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Perceived Barriers in Accessing Contraceptive Implants among Youths at Area 25 Health Centre in Lilongwe, Malawi

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Abstract

Introduction: *Contraceptive implants are more effective methods of family planning for youths as they enable them to control their reproductive lives better than other family planning methods. There is low usage of contraceptive implants by youths, hence making issues related to youth's health a topic of concern in most of the countries in the southern Africa including Malawi. Current studies identified several barriers that hinder youths from accessing contraceptive implants such as concerns over confidentiality, feelings of embarrassment, strained relationships with healthcare personnel, illiteracy, and a lack of emphasis on reproductive health services from parents. These barriers contribute to youths having unplanned pregnancies, lower utilization of family planning methods including implants, unsafe sex and sexually transmitted infections. Nevertheless, no known published studies have looked on the knowledge of implants among youths in Malawi.*

Aim: *The current study was conducted with the aim of describing barriers youths face when accessing contraceptive implants at Area 25 Health Centre in Lilongwe City, Malawi.*

Methodology: *Using qualitative study research design, 20 youths participated in the study at Area 25 Health Centre.*

Results: *The findings revealed that youths faced barriers when accessed implants at Area 25 Health Centre. Three categories of barriers were identified, namely those faced at the health centre, personal and those faced at community level.*

Conclusion: *Results from the study showed that youths faced barriers when accessing contraceptive implants at Area 25 Health Centre.*

Keywords: *knowledge, youth and implants*

1. INTRODUCTION

The global youth population is approximately 4 billion, with a significant concentration in developing nations (Rocca, 2020). In developing countries, around 20,000 girls under the age of 18 give birth daily, and many experience pregnancies, resulting in 10,000 youth fatalities each year due to complications from pregnancy and childbirth (Rocca, 2020). A study by Spies (2015) revealed that 8% of youths had knowledge on implants. In response to this issue, the United Nations Population Fund (UNFPA, 2014) proposed the implementation of comprehensive education regarding sex and sexuality, alongside family planning services for youths, management of abortion consequences, and treatment for sexually transmitted infections (STIs).

Approximately 8.8 million young people out of a total population of 17.56 million in Malawi represent a diverse demographic that requires a variety of sexual and reproductive health (SRH) information and services suitable for their life stages (GOM, 2016). In response to this need, the Malawi government introduced the Youth-Friendly Health Services National Standards and Youth-Friendly Health Services in 2007, aiming to offer high-quality SRH services tailored for the youth (USAID, 2014). A study conducted by the Coalition of the Prevention of Unsafe Abortion (COPUA) found that 80% of young individuals undergo unsafe abortions (USAID, 2014). This prompted COPUA and the law commission of Malawi to draft a bill for parliament advocating for the legalization of safe abortions (USAID, 2014). There is low usage of contraceptive implants by youths, hence making issues related to youth's health a topic of concern in most of the countries in the southern Africa including Malawi.

Current studies identified barriers for youths in accessing contraceptive implants that include concerns over confidentiality, feelings of embarrassment, strained relationships with healthcare personnel, illiteracy, and a lack of emphasis on reproductive health services from parents (Islam and Hassan, 2016). Additionally, male partners' objection serves as a barrier to use of contraceptive implants, where men oppose the use of contraceptives by their partners and some youths have a broad dislike of contraceptive methods because it controls fertility (Islam and Hasan, 2016). The fear of side effects and difficulty adhering to specific contraceptive methods have also been identified as barriers to use of contraceptive implants (Islam and Hasan, 2016). The fear of spousal retaliation resulting from the disagreement on the decision to use contraception has also shown to be a significant barrier to youths, among other factors (Kabagenyi et al., 2014).

Implants are a long-term contraceptive method chosen by 44% of youths in Malawi (Kapira, 2021). Secondary data collected from HMIS at Area 25 Health Centre revealed that 995 youths out of 1,622 (61%) used implants in the five years from 2018 to 2023. There is 23% of unmet family planning contraceptives among youths despite introduction of YFHS and youth corners to increase accessibility to family planning contraceptives including implants (UNFPA Malawi, 2014). There is scarcity of documented information on barriers of youths in accessing implants in Malawi hence a study to identify barriers youths face when accessing contraceptive implants at Area 25 Health Centre in Lilongwe, Malawi.

2. Materials And Methods

2.1. Research Design

This was a cross-sectional study using qualitative method of data collection through in-depth interviews. Qualitative method provided the real experience of youths who accessed implants (Polit & Beck, 2021). Qualitative study helped to explore meaning and interpretation of participant's life experiences (Gray, Grove & Sutherland, 2016). As little was known about the youth's experiences qualitative study provided a rich detail of their experiences. The study environment remained unchanged as the young individuals were observed in their natural surroundings while they sought to make sense of and interpret their experiences and the meanings behind them. Utilizing a qualitative design allowed the researcher to view the world from the perspective of the youth who used implants and to comprehend their experiences.

2.2. Research Setting

The research took place at the Area 25 Health Centre located in Lilongwe City. Lilongwe City is situated within the Lilongwe district, which is part of the central region of Malawi. The population of Lilongwe district is 2,203,911 (GOM, 2016). Area 25 Health Centre is one of the health centres in Lilongwe City. Area 25 Health Centre was chosen because it has well-functioning YFHS, youth corner and has increased number of youths accessing family planning methods such as implants.

2.3. Target Population

The study focused on the targeted and reachable population of youths who utilized family planning services at Area 25 Health Centre, specifically those aged 15 to 24 years. This age group was selected as they are in their reproductive years and are sexually active. The researcher gained consent from parents for youths aged 15-17 years while those age 18-24 years were able to give consent without parental approval. The study targeted youths that utilized family planning since they had lived this experience and gave a true reflection of their experience.

2.4. Sample Size

A sample of 20 youths were used for the interview and depended on saturation. According to Kumar, Govindaraj & Prabhu (2020), a sample size of 12-26 people to conduct an in-depth interview is adequate for qualitative research. The researcher successfully gathered the required data from the sample, as they comprised the appropriate demographic identified as youths. The researcher visited the Area 25 Health Centre to obtain information on implant usage by interviewing youths who utilized family planning services.

2.5. Data Collection Procedure

In-depth interviews were held with each participant who consented and signed the consent form. Open-ended questions were utilized during the interviews to permit participants to share information and articulate their experiences freely. Each individual interview lasted around 30 to 45 minutes. A tape recorder was employed to capture the interview proceedings. This enabled the researcher to revisit the recording and

ensure that no crucial information was overlooked while drafting the report. The researcher, along with assistance from a nurse at Area 25 Health Centre, selected study participants. Before data collection commenced, the nurse was trained on the data collection tools. Interviews took place at the family planning clinic in Area 25 Health Centre. Data was gathered through comprehensive interviews using a semi-structured interview guide. The researcher conducted the interviews to maintain consistency in the data collected. Two participants were interviewed daily and data transcription was done on the same day. Review of data was done constantly to identify further probes and gain in depth understanding of the information.

2.6. Data Management and Analysis

Data analysis started concurrently with data collection. Thematic analysis was done using the following steps: The researcher tape recorded the data, listened to it, and transcribed it word for word to guarantee transcription precision. The researcher translated the data into English, while an independent individual translated it back into Chichewa to confirm the accuracy of the data. The data was analysed through manual thematic content analysis, focusing on theme identification via coding. The researcher read the data multiple times, conducting manual coding line by line, organizing and grouping it by similar units. Lastly meanings were grouped into clusters of themes which revealed the common patterns in the data, thus similar responses were grouped together into themes.

2.7. Ethical Considerations

Ethical approval for the protocol was obtained from the Research and Ethics Committee at Kamuzu University of Health Sciences via the Research and Publication Committee of Texila American University. Consent to carry out the study was acquired from the Lilongwe Director of Social Services.

3. RESULTS

3.1. Demographic Data

In this research, demographic data are any data that provide an understanding of population size, distribution, and composition. Demographic data are important in a study because they assist in understanding the background in relation to the results found (Refae, Kaba & Elltter, 2021). The demographic data included age, marital status, residential areas, number of children, number of partners, highest qualifications, and religious affiliations.

3.2. Age

The research aimed to determine the age distribution of the participants. Among 20 youths interviewed, 3 youths were aged 15-18 years, 6 youths were aged 19-21 years and 11 youths were aged 22-24 years.

3.3. Marital Status

Participants were questioned about their marital status, revealing that 17 youths were married and 3 youths were not married.

3.4. Residential Areas

Respondents were inquired about their living locations, and findings indicated that 18 resided in urban areas, while 2 were from rural areas.

3.5. Number of Children

Participants were requested to specify the number of children they had, revealing that 12 youths had one child, 5 youths had two children and 3 youths had three children.

3.6. Highest Qualification

Respondents were asked to mention their highest qualifications and data showed that 12 youths had primary level, and 8 had secondary level education.

3.7. Religious Affiliations

Respondents were asked to mention their denominations and results showed that 8 were Roman Catholics, 6 were Pentecostal, 3 were CCAP, 2 were from other churches, and 1 was a Moslem.

3.8. Results on Barriers on Accessing Contraceptive Implants

Qualitative data was gathered through coding and thematic analysis. This approach aimed to extract relevant insights from the participants concerning their views on accessing implants. Themes were structured according to the research questions. Transcripts were manually coded based on each participant's individual answers to the interview questions. The research participants were prompted to share their opinions on access to implants. The predetermined theme was used during analysis on barriers the youths face when accessing implants. Sub themes were extracted deductively. The identified sub themes and formulated meanings are listed in table 1.

Table 1. *Themes, Subthemes and Formulated Meanings*

Predetermined theme	Subthemes	Formulated meaning
Barriers youths face regarding the use of implants	Barriers at health facility	What barriers are faced at health facility
	Personal barriers	What barriers are faced personally
	Barriers at community level	What barriers are faced at community level

3.9. Theme: Barriers Youths Faced Regarding the Use of Implants

This theme presents about barriers youths faced when accessing implants. Youths were asked about barriers they faced when accessing implants at health facility, personal barriers as well as at community level. Three subthemes emerged from barriers youths faced to access implants and they include barriers faced at health centre, personal barriers and barriers faced at community level.

3.9.1. Subtheme one: Barriers Faced at Health Facility Level on Implants

This subtheme assessed barriers faced by youths at health facility level. The results revealed that respondents faced the following health facility barriers when accessed implants, namely spent a lot of time on queues and this was so since there were many clients but few health workers, some family planning methods were out of stock such as pills as well as supplies, lack of privacy as most clients were assisted as a group especially those that chose injectables, and lastly some respondents mentioned that they were not properly assisted by health workers and this happened to clients that came late after health talks were done, they did not get adequate information or were sent back home to come another day. Participant 8 said:

"*I faced a problem of long queues as I spent a lot of time close to three hours waiting to be assisted by a nurse since there were many clients but only two nurses on duty assisted" (P8).*

3.9.2. Subtheme two: Personal Barriers

This subtheme assessed barriers faced by youths on personal level. The results showed that respondents faced personal barriers when accessing implants such as inadequate information on implants and this mostly happened when arrived at health facility after health talk. Secondly, clients required transport money to pay for transport when travelling to health facility especially those who came from distant places. Thirdly, health workers were not friendly to clients and the environment was not conducive to clients. Participant 7 said:

"I faced a problem of transport to travel from Madika to Area 25 health Centre. I need money to pay transport which is expensive since Madika village is very far away from Area 25 Health Centre. The roads are bad and only means of transport is hiring motor cycle which one way cost is K2000. 00 and I have to spent K4000 to access implants" (P7).

3.9.3. Subtheme three: Community Barriers

This subtheme assessed barriers faced by youths at community level. The results showed that respondents faced community barriers when accessing implants such traditional beliefs that using implants means that sex enjoyment will be reduced, that's what their husbands told them, some religions teach their faithful to avoid using implants since it's against the word of God to use them, many people in the community lack information of implants and also there are so many misconceptions on implants. Participant 3 said:

"We face problems of religious doctrines that says that church members should not use implants and also friends at church say that when we use implants, we will be barren due to bad effects of the methods, God wants us to bear children" (P3).

4. Discussion

The findings have offered valuable insights into the quality of care accessed by youths seeking contraceptive implants. The findings offered deeper perspectives on how youths are generally handled when seeking family planning services, particularly shedding light on the contributing factors to poor quality of care. To guide this discussion, the Health Belief Model was used as the conceptual framework. The discussion focuses on barriers faced by youths in accessing implants.

4.1. Health Facility Barriers to Implant Utilization

Respondents were asked to share health facility-based barriers they encountered when accessing implants. One issue raised by a majority of youths was **long waiting times and long queues**.

Respondents reported that they spent a lot of time on queues and this happened because there were many clients but few health workers. This aligns with the "perceived barriers" concept in the health belief model and demonstrates that some youths may be discouraged from seeking services due to delays. This is consistent with Bain, Amu and Tarkang, (2021), who reported that clients waited long periods to access contraceptives. Ngole and Joho (2025) found similar results, and Williams, Briton, Bullington, Wambua, Onyango and Tumlinson (2022) noted average wait times of 74 minutes, sometimes stretching beyond four hours.

Another barrier cited was the lack of privacy and confidentiality at health facilities. Youths expressed concerns about being seen at family planning clinics, fearing assumptions about their reasons for visiting. These concerns are significant perceived barriers to contraceptive use. The findings align with Shumet et al. (2024), who found that women feared judgment or stigma from family and peers. Similarly, Bain et al. (2021) and Kigongo et al. (2024) found that family planning services often lacked sufficient privacy and were offered at inflexible times.

A few participants also mentioned about poor treatment and negative attitudes from healthcare workers. Disrespectful or judgmental behaviour from staff discouraged some youths from seeking or continuing to use implants. This observation aligns with Bain et al. (2021), who reported unfriendly treatment toward family planning clients. Sulemana et al. (2025) also found that 29.3% of respondents cited poor staff attitudes as a barrier to service utilization. Furthermore, Soin et al. (2022) highlighted how a provider's training, experience, and comfort level significantly influence how they interact with clients.

Despite some negative reports, other participants noted positive experiences with healthcare providers. These positive interactions were seen as motivational and empowering, enhancing youths' confidence in healthcare services and providers.

Lastly, the shortage of contraceptive supplies including implants was reported as a barrier. When supplies are unavailable, clients who travel long distances may be reluctant to return, especially if they incur transportation costs. This shortage was a significant perceived barrier for many youths. These findings are consistent with Shumet et al. (2024) and Jisso et al. (2023), who noted supply shortages as a major barrier to family planning utilization. Ngole and Joho (2025) similarly reported long-term unavailability of certain contraceptives, which discouraged women from returning to clinics or accessing services altogether.

4.2. Personal Barriers Faced by Youths when Accessing Implants

Respondents were asked to mention personal barriers they encountered when accessing contraceptive implants. **Inadequate information** emerged as the most frequently reported barrier, cited by majority of the participants. Lack of information limits young people's understanding of implants and may lead to underutilization, as they are less likely to feel confident or motivated to use a method they do not fully understand. For those who had already received implants, experiencing common side effects without adequate information often led to early removal, as they were unsure how to manage the effects or lacked the knowledge that such side effects were normal.

These findings align with Obisie-Nmehielle et al. (2022), who found that limited access to sexual and reproductive health services including accurate and reliable information resulted in poor knowledge about family planning and negative SRH outcomes. Dioubate et al. (2021) also reported that inadequate information among adolescents and youths led to the spread of rumours and misinformation, further discouraging contraceptive use. Similarly, Etienne et al. (2019) highlighted how the inability of community health workers to offer effective counselling and manage side effects contributed to barriers in accessing family planning services.

Fear of side effects and stigma was another major barrier, cited by minority of respondents. Youths expressed anxiety about being seen at family planning clinics and feared being judged or having assumptions made about their sexual activity. These concerns reflect perceived barriers within the Health Belief Model (HBM), where privacy and confidentiality significantly impact contraceptive utilization. Osazuwa and Adjoh (2024) reported that many respondents feared side effects such as bleeding, headaches, weight loss, and dizziness, which limited their willingness to use contraceptives. Similarly, Self et al. (2018) found that adolescents feared waiting in queues with older community members who might report their clinic visit to

parents. Osazuwa and Adejoh (2024) also observed stigma associated with family planning, with some youths believing that contraception is only for individuals with multiple sexual partners, further discouraging service uptake.

Another barrier mentioned by minority of respondents was **lack of transportation** to visit health facilities. Youths living far from Area 25 Health Centre had to incur transportation costs, which many could not afford. In this context, transport cost was a key perceived barrier to accessing implants. Jisso et al. (2023) similarly found that participants in hard-to-reach areas had lower uptake of family planning services due to poor road and transportation infrastructure. Hunter et al. (2020) also identified transport cost as a significant issue, with 40% of women reporting it as a problem, and 21% stating it was the most problematic barrier they faced. Lee (2021) corroborated these findings, noting that many youths cited distance and transportation costs as a significant impediment to seeking family planning services.

4.3. Community Barriers Faced by Youths when Accessing Implants

Respondents were also asked to identify community-related barriers to accessing implants. **Misconceptions** were mentioned by majority of the participants, reflecting a significant perceived barrier in line with the HBM. These misconceptions, common around Area 25 Health Centre, included beliefs that implants reduce sexual desire or cause temporary infertility both of which discouraged use.

These findings are consistent with those of Meskele et al. (2024), who found that myths and misconceptions such as dizziness, headaches, reduced libido, abortion, and infertility were widespread and hindered contraceptive use. Mwaisaka et al. (2020) similarly reported beliefs that contraceptives compromise future fertility and could result in health complications such as prolonged bleeding or birth defects. The most common misconception among both male and female participants was that contraceptives cause infertility. Stevens et al. (2023) further highlighted beliefs unsupported by clinical evidence, including fears that contraceptives could damage the womb or permanently prevent pregnancy.

Religious beliefs were also cited as a barrier by minority of respondents. Some participants reported that their religious teachings discouraged contraceptive use, viewing it as contrary to divine will. This suggests that integrating religious perspectives into family planning interventions could improve acceptance. Brohi and Zamani (2016) found strong opposition to contraception within communities due to religious and cultural norms. Salam (2017) noted that some communities equated family planning with infanticide, especially when religious leaders condemned such practices in sermons. Sundararajan et al. (2019) also found that many participants viewed family planning as fundamentally opposed to their religious beliefs, often citing scriptures such as Genesis 1:28 ("Be fruitful and multiply") to justify their resistance.

Traditional beliefs were mentioned by minority of respondents. Participants reported that some cultural norms held that using implants reduced sexual enjoyment, thus discouraging use. This belief, too, represents a perceived barrier within the HBM. Bain et al. (2021) reported similar findings, noting that traditional beliefs such as stigma, disapproval by family and peers, and the idea that contraceptives were only for women hindered youths to access contraception. Jisso et al. (2023) found that in some communities, contraceptive use by women was considered dishonourable, with prevailing views that women were meant only for childbearing. Dioubate et al. (2021) also noted that in ethnic groups like the Malinke and Peulh, sexual activity and contraception were taboo for unmarried adolescents and youth, who were expected to remain faithful until marriage.

4.4. Study Recommendations

Based on the study findings, a recommendation is made to health workers in health facilities to offer family planning including implants sticking to the Malawi government working hours from 7:30 am to 4:30 pm to reduce congestion and maximize the legal working hours in order to reduce queues since some clients will be attended to in the afternoon. A second recommendation is made on health care workers to put emphasis on tangible issues regarding implants by dispelling misconceptions on **personal barrier of** fear of side effects so false side effects that are shared in the community are corrected.

4.5. Areas for Further Research

The current research was done at one health facility and may not represent the views of other health facilities. Therefore, there is need to

conduct another research at many health facilities. Another area for further research is to do similar research targeting heath facility catchment areas since the study was done at a health facility.

4.6. Study Limitations

Despite providing valuable insights into the barriers of youths in accessing in accessing contraceptive implants among youths at Area 25 Health Centre, this study had limitation of limited generalizability since it was conducted at a single health facility in Lilongwe, which may not be representative of other rural settings in Malawi, as such, the findings may not be generalizable to all youths across the country.

Another study limitation is for the study that relied on self-reported information from participants, which may be subject to social desirability bias or recall bias. Some respondents may have underreported or over reported their contraceptive use or attitudes due to stigma or personal beliefs.

5. Conclusion

The study findings indicate that youths face several barriers to access implants, including personal fears (particularly fear of side effects), community misconceptions, and systemic issues within health facilities such as long waiting times. Addressing barriers faced by youths when accessing contraceptive implants may directly enhance accessibility of youths to contraceptive implants.

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