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Accessibility to Family Planning: Marital Status–Related Disparities Among Adolescent Girls and Young Women in the District of Bamako, Mali

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Abstract **Original Research Article**

Introduction: Access to family planning (FP) is a key component of adolescents' sexual and reproductive health (SRH). In many countries in sub-Saharan Africa, including Mali, such access remains strongly influenced by sociocultural and institutional norms, particularly marital status. Adolescents face multiple barriers in accessing information and sexual and reproductive health services. The objective of this study was to analyze disparities related to marital status in access to family planning among adolescents in the district of Bamako. ***Methods:*** This was a qualitative study based on focus group discussions conducted with married and unmarried adolescent girls across the six communes of the Bamako district. Data were collected using an interview guide and analyzed through a thematic approach to explore adolescents' knowledge and conditions of access to family planning services according to their marital status. ***Results:*** The findings confirm that marital status is a key determinant of access to family planning services. Married adolescents benefit from greater social acceptance, although their decision-making autonomy is often limited by spousal influence. In contrast, unmarried adolescents face stigma, fear of judgment, and social norms that associate contraceptive use with marriage. ***Conclusion:*** This study highlights the need to strengthen interventions aimed at improving equitable access to family planning services and to promote adolescent-friendly services.
Keywords: adolescents and youth, marital status, access to family planning, Bamako, Mali.
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1. INTRODUCTION

Adolescents constitute one of the most vulnerable population groups, both because of the specific nature of their sexual and reproductive health (SRH) needs and their limited agency in expressing their sexuality [1]. According to the World Health Organization (WHO), ensuring adolescents' access to appropriate SRH services is a public health priority [2].

In developing countries, millions of women and young girls still have unmet needs for modern contraception, contributing to the persistence of unintended pregnancies and their associated health and social consequences [1]. It is estimated that approximately 21 million girls aged 15 to 19 become pregnant each year, and about 55% of these unintended pregnancies result in around 12 million births and abortions [2]. In Mali, issues related to adolescent reproductive health remain particularly significant. Early marriage and adolescent pregnancy are still common, and the prevalence of modern contraceptive use among adolescents remains relatively low, estimated at 7.4%, with disparities between the District of Bamako and other regions of the country in both the provision and effective access to family planning services [7].

Despite international efforts to improve adolescents' access to reproductive health services, they continue to face numerous barriers to accessing information and family planning services. These obstacles are often linked to sociocultural, institutional, and economic factors, including the stigmatization of youth sexuality, the lack of adolescent-friendly services, and sometimes negative attitudes from healthcare providers [3]. These factors can limit adolescents' access to modern contraceptive methods and contribute to the persistence of unmet needs for family planning (FP) [4]. Among these determinants, studies have shown that

marital status is a key factor influencing access to and use of family planning services among adolescents and young women, with marriage being perceived as the socially legitimate context for sexuality and childbearing [5].

Married adolescents, despite their legitimate need to use family planning, face constraints related to marital dynamics, particularly the influence of the spouse on decisions regarding contraceptive use [5]. In contrast, unmarried adolescents encounter barriers related to social norms and moral judgments surrounding premarital sexuality, which limit their use of family planning services [6].

A better understanding of these differences is therefore essential to inform policies and interventions aimed at improving equitable access to reproductive health services for all adolescents [1]. In this context, the present study aims to analyze disparities related to marital status in access to family planning among adolescents in the District of Bamako.

2. METHODOLOGY

2.1. Study Setting

The study was conducted in the six communes of the Bamako district. It focused on adolescents' access to family planning services in Bamako according to their marital status.

2.2. Study Design and Period

This was a qualitative study based on individual interviews and focus group discussions, carried out between July 1, 2024, and September 30, 2025.

2.3. Study Population

The study population consisted of adolescent girls aged 15 to 19 years from the six communes of the Bamako district.

2.4. Inclusion Criteria

All adolescent girls aged 15 to 19 years, residing in the Bamako district and who provided information on their marital status, were included in the study.

2.5. Exclusion Criteria

Adolescents who refused to participate or who withdrew from the study were not included.

2.6. Sampling

A non-probability sampling method was used. The sample consisted of 48 adolescents, with 8 participants per focus group.

2.7. Data Collection

Data were collected using a semi-structured interview guide administered during focus group discussions conducted with adolescents. The information collected focused on adolescents' knowledge of family planning and the conditions of access to family planning services. Investigators used smartphones to audio-record the discussions while also taking notes.

2.8. Data Processing and Analysis

Data analysis first involved the transcription of interview verbatim to create a usable database. Each recording was transferred to a digital format (MP4 audio files) and organized chronologically. All verbatim transcripts were initially handwritten on A4 paper and then converted into PDF files, as exhaustively as possible, without rephrasing participants' statements, following careful review. Audio recordings were securely stored.

Thematic analysis was conducted focusing on key themes related to adolescents' knowledge of family planning and the conditions of access to reproductive health services in Bamako, according to participants' marital status.

2.9. Ethical Considerations

The study received approval from the Dean's Office of the Faculty of Medicine and Odonto-Stomatology (FMOS) and the University of Sciences, Techniques and Technologies of Bamako (USTTB). Access to the data was strictly restricted to researchers directly involved in the study. It was verified that the informed consent obtained during the primary study included authorization for the use of data for secondary research purposes. Confidentiality and anonymity of participants were rigorously maintained.

3. RESULTS

3.1. Description of Participants

Participants were aged between 15 and 19 years, with a mean age of 17.25 ± 1.55 years, reflecting a predominance of late adolescents either completing their schooling or transitioning into adulthood.

Age distribution showed that 15 participants (31%) were 19 years old, 9 (19%) were 15 years old, 10 (21%) were 16 years old, 10 (17%) were 18 years old, and 4 (8%) were 17 years old.

Regarding marital status, 73% were single, 21% were married, and 6% were engaged. This diversity highlights the range of lived experiences among adolescents in Bamako, from early marital life to singlehood, often shaped by social constraints related to sexuality and reproduction.

3.2. Adolescents' Knowledge of Family Planning

All participants in the focus groups reported having no knowledge of their sexual and reproductive rights. As one participant stated: *"I have never heard about sexual and reproductive rights, so I cannot say anything about it"* (15-year-old, single). None of the participants were able to explain the reasons for this lack of knowledge. Another participant expressed: *"I don't*

know why adolescents do not know their sexual and reproductive rights" (16-year-old, single).

In contrast to this limited awareness of sexual and reproductive rights, adolescents demonstrated a good understanding of the importance of family planning. They identified key benefits such as the prevention of unintended pregnancies, birth spacing, and the preservation of maternal and child health. Some also emphasized its role in autonomy and life planning, particularly in continuing education and preparing for adulthood. As one participant explained: *"Family planning allows adolescent girls to study well and better prepare their future without thinking about the responsibility of motherhood"* (19-year-old, married).

3.3. Conditions of Access to Family Planning According to Marital Status

Perceived difficulty of access

The majority of participants perceived access to family planning services as difficult, although the reasons varied. Some emphasized differences based on marital status. For instance: *"Access to family planning is difficult, especially for us unmarried adolescents because we are afraid to ask for these services"* (16-year-old, single). Another noted: *"It is difficult to access FP services because some providers ask about your marital status before offering services. If you are married, you may be required to come with your husband to obtain his consent"* (19-year-old, married). Others highlighted social judgment as a key barrier: *"Access to FP remains difficult due to social judgment, as some people associate contraceptive use among adolescents with immoral behavior"* (18-year-old, single). *"Access is not easy because family planning is often poorly perceived and criticized by society. In some communities, it is even considered a taboo subject"* (18-year-old, single).

Perceived improvements in access

Despite these challenges, some participants reported that access has improved over time:

"Nowadays, access to family planning is easier compared to previous years. Adolescents, whether married or not, are using FP. Some use it after their first childbirth, others take advantage of child vaccination visits to request services" (18-year-old, engaged).

Having personal connections within health facilities was also seen as facilitating access:

"Adolescents have easier access when they know someone in the health facility, who can help them receive better or even free services" (19-year-old, married).

Role of marital status

Findings indicate that marital status is a key determinant of access to family planning services. Most participants stated that married adolescents have easier access due to greater social acceptance, sometimes supported by partners, in-laws, or healthcare providers.

In contrast, unmarried adolescents face greater barriers, often avoiding health facilities for fear of stigma: *"If you are married, it is easier to access contraception because society views it positively, unlike for single girls who are often considered not allowed to use it"* (17-year-old, single).

"Single adolescents hide when seeking FP services due to fear of being judged, while married ones access them without problems" (19-year-old, married).

Some participants went further, suggesting that family planning should not be available to unmarried adolescents: *"Family planning is not intended for unmarried adolescents; it is reserved for married women"* (16-year-old, married).

Constraints among married adolescents

Although marriage facilitates access, some married adolescents still face constraints, particularly spousal control: *"A married adolescent should not use contraception without her husband's consent"* (15-year-old, married).

Barriers to access

All participants agreed on the existence of multiple barriers, including social judgment, marital status, provider attitudes, shame, fear, financial constraints, religious beliefs, and partner or family opposition.

Misinformation about contraceptive methods was also reported: *"I heard that implants can disappear inside the body and that contraception can make a woman infertile"* (17-year-old, married).

Feelings of shame and fear of judgment were common among unmarried adolescents:

"I feel ashamed to ask for FP services because I am single; people may think I have bad behavior" (18-year-old, single).

Negative attitudes from healthcare providers were also highlighted: *"A midwife refused to provide me services because she said I was too young"* (15-year-old, single). Parental and partner opposition, though less frequent, were also reported: *"My parents refuse that I use contraception"* (15-year-old, single). *"Some husbands refuse contraception because they feel frustrated and fear social judgment"* (19-year-old, married).

Facilitators of access

Some facilitators were identified, including social connections within health facilities, marital status, financial capacity, and partner support: *"Knowing someone in the health center gave me the courage to seek FP services"* (17-year-old, married). *"My husband supported me and even accompanies me to the hospital"* (18-year-old, married).

Being married and having financial resources were also perceived as enabling factors.

Provider attitudes and differential treatment

Most participants reported differential treatment by healthcare providers based on marital status. Married adolescents were generally better received and better informed, while unmarried adolescents experienced stigma: *"As a married adolescent, I noticed that we are treated with more respect than single girls… single adolescents face disapproving looks and inappropriate remarks"* (17-year-old, married).

However, a minority reported no perceived discrimination, often because their marital status was not disclosed: *"I did not notice any difference because the provider did not know my marital status"* (15-year-old, single).

Factors influencing contraceptive use

Participants identified several reasons explaining higher contraceptive use among married adolescents, including continuation of education, birth spacing, personal control over fertility, and lack of access or information among unmarried adolescents.

Some also mentioned forced marriages and conflict contexts: *"Some adolescents use contraception to avoid pregnancy during their studies or to space births"* (18-year-old, married).

"Others use it in forced marriages or conflict zones as protection against unwanted pregnancy after sexual violence" (18-year-old, married).

Expectations and recommendations

Participants expressed the need for improved adolescent-friendly services, including increased awareness campaigns in schools and communities: *"Providers should better educate adolescents"* (19-year-old, single).

They also recommended reducing or eliminating costs, improving provider attitudes, ensuring respectful communication, and involving partners.

Key recommendations included:

- Awareness campaigns targeting adolescents
- Training healthcare providers in non-judgmental care
- Equal treatment regardless of marital status
- Creation of youth-friendly spaces ensuring confidentiality

As one participant summarized: *"Awareness campaigns should be organized and providers trained on how to receive and manage adolescents"* (17-year-old, single). *"Create spaces for young people while respecting women's privacy"* (19-year-old, married).

4. DISCUSSION

The objective of this study was to analyze marital status–related disparities in access to family planning among adolescents in the District of Bamako.

Two main thematic areas were identified, based on both the literature review and participants' narratives. The first relates to adolescents' knowledge of family planning according to their marital status, while the second concerns the conditions of access to family planning services based on marital status.

4.1. Adolescents' Knowledge of Family Planning

The findings of this study highlight a marked dichotomy between limited knowledge of sexual and reproductive rights (SRR) and a relatively good understanding of the importance of family planning. Nearly all participants reported being unaware of their SRR, despite demonstrating familiarity with family planning concepts and benefits, such as preventing unintended pregnancies, spacing births, and preserving maternal and child health.

Some participants also linked family planning to female empowerment, particularly in relation to continuing education and building a more stable future—an increasingly prominent discourse among urban youth in Mali.

This significant gap in knowledge of reproductive rights likely reflects insufficient comprehensive sexuality education and limited dissemination of institutional SRH messages among young people, especially in disadvantaged urban settings. In contrast, the relatively good understanding of family planning suggests that this topic is more widely disseminated socially, possibly through awareness campaigns, community experiences (e.g., early pregnancies), and peer education initiatives.

These findings are consistent with previous studies showing that adolescents often have limited knowledge of their reproductive rights while being more familiar with contraceptive methods and services *(IeDEA Collaborations, 2024)*. National policy documents such as the Health and Social Development Plan also highlight gaps in comprehensive sexuality education targeting youth *(PDDSS)*. Furthermore, Chandra-Mouli *et al.,* emphasize that improving adolescents' access to family planning is more effective when combined with education on sexual and reproductive rights.

The observed gap between knowledge of methods and lack of awareness of rights suggests that current programs tend to adopt a predominantly instrumental approach (focused on contraceptive methods) rather than an empowerment-based approach (focused on rights and autonomy). This calls for strengthening comprehensive sexuality education by integrating legal and ethical dimensions of SRR.

4.2. Conditions of Access to Family Planning According to Marital Status

The findings indicate that marital status is a key determinant of access to family planning services. Married adolescents appear to benefit from greater social acceptance, as their use of contraception is often justified by the need to protect family health or space births. In contrast, unmarried adolescents face moral judgment, fear of stigma, and sometimes implicit denial of services by healthcare providers.

This disparity reflects the strong influence of social and moral norms that condition access to services based on the perceived legitimacy of sexual activity within marriage.

These findings are consistent with studies conducted in Mali and other sub-Saharan African contexts, which show that family planning remains a taboo topic for unmarried youth and that stigma significantly limits their access to services *(Cohen et al., 2020)*. Similarly, national reports highlight inequalities in access linked to norms associating contraception with marital life *(PDDSS)*.

However, this study provides a more nuanced perspective by capturing adolescents lived experiences, including the emotions associated with these barriers—such as fear, shame, and avoidance of health facilities.

Comparable findings have been reported in other countries in the region. In Senegal, for instance, qualitative research shows that unmarried girls using contraception are often stigmatized, which discourages them from seeking services *(Cohen et al., 2020)*. In Nigeria, studies indicate that many healthcare providers perceive contraceptive provision to unmarried adolescents as encouraging promiscuity *(Sanchez et al., 2020)*. These moral judgments, similar to those identified in this study, constitute major barriers to equitable access.

In Guinea and other West African contexts, married adolescents often benefit from spousal or family support that facilitates access, while unmarried adolescents experience social isolation and self-censorship *(Ouma et al., 2021)*. This pattern is also reflected in the present study, where several participants reported avoiding health facilities due to fear of judgment or questioning about their marital status.

Importantly, although marriage facilitates access, it does not necessarily confer autonomy. Studies from northern Nigeria show that married adolescents often require spousal or family consent before using contraception *(Hamza, 2021)*. This dynamic was also observed in our findings, indicating that marital status does not guarantee free access but rather shifts the form of control exerted over adolescents.

Overall, these findings align with broader regional trends in which adolescents' access to family planning is strongly shaped by social norms and representations of youth sexuality, particularly for unmarried girls. However, the qualitative nature of this study adds depth by highlighting adolescents' emotional experiences, dilemmas, and coping strategies in navigating a health system perceived as judgmental or discriminatory.

This underscores the need to strengthen provider training on adolescents' rights, develop youth-friendly and non-judgmental services, and adopt gender- and context-sensitive approaches.

Facilitators and quality of care

This study also provides original insights into facilitators of access, including partner support, marital status, personal connections within health facilities, and financial capacity. These factors are less documented in national literature, highlighting the added value of these findings.

Additionally, marital status appears to influence not only access but also the quality of care received. Most participants reported that married adolescents are treated more respectfully and receive better guidance, whereas unmarried adolescents face stigmatizing attitudes or even denial of services.

These findings are consistent with research conducted in Mali, which shows that healthcare providers often associate contraceptive demand among unmarried adolescents with inappropriate sexual behavior, leading to discriminatory practices *(Sidibé et al., 2023)*.

However, some participants reported neutral experiences, particularly when their marital status was not disclosed. This suggests that standardized, needs-based care—independent of social characteristics—could reduce inequalities and improve equitable access to family planning services.

5. CONCLUSION

Overall, the findings demonstrate that marital status is a structuring factor in access to family planning in Bamako. Unmarried adolescents face a double burden: social stigma and institutional reluctance. Married adolescents, while benefiting from easier access, remain subject to significant social and relational control.

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