role of individual's life course in forming intentions to use contraceptives among men and women in the study population.

The fifth research question; "*What is the social cultural and economic context in which contraceptive use take place."* This question is answered through literature review, focus group discussions, in-depth interviews, key informant interviews and non-participant observations. To get information on the social cultural and economic context, study participants are asked the questions on traditional beliefs, religious beliefs, source of information and economic resources in the community. In addition, findings from a non-participant observation obtained by walking through the village are included. All the findings on social economic and cultural are synthesised and presented as the social cultural and economic context.

The last research question; "*What role does the understanding of sexual and reproductive health matters among men and women play in forming intentions to use contraceptives?"* The research question is answered through in-depth interviews, key informant interviews and focus group discussions. Men and women are asked to explain the concept of contraception and family planning. The responses are synthesised and presented as men and women's understanding of sexual and reproductive health that form their intentions to use contraceptives.

3 Research methodology

In this chapter, the first sections (Sections 3.2-3.5) briefly describe the context where the study is situated, in terms of location, economic activities, social activities and the general overview of the village as it was observed by the researcher. In the next section (Section 3.6), research participants are briefly described. In the next part of the chapter, research methodology (Section 3.7) and its application in the study are discussed. Here, the approaches used in the study, the research instruments (Section 3.8) used and the data collection process (Section 3.9) are discussed. In the last part of the chapter, ethical considerations (Section 3.10) of the study and reflection of the data collection and analysis (Section 3.11) are discussed.

3.1 Kera Village

The current research was conducted in July 2011 in Kera Village, Mangochi district, in Malawi. The study area was chosen because it falls within the catchment area of the Safe Motherhood project, which is being done in collaboration with the Population Research Centre in Groningen. The village is located along Lake Malawi in the southern part of the country. Because of the village's location, it serves as one of the fishing docks along the lake. The village is located about 35 kilometres from Mangochi town. It starts from the famous trading centre called Makawa trading centre. The trading centre is located along Mangochi Monkey Bay road and it extends towards the lake. The trading centre is famous for its bars, rest houses and nightlife.

As indicated earlier, the inhabitants of the village are mostly *Yaos.* Other tribes like *Chewa, Lomwe, Tonga, Sena and Nyanja* came from other parts of Malawi to settle because of the Lake. The inhabitants who are considered the original inhabitants or 'owners' of the village have settled a bit far from the lake but closer to the main road. The people who came to do business have eventually settled and acquired most of the land near the lake. They have built cottages, rental houses and rest houses.

The village also harbour a docking area along the lake where fish traders buy fish from fishermen. Next to the docking area, there is a market where fresh fish from the lake are sold to buyers. Closer to the beach area there is a wide fish drying area covered with fish drying racks. The village headman's house is few meters from the beach and docking area and near the fish racks.

A big dusty road connects the village to the main road. This is the road, which cars and trucks use when they go into the village to carry fish from the docking area to different parts of the country.

In general, Kera village could be described as a business-oriented village with nice houses for a village standard in Malawi. There are many activities going on in terms of business as well as entertainment. When there is a good catch of fish, people have money and the village becomes lively.

3.2 Economic activities in Kera Village

Fishing is the main activity in the area and most of the economic activities that take place in the village are related to fishing. Some residents, especially men, work in fishing boats as crewmembers or fishing labourers *(Alovi).* This type of occupation is called *Ulovi. Alovi* are employed by fishermen to fish and are paid per fishing trip in wages. Fishermen own boat or canoes and fishing gears.

Related to fishing, some villagers engage in firewood business. The village has many hawkers, restaurants, tearooms, rest houses, bars and video showrooms that are targeted at people who come to buy fish and tourism because of the lake.

The village has another small market few meters from the lake for the villagers where people from the village buy and sell their groceries, vegetables, fish and other foods.

3.3 Social activities in Kera Village

On a normal day, especially when schools are closed for holiday, different activities take place within the village. Situated along the road going towards the lake around 10.00 a.m, women and young children especially girls are seen carrying plates and clothes in big buckets on their heads going to the lake to wash. Young boys play by the beach and some people are seen selling their commodities like sugarcane, sweet potatoes, small fish etc along the dusty road connecting the lake and the main road. There is usually loud noise of music or voices from speakers from different video showrooms. Men are usually found nearby the lake sitting under a grass thatched shade mending fishing nets and conversing.

In the afternoon hours going through the village, women are seen sitting in their homes usually under a tree or a veranda chatting with fellow women while weaving mats. Women who are engaged in small-scale business like selling banana flitters, small fish *(usipa)* or other types of fish sit by the roadside selling their commodities while conversing and weaving mats.

3.4 Cultural context

The dominant religion in Kera village is Islam but there are also other religions in the area like Catholic, Presbyterians and Pentecostal. Kera village being a Moslem community their traditional beliefs are inclined to their religion.

One of the activities that take place during holidays (when schools close) are the initiation ceremonies. Young boys aged between eight to fifteen years go for initiation ceremonies called *Jando*. During the initiation ceremonies, the boys are circumcised and are taught how to respect the elderly and cultural values as part of traditional ritual. The boys stay in the initiation camp for almost a month. During this period, young boys and men from the village perform traditional dances for fun and celebrating the boys who have gone for the initiation rituals. The dancers go around the village during the evening entertaining people and collecting money to be used at the initiation camp.

Apparently, not only the boys who go for the traditional ceremony, also young girls go for their own type of initiation. The age for girls range from eight to twelve but for girls it is not as robust as for boys. For girls only few families send their girls for initiation ceremonies because it requires a lot of money to pay the counsellors (*Nankungwi*) and buy special food to be sending to the initiation camp. The girls' ceremony is called *Nsondo* .The girls stay at the initiation camp for a period of about two weeks. The girls are taught to respect elders, discipline and how to take care of themselves. Like for the boys' ceremonies, during this time there are also a traditional dances happening during the night to celebrate the girls initiation. A group of girls and young women also go around the village dancing.

3.5 Study participants

As indicated by Hennink (2010) in Qualitative Research Methods, a clear definition of study population determines who to recruit in your study and how to recruit them. As defined earlier chapters, the current study is aimed at gaining detailed understanding of how the social, cultural and economic context in which men and women of the reproductive age groups in Mangochi are embedded shape their understanding of sexual and reproductive matters and contraceptive behaviours. As indicated earlier, the study participants are men and women from Kera village within the reproductive age group. Residency in Kera village and experiencing most part of their life in Kera village are other important aspects in defining the study population for this study. Residency in the area determines situates individual's motivations to use contraceptives, beliefs, life course and understanding of sexual and reproductive health within Kera village *context*. In order to know the context of contraceptive within the village, a group of elderly women are included as key informants.

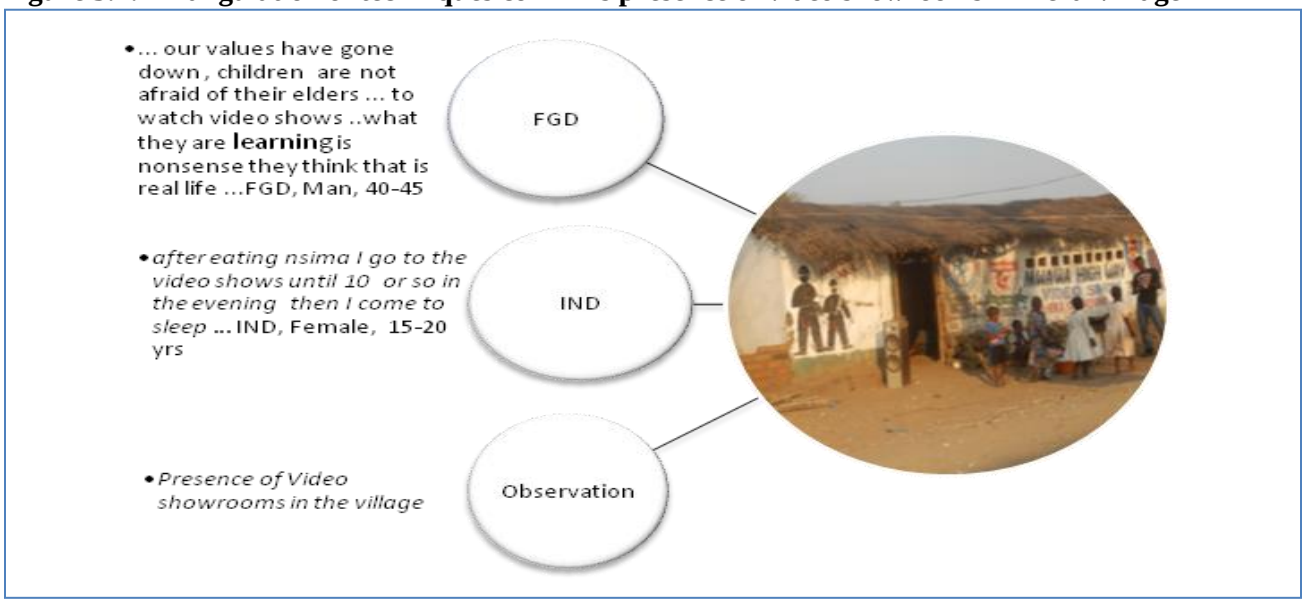
3.6 Research methods used for data collection

The current study used a qualitative research methodology approach to answer the research questions that are outlined in chapter one. "*Qualitative research is typically used for providing in-depth understanding of issues that embraces the perceptive of study population and context in which they live"* (Hennink, et al. 2011). The qualitative method was an appropriate approach for this study because the study aims at gaining an in-depth understanding on contraceptive behaviour among men and women in Kera Village. In addition, qualitative research methods provide a linkage between individual's perspectives and the context in which they live (Hennink, et al., 2010).

Even though the study uses qualitative approach, the conceptual framework from which the data is collected is adopted from the theory of planned behaviour, which was initially meant for quantitative analysis. The theory was adapted in this study to refine research questions and build on the conceptual framework. Hennink et al., (2010), describe this idea as deductive theory. The research is also framed on interpretive paradigm. "Paradigms are models or frameworks for observation and understanding which shape both what we see and how we understand it." (Babbie, 2010 p.33). Applying the interpretive paradigm, as from researchers viewpoint it was acknowledged that men and women in Kera village attach meanings to their experiences such that their perceptions towards contraceptive use are based on their own personal experiences as situated in Kera Village. It was also acknowledged that researchers had their our *own* perceptions towards contraceptive use based on their background but an effort was made not let researchers viewpoint interfere with the study participants' perspectives by taking the ideas from the participants' point of view . The analysis of the findings is guided by the combination of deductive and inductive reasoning.

As indicated in the operationalisation (Section 2.4), the study used in-depth interviews, key informant interviews, focus group discussion and non-participant observation to collect information. The three techniques in data collection are used in order to triangulate the information collected. In-depth interviews collected information more on personal experiences, insights, stories and feelings. Focus group discussions and key informant interviews collected information about the context and opinions in the community. The non-participant observation was used to collect information on the context of the study area. The observation described the context of Kera village in terms of location, economic activities and social cultural activities. For example, during the in-depth interviews and focus group discussion the study participants mentioned video shows as something that is affecting the moral values of adolescents in the area. In the non-participant observation, it was noted that there are many video show rooms in the village. Figure 3.1 illustrates how the triangulation worked in defining the context of Kera village.

Figure 3.1: Triangulation of techniques confirms presence of video showrooms in Kera Village



In-depth interviews were an appropriate data collection method for this study because they provided a framework for collecting detailed information on personal experiences, insights, stories and feeling with regards to contraceptive use as situated in Kera Village context. "In-depth interviews are one to one method of data collection that involves an interviewer and interviewee discussing specific topics in depth" (Hennink, et al., 2011). Specific issues in this study were derived from the proposed conceptual model, topics discussed in detail ranged from the individual's life course, understanding of sexual and reproductive health, motivations and beliefs. Establishment of rapport with the study participants was very important during the interviews. The use of probing techniques, encouraged study participants to open up and tell their personal experiences, beliefs, motivations and what they knew on topics presented to them during the interviews. Two types 'of in-depth interviews were conducted, individual in-depth interviews and key informant interviews. The approaches to both interviews were the same but they differed in the content of the interview guides and target study participants. The in-depth interviews were conducted with men and women within the reproductive age group. More women than men were interviewed. This was because it was postulated that women are more conversant with reproductive health issues than men are.

Key informant interviews were conducted with women past the reproductive age group. As indicated earlier, key informant interviews were used to get detailed account on cultural traditions and contraceptive behaviour in Kera Village.

Focus Group Discussions were used to obtain information on the social-cultural norms, economic activities, and family planning practices in Kera Village. Focus group discussions are interactive discussions between six to eight pre-selected participants led by a trained moderator focusing on specific issues (Hennink, et al., 2010). Literature suggests that focus group discussions highlight study participants attitudes, priorities, language and framework of understanding of issues and they also encourage conversation about embarrassing subjects and permit criticism for others (Kitzinger, 1995).The focus group discussions helped to unveil issues that were not covered in the in-depth interviews about the context of Kera Village. Like in-depth interviews, focus group discussions also required interviewers to develop rapport with the participants. The purpose of the discussions was to get as much information on the discussed topics as possible. In addition, the discussions also required good facilitation skills. The

focus groups were made up of seven participants in all the focus group discussions that were held. The in-depth interviews and focus group discussions were done in Chichewa.

Non-participant observation was done to observe structures and daily activities in Kera village. This approach was necessary in this study because it explains Kera village from researcher's perspective and it serves as a confirmation to what the study participants said about Kera Village as a context.

3.7 Research instruments

The conceptual framework model that was based on existing literature and theory guided the formulation of data collection tools. The tools included a semi-structured interview guide, a key informant interview guide and a focus group interview guide (Appendix 1). The semi-structured interview guide contained questions on the study participants understanding of sexual and reproductive health, attitudes, beliefs and subjective norms associated with contraceptive use. A similar format was adopted for the key informant interview guide with slight changes on some questions to reflect on the purpose of the interviews. The focus group guide mostly contained discussion points about the contextual aspects of Kera village in general. It should be noted that the interview and focus group discussion guide were first formulated in English but were later translated into Chichewa (Appendix 1). Interviews and focus group discussions were recorded using a voice recorder.

3.8 Participant recruitment

In order to collect intense information on contraceptive use and Kera context, the participants were purposively recruited and a gatekeeper was used to identify the participants. 'Gate keepers are people who have prominent and recognized role in the local community, they typically have knowledge about the characteristics of the community members and are sufficiently influential to encourage community members to participate in the study' (Hennink, et al., 2011 p.92). Participants who had lived most of their life in Kera Village and had experienced the social economic and cultural context of Kera Village were recruited. Here, a woman resident from Kera village who is well known in the village because she has delegated duties by the village headman was used to identify study participants. The woman was well conversant with the village and she knew many people in the village. This recruitment strategy worked for in-depth interviews, key informant interviews and focus group discussion participants. However, it should be acknowledged that the use of a gatekeeper could have introduced selection bias in the conduct of the study because; the selection of study participants was according her choice.

The eligibility criteria for participating in the in-depth interviews included being reproductive age group for both men and women. An age criterion of reproductive age group was specifically included because the group is more conversant with sexual and reproductive health issues including contraceptive use. In addition to this criterion, residency in Kera village for most part of the participant's life was considered. Here it was assumed that if individuals have lived in Kera village for most part of their life, their understanding of concepts and behaviour is embedded in their context since this is where they have spent most part of their life in. In the recruitment of study participants, an effort was made to make the group of study participants as more diverse as possible within the reproductive age group. This was done to get insights from people of different ages within the reproductive age group. It was initially planned that sixteen interviews would be conducted for the study .The assumption was that saturation point would be reached by the sixteenth interview. Saturation level is when the information that you are collecting starts to repeat itself and it is the guiding principal for data collection in qualitative research. (Glaser & Straus, 1967 cited from Hennink et al., 2010). Contrary to the planning, it turned out that saturation was reached after the eighteenth interview. Many women were interviewed as compared to men because it was assumed that women use contraceptives more than men do. In addition to in-depth interviews, three key informant interviews were done (see Appendix 1). The guide also identified the participants.

The eligibility criterion for focus group participants was men and women within the reproductive age group. Four groups of seven participants in were recruited in each group. There were two groups of women and two groups of men. Researchers have argued that use of same sex in focus groups to encourage active participation a concept called homogeneity (Kitzinger, 1995). The concept of homogeneity was adopted for this study with a notion that men or women share similar experiences concerning contraceptive use. This approach, encouraged men and women to discuss contraceptive use productively and provoked informative debates.

3.9 Data collection

The data collection process started with meeting a research assistant to brief her about the research. The research assistant is a Health Surveillance Assistant (HSA) by profession she was referred by someone who had worked with her before. The Research Assistant was chosen to be suitable for this exercise because of the nature of her job, which includes holding discussions with men and women in the community. It was also envisaged that she could help in answering some of the questions that the study participants could have been related to reproductive health. It was agreed that she was going to be paid 50 Euros by the end of the interview period. The fee also included bicycle tax fare for the whole interviewing period. The involvement of the HSA as a research assistant could have had some implications on the application of interpretive approach on in the conduct of the study. Nevertheless, the research assistant was informed in advance not to let her own perspectives interfere with the study participants. This meant that she had to act as neutral as possible and encourage the study participants to speak out their own experiences and feelings.

During the first meeting with the research assistant, focus group discussion and interview guides were reviewed. This was done to check if the translation was properly done and the questions were clear. Ideally, the interview guides could have been translated into Chichewa then back translated into English to ensure that no meaning was lost. However, the back translation was never done because of time constraint. During the same meeting, it was also arranged to meet the chief who is responsible for the study area. This was done to seek permission for entry into his village. It is a custom in Malawi that when anyone wants to meet village headman for any reason, they are supposed to give something as an appointment fee. Usually people bring chicken or equivalent price of a chicken. Two envelopes were prepared in advance to be given to the village headman. One envelope contained a brief introductory letter and the other envelope contained the fee, which was MK1, 000.00 equivalents of 5 Euros.

Meeting with the village headman was planned for the following day. He was visited at his compound. During the visit, the aim of the visit to his village was briefly explained to him. In addition, permission to go around conducting interviews and holding discussions with different groups of people was requested. The permission was granted. The village headman was then given the introductory letter as a reference to the visit and the envelope containing the appointment fee. The village headman offered to give one of the village health Committee (VHC/Volunteer) members as a guide around the village. It was agreed, that the team would meet the volunteer on the following day, but he did not make it because he was involved in another assignment so the VHC identified another person. The person that was identified was a woman from the same village. The woman, identified as *a guide* is a predominant resident of the village. She practically knew almost everyone in the village. The guide was given twelve Euros as a token of appreciation for her time; however, she was not informed about the payment until on the last day when the data collection was finished.

In order to pre-test the research instruments, pilot interviews were planned. The Pilot in-depth interview and focus group discussion were conducted on 23 July 2011. The researcher conducted the pilot interview and the interviewee was the guide. The Research Assistant observed this interview to have a feel of what was required in the in-depth interviews, using the research instruments that were reviewed earlier. The guide was used as an interviewee because it also gave her an idea on issues that were to be discussed with

the study participants. It was interesting to note that for her own interview, the guide chose her home as the place where her interview was to be held. The guide offered a mat to sit outside her house away from distractions. The actions of the guide gave a notion that in the following interviews, participants were to make a choice on the place of the interview. It was not difficult to establish rapport with the interviewee because this was already established during the first meeting. Although the guide had already agreed to the interview, a formal consent was taken by going through the consent form (see Appendix1). Going through the questions was easy and the interviewee was able to generate stories from the questions so it was presumed that the questions were clear.

The pilot focus group discussion took place in the same village. Usually when conducting focus group discussions there is, need to make prior arrangements with the people to participate but this was not the case. A group of women were chatting nearby the house where the pilot in-depth interview was held. This presented an opportunity for a pilot focus group discussion. The group was big enough for the focus group discussion. There were seven women different ages, out of the seven, four were within the reproductive age group, and two were elderly. They were already seated facing each other in a circular manner conducive to discussion. The guide made formal introductions to the group. Formal verbal consent to hold a focus group discussion was obtained from the group and they agreed to participate. However, in the course of the discussion, it was noted that interruptions were inevitable because prior arrangement were not made with the group.

3.9.1 In-depth interviews

In total, eighteen in-depth interviews were conducted as indicated in Table 1 below. The table includes demographic characteristics like age, sex and number of children. It should be noted that number of children was not among the recruitment criteria. Number of children has been included in the Table 1 to add to the description of the study participants. There were more female study participants than male. According to the recruitment plan, it was anticipated that sixteen in-depth interviews would be conducted and the distribution was six men to ten women. As it turns out, five men were interviewed to thirteen women. The interviews were normally conducted at the study participants' home except for two men who were interviewed at their place of work. The guide would first approach study participant at their house asking them if they were interested to participate if they agreed, we could then visit the house later in the day. The guide also took advantage of the settlement pattern in the village in identifying the participants. Usually, extended families build their houses close to each other and in some cases the houses are built in form a compound enclosed by a fence. A compound can comprise of two or more houses. When the guide visited such compounds, it was logical for the guide to arrange interviews with two people from the same compound. In that case, two interviews were conducted at once. In all the interviews, study participants offered a place to sit and they were welcoming, verbal informed were obtained and voices were recorded.

Table 3.9: The characteristics of the In-depth interviews participants

No	Pseudonym	Age	Sex	Number of Children
1.	Rozi	22	F	2
2.	Daisy	34	F	4
3.	Lilly	34	F	4
4.	Lene	30	F	4
5.	Chemwa	22	F	1
6.	Lefa	27	F	4
7.	Lizi	25	F	3
8.	Betty	38	F	1
9.	Missy	33	F	2
10.	Sisi	21	F	1
11.	Mwali	32	F	4

12.	Puna	20	F	1
13.	Lakwani	22	f	2
14.	Phiri	40	M	5
15.	Banda	25	M	1
16.	Manda	33	M	3
17.	Dzimbiri	36	M	2
18.	Sipokosi	34	M	3

3.9.2 Focus group discussions

Three focus group discussions with men and women in the reproductive age were conducted for this study. The ages of the people who participated in focus groups are as shown in Table 3.9.2.The FGDs were conducted with *Alovi* (Fish labourers), Fish sellers (men) and women involved in different trades.

Table 3.9.2: The distribution of the participants within the focus group

Group 1 Men (Fishermen)		**Group 2 Women (fish Sellers)**		**Group 3 Men (House wives)**	
Pseudonym	**Age**	**Pseudonym**	**Age**	**Pseudonym**	**Age**
John	42	Nabanda	32	Moze	27
Josef	35	Naphiri	28	Mike	25
Jack	22	Nagamba	25	Moby	24
Jill	37	Nanyoni	37	Mili	30
Jona	36	Nasibeko	27	Moris	35
Jeke	52	Nangondo	23	Mustafa	28
Jozi	40	Nanthola	35	Maliki	29

3.9.3 Key informant interviews

Three key informant interviews were conducted. The key informants were women who are involved in advising young girls or women. The key informants advise girls when they transit adulthood and when they bear/expect their first children.

3.10 Data analysis and procedures

As indicated earlier, the interviews, focus group discussions and key informant interviews were recorded using a recorder. The recorded audios were then transcribed word for word into interview transcripts. *"The process of making a record of an interview or group discussion for data analysis is called transcription"* (Hennink, et al., 2010). The transcribed transcripts were then translated into English. Initially the transcripts were transcribed in Chichewa and later translated into English for half of the interviews but later it was switched to translating while transcribing to save time. This could have had an implication of the quality of the transcription as translation of half of the interviews was directly hence there was no time to review if the data really presented the colloquial meaning of the words.

After transcription, the data was anonymised, thus all the information that could be used to identify a person was removed. In this study, pseudonyms were used for names of people, in some cases of unique occupations of people that could easily be used to identify people. The Translated transcripts were coded using Maxqda software. All the transcripts were merged in one document. The codes were developed basing on the concepts in interview and FGD guide (deductive codes) and other related issues that emerged from the data collection (inductive codes). The deductive are codes that are derived from the interview or FGD guide where concepts of theory and literature were used and inductive codes are derived from the data that has been collected (Hennink, et al., 2010). Efforts were made to exhaust all the possible codes that could have emerged from the transcripts. The description of codes was automatically compiled in form of the codebook. The codebook that was used in the analysis of the data collected is attached in appendix 3.

3.11 Ethical considerations

As per ethical requirement of any scientific research, the research was conducted according to social research ethical guidelines. The college institutional review board, Population Research Centre of Groningen University, approved the research. Since the study involved interviewing people on their personal lives, the following ethical steps were followed. Informed consent was obtained from the study participants. The participants were informed about the purpose of the study and their voluntary participation into the study. In addition, the study participants were assured of confidentially and anonymity in the course of the study. Thus, they were informed that information that was collected through the interviews and FGDs was not to be disclosed to anyone at any point and their identities will not be revealed anywhere in the final report. Babbie (2010) in *The practice of social research* discusses confidentiality to mean when the researcher can identify a give persons response but promises not to do so publicly and anonymity as when neither the researcher nor the reader identifies a given response with a given study participant. It was acknowledged that information on sexual and reproductive health is a sensitive topic on people's lives hence privacy when conducting the interviews was observed at all times. In the data processing and analysis, pseudonyms are used to ensure anonymity. The transcripts and the recorded interviews are only available for academic purposes related to the current study. The copy of the informed consent form that was used for the interviews and FGD is attached in the Appendix 1

3.12 Reflection on data quality and limitations

Initially it was planned that interviews were going to be conducted with men and women who are involved in imparting cultural traditions to young men and women to find out if there is any relationship between contraceptive behaviour and cultural traditions within the village and this was applicable to men and women. However, during the data collection period, only women were available for the interviews, men were involved in the boys' initiation camps. Inclusion of men's could have been important hence the data collected lacked information on the information that is relayed to boys that could have an influence on men's adoption of contraceptive use in Kera Village.

Another aspect in that might have compromised the quality of the data that was collected during this research study is the quality of recording. The interviews were recorded using voice recorders that were capable of recording any sounds including the background. In some interviews, especially for the interviews that were conducted near the centre, there was background noise that masked the discussions. Hence, some audio transcripts were not clear as a result some responses were not transcribed.

When conducting focus groups participants need to be participants need to be motivated by providing with refreshments and a nice quiet place, suitable for discussion (Kitzinger, 1995). In Kera village, it was not possible to find such a place suitable place, free from onlooker. Refreshments were planned for the discussions but it was not possible to provide the participants with refreshment attracting attention from onlookers especially children so it was agreed that provision of refreshments would not be ideal in the discussions.

The voice recorders that were used for data collection were using batteries. Apparently the batteries that were purchased for this purpose were not long lasting. One whole focus group discussion with women was missed because it was not noticed in good time that the recorder had stopped. The whole interview was considered missed and was not included in the transcripts.

The data was collected in Chichewa and it had to be translated into English. Hence, some colloquial meanings might have been lost in the process of translation. However, an effort was made to maintain colloquial terms. There are specific expressions "*nsana''* in Malawian context means literally means the back of a person , and in another context it means one's ability to reproduce and it is applied to mostly women , but in course of interviews the expression came out frequently within different contexts and it was also used to describe men's fertility.

Transcription of the audios was initially done by transcribing the audio into Chichewa then later translating the transcript into English, this process was time consuming and because of the double translation, the meanings might have been lost in translation.

4. Research findings

In this chapter, the findings on motivations, beliefs, understanding of sexual and reproductive health and life course that form their intentions to use contraceptives and the social, cultural and economic context in which contraceptive behaviour takes place in Mangochi are reported. In the first part (Section 4.2), motivations among men and women to use contraceptives are reported. In the next sections, men and women's attitudes (Section 4.3), subjective norms (Section 4.4), and perceived behaviour control (Section 4.5) on contraceptives are reported as described by study participants. These sections are followed by the findings on how men and women described contraception and family planning (Section 4.6). Later, the findings on the relationship between life course (Section 4.7) and contraceptive use is described. In the last sections of the chapter, the contraceptive situation in the village (Section 4.8), the number of children (Section 4.9) , the role of the family (Section 4.10), general life style in the village (Section 4.11) and existing traditional beliefs (Section 4.12) , intentions to use contraceptive and summary of the findings as reported by the study participants are described . It should be noted here that the findings described in this chapter are as embedded within the social, cultural and economic context of Kera village described in Chapter 3.

4.1 Motivations for contraceptive use

In the following paragraphs, motivations that form intentions to use contraceptives are reported. Following the conceptual model, participants were asked to explain their motivations for using contraceptives. The data revealed intersections between positive attitudes (outlined in Section 4.2) and motivations to use contraceptives. It could have been interesting to know if the respondents were using contraceptives at the time of the interviews but it was possible from the available data.

It was frequently reported that participants would use contraceptive in order *to give time for the baby to grow* and the mother to take care of the child (See Table 4.1). This indicates that individuals would use contraceptives *to space children*. A possible explanation for this motivation could also be that men and women who were interviewed were within the reproductive age group; hence, they have not yet reached their desired number of children.

Some study participants reported that they are living in *hard times* as such; they would use contraceptives to limit the number of children. The expression *hard times* have different connotations. This could imply that men and women in general, find raising children challenging due to circumstances in their context. The possible explanation for this finding could be that the population understudy is situated in Malawi, where the economy and food availability heavily relies on agriculture (NSO, 2011). The unpredictable weather patterns makes it difficult for men and women to be certain about the availability of food and income required for raising children. Hence, *hard times* could also mean the *rising cost of living* and *prevalence of droughts*. In relation to contraceptives use, the desire to have limited number of children whom they can manage to raise regardless of hard times *motivates* intentions among men and women to use contraceptives.

In addition, the study participants indicated that if they could have minimum number of children they would be able *to support them with available resources* (Table 4.1). Again, it should be recalled that the population under study relies on fishing for its source of income. Recent reports indicate that overfishing and climate has led to the decrease in fish catch in Lake Malawi (Weyl et al.,2010).This implies that men and women no longer have reliable source of income to support their children. Hence, men and women are motivated to limit the number of children in order to cope with what they have and be able to provide for their needs. Concerning contraceptive behaviour, it could be argued that men and women form intentions to use contraceptives with an aim of achieving the minimum number of children.

Other participants also reported that they are motivated to use contraceptives because nowadays *people are not living for long* (Table 4.1). Here, participants reported that they do not want to die and leave their young children to be a burden to others. This could possibly be attributed to the prevalence of HIV/Aids in Malawi. The current HIV prevalence rate is at 11 percent (NSO, 2011). It should be noted here that the study participants are situated in the context where they are experiencing and observing the impact of HIV/Aids. The study participants see themselves as being at risk. Hence, over time their decisions are framed with the notion that at some point they will die and leave their children behind. Concerning contraceptive behaviour, fear of unknown and safety for their children motivates men and women to form intentions to use contraceptives.

Table 3.1: Motivations for using contraceptives

Study participant	Response
Female Study participant IDI , Puna* 20-25yrs	" *If I am to use the family planning methods as I am saying would be to allow this baby*(pointing at her baby in her hands) *to reach 2 years then I get another baby again…*"
Female Study participant IDI , Betty* , 35-40 yrs	*"…if you know that your problem is money ...then your actions should show that money is the problem …how do you do that …by making sure that you have enough for the family ….if the family is big …how much money do you need …you need more money …so yah… I think using family planning methods is doing justice to yourself...nowadays everything is money …and the children take a large part of family money…"*
Key Informant, 60-70 yrs	*"… nowadays the world is not a better place, people are not living that long so if you have a lot of children ...it is your children who are going to suffer because you might not be so lucky to see them growing …and also it is difficult to find money these days and for you to raise children you need more money to support them*."

* Pseudo names are used

4.2 Attitudes towards the use contraceptives

In following paragraphs, findings on attitudes that form intentions to use contraceptives are reported. Attitudes are personal judgment that performing behaviour is either bad or good (Ajzen and Fishbein 1980; Hutter 1996, p.8). Here, the participants' ideas about consequences of using contraceptives and whether they are perceived to be an advantage (good) or disadvantage (bad) in their context are reported. The analysis of the interviews and focus group discussions revealed the concepts as shown in Table 4.2 below. The participants' individual judgment that using contraceptives is good or bad is expressed as consequences that the individuals face when contraceptives are used. As indicated in Table 4.2, the analysis revealed that the participants consider the use of contraceptives in terms of side effects, prevention of unwanted and wanted pregnancies and acceptability of the contraceptive method.

Table 4.2: Attitudinal beliefs that form intention to use contraceptives

Findings	Consequence of contraceptive use	Perception	Judgement about the use of contraceptive method
Side effects(Modern FP methods)	Prolonged bleeding	Unhealthy and unacceptable	Bad
	Feeling Sick	Unhealthy and unacceptable	Bad
Prevention of unwanted pregnancy (Any FP Method)	Prevention of pregnancy related risks	Woman is healthy	Good
	Free time to look after oneself and children	Babies do not suffer from *utumbidwa* No depression	Good
	Free to have sexual relations	No fears or doubts	Good

Prevention of wanted pregnancy (Any FP Method)	Unable to conceive again	No need to use FP	Bad
Acceptability of the method - **Condoms** - **Periodic sexual abstinence**	Reduced sexual pleasure Deprivation of sex	Not ideal in marriage	Bad

4.2.1 Side effects

The analysis revealed that the study participants reported disadvantages of using contraceptives based on their own personal experiences and what they have seen or heard had happened to their friends, family or other people. It was interesting to note that some study participants in the course of the interview would start with an expression "*if your body rejects the method then you experience…*" to describe their judgment on contraceptive use. The study participants reported that experiencing side effects is what makes the use of contraceptives bad. The most frequently mentioned side effects were those that are caused by modern contraceptives. The side effects reported ranged from general body discomforts, prolonged bleeding and abdominal pains. One of the study participants had this to say about her experiences with modern contraceptive methods. *"…. like for me when I was using injection I was having heavy periods and they were not regular….I tried pills before changing to injection I was also experiencing headaches so that was why I changed"(IDI, Female , Lilly , 30-35yrs)* .The findings indicate that some of the study participants have tried using modern contraceptives and have experienced side effects. While others, reported that they have *heard* or *observed* that their *friends* or *family* have experienced side effects. This gives an indication of the effect of social interaction among men and women in the study population. This forms empirical evidence that men and women form attitudes based on what they have heard or observe from their friends and family (*social context*). The finding also suggests that men and women are not adequately informed about the side effects of contraceptives in advance hence they consider side effect as a major concern. The duty of giving information on contraceptives lies in the hands of Village Health Committee members, Community Based Distribution Agents, and health workers. Whether the service providers indeed provide such information or are adequately informed themselves to provide contraceptive information to the study participants, it is beyond the scope of this paper. Nevertheless, the bottom line is, if men and women are well informed about the side of effects of contraceptive methods they wish to adopt, they would make informed decisions.

4.2.2 Prevention of unwanted pregnancy

In relation to prevention of pregnancy, the study participants frequently reported that when a woman is using contraceptives, she looks healthy and happy. The concept of being healthy was explained among the study participants as a woman's body condition that comes because of *preventing pregnancy related risks*. One participant expressed her concerns as follows;"*...what happens is that when a woman is giving birth she loses a lot of blood, just imagine if you are to give birth year after year and losing blood each year …I do not think your body will be normal, so family planning helps women to avoid that ….family planning enables women to pick up their lost blood and weight after delivery …it is like you are giving time to your body to be fresh*" *(IDI, Female, Lene, 20-30yrs*). This finding links motivations to attitudes towards contraceptives use. Men and women find contraceptives use as being advantageous because they are able to prevent unwanted pregnancy. Apparently, according to the findings, pregnancy is associated with a health condition. Literature suggests that individuals are motivated to perform behaviour in order to achieve a physical wellbeing (de Bruijn, 1999). This finding could also be linked to the context in which men and women are situated. In Malawi, maternal morbidity and mortality are high (WHO, 2011). Possible reasons for this finding could be that men and women have experienced or observed pregnancy related risks in the area hence; they find contraceptive use as the best way to prevent maternal morbidity and mortality.

In relation to health of the children, the study participants reported that if a woman is spacing her births, she is able to take care of her baby before another baby is born. When the baby is well looked after, it

does not get sick. It was reported that if another baby is born while a woman has a young child, the young child suffers from a condition called "*utumbidwa''*, an illness in young children that emerges when a baby is not properly taken care of especially when the mother is pregnant or has another young child. The symptoms are pale swollen body and loose hair (Gwengwe, 1965). One female participant had this to say "*...if I* [Study participant] *give birth ...one child after another without waiting for the other one to grow, I will harm the child, the child will not grow healthy and he might suffer from utumbidwa* …(meaning the child could become pale and would not look healthy)*'' (IDI, Female, Mwali 30-35 yrs).* Again, this finding is linked to motivations to use contraceptives. Men and women find contraceptive use advantageous because they are able to prevent unwanted pregnancy. Prevention from unwanted pregnancy subsequently prevents their babies from suffering *utumbidwa. Utumbidwa* in this case could be considered as a cultural schema. "Cultural schemas are structures that make identification of objects and events possible" (D'Andrade, 1992 p.33 cited from Bailey, 2006). Individuals use cultural schemas to rationalize their behaviour (Bailey& Hutter, 2006). Another dimension to look at this finding is by considering the prevalence HIV related illnesses and malnutrition in the area understudy. Malawi faces malnutrition and HIV related morbidity in under five children (NSO, 2011), which happen to have similar symptoms as *utumbidwa*. This could mean that men and women in the study area are experiencing the effects of HIV and malnutrition in children hence contraceptive use is seen as a proxy to minimising child illnesses.

The study participants also reported that use of contraceptives prevents depression that comes because of being overwhelmed with pregnancy and looking after young children at the same time. "*...I [male study participant] would want to have a child ...look after the child..., giving him all the care he needs before the mother gets pregnant again...it is not good for a woman to have children every year and when you look at her… she is wodwala* (pregnant) *and she has one child in her hand… and the other one at her back ...both the children and the mother do not look happy...eh because each child needs attention from the mother''(IDI, Male, Manda, 30-35yrs).* Men and women perceive that being able *to have time to raise babies* is important hence they form a belief that contraceptive use are advantageous. It was not clear from the data how study participants space their births, but this finding suggests that study participants might have experienced or observed challenges that women face when they conceive and have young children.

Concerning freedom to sleep with their partners, the study participants also reported that women are happy and free to sleep with partners without any *fear of getting pregnant*. Some study participants in particular reported that use of family planning methods could have prevented pregnancies that have led them or other women in the village to have children with unstable partners or drop out of school. One of the study participants had this to say on the matter *"...you have a boyfriend and he impregnates you and yet you know that you will never get married ...so using family planning methods for prevention of pregnancy would be ideal for me because ...sometimes you get pregnant when you are not ready to start a family*" *(IDI, Female, Lakwani, 20-25 years).* This finding compliments what another participant mentioned in a focus group discussion that many women have children *without fathers*. The underlying implication to this finding is that raising children among the study population *(context)* seem to be acceptable within marriage union. In addition, when women have children outside marriage they experience stigma. This is evidenced by the expression having children *without a father*. Hence, women feel obliged to use contraceptives in order to avoid stigma from family and friends.

4.2.3 Prevention of wanted pregnancy

Interestingly, it was also reported among female study participants that other contraceptive methods cause women to stop having children. Quite a few women reported that women were unable to conceive again after they stop using contraceptives. As observed in Section 4.9, children are considered important among men and women. This finding suggests that men and women consider contraceptives as a hindrance to having children. Hence, *contraceptive use* is seen as a disadvantage. Another possible explanation for this

attitude could be that infertility could be common among study participants. If infertility occurs to women who have used contraceptives before, they attribute it to prior contraceptives use.

4.2.4 Acceptability of the method

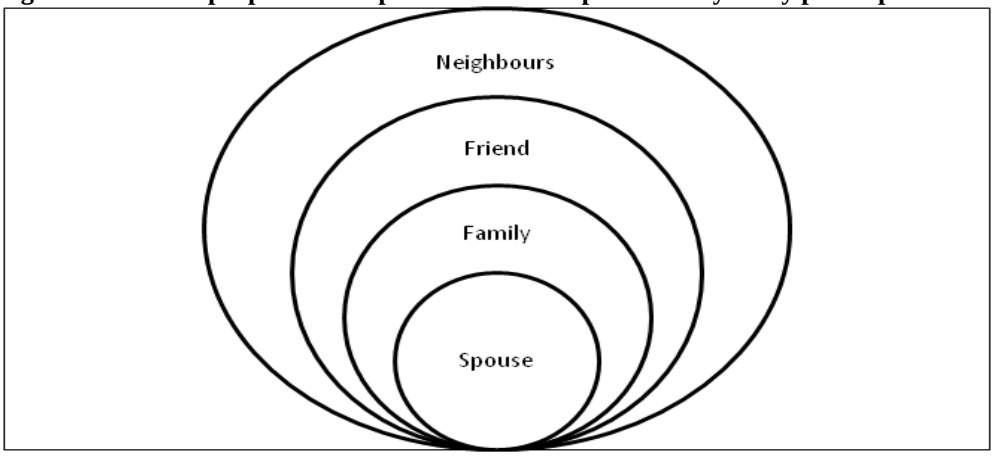
In relation to acceptability of contraceptive methods, the study participants in the focus group discussion with men and women it was reported that within marriage when condoms are used as family planning, it reduces sexual pleasure. Hence, men do not like using condoms instead; they encourage their partners to use other contraceptive methods. This is consistent with what other researchers in Malawi have found concerning use of condoms within marriage; condoms are seen as intruders within marriage (Chimbiri, 2007). This could also mean that the qualities of condoms that are available for use are not user friendly; hence, men do not find them easy to use.

Periodic sexual abstinence was frequently mentioned as one way of naturally preventing pregnancy that is advocated when a woman has just given birth. The data revealed that the method only works for some time within the family for fear of the husband suffering from *msempho* (a condition that men suffer when they sleep with women when they are having menses or when they have just delivered a baby; more on this will be discussed under cultural beliefs) afterwards *sexual abstinence does not work anymore*. This finding shows an example of how cultural beliefs change over time. Apparently, periodic abstinence is linked to cultural belief and is seen as a sanction for birth control, of recent men are not finding it acceptable. Hence, rules for these sanctions are being softened such that periodic abstinence is becoming shorter. In relation to attitudes that form intentions to use contraceptives, the outcomes could be twofold, this could mean that individuals would seek for other forms of contraceptives or men would find use of contraceptives as a disadvantage because they fail to satisfy their needs.

4.3 Subjective norms on the use of contraceptives

In the following paragraphs, existing subjective norms that form intentions to use contraceptives among the study population are reported. According to the conceptual model, the study participants were asked on the people they discuss contraceptive use with and what would they would say or do if they knew that the study participants were using contraceptives. Figure 4.3 below shows a graphical presentation of the most influential people to the study participants. These are the people whom the study participants discuss contraception issues with, and whose opinion matters most. The most influential and frequently mentioned person is placed at the core of the diagram and the least important on the peripheral of the diagram.

Figure 4.3: List of people whose opinion matters as perceived by study participants



In the following paragraphs, reasons why the study participants frequently mentioned the influential people in that order are explained. The data revealed that husbands or wives are most influential persons

in forming the intention to use contraceptives among the study participants who were married. The female study participants in both the focus group discussions and in-depth interviews reported that using of contraceptives within a marriage is discussed with husbands. If the husbands agree then, families would use contraceptives. They also reported that if the husbands agree to use contraceptives, they provide *financial* and *moral support* to women. This was echoed by male study participants who reported that they discuss the use of contraceptives with their wives and they give them (their wives) support. It was also noted that if the husbands or a wives are against use of contraceptives due to reasons known to themselves it is unlikely that they would use them. This is what one of the male study participants reported in relation to the use of contraceptives in his family; "…*I* [husband] *had to convince my wife to go for her injections… because I told her if she wants children every year and no time for raising other children and doing other things… I better make a move …so I think she wanted to preserve her marriage because I told her I would pack my bags to go where people would listen to me…" (IDI, Male, Banda, 25-30yrs).*

4.3.1 The family

In relation to family forming subjective norms to contraceptive use, there were mixed responses. Some study participants said family would not do anything if they heard that they were using contraceptives while others said they would *talk*. One study participant specifically reported that his wife was being told by her mother not to use contraception because it was time for them to have another child. This is what he had to say; "…*why we discuss this a lot …is that we face a lot of resistance from her family …I think her family has gotten used to seeing people with children that are so closely followed and they find it strange that my child has reached 3 years and yet there is no sign of another child*…" *(IDI, Male, Banda, 25-30yrs).*This finding gives an indication of the extent of family influence. Families as embedded in a community where children are valued (see Section 4.9) hence, they have expectations on the number of children their children would have and when they would have them.

4.3.2 Friends

In relation to the influence due to friends, the data revealed that study participants discuss contraceptive use with friends. The issues mostly discussed are their experiences and friends experiences with contraceptives. When asked what would be the reaction of your friends if they heard or knew that they are using contraceptive, the study participants reported that friends would *talk because* of the stories that go around the village about side effects of contraceptives. While others participants reported that friends would not do anything if they heard that they were using contraceptives. The study participants seem not to be comfortable with people *talking* about other people's contraceptive use. This gives the notion that contraceptive use as something personal.

4.3.3 Religious leaders

It was earlier anticipated in the conceptual model that religious leaders could have an influence on people's intentions to use contraceptives. It was interesting to note that study participants reported that religious leaders would not have any influence on their use of contraceptives.

4.4 Perceived behaviour control over the use of contraceptives

Here, study participants were asked to describe how easy it is for them to use any family planning method. The responses were mixed; others reported that it is easy while others reported that it is not easy. For the study participants who reported that it is easy to use contraceptives cited *agreement* with their spouses, *knowledge* of where to get the contraceptives, *availability* of the contraceptives in the village as aspects that would make it easy for them to use contraceptives. While those who said it is not easy to use contraceptives cited *lack of knowledge* on how the contraceptives work and *lack of money* to pay for contraceptives which are easy to use or can be used without knowledge of their partners. In addition, other study participants mentioned *lack of support* and *approval* from their spouses as a hindrance to their use of contraceptives. Some of the responses are summarised in Table 4.4 below.

Table 4.4: How easy is it for participants to use contraceptives

How easy is it for you?	Examples
Not easy	*"...on my own I cannot manage it will depend on how my husband takes it if he agrees then we go for family planning but if he is reluctant then I will also follow what he wants because all I want is to keep the marriage ..."(IDI, Female, Chemwa*, 20-25yrs)*
Easy	*"...For me it is easy for me because it is my wife who does it…. but at times when we do not have money for her to go for injection we go for condoms and that is okay with me but if my wife was not using then we could have problems because I do not like condoms neither..."(IDI, Male, Sipokosi*, 30-35yrs)*
Not easy	*"...you know pregnancies just come when you are not ready... when you sleep with a man "(IDI, Female , Lizi*, 25-30yrs)*
Easy	*"...the time that I was going for my injection regularly, I was with my former husband and he was okay with it... but when I told this to my new husband hey! he looked like he was not very interested... because he also wanted me to have his child so the fourth child is his child... but me I still maintain secretly because I know that without that I will bearing children every year...and the only thing that can prevent me from using it is my husband."* (*IDI, Female, Lilly*, 30-35yrs)*

*Pseudo names are used

The data revealed different dimensional aspects of perceived behavioural control that form intentions to use contraceptives among men and women in the study population. It was noted that the study participants mostly women reported that spousal *agreement* would determine whether they are able to use contraceptives or not. This notion demonstrates decision-making and gender roles within marriage. From the interviews, it was noted that if men would disagree with contraceptive use women find it difficult to form intentions to use contraceptives. Women (*Chemwa*, Table 4.4)* adhere to their husbands decisions, in order to preserve their marriages. This also gives an indication of the values of marriage to individuals within the study population. Again, on gender roles, it could insinuated that men consider contraceptive use as a woman's responsibility (*Sipokosi*, Table 4.4).*

Study participants indicated that *knowledge* of where to find the contraceptives would form their intentions to use contraceptives. The idea seems logical, because even though men and women would like to use contraceptives but if they do not know where to find them their willingness is irrelevant. Importantly, is the *availability* of contraceptives. As reported in Section 4.7, not all contraceptives are available within reach in the study population. If contraceptives were not available, men and women would not have access to them. Hence, *unavailability* of contraceptives would form perceived behaviour control over their intentions to use contraceptives.

The notion that *lack of knowledge* on how contraceptives work is related to the understanding of men and women of reproductive health presented in Section 4.6. This could be an equally important aspect for men and women to form intentions to use contraceptives. Literature suggests that if individuals lack knowledge, they lack confidence and skills to perform the behaviour in question (Ajzen, 2007). Similarly among the study participants, men and women mentioned *lack of knowledge* as a perceived behavioural control that would form their intentions to use contraceptives (*Lizi*, Table 4.4)*. Another dimension to perceived behavioural control is *lack of money* to pay for contraceptives of their choice. It was learnt from the focus group discussions that contraceptive use is a challenge when an individual has no money. For

example, it was mentioned that during the dry months and fishing off season their priority changes. The money available is used for food hence; contraceptive use is not seen as a priority. Similarly, when money is available among the study population, thus when fishing is in season or harvest time, people are able to pay for contraceptive method of their choice, usually injectables.

It was mentioned that *lack of support* and *approval* from spouses form perceived behavioural control on men and women's intentions to use contraceptives. As discussed in Section 4.3, spouses are influential in decision making on matters related to contraceptive use. It was interesting to note from in-depth interviews and focus group discussions that women it is common for women to use contraceptive methods like injectables because they go unnoticed by husbands. This happens when husbands would like to have children and women do not want *(Lilly*. Table 4.4).*It was also noted that women use injectables when they do not want anyone to know that they are using contraceptives. Probably, this is because the study population (*social context*) value children or they are afraid that they would get discouraged because of the stories circulating about side effects of contraceptives.

4.5 Life course of individuals

In the following paragraphs, the life course of individuals as embedded in the research framework is reported. The life course is thought to influence individual's reproductive and contraceptive behaviour, and is outlined as number of events that study participants went through passing though different stages of their life. As indicated earlier, the life course is defined as *stages in individual life that individuals undergo different ceremonies within their life course.* Apparently, men and women within the study population pass through three different stages namely, transition into adulthood, marriage and birth of first child. This is similar for men and women. According to the findings men and women's *motivations, beliefs* and *understanding of sexual and reproductive health matters* that form intentions to use contraceptives develop through the stages. Importantly, the life course of the study population is embedded within the social, cultural and economic context of Kera village.

It was noted that when an individual is born in Kera village, he or she is expected to undergo three important events in the course of their lives. In women, it was reported that the first event that occurs is the starting of menstruation. This event is biological but it is also culturally linked with a ceremony, whereby elderly women usually grandmothers come and advise the adolescent. The advice that is given ranges from prevention of pregnancy, dressing, personal hygiene, respect for elderly and obedience. The study participants reported that they are told that start of menstruation represents maturity hence if they sleep with a man/boy they can become pregnant. The study participants also reported that they are advised to inform their elders when they are ready for marriage. In general, this marks an important stage in women's lives, because they are taught things related to reproduction and sexuality. Apparently, girls do not know about reproductive issues until they go through the ceremony. One female study participant explained as follows regarding her biological transition into adulthood; ..."*I did not know anything whatsoever so when I noticed that I was bleeding I went and tell my friend who was older than me she told me some of the things but she told me that I cannot tell you (*the study participant) *everything but ...you need to tell your mother because someone can get sick from your family and they will say that it is you because you will be applying salt in their food... " (IDI, Female, Missy, 30-35yrs).*
This gives an indication that for girls, the first step to acquiring knowledge on contraception is at this stage of their life. It is possible that girls would get some information from the radio or from school but that did not come out during the interviews. The data revealed that girls are told about abstinence *(not to sleep with men)* as the only way of preventing pregnancy.

Male study participants, like their female counterparts reported that they also reach a stage in their life, which is marked by initiation as per their traditional requirement called *Jando*. *Jando* is traditional rite

where boys undergo circumcision and they stay about two months in the initiation camp, it is common among people of Yao tribe (Gwengwe, 1965). Unlike the women, *Jando* is not linked to any biological event, the age of initiates ranges from eight to fifteen years. The boys initiated by *Ngalibas* (counsellors) who may not be a relation. Like women, they are taught how to respect the elderly and how to live as a man. The study participants in the in-depth interviews did not explain further than that. Apparently, it was learnt later during focus group discussions that boys are taught about sexuality during this period. In one of the focus group discussions with men, one of the participants added that boys are told not to *look dusty* implying that men should be having sexual affairs. This is what one of the FGD participants said; "…*boys in this village go for initiation rite ….they call it Jando...and one of the lessons that are taught there is how to be man ...that means their skin has to be shiny ….so they need oil to polish their skin eeh (have sex)…in that way they look for girls to sleep with… in order to be shiny …because that is what they were taught …" (FGD, Mike , Male, 20-25yrs).* The expression *looking dusty* implies that someone has had no sex for a long time. This expression is an opposite of *looking shiny* .It is believed that when men/boys have sex regularly, they look healthy and their skin looks shiny/glows. This belief has an implication on intentions to use contraceptives in men. It was not clear from the interviews whether, the boys are taught to avoid pregnancies when they are *polishing their skin* (having sex). Nevertheless, study participants explicitly attributed teenage pregnancies to this practice by boys.

The second stage in men and women's life course is the time when they get married. It was reported that men and women are advised again on their engagement or wedding day. At this stage, individuals acquire another status in the community. It was reported that on the wedding or engagement day, men and women are approached again by elderly people in the community usually grandmothers or aunts sometimes both. The grandmothers pass additional information to the couple. This time, the information is framed on how to *sustain their marriage*. It was learnt that sustaining marriage means being obedient for women and men being able to have children. This was what one of the key informants had to say; *"…if your son gets a wife and they stay for about a year without a child ….you get them all to see a traditional doctor or to the hospital for help ….ah sometimes they say the woman is fertile but the man is not …so you take the man to the hospital or traditional doctor ...and with God's help others do conceive but if they do not then you try but if it fails...then that is the <u>end of the marriage</u> if the woman really wants a child she might go and get married somewhere else… the man will be sent packing ….the same happens to women sometimes the man can be fertile and the woman not …then people from the husbands side they say we want children and he gets another wife to give him children ….children are really important.,…<u>marriages can end</u> when there are no children in the family (*Key Informant, 60-70 yrs). In relation to intentions to use contraceptives, when men and women marry family expect them to have children. Hence, in the advice that is given to newlyweds prevention of pregnancy is not included.

The final stage within the life course of individuals is when the woman is pregnant and is about to deliver. Here, the woman is told how she is going to deliver the baby and how to look after the baby and the whole family. The advice given is culturally constructed and the goal is prepare the woman so that she must not to get pregnant again before the baby is old enough. Cultural schemas used as discussed in Section 4.10 include *Kumanga mpingu* and *Kupititsa mwana kumphasa.* The expressions *Kumanga mpingu* is used to tell the couple to be careful not to have sex while her baby is young. In addition, the expression *Kupititsa mwana kumphasa* means resumption of sexual activity six to seven months after the baby is born. In relation to intentions to use contraceptives, there is the period when periodic sexual abstinence is observed and it was learnt from key participant interviews that women are specifically told to avoid their husbands, in order for the baby to grow.

As indicated in the opening paragraph of this section, men and women form their understanding of sexual and reproductive health matters especially on contraception and natural contraceptive methods within the various stages outlined in addition to what they hear from other sources. In relation to motivation to use

contraceptives, men and women are motivated to use periodic sexual abstinence because they would like to prevent pregnancy after childbirth.

It could be said that attitudes, subjective norms and perceived behavioural control towards contraceptive formed overtime as men and women pass through their life course. During this period, men and women observe what goes on around them. For example, they observe how family, friends and the community perceive men and women with or without children. The reaction of the family, forms their perceived behavioural control and subjective norms. They learn from experiences like trying experiment with different contraceptive methods, which form their attitudes towards contraceptive use. This notion is similar to Easterline hypothesis on fertility behaviour, he alludes fertility preferences to be moulded by experiences during formative period in adolescence at the parental home (de Bruijn, 1999).

4.6 Understanding of sexual and reproductive health

In order to get a feeling of how the study participants understand sexual and reproductive health, and how this could influence contraceptive behaviour. Men and women were asked to briefly explain in their own words, how *does a woman conceive*, and what they *know about contraceptives*. The following paragraphs outline briefly the responses of the study participants.

4.6.1 Knowledge on contraception

The explanations given by the study participants on how women get pregnant were diverse. Most of the participants reported that pregnancy occurs when a woman sleeps with man, this echoed with the message that women are told during their transition into adulthood. The responses were similar among male and female study participants. In addition to this explanation, the study participants also gave signs of pregnancy as an indication that one is pregnant. Table 4.6a below indicates a representation of three different responses from participants. From the explanations given, it could be seen that their knowledge is culturally constructed. The explanation are given by cultural schemas, Lakwani*(Table 4.6a) uses the expression *chinsana chanu chayandikana*, meaning if a woman and man are both fertile when they sleep together a woman can become pregnant. In general, according to Table 4.6a, men and women base their decisions on the knowledge base as indicated by their explanations. The explanations given are not conclusive of all that an individual needs to know about contraception in order to make an informed choice. Hence, it could be said that men and women's decisions on contraceptive use are based on *limited information*. In relation to contraceptive use, having limited information would affect their intentions to use contraceptives.

Table 4.6a: Explanations for pregnancy as given by participants

Study participant	Response
Female Study participant IDI, Lakwani* 20-25yrs	"…mmmh I do not know …what I know is when you sleep with a man you get pregnant...they say (silence) when (*chinsana chanu chayandikana*) you are compatible …the woman conceives …I don't know ...but what I know is that when you sleep with a man and you notice that after sometime you are not having your periods …then you know that you are expecting …"
Female Study participant IDI, Daisy* 30-35 yrs	"… when a woman, sleeps with a man ...eh and the male seed meets the woman's egg…they form the pregnancy …it takes about 9 months for the pregnancy to become mature..."
Male Study participant IDI, Manda* 30-35yrs	"…what I know is that when a woman is capable of having children… when she sleeps with a man and the man is also fertile the woman may get pregnant, after a month she notices that she stops having periods and her stomach begins to grow not to mention her habits she begins to chose foods and sometimes she feels like vomiting a lot."

*Pseudo names are used

In relation to knowledge of reproductive health issues, it was interesting to note that most of the female study participants reported that when they started menstruating for the first time they did not know what

was happening. Female participants reported that thought they were either sick or they had done something wrong. One female study participant explained as follows regarding her biological transition into adulthood; ..."*I did not know anything whatsoever so when I noticed that I was bleeding I went and tell my friend who was older than me she told me some of the things but she told me that I cannot tell you (*the study participant) *everything but …you need to tell your mother because someone can get sick from your family and they will say that it is you because you will be applying salt in their food…* " *(IDI, Female, Missy, 30-35yrs).* This indicates that in general, the only time they start hearing about sexuality and reproductive health is when a man or a woman is considered grown up, and they are married and have undergone their births. Prior to that issue on contraception are rarely discussed. This is consistent with an earlier study conducted in Malawi by Munthali and Zulu (2007), in the study, they noted that adolescents were sad, anxious and surprised when they discovered that they have started menstruating.

4.6.2 Knowledge on family planning

In order to get an understanding of how the study population perceive family planning, men and women were asked to describe family planning in their own words. The following paragraphs report on the description of family planning as per study participants. Table 4.6b below briefly outlines how the study participants described family planning in their own words. In general, the study participants especially women mentioned different types family planning methods including traditional methods. On the other hand, men were only able to mention a few. The most commonly mentioned family planning methods among men were condoms, pills and injectables. Possible explanation for women being more knowledgeable than men is the following; apparently, after the giving birth, women become in contact with health workers when they go for under five clinics with their children who inform them about modern contraceptive methods. However, this was different for women who have never had children; their knowledge levels could be similar to men. The explanations in Table 4.6b are interesting, they give an indication that men and women have an idea on what is family planning.

Table 4.6b: Definition of family planning as given by study participants

Female study participant , Rozi*, 20-25 years
I: *would you tell me about family planning?* *R: I just hear that there are family planning methods that women can use to prevent unwanted pregnancies but I do not actually know how this works …I have never used them before* *I: what is the little that you have heard?* *R: They say there is family planning method called injection,….and there is also this method they put here* [showing the arm] *norplant and there is also another family planning method called pills ,and female condoms all those can be used to prevent pregnancy*
Female Key Informant , 60-70 years
"…yah mostly to me and the way I tell my girls…. I tell them this does not mean they should not be having children but they should be having like this year and the jump two or three years up to the time when the other child is able to run….then they can have another one like that ...this give you time as a mother to breastfeed the baby properly for a long time and also take care of yourself and the family …the rule is when they give birth they should take at the baby to bed at least six month after giving birth …when I tell them that they should be breast feeding this also helps the women to conceive …but sometimes it is not always the case ..so if the woman is clever they go and get family planning from the hospitals …"
Male Study participant, Sipokosi*, 30-35years
"I hear that family planning Is what families do in order to prevent children from being born so close to each other like every year, which is not good, so to prevent this… women and not only women men agree with their wives to give their children time to grow so they go to the hospital to get family planning methods…"

*Pseudo names are used

In relation to contraceptive use, men and women would form intentions to use contraceptive if they are conversant with the contraceptive methods. That means that men and women would feel confident to use contraceptives. However, even though there seems to be some knowledge on contraceptive, the knowledge is not conclusive enough to enable men and women to use contraceptive efficiently.

4.7 Contraceptive provision in Mangochi

In the following paragraphs, the contraceptive situation in Mangochi is described. Outlining the contraceptive provision not only to situate the research findings on the social, economic and cultural context as outlined in Chapter 2 but also it also situates the research findings in the context where the availability , accessibility and sources of information on contraceptives are defined.

As mentioned earlier, the study is conducted in Mangochi District in a village called Kera. The area is located within the vicinity of two health centres called Koche Health Centre and Maldeco clinic; these two health centres offer Family-planning services. Koche Health Centre offers family planning methods like pills and condoms are free while Maldeco is a paying clinic. In addition, there are Community Distribution Agents (CBDAs) or Health Volunteers who stock contraceptives like pills and condoms for the area and neighbouring villages. If residents require other family planning methods other than either pills or condoms they go to Maldeco Clinic or they travel 25km away to the district hospital in Mangochi or Monkey bay Hospital in Monkey bay.

It was reported that the main source of contraceptive information in the area is through the radio and health centres. Women study participants reported that apart from the radio, they get information on contraceptives from health workers when they go for under five clinics at the health centre or when Health Surveillance Assistants come to conduct under five clinics in their village. Men on the other hand, indicated that their sources of information on contraceptives are their wives and radios.

4.8 The role players in the family

In the following paragraphs, the focus is on the broader socio-cultural context of Kera village, and the roles of family are reported. In demography, family is referred to as a social institution in which individual's social activity takes place (Tillman & Nam, 2008). It was noted during the interviews that family is an important aspect within the study population. This was evidenced by the living arrangements and settlement pattern in the village, most of the study participants had their houses among relatives. One of the female study participants in particular reported that she stays with her family, implying that she stays with her husband and children in the same house, her sisters, her mother and grandmother stay within the same vicinity. Table 4 below shows what transpired when the study participants were asked to described the role of each family member within this type of living arrangement. The living arrangement depicts the *matrilineal society* set up. In this society relationship is traced from mothers to daughters (Peoples & Bailey, 2011) hence the living arrangement. As discussed earlier, family form *subjective norms* among men and women that form intentions to use contraceptives. This is also in relation to this matrilineal system, as it can be observed from Table 4.8, women and their family descendant play an important role in family. In addition, family is defined inclusive the sisters and brothers to study participants.

Table 4.8: Role players in a family

Key Player	Role
Husband	- Provide for the family financially - To provide shelter - Decision making
Wife	- Taking care of the family (children , husband and in-laws) - Taking care of herself - Taking care of contraception issues - Take care of the household
Family (sisters, brothers, mothers, fathers, grandmothers)	- Supporting in raising children - Giving advice to children they grow up or when they are getting married (advisory role, specific to grandmothers and uncles)

4.9 Number of children wanted

The term "*children''* was frequently mentioned in the course of the interviews and was discussed in different dimensions. The dimensions reported here are; individuals' *desired number of children*, *the value of children* to individuals and the individuals' *plans for the future* for their children. When the study participants were asked on their desired number of children, most study participants replied four while few replied five but not more than that. The preference of those who replied four children were two boys and two girls and for the study participants who replied five they did not specify the distribution. When asked why they mentioned their respective preferred number of children, the study participants frequently reported that four or five were a manageable number of children they could be able to support according to the resources that they have and the money they make. It is interesting to note that the current TFR for Mangochi is seven children per woman (NSO, 2011). This finding suggests men and women prefer fewer children than current average number of children of seven. The reduction in the number of children is motivated by the rising cost of raising children. It is anticipated that this change in preference of children, would form intentions to use contraceptives, as men and women would want to use contraceptives in order to limit the number of children. Other study participants reported that they want more children because they were not sure of the survival of the children and if they happen to lose any of the children at least some of them should remain. They indicated that in their community, it is possible to lose children.

On the value of children, it was reported among IDI and Key informant interviews that children are considered important to individuals. To begin with, when an individual has a child they are elevated and accepted in the community. This was echoed by one of the study participants "*… having children in this village is a must because when you marry everyone is looking at you ….especially when you move and stay at your wife's place ...the moment you marry they give you about six months and stories begin… if you do not have a child they say things like ..this man must be lazy up to now no issue ...so yeah ...when you get married the first thing is to make sure you make your wife pregnant ...everyone is happy that way…without that they will suggest that you go to hospital or herbalist to find out the problem ….*" *(IDI, Male, Banda, 25-30yrs).* Importantly, being a matrilineal society where the wife's family makes some decisions, men are obliged to have children in order to be accepted by the family. This is related to the notion that children hold marriages together. It was frequently mentioned among female and key informant study participants that. If there are no children in the family, it is easy for marriage to break up. Additionally, children help to do small errands in the house and take care of parents when they are sick. It is anticipated that children would take care of their parents in future when they grow old by supporting them financially and morally. In relation to contraceptive use, due to the pressure from the family to have children men and women form beliefs about contraceptive use which later affects their intentions to use contraceptives.

It was noted that not only are men and women are interested to have children to fulfil their needs but they also have *plans for their future*. The study participants reported that they would like their children to get good education and get good jobs when they grow up.

4.10 Existing traditional beliefs related to contraceptive use

It was noted that there are traditional beliefs in the study population that are related to contraceptive use. The following paragraphs briefly explain existing traditional beliefs as reported by study participants. The data revealed existence of traditional beliefs and cultural schemas in the study population directly or indirectly related to contraceptive use. Table 4.10 below shows the traditional beliefs and cultural schemas that are common in the study population.

Table 4.10: Terms used to describe some of the events related to sexual and reproductive health

Term used	Meaning	Definition
Kupititsa mwana kumphasa	Resumption of sexual activity	A ritual /ceremony that is done seven to eight months after a baby is born within a family
Msempho	Sickness in babies and adults	A sickness that can affect a man or a baby if a woman resumes sexual activities before the recommended time of seven to eight months.
Utumbidwa	A sickness in babies	This is a sickness in babies that occur in babies when a mother is pregnant while she breastfeeding the baby
Nsana	Reproductive capability literal meaning a 'human back''	A term used to denote whether someone is fertile
Wodwala	Literal translation a woman who is sick	An expression used to define a woman who is pregnant
Kunja Kwaopsa	Hard times	This is a term used to describe the era of HIV and its impact on the people
Kumanga mpingu	Being careful	Term used to advise women not to sleep with husbands when a baby is young
Mphavu	Strength	A term used to describe a man's libido or sperms when used in sexual context

In general, the study population has their own cultural schemas that are used to identify sexual and reproductive health issues. Schemas assist researchers in predicting individual's motivations towards behaviour (de Bruijn, 1999). The schemas in the study, describe health conditions and biological terms that exist among the study population. The findings suggest that birth control is acknowledged among the study population. This is evidenced by the existence of cultural beliefs on children and men's sicknesses like *Msempho* and *utumbidwa.* Apparently, these sicknesses befall on a baby and its father when couples resume sexual activities earlier than recommended. Sociologist have demonstrated that among societies the attribution of illness to various forms of misconduct is a form of social control that reinforces and maintains behavioral norms by linking health to goodness and conformity and associating illness with deviance (Landrine & Klonoff, 1992). In the case of the study population using the sociologists' observation, resumption of sexual activities is seen as deviance when a woman has just delivered. It could be argued that, within the study social cultural context an individual is obliged to use contraception. Failure to use contraception will put an individual at fault for violating the behavioural norm of observing periodic abstinence. Again, within the community a woman who is pregnant is seen as someone who is *sick* expressed as *wodwala* as a cultural schema. In cultural studies, the social construction of pregnancy of being unhealthy gives an indication underlying causes within the community (Landrine & Klonoff, 1992). The possible explanation for this, could the prevalence maternal morbidity and in the study area. In relation to the study, a feeling that being pregnant is unhealthy forms motivations to use contraceptives.

As explained in Section 4.1 the advent of HIV/Aids within the study population has formed cultural schemas like *Kunja Kwaopsa*, which describes the impact of HIV/Aids like prevalence of HIV related illness in the area. This cultural schemas form beliefs that subsequently affect men and women's intentions to use contraceptives.

It was frequently reported that they would rather not discuss issues to do their use of contraceptives with anyone because according to the study participants when bad people hear that you are using contraceptives they would use that against you by sending you sickness. The following quote explains the story that one of the study participants reported. *"…for example somebody went to insert loop (IuD)*

everybody know that when you put a loop you can you can only experience small problems here and there but that woman died of loop complications and people were saying that because she was telling everyone that she is using loop some bad people heard and they used her small problems with loop to kill her using witchcraft….so when you see that people can talk it is up to you in your house you agree with your husband on which method to use then you quietly go to the hospital and no one should know…''(IDI, Female, Daisy 30-35yrs). This finding is consistent with what is available in literature concerning beliefs on sickness. Literature suggests that because of emotions like feeling of envy and jealous someone could send a disease as punitive measure (Landrine & Klonoff, 1992). Similarly, this could be the possible explanation for this belief, it could be that men and women believe that because they are using contraceptive and are bragging about it, other people are not happy hence, they send sickness. In relation to their intentions to use contraceptive use, the fear to known to friends that they are using contraceptives would form perceived behaviour control over their intentions to use contraceptive.

4.11 Life style of the people in the village

Findings on the life style of the study population give an account of the social cultural and economic perspective of the study population. The following paragraphs, give a picture of the life style among study participants and how it relates to the study findings.

It was reported among focus group participants that people in the village earn lots of money when the fish catch is good. The money is distributed among the adults as well as young boys and girls. It was noted that the availability of money has led to problems in their village. The money earned by boys is used for drinking, smoking and sleeping with women. It was noted that the boys or young men who sleep with women do not use protection and they end up *impregnating women* and getting *infected with HIV*. Again, it was learnt that the money that is given to young girls and boys is spent on video shows not suitable for children *(X-rated movies)*. The general feeling was that even though the children are well brought up by parents, their habits are influenced by *money* and *video shows*. It is alleged that when children see X-rated movies, they try to copy and end up getting pregnant. A key informant who reported that the videos are instilling bad habits in children hence polluting their tradition echoed this. The following excerpts are extracted from a focus group discussion that was held with men.

R3: There is the good and the ugly In this village and we are famous for both …as you can see this village is along the lake when we are catching lots of fish even young children as young a five year olds have money, what happens is that this young boys go and pinch fish from the boats and they exchange for money the end result is that the children take the money to <u>video shows</u> and they do not go to school...

R4: In relation to the same … I think is the same problem of money being found with anyone. ..a lot of women have children with no fathers here ...because when we are in business it is easy for men to <u>sleep with women for money</u> and most of the men that these women sleep with are either not from here or are already married so you see most women have children but are not married …

R5: And there are boys or I should say young men of this village, they do not go to school… when they get the money from that days trip they go out with the money …others <u>use it for women</u>, others drinking and smoking marijuana and others who are responsible take the money to their families, a lot of boys do not go to school, what they know is they go to the lake find something to do they are paid and life goes on no ambitions whatsoever ….

R2: …and there are some men who work as lovis they get a lot money instead of doing something useful they go and <u>sleep with women</u> and get infected with HIV and later they go and pass it on to their wives ...that is our village

The claim by the study population that the presences of videos in the area , the decaying morals among the study population and increase in number of school drop outs due to pregnancy could possibly be true. According to the study conducted by Chandra et al., (2009) it was found that long exposure to high sexual content to teenagers predicts teen pregnancy.

According to the findings, (*see as underlined*) there is evidence sex *for money business*. Apparently, due to fishing, men and boys in the village have access to money and fish, which women in the community seek. This is in consistent with the studies done earlier in Malawi. The study demonstrated that transactional sex occurs when men have money and their partners seek money to support their living (Swidler & Watkins 2007). In the context of the study population, men and boys use money and fish to lure women to sleep with them or alternatively women entice men to get money or fish. In relation to contraceptive use, it could be said that *teenage sex* and *transactional sex* would have an effect on contraceptive use because unprotected sex lead to unwanted pregnancy.

4.12 Intentions to use contraceptive

Finally, the study participants were how much they were willing to use contraceptives bearing in mind their social cultural and economic context. In the following paragraphs, findings on intentions to use contraceptives are going to be reported. The intentions to use contraceptives were defined as the willingness to use contraceptive when they intend to prevent pregnancy. It was interesting to note that among all study participants that were asked this question, only a few answered definitely, while most of them said they would not manage. The one who responded definitely cited determination as the most important thing that would enable him to use contraceptives. This is what he had to say ,"*I am the kind of person who is determined to make what I want happen ….what I want I get... if I say I want this I make sure that I use all means to get it the same... " (IDI, Male, Banda, 20-25yrs).* The possible explanation for his definite answer could have been because he is a man hence considered a decision maker or he is motivated to do so. However, for the majority gave reasons ranging from side effects, wanting to children, lack of money, and lack of knowledge and unavailability of contraceptives among other things that would prevent them to use contraceptives.

4.13 Summary of Research findings

In summary, the findings suggest the following:

- Apart from the desire for material and economic well being that is common in literature, desire for physical well being for mothers and children form motivations to use contraceptives. This motivation is formed among men and women because of the prevalence of maternal morbidity, mortality and child illnesses in the study population.
- There are a couple of attitudes that form intentions to use contraceptives like prevention of unwanted pregnancy, side effects, unacceptability of contraceptive method and prevention of wanted pregnancy. Important finding among attitudes that form intentions is the attitudinal belief that contraceptives prevent wanted pregnancy.
- In relation to subjective norms, it is apparent that spouses would form intentions to use contraceptives among men and women but it is interesting to note that in this matrilineal society, family is equally important.
- Within the conceptual framework, perceived behavioural control seems to be multidimensional and hold more strength in forming intentions to use contraceptives. Because of this, it appears that men and women would supposedly be classified, as they cannot manage to use contraceptives because either one or more perceived behaviour controls are have not been satisfied.
- Contrary to the proposed conceptual model the life course of an individual does not directly form intentions to use contraceptive but rather provides a platform from where beliefs, motivations and understanding of sexual and reproductive health develop in individuals
- Understanding of sexual and reproductive health is very important in forming intentions to contraceptive use , as it turns out that men and women are not conversant with the process of contraception and contraceptive methods hence adopting contraceptives proves to be difficult because they lack confidence and skills to so.

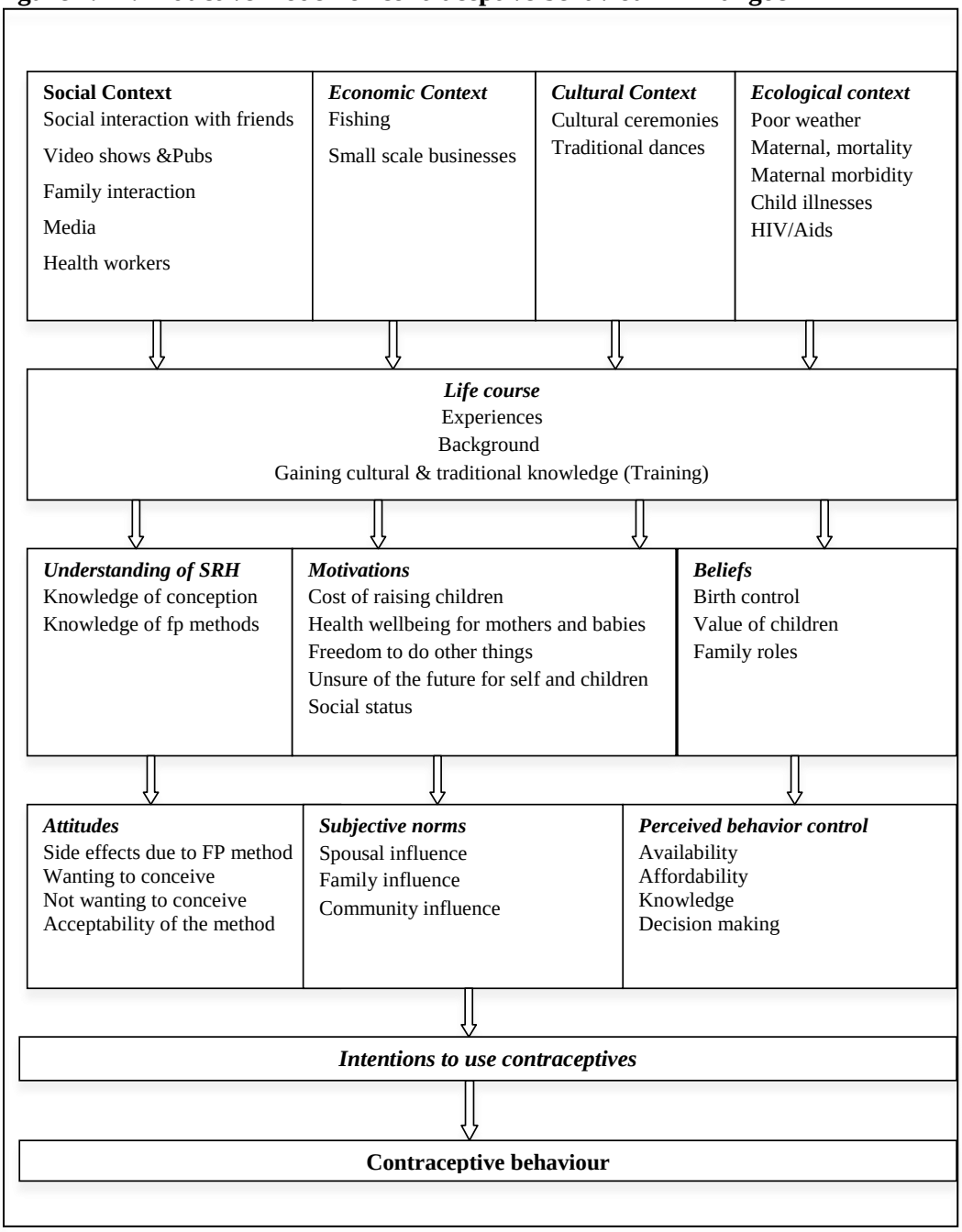
- There is limited choice of contraceptives is available for men and women in the study population, other methods are paying and can be obtained in referral hospitals.
- Children are valued among the study population; hence, they form motivations and attitudes to contraceptive use
- The social cultural and economic context shape men and women's motivations, beliefs, understanding of sexual and reproductive health and life course.

4.14 Inductive model for contraceptive behaviour

Following the findings of the study, an inductive model that has been developed (Figure 5). In brief, the inductive model explains that intentions to use contraceptives among men and women in Mangochi are formed by attitudinal beliefs like side effects, prevention of unwanted and wanted pregnancy and unacceptability of contraceptive method. Subjective norms that form intentions to use contraceptives are; spouses, family and friends (community). Perceived behavioural control that form intentions to use contraceptives are; availability, affordability, knowledge and decision making in relation to contraceptive use, knowledge and personal motivations. The beliefs on (birth control, value of children and family role) coupled by knowledge (on family planning and contraceptives) and motivations (desire to be healthy, free, reduce costs and safety) are embedded in social cultural and economic context and are formed over the individual life courses. In comparison to the deductive model, the inductive model includes findings from the in depth interviews, focus group discussion, key informant interviews and observation of the study area.

The deductive model was based on theory of planned behaviour and the process context approach. In brief the model proposed framework on which study was conducted. The concepts were derived from literature and purely theoretical. On the other hand, the inductive model provides a framework for contraceptive behaviour in Malawi, particularly in Mangochi. The inductive model is similar to the deductive model, in structure but it provides more meaning to contraceptive behaviour in Mangochi context as it gives empirical meanings to the concepts. Importantly, it redefines the concepts to fit the context. Interesting is the definition of context. In the deductive model, the context was limited in its definition. The context was categorised as social, economic and cultural context. What is found in the inductive model, the context is more diverse it also includes another category ecological context that was previously included in the deductive model. The ecological context applies to the environment that is created because of the physical interaction between people and the environment. This concept is usually used to describe the existence of various forms of diseases within the context in which people are situated (adopted from Mosley& Chen, 1984). The context is not only limited to income, friends, peers, religious leaders as highlighted in the deductive model. Within the framework of contraceptive use in Malawi, the context includes, maternal morbidity and mortality, weather patterns, fishing business, video shows, child illnesses, life style, HIV/Aids prevalence, tourism industry and contraceptive situation in addition to aspects already in included in the deductive model. In the deductive model, it was postulated that individual life course plays important role in forming motivations, understanding of sexual and reproductive health and it is embedded within the context. This postulation was found to be consistent empirically. In the inductive model within the individual life course in addition to background, life experiences background, the culturally constructed learning at different stages of individual life course are added to the inductive model. In the deductive model, motivation, understanding of sexual and reproductive health and behavioural beliefs are limited to mere definition according to literature. On the other hand, within the inductive model, motivations, understanding of sexual and health and behavioural beliefs to use contraceptive have been empirically derived. In the deductive model, the antecedents that form intentions to use contraceptives were listed as derived from literature, while in the inductive model, antecedents that form intentions to use contraceptives are explained in detail as situated Mangochi context.

Figure 4. 11: Inductive model for contraceptive behaviour in Mangochi



5. Summary and discussions

The main objective of the study was to get an insight on the role of individual's beliefs, understanding of sexual and reproductive health, life course, and personal motivations as embedded in the social cultural and economic context in forming their intentions to use contraceptives in Mangochi. This chapter discusses the findings in detail by linking the aims of the study and as embedded in the available literature. Importantly the chapter discusses the contribution of the study and the implications of the study findings. The chapter is approached by looking at how the research questions have been answered in the study.

Research question 1

What motivates men and women to use contraceptives in Mangochi?

The research question was answered through focus group discussions and interviews. Individual motivations are formed to achieve, physical, material, economic, emotional, security and safety well being (de Bruijn, 1999). The findings suggests that men and women are motivated to use contraceptives to limit the number of children due to the rising cost of raising living, the desire to be healthy especially for women and their children, the desire to space children in order to have free time to do other things other than taking care of babies. It could be argued that the basis for these motivations is the social cultural and economic context in which they are situated. The economic situation, the prevalence of child illnesses, maternal morbidity and mortality are the examples of the contextual aspects that form motivations in individuals. Malawi currently experiences, HIV/Aids, malaria, maternal mortality and malnutrition. These problems are common among children and women (NSO, 2011). The findings on motivations to use contraceptives go beyond the usual economic and child spacing to include health reasons. This is an important finding because not only does it show motivations for contraceptive use among men and women but it also gives an indication of burden of diseases in the study population. Importantly, the findings show how contraceptive behaviour is constructed in advent of HIV/Aids, maternal mortality and morbidity, child illnesses and high levels of poverty. By considering the context as the basis for individual's motivations, policy planners can use individual motivations to identify problems that exist in area for example, from the listed motivations the problems in this area, could be identified as prevalence of HIV/Aids, child morbidity and economic instability due to dependence on fishing.

Research question 2

What are the individual's attitudes, subjective norms and perceived behaviour control that form intentions to use contraceptives in Mangochi?

The findings on attitudinal beliefs that form intentions to use contraceptives suggests that individuals placed within the Mangochi social, cultural and economic context base their intentions to use contraceptives on the beliefs that have been formed through lived experiences, what they have heard from their friends or observed had happened to their friends with regards to contraceptive use. From the Malawi Demographic Health survey, women who have ever used contraceptives accounts for almost 50 Percent (half of the population) in Mangochi (NSO, 2011). This gives an indication that at some point women within the study population had used contraceptives hence are familiar with the side effects. Important to note here, is the finding that contraceptives are not good because they prevent future wanted pregnancies. This finding is rather strange, but emphasis must be put on what could be the possible reasons why men and women consider contraceptives use as such. As indicated earlier, this could be due to infertility that is wrongly attributed to contraceptives. Previous studies have found that infertility is not well covered in the Malawi. Men and women do not self-report infertility because of stigma associated with it; subsequently it was recommended that men and women should be reporting on difficulties in getting pregnant (Barden-O'Fallon, 2005). Hence, the finding could imply that women face problems of difficulty in getting pregnant within the study population. Policy implication on this finding is that there is need to investigate the underlying causes of such allegations. In general, attitudes towards contraceptive methods especially modern contraceptives method, give an indication of the quality of contraceptives

available, adverse events associated with the contraceptive method and misconceptions among the user community.

In relation to subjective norms that form intentions to use contraceptive, an important finding is the influence of family, in addition to spouse and friends in contraceptive behaviour of men and women. As indicated earlier, the equally important influence of family on intentions to use contraceptive is attributed to the matrilineal system of society. This gives an indication on how the social context exerts influence on the subjective norms of individuals in performing behaviour. Studies conducted earlier have found matrilineal system to influence fertility behaviour. Apparently, matrilineal society enables women play bigger roles in decision making in matters related their fertility (Takyi, 2005).This is consistent with the findings on subjective norms that form intentions to use contraceptives in Mangochi, bearing in mind that contraceptive behaviour is related to fertility behaviour. The implication for policy for this finding is that, when planning for behavioural interventions, the lineage system of family should be considered as this gives indication of power dynamics and decision making among the population of interest. In general, the findings on subjective norms give an indication of which groups of people should be targeted in coming up with interventions.

Finally, perceived behavioural controls that form intentions to use contraceptives have been found to be multidimensional. The dimensions are motivational, cognitive, experiential, and self-efficacy. Men and women are motivated to use contraceptives when they have money, the contraceptives are available and when their spouses agree and support them. In relation cognitive dimension, it has been noted that when men and women understand the concept of contraception and family planning they acquire skills and are confident to use contraceptives. The experiential dimension is linked to what men and women experience over their life course with regards to contraceptive use. For example, through experimenting with contraceptive methods some methods are classified as unacceptable. Within the self-efficacy dimension men and women, rightly judged how well they could manage to use contraceptives taking into consideration their social, economic and cultural context. From the findings, men and women would supposedly be classified, as they cannot manage to use contraceptives when either one or more perceived behaviour controls have not been satisfied. This gives an indication that even though perceived behavioural controls are multidimensional their contribution in forming intentions to use contraceptives is equally important. This is consistent with what is postulated about the strength of perceived behavioural control in the theory of planned behaviour (Azjen, 1991). Apparently, perceived behavioural control coupled with intentions to perform specified behaviour successfully predicts performance of the behaviour. Like the subjective norms and attitudes that form intentions to use contraceptives, their formation has a genesis from the context in which the population of interest is positioned. Implications for policy on the findings on perceived behavioural control is that in implementing behavioural interventions perceived behavioural controls need to be identified well in advance among the population of interest in order for the interventions to be successful.

Research question 3

How are the intentions to use contraceptives embedded in the socio-cultural and economic context in which men and women live in Mangochi?

Findings on intentions to use contraceptives, suggest that intentions are formed based on the social cultural and economic context indirectly through motivations, beliefs and understanding of sexual and reproductive health. Hence, the intentions are equally formed by the same social cultural and economic context that forms motivations, beliefs, understanding of sexual and reproductive health. As earlier expressed in earlier chapters, the social cultural and economic context is made up the social interaction through friends, family, video shows, traditional and cultural beliefs coupled by sources of income among other others. This concept was used as a proxy to predict the actual contraceptive behaviour. The policy implication for this finding is that if policies are to be successful and relevant assessment of the context before designing behavioural interventions is necessary.

Research question 4

What is the role of life course in forming men and women's intentions to use contraceptives in Mangochi?

The findings suggest that stages in the life course of men and women present opportunities for the family and other people to instil cultural values and knowledge on sexuality and reproduction in individuals. In the context of Mangochi, at different stages within the individual's life course specific knowledge is imparted which changes the course of any behaviour. This is in consistent with explanation about the effect life course in individuals. Apparently, during the life course is when cognitive processes that signifies turning point for behaviours take place in individuals (de Bruijn, 1999). According to the findings, at the beginning of the married life individuals are looking forward to start a family so is the social expectation. Hence, contraceptive use is not relevant at that stage in life. In a nutshell, contraceptive use is not consistent in individual's life. In general, when considering the life course of individual in relation to contraceptive use, it is important to look at motivations and knowledge levels at different stages of their life. Importantly for policy purposes , understanding of what goes on in individuals lives at different stages of their lives gives indication of which stages could be targeted when planning for contraceptive use or any other behaviour interventions which are relevant. For example, elaborate information on contraception could be imparted to young men and women during the initiation rites but this could only be possible if the counsellors are well informed on sexual and reproductive health.

Research question 5

What is the social cultural and economic context in which contraceptive use take place in Mangochi?

The findings suggest that contraceptive use in Mangochi takes place in a complex and dynamic context. Socially, contraceptive use is situated in the context where family is considered very important and it follows matrilineal system, children are valued, socialisation is with friends, family and colleagues. Economically, contraceptive use takes place in a context where fishing is the main source of income. All income-generating activities are related to fishing, any set back in fishing for example bad weather or drought economy of the village is affected. Culturally contraceptive use takes place in context that is very rich in culture so much so that most of the beliefs, knowledge base and motivations are culturally constructed. There is also the prevalence of HIV/Aids, malnutrition, malaria and other communicable diseases and drought that occur within the ecological context. As noted by de Bruijn (1999), the context is more diverse and it forms the framework for formation of individual behaviour. Awareness of the context in which contraceptive behaviour takes place, would enable policy planners to come up with interventions that are context specific.

Research Question 6

What role does the understanding of sexual and reproductive health matters among men and women in Mangochi play in forming their intentions to use contraceptive?

The findings suggest that understanding of sexual and reproductive health in Mangochi plays an important role in forming intentions to use contraceptives. In a way, understanding of sexual and reproductive health forms perceived behavioural control in forming intentions to use contraceptives. Importantly, understanding translates to knowledge and skills required perform behaviour of interest (Ajzen, 1991). As noted earlier, knowledge gives confidence in men and women to use contraceptives successfully. Studies done earlier on contraceptive behaviour, found that adoption of contraceptives depend on the awareness of existing alternatives, contraceptive knowledge and the concept of contraception; this brings familiarity with contraceptive use and brings about confidence in individuals that they are able to control births. (Bruijn, 1999, Jeejbhouy, 1992).

This implies that because men and women have limited knowledge on biological processes of contraception and how each contraceptive method works, they are unable to use the contraceptive method effectively. A policy implication for this finding is that assessing knowledge base on the area of interest

before implementation of behavioural interventions is important among study participants. This gives a picture of conceptual tools are to be used in the design the interventions.

5.1 Conclusion and recommendations

The following paragraphs outline conclusions for this study and the recommendations where further investigations need to be conducted. The study was commissioned to gain a detailed understanding on the social, cultural and economic context in which contraceptive behaviour for men and women of the reproductive age groups in Mangochi takes place. And to describe how men and women's motivations, beliefs, understanding of sexual and reproductive health and life course form their intentions to use contraceptives in Mangochi.

Following the first objective, gaining detailed understanding on the social, cultural and economic context in which contraceptive behaviour for men and women of the reproductive age groups in Mangochi takes place, an effort was made to exhaust all dimensions within the social, cultural and economic context was made. In the course of the study, it was learnt that the context in which contraceptive use goes beyond social, cultural and economic context. From the findings, it was learnt that another dimension of the context, ecological context was missed in framework that was missed for the conduct of the study. The concept emerged in the course the study hence was added later inductively. The ecological context applies to the environment that is created because of the physical interaction between people and the environment. This concept is usually used to describe the existence of various forms of diseases within the context in which people are situated. Apparently, the ecological context forms the one of the most important findings in this study on the context in which contraceptive use takes place. Apart from the economic situation that defines the economic context , the matrilineal system of family within the social context, prevalence of maternal mortality and morbidity and child illness within the ecological context forms important aspects in the study population that are worth to note.

On the second objective, to describe how men and women's motivations, beliefs, understanding of sexual, reproductive health, and life course form their intentions to use contraceptives in Mangochi, different aspects have been explained in Sections 4.1 to 4.7. In general, economical (rising cost of living), health (the prevalence of diseases), emotional (the desire for free time), Social (the desire for status) are the main motivations for intentions to use contraceptives. However, important findings that men and women are motivated to use contraceptives because they want to limit the number of children with an aim of achieving health well being of mother and child. Additionally, there is a notion among the study population that if limit the number of in future when they die the burden of raising their children would not much (*safety for future of the children*). In relation to beliefs that form intentions to use contraceptive, side effects, prevention of wanted and unwanted pregnancies and unacceptability form attitudinal beliefs, while spouses, family and friends form normative beliefs. Lastly, control beliefs that form intentions to use contraceptives are lack knowledge and skills, availability, affordability and decision making with regards to contraceptives. Importantly, prevention of wanted pregnancies marks an important finding that need to be explored further. Interestingly, religious leaders did not come out during the interviews as being influential in contraceptive behaviour. Of significance is the understanding of sexual and reproductive health operationalised by explanation of contraception and family planning among men and women .The understanding of sexual and reproductive health was culturally constructed derived from the social context coupled by biological explanations. In general, explanations given for contraception and family planning seem limited consequently; decisions to use contraceptives are based on limited information. Apparently, during the life course of individuals in Mangochi is when men and women observe what goes around them like the value of children, the burden of children so forth, they also acquire knowledge through social interaction and culturally constructed stages of development (initiation and other rituals). Hence, choices to adopt contraceptive use are made according to the individual priorities at different stages of their lives.

Other findings in the study worth noting are the importance of children of children among the study population and the desired number of children. The desired number of children from the interviews was four comparing the number with the current estimated average number of children per woman in of seven children per woman in the district. Again the life style of men and women is worth mentioning as it gives a good picture of the context in which use of contraceptive happen, where fish, money and video shows are the order of the day. Traditional beliefs also form part of the context for contraceptive use. Interestingly, contraceptive use among men and women is concealed and considered more personal for fear of being targeted by evil people.

On overall conduct of the study was interesting, it started with development of the proposal, literature review then defining the research methodology. Being qualitative research, operationalisation of the concepts was challenging. It was exciting to conduct the interviews because of the welcoming atmosphere of the interviewees hence many interviews were done. It was nice to conduct many interviews but when it came to translation, this might have an effect on the timing of submitting the write up for the findings since all the interviews transcribing required more time.

5.2 Recommendations for action

The findings from the study indicate that men and women have different motivations for contraceptive use. Apparently, the DHS collects information on the contraceptive use but it never collects information on why men and women would want to use contraceptives? Collecting this information would give an indication of emerging issues in the population that need attention for policy.

The findings on motivations to use contraceptive, uncertainty on the future was most frequently mentioned in as a reason why one would want to limit the number of children, need to further investigate on the *impact of maternal morbidity and mortality on contraceptive use* in the study population.

The attitudinal belief that contraceptive use prevents wanted future pregnancies need to be further investigated. This could be addressed by looking at the *prevalence of sexual and reproductive health problems in the* study population.

It would also be interesting know the what would happen if men are more involved in sexual and reproductive health interventions, would women's perceived behavioural control be different *?*

References

Ajzen, I. & Fishbein, M. (2010). Predicting and Changing Behaviour: *The Reasoned Action Approach.* Psychology Press, Taylor and Francis Group, LLC: New York

Ajzen I., Albarracín, D. & Hornik, R. 2007). Prediction and change of health behaviour: *Applying the reasoned action approach*. Mahwah, NJ: Lawrence Erlbaum Associates.

Ajzen, I. (1991). The theory of planned behaviour. *Organizational Behavior and Human Decision Processes,* Vol. 50, pp. 179-211.

Babbie, E. (2010). *The practice of social research*. Belmont: Wadsworth Publishing Company

Barden-O'Fallon, J. (2005). Associates of self-reported fertility status and infertility treatment-seeking in a rural district of Malawi. *Human Reproduction,* 20, 8, 2229–36.

De Bruijn B.J. (1999). Foundations of demographic theory: choice, process, and context. PhD dissertation, Groningen University, The Netherlands

Bulatao, R.A. & Fawcett J.T. (1981). Dynamic perspectives in the study of fertility decision making; successive decisions within a fertility career in: *IUSSP International population Conference, Manila, 1981,* Vol.1.IUSSP, Liege, Belgium pp 433-449.

Caldwell, J.C & Caldwell P. (1987). The Cultural Context of High Fertility in sub-Saharan Africa. *Population and Development Review,* Vol. 13, No. 3 (Sep., 1987), pp. 409-437 Published by: Population Council

Caldwell, J.C. and Caldwell, P. (1990b). High fertility in Sub-Saharan Africa. *Scientific American,* 62(5): 118-25.

Cates, W. Jr. (2010). Family planning: the essential link to achieving all eight Millennium Development Goals,' *Contraception* vol. 81, no. 6, pp. 460–461,

Centre for Reproductive Health (CRH) (2004). *Lungwena Demographic and Health Survey Mangochi.* Department of Community Health, Centre for Reproductive Health

Cleland, J. Bernstein, S. Ezeh, A. Faundes, A. Glasier, A. Innis, J. (2006). Family planning: the unfinished agenda. *The Lancet*, Volume 368, Issue 9549, Pages 1810-1827

Francisco A., Mueller R., d'Arcangues, C. (2007). Sexual and reproductive health for low and middle-income countries. Global Forum for Health Research and World Health Organization Geneva, Switzerland

Gama J.B. (2009). An assessment of the capacity of faculty-based youth friendly reproductive health services to promote sexual and reproductive health among un married adolescents: evidence from rural Malawi' PhD Thesis Queen Margret University

Giele, J. Z. & Elder, G. H., Jr. (1998). Methods of Life Course Research*: Qualitative and Quantitative Approaches.* Thousand Oaks, CA: Sage.

Glasier, A., Gülmezoglu A.M., Schmid G.P., Moreno C. & Van Look, P.F.A. (2006). Sexual reproductive health: A matter of life and death. *Lancet*; 368(9547):1595–607

Gwengwe, J. (1965). Kukula ndi Mwambo, Malawi Publications and Literature Bureau, 1965

Hennink, M., Hutter, I. Bailey A. (2010). Qualitative Research Methods. 1st Edn. SAGE Publications

Hutchison, E. D. (2010). Dimensions of human behaviour: Person and environment. SAGE Publications Inc.

Hutter I. et al., (1998). *Child Spacing and Reproductive Health in Rural Karnataka, India*. Demographic Reports, Faculty of Spatial Sciences

Hutter I. (1998). *Research programme on reproductive health. CDS Research Strategy paper* no.3, PRC-NIDI report, 1998.

Jejeebhoy S, (1995). Women's Education, autonomy and Reproductive Behaviour Experience from Developing Countries' Oxford Clarendon Press

Kitzinger, J. (1995). *Introducing focus groups.BMJ; 311:299–302.*

Kulkarni, M. (2007). Predicting Contraceptive Behaviour in India Using Attitude Theories. *Journal of Applied Social Psychology*, 37: 2475–2495.

Landrine, H. & Klonoff E. (1992). Culture and health-related schemas: A review and proposal for interdisciplinary integration. *Health psychology*, 1992, *11(4),* 267-276 Lawrence Erlbaum Associates, Inc.

Maslow, A. H. (1970). Motivation and personality (Rev. ed.). New York: Harper

Merkh, R. D., P. G. Whittaker, Baker, K. Hock-Long, L. and Armstrong, K. (2009). Young unmarried men's understanding of female hormonal contraception. *Contraception* 79:228-35.

Munthali, A.C., Chimbiri, A & Zulu E. (2004). Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence' Occasional Paper No. 15 New York Washington The Alan Guttmacher Institute.

Munthali, A.C. & Zulu, E. (2007). The timing and role of initiation rites in preparing young people for adolescence and responsible sexual and reproductive behaviour in Malawi'. Africa Journal of Reproductive Health; 11:150–167.

Mosley H. & Chen L. (1984). Child Survival: Strategiesfor Research, *Population and Development Review*, Vol. 10, pp. 25- 45

Mtika, M.M & Doctor, H. V. (2002). Matriliny, patriliny and worth flows variations in Malawi. *African Sociological Review* 6**:**71-97.

National Statistical Office (NSO) [Malawi], and ORC Macro. (2011). Malawi Demographic Health Survey Preliminary Report, Calverton, Maryland: NSO and Macro.

National Statistics Office Malawi (NSO). (2008). Population and Housing Census. National Statistics Office Malawi.

Peoples, J. & Bailey, G. (2011). Humanity: An Introduction to Cultural Anthropology. Wadsworth Publishing; 9th edition,

Solo, J. Jacobstein, R. and Malema, D. (2005). Repositioning family planning—Malawi case study: Choice, not chance. New York: The ACQUIRE Project/Engender Health.

Stephenson, R., Beke, A. & Tshibangu, D. (2008) Community and health facility influences on contraceptive method choice in the Eastern Cape, South Africa. *International Family Planning Perspective 2008*;

Tillman, K.H. & Nam, C.B. (2008). Family Structure Outcomes of Alternative Family Definitions. *Population Research and Policy Review*. Volume 27, Number 3, 367-384

UN, (2011). The millennium development goals report 2011. Geneva.

UNDP, (2011). International Human Development Indicators. Available from **http://hdrstats.undp.org/en/countries/profiles/MWI.html** [Accessed 05 May 2011].

UNICEF, (2011). Malawi Statistics available from http://www.unicef.org/infobycountry/malawi_statistics.html [Accessed 05 May 2011].

Weyl, O., Ribbink, A. & Tweddle, D. (2010). Lake Malawi: fishes, fisheries, biodiversity, health and habitat. Aquatic *Ecosystem Health & Management*, 13, 241-254.

WHO, (2008). Integrating poverty and gender into health programmes: *a sourcebook for health professionals:* module on sexual and reproductive health. World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland

WHO, (2011) Sexual and Reproductive Health: Promoting family planning available from http://www.who.int/mediacentre/factsheets/fs351/en/index.html [Accessed 05 May 2011)

Severy, L. J. & Spieler, J. (2000). New Methods of Family Planning**:** Implications for Intimate behaviour. *Journal of Sex Research*; Aug 2000, Vol. 37 Issue 3, p258-265

Takyi, F. K., & Dodoo F. N. (2005). Gender, lineage, and fertility-related outcomes in Ghana. *Journal of Marriage and Family* 67:251–57

Tremayne, S. (2001). Managing reproductive life: cross-cultural themes in sexuality and Fertility, Berghahn Books.

Yeatman, S. and Trinitapoli.J. (2008). Beyond denomination: The relationship between religion and family planning in rural Malawi. *Demographic Research* 19*(Article 55):* 1,851–1,882.

Appendix: 1

Informed Consent

My name is Olivia Jelenje. I am a student at University of Groningen and I am conducting this interview for my master's course. I am conducting this interview to have an in-depth understanding of how is individual understanding of sexual and reproductive health matters related to contraceptive adoption in Mangochi. I would like to ask you questions pertaining to your knowledge of reproductive health matters and contraceptive use. Nothing that you are going tell me will be shared with anyone and your name will be kept anonymous to ensure that the information given is not linked with you. I am going to record our conversation for my own reference. The interview will take about 60 to 90 minutes. The consent confirms your voluntary participation. Do you have any questions for me before I proceed?

Dzina langa ndine ……ndipo ndikupanga kafukufuku wa m'mene anthu amamvera nkhani umoyo wobereka pakukukambirana zakulera. Kafukufukuyu ndi mbali yamaphunziro a zachiwerengero cha anthu . Ndidzakufunsani kuti tikambirane za momwe mumamvera nkhani za kulera.Khalani omasuka kufunsa mafunso pamene simukumvetsa. Kukambilana kwathu kudzatenga nthawi yosapitilira ola limodzi. Dziwani kuti simuli okakamizidwa kutenga nawo mbali pazokambirana zimenezi. Zokambiranazi ndi zachinsinsi kuthandauza kuti zokambirana zathu sizidzadziwika kuti munanena ndi inu dzina lanu silidza tchulidwa penapaliponse komanso ngakhale titadziwa kuti mwakamba nkhani ndi inu sitidzakambilana ndi wina aliyense zimene takambilana pano. Mukambilana kwathu tidzagwiritsa ntchito cho tepela mau, kuti tikathe bwino kukumbukila zomwe takambilana komanso pena ndi pena tidzilemba. Mudzatisayinira pepala lina kusonyeza kuti mwavomeleza kutenga nawo mbali pa zokambilana zimenezi. Khalani omasuka kufunsa mafunso. Zikomo

Background Information

Interview No:
Age:
Number of Children:
Education of the spouse:
Occupation of a spouse:
Opening Questions

1. Can you tell me about the people you live with?
   Probes: Any parents, in-laws, children, friends, workers
   Mungandiuzeko anthu omwe mumakhala nawo?
   Makolo, azilamu, ana , abale , antchito

2. How do you spend your days?
   Probes: day to day activities, how often do you leave the house? The people you meet**?**
   Mumapanga chani pa umoyo wanu watsikunditsiku
   Ntchito yanu ya tsiku ndi tsiku?mongoyelekeza mumakhala pakhomo nthawi yayitali bwanji?

3. Who are the people you interact with mostly?
   Probes: colleagues, family, neighbors, how often
   Mumacheza ndi ndani nthawi zambiri
   Akuntchito, kubizinezi , abale, a neba ,

Questions about Life course

I find that the best way to learn about your life is to start from the beginning of your life. I want to focus on events in your life but also the things that have influenced life.

Ndimaona kuti munthu udziwe zambiri yamunthu ndibwino kuyambira komwe munthu wakulira ndi zomwe zachitika pamoyo wake panthawi imene akukula komanso zinthu zimene zachitika kupangitsa munthu kuti akhale m'mene alili panopa.

4. Can you tell me about the environment where you grew up?
   Probe: Family, Location, stages of development

   Mungandiuzeko za kumene mwakululira
   Kubanja kwanu, komwe mwakulira, zomwe zinchitika mutatha msinkhu

5. Can you remember the time you become an adult , would you tell me what happened (for women started menstruating)
   Probe: special ceremony, changes in habits, people involved

   Mungakumbukile nthawi imene munatha msikhu, chinachitika ndi chani
   Probe: Liti , Mwambo; kakhalidwe , anthu omwe anabwera, anthu omwe anakuthandizani

6. Can you remember the time you became married, would you tell me what happened?
   Probe: when, special ceremony, who came, people involved

   Mungakumbukire nthawi imene munakwatira kapena kukwatiwa ?
   ndiliti , mwambo wanji , anabwera ndani , anthu amene zinawakhudza?

Questions about understanding of sexual and reproductive health maters

7. Would you tell me what actually happens for women to conceive?
   Probe: Biological processes.

   Mungandiuzeko kuti chenicheni chimachitika ndi chani kuti munthu wa mkazi akhale ndi pakati
   Probe:Fotokozani zimene zimachitika mkati mwa thupi

8. What do you think about having children?
   Probes: desire for children, how many, when, why

   Kodi mumganiza bwanji pa nkhani yokhala ndiana
   Ana angati, liti , chifukwa chani

9. Can women control when they get pregnant?
   Probes: Traditional, modern methods

   Kodi amayi angathe kusankha kuti kutenga pakati ?

Pogwiritsa ntchito njira zolera za makolo, njira za makono

10. Can you tell me what do you understand by family planning?
    Probe: Modern, traditional, side effects, advantage, disadvantages? Information source

    Mungandifotokozeleko kuti akati maleleredwe ndi chani
    Njira zamakolo, makono, ubwino, kuyipakwake, mavuto amene amadza chifukwa cha malaeredwe

Questions about Motivations for contraceptive use

11. If you would make a choice to use contraceptives what would be the reason?
    Probe: Motivation, goals

    Nchfukwa chani mungasankhe kugwiritsa ntchito njira za kulera ,
    Masomphenya,

Questions about Attitudes towards contraceptive use

12. Can you tell me what happens to individuals when they use contraceptives?
    Probe: side effects, yourself, other people

    Mungandiuzeko zimene munamva kapena kuona zimene zimachitikira anthu akamagwiritsa ntchito njira zolera

13. Would you tell me why some individuals do not want to use contraceptives?
    Probe: yourself, friends, spouse

    Kodi nchifukwa chani anthu ena safuna kugwiritsa ntchito njira za kulera
    Amuna anu , anzanu, inuyo

14. What do you think of people using contraceptives?
    Probe: Morally, culturally, economically
    Kodi anthu amene amagwiritsa ntchito njira zolera mumawaganizira

Questions about Subjective norms towards contraceptive use

15. Can you tell me the people that you would discuss family planning issues with
    Probes: Partner, Family, Friends

    Mungandiuzeko anthu amene mumasuka nawo ndikukambirana nkhani za kulera

16. Would you tell me if you were to use contraceptives, what would be the reaction of the people around you?
    Probes: Friends, family

    Tandiuzani, anthu omwe mumakhala nawo pafupi atadziwa kuti mukugwiritsa ntchito njira zolela angapange chani

Questions about Perceived behavioral control on contraceptive use

14 Would you tell me how easy it is for you to use contraceptives?
Probe: decision making, knowledge, availability, accessibility, culture, religious affiliation

Tandiuzeni kodi nchapafupi kwainu bwanji kuti muthe kugwiritsa ntchito njira zolera ?
Amaganiza ndani , kudziwa za maleleredwe, kupezeka kwanjira zolera, mwambo, komwe mumapembedza.

Questions about intentions to use contraceptives

15 If you intend to use contraceptives to prevent pregnancy given the social, cultural and economic context, how confident are you that you would succeed

Mutati mukufuna kugwiritsa ntchito njira zakulera ndi mene zinthu ziliri mudzimuno mulindichikhulupilirao chotani kuti mutha kukwanitsa , tafotokozani

Closing questions

17. What do you think is the role of individuals in keeping the family
Probes: men, women, father, mother, friends

Kodi inuyo mumaona kuti udindo wa aliyense m'banja ndi otani ?
Abambo anu, amayi anu, Amuna anu, Akazi anu, anzanu

18. What are your hopes for your children in the future
Education, career

Kodi muli ndi maganizo otani kumbali la tsogolo la ana anu
Mumafuna adzaphunzire motani, kapena mumafuna adzagwire ntchito yotani mtsogolo

19. Is there anything you would like to talk about from what we have discussed?

Pali china chilichonse mungafune kuti tikambirane kupatula pa zomwe takambirana kale

Interview No:

Introduction Questions

1. As introduction would we go round and introduce ourselves by stating what we do for a living.
   Choyamba tidziwane , pakufotokoza ntchito yomwe timagwira

2. Can you describe the main sources of income for men and women in this village?
   Kodi anthu a mmudzi muno amapeza ndalama potani

3. Would you tell me what makes this village different from other villages?
   Mungandiuuzeko zinthu zimene zimachititsa mudzi uno kuti ukhale opambana kuposa midzi ina yozungulira

Topic 1: **Family planning Practice**

- What measures are taken in this community prevent pregnancies
  Ndi njira ziti zimene anthu amudzi muno amatsata kuopa kukhal ndi pakati posakonzekela

- What are the sources of information on family planning in this community?
  Kodi anthu amudzi muno amamvera kuti nkhani za maleleredwe mudzi muno

- What are the sources of contraceptive methods in this community
  Kodi anthu amudzi muno ampeza kuti njira za maleleredwe

- What do people think about contraceptive in this community?
  Kodi anthu amati chani za njira zakulera ?

    - Ndi chifukwa chani anthu amudzi muno amalera

Topic 2: Family Planning and Cultural Context

- What traditional practices are common in this community?
  Ndi miyambo iti imene imatsatidwa mudzi muno?
  Probe: banja,chikhalidwe,

- Prevailing traditions and family Planning?
- Sub topics gender, stigma, norms and traditions?
  Kodi ndi miyambo iti imene imakhudazana ndi nkhani zakulera

- What is the role of religion in family planning in this community
  Palikugwirizana bwanji pakati pa zipembedzo ndi maleledwe m'mudzi muno

Topic 3: Family Planning and Economic Context

- How would you describe the cost of contraceptives in this community

Mungatiuzepo chani za mtengo wa maleredwa mudzi muno

- How would you describe the Quality of family planning services that are offered I this community?
  Mungakambeko chani za quality/mtundu wa chithandizo colera chomwe anthu amudzi muno amatenga

- What Economic resources are present in this community
  Kodi anthu mudzi muo amepeza kuti ndalama

Closing Questions

- What recommendations would you make towards making family planning programs?
  Kodi munga walangize zotani anthu amene amabweretsa nkhani zolera mudzi muno

Background Information
Interview No:
Age:
Number of Children:
Education of the spouse:
Occupation of a spouse:

Opening Questions

1. Can you tell me about ethnicity of the people in this community
   Munganduzeko mitundu ya anthu omwe amakhala muno mwa kera

2. Can you tell me, what is your role in this community?
   Mungandiuzeko mbali imene mumathandizira munoo mwa kera

3. Can you tell me what do you do in your normal day?
   Probes: day to day activities, how often do you leave the house? The people you meet?
   Mumapanga chani pa umoyo wanu watsikunditsiku
4. Can you tell me the people you mostly interact with**?**
   Probes: colleagues, family, neighbors, how often
   Mumacheza ndi ndani nthawi zambiri

Questions about Life course

5. Would you tell me what happens to girls and boys when they reach puberty**?**
   Probe: special ceremony, changes in habits, people involved
   Kodi zimatani kumudzi kuno mwana akakula

6. Would you tell me what advice is given to boys or girls when they grow into adulthood that you think might shape the way people see family planning?
   Kodi ana akakula amalangizidwa chiyani pa nkhani zolera ana mnyumba
7. Would you tell me what happens when men or women get married, what happened?
   Probe: when, special ceremony, people involved?

Nanga akawatira kapena kukwatiwa amalangizidwa chani anyamata ndi atsikana

8. Would you tell me what advice is given to married couples when they get married that you think might shape the way people see family planning
   Kodi malangizo amene amakhudzana ndi zakulera ndi ati

Questions about understanding of sexual and reproductive health maters

9. Would you tell me what actually happens for women to conceive?
   Probe: Biological processes,
   Mungandiuzeko kuti chenicheni chimachitika ndi chani kuti munthu wa mkazi akhale ndi pakati
   Probe:Fotokozani zimene zimachitika mkati mwa thupi

10. Can you tell me what do you understand by family planning?
    Probe: Modern, traditional, side effects m, advantage, disadvantages? Information source
    Mungandifotokozeleko kuti akati maleleredwe ndi chani
    Njira zamakolo, makono, ubwino, kuyipakwake, mavuto amene amadza chifukwa cha malaeredwe

20. Can you tell me in your opinion can women control when they get pregnant?
    Probes: Traditional, modern methods
    Mungandiuzeko ,ndizotheka amayo kusankha nthawi yoti atenge pakati? tafotokozerani

21. Can you tell me how do people value children in this community
    Probes: desire for children, how many, when, preferences
    Mungandiuzeko kufunika kwa ana mudzi muno

Questions about Motivations for contraceptive use

11. Would you tell me why do you think people use contraceptives?
Probe: Motivation, goals
Mungandiuuzeko chifukwa chani anthu amalera

Questions about Attitudes towards contraceptive use

12. Would you tell me what happens to individuals who use contraceptives?
    Probe: people you interact with, perceptions on contraception
    Kodi nchifukwa chani anthu ena safuna kugwiritsa ntchito njira za kulera
    Amuna anu , anzanu, inuyo

13. Would you tell me why some individuals do not want to use contraceptives?
    Probe: people you interact with
    Mungandiuzeko nchifukwa chani anthu salera ?

14. Can you tell me what do you think about individuals using contraceptives?
    Probe: Morally, culturally, economically
    Kodi anthu amene amalera mumawaganizira zotani?

Questions about Subjective norms towards contraceptive use

15. Can you tell me the people that you would discuss family planning issues with
    Probes:, Family, Friends, community

Questions about Perceived behavioral control on contraceptive use

16. How easy is it for people to use contraceptives?
    Probe: decision making, knowledge, availability, accessibility, culture, religious affiliation

Nkosavuta bwanji kugwiritsa njira zolera mudzi muno?
Questions about intentions to use contraceptives

17. Can you tell me in your opinion If individuals would intend to use contraceptives to prevent pregnancy in this community , how confident are you that they may succeed
    Kodi anyamata ndi atsikana mudzi muno mene mumawaonera akhoza kukwanitsa kulera popanda vuto ?

Closing question

18. How do you see this community in five years to come
    Kodi mudziwu mukuona bwanji kutsogoloko

19. From what we have discussed is there anything that you would like to add
    Ngati pali zina zoti tithe kukambirana khalani omasulka

Appendix 2: Codebook

Code System	Main Code	Subcode1	Subcode2	535
	Acceptability			6
	Way of living/life style			14
	Motivation			15
		look healthy		5
		Fear of losing children		3
		Percieved Financial Benefit		9
	Life style			1
		and also our girls you have seen		1
		money talks in this village		5
		witchcraft		4
	Intention to use contraceptives			
		you cannot sleep hungry when		1
	when you sleep with a man			5
	influence of peers			2
	male involvement			4
	HIV			3
		Kunja kwaopsa		3
	video shows			5
	Obwera (Immigrants)			1
	mphavu			1
	religious influence			3
	kumanga mpingu			1
	lovi			3
	nsana			3
	Norms			9
	Source of information on fp			8
	Percieved behaviour control			25
	msempho			4
	economic activities/context			9
		gain		4
		Source of Income		3
	Attitudes towards family planning			1
		Reasons foro using fp		12
		Acceptability of fp methods		1
		Stories on fp		3
		Reasons for not using fp		2
		disadvatages of traditional methods		1
		why men do not want to use fp		18
		disadvatages of family planning		14
		why women do not want to use fp		3
		Advantages of family planning methods		10
		Side effect		7
	how easy is for a person to use fp method			7
	Knowledge on reproductive issues			3
		Source of fp		3
		conception		21
		family planning		22
		Types of contarceptive		5
	Curtural beliefs			17
		kupitsa mwana kumphasa		2
		people who give advise		11
		Traditional ceremonies		20
	Life course			10
		messages on marriage		11
		messages on pregnancy		17
		messages on growing up	sleeping with boys/man	11
		stages of development	sleep with any woman	1
		traditional ceremonies		5
		Childhood residence		14
	Social Interaction			14
		Family		14
			Family's role in a marriage	2
			Husbands role	7
			Wifes role	7
			Decision making in a family	1
			living arrangement	19
			influence of family	11
	Children			2
		Future Plans for the children		12
		desired number of children		8
		value of children		17
		number of children		6
	Age			3