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"Condoms make you lose both the child and pleasure": perceptions on contraceptives use in Malawi

PIERSON NTATA[1], PETER MVULA[2] and ADAMSON S. MUULA[3*]
[1]*Department of Sociology, Chancellor College, University of Malawi, Zomba, Malawi*
[2]*Center for Social Research, University of Malawi, Zomba, Malawi*
[3]*University of Malawi, College of Medicine, Blantyre, Malawi*

Abstract: A qualitative study comprising 91 focus group discussions (FGDs) of adult married men and women and 21 key informant interviews (KIIs) was conducted in Malawi in 2008. The purpose of the study was to explore the knowledge, perceptions and practices towards contraceptives and family planning. Data were analyzed using content analysis. The perceived effectiveness, physical health gains and socio-economic benefits of contraceptives and/or family planning were well recognized by the study participants. Covert use of contraceptives by women was despised by both men and women and considered a punishable offence. Women reported men as less likely to provide support for contraceptive use. A woman's own relatives were reported to be more likely to support contraceptive use, while her in-laws and friends identified as not as supportive. Concerns regarding adverse health effects of hormonal contraceptive use included vaginal bleeding and delayed return to fertility. Unwanted social or personal consequences were that vaginal bleeding or spotting as a consequence of hormonal contraceptive use limited women's availability to their male partners for sex, that a woman who was using contraceptives was not fulfilling her childbearing responsibilities and that contraceptive use promoted extramarital sex as there was no more fear of pregnancy. Having a wide range of contraceptives in health facilities or community sources, a supportive healthcare and supportive social network could improve contraceptive uptake.

Keywords: family planning, contraceptives, male involvement, masculinity, Malawi

Introduction

Widespread use of effective contraceptives is critical to the realization of Millennium Development Goals (MDGs) 4 and 5 which concern the need to reduce child mortality and improve maternal health (Landry & Rama, 2008). However, other MDGs such as the eradication of extreme poverty and hunger (Goal 1), achievement of universal primary education (Goal 2) and promotion of gender equality and empower of women (Goal 3), also relate to contraceptive use and family planning.

The final report of the Malawi Demographic and Health Survey (MDHS) of 2004 (National Statistical Office & ORC Macro, 2005) reported on the unmet demand of family planning compared to two previous MDHSs conducted in 2000 and 1992. The MDHS-2004 report (National Statistical Office & ORC Macro, 2005) defined women with unmet contraceptive need as those women who report either that they do not want any more children or that they want to wait two or more years before having another child, but in both cases are not using contraception. Women with met need are those who are currently using contraceptives. Women with unmet need combined with those with unmet need constitute the total demand for contraceptives.

The unmet demand was 28% in 2004 compared to 30% and 36% in 2000 and 1992 respectively. Total demand for family planning services was 49% in 1992, 60% and 62% in 2000 and 2004, respectively. Demand was satisfied for only about a quarter of women (26%) in 1996, but rose to 53% and 55% in 2000 and 2004, respectively (National Statistical Office & ORC Macro, 2005). Modern contraceptive remained the same between 2000 and 2004 in Malawi; the 2004 DHS reported 28% of Malawian married women, ages 15–49 years, were using a modern method

* Correspondence: Adamson Muula; E-mail: amuula@medcol.mw

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of contraception while 26% modern method use found in the 2000 DHS. Using different sampling approach, the 2006 Multiple Indicator Cluster Survey (MICS) reported modern method use at 38% (National Statistical Office & UNICEF, 2008).

The negative attitudes and practices of married men towards their partners' contraceptive use have been suggested as one of the important barriers towards meeting women's unmet contraceptive needs. In a qualitative study of women in Madagascar, it was found that lack of knowledge about the range of available contraceptive methods, misinformation and negative perceptions, and social opposition to contraceptive use from male partners were important barriers to women's use of contraceptives (Randrianasolo *et al*., 2008). Structural and health system barriers such as distance to sites where contraceptives are available (geographical access), unfriendly staff, inaccessible opening times and irregular supplies, have also been reported as impediments towards women's use of contraceptives (Flaherty *et al*., 2005; Grossman *et al*., 2006). In Malawi however, using geographical information system (GIS), Heard *et al*., (2004) did not find that proximity to a health facility providing reproductive health services was associated with contraceptive use among Malawian women.

In Malawi, between 2004 and 2006, injectable contraceptives were least likely to have been out of stock (19%), followed by pills, condom and hormonal implants (Chimnani *et al*., 2006; John Snow, 2006). In response to that many women who use contraceptive often use injectables compared to other types of contraceptives. To increase access, in 2008, the Ministry of Health decided that injectable contraceptives could be provided by Health Surveillance Assistants (HSAs), who are community health workers with 6 weeks training. This followed wide ranging stakeholder consultations including rural communities (Richardson *et al*., 2006; 2007; 2009).

There is need to enlist the support of men to promote contraceptive use among couples in Malawi. However there is limited in-depth understanding as to what men's fears are or what may facilitate their involvement in supporting their partners' use of contraception. Furthermore, the understanding of the socio-cultural milieu they would have to negotiate in order to provide this required support to their female partners has been understudied. As intervention efforts aimed at increasing the active involvement of men in contraceptive use may be more effective if they are designed cognizant of men's perceptions and experiences with their partners' prior use. A qualitative study was therefore conducted to reproductive health programme design with the aim of putting men at the centre of family planning and contraceptive use in Malawi.

Materials and Methods

Study setting and participants' recruitment

A total of 91 focus group discussions (FGDs) and 24 key informant in-depth interviews (KIIs) were held in Malawi in 2008. Seven districts (one in the northern region of the country, 2 in the centre and 4 in the south) were selected for the FGDs. These districts were Karonga (North); Nkhotakota and Salima (Centre) and in the South - Balaka, Chikwawa, Mangochi and Phalombe. The number of districts in each of the regions roughly correlated with the population i.e., the north is sparsely populated and has the lowest total population, followed by the centre. The south comprises 45% of the national population of the country (National Statistical Office, 2009).

In each of the selected districts, an urban or peri-urban centre and a remote area were selected purposively. The study aims were explained to community health workers who were then asked to recruit men and women, current users and non-users of contraceptives. Study participants in the FGDs were married men and women who identified themselves either as current users of family planning methods or non-current users to community health workers. Study participants participated in single sex FGDs.

In the case of key informant interviews, these were individuals perceived to be knowledgeable of their community and/or contraceptive use. The data collection team recruited

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9 traditional chiefs, 5 each of religious leaders and health surveillance assistants (HSAs), 4 traditional birth attendants and 1 community-based distributor of contraceptives. The definition of 'key informants' we have used in this study is that these were individuals who were likely to be knowledgeable on the topic of interest, because of their position or their responsibilities within the community. Key informant interviews were conducted in selected districts: Chikhwawa, Phalombe, Mangochi, Balaka, Salima and Nkhotakota.

The majority of residents of Karonga are the Tumbuka, a patrilineal (inheritance is from the paternal side) and virilocal (a woman stays with her husband family). The district is served by a major highway from northern Malawi to Tanzania. Nkhotakota and Salima, inhabited by the Chewa and Yao are largely matrilineal and uxirilocal (a married man stays in his wife's village). Some parts of northern Nkhotakota are inhabited by the Tonga, which is a patrilineal and virilocal tribe. In the South, Balaka is predominantly inhabited by the Yao with minority Nyanya and Ngoni tribes. Chikhwawa is largely occupied by the Sena and Nyanja while Phalombe is largely inhabited by the Lomwe. The Sena have mixed inheritance patterns. For most of the districts interviews were conducted in Chichewa, the main national language (the other is English) except in Karonga where Tumbuka, the commonest language in northern Malawi, was used.

Data collection

Data were collected via FGDs and key informant in-depth interviews. These were single-sex groups comprising 8 to 12 individuals. Sixteen trained research assistants and four supervisors participated in the data collection. Each focus group was facilitated by one research assistant and a note taker. Study interview guides were used to collect information on the following topics: what contraceptive methods are known by the study participants; what were the benefits and concerns about family planning; where do the people obtain contraceptives; why do couples or individuals use contraceptives; and what challenges are experienced in using or wanting to use contraception.

All in-depth and key informant interviews were conducted at a place that assured privacy. No names or any personal identifiers were collected in the interviews. Study participants in the FGDs were identified by community health workers as those who use contraceptives and those who do not use contraceptives. The community health workers were individuals who knew the contraceptive use status of the individuals. However, being included in a FGD of either users or non-users provided an opportunity where, because of being included in a particular group, the contraceptive use status of oneself and others was revealed to group members. The FGD members were however informed that information from the groups should only be used for the research purposes by the researchers and personal information to remain within the group, not to be divulged elsewhere.

Data analysis

Data were analyzed using content analysis. Initially, the transcripts were read to identify emerging themes as well as to identify study participants' responses which answered the study objectives. Following the identification of themes, the transcripts were re-read and corresponding data identified. Exemplar statements were isolated and are reported in this paper in support of particular themes (Denzin & Lincoln, 2005).

Results

Distribution of the focus group discussions per selected district

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Between 2 and 4 FGDs of each category (self-reporting using or not using contraceptives) of men or women were held in each of the study districts. The distribution of the FGDs is as shown in Table 1.

Table 1: Number of Focus Group Discussions conducted in each study district

Participants	Karonga	Kasungu	Nkhotakota	Salima	Balaka	Mangochi	Phalombe	Chikwawa	Total
Men using	4	4	4	4	4	4	4	2	30
Men not using	4	4	2	3	4	3	4	2	26
Women using	2	2	2	2	2	1	2	2	15
Women not using	2	2	4	3	2	3	2	2	20
Total	12	12	12	12	12	11	12	8	91

Main themes identified

The main themes identified from the KIIs and the FGDs included commonly used contraceptive method, barriers to contraceptive use, perceptions on what contraceptives were meant to achieve, what the adverse effects were, what the added (non-contraceptive) benefits were, sources of support or discouragement, cultural and religious impediments.

Preferred contraceptive methods

Injectable hormonal contraceptives were reported to be the preferred or commonly used modern contraceptive method by women. Sterilization was the least preferred method by both men and women while other methods such as diaphragms and vaginal rings received no attention at all. The reasons given for such preference included: convenience of a single injection once every three months; being readily available for free in government health facilities and the possibility for covert use among women who did not have spousal support to use contraceptives.

Perceived benefits of contraceptive use

Both male and female FGDs and as well as key informant interviews identified several perceived benefits of contraceptive use. These included: that women's and child health are promoted through their use; that a woman who is not always having children is able to "participate in development activities" and that a family with fewer children does not have as much burden of caring for their children as the family where the number of children is large. There were also perceived personal benefits of using contraceptives. In one FGD, a man using contraceptives reported that:

"A woman who is using contraceptives looks more beautiful when on contraceptives than when they were not using."

Contraception or family planning

Study participants used the vernacular terms for family planning or contraceptive, which were either *kulera* or *maleredwe*. These terms are generally understood as suggesting a pause or temporally situation, in this case a pause in childbearing. With this idea in mind, many FGDs attempted to discuss contraceptive use as an attempt to achieve an ideal birth interval but not permanent cessation of having children. Surgical sterilization procedures for both males and females were described as "self-inflicted disability" and were reported as the least popular method of family planning.

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Contraceptive use was at times looked at in the same light as killing of an unborn child. A study participant reported that her parents, when discussing with her the merits and demerits of contraception asked her if she herself would have been born if her parents were using contraception. Another study participant, not using contraceptives in Chikhwawa, reacting to messages promoting contraceptive use said:
"You are asking me to kill the people who will look after me when I am old?"

"Child delivery is cure for acquired immune-deficiency syndrome (AIDS)"
There was perception that childbearing was a cure for AIDS. One woman in an FGD said that her parents were against her using contraceptives, having told her that: *"giving birth to children removes the disease in you especially AIDS*." The woman supported such an advice by suggesting that the AIDS goes out of a woman's body with the child *"so it is important that you have more children so that you don't have AIDS*."

Contraceptives are associated with adverse events
There was perception that hormonal contraceptive may be responsible for ill health, in some cases life-threatening medical conditions such as cancers. A man in a FGD said: *"Some women stopped menstruating and got very sick, others were even diagnosed with cancer."* A male study participant reported: *"My sister died because she was menstruating continuously."* A woman, who identified herself as a previous contraceptive user reported: *"I was bleeding for three weeks nonstop; a husband can easily leave you for other women. So I decided to stop*."

It was also reported that when the women returned to the health clinics in the event of adverse event such as vaginal bleeding (spotting), they were often advised that "the bleeding will stop on its own." For a few women however, the bleeding or spotting was reported to be so problematic as to result in medically-advised discontinuation of use.

Future fertility and contraception
Secondary infertility was also reported as a possible adverse effect following hormonal contraceptive use. It was also reported that fewer children did not augur well in an environment of high infant and child mortality. A man using contraceptives in Balaka said: *'If some children die, the remaining ones will support you in the future, all of them can't die. If you have only two children, both of them could die and you have none."* Some study participants also observed that with the growing number of orphan children, having many children was contributing to sub-optimal care of both orphan and non-orphan children.

Women who use contraceptives are unfaithful
The effectiveness of contraceptives was not in question. However men in central Malawi expressed concern that contraceptive use was responsible for the deterioration of "morals" because young people become promiscuous as they "did not fear pregnancy." This observation was supported in a women-only FGD in Mangochi (southern Malawi) where the women suggested that they preferred injectable hormonal contraceptive as this made them avoid pregnancy when their husbands travelled out of the country. Many men from the area are migrant workers or travel for business to neighbouring countries. In northern Malawi, a male FGD participant complained: *"Contraceptives, especially the injection is no good, because our women start sleeping with other men since they are not afraid of getting pregnant".*

Men's FGDs reported that a woman was supposed to seek permission from her husband before using any contraceptive. There were suggestions of intimate partner violence against women who may be using contraceptives without their husband's knowledge*: "She has crooked thoughts, likely she is going out with other men…Slap her a bit…Divorce her."* Covert use of contraceptives was

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described as marker of a cunning and ill-willed individual. Furthermore, contraceptives use by women without the knowledge of their partners was described as "*witchcraft and childish*".
Men also believed that women were responsible for initiating discussion on contraceptive use. Men who supported their partners in contraceptive use were perceived as caring and "*wishing the woman well*."

Friends are not always helpful
In order to identify people who, within an individual's social network would support or present a barrier to contraceptive use, study participants were asked about their perceptions and experiences of support from other people. In many study groups, it was reported that friends were least supportive while relatives of the woman were more likely to support contraceptive use. On the part of spouse's relatives, female in-laws were more likely to accept contraceptive use than male in-laws. Among the people of northern Malawi, where inheritance is patrilineal and resident virilocal, the perception sometimes was that it was a woman's duty to bear children. In Karonga for instance, a participant reported that people express that: "*She came to this village a long time ago but why does she have few children? What did she come here to do? After all, the children are not hers so why is she stingy in bearing them?"*

"God wants more children"
One of the barriers to contraceptive use identified was that the number of children a couple eventually has is determined by God; there is therefore nothing else couples or individuals can do. A man within a couple using contraceptive said: *"It is the plan of God, God just created some families to have many children and so it is unavoidable. It is the same God who created some families not to have children."*

Some study participants even believed that God encourages people to have children. One man, not using contraceptives said "*Mulungu saletsa kubala*" (God does not forbid childbearing)." Another study participant suggested that *"We just look up to heaven what we will be given, we receive,"* while another reported on the unpredictability of the "womb". This participant said: *"You cannot trust what happens in the womb, you can bear four children at once."*

Condoms are for extra-marital sex
The importance of male condoms in the prevention of HIV infection was well recognized; but this was largely with regard sexual intercourse within extramarital relations. As exemplified by one individual who said: "*Makondomu sitigwiritsa ntchito mnyumba ayi, izo ndizakumbali*" [Condoms cannot be used within a marriage, but extramarital relationships].

There were also concerns that condoms interfered with sexual pleasure. Condom use was considered a 'double loss' of both possible conception and pleasure. Summing up his thoughts, a male key informant said: *"You cannot lose both the child and pleasure."*

Discussion

In a qualitative study using FGDs, key informant and in-depth interviews in Malawi, barriers and facilitators to contraceptive use were identified. We suggest that contraceptive programming in Malawi pay special cognizance of these factors if it must succeed. This study found that injectable hormonal contraceptives were the commonly reported contraceptive used by women. Although there is no ideal contraceptive mix recognized by the international community, Sullivan *et al.* (2006) suggested that "there may be reason for concern when one or two methods predominate in a given country". These authors defined contraceptive method skew as when a single method constitutes 50% or more of contraceptive use in a given country. Malawi was identified as one such country where the injectable contraceptive predominates creating a method skew. Although there are no

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restrictive population policies in the country, lack of access to a broad range of methods and provider bias contributes to the skewed method choice in the country.

According to the Malawi Demographic and Health Survey of 2004 (National Statistical Office & ORC Macro, 2005), the most widely known modern methods of contraception among men were: the male condom (96%), injectables (85%), the pill (82%), female sterilization (79%), and male sterilization (72%). Injectable contraceptives were reported the most commonly used. The Malawi Ministry of Health (MoH) change of policy from only allowing provision of injectables in health facilities to having community health workers (health surveillance assistants) provide potential to further skew the contraceptive mix in the country; unless of course other remedial measures are put in place to improve contraceptive choices.

Women using contraceptives were perceived as looking beautiful. Such a statement could imply a double-edged sword. On the one hand men who believed that a woman who uses contraceptives "looks more beautiful" may be motivated to have their partners use condoms, if they would want such benefit. However, it is also plausible that men, who believe that an enhanced status of women (physically or otherwise) makes them more likely to have extra-marital partners, may be disinclined to support contraceptive use.

The perception that contraceptive use was similar to "killing" may have resulted from low-literacy levels in most of rural Malawi. There are also some religious teachings that support the idea that contraceptive use in an active obstruction to the creation of life. Although we are not sure of the level of knowledge regarding how contraceptives' function, we would suggest that it is limited in our setting. It would be interesting to explore in the future whether this same perception of contraceptives as killing would be sustained among the different contraceptive methods including condoms.

There are a number of "AIDS-cure myths" in Southern Africa; arguably the most popular and pervasive being that sex with a virgin is cure for AIDS or HIV infection (Jewkes *et al*., 2002; Pitcher & Bowley, 2002; Meel *et al*., 2003). However, from the evidence from Demographic and Health Surveys in many countries in the region, it appears that the majority of the population in Eastern and Southern Africa have adequate basic knowledge on HIV and AIDS, including the fact that there is no known cures for HIV infection (Central Statistical Office-Ethiopia & ORC Macro, 2006; Central Bureau of Statistics-Kenya et al, 2003; Central Statistical Office-Zambia et al, 2003; Central Statistical Office-Zimbabwe & ORC Macro, 2007; Central Statistical Office-Swaziland & ORC Macro, 2008; Department of Health-South Africa *et al*., 2007). There is fairly widespread knowledge that although available therapies reduce viral load, allows the immune system to recover, prolong and improve the quality of life of HIV infected persons and their families, these (antiretroviral therapies) are not cures. The belief that women somehow remove impurities through genital tract via expulsion of baby or blood therefore deserves further study. There is a belief among some women that regular and "adequate" menstruation is essential to maintain health. The menstrual blood is often seen impure which need to be cleared up from the body regularly. If a woman is not menstruating and is not pregnant, it is interpreted that she will be accumulating these impurities which will harm her health. We can therefore identify an association that since an HIV infected woman may deliver an HIV infected baby, without a clearer understanding of the biology of HIV and its transmission, (some) people assume that the baby is cleaning out HIV is understandable, but needs to be dissuaded.

As is the case with virtually all medical interventions, there are gradations of adverse events (side effects) associated with contraceptive use. The concerns about potential side effects when using and after use of hormonal contraceptives are long standing issues in Malawi, as is the case elsewhere (Moreau *et al*., 2007; Gilliam *et al*., 2009; Grabbe *et al*., 2009). These concerns are possibly magnified by the low education status of many adult Malawians, in an environment where large family size continues to be the norm. The perceived failure of health care workers to attend to contraceptive user' concerns and deliberate distortion of information by people add to the negative perceptions and low use of contraceptives. While women who have serious side effects are likely to

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be fewer in number, their stories have potential to gain prominence within the community. In any case, while the severity of side effects may be interpreted as medically inconsequential by health professionals, a woman whose quality of life is affected by continuous (vaginal) spotting may decide not to use hormonal contraceptives at the expense of an unwanted pregnancy. Thus we identified health care quality issues here: failure to ensure that women understand the possible side effects of hormonal contraceptives and limited ability to attend to their concerns. Another limitation on the part of the health system is failure to recognize that women on hormonal contraceptives will respond as individuals and each woman will experience or not experience side effects as individuals. There is therefore need that health workers treat women as who, despite equal adverse events may perceive them either as tolerable or intolerable.

It is worth noting that biomedical data supporting the association between contraceptive (especially hormonal) use and reproductive tract cancers are controversial (Vanakankovit & Taneepanichskul, 2008; Dorjgochoo *et al*., 2009; Rosenblatt *et al*., 2009). Certainly, older and high dose contraceptives used in past decades, but no longer in use internationally, were associated with significant medical conditions. However, we speculate that the fact that some hormonal contraceptive use is associated with vaginal spotting (bleeding), a symptom of some reproductive tract cancers, may be confused as and causal association by the community. Furthermore, contraceptives use have been blamed for many other medical conditions such as sterilizing children, that it cannot be doubted that these myths are generated to dissuade others from use. From the contraceptive programmatic side however, these myths need identified, assessed and an effective intervention implemented.

Study participants reported delayed return of fertility as a significant concern in using hormonal contraception. This should not be surprising as the literature has previously reported on delayed return to fertility following hormonal contraceptive use (Speroff *et al*., 1989; Vessey *et al*., 1978). Childbearing is a valued experience in the country and anything that stands in its way, poses a challenge to personal and community existence.

Study participants perceived contraceptives as a tool that has potential to liberate women. Such tool, if it had to be used had to be used with the blessings of the male partners. The perception of men that women required to seek permission from them before using contraception is interesting and appears to be a barrier against (contraceptive) use among women who would not get the needed support of the partners. Chimbiri (2007) has reported that condom use was not preferred within marriage in rural Malawi; they have been construed as an “intruder” within such a relationship.

That study participants referred to God or religion as pro-creation and against contraceptive use is not surprising and not unique to Malawi. Some religions promote childbearing while discouraging contraceptives (Kridli & Newton, 2005; Mehryar *et al*., 2007; Degui *et al*., 2008; Hirsch, 2008; Doctor *et al*., 2009). It may therefore be beneficial to enrol the support of religious leaders and other community leaders who believe that contraceptive use is non incongruent with the will of God. Kaler (2004) has described how rural Malawian community attitudes towards condoms were weaved into the discourse of disease, coercive population control, and malevolence. Such a situation where condoms are associated with negative outcomes or processes could explanation, at least in part, the often negative attitude of condoms with marriage.

Condom use was perceived in our study as potentially useful in extramarital relations but not within marriage. As stated above, Chimbiri (2007) has reported that condom use was not preferred within marriage in rural Malawi; they have been construed as an “intruder” within such a relationship. Marchi *et al.* (2008) reported similar sentiments among men in Brazil where condoms were perceived to be useful for prevention of sexually transmitted infections in extra-conjugal relationships. Men did not consider that their spouse may also be involved in extra-conjugal relations where condoms may not have been used. The concern about condoms is not a rare concern as people in diverse settings have complained the possible limitations of pleasure when

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condoms are used. A purely biomedical approach to understanding this concern has not helped either. Crosby *et al.* (2008) have studied what they describe as "condom turn offs." In their study, more than three-quarters of the men and nearly 40% of the women reported decreased sexual sensation. The act of putting on a condom itself, or the smell of it was reported as turn-offs. Randolph *et al.* (2007) in a study of men and women who reported ever to have had penetrative vaginal sex t reported diminished sensation when the condom was used and acceptable sensation when the condom was not used. Philppott *et al*. (2006) have argued that sexual pleasure and safer sex need not be mutually exclusive. These authors have argued that it is possible to have safer and pleasurable sex at the same time.

Some workers have reported that of contraceptive use, specifically condom use as signalling a non-serious relationship, or a possibly unfaithful partner (Benefo, 2004; Tavory & Swidler, 2009). That study participants in the current study had similar view is therefore not surprising. Most of the perceptions reported in this study were obtained in diverse settings, i.e. rural and peri-urban, North, Centre and South as well as among individuals using contraceptives as among those not using. Due to the nature of the question guides, it is not possible to ascribe the responses to any particular group as holding those perceptions as people were allowed to report what other perceived. It is however important to note that study participants in the North, where virilocality and partnal inheritance is almost universal preferred stronger male influence than the Centre or the South.

Despite the fact that data were collected in all regions of the country with diverse cultures and traditions and a large number of FGDs were conducted, this study has a number of limitations. Firstly, data were self-reports within groups of similar sex or one-to-one interviews with key informants. To the extent that some study participants may have mis-reported either intentionally-perhaps as a manifestation of social desirability- or unintentionally, our interpretations may suffer a measure of bias. Although data were collected from at least one rural-remote area and periurban area, it is not clear to us how our findings can be compared with similar settings in other countries. This is because the definitions of urban or rural differ from country to country, and even within the same country, may differ from setting to settings (Muula, 2007). However, for our purposes, we found that knowledge and attitudes differed little by rural-urban difference. Finally, religion, an important determinant of contraceptive use in some settings, was not assessed.

Despite the negative perceptions and practices reported by study participants, it was also evident that knowledge about family planning and contraception was high. Much of the reports and opinions mirrored the "official" health education messages on family planning. Study participants reported that child spacing allowed children grow health, offered the mother opportunity "to regain strength" and allowed the uterus to recover before another pregnancy. Such recovery of the uterus would prevent rupture at subsequent delivery. Implied in these statements is the idea of child spacing being preferred rather than cessation of having pregnancies. Family planning was also seen as allowing women to engage in economic activities which would have been hindered if they were pregnant most of the times.

In order to improve the uptake of contraceptives and family planning in Malawi, it appears that more work is needed in order to recruit the support of the majority of males; however female friends were also not supportive, but female relations were. The support of female relation could be due to the intimate understanding with child bearing that most women have in comparison to men.

Adverse effects or side effects of contraceptive use experienced or imagined are potential barriers to contraceptive uptake or continuation. The general perception is that may be women do not have as much information about possible side effects as they should. It is also possible that women who had experienced significant side effects are more likely to report such experiences and decide, based on this, not to use and to discourage others from using contraceptives. The reports that women who had used contraceptives later ended up developing cancers need to be further investigated although it is possible that the experience was coincidental. Women who receive contraceptives should also be encouraged to receive pap smear for detection of cervical dysplasia

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(McFarlane *et al.*, 2008). They should also be screened for other gynaecological cancers. Much of the discussion on contraceptive revolved around injectable hormonal contraceptives as this is the most widely available contraceptive in the country. Having a wide range of contraceptives may obviate the need for health workers to have higher preference of some types of contraceptives over others.

Although Malawi has made significant strides in promoting modern contraceptive use and family planning, there still exist significant attitudinal and cultural impediments to widespread use within families. The concerns that condoms diminish pleasure during sex, side effects of hormonal and non-hormonal contraceptives, the quality of care within health clinics, the perceived role of women in society and social consequences of using contraceptives were identified as important among study participants. There should be innovative ways of addressing these individual and societal concerns, including myths, if the present gains in family planning must be consolidating and more new couples interested to consider family planning themselves. Finally, men are not always negative toward contraceptives but their concerns, just as those of women, must be recognized and attended to. Health care workers attending individual couples or women accessing reproductive health services including contraceptive will also be well prepared if they consider that different couples arrive at decisions different and men and women may differentially lead in decision making depending on the decision to be made

Authors' contributions

PRT conceived the study design, mobilized the data collection team and provided overall supervision to data collection, transcription and interpretation. PM participated in the data collection and analysis of the study. ASM participated in the analysis and interpretation of the findings. He also drafted the initial manuscript for comment and input by the other authors. All authors approved the final copy of the manuscript.

Competing interests

The authors declare that they have no competing interests.

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