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Contraceptive Conversations among Adolescent Girls and Young Women and their Partners, Peers, and Older Female Family Members in Lilongwe, Malawi: A Qualitative Analysis

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Abstract

In Sub-Saharan Africa, adolescent girls and young women (AGYW) have high levels of unmet need for contraception, particularly those who are unmarried or nulliparous. Conversations with partners, peers, and family members influence AGYW contraceptive decision-making yet little is known about conversation content and impact or how they vary by relationship status and parity. This paper draws on qualitative data from 60 AGYW (age 15–24) participating in a sexual and reproductive health study in Malawi to examine contraceptive conversation patterns among participants and their social ties. AGYW's relationship status and parity influenced whether they talked about contraceptives, who they talked to about contraceptives, and the type of

contraceptives that were endorsed during conversations. Unmarried and nulliparous AGYW were less likely to discuss contraceptives with all social ties and when conversations occurred, norms and misinformation regarding non-barrier methods were reinforced, and condoms were largely prescribed. Conversations with intimate partners often provided permission for contraceptive use while conversations with peers and older women in the family provided information on contraceptive methods. Our results highlight the unique roles that social ties play in AGYW contraceptive decision-making and suggest that existing contraceptive conversation patterns might exclude unmarried, nulliparous AGYW from accurate and comprehensive contraceptive information and options.

INTRODUCTION

Pregnancy and childbirth complications are the leading cause of death among adolescent girls and young women (AGYW)(World Health Organization 2020). The majority of pregnancies among AGYW, ages 15–24, occur in lower-middle income countries (LMICs) and the highest rates of early childbearing are found in sub-Saharan Africa (SSA) (World Health Organization 2020; Darroch et al. 2016). Among pregnancies to AGYW in SSA, more than 45% are reported as unintended or mistimed (Darroch et al. 2016; Ameyaw et al. 2019; Hubacher, Mavranezouli, and McGinn 2008). Unintended pregnancy largely reflects unmet need for reproductive healthcare such as access to and utilization of contraceptives (Ameyaw et al. 2019; Centers for Disease Control and Prevention 2018; Bellizzi, Palestra, and Pichierri 2019; Chandra-Mouli et al. 2014). Contraceptive use among AGYW in SSA is substantially lower than other LMIC regions and varies by age, relationship status, and parity (Blanc et al. 2009; Kalamar, Tunçalp, and Hindin 2018; Ahinkorah 2020). This scenario is particularly the case in Malawi, where 50% of AGYW have had a first child by age 19 and 45% report their pregnancies as unintended or mistimed. The proportion AGYW in Malawi using contraceptives is 15% for individuals ages 15–19 and 45% for individuals ages 20–24. Disaggregating contraceptive use by relationship status reveals that 20% of unmarried AGYW utilize contraceptives compared to 46% of married AGYW (National Statistical Office (NSO) and ICF Macro 2016). Similarly, only 5% of all nulliparous women were using any modern method as compared to 58% of all women who had a living child (National Statistical Office (NSO) and ICF Macro 2016). Taken together, these estimates underscore the urgent need to improve unintended pregnancy prevention efforts for AGYW in Malawi and illustrate the importance of engaging younger, unmarried, nulliparous AGYW in interventions to increase contraceptive use.

AGYW's contraceptive decision-making is complex and informed by individual, interpersonal, community, and structural factors (Chandra-Mouli et al. 2014; Blum, Mmari, and Development 2004). However, given that adolescence and young adulthood are developmental periods where individuals are still largely influenced by those around them, examining the role of AGYW's interpersonal context on contraceptive decision making is key (Umberson, Crosnoe, and Reczek 2010; Kotchick et al. 2001). During adolescence and young adulthood, sources of social influence often shift from family members to peers. In addition, early sexual activity and marriage, particularly in countries such as Malawi, expose young people to the beliefs and behaviors of their intimate partners and new family

members (National Statistical Office (NSO) and ICF Macro 2016). According to Social Networks Theory and Diffusion of Innovations Theory, communication is one of the primary mechanisms through which social ties influence health beliefs and behaviors (Valente and Pitts 2017; Valente 1995). In Malawi, few studies have examined the association between contraceptive communication and AGYW contraceptive use. Existing evidence suggests that conversations with intimate partners, peers, and older women in the family influence AGYW's decision to use contraception (Palamuleni 2017; Chipeta, Chimwaza, and Kalilani-Phiri 2010; Shattuck et al. 2011; Schwandt and Underwood 2013; Bhushan et al. 2021). However, the strength and nature of the conversations may vary by type of social tie, as well as marital status or parity.

To develop and improve interventions that encourage contraceptive communication between AGYW and their social ties, we must further understand challenges in discussing contraception; how conversations affect adolescents' contraceptive behaviors; and how conversations differ, in content and effect, across peers, intimate partners, and family members. Qualitative research can be particularly useful for understanding complex interpersonal interactions such as contraceptive conversations. Although qualitative research on the role of communication in contraceptive decision making exists in SSA at large, it has not to our knowledge been conducted in the context of AGYW contraceptive use in Malawi (Ochako et al. 2015; Capurchande et al. 2016; Krugu et al. 2016; Schuler, Rottach, and Mukiri 2011).

To address this gap, we qualitatively explored the nature of contraceptive conversations among AGYW enrolled in Girl Power, a sexual and reproductive health study conducted in Lilongwe, Malawi. We describe the challenges, content, and impact of contraceptive conversations between AGYW and their intimate partners, peers, and older female family members and discuss the implications of these communication patterns for future sexual and reproductive health interventions for this population.

METHODS

Study Context and Design

We conducted this qualitative study within the context of Girl Power-Malawi, a quasi-experimental study implemented across four health facilities in Lilongwe, Malawi between February 2016 and August 2017. We enrolled 1000 adolescent girls and young women (aged 15–24) and assessed them at three time points for uptake and adherence of sexual and reproductive health services as well as related health behaviors and health outcomes. Eligibility criteria include being 15–24 years old, residing in the clinic's catchment area, and willing to be enrolled for a one-year period (Rosenberg et al. 2017). We selected participants who were sexually active. Six months after enrollment, we purposively sampled sixty participants for individual in-depth interviews based on sexual and reproductive health service uptake and HIV status, factors which may influence contraceptive use and communication. From each of the four clinics, we recruited and enrolled 5 participants with low service uptake, 5 participants with high service uptake, and 5 HIV-positive participants. We assessed service uptake by a review of clinic and study visit logs. High service uptake participants were defined as those who adhered to the study schedule of care services in the

past 6 months. Low service uptake participants were defined as those who did not adhere to the study schedule of care services in the past six months. Individuals who consented were enrolled in the qualitative study and compensated for their participation and transport to interview location at the end of the interview.

Data Collection Procedures

We collected qualitative data collected from December 2016-Feburary 2017. One member of the study team developed a semi-structured interview guide which was then reviewed and revised for applicability and content validity by the principal investigator and three other study team members. Interview questions of interest for this qualitative study pertained to the context, content, and impact of contraceptive related conversations between AGYW and their sexual partners, peers, and older women in their families. Specific interview questions are listed in Table 1. We used neutral probes to gather detailed responses and elicit illustrative examples where necessary. This gave participants the chance to elaborate on information that they felt important to tell the interviewer. Two experienced Girl Power staff members conducted the interviews in Chichewa, the local language. The staff members met participants at their assigned health facility for interviews which lasted approximatively 60 minutes and were digitally recorded. Study staff used a transcription protocol to transcribe the interviews in Chichewa and then translate them into English. Staff members who conducted the interviews then reviewed the transcripts for transcription and translation accuracy. The National Health Science Research Committee in Malawi and the University of North Carolina at Chapel Hill Institutional Review Board provided approval for this study. We obtained voluntary written informed consent from AGYW 18–24 years old and assent and permission from the a parent, guardian, or authorized representative for AGYW 15–17 years old. All informed consent documents were read and discussed aloud in Chichewa and, in cases of limited literacy, an impartial witness was present.

Data Analysis

Four team members (NLB, TP, BM, DV) discussed the resulting qualitative transcripts and study objectives to develop a codebook. Subsequently, one co-author created an index of thematic codes which was independently reviewed and verified by the other team members. Each coder then then applied the deductive codes to three transcripts using QSR NVIVO (Version 10, Berlin, Germany). The study team reviewed the coded transcripts for gaps and redundancies and then accordingly revised the codebook. Two study team members then used the finalized codebook to independently code each of the 60 transcripts to ensure consistency in coding and assignment of the coded data to priority themes/categories. The team met to discuss discrepancies in the application of thematic codes. Coders used consensus to resolve areas of disagreement and subsequently achieved satisfactory agreement (Cohen’s Kappa = 0.83).

We used content analysis to analyze the qualitative data based on emerging themes and sub-themes in line with the analytic objectives (Krippendorff 2018; Hsieh and Shannon 2005). We then examined the results of the coding process across participants and synthesized the information using analytical matrices. We structured the matrices so we could compare emerging themes and codes within and between participants, their marital status, and parity.

The study team reviewed final results and quotes within the context of the full interview transcripts to make sure they were interpreted appropriately.

RESULTS

Participant Characteristics

Table 2 describes the characteristics of all 60 participants at their baseline visit. Approximately half were 20–24 years old (N=32, 53%), most were unmarried (N=43, 72%,) and had completed primary school (N=51, 85%). The majority of participants indicated that they had a primary sexual partner (N= 50, 83%) but few were cohabitating with a partner (N=11, 18%).

More than half of all participants reported a previous pregnancy (N=35, 58%) and among those, 11% wanted to be pregnant at the time (N=4), 66% wanted to wait (N=23), 23% percent didn't want the child (N=8). When asked about the chances of pregnancy in the next year, the majority of participants reported no chance of pregnancy (N=42, 70%). Nearly half of all participants had one living child (N=28, 46%) and the median number of ideal lifetime children was 3 (IQR 2–3).

Among the 58 women who had ever utilized any type of contraceptive, 95% (N=55) had used condoms and 43% (N=25) had used a non-barrier modern method (pills, injections, intrauterine devices, or implants). Contraceptive communication varied by social tie. The largest proportion of women had spoken with their peers about contraceptives (N=39, 65%), followed by partners (N=32, 53%) and then older women in their family (N=26, 43%).

Barriers to Contraceptive Conversations

Participants' barriers to having contraceptive conversations were similar across social ties. However, they were largely dependent on the participant's relationship status and childbearing experience. Women who were single and had never given birth experienced the most significant barriers to discussing contraceptives.

Contraceptive Use Signifies Engagement in Sexual Activity—A primary concern was the assumption that discussing contraceptive use with any social tie would signify sexual activity. With older women and peers, participants who were single or who had never had children feared assumptions of promiscuity, accusations of prostitution, and general disclosure of sexual activity by bringing up the topic of contraceptives:

> "No. I can be free with my sister but not with my parents or other people because they can be surprised as to why I want to be practicing such things… If I can approach them, they can think that I am being promiscuous."
>
> (Single, Age 21, Used Family Planning, No Children)

> "No, we don't discuss as friends. I am afraid of what they will think if I say such things when I have not been married. Each one knows what she is doing on her own. Maybe they are ashamed because people say that when you are on family

> planning it means you are involved in sexual behavior. So, they are ashamed to be known that they do sexual intercourse."
>
> (Single, Age 15, Never Used Family Planning, No Children)

With intimate partners, participants feared that discussing contraceptives would signify multiple sexual partners. This fear was most pronounced for participants in non-marital relationships.

> "I am afraid that if I talk to him [my partner] about that I may give him ideas that I have a relationship with another person and he would be angry"
>
> (Single, Age 19, Never Used Family Planning, No Children)

> He doesn't know I am [using a] contraceptive method because if I can tell him, he can be thinking that I have other partners besides him.
>
> (Divorced, Age 23, Used Family Planning, 1 Child)

Cultural Norms—Participants described concerns related to cultural norms about contraceptive use. Many mentioned that in Malawian culture, it is understood that non-barrier methods are not for young, unmarried women or for women who haven't given birth. These norms were rooted in the importance of fertility for womanhood, myths associating non-barrier methods and infertility, and beliefs that non-barriers methods are only for birth spacing. The perception that older women subscribed to these norms made young girls, particularly those who were not married or had not given birth, hesitant to initiate conversations with older women:

> "Mostly, with the older people I still have my reservations because I see that they are not my level, so I am just afraid because I do not know where to start from with talking. I know they think contraceptives should be taken by people, who have already given birth and it is not good for someone who has not given birth, it can bring you problems in future, and sometimes you can even not give birth, apparently it freezes you and causes infertility. They will think that even if I want to be knowing about some methods that are not condoms"
>
> (Single, Age 16, Never Used Family Planning, No Children)

This was echoed by another young women who did not feel comfortable discussing non-barrier methods with her mother:

> "Because my mum says that family planning is not for young people like me who haven't had children yet. She is also embarrassed to talk to me about these kinds of things. I get most of this information from the people who live close to my house"
>
> (Single, Age 17, Never Used Family Planning, No Children)

Participants reported being excluded from contraceptive conversations with peers due to norms regarding who should be utilizing contraceptives:

> "I have the friends, but they too, have never discussed family planning with me. They see that I don't have a husband and that's why they don't discuss family planning with me.
>
> (Single, Age 20, Never Used Family Planning, No Children)

Similarly, perceiving that an intimate partner, particularly an older partner, subscribed to prevalent contraceptive norms made it difficult for participants to initiate a conversation concerning non-barrier methods.

> "I do not talk to my partner because most men have a negative attitude towards family planning methods, especially towards girls who have never given birth before. They say family planning is not good because it damages you somehow. It seems men look at family planning negatively because their aim is to impregnate girls. I think it's not correct [the information men have], because it's not all the time that it'd damage you internally. It just depends on your body type and how your body would respond to the contraceptives."
>
> (Single, Age 17, Never Used Family Planning, No Children)

Negative Reactions—Participants hesitated to discuss contraceptives with social ties due to fears of negative reactions. With older women, there was a heightened fear that initiating contraceptive conversations could lead to consequences such as changes in housing and care, refusal of financial support, and disclosure of contraceptive use to parents:

> "But I don't talk to older people like my parents. My parents, no, I don't talk to them, we have never talked about it, they would be very upset. I can't tell her [my mother] that or talk to her about these problems because she can either shout at me or kick me out of her house."
>
> (Single, Age 20, Never Used Family Planning, No Children)

With peers, there was a fear that discussing contraceptives might lead to social exclusion or that their disclosures might turn into gossip:

> "Ok I don't talk with them because I may be a subject of ridicule and they would not be my friends…Most girls are not trustworthy, they would start telling everyone about you and then they would even tell my mom."
>
> (Single, Age 18, Never Used Family Planning, No Children)

With partners, participants worried that they may appear presumptuous if conversations about children were brought up too early in a relationship. They also expressed fear that a partner's negative reaction could result in a violent outburst.

> "No, we have never talked about it. Because I do not tell him. I am scared that 'mmm, if I tell him maybe he will think of other things'. So, I am scared that 'mmm, how will I start telling him?' What am I scared of? I am not scared

of anything, but I feel that maybe he will not like it, he will be angry and do something.

(Single, Age 17, Used Family Planning, 1 Child)

Conversation Content and Impact on Contraceptive Behavior

The content and impact of contraceptive conversations varied by type of social tie. Conversations with older women in the family and peers focused on the benefits and barriers of general contraceptive use and which method might be best suited for an individual based on their relationship status, childbearing history, and body. Conversations with intimate partners provided implicit approval or refusal for contraceptive use and focused on the need for contraceptive use within the relationship.

Conversations with Peers—Conversations with peers were largely embedded within discussions of their intimate partner relationships. Peers began by sharing stories of previous experiences, current relationship issues, or anticipated sexual encounters.

Supportive contraceptive conversations with peers primarily occurred between contraceptive users and their friends and focused on the benefits and barriers of general contraceptive use as well as different types of methods. They described the need to avoid unwanted pregnancy to stay in school, limit population growth, and space the birth of future children. Contraceptive users also talked to their friends about the side of effects of using Depo-Provera, the burden of taking birth control pills every day, concerns about long and short menstrual periods due to the implant, and the benefits of using long-acting methods such as the loop. When asked if they trusted the information they received from friends, participants overwhelmingly replied that they weren't sure if everything they heard was correct:

"I really do not know what is the truth about what we talk about. Everyone is saying something. I do not know what is in their hearts. I have used contraceptives before, but I do not know how it will affect my fertility in future."

(Single, Age 19, Used Family Planning, No Children)

Non-supportive contraceptive conversations with peers most often occurred between contraceptive non-users and their friends. These conversations focused on overall contraceptive use and their related apprehensions. For example, many participants reported that non-barrier contraceptives cause infertility which was described as "freezing you", "burning or destroying the uterus", and "making the blood cold". They also cited concerns about being labeled as a "bad girl" or "that kind of girl" which was in reference to norms sanctioning contraceptives only for married women who have given birth. Non-users more frequently told their friends that condoms would be the easiest to use as no device or medicine would be put into the body or "stuck in the womb". Conversations about contraceptive related infertility and contraceptive social norms reinforced decisions to not use contraceptives among unmarried participants who hadn't given yet birth:

"It [friend's opinions] has affected me heavily because I may decide to use the family planning methods with my partner and a friend can come and say 'well if you use the methods you may not be able to have children in your life'. That may

> affect you because when you chose to use the methods and you have permission to method you knew that when you do that you won't be able to have children because you are still in school and you already considered that when you use the methods you will be able to finish school but because someone has come with these ideas you might decide to follow what they have said instead. So many times I am discouraged."
>
> (Single, Age 20, Never Used Family Planning, No Children)

Conversations with Older Women in the Family—Conversations with older women in the family were infrequent. When they occurred, they were shaped by the participants' relationship status and reproductive history. AGYW who were single or without children only spoke to aunties, neighbors, and older sisters while those who were married or had children additionally spoke to mothers and grandmothers. If participants spoke with older women in their lives about contraceptives, the content and impact of conversations were described positively and often encouraged contraceptive use. Among those had previously given birth, mothers and grandmothers stressed the importance of using contraceptives to either limit or space future births:

> "Soon after I gave birth my grandmother encouraged me to go back to school and to start using family planning because she said if went to school without using family planning I would get another pregnancy…when I am talking to my grandmother it's like we are chatting, and also my pregnancy was a burden to her so she never wants me to get unplanned pregnancy again."
>
> (Single, Age 17, Used Family Planning, 2 Children)

Among participants who had never had children, older women (aunties, neighbors, older women) in their lives shared stories of their own contraceptive and pregnancy experiences. Participants described trusting these older women because they "had lived" or "knew life" and could point to children they did or did not have as examples of their intentional contraceptive choices. Older women also discussed the type of contraceptive methods they had utilized and related advantages and disadvantages. Young women felt cared for and encouraged by older women and trusted the information they received.

> "Yes, my mother. She is the one who advised me to use family planning so that I should not fall pregnant very soon. My two sisters (they are adults, one has four children and the other one has three children). They tell me that family planning methods are good because you don't really get pregnant. But when you are using the condoms, the condoms can have a hole so you should be using a family planning method, that is what they told me. So I used that and that is why I come for the injection and I am not even discouraged"
>
> (Single, Age 16, Used Family Planning, 1 Child)

Intimate Partners—Contraceptive conversations with intimate partners often provided permission for contraceptive use. Almost all participants mentioned speaking to their partners before they began using contraceptives. Even the small proportion of participants

who started using contraception before disclosing mentioned that eventual discussion with their partner made them feel relieved to have their partner's support:

> "It (the conversation) encourages me that anytime I want to be on a family planning method, I'm free to do that. Because there are other boyfriends who when you're taking contraceptives, they do not agree with that, they do not allow you, then you do not do it. Where my boyfriend does not have any problem with that, he has told me. I don't have any problem, any time I want to take contraceptives, I'm free to do so… Because he encourages me a lot. So, I'm supposed to be doing that."
>
> (Single, Age 22, Used Family Planning, No Children)

The content and impact of supportive contraceptive conversations with partners varied by relationship status, the couple's shared childbearing experience, and the age of the male partner. Participants with long-term partners, husbands, and older partners reported partner concerns about the financial burden of raising children, interest in giving their current children proper care, and avoiding the maternal health consequences of multiple births. Participants who had previously given birth felt comfortable bringing up the topic of contraception and mentioned that their husbands often reminded them of their upcoming family planning appointments.

> "My husband engages the topic. At the end of our conversations we agree on one thing. To use family planning. Yes, we plan together at home where it is private. It is serious."
>
> (Married, Age 23, Used Family Planning, No Children)

Participants with boyfriends, casual partners, and younger partners reported partner concerns about the possibility of being forced into marriage due to pregnancy, having to drop out of school, and the negative social consequences of exposing an extramarital affair. Contraceptive conversations with these types of partners were often initiated by partners and included sharing stories of friends who had unintended pregnancies or recently tested positive for STIs/HIV and ended with partners emphasizing the desire to avoid these outcomes. In addition, some participants reported that these types of partners encouraged contraceptive use after they terminated a previous pregnancy:

> "He was also one of the people who encouraged me to do it. Because at that time it just happened that I got pregnant. I got pregnant, but then it was hard for me to keep the pregnancy. When I got the pregnancy terminated, he encouraged me to say, 'now for us not to have a problem again you need to start using the depo.'"
>
> (Single, Age 21, Used Family Planning, 1 Child)

The content and impact of non-supportive contraceptive conversations with partners were rooted in beliefs that contraceptive use may impact the couple's ability to have a child in the future. Partners often said that condoms were for "girls" or those who are "young" and other methods were for "women" who had already given birth. Participants described having discussions with their partners where they refused the use of any non-barrier methods:

> "Yes. He let me just say my boyfriend refuses, he says I am still a young girl and you are not supposed to be on any contraceptive methods. So, I tell him

> that sometimes you get carried away and say that we will not use a condom, I can get pregnant unexpectedly. Sometimes he understands but sometimes he still refuses. He tells me that sometimes you might struggle to get pregnant, because the injection may cause you to have a late pregnancy and I cannot have a child"
>
> (Single, Age 20, Never Used Family Planning, No Children)

Participants mentioned their partners' desire for, or the previous occurrence of, unprotected sex as an opportunity to discuss what method might be best for the couple. Participants tried to stress the importance of condoms if partners were skeptical of non-barrier methods or non-barrier methods if partners refused to use condoms. However, refusals often discouraged participants from continuing to discuss or use contraception:

> "Ok my boyfriend too, he cannot understand that choice. Yes I tried talking to him but whatever I said did not hold water to him. I just felt like I have wasted my effort talking to him he just asked me to forget about it. Um no he did not agree with me and I do not use [family planning]."
>
> (Single, Age 18, Never Used Family Planning, No Children)

DISCUSSION

We found that AGYW's decision to use contraception was influenced by the reproductive health conversations they had with their intimate partners, peers, and older women in their families. Though the content and impact of these conversations varied by type of social tie as well as the relationship status and parity of the AGYW, barriers to contraceptive conversations remained largely the same: cultural norms, fear of negative reactions, and an implied association between contraceptive use and proscribed behavior. Below, we discuss these patterns in depth and implications for future reproductive health related research and interventions.

AGYW who were unmarried and had not yet given birth were often hesitant to discuss contraception with their social ties. Among AGYW who were unmarried, the hesitation to discuss contraception was due to the implication that using contraception meant being sexually active. In Malawi, sexual activity before marriage, though common, is considered taboo (Bobel et al. 2020; Munthali, Chimbiri, and Zulu 2004; National Statistical Office (NSO) and ICF Macro 2016; Sunny et al. 2019). Studies among AGYW in other countries in SSA have similarly found that unmarried AGYW are unlikely to initiate conversations related to sexual health for similar associations with sexual activity and fears of being labeled as a "bad girl" or "immoral" (Hall et al. 2018; Krugu et al. 2016; Muhwezi et al. 2015; Melaku et al. 2014). Given that contraceptive-related communication is a predictor of contraceptive use, future research should explore strategies to decrease communication barriers between unmarried, nulliparous AGYW and their social ties.

Among AGYW who had not yet given birth, the hesitation to discuss contraception was also due to prevailing social norms and misconceptions surrounding fertility and non-barrier

methods. In Malawi and other countries in SSA, proving one's fertility is linked to gaining status and acceptance as a woman in society (Kaphagawani and Kalipeni 2017; Wood and Jewkes 2006; Munakampe, Zulu, and Michelo 2018). This norm is reflected in the prescription of only condoms for nulliparous women due to misconceptions that using non-barrier methods can lead to infertility, prolonged mensuration, and uterine cancer (Chipeta, Chimwaza, and Kalilani-Phiri 2010; Chandra-Mouli et al. 2014; Nalwadda et al. 2010; Gueye et al. 2015). Strategies that modify existing social norms and dispel misconceptions related to non-barrier methods might be particularly useful (Chipeta, Chimwaza, and Kalilani-Phiri 2010; Palamuleni 2013; Shattuck et al. 2011; Schwandt and Underwood 2013; Bhushan et al. 2021).

AGYW's relationship status and parity impacted the types of peers and older women in the family they talked to about contraception and the types of contraception that were endorsed during conversations. Conversations often occurred with individuals who shared the same relationship status or childbearing history and covered either only condom use and or all types of contraceptive methods. Studies among women in Mali and Kenya have similarly found that individuals had a considerable preference for homophilous ("women like me") conversation partners and that their contraceptive choices often reflected those of their social network members (Behrman, Kohler, and Watkins 2002; Kohler, Behrman, and Watkins 2001; Madhavan and Adams 2003). Beyond reinforcing social norms and contraceptive misconceptions, these communication patterns potentially inhibit the spread of reproductive health knowledge and non-barrier method related information to unmarried, nulliparous AGYW. Interventions that seek to increase contraceptive uptake through peer opinion leaders or other social network-based communication strategies should attempt to ensure that this vulnerable population is being reached.

Intimate partners, peers, and older women in the family each played different roles during contraceptive conversations. Conversations with intimate partners often provided approval for contraceptive use while conversations with peers and older women in the family provided information on contraceptive methods and helped AGYW decide which method was best for them. This distinction might partially explain why contraceptive-related interventions that exclude male partners and solely engage peer influence, family communication, and educational strategies are found to have mixed results (Speizer, Magnani, and Colvin 2003; Mwaikambo et al. 2011; Gottschalk and Ortayli 2014). Even if AGYW perceive that their family and peers support contraceptive use, contraceptive uptake may continue to be unchanged if AGYW do not feel as if they have the approval from their partners. Encouragingly, we did find that partners were often supportive of contraceptive use for a variety of reasons: avoiding marriage due to pregnancy, avoiding school dropout due to pregnancy, avoiding negative social consequences of exposing an extramarital affair, spacing the birth of future children, and concerns related to the financial burden of children. Given that partners were influential in all relationship types (i.e. casual and long-term) and that fear of violence inhibited AGYW from having conversations with them, interventions must provide AGYW with the space or skills to effectively and safely communicate with their partners and advocate for their reproductive health needs. In addition, engaging men in interventions that counter existing gender imbalances in family planning decision making

and emphasize how they benefit from their female partner's contraceptive use might be particularly effective.

Though conversations with older women in the family were infrequent, AGYW reported that they trusted information from these women more than from their peers or intimate partners. Older women in the family were deemed as trustworthy because of their inherent concern for the well-being of the AGYW or their life experience with marriage and childbearing. Previous studies in SSA have found that infrequent communication between older women in the family and AGYW is often due to discomfort and lack of sexual education on the part of the adult and apprehension on the part of the AGYW (Muhwezi et al. 2015; Baku et al. 2018; Rasch et al. 2000; Adeyemo and Brieger 1994; Kumi-Kyereme et al. 2007; Biddlecom, Awusabo-Asare, and Bankole 2009). Interventions that equip older women (i.e., aunties, older sisters, trusted community health workers, and others) to effectively and accurately discuss reproductive health could potentially improve contraceptive use among AGYW.

This study has several important limitations. First, with a purposively selected sample, our findings cannot be generalized to a wider population. As AGYW were sampled from peri-urban clinics in Lilongwe, we cannot say to what extent these findings represent experiences of AGYW in other regions of the country, particularly rural regions, or those not reached by a health intervention. The purpose of these interviews was not to produce generalized findings, but rather to describe in depth the experiences of AGYW in this setting. Second, participants were enrolled in a study in which some received youth friendly services and small-group behavioral sessions that addressed contraceptive communication, and their impression of contraception or reporting of contraceptive-related discussions with their social ties may have been influenced by study interventions or reflect social desirability. Third, we only asked about the contraceptive related conversations among AGYW and their intimate partners, peers, and older women in their family. There are might have been other important communication sources that were not captured such as health care workers and teachers. In addition, we only interviewed AGYW and not the social network members they discussed. Given that communication inherently involves another party, their perspective on these findings is missed. Fourth, one third of our sample were young women living with HIV and this health condition might have impacted their contraceptive decision making. We compared contraceptive communication patterns by HIV status and found patterns to be largely the same. However, it is possible that by not directly asking about the impact of HIV on contraception communication and uptake, we missed important information. Finally, the transcripts were translated from Chichewa to English and as with any translation, there was undoubtedly some level of information and understanding that was lost during the translation process. To minimize information loss, transcripts were reviewed by the two research officers, (TP and LK) who conducted the interviews for transcription and translation accuracy as they were fluent in Chichewa and English present for the interviews.

CONCLUSION

Many reproductive health interventions treat AGYW as a homogenous group, overlooking the needs of unmarried, nulliparous individuals, who are at highest risk for unintended

pregnancy. Our results suggest that conversations with social ties do influence AGYW's contraceptive decision-making, and existing contraceptive-related communication patterns might additionally exclude this vulnerable group from accurate and comprehensive reproductive health information. Future reproductive health interventions that utilize communication-based strategies to increase contraceptive use must reach unmarried, nulliparous AGYW and attempt to engage intimate partners, peers, and older female family members in their activities.

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DATA AVAILIBILTY

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

REFERENCES

Adeyemo MO, and Brieger WR. 1994. "Dissemination of Family Life Education to Adolescents by Their Parents in Suburban Ibadan, Nigeria." International Quarterly of Community Health Education 15 (3): 241–52. 10.2190/5D3N-J0DF-YDM5-JE2D. [PubMed: 20841242]

Ahinkorah Bright Opoku. 2020. "Predictors of Modern Contraceptive Use among Adolescent Girls and Young Women in Sub-Saharan Africa: A Mixed Effects Multilevel Analysis of Data from 29 Demographic and Health Surveys." Contraception and Reproductive Medicine 5 (1): 32. 10.1186/s40834-020-00138-1. [PubMed: 33292675]

Ameyaw Edward Kwabena, Budu Eugene, Sambah Francis, Baatiema Linus, Appiah Francis, Seidu Abdul-Aziz, and Ahinkorah Bright Opoku. 2019. "Prevalence and Determinants of Unintended Pregnancy in Sub-Saharan Africa: A Multi-Country Analysis of Demographic and Health Surveys." PLoS ONE 14 (8). 10.1371/journal.pone.0220970.

Baku Elizabeth AKu, Agbemafle Isaac, Kotoh Agnes Millicent, and Adanu Richard MK. 2018. "Parents' Experiences and Sexual Topics Discussed with Adolescents in the Accra Metropolis, Ghana: A Qualitative Study." Advances in Public Health 2018.

Behrman Jere R., Kohler Hans-Peter, and Watkins Susan Cotts. 2002. "Social Networks and Changes in Contraceptive Use over Time: Evidence from a Longitudinal Study in Rural Kenya." Demography 39 (4): 713–38. [PubMed: 12471851]

Bellizzi Saverio, Palestra Francesca, and Pichierri Giuseppe. 2019. "Adolescent Women with Unintended Pregnancy in Low- and Middle-Income Countries: Reasons for Discontinuation of Contraception." Journal of Pediatric and Adolescent Gynecology, 11. 10.1016/j.jpag.2019.11.004.

Bhushan Nivedita L., Fisher Edwin B., Maman Suzanne, Speizer Ilene S., Gottfredson Nisha C., Phanga Twambilile, Vansia Dhrutika, Pettifor Audrey E., and Rosenberg Nora E.. 2021. "Communication, Social Norms, and Contraceptive Use among Adolescent Girls and Young Women in Lilongwe, Malawi." Women & Health 61 (5): 440–51. 10.1080/03630242.2021.1917479. [PubMed: 33941050]

Biddlecom Ann, Awusabo-Asare Kofi, and Bankole Akinrinola. 2009. "Role of Parents in Adolescent Sexual Activity and Contraceptive Use in Four African Countries." International Perspectives on Sexual and Reproductive Health 35 (2): 72–81. [PubMed: 19620091]

Blanc Ann K., Tsui Amy O., Croft Trevor N., and Trevitt Jamie L.. 2009. “Patterns and Trends in Adolescents’ Contraceptive Use and Discontinuation in Developing Countries and Comparisons with Adult Women.” International Perspectives on Sexual and Reproductive Health 35 (2): 63–71. 10.1363/ipsrh.35.063.09. [PubMed: 19620090]

Blum Robert W., Mmari Kristin Nelson, and World Health Organization Dept of Child and Adolescent Health and Development. 2004. “Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries : An Analysis of Adolescent Sexual and Reproductive Health Literature from around the World : Summary.” http://www.who.int/iris/handle/10665/43045.

Bobel Chris, Winkler Inga T., Fahs Breanne, Hasson Katie Ann, Kissling Elizabeth Arveda, and Roberts Tomi-Ann. 2020. “The Palgrave Handbook of Critical Menstruation Studies.”

Capurchande Rehana, Coene Gily, Schockaert Ingrid, Macia Manuel, and Meulemans Herman. 2016. “‘It Is Challenging… Oh, Nobody Likes It!’: A Qualitative Study Exploring Mozambican Adolescents and Young Adults’ Experiences with Contraception.” BMC Women’s Health 16 (1): 48. 10.1186/s12905-016-0326-2. [PubMed: 27475909]

Centers for Disease Control and Prevention. 2018. “Prevent Unintended Pregnancy.” 10 4, 2018. https://www.cdc.gov/sixeighteen/pregnancy/index.htm.

Chandra-Mouli Venkatraman, McCarraher Donna R, Phillips Sharon J, Williamson Nancy E, and Hainsworth Gwyn. 2014. “Contraception for Adolescents in Low and Middle Income Countries: Needs, Barriers, and Access.” Reproductive Health 11 (January): 1. 10.1186/1742-4755-11-1. [PubMed: 24383405]

Chipeta Effie K., Chimwaza Wanangwa, and Kalilani-Phiri Linda. 2010. “Contraceptive Knowledge, Beliefs and Attitudes in Rural Malawi: Misinformation, Misbeliefs and Misperceptions.” Malawi Medical Journal 22 (2). https://www.ajol.info/index.php/mmj/article/view/58790.

Darroch Jacqueline E., Woog Vanessa, Bankole Akinrinola, Ashford Lori S., and Points K. 2016. “Costs and Benefits of Meeting the Contraceptive Needs of Adolescents.” Guttmacher Institute.

Gottschalk Lindsey B., and Ortayli Nuriye. 2014. “Interventions to Improve Adolescents’ Contraceptive Behaviors in Low- and Middle-Income Countries: A Review of the Evidence Base.” Contraception 90 (3): 211–25. 10.1016/j.contraception.2014.04.017. [PubMed: 24916724]

Gueye Abdou, Speizer Ilene S., Corroon Meghan, and Okigbo Chinelo C.. 2015. “Belief in Family Planning Myths at the Individual And Community Levels and Modern Contraceptive Use in Urban Africa.” International Perspectives on Sexual and Reproductive Health 41 (4): 191–99. 10.1363/4119115. [PubMed: 26871727]

Hall Kelli Stidham, Manu Abubakar, Morhe Emmanuel, Dalton Vanessa K., Challa Sneha, Loll Dana, Dozier Jessica L., Zochowski Melissa K., Boakye Andrew, and Harris Lisa H.. 2018. “Bad Girl and Unmet Family Planning Need among Sub-Saharan African Adolescents: The Role of Sexual and Reproductive Health Stigma.” Qualitative Research in Medicine & Healthcare 2 (1): 55–64. 10.4081/qrmh.2018.7062. [PubMed: 30556052]

Hsieh Hsiu-Fang, and Shannon Sarah E.. 2005. “Three Approaches to Qualitative Content Analysis.” Qualitative Health Research 15 (9): 1277–88. [PubMed: 16204405]

Hubacher David, Mavranezouli Ifigeneia, and McGinn Erin. 2008. “Unintended Pregnancy in Sub-Saharan Africa: Magnitude of the Problem and Potential Role of Contraceptive Implants to Alleviate It.” Contraception 78 (1): 73–78. 10.1016/j.contraception.2008.03.002. [PubMed: 18555821]

Kalamar Amanda M., Tunçalp Özge, and Hindin Michelle J.. 2018. “Developing Strategies to Address Contraceptive Needs of Adolescents: Exploring Patterns of Use among Sexually Active Adolescents in 46 Low-and Middle-Income Countries.” Contraception 98 (1): 36–40. [PubMed: 29550455]

Kaphagawani Nanzen Caroline, and Kalipeni Ezekiel. 2017. “Sociocultural Factors Contributing to Teenage Pregnancy in Zomba District, Malawi.” Global Public Health 12 (6): 694–710. 10.1080/17441692.2016.1229354. [PubMed: 27687242]

Kohler Hans-Peter, Behrman Jere R., and Watkins Susan C.. 2001. “The Density of Social Networks and Fertility Decisions: Evidence from South Nyanza District, Kenya.” Demography 38 (1): 43–58. 10.1353/dem.2001.0005. [PubMed: 11227844]

Kotchick Beth A., Shaffer Anne, Miller Kim S., and Forehand Rex. 2001. “Adolescent Sexual Risk Behavior: A Multi-System Perspective.” Clinical Psychology Review 21 (4): 493–519. [PubMed: 11413865]

Krippendorff Klaus. 2018. Content Analysis: An Introduction to Its Methodology. Sage publications.

Krugu JK, Mevissen FEF, Prinsen A, and Ruiter RAC. 2016. “Who’s That Girl? A Qualitative Analysis of Adolescent Girls’ Views on Factors Associated with Teenage Pregnancies in Bolgatanga, Ghana.” Reproductive Health 13 (1): 39. 10.1186/s12978-016-0161-9. [PubMed: 27080996]

Kumi-Kyereme Akwasi, Kofi Awusabo-Asare Ann Biddlecom, and Tanle Augustine. 2007. “Influence of Social Connectedness, Communication and Monitoring on Adolescent Sexual Activity in Ghana.” African Journal of Reproductive Health 11 (3): 133–49.

Madhavan Sangeetha, and Adams Alayne. 2003. “Women’s Networks and the Social World of Fertility Behavior.” International Family Planning Perspectives 29 (2): 58–68. 10.1363/ifpp.29.058.03. [PubMed: 12783769]

Melaku Yohannes Adama, Berhane Yemane, Kinsman John, and Reda Hailemariam Lemma. 2014. “Sexual and Reproductive Health Communication and Awareness of Contraceptive Methods among Secondary School Female Students, Northern Ethiopia: A Cross-Sectional Study.” BMC Public Health 14 (March): 252. 10.1186/1471-2458-14-252. [PubMed: 24628909]

Muhwezi Wilson Winstons, Anne Ruhweza Katahoire Cecily Banura, Mugooda Herbert, Kwesiga Doris, Bastien Sheri, and Klepp Knut-Inge. 2015. “Perceptions and Experiences of Adolescents, Parents and School Administrators Regarding Adolescent-Parent Communication on Sexual and Reproductive Health Issues in Urban and Rural Uganda.” Reproductive Health 12 (November). 10.1186/s12978-015-0099-3.

Munakampe Margarate Nzala, Zulu Joseph Mumba, and Michelo Charles. 2018. “Contraception and Abortion Knowledge, Attitudes and Practices among Adolescents from Low and Middle-Income Countries: A Systematic Review.” BMC Health Services Research 18 (1): 909. 10.1186/s12913-018-3722-5. [PubMed: 30497464]

Munthali Alister, Chimbiri Agnes, and Zulu Eliya. 2004. “Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence.”

Mwaikambo Lisa, Speizer Ilene S., Schurmann Anna, Morgan Gwen, and Fikree Fariyal. 2011. “What Works in Family Planning Interventions: A Systematic Review of the Evidence.” Studies in Family Planning 42 (2): 67–82. [PubMed: 21834409]

Nalwadda Gorrette, Mirembe Florence, Byamugisha Josaphat, and Faxelid Elisabeth. 2010. “Persistent High Fertility in Uganda: Young People Recount Obstacles and Enabling Factors to Use of Contraceptives.” BMC Public Health 10 (1): 530. 10.1186/1471-2458-10-530. [PubMed: 20813069]

National Statistical Office (NSO), and ICF Macro. 2016. “Malawi Demographic Health Survey 2015–16.” Zomba, Malawi and Calverton, MD: NSO and ICF Macro.

Ochako Rhoune, Mbondo Mwende, Aloo Stephen, Kaimenyi Susan, Thompson Rachel, Temmerman Marleen, and Kays Megan. 2015. “Barriers to Modern Contraceptive Methods Uptake among Young Women in Kenya: A Qualitative Study.” BMC Public Health 15 (1): 118. 10.1186/s12889-015-1483-1. [PubMed: 25884675]

Palamuleni Martin E. 2013. “Socio-Economic and Demographic Factors Affecting Contraceptive Use in Malawi.” African Journal of Reproductive Health 17 (3): 91–104. [PubMed: 24069771]

———. 2017. “Trends and Determinants of Contraceptive Use among Female Adolescents in Malawi.”

Rasch V, Silberschmidt M, Mchumvu Y, and Mmary V. 2000. “Adolescent Girls with Illegally Induced Abortion in Dar Es Salaam: The Discrepancy between Sexual Behaviour and Lack of Access to Contraception.” Reproductive Health Matters 8 (15): 52–62. [PubMed: 11424268]

Rosenberg Nora E., Pettifor Audrey E., Myers Laura, Phanga Twambilile, Marcus Rebecca, Bhushan Nivedita Latha, Madlingozi Nomtha, et al. 2017. “Comparing Four Service Delivery Models for Adolescent Girls and Young Women through the ‘Girl Power’ Study: Protocol for a Multisite Quasi-Experimental Cohort Study.” BMJ Open 7 (12): e018480. 10.1136/bmjopen-2017-018480.

Schuler Sidney R., Rottach Elisabeth, and Mukiri Peninah. 2011. "Gender Norms and Family Planning Decision-Making in Tanzania: A Qualitative Study." Journal of Public Health in Africa 2 (2). 10.4081/jphia.2011.e25.

Schwandt Hilary M., and Underwood Carol. 2013. "Making a Difference in Adult–Child Relationships: Evidence from an Adult–Child Communication Intervention in Botswana, Malawi, and Mozambique." Journal of Adolescence 36 (6): 1177–86. 10.1016/j.adolescence.2013.09.005. [PubMed: 24215964]

Shattuck Dominick, Kerner Brad, Gilles Kate, Hartmann Miriam, Ng'ombe Thokozani, and Guest Greg. 2011. "Encouraging Contraceptive Uptake by Motivating Men to Communicate About Family Planning: The Malawi Male Motivator Project." American Journal of Public Health 101 (6): 1089–95. 10.2105/AJPH.2010.300091. [PubMed: 21493931]

Speizer Ilene S, Magnani Robert J, and Colvin Charlotte E. 2003. "The Effectiveness of Adolescent Reproductive Health Interventions in Developing Countries: A Review of the Evidence." Journal of Adolescent Health 33 (5): 324–48. 10.1016/S1054-139X(02)00535-9.

Sunny Bindu S., DeStavola Bianca, Dube Albert, Price Alison, Kaonga Allan M., Kondowe Scotch, Crampin Amelia C., and Glynn Judith R.. 2019. "Lusting, Learning and Lasting in School: Sexual Debut, School Performance and Dropout among Adolescents in Primary Schools in Karonga District, Northern Malawi." Journal of Biosocial Science 51 (5): 720–36. [PubMed: 31030681]

Umberson Debra, Crosnoe Robert, and Reczek Corinne. 2010. "Social Relationships and Health Behavior Across the Life Course." Annual Review of Sociology 36 (1): 139–57. 10.1146/annurev-soc-070308-120011.

Valente Thomas W., and Pitts Stephanie R.. 2017. "An Appraisal of Social Network Theory and Analysis as Applied to Public Health: Challenges and Opportunities." Annual Review of Public Health 38: 103–18.

Valente Thomas W. Thomas W 1995. Network Models of the Diffusion of Innovations. 303.484 V3. http://www.sidalc.net/cgi-bin/wxis.exe/?IsisScript=sibe01.xis&formato=2&cantidad=1&expresion=mfn=019132.

Wood Kate, and Jewkes Rachel. 2006. "Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa." Reproductive Health Matters 14 (27): 109–18. 10.1016/S0968-8080(06)27231-8. [PubMed: 16713885]

World Health Organization. 2020. "Adolescent Pregnancy Factsheet." 1 31, 2020. https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy.

TABLE 1

Interview Questions

Social Tie	Interview Questions
Sexual Partners	Do you discuss condoms and family planning with your sexual partner(s)? • Can you tell me about those conversations? How or when does the topic come up? Did you initiate the conversation? • Can you give some examples of what you talk about? • What are his views on contraception? How they different from yours? • How does this influence your decisions? • How do you feel about the information you have received from your partner? Do you feel that the information is accurate?
Close Friends	Do you talk to any close friends about condoms and family planning? • Can you tell me about those conversations? How or when does the topic come up? Did you initiate the conversation? • How do you talk about it? (Seriously, joking, one-on-one, in groups, etc.) • Does the conversation vary depending on which friends you are talking with? • Can you give some examples of what you talk about? • What are their views on contraception? How are they different from yours? • How do their views influence your decisions? • How do you feel about the information you have received from your friends? Do you feel that the information is accurate? What makes you trust the information?
Older Women	Do you talk to any older women about condoms and family planning? • Can you tell me about those conversations? Can you give some examples of what you talk about? Did you initiate the conversation? • How do you talk about it? (Seriously, joking, one-on-one, in groups, etc.) • Does the conversation vary depending on which older women you are talking with? • What are their views on contraception? Are they different from yours? • How do their views influence your decisions? • How do you feel about the information you have received from older women? Do you feel that the information is accurate? What makes you trust the information?

TABLE 2

Baseline Characteristics of Participants *

	Participants (N = 60)	
	N	**%**
Demographics		
Age		
15–19 years	28	47%
20–24 years	32	53%
Marital Status		
Single	43	72%
Ever Married	12	20%
Education		
Completed Primary School	51	85%
Less than Primary School	9	15%
Has Primary Sex Partner	50	83%
Living with Partner	11	18%
Pregnancy and Children		
Ever Pregnant	35	58%
Pregnancy Intention at First Pregnancy		
Wanted to be Pregnant	4	6%
Wanted to Wait	23	38%
Didn’t Want Child	8	13%
Pregnancy Chances in Next Year		
No Chance	42	70%
Some Chance	6	10%
Very High Chance	7	12%
Don’t Know	5	8%
Living Children		
0	7	12%
1+	28	47%
Never Pregnant/Don’t Know	25	42%
Ideal Number of Lifetime Children		
1	1	2%
2	24	40%
3	10	41%
4+	25	15%
Contraception		
Ever Contraceptive Use		
Condoms	55	92%
Non-Barrier Methods +	25	42%
Contraceptive Conversations		
Intimate Partner	32	53%

	Participants (N = 60)	
	N	%
Peers	39	65%
Older Women in the Family	26	43%

*Totals do not add up to 100% due to missing data.

+Pills, injections, intrauterine devices, and implants