Factors Affecting Demand for Family Planning

ABOUT THIS BRIEF

In 2016–2017 FANTA conducted qualitative formative research with the USAID Office of Food for Peace (FFP)-funded Njira development food security activity implemented by Project Concern International and Emmanuel International in Balaka and Machinga districts in Malawi.

The study was conducted to inform the strategic design of the family planning activities within Njira. It was also intended to serve as a proof of concept to generate learning more broadly on a process to help understand how to best integrate FP into multisectoral development food security activities.

This brief is one in a series of four and presents findings from one of three research objectives. Additional findings and an overview of the study and methods used are available at www.fantaproject.org/FPintegration.

Introduction

Voluntary use of family planning (FP) is influenced by a myriad of factors at the individual, family, community, and health systems levels. Considered a late adopter of FP programs, Malawi has made great strides with declining fertility rates—from six children per woman in 2004 to 4.4 in 2015–16 (NSO and ICF 2017). Yet, the unmet need for FP among married women is 18.7 percent and among sexually active unmarried women it is 39.8 percent (NSO & ICF 2017). Close to a third of girls 15–19 years of age (29 percent) have already started childbearing (NSO & ICF 2017). This brief presents qualitative formative research findings on demand-side factors affecting FP use among adult women and adolescent girls and young women (AGYW) in Balaka and Machinga districts in Malawi (see box). Supply-side factors affecting FP access in these communities are described in Brief 3 of this series.

The data sources for the findings discussed are 16 focus group discussions (FGDs) and 46 semi-structured interviews (SSIs) conducted with a range of respondents: community members, including adult women with young children who are members of Njira Care Groups; AGYW and adolescent boys and young men (ABYM) 18–24 years of age who belong to youth groups; adult men who are husbands/partners of Care Group members and/or members of Father Groups; community leaders who are members of village civil protection committees (VCPCs); facility- and community-based government health providers; and activity informants. Additional information on methods is available in Brief 1.

Key Findings

FP knowledge. Across all informant types, FP knowledge was high. When asked what they knew of or had heard about FP, community members responded in one or more of the following ways: describing FP as a way to space children, limit family size, or prevent unwanted pregnancies; listing a few contraceptive methods they were aware of; or discussing the benefits of FP, spacing children, or having a smaller family. Across all informant types, child spacing was viewed as the primary or most acceptable reason for using FP.

Health providers at hospitals emerged as not only the most commonly mentioned source of information about FP, but also as the most trusted or important source. Two other sources of information mentioned were providers at antenatal care and under-5 clinics held in the community and peers within the community. Care Groups, mobile clinics, radio, school, youth groups, and church were less frequently mentioned as information sources.

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Community members were familiar with short-acting (hormonal and non-hormonal) and long-acting contraceptive methods. When asked which methods they knew about, the most commonly mentioned methods across informant types, in order, were injectables, implants, condoms, pills, intrauterine devices (IUDs), and sterilization methods (vasectomy and tubal ligation). Abstinence, cycle beads/standard days, and traditional method were mentioned by one person respectively; the lactation amenorrhea method (LAM) was not mentioned.

Community members were also aware of places to access FP services, including health facilities (hospital and health center) and services within their community delivered by health surveillance assistants (HSAs), community-based distribution agents (CBDAs), and private providers from non-governmental organizations such as Marie Stopes International—called Banja La Mtsogolo (BLM) in Malawi. Community-based services mentioned included: under-5 or antenatal clinics, door-to-door services, HSA or CBDA in homes, BLM mobile clinics, and youth club meetings. However, as discussed further in Brief 3, community member perspectives of availability and quality of community-based FP services varied.

Despite high levels of awareness of the benefits of FP, types of contraceptive methods available, and places to access services, the study highlighted two knowledge-related barriers:

- Misconceptions and inaccurate understanding of some modern contraceptive methods and side effects, especially hormonal methods, persist across the various respondent groups (discussed further in contraceptive method preferences and concerns section below). For instance, an AGYW FP user in Balaka said, *"My concern is that I heard women saying that a condom can pass through the vagina from men into the stomach it affects intestines, and my other concern is that the lubricant found in condoms it is dangerous it affects the uterus."* And, according to a few providers, some AGYW confuse birth control pills with emergency contraception. Concerns about permanent infertility and negative effects on men's libido and genitalia (e.g., sores) were also prevalent among all respondent types.

"Yes, we hear it from the elders as we chat here at the mango tree. They talk about child spacing, condoms, jadele, norplant and there is loop; all these are for family planning."

SSI with AGYW (FP user), Machinga

"[I like the hospital] because we meet the nurse and doctor who explains everything in the simplest way rather than to be told by someone by the road. It can be good to give the advantages and the disadvantages so that I can be in a position to know how important it is to have child spacing and what problems can I face. Therefore, when we go to the hospital or antenatal clinic we get the truth about the advantages and disadvantages of FP."

SSI with mother (non-FP user), Balaka

- Inconsistent knowledge on timing of postpartum FP initiation is another knowledge barrier. When participants were asked how soon after the birth of a child a woman should begin using FP, a wide range of responses emerged suggesting a potential knowledge gap. Although many participants believed women should wait six weeks after birth before initiating FP, responses ranged from waiting three weeks to two years. Some participants associated postpartum FP initiation with certain milestones, such as soon after delivery, before or after the return of menses, or at any time while a woman is breastfeeding. The risk of pregnancy and return to fertility after childbirth or the conditions of LAM were not fully understood by some study participants as demonstrated in this statement from a mother who was not using FP at the time of the interview: *"I started to have sex with my husband when my child was 5 months old and they were saying that when we were having exclusive breastfeeding you could not have pregnancy. Indeed it is true because since my child was born I did not have menses even though we are just staying in our house without using any family planning methods like condoms. My child will be 1 year and 1 month this month but I am still not pregnant."*

Family size and child spacing preferences. When asked about family size preferences, having four children was considered ideal by more than half of those responding (range was from one to nine). The next most common response was two children (a little over a quarter of coded responses); about 10 percent of respondents desired five or more

children. A strong preference for spacing children five years apart also emerged across interview types. Although the responses ranged from one to 10 years, close to three-quarters of respondents said spacing children between three and five years was ideal, with close to two-thirds of them choosing five years.

Demand for smaller families and child spacing was largely driven by a family's ability to care for the children, especially given the broader environmental and socioeconomic factors affecting communities, such as climate change, land shortages, hunger, and poverty. These environmental factors are discussed more in Brief 4, which describes community perspectives on the linkages between population growth, family planning, health, and food security.

Perceived benefits of family planning, child spacing, and smaller family size. Participants across respondent types articulated many benefits of FP, child spacing, and smaller family size. Since FP is seen as a way to space and/or limit family size, there was much overlap in perceived benefits of the three. Overall, the most commonly described benefits fell within four categories: child health and development, maternal health, educational opportunity for young girls, and household income and assets (see Table 1).

Table 1. Perceived benefits of family planning, child spacing, and smaller family size

Benefit	Quote
Child health and development • Provide better care for children (nutrition, clothing, healthcare) • Able to send children to school	*"The other advantage of family planning is that you are able to feed the children but if you have many children they fight for the small amount of food available. You cannot be able to clothe them and they look [unruly] but if you are doing child spacing all these things do not happen because you are able to support all the children you have in the family. And even the parents look very nice and you have space to breath and relax."* SSI with mother (non-FP user), Machinga
Maternal health • Avoid dangers of frequent childbirth • Regain health between pregnancies • Have good health • Look attractive	*"The woman's life who is bearing many children is putting her life in danger because she loses blood when she is giving birth. In addition to that, when she is just giving birth frequently, she loses her natural beauty. In a proper language we would say that she gets old faster."* FGD with ABYM, Machinga
Educational opportunity • Allows young women to continue/finish school • Allows young women to have more control over future • More educated society/community develops	*"For me to know that there is family planning, when I started dating my boyfriend, my aunt she was worried that maybe I will not complete school because I was involved in a relationship, she is the last born in my mom's family, she is my age. One day she took me to the hospital and when we got there she told me that she brought me there so that I start using family planning implant method because she wants me to complete school, I agreed."* SSI with AGYW (past FP user), Balaka
Household income and assets • Parents have time to work • Families can save money and accumulate assets	*"Alright fine, when you use FP, you live a happy life. You can do heavy jobs as well. You can be able to farm up to say 12 noon even 13:00 hours when you don't have a small child, but when you do, you will work little to care for the child and even you are working, you would be stopping to breastfeed a little."* SSI with community leader, Balaka
Other • Couples can have sex freely • Time for personal activities • Men don't cheat or abandon family	*"Nowadays people are being encouraged once they deliver that they should take part in family planning because when you use family planning while the child is still very young the womb gets back to normal while still medicated, they encourage woman to use family planning methods soon after giving birth because men nowadays they go out to cheat because the wives have a small baby. At the hospital they encourage that as soon as a woman gives birth she must use family planning and two months after giving birth a woman can have sex with the husband."* SSI with lead mother, Balaka

Contraceptive method preferences and concerns. Using a card sorting exercise, community members were asked which FP methods they thought adult women with young children and AGYW should and should not use. Although pros and cons were discussed for all methods, overall, the four methods that emerged as being more acceptable for use by both target groups were injectables, male condoms, implants, and pills. Tubal ligation, cycle beads, and IUDs were considered not as suitable for use. Among current FP users in this study, the top three methods used were injectables (48 percent), male condoms (32 percent), and implants (13 percent); notably the study sample did not include current pill users. In the SSIs with AGYW and mothers, non-users were asked about future FP use. Five out of the six mothers said they would prefer a long-acting or permanent method (tubal ligation) and one preferred implant. Among the AGYW, two wanted to use an implant in the future, and one chose injectable. As discussed in Table 2 and later in this brief, many community members believed that AGYW who had not begun childbearing should not use any method other than condoms for fear of infertility.

Method-related preferences and concerns were driven by one or more of the following four factors: perceived risk of side effects, perceived ease of use, perceived effectiveness, and perceived ability to use secretly (see Table 2). The fear of negative side effects from contraceptive use, as well as misconceptions and myths regarding its use, emerged most often in discussions. Preferences and concerns were generally based on personal experiences or the experiences of an acquaintance or client; in several cases hearsay or hypothetical concerns were based on common beliefs within the community.

While several mothers and AGYW preferred injectables because they believed this method can be used secretly, many participants across all respondent groups expressed concerns about using injectables because they believed they could cause infertility, especially among AGYW, or had negative effects on men's sexual performance and/or pleasure. Some fathers and ABYM reported liking injectables and condoms mostly for their ease of use and believed they had fewer side effects than other methods. Young men and women also liked condoms because of the dual protection the method offered (prevention of sexually transmitted diseases and pregnancy). A few mothers expressed concerns about the lubricants in condoms causing diseases such as cancer, their being less reliable since they can break, and the perception among men that they reduce sexual pleasure.

Several respondents viewed the need to take a pill daily and to obtain a monthly supply as a significant disadvantage of the method. Concerns about effectiveness were often related to concerns about ease of use—for example, because it is difficult to remember to take a pill every day, some participants worried that missing doses reduced its effectiveness. Tubal ligation was perceived as highly effective, but not the right choice for women with young children and AGYW who have not met their fertility goals. When asked about using long-acting reversible contraceptives (LARC) like implants and IUDs, effectiveness and ease of use were the main desirable characteristics[1] because they provide protection for a longer duration (five years). This eliminates the need for making frequent visits to the provider; taking pills daily; scheduling follow-up injection dates; or storing supplies, like condoms or pills, in their homes, which can be an issue for those seeking to use the method secretly. However, there were considerable concerns among some participants about negative side effects from using implants, such as weakness, discomfort, and paralysis in arm/hand; irregular or persistent menstrual bleeding; and permanent infertility, weight change, and high blood pressure. There was also some concern about the visibility of implants, especially for use by AGYW, and about needing provider intervention for removing IUDs and implants.

Examining each method by the four factors highlights where programs can better focus their social and behavior change (SBC) efforts to address potential barriers to contraceptive use.

1 Respondents almost exclusively discussed implants unless specifically asked about IUDs.

Table 2. Summary of four factors affecting choice by contraceptive method

Contraceptive Method	Perceived and Actual Risk of Side Effects	Perceived Ease of Use/ Access	Perceived Effectiveness	Perceived Ability to Use Secretly	
Short-acting, hormonal methods					
Injectable	• Irregular or prolonged bleeding • Permanent infertility • Harmful effects on men's sexual performance	• Periodic appointments required • Does not need provider visit to discontinue use • Occasional stock-outs	• Effective if injection appointments occur on schedule	• No products to store • Partner may notice side effects, provider visits	*"A lot of young women fear that getting injectables will make their uterus rigid and they fear that maybe they may not have children again."* SSI with facility provider, Machinga *"They say men feel weak when doing sex mostly when the woman is using injectable."* FGD with mothers, Balaka
Pills	• Accumulate in stomach/ cause cancer • Irregular or prolonged bleeding	• Difficult to remember daily pill • Requires frequent provider visits	• Inconsistent use limits effectiveness • Confusion with emergency contraception	• Partner/parents may notice pills	*"People in the community like the injection method and condoms. They do not like pills because they have to take them on a daily basis."* SSI with youth leader, Machinga *"Some young women also believe that the pills stay at one place in the body and cause swelling. I try my best to tell them that it is not true by demonstrating. I do this by putting the pill into water and watch it melt."* SSI with adult CBDA, Balaka
Long-acting reversible and permanent methods					
Implants and IUDs **(Reversible)**	• Disability and susceptibility to illness (weakness/ paralysis/ swollen arm/pain • Irregular or prolonged bleeding • Weight change, high blood pressure	• Easy to use once inserted • Needs provider intervention for discontinuation	• Like the long duration of protection (5 years), particularly for spacing	• Doesn't require regular doctor visits or storing of supplies • Visibility of implant	*"Young women who are married feel that the [LARC] methods are very good. Those who are not married do not use them because they fear that their parents will notice it on their arms."* SSI with male youth leader, Balaka *"Because when we go to the health centers they are able to insert the Norplant but if there are some side effects and you want it removed sometimes they refuse. But at [name] is a private entity and they can help you to remove it after paying some cash."* FGD with AGYW, Machinga
Tubal Ligation **(Permanent)**	• Fewer medical concerns vs. hormonal methods • Fainting or weakness after surgery • Damages the uterus	• Available through mobile clinics and higher-level health facility	• Effective for those who have met their fertility goals	• Requires partner cooperation because of permanence/ irreversible	*"Women that have the number of children they wanted use tubal ligation method and others use implant."* SSI with lead mother, Machinga
Non-hormonal, short-acting methods					
Condoms (male and female)	• Fewer medical concerns vs. hormonal methods • Irritation or discomfort during intercourse • Reduced sexual pleasure • Fear of female condoms bursting	• AGYW rely on partners to obtain condoms • Female condoms uncomfortable, difficult to use • Occasional stock-outs	• Reliability concerns (condom breaking/ tearing)	• Requires partner cooperation • Parents may notice stored condoms	*"Those still schooling should use condoms because we said they shouldn't use any of the other FP methods like injections and pills as they will affect their bodies. But for the condoms, there is nothing that will affect her body, they will just be in contact and it ends there."* FGD with fathers, Balaka *"Pills are readily available, but sometimes we run out of male condoms because they are the ones demanded most. So sometimes when we don't have male condoms, we give them female condoms which they complain that they are difficult to put on."* SSI with facility provider, Balaka
LAM	• None mentioned	• Complicated to understand/counsel on • Difficult to use correctly	• Inconsistent/ incorrect use limits effectiveness	• Not mentioned	*"[LAM] is a good method though many people do not know it very well. If you do not know something, it is better not to use it. Because you may end up using it wrongly."* FGD with ABYM, Machinga
Standard Days Method/Cycle Beads	• None mentioned	• Complicated to understand/counsel on • Difficult to use correctly	• Inconsistent/ incorrect use limits effectiveness	• Not mentioned	*"But I don't usually give the bead method because it is difficult for someone from the village to understand the method so I focus on the injection only."* SSI with HSA, Balaka

Partner support and gender norms around FP decision making. The study found that although male partner support for FP is perceived to be improving, gender norms that favor male control of FP decisions continue to impose barriers to contraceptive use.

For adult women. Only a handful of adult male and female participants gave concrete examples of the type of support men provide their partners, such as reminding women to take pills or go for injection appointments, accompanying women to the health center for FP visits, and offering to use condoms if a woman experiences adverse side effects from another method. Male support for smaller families was primarily driven by concerns about being able to raise many children with the changes in climate and land shortages. However, there was ample evidence across interviews that not all men support their partners' contraceptive use, resulting in women not using, stopping, or using contraception secretly. As highlighted in the quotes below, women can face negative consequences from partners. While women could face abandonment or divorce if discovered using FP secretly, some women may choose to use FP secretly to safeguard against divorce or abandonment if they have too many children to provide for. In a few instances, male support for contraception was phrased in ways that was misleading—and perhaps coercive toward their partner.

There was fairly broad consensus, especially among ABYM and fathers, that male partners should, at a minimum, have input on whether their partner uses contraception, and that men—particularly husbands—as the head of the household should make the final FP decision. Similarly, in the case of determining family size, although many women said their partners agree with them on desired family size, where there was disagreement, many women said they deferred to their male partner as the primary breadwinner and responsible for taking care of the family.

"The discussion of family planning is started by a woman and the man has just to make the decision, but if the man says no, then the woman doesn't have the courage to go and get contraceptives."

FGD with mothers, Balaka

"Because that's how things are supposed to be. A woman cannot be the one making such [family planning] a decision."

FGD with ABYM, Machinga

Support for contraceptive use	Against secret use of contraception	Potential partner coercion to use contraception	Negative repercussions of large family size
"They [male partner] encourage their wives after giving birth to use family planning. When the method a woman using is not good for her she talks to her husband and the husband is the one who says the way things are now go and get another method, others when their wives are having problems with family planning method they are using, the husband takes part by using condoms." SSI with lead mother, Balaka	*"You really have to agree because if the woman gets the FP method on her own, there will be no peace in the home. The man may even abandon the marriage if she just decides on her own to use FP methods. So they have to agree. But if she does it secretly, it might seem as if she prostituting."* FGD with fathers, Balaka	*"I even tell my wife that she may even lose her life if she doesn't want to use FP. And I also tell her that I would divorce her if she doesn't want to use FP because I cannot manage to feed many children."* FGD with fathers, Machinga	*"In this community it is not common for men to take part in family planning, women they sneak to get family planning methods... On your own you know that marriages are not certain, they can end; he will leave you with so many children, so you sneak to get injection of family planning."* SSI with AGYW (FP user), Balaka

For AGYW. Among AGYW and ABYM, although there was recognition that young people in sexual relationships should use FP to avoid unintended pregnancies or to delay pregnancy, it was common for young couples not to discuss the use of FP within relationships before marriage. As discussed further in the next section, although some AGYW said their partners were supportive of FP use, in general, the responses from them and ABYM suggested it was more acceptable for young people to use contraception if they were married, after the birth of the first child, or to continue their education. There was also a strong preference among both AGYW and ABYM to restrict contraceptive use to male condoms before marriage or the birth of the first child (discussed further under community norms). Several ABYM also admitted that usually the girl in the relationship insists on condom use. When ABYM were asked how they would feel about their girlfriend using FP, most said they would be against it if the girlfriends were using it secretly because it would damage the trust in the relationship. As one young man said, *"If the girl uses family planning, then I may suspect that she may be having other partners unless it is agreed between the two of us."*

"No the best time [to initiate FP] is now as a young woman and then she can continue when gets married or after first child. But young women can use condoms, but when married she can use family planning methods from the hospital, like injectables and implants."

SSI with AGYW (FP user), Balaka

"Many [couples] do not talk about it [family planning] until they give birth to a child. That's when they start thinking about family planning. It is very rare for people to be talking about FP before they get into marriage. The normal thing is you get into marriage, give birth to your first child and then the woman goes to growth monitoring. That's where she is told about FP for the first time."

FGD with ABYM, Machinga

Community norms and support for FP. Although overall acceptance for FP use is increasing, pockets of opposition from the broader community, especially when it comes to use by AGYW, persists.

For adult women. Several women said they did not face resistance from their family members, citing one or more benefits of FP described in Table 1. In some cases, they acknowledged their family members were also FP users. Only a handful reported mixed opinions—some family members were supportive of FP while others were not. The resistance usually came from relatives who had experienced severe side effects from a contraceptive method, as one non-user mother described: *"I have my young sister.. She went to get FP methods but that method almost killed her.. It was bad and that's why we are afraid after that scenario. That's why I say I cannot use FP methods but pray to God to protect me and have no more child after this baby so that I can stop having children."* Respondents attributed community opposition to FP to being older, illiterate, not knowing enough about FP, or having religious beliefs that did not support FP use.

"In the past it used to happen e.g. Muslims and even Christians could oppose the use of FP methods arguing that God created us to multiply. Now people are informed of the advantages of FP."

FGD with fathers, Machinga

"Aah, I cannot be able to know exact time when I will have the child because the child is gift from God."

SSI with AGYW (non-user), Machinga

Overall, more respondents believed religious leaders support FP use than oppose it. The main reasons offered for their support were that FP allows women time to attend religious activities, helps girls complete schooling, and ensures child health and development. For example, one mother said, *"They encourage people to use family planning so that they cannot bear children very often; because sheikhs and priests are the people who feel sorry when a child is not given the needed support and care because the family has another baby."* Among those who believed religious leaders oppose FP, a common reason was: *"It is forbidden in their religion and in the books of which they are reading."* A few participants also held religious beliefs around FP and childbearing, the most common being that children are a gift from God and that it is God, not the parents, who has control over pregnancy.

For AGYW. The study found a mixed normative environment and social acceptance for FP use among AGYW. Young women are faced with many competing demands. While the community expects AGYW to delay marriage and childbearing until they are physically mature, have completed school, and are financially independent, AGYW receive little support to meet these expectations for multiple reasons, including:

- Financial constraints within families often force AGYW to drop out of school, engage in transactional sex, or be forced into early marriage
- Community beliefs hold that young unmarried adolescents and women who use FP are promiscuous, are prostitutes, or have multiple partners
- A strong community preference, which is also internalized by young men and women, to delay contraceptive use, other than condoms, until after the first birth. Two underlying reasons drive this preference:
  - **Belief that contraception causes infertility and barrenness.** This was the most common reason provided by community members for delaying contraceptive use until after the first birth. While providers and project informants confirmed that their clients had this concern, a few CBDAs also appeared to share it. For example, an adult CBDA in Balaka said *"Because as I said earlier, we only serve people who are married and are bearing children. The risk with young women is that they may never give birth to children if they start using pills at a young age."* A youth CBDA when discussing FP use among his clients said, *"I haven't gone deep with issues of motherhood but I just think that they may have problems in bearing children if they start using contraceptives at a young age."*

"If I use family planning method now.. later when I want to have a child, because I was using family planning method when I was in school I would not be able to bear children and I would suffer. Because there are other family planning methods, like injection, it kills something in the uterus.. when that happens you can't bear children."

SSI with AGYW (condom user), Balaka

"I think it's not good because we already said that if the young people get FP methods before they have children, they may have problems later maybe inability to have children and also that the use of FP methods may increase their sexual activities."

FGD with fathers, Machinga

  - **Pressure to prove fertility.** Study participants, especially ABYM, described a community expectation for newly married couples to have children soon after marriage. For example, one young man said, *"Mostly, they wait for 4 or 5 months. This is the period that they just want to verify if the girl is pregnant. If there is no pregnancy, they start doubting the man's fertility."* A few young women expressed personal uncertainty about their own fertility—they were unsure if they would be able to have children and were nervous to use FP until they knew for sure that they were able. One girl using male condoms said *"My concern is that I am a girl.. I have never given birth.. [it] will be hard for me to use family planning.. I don't know how fertile I am."*

“[A]round here most people think using family planning when you just got married is not good, most people they don’t take part in family planning when they just got married, they say why would someone use family planning when you just got married they would want to have a child.”

SSI with lead mother, Machinga

“In our Yao culture it is difficult because they think that if they enter into marriage they should have pregnant instantly.. If some months passes without the sign of pregnancy they start doubting.”

SSI with mother (non-user), Balaka

Conclusions and Program Recommendations

The formative research study findings discussed in this brief provide important insights into the social and cultural context of FP use in Malawi’s Balaka and Machinga districts. Although the culture of acceptance for voluntary FP is improving, the study identified several factors that continue to influence the demand for modern contraceptive use among adult women and AGYW in these communities.[2] At the individual level, while community members are well informed of the various benefits of FP, there were knowledge gaps around the timing of postpartum FP initiation, and fears and misperceptions around a range of modern contraceptive methods. A preference for short-acting contraceptives was noted. The findings also highlight how inequitable gender norms and power dynamics within couples can negatively impact FP use. At the broader community level, the study results underscore the need to improve the normative environment around contraceptive use, especially among AGYW, and to normalize FP use among adult women who choose to delay, space, or limit family size. These findings suggest several opportunities for SBC and capacity strengthening programming to improve knowledge, attitudes, behaviors, and gender and social norms related to voluntary contraceptive use. The recommendations for consideration by Njira and other programs working to address unmet need for FP in Malawi are as follows:

At the individual level:

- Train facility- and community-based health providers and relevant project staff to provide voluntary FP client-centered information and counseling on the range of available contraceptive methods to ensure informed choice and expand method choice. These efforts should:
  - Recognize that every client is unique and will have different contraceptive needs based on their stage in life and fertility goals (e.g., unmarried adolescents in and out of school, married adolescents and young women, first-time parents, women with children, breastfeeding mothers).
  - Address prevailing client concerns about contraceptive methods including fears and misconceptions relating to perceived and actual negative side effects, ability to use secretly, perceived ease of access, and effectiveness.
  - Improve postpartum FP knowledge, including return to fecundity, pregnancy risk after delivery, LAM and transition to another method, and contraceptive options for the immediate and extended postpartum period for breastfeeding and non-breastfeeding mothers.
  - Raise awareness about the safety and effectiveness of hormonal and long-acting reversible and permanent methods, including among AGYW (Family Planning 2020 2015).
  - Address provider biases, especially about contraceptive use by AGYW.
  - Target not only adult women and AGYW, but also the key influencers and gatekeepers in their lives, including partners/spouses and parents.

2 Refer to Brief 3 for the supply-side context and barriers.

- Improve self-efficacy and agency among adult women and AGYW, with a focus on improving communication and negotiation skills to discuss and act on their fertility desires. Sharing stories of women like them who have successfully used modern contraception to achieve their fertility and life goals through channels such as education entertainment and other SBC strategies may be useful.

At the household level:

- Engage men and ABYM as supportive partners and agents of change for FP. Leverage the fact that male support for smaller families with timed, spaced children is increasing, especially given the broader environmental and economic challenges facing communities. Men want to be involved in FP decisions and view their support as being part of their responsibility as the head of household. Given that inequitable gender norms around FP use persist, any effort to engage men and ABYM as supportive partners must be done in a thoughtful and careful way to ensure the safety of women and AGYW.
- Promote more equitable, open communication and decision making among couples about fertility intentions, desired family size, and FP so women do not need to resort to using contraceptives secretly. Equipping providers, especially community-based providers who make home visits, with couples counseling training may facilitate this.

At the community level:

- Hold group-engagement sessions for critical reflection and dialogue aimed at creating an environment where voluntary FP use by adult women and AGYW is an accepted social norm. These sessions, led by or involving respected and credible individuals within the community, should:
    - Challenge social and gender norms that oppose or limit voluntary contraceptive use.
    - Position the benefits of modern contraceptive use within the broader environmental, economic, and social contexts of people's lives and within the context of building resilience (refer to Brief 4).
    - Discuss strategies to keep girls in school to prevent early marriage, transactional sex, and unintended pregnancy.
    - Discuss strategies to support young people in delaying first birth until they are physically mature, financially independent, and emotionally ready to have children.

References

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