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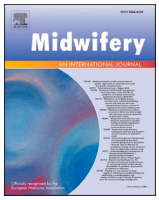

Turned away and sleeping apart: A qualitative study on women's perspectives and experiences with family planning denial in Malawi

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ABSTRACT

Introduction: Barriers to family planning for potential clients have been explored in the literature, but rarely from the perspective of the women themselves in a low-income setting. This research aimed to understand clients' perspectives on being turned away from receiving a method of family planning at a facility on the day it was sought.

Methods: Three focus group discussions were held in two districts of Malawi in 2019 with clients who had been turned away approximately three to six months prior.

Results: The reasons for turnaway participants mentioned fell into eight categories: no proof of not being pregnant, method and/or supply stock-outs, arriving late, provider unavailable, provider refusal, needing to wait longer after delivery of a child, financial constraints, and medical reasons. Participants were often turned away more than once before finally being able to initiate a method, in some cases returning to the same facility and in others finding it through community health workers, traditional healers, or private facilities. Clients often resorted to sleeping apart from their husbands until they could initiate a method and reported stress and worry resulting from being turned away.

Conclusions: Clients are turned away without a method of FP on the day they seek one for multiple reasons, nearly all of which are preventable. Many examples given by the participants showed a lack of knowledge and respect for clients on the part of the providers. Changing attitudes and behaviour, however, may be difficult and will require additional steps. Increasing the availability and use of pregnancy tests, having a more reliable supply of methods and materials, increasing the number of providers—including those trained well in all methods—and providing daily FP services would all help reduce turnaway. Improved access to family planning will help counties achieve their Sustainable Development Goals.

Introduction

The importance of high-quality family planning (FP) services in achieving the Sustainable Development Goals (SDGs) cannot be underestimated. Traditionally recognised for its role in maternal and child health, FP also contributes to the success of the SDGs in eliminating extreme poverty, increasing health and well-being, ensuring quality education for all, and lessening the impact of climate change, among others (Starbird et al., 2016; United Nations, 2015). In 2019, 218 million women in low- and middle-income countries were estimated to have an unmet need for FP (Sully et al., 2020). In many cases, unmet need can be attributed to the various barriers women face in accessing FP (Starrs et al., 2018).

Women must often overcome many barriers to FP before even reaching a facility that provides it, including taking time away from domestic or income-generating responsibilities to obtain services, finding the resources needed to arrive at the facility, and in some cases, doing so while concealing their reason for the visit. Women can

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encounter other barriers after arriving at the facility, resulting in them being turned away without receiving a method. Those FP barriers that have been frequently categorised in the literature include geographic (e.g., long distances between clients and services), financial (e.g., unaffordable methods, services, or transportation to obtain a method), and medical barriers (Bertrand et al., 1995; Campbell et al., 2006; Starrs et al., 2018). Medical barriers can include non-medically necessary policies or practices 'that inappropriately prevent clients from receiving the contraceptive method of their choice or impose unnecessary process barriers to access family planning services' (Bertrand et al., 1995). For example, a medical barrier could include requiring direct observation of menstruation (i.e., a soiled menstrual pad) to rule out pregnancy, lab tests, or vaccinations (Campbell et al., 2006; Stanback et al., 1997; Brunie et al., 2013; Hazel et al., 2021). Clients may also face barriers due to a lack of information on how FP or particular methods work, stock-outs of supplies or methods, or bias on the part of providers (Solo and Festin, 2019; Campbell et al., 2006; Bertrand et al., 1995).

In the case of provider bias, providers may require clients to be married or of a certain age or they may impose their own beliefs regarding ideal family size or spacing of pregnancies, including limiting the use of contraception for nulliparous women or women who have had fewer than the socially accepted number of children (Campbell et al., 2006; Stanback and Twum-Baah, 2001; Tavrow et al., 1995; Tumlinson et al., 2015). Providers may also determine the method dispensed to a client based on ease of initiation or availability of supplies rather than client preference (Solo and Festin, 2019; Farmer et al., 2015; Hasselback et al., 2017).

Many of the barriers to FP are related to the social determinants of health, including economic status, area of residence, education, social inclusion and non-discrimination, and access to affordable, quality health care (Marmot et al., 2008). These are defined by the WHO as 'non-medical factors that influence health outcomes' (World Health Organization, 2022b; Marmot et al., 2008). While social determinants of health exist in countries of all income levels, they can be harder to overcome in low- and middle-income countries, where resources and alternatives are more limited (World Health Organization, 2022b). Overcoming or minimizing the impact of social determinants of health is a key element in helping the world to meet the 17 SDGs and achieving equity in health, yet their presence can be noted in many of the aforementioned barriers to FP (United Nations, 2015).

The term 'turnaway' was first used by researchers exploring access to abortion services in the United States from 2008–2016 (Biggs et al., 2017; Foster, 2021). In the 1990s, Tavrow at al. showed that many Malawian women were denied FP at the facility entrance before even seeing a provider for reasons including missing group counselling, coming on a non-family planning day, provider unavailability, and unavailability of commodities (Tavrow et al., 1995). More than two decades later, further research showed that Malawian women were still being turned away from FP services for reasons including refusing other services such as an HIV test or vaccination or a facility being closed during normal operating hours (Hazel et al., 2021). Turnaway in Malawi also resulted from closures or understaffing of facilities, long wait times, stock-out of methods preferred by the women, or FP being offered only on certain days of the week (Peterson et al., 2022b).

Unlike evidence on the presence and types of barriers to accessing FP facing women, evidence on the impact of denying FP methods is sparse (Solo and Festin, 2019). Although related issues such as a limited method mix resulting from provider bias or method stock-outs have been explored, these studies have not given a strong voice to women on the effects on their lives of limited choice and access (Solo and Festin, 2019; Bertrand et al., 1995). In this paper, we aim to give women the opportunity to describe their experiences with turnaway from FP in Malawi and explore and analyse the reasons women understood they were turned away and the potential outcomes and consequences.

Setting

Malawi is a country of approximately 20.8 million people located in southern Africa (Central Intelligence Agency (CIA), 2022). It is divided into three regions and 28 districts, with approximately 82% of the population living in rural areas (Central Intelligence Agency (CIA), 2022). Christianity is the most common religion, with 77% of the population practising some type of Christianity, whereas Muslims account for 12% of the population (Central Intelligence Agency (CIA), 2022).

Malawi has a total fertility rate of 4.4, an infant mortality rate of 42 per 1,000 live births, and a maternal mortality ratio of 349 per 100,000 live births (Malawi National Statistics Office, 2017; World Health Organization, 2019). The modern contraceptive prevalence rate for married women is 58%, with an unmet need for FP of 19% (Malawi National Statistics Office, 2017); the turnaway rate has been estimated to be 15% for three districts studied (Peterson et al., 2022b). Fewer than three-quarters (72%) of women are literate (Malawi National Statistics Office, 2017). Malawi was one of few sub-Saharan African countries to reach the Millennium Development Goal 4, to lower child mortality, which was achieved through general health system strengthening, among other activities (Gunnlaugsson and Einarsdóttir, 2018; Haraldsdóttir et al., 2021).

From 1982 to 1992, Malawi had a conservative FP policy in place requiring women to be married, undergo a full physical exam, meet age and parity restrictions, and have permission from their husbands to initiate FP (Tavrow, 1999; Devlin et al., 2017). Health facilities offered FP services only once per week (Tavrow, 1999). In 1992, the Ministry of Health and Population (MOHP) introduced a new FP policy relaxing many of these restrictions (Tavrow, 1999). The policy eliminated requirements related to age, parity, and permission of husband and allowed FP for limiting births rather than just birth spacing. It also set the expectation that FP services should be offered daily at MOHP facilities.

Today, trained community health workers in Malawi are allowed to initiate women on oral contraceptive pills (OCPs) and injectable contraception, but facility-based services remain an important source of FP for many women in Malawi (Government of Malawi Ministry of Health, 2009). Facility-based FP services are usually provided by nurses, midwives, clinicians, and health surveillance assistants (HSAs), who generally start with a group counselling session for prospective clients, which is held in the morning. During each session, various FP methods are explained to clients, including their possible side effects. After the group counselling session has ended, clients speak with providers individually to decide upon and receive a method, as appropriate and available.

Methodology

This qualitative study was part of a larger mixed-method study that gathered data on clients and providers from FP units in 30 health facilities in three districts in Malawi from October to December 2019 (Peterson et al., 2022b; Peterson et al., 2022a). In the first part of the study, clients who were turned away from receiving a method of FP at a facility on the day they sought one participated in a survey on the day of turnaway. Clients who agreed and provided a phone number were followed up six- and 12-weeks post turnaway. At the time of the 12-week follow-up visit—or the six-week follow-up for those reporting pregnancy at six weeks—research assistants asked clients via telephone if they would be willing to participate in a focus group discussion (FGD). The two districts with the highest turnaway rates were selected for the FGDs. Data collectors attempted to reach all clients who lived in the two selected districts and stopped when they had eight participants agreeing to participate. No alternate participants were selected. Turned-away clients were eligible for an FGD if they had access to a phone, were willing to be contacted, and expressed interest in participating.

We chose to use FGDs to allow women to share their experiences in

their own words. Qualitative research, including FGDs, allows for a greater understanding of complex issues than quantitative methods alone and offers greater opportunities to bring unanticipated findings to light (Baum, 1995; Bryman, 1984; Krueger and Casey, 2000). In our case, a qualitative methodology put the turned-away clients in the position of expert witnesses and allowed researchers to see the world through their eyes (Bryman, 1984). In some cultures, participants may feel shy about sharing personal information in a group setting. In Malawi, however, local researchers advised that clients would feel more comfortable sharing personal information in an FGD than in individual interviews because they would know in a group setting that others were also sharing such information; thus, the risk of social desirability bias would be reduced (Elrofaie, 2020).

Study design and data collection

The qualitative data presented here are taken from three FGDs with turned-away clients conducted three to six months after turnaway. The number of FGDs was constrained by cost and feasibility. The turned-away clients came from two districts in Malawi, Kasungu and Zomba. The team intended to include six to eight participants per FGD, but in two cases, five participants attended. Discussions took place in a private space at available primary school classrooms in each district in late March and early April 2020. Clients participating in FGDs were compensated 7,000 Malawian kwachas, or approximately US$10, for their time, as required by the Malawian institutional review board, the National Health Sciences Research Committee (NHSRC). Although COVID-19 had not yet been detected in Malawi at the time of the FGDs, rates were rising throughout the world. To accommodate social distancing in their transportation to and from the FGDs, participants were offered transportation reimbursement and encouraged to use transportation that could best ensure social distancing (motorcycle taxi in place of minibus, for example). Those needing reimbursement for transportation received US$2–US$15, depending on the distance travelled and means of transportation used.

The data collection team consisted of a lead interviewer and a note-taker, both Malawian women with bachelor's degrees in relevant fields and previous experience with qualitative data collection in health-related studies. Both had participated in the quantitative portion of the study and were familiar with the research goals and objectives. Prior to initiating the FGDs, they received an additional two days of training on qualitative data collection, including modules on key components of effective facilitation, such as not interrupting respondents, not making assumptions about what participants will say, and clarifying points that are unclear.

During the FGD, the interviewer used a semi-structured, open-ended discussion guide to lead the participants through predetermined questions and topics. The research team developed the discussion guide after analysis of the turnaway and follow-up survey data. The aim was to gain a deeper understanding of those results by allowing the women to express their views on their FP visits. The broad topics included experiences with and reasons for turnaway, perceptions of the quality of the services they had received (including their understanding of why they had been turned away), what clients do as a result of being turned away, and subsequent outcomes after turnaway. The FGDs were conducted in Chichewa.

Data management and analysis

FGDs were audio recorded and transcribed directly into English by the lead interviewer; transcriptions were reviewed by the note-taker present at the FGDs. Transcriptions included bracketed notes from the transcriber/lead interviewer to add context to comments where necessary. Further context was provided by Malawian members of the research team to its non-Malawian members.

We used grounded theory to analyse the transcripts, first by open-coding to find similarities and differences in results, then using axial coding to establish connections between categories and subcategories, and finally, selective coding to establish core categories, themes, and the grounded theory (Priest et al., 2002). While we expected some topics to overlap with what we had found in the quantitative surveys regarding reasons for turnaway, we chose to use a grounded theory framework to allow for new categories to emerge and to capture nuances in how clients might describe the reasons for turnaway and other topics explored. We allowed themes to develop across questions rather than simply quantifying responses to particular questions.

The transcripts were imported into NVivo (QSR International Pty Ltd., 2018) for analysis. We performed inter-coder agreement checks with two coders and discussed any discrepancies until we reached agreement. Demographic information for the FGD participants was based on follow-up surveys conducted six and 12 weeks post turnaway. Specific comments made during FGDs were not linked to the demographic details given at the time of the initial survey.

Ethics

The study protocol was reviewed and approved by FHI 360's Protection of Human Subjects Committee in Durham, NC, USA, as well as the National Health Science Research Committee in Malawi. All study staff completed training on research ethics, the protocol, and informed consent administration. All participants provided their written informed consent to participate.

Results

Three FGDs were held—two in Kasungu District with five participants each and one in Zomba District with six participants—for a total of 16. Participant quotes are presented verbatim with minimal editing for clarity.

Participant background and demographic data

Demographic data for FGD participants were collected during the exit survey conducted at the facility the day they were turned away and was available for 15 of the 16 participants. The participants were on average age 26.3 years (range 19–42). All but one was married, and all had given birth at least once, including eight who had given birth within six months of the day we first spoke to them. Nine had a primary school education, and six had a secondary school education. One of the participants reported on the six-week survey that her partner disapproved of her use of FP; the others reported their partners had approved FP use. Based on the six-week post-turnaway survey, eight of the FGD participants were able to start a method by that time, and three more were able to start by 12 weeks post-turnaway.

Reasons for 'turnaway'

After establishing the meaning of the term 'turnaway' with FGD participants as leaving a health facility without a method of FP on the day a client wanted one, facilitators asked about why clients get turned away. Using thematic analysis as a part of our grounded theory framework, we classified the reasons for turnaway most discussed into eight categories (Table 1). All were mentioned in two or more FGDs.

No proof of not being pregnant

Women discussed being turned away when they could not demonstrate they were not pregnant. If a woman had missed a period, or came in between periods, health workers asked her to come back after taking a pregnancy test or while she was menstruating. In some cases, not menstruating was mentioned in the context of initiating a new method, but in many cases the participants were referring to clients coming for a reinjection. Participants noted this was particularly unfair for women

Table 1
Data analysis depicting key codes, themes, and categories of reasons for turnaway after seeking contraception method at a health facility, participants in Kasungu District and Zomba District, Malawi, March–April 2020.

Codes	Theme	Categories
• Missed period • In between periods • No period while on methods	Menstruation related	No proof of not being pregnant
• Arrived late, turned away immediately • Arrived late, not seen by 2pm • Went to another service area first, arrived late to FP	Arrival time to FP services area	Arriving late
• Method not available/ in stock • Insertion device not available	Method or supplies unavailable/not in stock	Methods and supply stock-outs
• Provider trained on preferred method not available • Provider busy with other tasks	No provider available for service delivery	Provider unavailable
• Provider tired/on break • Not coming on assigned day • Provider saving methods for someone else	Provider or method available that day, but service still not received	Provider refusal
• Baby must be six weeks old before starting a method	Coming too soon after delivery	Need to wait longer after delivery of a child
• Provider selling method • Need to go to provider house to access method for a fee • Fee for hospital construction	Payment requested in exchange for method or services	Payment requested
• Anemia • High blood pressure • Risk of blood clots	Medical contraindications	Medical reasons

who missed a reinjection date by just a few days, given that missing periods while using injectable contraception is common.

> If the day you were appointed to come for FP and you did not come and go the following day, they turn you away so that you get a pregnancy test first, so they see evidence that you are eligible to access FP (FGD-03–05).
> If a woman has gone after the appointed date has passed, she is told to come back when she is menstruating. It's not right because some methods make some women not to menstruate … For example, Depo [injectable], most people stop menstruating when they are using this method, and yet the providers want you to menstruate first as proof that you are not pregnant. This is not right (FGD-02-02).

Method and/or supply stock-outs

Facilities can run out of methods or the supplies needed to initiate a method, such as the trocar needed to insert a contraceptive implant. Known as 'stock-outs', this reason for turnaway was frequently mentioned by FGD participants. Specifically noted by the participants were stock-outs of injectables, implants, intrauterine devices (IUDs), and insertion materials. In some cases, participants said that during a stock-out the providers would give them advice on where else they could go to get the method or a future date when the method should be back in supply. Some women also mentioned being advised to use pills or condoms while waiting for injectables to be available, but other women reported that they had not been offered any backup methods and had simply been turned away. One participant gave an example of the consequences of stock-outs:

> Sometimes they know that we are going to get our children checked by the scale [at the under-five growth monitoring clinic], but the stock is little, like for Depo [injectable], to cater for all of us. They communicate when we should come back, but while waiting some women end up pregnant (FGD-03-05).

Participants found it disappointing to be turned away for method or supply stock-outs but understood this reason for turnaway when all women seeking that method were turned away.

Arriving late

Participants explained that they can get turned away when there are too many clients for providers to see by a certain time. In one example, a participant reported that providers will see clients up until 2pm, but any clients still waiting at that time are asked to come back another day. In other cases, clients who arrive late to the facility are turned away upon arrival. 'Like for [Health Centre], they open at 8 o'clock, so if you are late beyond 11 o'clock, they send us away,' one client explained (FGD-03-04).

Another participant tried to access two services on one day, making her late for FP services:

> The second time [I was turned away] they said that I came in late. That day I was also weighing my child [at the under-five growth monitoring clinic]. When I explained, they said that I should only come for one thing (FGD-03-02).

Being turned away for these reasons was frustrating for clients who came long distances and preferred to receive more than one service in a single trip to a facility, but other participants saw it as fair.

Provider unavailable

Providers must not only be present but also trained in all methods. Participants described being asked to return on a different day when the provider trained to supply a particular method was not present on the day they were seeking it. 'For example, if you want the method placed in the arm, the providers know that the person responsible to insert the method is not around, they advise that you come the following day when the specific provider comes around' (FGD-03-05).

Another client shared another example of a difficult-to-understand reason for turnaway:

> Like when you go and you know that you don't react well to Depo, and you want to collect pills, they tell you that 'we have no pills,' or the person responsible to supply pills is not there. You end up disappointed because the pills are needed every day (FGD-03-02).

Clients also discussed that providers may get pulled in to work with other clients, such as those in need of immediate care, leaving the FP-service area temporarily without a provider. Although clients could understand the need for FP providers to respond to emergency circumstances, they found this disappointing and frustrating.

Provider refusal. Participants described situations in which providers refused to give them a method. They had trouble understanding why they should be turned away just because a provider was tired, or wanted to take a lunch break, or had other responsibilities to tend to. One participant said, 'The supplies may be available, but [the providers] will say they are tired, and the clients won't get the methods' (FGD-01-01).

More frequently mentioned was refusal when a client showed up for

a reinjection, but not on the assigned day. One participant explained, 'FP days at our facility is Tuesday and Thursday. If the appointment date falls on a different day other than Tuesday or Thursday, we are turned back. Sometimes we end up falling pregnant as a result of this' (FGD-02-03).

In some cases that participants found frustrating, providers appeared to be saving the requested method for particular women, such as those who arrived in cars or who had 'personal connections' to the providers.

> It also happens at our health facility that others access the same FP methods you are going for, and yet we are turned away. Usually they prefer well-to-do people: those that have come by car go straight in the provider room and get assisted, while the rest of us are sent back. Sometimes they judge us with the way we are looking or are dressed; we are turned away without any assistance (FGD-02-01).

Needing to wait longer after delivery of a child. Some FGD participants had been told they had come to initiate FP too soon after delivery. 'Sometimes they tell us that the baby is still young, so it is impossible to get a method of FP before the baby reaches six weeks.' (FDG-03-01) Participants said they had been told to wait until six weeks after the birth of a child to initiate a method, without mentioning the method they had been denied or if they had been offered a backup method, such as progesterone-only pills or IUDs, which can be used immediately after delivery.

Payment requested. Despite methods being offered for free at public facilities, FGD participants noted several examples of providers asking for payments from clients. Some participants mentioned providers selling methods for a profit or needing to be 'connected' to a provider to receive methods that are in short supply. One participant said, 'It happens that sometimes that some [providers] are selling the family planning methods, so maybe money is hard to find, so we fail to access FP.' (FGD-03-01). Another said:

> The providers share amongst themselves. We go to the facilities, and they tell us that there is a stock-out, but the same provider will tell you that the same method he has at home. So, I was wondering why the FP services are found in their homes and not at the health facility. I did not go to their house to get a method. (FGD-02-01)

Yet another participant mentioned making payments. When asked to clarify if the payment was for all services or particular services, she explained:

> It's mostly the method one is looking for, to help build another hospital. Like when I went there, they said we should pay 200 kwachas, and then the person handling the records suggested that we pay more the next time we go, like add 300 kwachas so that each one should contribute 500 kwachas [approximately USD 0.60] in total (FGD-02-04).

Participants expressed frustration in these cases and did not understand why they should have to pay for methods that should be available for free. They reported refusing to pay and instead going without FP until it could be obtained for free.

Medical reasons. Women also discussed medical reasons for being turned away, including showing up before a scheduled resupply or reinjection date, anaemia, high blood pressure, and risk of blood clots. One participant said, 'For me, when I was getting a removal, they denied me another method because I was told I have anaemia, and so I was told to wait for three months to observe the situation' (FGD-03-03).

Participants understood that for medical reasons, some methods were incompatible with some women.

What do clients do when turned away?

Participants mentioned several approaches they take to cope when turned away. Most frequently mentioned was sleeping apart from their husbands to abstain from sexual relations. This was preferred to 'eating sweets still in their wrappers,' the local saying used to describe having sex with condoms. But women also mentioned the failure to obtain a contraceptive method leading to quarrels with their husbands, who sometimes felt their wives had deliberately failed to get a method because they wanted more children.

Other coping mechanisms discussed were returning to the facility on a different day, seeking FP through an outreach service, and accepting a second-choice method in place of the one they preferred. Accepting an alternate method was usually noted in conjunction with a second or third turnaway. Going to an HSA who is a paid and trained community health worker, a traditional healer, or an assistant at a private facility, were also mentioned. One participant said there was nothing she could do because other facilities did not exist in her area. Several noted the stress of the situation. One participant said, 'You get stressed when turned away. You go everywhere. You ask friends, neighbours, and HSAs for help' (FGD-03-06).

Participants in all three of the groups discussed the advantages of going to private facilities when they can afford it, because at private facilities all methods are in stock and available. They tried other facilities—either public or private—when they felt they had not been treated well by a provider or thought they had a better chance of accessing a preferred method.

> I didn't take long before I sought a method. I knew that my husband sleeping alone was not a good idea, so I tried hard to visit [the District Hospital] to look for my method, and so I got it a week later (FGD-01-01).

Participants said they did not return to any facility when they were geographically isolated and/or had to pay large amounts for transport to a facility. 'Sometimes the transportation is tricky. You see that you travelled a long distance only to be turned away. So, you start contemplating on not going [back] for fear of experiencing a similar predicament' (FGD-01-06).

Finally, unwanted pregnancies were noted as an unfair consequence of turnaway. 'Sometimes you go to access FP methods, and you are not assisted, it leads to an unexpected pregnancy, so this is hurtful.' (FGD-03-06). As described by another participant, 'It's not right to be turned away, because if we get turned way there are high chances of us getting pregnant and we will be giving birth frequently' (FGD-01-01).

Multiple turnaways are common

Participants in the focus groups described being turned away one to three times in relation to the time we first met them. Many went back in the week following the initial turnaway and were then able to initiate a method. But for others, it was more difficult. One participant said, 'The first time I was turned away was in December due to a holiday. The second time they told me there was a stock-out of sterilizing materials. I got a method on my third try' (FGD-03-03).

Another participant looking for an implant explained, 'After being turned away from [my local] health centre, I went to another hospital, but I didn't find it again, and then I found [an outreach service], and that's where I got it' (FGD-02-05).

One participant spoke of finding implants stocked out twice, and then the materials for inserting implants were unavailable, so she finally agreed to an injectable instead. Another participant said after two unsuccessful attempts at her local public facility, she visited a private facility and was able to initiate her chosen method.

Perceived quality of services

When asked about providers during the FGDs, participants expressed several concerns about the quality of the services provided. For example, participants mentioned that providers do not always take the time to explain methods and can treat clients poorly when they are in a hurry. 'Like when they want to inject us with Depo, they do not consider that we are in pain, they just bring in many people and inject us in a hurry, then we go back home we start swelling up' (FGD-02-03).

Clients said sometimes there are not enough staff, and providers get tired. One participant suggested that providers be rotated among facilities. 'We need to reshuffle the providers because the ones we have now are used to us and don't respect us anymore' (FGD-02-03). Participants also reported that providers can be 'mean' and 'shout at us.'

Some participants provided positive feedback related to providers giving them comprehensive information on all methods and helping them find the right one for their circumstances. One participant recognised that providers give better information than friends do.

> The problem that I noticed amongst women is that we listen to our friends, we find out they are complaining about FP services, and we take it from them that there is no help we can get from the providers. We get easily discouraged, but if we could take the initiative to hear from the providers themselves, I believe it would help us all (FGD-02-01).

Discussion

This qualitative research presents women's experiences with, and perceptions of, turnaway from receiving a method of FP in two districts in Malawi. Nearly all the reasons described for being turned away were medically incorrect, preventable, and potentially harmful to women seeking FP. Clients described how not receiving FP on time—either new methods or resupplies—was stressful for them and had real implications. Whether clients had to return to search for methods another day, refrain from sexual relations, or adopt a second-choice method, it caused them worry and inconvenience. Although none of our participants mentioned being pregnant at the time of the FGDs, they discussed it as a possibility.

Three additional reasons for turnaway were mentioned by women in the FGDs that were not seen in the survey results (Peterson et al., 2022a) include provider refusal, charging of informal fees and late arrival (Table 1). Provider refusal included providers being tired or needing a break or giving preferential services for women assumed to be 'well--to-do.' Providers charging informal fees—another category of turnaway not seen in survey results—and preferential treatment have been seen before, for example, in Kenya, Tanzania, Uganda, Sierra Leone, and Malawi (Busse et al., 2022; Tumlinson et al., 2013; Tumlinson et al., 2021; Hunt, 2010; Pieterse and Lodge, 2015; Mamba et al., 2017). Identifying these barriers in interviews with the women seeking the services, but not in the survey, illustrates the importance of applying multiple research methods in exploring care-seeking behaviour and its outcome. These practices raise issues of inequity of access to FP based on socioeconomic status or personal connections to providers and should be studied further to design and implement interventions to prevent them.

Late arrival, the third new category of reasons for turnaway mentioned during the FGDs, could be another aspect of inequity in service delivery resulting from financial status—women who cannot afford to use transportation methods such as mini-buses, taxis, or bicycle taxis might be more likely to arrive late. Women who live further from facilities may also find it more difficult to arrive at a facility early in the morning. The impact of these potential inequities should be considered when formal or informal policies on the availability of FP services based on the day of the week or time of arrival at the facility are implemented (High Impact Practices in Family Planning (HIPs) Partnership, 2021; Stratton et al., 2021).

The women frequently mentioned the need to be currently menstruating to receive a method. In the era of cheap, accurate pregnancy tests (estimated to cost a facility US$0.08–US$0.25 each in Malawi in 2016), this requirement seems unnecessary (Kolesar et al., 2017). Also, Malawian providers' pre-service training materials include the option for providers to rule out pregnancy in many cases through the use of the *Reasonably Sure Not Pregnant Checklist* (Kolesar et al., 2017; Ministry of Health and IntraHealth International, 2010). Although providers usually do not control whether a pregnancy test is available at a facility, they could use this checklist more frequently to rule out pregnancy (Peterson et al., 2022b). For the women, needing to come to a facility when menstruating is both costly and inconvenient and presents extra challenges and added stress (Peterson et al., 2022a). At the same time, the providers are navigating the dilemma of potentially initiating a method to a pregnant woman against preventing a loss in confidence in the effectiveness of modern FP methods.

In the FGDs, the women felt especially frustrated being scheduled for re-injection of injectable contraception on a non-FP day, refused that day, and then denied a re-injection again for coming in a day or two late, on the closest FP day to their scheduled appointments. Officially, Malawi follows the World Health Organization's medical eligibility criteria, which state that women can come up to two weeks before or four weeks after a scheduled appointment date to receive a re-injection, but this does not appear to happen consistently in practice (Ministry of Health and IntraHealth International, 2010). As noted by one participant, asking women who are current users of injectables to wait until they begin menstruating again seems unreasonable, especially given that this can take several months (DEPO-PROVERA- medroxyprogesterone acetate injection spi, 2020). Providing FP services daily is in line with MOHP expectations and is reasonable, particularly for re-injections, which require little time for counselling.

Stock-outs of supplies and methods lead to turnaway but are normally out of the control of individual providers. A worldwide shortage of injectable contraception in 2019, due to the shutdown of a manufacturer sterilizing facility (U.S. Food and Drug Administration, 2019), likely affected the supply of injectables in Malawi during our research. In addition, ordering and delivering commodities is a complex process involving a host of players, including pharmacy technicians, FP coordinators working for the Reproductive Health Unit in the MOHP, the MOHP Health Technical Services and Support Unit, and the Central Medical Stores Trust, which is responsible for procurement (Government of Malawi, 2015). This system has been noted to lack accountability, perhaps allowing individual providers to sell methods on the side (Government of Malawi, 2015)—an issue raised by the women. These findings are in line with other research in Malawi showing the 'leakage' of essential drugs from official health facility stocks, as well as the frequency with which others have seen official drugs being sold through unofficial channels (Carlson et al., 2014; Msoma et al., 2020). Consequently, to effectively limit turnaway of women seeking FP and support the providers, better control around essential drugs is crucial.

The FGD highlighted turnaway resulting from having too few providers or providers not trained on all methods. Low caregiver-to-patient ratios are seen throughout sub-Saharan Africa, including in Malawi, where there are just seven nurses or midwives per 10,000 people (World Health Organization, 2022a). Providers in Malawi have expressed frustration with being short staffed or not having staff trained in all methods (Peterson et al., 2022a; Mwafulirwa et al., 2016; Haraldsdóttir et al., 2021). Overworked providers grow weary and frustrated when they cannot keep up with their workloads or do not have the supplies and training needed to do so. Yet, lashing out at clients or treating them in a rude and disrespectful manner, as described in the FGDs, and reported elsewhere (Tumlinson et al., 2013; Nalwadda et al., 2010; Mannava et al., 2015) is unacceptable. Furthermore, providers should not partake in selective practices, with women who appear to be financially advantaged having better access to services and methods than those judged to be poorer, as was described in the FGD.

Stock-outs and staffing issues, including training on all methods as

well as client eligibility, are systemic challenges that should be addressed by the MOHP and district authorities. For example, providers should know that clients should be able to receive progesterone-only pills any time after delivery and that an IUD can be inserted within 48 hours of delivery or after four weeks, as well as the medical eligibility criteria for reinjections of injectable contraception (Ministry of Health and IntraHealth International, 2010). Efforts should also be made at a systemic level to eliminate the occurrence of providers privately selling methods acquired through unofficial channels or giving preferential treatment to some clients. Providing turned-away clients with alternative options, such as referrals to other means of initiating FP (through outreach facilities or HSAs), and talking to them consistently about second-choice methods are other practical steps that can be taken to ensure the FP needs of women in Malawi are met in a timely manner.

In this study, Malawian women draw attention to their experiences of being turned away when seeking FP. Most of the reasons they highlight are preventable, indicating that these barriers can be removed if there is a will for systemic changes and if providers adopt a client-centred approach that enables easy access to the methods of contraception Malawian women need and are entitled to receive. If these barriers are addressed while giving due attention to the provider perspectives (Peterson et al., 2022a), policymakers and program implementers will be able to reduce FP turnaway, not only in Malawi but with potential implications elsewhere.

A strength of this study is that it provides information on an understudied area—the impact of client turnaway on women and their families in their own words. The study is unique because it recruited women who had been followed longitudinally to understand their experiences with and the outcomes of turnaway. Another strength of the research is the diversity of the research team. The composition of the team, which included men and women, Malawians and non-Malawians, and a generational spread, allowed us to reflect on how these and other characteristics may have influenced the research and to attempt to mitigate any personal interference in how the participant voices were heard and understood. Nonetheless, the sample was limited to clients with access to a mobile phone who were willing to be contacted—two factors that could bias the results. The number of FGDs is another limitation; the research struggled with sample size because it started just as the COVID-19 pandemic began, when people were becoming wary of going out or gathering with others. Given that most of the reasons for turnaway were discussed in multiple FGDs, however, we consider the results a reliable representation of the range of reasons why women have been turned away.

Conclusions

Clients are turned away without a method of FP on the day they seek one for multiple reasons, nearly all of which are preventable. Many examples given by the participants showed a lack of knowledge and respect for clients on the part of the providers. At the same time, the practical constraints experienced by the providers can not be underestimated and need to be simultaneously addressed. Thus, health policymakers aiming to improve FP services need to consider the perspectives of the FP providers as well as those of the clients, as presented here.

Ensuring providers have a client-centred attitude and improving their morale, motivation, and practices could improve client-provider interactions. Changing attitudes and behaviour, however, may be difficult and will require additional steps, such as additional training and oversight. In addition, increasing the availability and use of pregnancy tests, having a more reliable supply of methods and materials, increasing the number of providers—including those trained well in all methods—and providing daily FP services would all help reduce turnaway. Enabling all medically eligible women who are seeking a method of FP to obtain one the day it is first sought will help Malawi and other low- and middle-income countries achieve their SDGs in women and children's health and beyond.

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Ethics statement

The study protocol was reviewed and approved by FHI 360's Protection of Human Subjects Committee in Durham, NC, USA, as well as the NHSRC in Malawi. All study staff completed training on research ethics, the protocol, and informed consent administration. All participants provided their written informed consent to participate.

CRediT authorship contribution statement

Jill M. Peterson: Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration, Funding acquisition. **Jaden Bendabenda:** Conceptualization, Methodology, Writing – review & editing. **Alexander Mboma:** Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – review & editing, Visualization. **Mario Chen:** Conceptualization, Methodology, Writing – review & editing. **John Stanback:** Conceptualization, Methodology, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Geir Gunnlaugsson:** Writing – review & editing, Supervision.

Declaration of Competing Interest

The authors report no conflicts of interest.

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