Findings from Research

CT Innovation Lab

Imagining the future of women's contraception

Project Report / March 2018

Findings from Research

Our field research generated a collection of findings, ranging from socio-cultural trends and macro shifts that will affect the use of CT to insights specific to contraceptive experiences. Findings are supported with observations, voices from a range of stakeholders and in some cases statistics as well.

1. **Macro Social, Community and Familial Trends**

   Social norms and practices are changing, including women's roles.
   Despite empowerment, norms around marriage and fertility persist.

   Shifting patterns of familial and community support in child-rearing influence family planning.

2. **Role of Influencers**

   Regardless of relationship quality, husbands have an influence on contraceptive decision-making.

   Providers are often the most trusted source for contraceptive information and purchase.

   Discretion in contraceptive use is important as support structures and belief systems vary.

3. **Health System Dependencies**

   While healthcare quality and access are improving, women's contraceptive experience remains unsatisfactory.

   Family planning is often positioned as being child-centric rather than woman-centric.
   Traditional methods and medicine systems are still valued.

4. **Sexual Behaviors and Patterns**

   Sexual behaviors and patterns are highly varied.

   Open and frank discussions around sexuality and sexual health are lacking.

5. **Fertility is Crucial**

   For women who have not had children, fear of infertility is a deterrent to contraceptive use.

6. **External Factors Around Contraceptive Methods**

   Contraception is not just about unit price, but rather the cost of use.

   Modern contraceptive methods are available but not accessible.

7. **Methods, Experiences and Beliefs**

   Over their reproductive cycle, women experiment with many methods.

   Perceptions and biases around the appropriateness of methods vary across life stages.

   Long-term methods are both a blessing and a curse.

   The safe and non-medical nature of traditional methods outweighs the risks and challenges associated with use.

8. **Method-Use Barriers**

   Women do not feel in control of the methods they use.

   Familiar formats increase acceptability but do not necessarily guarantee adherence.

   Despite awareness, most methods are not relatable.

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Macro Social, Community and Familial Trends

Social norms and practices are changing, including women's roles.

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Economic realities are transforming ideas about gender roles, relationships and ideal family size. Rising costs and shifting social norms are having a marked effect on perceptions about when and whether to get married, when and how many children to have, and who is involved in such decisions. Increasingly, women play an important role both in and out of the home, with traditionally gendered roles of 'provider' and 'caregiver' becoming ever more blurred.

Mass and social media consumption is increasing and together with education and urbanization constitute a powerful modernizing influence that has helped form a more liberal and progressive younger generation.

1. ***Large family sizes are no longer the dominant ideal. The average number of children decreased by 20% overall - in India between 2005 and 2013 and in Kenya between 2003 and 2014.*** DHS

2. ***In India, 63% watch television at least once a week, with access to over 700 cable and satellite channels.*** Open Society, 2014

   Almost 90% of Kenyan households have a mobile phone, while 68% have a radio and 35% have a television. Kenya DHS, 2014

3. ***In Kenya, three-quarters of married women aged 15-49 reported employment in the previous year, but 20% of those received no compensation for their work.*** Kenya DHS, 2014

Social norms and practices are changing, including women's roles.

In India, while marriage remains the norm, subtle shifts in power dynamics are reflected in delaying marriage and pregnancy to pursue educational and/or professional goals. Earlier, while having more children was a sign of prosperity and stability, women, especially in India, are increasingly seeking to have smaller families. Public health campaigns that discourage marriage before 18 and childbirth before 21 have also driven this shift.

Attitudes are shifting towards a more inclusive gender mix. In India, this is reflected in shifting family structures that are being spurred by a more liberal younger generation. There is growing recognition that girls should also be educated. Government schemes are promoting this, which has led to decreased gender bias.

> ***"He wants me to be at home, but I want to work. My money is mine. It feels good to have an income so you don't have to ask your husband for money."***
>
> Rani, 30, West Bengal

Social norms and practices are changing, including women's roles.

Women now play an important role in both the home and the outside. In Kenya, a large number of women express the need and desire to be self reliant owing to the fast-changing roles of men and women within the community. In India, women also express the need to supplement household income, but are more likely to work in the informal sectors. Most women want better lives, primarily to safeguard the health and welfare of their children.

The perception that men are less responsible than in previous generations has reinforced the desire for self-sufficiency amongst Kenyan women. Women raising children on their own without the obligations of marriage is becoming more prevalent. Furthermore, having multiple sex partners - even in marriage - is becoming common. The economic volatility that most people experience is also leading to the rise of new kinds of plural relationships. Many of these might have a functional or transactional ambit.

> ***"In African culture the man is the head of the family, but in this generation it's just a title. It is the woman who controls everything and holds it all together."***
>
> Lilly, 26, Nairobi

"When I was younger, the man would be the one to put food on the table while women took care of the children. But today, women are everything - providers and caregivers."

Sophie, 29, Nairobi

Despite empowerment, norms around marriage and fertility persist.

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Despite increasing empowerment, traditional roles still represent the future for many women. For many, the pressure to marry and conceive young remains the norm. In both contexts, women are expected to assure family lineage, and demonstrating the ability to conceive remains a key responsibility associated with the role of a wife. This empowerment, therefore, has not led to a change in the norms around fertility and its understanding, the preservation of which remains sacrosanct for both men and women.

1. *In Kenya, current employment has increased among women from 57% to 61% since 2008-09. At the same time, 29% of women in the ages 25-49 were married by age 18, and 48% by age 20, while 25% of Kenyan women in the ages 25-49 had given birth by age 18 and 47% by age 20.* Kenya DHS, 2014

2. *In India, 26% of married girls in the ages 20-24 got married before the age of 18.* NFHS 2016

3. *More girls are being educated, but they are not working. In rural India, 67% of female graduates do not work; in more urban settings, 68.3% female graduates do not have a paid job.* UNDP 2015

Despite empowerment, norms around marriage and fertility persist.

Marriage and motherhood are the reality for most women in India, irrespective of their level of education and employment, as the family has to be their first priority. Despite some young empowered girls going against the grain to delay marriage, the pressure to settle down persists even for them. For many Indian women, (re)entering the workforce is only possible when children are of school age or grown, and women's negotiating power within the family increases as they - and their children grow older.

The need to demonstrate one's fertility immediately after marriage was called out as important by women in both India and Kenya. Moreover, in Kenya, the need to remain fertile continued even in the later years of a woman's life, in case she is remarried or her husband desires more children. In Kenya, many men desire large families and equate their having many children as a sign of masculinity. In India, this perception is steadily shifting given the multiple government programs aimed at promoting smaller families.

> ***"You get married to have children. If you aren't fertile, your husband will find another wife."***
> Sheila, 25, Nakuru


“I wanted to at least finish school but I had to drop out in 10th, once my marriage got fixed. Now my only dream is to give my kids the opportunities I didn’t have.”
Lata, 21, Delhi

Shifting patterns of familial and community support in child-rearing influence family planning.

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In Kenya, the community's role in child-rearing appears to be reducing owing to changing social and economic structures. Traditionally, the community was responsible for ensuring that a child is inducted into all the spheres of community life. However, changing value systems, aspirations and realities are leading to a fragmentation of community ties. This has a direct impact on fertility aspirations as well as the socio-cultural upbringing of children.

On the contrary, in India, family planning has mostly been an extended family affair - women's and even couple's preferences may take into account opinions of elders, particularly the mother-in-law.

1. ***A 2013 study conducted largely in urban Kenya found that 23% of men and 30% of women reported their never discussing family planning with their partner.*** Tumlinson et al., 2013

2. ***In India, despite a progressive increase in nuclear family structures, extended families still play a critical decision-making role in almost all aspects of life including career choice, mate selection and marriage.*** Chadda and Deb, 2013

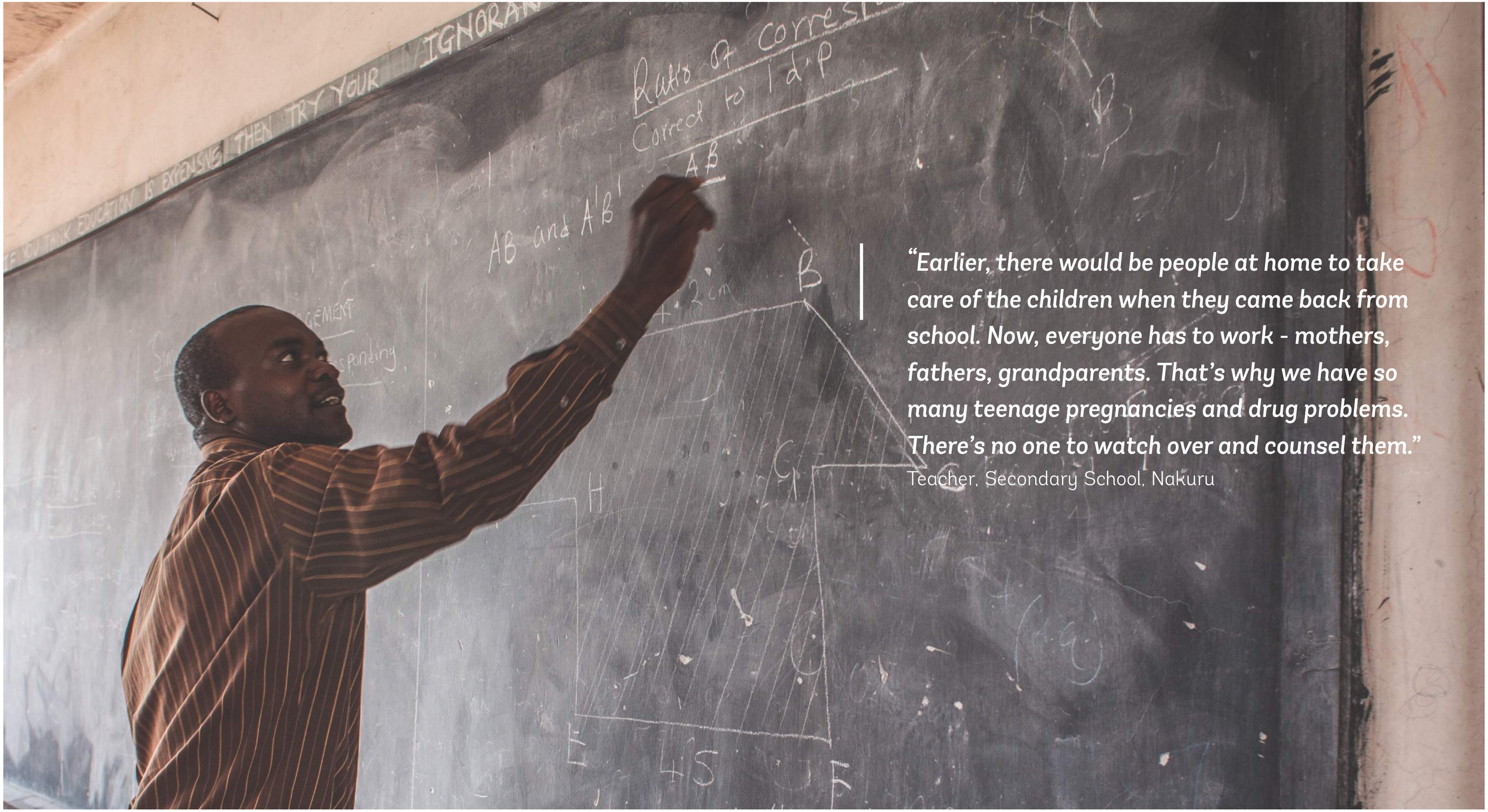
Shifting patterns of familial and community support in child-rearing influence family planning.

In Kenya, traditional family structures are becoming less apparent. Women - whether single or married - bear the burden of managing their families primarily by themselves. Husbands or male partners are mostly excluded from decision-making around family planning, especially if they are perceived as unable or unwilling to provide financially.

In both countries, newly married couples are expected to have a first child immediately after marriage. Women also rely on the wisdom, experience and aspirations of their extended families and community circles to help with raising their children.

In India, decisions around child-rearing and family planning are not made solely by the husband and wife, but involve opinions of and permissions from other family members. But increasingly, some younger couples may deviate from their family's wishes and seek more autonomy in planning and managing their family.

> ***"After my second daughter was born, my husband and I decided I should get the operation. My mother-in-law was against it as she wanted us to try for a son. But, my husband took my side, because he knew we couldn't afford another child."***
>
> Maya, 25, West Bengal



"Earlier, there would be people at home to take care of the children when they came back from school. Now, everyone has to work - mothers, fathers, grandparents. That's why we have so many teenage pregnancies and drug problems. There's no one to watch over and counsel them."

Teacher, Secondary School, Nakuru

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Role of Influencers

Regardless of relationship quality, husbands have an influence on contraceptive decision-making.

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Women's decisions around contraceptive use are often made collectively, in consultation with different stakeholders.

In India, we found that women felt it was essential to take into account their husband's preferences, evident or perceived, while choosing a CT for themselves. Even providers, when talking to women about contraception, discuss the partner's involvement. Women also usually informed their partners about their CT choice and use. For methods like tubal ligation, active partner consent was a must.

Also, given that sex is still a taboo topic, husbands are often the ones procuring contraceptives from the market for their wives; they might even play a role in ensuring compliance.

In cases where families were living jointly, contraceptive decisions were affected by other family members and relatives. Since knowledge around contraception usually occurs only after marriage, the husband, mother-in-law and sisters in-law are often the first points of awareness around sex and fertility.

> ***"My husband and I talked about it and decided we don't want another child for 7-8 years. I don't know much about these things but when our son is a little older, we will go to the doctor and decide what to use. If my husband doesn't agree to something, I will not use it."***
>
> Aarti, 18, Delhi

"I didn't know how babies were born. When I didn't get my menses, I told my husband. He bought me a pregnancy test and told me how to use it."

Parvathi, 26, West Bengal

Providers are often the most trusted source for contraceptive information and purchase.

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There is always some anxiety around proper method use or managing side effects; thus, many women prefer to obtain methods at the clinic, where they feel they have access to more accurate information. Even if a method is self-administered, women might prefer to first get it at the clinic, so they can understand how to use it correctly.

Clinics are also trusted to provide authentic products in contrast to counterfeit or fake products that might be given in the open market. When providers communicate the right information about methods, including side effects, even troubling ones such as changes in menstrual cycles, it is better accepted by women.

In spite of this crucial role that providers play within the reproductive health ecosystem, there is often lack of information and adequate training among different providers and facilities. This implies that women may receive inadequate information and are sometimes even left to themselves to understand and manage contraceptives.

> ***"The family planning clinic is the only place one woman can talk to another behind a closed door about things that are usually not discussed."***
>
> Nurse, Family Planning clinic, Nakuru

“After my baby was born, the doctor gave me some pills to take. I didn’t know what they were but I started feeling very unwell. That’s when I found out they were to stop children. But I wasn’t angry, she did it for my own good.”

Rekha, 28, Delhi

Discretion in contraceptive use is important as support structures and belief systems vary.

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In Kenya, contraception is often seen as a sanction for wayward behavior; using it could signify a ‘weak bond’ in the relationship. Even women with multiple partners often chose not to use contraception at all, owing to a fear of judgment and lack of support from their partners.

Adolescents, especially in urban areas, may have relationships with multiple partners - in which contraception may or may not be used. Lack of support from partners and other community members often leads to non-use of contraception in both countries.

Being regarded as a private matter, contraceptive methods like injectables are extremely popular in Kenya, even amongst women in stable relationships, because they may be used without partners or families finding out. Conversely, in India, because contraception is not a private matter, women desire discretion in order to have more control over their choice and use.

> ***“It’s usually men who come to buy the pills for their wives. They won’t know the names, but they will carry the previous packet to show me which one they want.”***
> Chemist, Delhi

"For my first method, I preferred Depo over pills because I didn't want my husband to find out I was using something."

Alice, 42, Nairobi

Findings from Research

Health System Dependencies

While healthcare quality and access are improving, women's contraceptive experience remains unsatisfactory.

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Both Kenya and India have made important strides to reduce maternal and child morbidity and mortality. However, disparities exist across geographic contexts. While urban populations have access to a wider range of public, private and faith-based options for healthcare, in rural areas, services are primarily delivered through public sector and community-based services. However, across the spectrum, family planning services are lower in priority.

Although access is improving, the quality of services continues to be uneven and unreliable across different settings with stretched systems and overburdened health workers. Contraceptive methods are gradually becoming more accessible, but still do not fulfill the needs of many women.

1. *[In Kenya] six in ten live births were delivered in a health facility, 46% in the public sector and 15% in the private sector. Still, more than one-third of births (37%) took place at home.* Kenya DHS, 2014

2. *Around 900,000 public-sector ASHAs in India are improving last mile access to healthcare and nutrition.* NHM, 2013

3. *85% of the Indian family planning budget is allocated for female sterilizations.* PFI 2016

   77% women had not used any other method of contraception before accepting sterilization. NFHS-3 2006

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In both countries, most women - urban and rural - access maternal and child health (MCH) and family planning (FP) services through the public sector, with community health workers being frontline providers. Despite this, some women (unmarried, adolescent, religious minorities) find these services hard to access. Women may also prefer private sector chemists, registered medical practitioners (India) or other providers, as they are perceived to be faster to access with less hassle involved. Yet, some health officials worry that the private sector is less regulated.

Even though access to FP services has increased in India, estimates of modern contraceptive use indicate a decline over the last decade. Uptake of reversible modern methods remains low, with female sterilization accounting for 76% of method use. But high sales of emergency contraception and abortion kits suggest that the demand for spacing methods exists.

In Kenya, contraceptive use is prevalent, but FP needs remain unfulfilled for many. Shorter-term methods, including injectables, pills and condoms are being used, while multiple barriers to long-acting and permanent contraception continue to exist.

> ***"We only have two nurses who are trained to insert IUDs. Sometimes when women come asking for an IUD and those nurses aren't available, we just have to give them injectables instead."***
>
> Nurse, Local Dispensary, Nakuru

"I became an ASHA worker for financial reasons, but I always wanted to learn about health and be able to help others through that. It is what keeps me going."

ASHA, West Delhi

Family planning is often positioned as being child-centric rather than woman-centric.

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Family planning services are often bundled under maternal and child health services, which means many women get counseling only after they have had at least one child. Many regret their lack of knowledge about contraception and wish they had better knowledge and protection at the time they started having sex.

In Kenya, we heard providers say they would caution nulliparous married women against using hormonal methods such as OCPs and injectables, as they felt it would make them infertile (a perception fueled by variable rates of return to fertility, especially with injectables). In India, we saw ASHAs position contraceptives as a means for postpartum spacing and child development, which might exclude couples who wish to delay starting a family as well as unmarried women.

> ***"I go to new mothers to counsel them about contraception so they can wait before having their next child. I do not talk to young girls; if I do, then people will say I am promoting pre-marital sex."***
>
> ASHA, West Bengal

"I was told to come for counseling a few weeks after my baby is born. I still don't know much about contraception."

Catherine, 17, Nairobi

Traditional methods and medicine systems are still valued.

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While Western medicine has made significant in-roads in both urban and rural areas, it is common in both countries for people to complement this with traditional remedies. Western medicine is deemed to be reactionary rather than preventative. Traditional medicine, however, is seen by many as providing holistic solutions that take into account more than just the presenting ailment or disease.

1. ***In India, about 70% of rural population depends on the traditional Ayurvedic system of medicine. Most practitioners of traditional systems of medicine prepare formulations with their own recipes and dispense such preparations to the patients.*** Pandey et al., 2013

2. ***In Kenya, regulation of traditional medicine and practitioners can be problematic, and there is tension between conventional providers and those they perceive as 'quacks'.*** Africa Research Institute

3. ***In Kenya, traditional healers are both common and popular, particularly among rural populations where access to 'Western' medical services and/or financial constraints may constitute barriers to such care.*** Africa Research Institute

Traditional methods and medicine systems are still valued.

In India, many people use Ayurvedic medicine exclusively or combined with conventional Western medicine. Its guiding principles on health and disease promote individualized treatments, including herbal compounds together with diet, exercise and lifestyle recommendations. This is in contrast to Western medicine, which is seen as more disruptive to the body.

In Kenya as well, there is a preference for 'natural'/herbal and holistic treatment systems versus the 'chemical' nature ascribed to 'Western' medicine. Herbalists and local healers in Kenya are also more trusted than Western medicine providers, who offer unfamiliar solutions with little explanation.

Traditional contraceptive methods, like fertility awareness, withdrawal, lactational amenorrhea, continue to be used by women despite the availability of modern methods. They are championed as being all-natural and offering more user control. However, these often require careful use, partner compliance and body literacy (and numeracy).

> ***"What's the point in using a contraceptive if you still get pregnant while using it? I would rather use a natural method instead of going through this."***
>
> Rose, 34, Nairobi

"When my children fall sick, I take them to the doctor. But for myself, I prefer going to the Ayurvedic doctor. Our family has been going to him for many years. He knows us and listens to our troubles instead of just handing out medicines."

Mala, 32, West Bengal

Findings from Research

Sexual Behaviors and Patterns

Sexual behaviors and patterns are highly varied.

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People exhibit a wide range of sexual behaviors - spontaneous vs planned, infrequent vs often. Current contraceptive methods do not always match these patterns of sexual frequency and spontaneity.

Sometimes sex is seen as something that panders to men's desires, with their being the initiators. Women may not be able to refuse, believing that it is their duty to make their partners happy. However, some women also derive pleasure from and are also the ones to initiate sex. No matter what the context, sex most often is not planned and predictable.

While the unplanned nature of sex made it difficult to use on-demand methods, many women felt it was needless to use 'continuously acting contraceptives' given the varying frequency of sex. They felt that this caused them to unnecessarily have a lot of medicines in their body, which would cause harm in the long term.

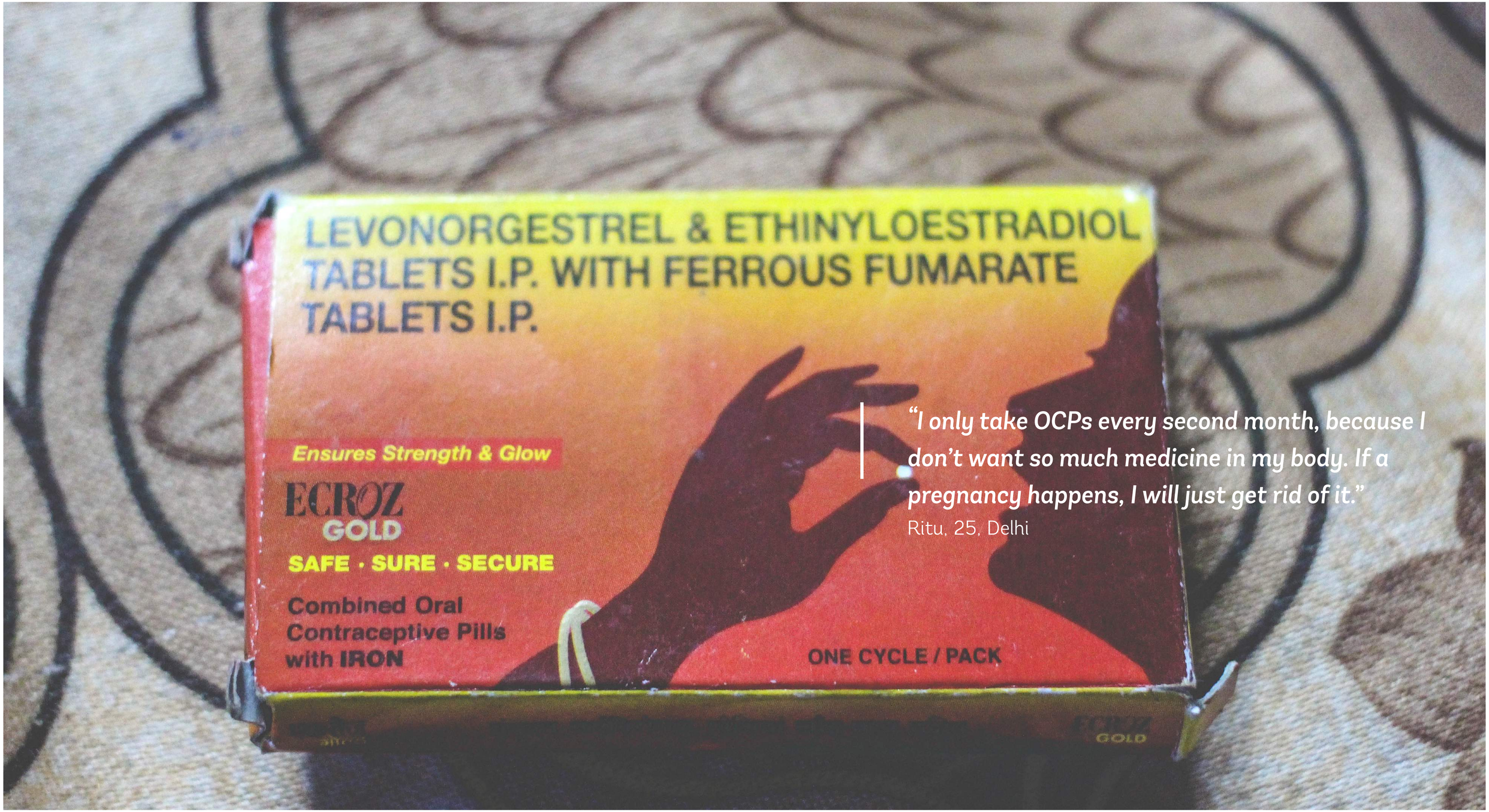
> ***"People think a husband and wife have sex everyday, but when you see each other all the time you don't even feel like it."***
>
> Community Health Worker, Nakuru

Sexual behaviors and patterns are highly varied.

CT perceptions and behaviors of young adults, in particular, mirror their spontaneous and unplanned sexual frequency and patterns, whereas most existing methods require a long-term planning mindset. In both India and Kenya, we found that time or procedure-intensive methods do not fit 'youth lifestyles' and are perceived to be more relevant for 'serious' married audiences. They preferred methods that did not involve long waiting times or elaborate screening and procedures, and their perceptions around contraception tend to be reactive, not preventative.

Continuous protection is not necessary for everyone and can be perceived as too much exposure to 'medicine'. Many women prefer to minimize their risk of side effects by using on-demand, emergency or short-acting methods and prefer not to contracept continuously when sex is infrequent. Some women have used abortion kits multiple times as a 'backup' CT when other methods were unavailable or unsuitable.

> ***"The youth club promotes LARCs, but the client wants 'right now' methods like injectables and e-pills. Stuff that is very quick."***
>
> Counsellor, Youth Club, Kisumu



"I only take OCPs every second month, because I don't want so much medicine in my body. If a pregnancy happens, I will just get rid of it."

Ritu, 25, Delhi

Open and frank discussions around sexuality and sexual health are lacking.

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Whether in India or Kenya, talking about sex is taboo for unmarried adolescents. Among adult women and men, even for those in equitable relationships, many topics remain unspoken - especially when it comes to intimacy, sex and relationships.

While conversations around sex are limited, the younger generations are pushing back, exploring and expressing themselves more. In Kenya, Sheng, a popular youth slang is fast becoming the language for youth to discuss intimacy, sex and other previously taboo topics. In India, young people are increasingly choosing their own partners, as against the arranged marriage norm.

1. ***In India, only 15% of young men and women in ages 15–24 had received family life or sex education.*** National Study, 2006-07

2. ***In Kenya, one in four adolescent girls in ages 15–19 in the lowest wealth quintile has begun childbearing. Even among the wealthiest, one in ten girls in ages 15–19 has begun childbearing.*** DHS 2014

3. ***There is support for sexuality education from the Kenyan government, but education-sector policies have largely promoted an abstinence-only approach.*** Guttmacher 2017

Open and frank discussions around sexuality and sexual health are lacking.

Family members are often the first source of information about sex, but the information itself may be superficial and may arrive later than needed. Sexual and reproductive health (SRH) education and awareness continue to be limited in both countries.

In India, women arrive in their husband's home with little information about sex, pregnancy or contraception. They must rely on their mother-in-law or sisters-in-law for such information. The first pregnancy for women - whether married or unmarried, often comes as a surprise and brings with it an understanding of the link between sex and reproduction. Many women express regret about their not being better informed or prepared.

> ***"Both my husband and I didn't know anything (about sex). When I went back home, my sisters asked me about it and I said we didn't do anything. Then she explained it to me, and said when he comes into the room at night, I should give him my permission."***
>
> Aafiya, 25, Delhi

Open and frank discussions around sexuality and sexual health are lacking.

Both in India and Kenya, socio-cultural biases prevent young girls and women from getting the information and services they need. In Kenya, young girls may be cautioned by family and elders, who inflate the fear of contracting HIV or other sexually transmitted diseases as a way to get them to abstain from sex. But, several strategies are being implemented to bridge these information gaps. They include the use of youth friendly spaces and adolescent friendly clinics in Kenya and the engagement of ASHAs in India who are trained to use humor as an ice breaker.

Older women also lack safe spaces to talk about sex. They may rely on trusted 'others' to discuss issues that arise within their relationships. In Kenya, this was sometimes the mother, a pastor or even a family planning provider, as their partners would often not participate in conversations around sex and relationships.

> ***"We have a health club at school, but they only teach us about sexual violence or diseases. Nobody wants to have a real conversation with us, so we go to the internet. But even that can have wrong information."***
>
> Mercy, 17, Nakuru

"Young people don't come to me for advice about contraceptives and family planning, only married people do. They don't want anyone in their community to know they're having sex."

Community Health Worker, Nairobi

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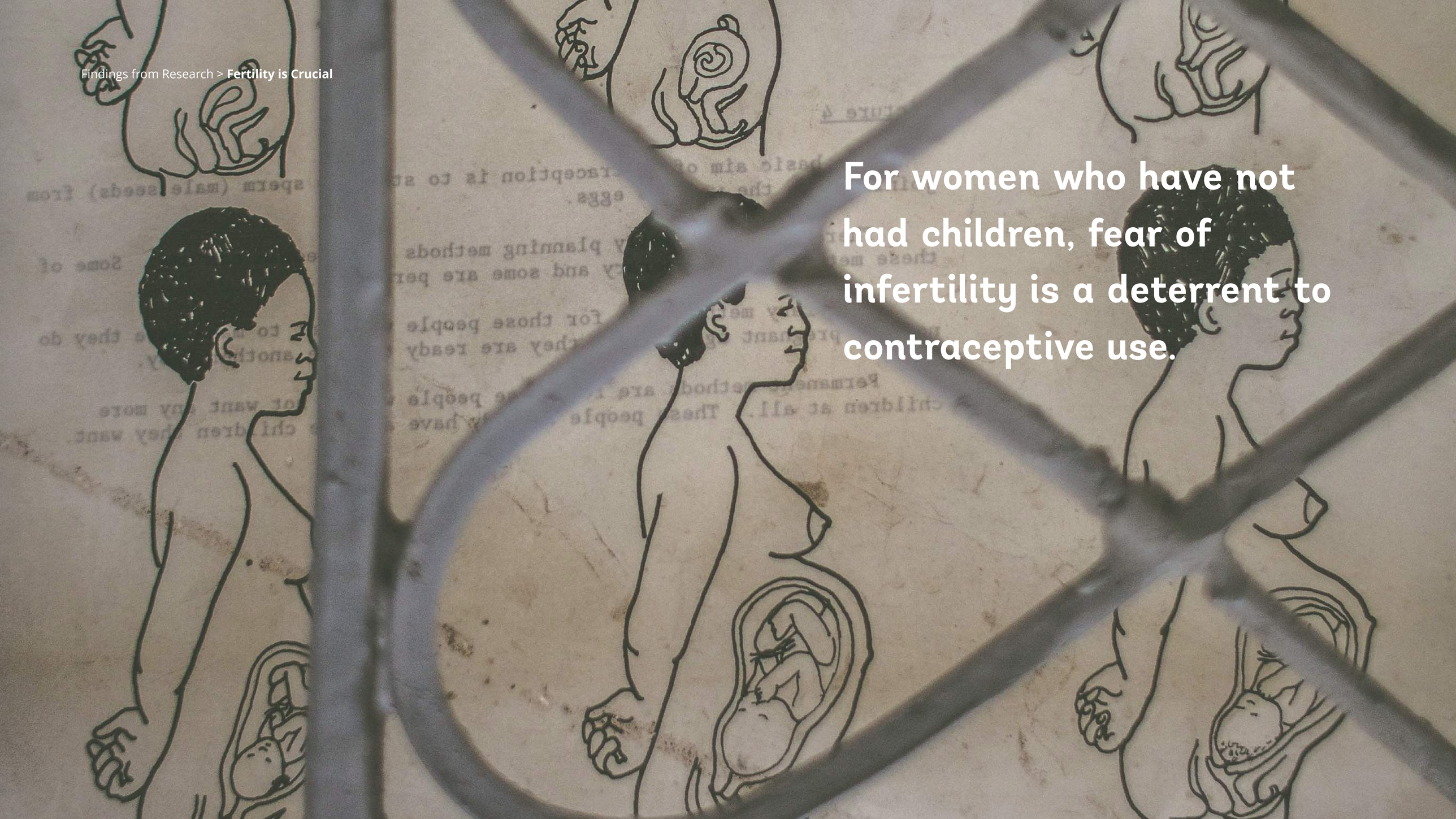
Fertility is Crucial



For women who have not had children, fear of infertility is a deterrent to contraceptive use.

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Many of the myths, misconceptions and urban legends around modern contraceptive technologies arise from a desire to protect future fertility and pregnancy aspirations. In both India and Kenya, women consider irregular menstruation and amenorrhea to be abnormal and menstruation to be a natural indicator of fertility. Because hormonal methods are closely associated with undesirable side effects, including menstrual cycle changes, they are less popular among some women.

An unpredictable return to fertility can cause anxieties, even within families that already have children. In both India and Kenya, a woman's childbearing ability is considered paramount, irrespective of how many children she has. There is a fear of partner and community rejection if you are not fertile.

Amenorrhea can be more acceptable in later stages of life. Women do not mind the absence of periods after achieving their desired family size, which makes hormonal methods more acceptable. Nevertheless, in Kenya, women ruled out the use of permanent methods in case their situation changed, and instead opted for long-acting hormonal methods like implants.

> ***"After five years of using Norplant, it takes another three years to get a baby. If this individual has to wait three more years, there will be suspicion from the community about why she is not getting pregnant."***
>
> Margaret, 30, Nakuru

"I have heard that when you take the pill you don't get your period anymore. That is not natural. Your period is the reason you are able to have a child and it is a woman's duty to have children."

Sangeeta, 21, Delhi

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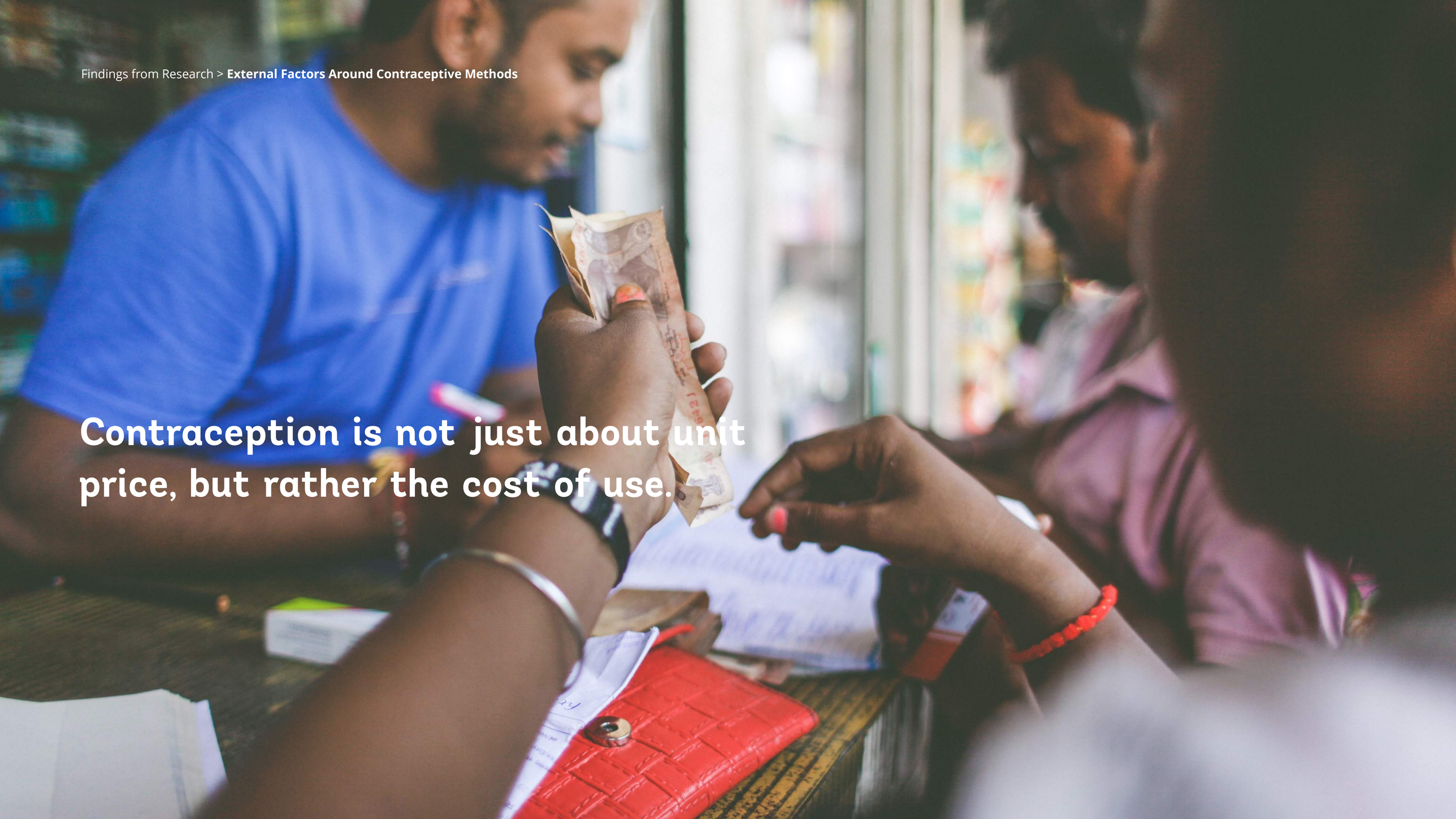
External Factors Around Contraceptive Methods



Contraception is not just about unit price, but rather the cost of use.

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In India, female sterilization remains the most common method, but it also requires sufficient recuperation time to avoid infections and complications . However, many women delay it till they can afford to take the time off for aftercare and may use traditional methods in the meanwhile, which may fail and lead to unplanned pregnancies. In Kenya, implants are provided free of cost but removal may require a substantial fee.

The opportunity cost of missing work days because of side effects becomes a barrier to adoption and use. In both India and Kenya, we found not only that aftercare recommendations were difficult and costly to follow through, but also that the physical side effects. and possible complications had financial implications for women who had to miss work or travel far to receive treatment.

In affecting women's libidos, contraceptive use may cause problems between married couples, which thus makes side effects a cause for physical as well as emotional distress. Also, side effects like heavy bleeding that limited sexual activity put a stress on relationships.

> ***"I need a permanent solution, but I don't want the operation right now because I have just started work and can't afford the three-month bed rest that it requires."***
>
> Lata, 32, West Bengal

"We went there because they were putting in the implant for free, but we had to pay 2000 shillings to remove it."

Mercy, 34, Nairobi

Modern contraceptive methods are available, but not accessible.

Modern contraceptive methods are available, but not accessible.

Providers' perceptions and biases around the appropriateness of methods for women at different reproductive stages can impact access and method choice. In India, stigma around premarital sex acts as a barrier for unmarried women to access contraception, especially at public health clinics. In Kenya, many adolescents called out 'over-counseling' or 'asking too many questions' as a reason for preferring chemists over youth clinics, even though the latter provides free-of-charge products and services. Even community health workers who stock oral contraceptives are only allowed to give it to clients once they have obtained a prescription from the local clinics. Thus, girls would resort to using emergency contraceptives when they have had sex, often bought by their boyfriends from a private chemist.

> ***"It is very difficult to get condoms from government hospitals. They will ask questions like 'Who is your boyfriend? Where do you live?' Most girls will send their boyfriends, because they are too scared to go themselves."***
>
> Pinky, 20, Delhi

Modern contraceptive methods are available, but not accessible.

Barriers to access are felt even by older women. In Kenya, older women felt embarrassed or self-conscious of going to public clinics or chemists, as they did not want people to know they were sexually active. Many women also missed their recurring injectable shots because they could not afford transport to the clinic. In India, as sterilization is the method of choice to limit, most middle-aged and older women did not really access other forms of CT. Those who did not opt for sterilization had to find convoluted ways to access contraception- through ASHAs or their husbands- and sometimes even by refusing to have sex.

> ***"If an older client comes to the clinic, I will make sure I make her sit in a separate section, as they get embarrassed to sit in a room with young-young girls."***
>
> Nurse, Private Clinic, Nakuru

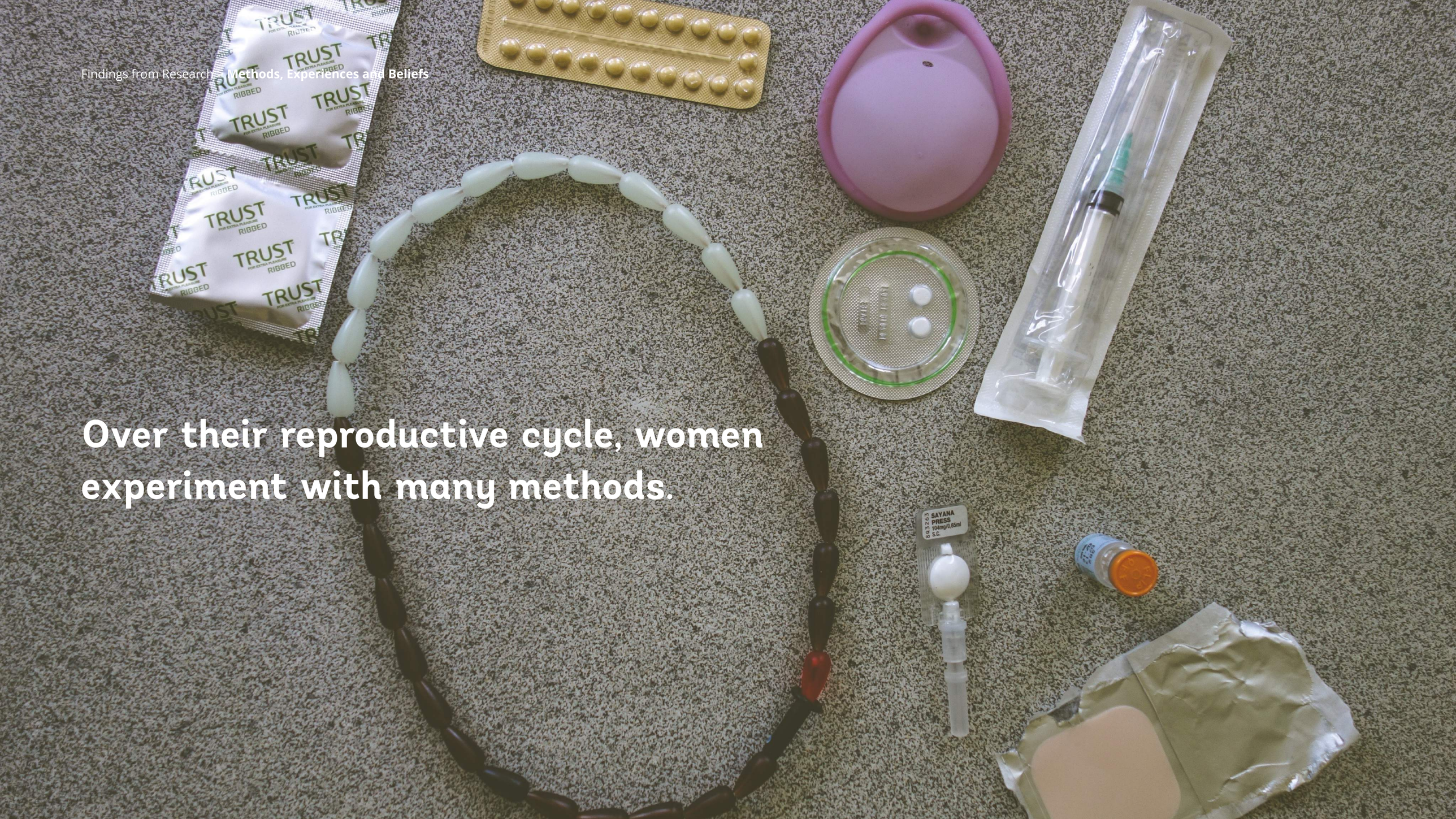
“We had a stock of P2 that was nearing expiry, and we sold it to the private sector. Apparently the stock got sold out within three months.”*

Administrator, Public Hospital, Nakuru

*A brand of Emergency Contraception popular in Kenya

Findings from Research

Methods, Experiences and Beliefs



Over their reproductive cycle, women experiment with many methods.

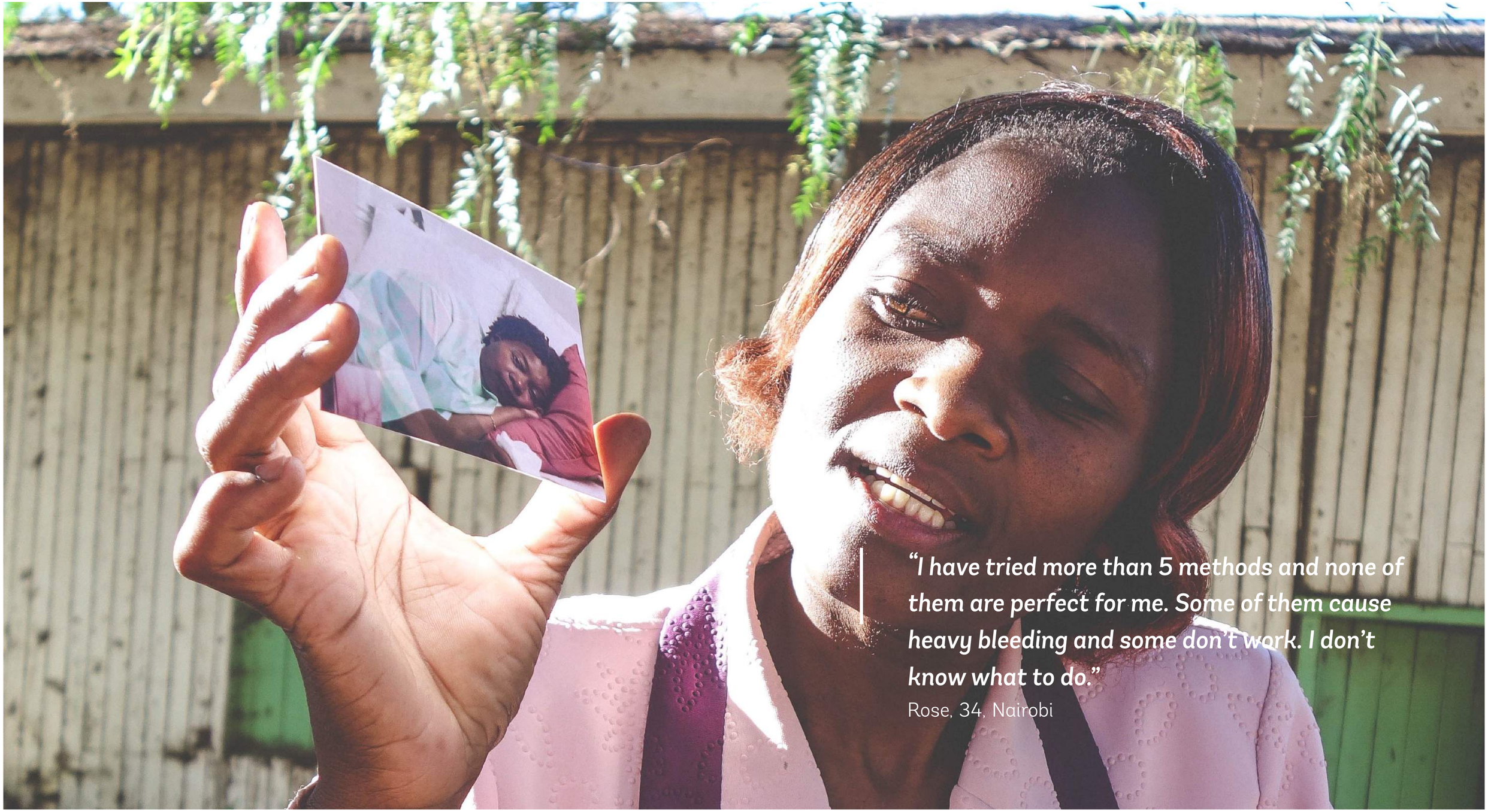
Over their reproductive cycle, women experiment with many methods.

Each time a method proves to be ‘ineffective’ (i.e., they fall pregnant) or ‘intolerable’ because of side effects, women look for a new method. Hormonal methods are the least popular amongst women because of their side effects. However, accidents or method failures that cause them to seek abortions have also been triggers for women to adopt methods previously deemed too invasive or ridden with side effects.

Women who have used multiple methods and suffered a lot because of side effects are willing to pay for a method that does not affect their body. In both Kenya and India, we found some women to have a strong preference for herbal and natural methods, which are also well-branded and actively promoted around the ‘natural’ angle.

In Kenya, we heard about the once-a-month ‘Chinese pill’, which was available through herbalists. In India, we found an Ayurvedic pill (B Gap), meant to be taken once in six months, that women spoke about positively.

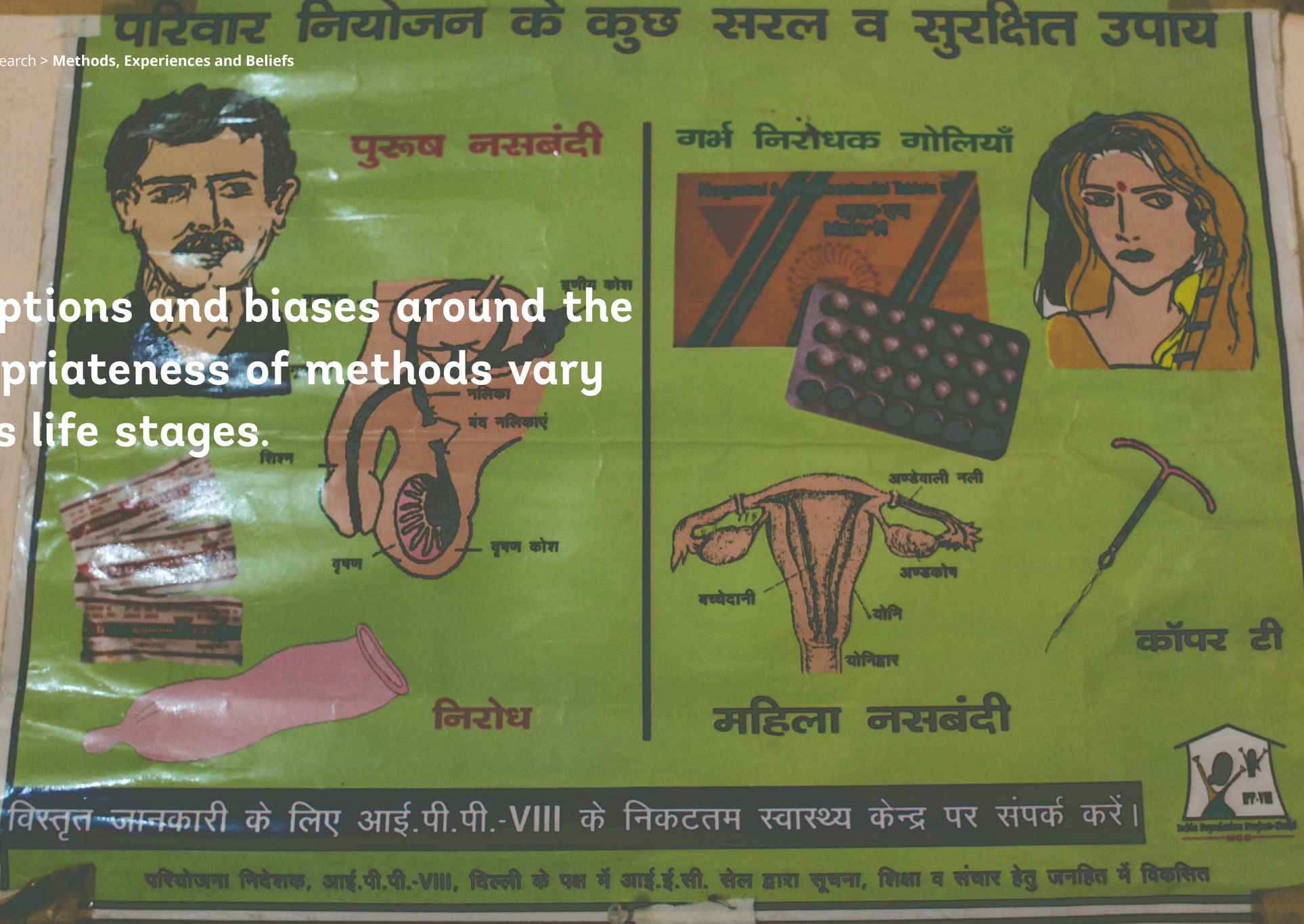
> ***“I started using the pills after my first baby was born, but I would feel very dizzy. The doctor recommended another pill, but I just didn’t want to use medicine. That’s when I tried the IUD, but that gave me intense pains in my stomach. After that I decided it’s just better to use control.”***
>
> Neelam, 27, Delhi



"I have tried more than 5 methods and none of them are perfect for me. Some of them cause heavy bleeding and some don't work. I don't know what to do."

Rose, 34, Nairobi

Perceptions and biases around the appropriateness of methods vary across life stages.



Perceptions and biases around the appropriateness of methods vary across life stages.

The stigma around premarital sex acts as a barrier for unmarried women to access contraception. Providers prescribe very specific methods based on generalizations around a client's life stage, parity, and gender composition of their children.

Providers also perpetuate biases against hormonal methods. For nulliparous women, the fear of infertility is a deterrent to contraceptive use. Providers themselves often worry that hormonal methods could affect a woman's fertility, thus leaving nulliparous women intent on delaying childbirth with few CT options. Even in India, where women tend to marry young, the pressure to have children immediately is beginning to ease, with husbands and mothers-in-law favoring delaying childbirth until the woman seems ready for motherhood. However they do not condone use of hormonal contraception.

> ***"I don't recommend IUDs to just any women. If she's a young woman with one baby and wants to wait before having another one, she can get the IUD — so she can put it and forget about it. But if she hasn't had a baby, I can't put something in her stomach."***
>
> FP Nurse, Local Dispensary, Nairobi

"If a girl hasn't had children I only provide condoms, not pills. Pills can change their hormones and should only be used by women who already have children."

ASHA, West Bengal

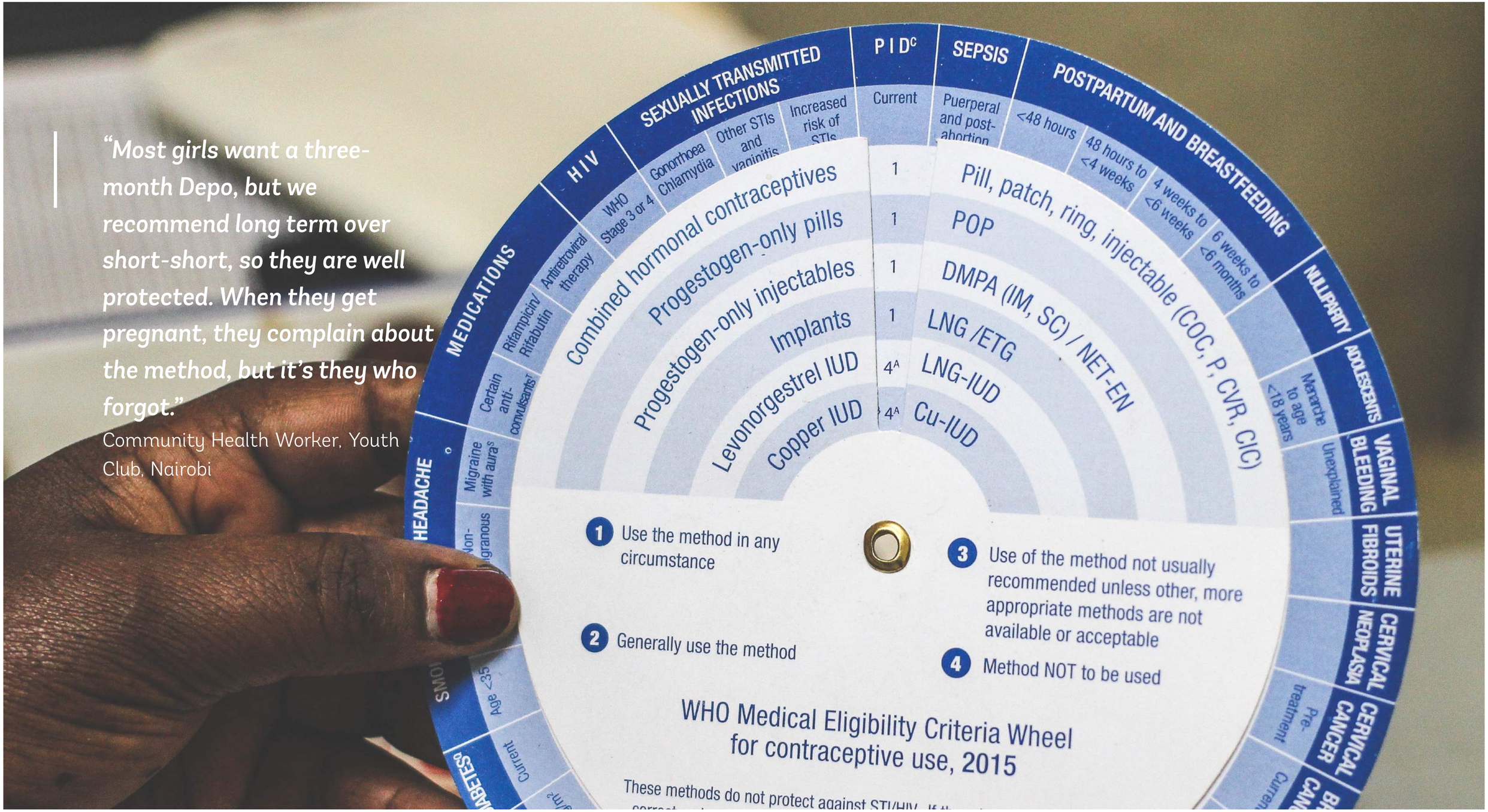
Long-term methods are both a blessing and a curse.

Long-term methods are both a blessing and a curse.

Long-acting methods are perceived as highly effective by both providers and users, but since appropriate screening may not always take place, users are wary of being tied to a method in case they experience side effects.

While many providers endorse long-acting methods like IUDs and implants as being cost effective and ‘foolproof’, short-term methods like injectables are preferred (even though they have some of the same side effects as LARCs), because they allow users to ‘take a break’ from side effects, are not as invasive to insert and do not require a highly trained healthcare provider to access or to remove.

> ***"My neighbor tells me you get backaches and pain 'down there' for many days (after getting IUD). And even then, it might not fit your body and you need medicines to feel better. I find it too scary - condoms might be risky, but at least it is outside."***
>
> Sunita, 35, Delhi



"Most girls want a three-month Depo, but we recommend long term over short-short, so they are well protected. When they get pregnant, they complain about the method, but it's they who forgot."

Community Health Worker, Youth Club, Nairobi

The safe and non-medical nature of traditional methods outweighs the risks and challenges associated with use.

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External applications are preferred and perceived as less interfering than invasive methods. The idea of having objects that ‘don’t belong in the body’ is a cause for concern for many. It is seen as being disruptive to the body’s natural processes. For Muslim women, in particular, surgical interventions that alter a woman's physiology are considered to be prohibited on religious grounds.

Those in equal relationships who are apprehensive of modern methods or have had failed experiences prefer their partner uses natural methods such as ‘control’.

Fertility awareness methods (FAMs) are desirable, but seen as more appropriate for ‘educated’ people. Women felt they needed to have basic numeracy and body literacy to understand their ovulation cycles - something they did not have.

> ***"I got the implant after my first baby, but it made me bleed a lot. I became very weak and skinny. Anything that goes into your body and stays there for so long will effect your blood. After that I started using natural FP."***
>
> Miliscent, 32, Nairobi

“I trust my husband, he has good control. Anything can happen even if you use condoms, pills or IUD. So might as well use this (withdrawal).”

Kshama, 27, West Bengal

Findings from Research

Method-Use Barriers

Women do not feel in control of the methods they use.

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Even though multiple products are available, women feel there is a lack of options when it comes to finding a contraceptive which combines their preferred delivery mechanism and duration.

Women feel that they have little or no control - especially with longer-term methods, as fertility is unpredictable, and they are unable to opt out in case of side effects.

Women will accept certain trade-offs for higher assurance and control. Accidents with short-term and daily use methods that lead to abortions might trigger women to adopt more invasive methods such as IUDs.

In India, women often choose sterilization over other methods and tolerate the pain and discomfort of the procedure, so that they can be ‘tension-free'. It provides reliable and permanent contraception and does not require experimenting with long-acting reversible but ‘medical’ methods. Thus, the trade-offs are worthwhile to limit fertility reliably and without ‘medicine’.

> ***“Women who are fed up with the heavy bleeding and pain from IUDs come to get ligations. I try to counsel them against it, because once you get it you can’t change your mind, but they don’t want to deal with side effects anymore.”***
>
> OBGYN, Private Clinic, Delhi


“After my second child was born, the nurse told me to get the injectable. I had really bad headaches and heavy bleeding, so I went back and told her to remove it. But she said that wasn’t possible and I will just have to wait.”
Lucy, 24, Nairobi

Familiar formats increase acceptability, but do not necessarily guarantee adherence.

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The familiarity of pill-based medicines as a format makes it easier to adopt oral contraceptive pills (OCPs). In Kenya, injectables are commonly used because the injection format is familiar. However, women sometimes find it difficult to adhere to the strict regimen.

While women are aware that the IUD provides reliable long-term reversible contraception, the unfamiliar physical format as well as the procedure for placement appears to be disconcerting and has led to myths and misconceptions that make IUDs fairly unpopular.

> ***"My sister told me not to get Depo, because it is easy to forget to get the next shot. I went to get the implant, but when I went to the clinic I found it too scary and decided to choose the injection instead. "***
>
> Nancy, 24, Nairobi


“I like the pill, because it’s easy to take. I know about the IUD, but I’ve heard it can travel up to your heart and cause problems.”
Mukta, 23, New Delhi

Despite awareness, most methods are not relatable.

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The ‘medicalized’ vocabulary around contraception is alienating to most users. Many women spoke about how the medical terminology around contraceptive products made them feel like patients and made them wary of putting unfamiliar and unnecessary medicines into their bodies. This also led to a preference for methods that were seen as herbal or natural.

In India, most of the knowledge around contraception is passed on from other women relatives and peers and is often biased. Many women stated that currently available methods were targeting ‘other’ women at different life stages.

In Kenya, protection against sexually transmitted infections (STIs) was emphasized, particularly by women whose partners might be in multiple relationships. Similarly, in India, some unmarried girls with higher levels of awareness also considered STI protection to be important. They felt that few methods provided the kind of protection that condoms did, but also concluded that its use is not always easy to negotiate with partners.

> ***“I took Mala-N* for five years. It was fine initially, but then I got intense pain around my navel. The doctor told me all the pills had accumulated in my stomach.”***
>
> Ramya, 29, Delhi

* Mala-N is a brand of OCPs popular in India


“Condoms are the best, because they protect from STIs and have no side effects, but it depends on your husband. Not all husbands will agree to using condoms.”
Josephine, 24, Kisumu

CT Innovation Lab

Imagining the future of women's contraception