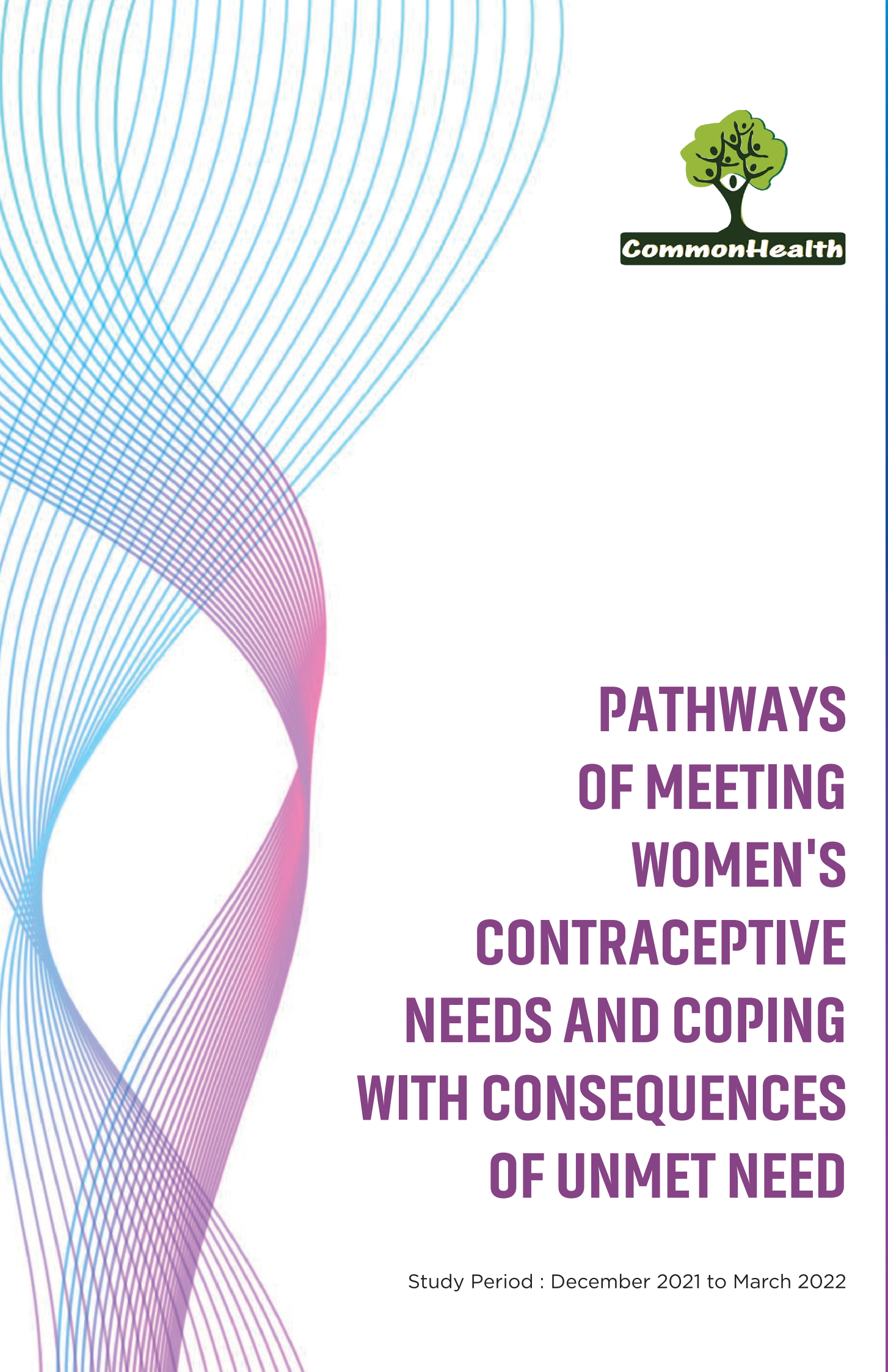

PATHWAYS OF MEETING WOMEN'S CONTRACEPTIVE NEEDS AND COPING WITH CONSEQUENCES OF UNMET NEED

Study Period : December 2021 to March 2022

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CommonHealth

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Sahaj towards alternatives in health and development | ISRD | ASHAN FOUNDATION | Faith Foundation | Sahayog for equity and sustainable development | ARPAN | RUWSEC

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Introduction

India was the first country in the world to launch a family planning programme in 1952. The programme evolved from a targeted approach to control and stabilise population to a target free approach to reduce maternal and child mortality and morbidity. In the first two and a half decades till 1977, with its aim of population control and family limitation, it had imperative target orientation with emphasis on clinic based contraceptive service provision. Sterilisation became the hallmark of the demographic, target driven and at times, coercive Family Planning programme. In the next decade till 1999, especially having burnt its fingers in implementing coercive sterilization during the 1975 emergency period, concepts of 'voluntarism', 'family welfare' and 'population stabilisation' through 'replacement fertility' gained currency. The programme was designed to simulate a "cafeteria approach" to offer a "basket of choices". The method-mix offered was — female sterilisation, male sterilisation, intrauterine contraceptive device (IUCD), oral contraceptives, and condoms.

At the turn of the century, despite decades of implementation of the family planning programme, maternal mortality remained stagnant, the country was still far away from the goal of replacement fertility, and modern spacing methods accounted for less than a tenth of contraceptive use. In 2001, the Government of India recognising the need to revitalise the family planning programme, integrated it with reproductive health to meet 'unmet need' and efforts were directed at enhancing access, choice and quality of services. A decade later, in 2012 at the London Summit, Government of India made the commitment (FP2020) to increase modern contraceptive use and to achieve that it introduced newer contraceptives; strategies to strengthen social marketing of condoms and pills; community and family level promotional schemes, innovative awareness creation methods, commodity security, capacity building of service providers; creation of enabling environment through inter-sectoral convergence and rolled out full range of contraceptive services at all levels.

More than six decades after the launch of the family planning programme and efforts at reconceptualisation and repositioning, while India has attained replacement fertility (2.0 as per National Family Health Survey 5 (NFHS5)) the impact of the programme remains uneven[1]. Guttmacher study on abortion and unintended pregnancy in six Indian states reported that fifty percent of pregnancies were unintended. Majority of these unintended pregnancies (55–75%) were terminated using medical methods of abortion (MMA), in settings other than health facilities and were not only illegal under the current MTP Act but were potentially unsafe.

1 (Pachauri S. Priority strategies for India's family planning programme. Indian J Med Res. 2014;140 Suppl(Suppl 1):S137-S146).

Two consecutive National Family Health Surveys have also shown that women tend to have more children than what they desire. This reflects the continued need for and dissatisfaction with the contraceptives that had been adopted[2]. Unintended pregnancies are an indicator of unmet need for contraception - either no method is used; an ineffective method is used; method is used inconsistently or incorrectly or discontinued, and tends to push women to opt for unsafe methods to terminate the pregnancy.

Data for the year 2019-2020 from the annual progress report of FP2020 showed that though Contraceptive Prevalence Rate for modern contraceptives (mCPR) in married women was 55%, unmet need for contraception was stagnant at 18.6% and discontinuation rates for modern reversible methods was as high as 44% within the first year. Only 12% of those who discontinued did so because they wanted to have a child (12%), and 6% because they wanted to switch to a different method[3]. A prospective study in Haryana and Odisha with married women of reproductive age (15–49 years) who had recently started using IUCD, injectable or Oral Contraceptive Pill (OCP) had found that while side effects are an important reason for discontinuation, not all women who experience side effects stopped using the method[4].

These data underscore the need for more nuanced qualitative approach to explore different reasons, especially for discontinuation and inconsistent use. Stories emerging from the field level suggest an increase in discontinuation, coercion and often denial of services to those in need, often propelling them towards unsafe options for addressing consequences of unprotected sex. The Guttamacher study was conducted in the pre-COVID era. These vulnerabilities of women were particularly exacerbated during the recent pandedmic. As per Foundation for Reproductive Health Services, India (FRHSI) the nation-wide lockdowns has serious adverse impact on contraceptive use. In their estimate 24.5 million couples were not able to access contraceptives during this period and this would have led to 1.94 million unintended pregnancies and 1.18 million abortions of which 6.81 lakhs would have been unsafe.

2 Mozumdar, Arupendra, Elizabeth Tobey, Kumudha Aruldas, Rajib Acharya, and Aparna Jain. 2020. "Contraceptive use dynamics in India: A prospective cohort study of modern reversible contraceptive users," Research Report. Washington, DC: Population Council, The Evidence Project

3 Jain A, Dwyer SC, Mozumdar A, Tobey E. Not All Women Who Experience Side Effects Discontinue Their Contraceptive Method: Insights from a Longitudinal Study in India. Studies in Family Planning. 2021 Jun;52(2):165-178. DOI: 10.1111/sifp.12150. PMID: 33890682.

4 Jain A, Dwyer SC, Mozumdar A, Tobey E. Not All Women Who Experience Side Effects Discontinue Their Contraceptive Method: Insights from a Longitudinal Study in India. Studies in Family Planning. 2021 Jun;52(2):165-178. DOI: 10.1111/sifp.12150. PMID: 33890682.

While the impact of COVID restrictions on contraceptive availability and use has been estimated, how women coped with restricted to non-availability is yet to be explored. CommonHealth believes that these lived in experiences of women (especially marginalised and vulnerable women) should be explored and documented not only to understand their needs, and barriers faced by them but also to identify potential solutions and alternative pathways of meeting their needs.

Study Methodology

Study Objectives

This ***exploratory qualitative*** study aimed to explore and document women's:

- reproductive intentions, the pathways they adopt to meet those, their preference for specific contraceptive and determinants of that preference;
- use of contraceptives and determinants of use (especially newer methods such as injectables / MPA[5], Centchroman[6] and IUCDs)
- experiences of contraceptive use and reasons for uptake, continuation and discontinuation of contraceptives (especially newer methods such as injectables/ MPA, Centchroman and LARCs)
- reasons across varying socio-demographic and health system contexts for discontinuation of contraceptive methods despite wishing to prevent a pregnancy, or continuation despite side effects, or uptake despite lack of willingness

Study Sample

Scope*:* The study was conducted in nine States – Gujarat (SAHAJ, Vadodara), Haryana (Institute for Social Research and Development, Chandigarh), Jammu & Kashmir (AHSAAN Foundation, Srinagar), Maharashtra (SAHELI, Pune and Amhi Amchya Arogya Saathi, Gadchiroli), Meghalaya (Faith Foundation, Shillong), Odisha (SAHAYOG, Bhubaneshwar), Punjab (Guru Angad Dev Sewa Society, Ludhiana, ARPAN, Rupnagar), Tamil Nadu (Rural Women's Social Education Centre, Chengalpattu) and Uttar Pradesh (Gramin Punarnirman Sansthan, Azamgarh), where CommonHealth Civil Society Organisation (CSO) members were willing to undertake it. Efforts were made to ensure that all regions – North, South, East, West and North-East were represented.

5 MPA is given every 3 months by injection.

6 Chhaya or 'Saheli' tablets need to be taken only twice a week for the first 3 months and then once a week.

Methods

The study employed a mixed method approach with both quantitative and qualitative approach. Secondary data in the public domain for the study states was analysed. Key informant interviews and FGDs were conducted with respondents. The member CSOs in these states have field presence and some of them work in collaboration with frontline workers. All respondents or participants in the study were from work area of the CSOs.

Respondents

Categories of respondents included:

- For Key informants interviews:
    - government officials at block and district level
    - government or private health service providers of reproductive health services
    - frontline workers such as ANMs, ASHAs and Anganwadi workers
    - chemists
    - field staff of other local CSOs / Non-government organisation (NGOs)
- For Focus Group Discussions: Women 18-45 years of age.

Sample

It was an exploratory, qualitative study and the number of participants is largely based on feasibility of member CSOs doing the study in the available budget. Since, we were not trying to establish any statistical validity of findings nor generalise them, sample was purposive, based on the willingness and ability of respondent to provide information on the topic. Within the nine states, we conducted at least 10 key informant interviews (2 each of - health service providers, frontline workers, Chemists, local CSO's ground level staff and block / district or state level government officials) and two FGDs- women 18-24 years of age and older women 25 to 44 years of age.

Attempt was made to get the perspective especially of respondents with marginalised identities such as adolescent girls, Dalit women, Adivasi/tribal women, women with HIV/AIDS, women with disabilities, female sex workers and women from lower socio-economic backgrounds living either in urban slums or rural areas.

Tools

Semi-structured interview field guides and focus group discussion guides were developed. Listed questions in these were to guide the interview / discussion and to ensure that the interviewer / moderator didn't miss out on any aspect of the topic. At the same time, they were not expected to limit the interview. The interview / FGD flow decided the sequence of questions in the field and therefore the transcript. The tools were shared with the members of Steering Committee and Programme Implementation Committee of CommonHealth for review and comments. Members of these committees have relevant experience in qualitative research. The guides were finalised after receiving the inputs and incorporating them. The final tools were translated in local language for the state in which the study took place.

Study team

Study was co-ordinated by Dr. Alka Barua and Dr. Souvik Pyne of CommonHealth. Staff of CSO members of CommonHealth who agreed to undertake the study were enlisted as state level study team. Each CSO had team of four investigators led by a supervisory level staff member. It was ensured that the investigators were at least graduates, preferably in Social Work. Online training of one day was conducted for them on study objectives, methodology, interview and FGD guide and ethical considerations in conducting fieldwork related to sensitive information seeking. Most of the member organisations had staff members who have been trained in qualitative research, specifically in-depth interviews for other CommonHealth studies on access to abortion services, maternal health and reproductive history in the recent past.

Process

The participant recruitment for FGDs was done through field workers of partner CSOs. Only if they were not able to directly do so, the assistance of frontline workers was sought for recruitment- taking care that these workers first sought potential participants' agreement to participate and then share their contact details with CSOs if they agreed. For chemists, teams depended on those mentioned / listed by women or service providers as sources of contraceptive methods or on the CSOs themselves as most of them have been working in these areas for years and have information about Chemists who are sources of contraceptives. Key Informant Interviews were first conducted with CSO staff and frontline workers followed by FGDs with women and then interviews with service providers and chemists (as mentioned by women).

Two teams of two went for these interviews or FGDs. One conducted the interview/ FGD, the other noted down the responses - including body language which is very critical in sensitive subjects. The interview/ FGD were expanded in the evening based on notes. If there were gaps, they went back next day. After interviews/ FGDs for 2 days (not more than 2 interviews or FGDs in a day), one day both of them sat in the office and transcribed all the interviews/ FGDs conducted in previous two days based on expanded notes and recordings if any. If there were gaps in terms of questions listed in the guide and information garnered, the team went back again and collected that information. CSO research team lead and study co-ordinators reviewed collected data at frequent intervals.

All the interviews were in person barring in areas where the pandemic situation prevented in-person interaction. In these situations, interviews were conducted telephonically. Before the interviews, informed consent for interview was sought from all respondents with the help of frontline workers or CSO community level staff. Key Informant Interviews and FGDs were recorded only when permitted by respondent.

CommonHealth Co-ordinator, consultant and study co-ordinators (depending on need) provided telephonic inputs and clarity to study teams as and when required. CommonHealth Co-ordinator conducted weekly telephonic follow-up meetings to monitor the process, of data collection and the progress and to provide mentoring support to address any challenges in the field.

Data transcription

Interviews notes were transcribed in local language and entered in English in Excel data entry software developed for the purpose. Final transcripts are in English (except for Azamgadh in Uttar Pradesh, where the interview transcripts are in Hindi) while retaining some illustrative quotes in local language to ensure that nuances are not lost.

Data were analysed for emerging patterns and themes and limited itself to the study purpose. The analysis explores needs, barriers and experiences without making any attempt to generalise study findings or interpret these as representative of the community / area or statistically valid.

Ethical considerations

A detailed informed consent form was developed and used for each woman/key informant. The consent was oral. The investigator signed the consent form after explaining the study to the respondent. The team leader in the member organisation

countersigned the consent form after confirming that the investigator had explained the study purpose, assured confidentiality, given the option of refusing participation (with no adverse consequences for doing so) or withdrawing half way or refusing to answer some questions, informed about non-availability of any amount for participation, provided contact number of contact person in the organisation, and offered to send a copy of the consent form for their record.

In case of women as mentioned earlier, frontline workers / CSOs' ground level staff identified them in the course of their regular contact and work with them, explained the study and sought their consent for FGDs. Once they agreed, they provided the investigators with the contact details of these women for conducting the interviews.

Given the prevailing pandemic situation, to safeguard the investigators and the respondents, all the interviews in restricted areas were telephonic. Interviews were recorded if permitted by respondent. Training session on COVID prevention and management was included in the training schedule for the study teams.

Results of the study

Findings of the study will be shared at the regional as well as national level through webinars, reports, blog pieces and articles.

Information will be used for advocacy for client centred contraceptive services- ranging from message content, awareness creation, counselling, availability of contraceptives and services and follow up of cases. CSO members will be provided with one/two pagers in local language on the findings for them to share the results with local authorities and community members. The two pagers would be prepared carefully keeping in mind the sensitivity of information.

Also, if necessary and if funds are available, then a larger study will be conducted to probe further into findings that have bearing on contraceptive acceptance and continued usage in case of those with unmet need.

Limitations

Scope and sample of the study were purposive, convenience based and are not representative of eith the State or the marginalised groups included. Also, in many places the interviews were telephonic and therefore restricted to respondents who had access to mobiles.

KEY FINDINGS

Profile of respondents

Doctors: A total of 26 doctors were interviewed. Of these 23 were practitioners of recognised systems such as allopathy and Indian Systems of Medicine such as Ayurveda and Homeopathy. Thirteen doctors worked in the public sector as Medical Officers, Block Medical Officers and Senior Medical officers. Ten doctors were in private practice. Three doctors did not have recognised qualifications for practicing medicine. Two had Bachelor of Science degree and one had a degree in Pharmacy. Work experience of these practitioners ranged from five to 45 years.

Frontline Workers: This category consisted of ANMs (14), ASHAs (13) and AWWs (4). Minimum educational status of ASHAs and AWWs was 10th standard. All of them had at least two years experience.

Chemists: Twenty-one chemists interviewed across all study sites. They were either degree holders in pharmacy or had a diploma in pharmacy and were in business for at least five years.

Representatives of NGOs/CBO: Twenty representatives of NGOs / CBOs were interviewed for the study. They held different positions in the organizations right from outreach workers to president of the organization. Their educational qualifications ranged from no formal education (but had training by the organisation) to post-graduation. They had minimum experience of three years.

Self-Help Group members: Five SHG members were interviewed. Their educational qualification ranged from no formal education to 12th standard. They had been SHG members for at least a year.

Government officials: It was a mix of officials working in different positions in the government, namely, Block Educator, Panchayati Raj Institution member, Block extension educator, BCC coordinator, Counsellor, Health Education Officer, RCHO and CDPO. Their educational level ranged between 10th standard to graduation and experience between one year to eleven years.

Women in reproductive age group: About 174 women aged between 18 years to 45 years were respondents for FGDs. Educational status of these women ranged between no education to graduation. Most of them were housewives but were also involved in farming. Only four women were formally engaged in income generation activities like tailoring shop, employment in private sector or government sector.

Women in need of contraceptives

Respondents were asked about which women were in need for contraceptives. Respondents across categories mentioned that all married women in reproductive age group need contraceptives to either delay first pregnancy after marriage or to have spacing between two consecutive pregnancies or to stop child bearing. ASHAs and ANMs corroborated this based on their field experiences.

> *"Married women and those women who do not want to have unwanted pregnancies takes these methods and use these contraceptives. Also, for spacing of children"*.
>
> ASHA, Jammu and Kashmir

> *"Women who have had a child recently and/or want a gap between their children. For example, if a couple has one child and they want their next child after 2-3 years, then the wife may need contraceptives"*.
>
> ANM, Haryana.

Respondents also said that the need was driven by the socio-economic and demographic profile of women. According to respondents, those who are educated are more mindful of consequences of large family size and want either one or two children. They need contraceptives to realise their reproductive intentions.

> *"Those women who are educated, those who think seriously about consequences of unwanted pregnancy, and those who want to avoid unwanted pregnancy are the ones who need contraceptives".*
>
> NGO representative, Uttar Pradesh

Both ANMs and doctors further elaborated that this need was more pronounced in case of those working outside the home or belonging to Below Poverty Line (BPL) families.

> *"Any women who wants to have a healthy system that would allow her to provide the best for her family – will need these. It helps a woman who comes from a weak economic background allowing her to devote her time, her health, her earning to her family".*
>
> ANM, Meghalaya

> *'There are so many reasons for using contraceptive like job going women don't want to have child earlier or some use because of excess number of children and some need because of poverty'.*
>
> Medical officer, Jammu and Kashmir

Respondents, specifically those working in the community from Meghalaya and Jammu and Kashmir said that contraceptives are needed in case of women who are not physically or mentally fit to have children.

> *"The ones whose body is weak, who is ill are the ones who need to use contraceptives. And the ones who are healthy I think they can somehow manage it on their own".*
>
> SHG member, Meghalaya

Interestingly, almost all of them said that not only married but even unmarried women/girls, especially those who are in live-in relationships or have been exposed to sexual abuse can need contraceptives. In the context of unmarried girls and sex workers it was said that they need contraceptive methods that only help them avoid unwanted pregnancy but also infection.

> *"There are instances of unmarried people, who engaged in unprotected sex and conceived because of their ignorance. Girls are mostly affected and their families face many troubles. So, to avoid such situations, contraceptive methods should be available to them also".*
>
> SHG President, Tamil Nadu

> *"Unmarried girls/women need contraceptives to avoid pregnancy as well as infection from their partner. Specially those who are involved in sex works".*
>
> NGO worker, Haryana

> *"People think only married women are eligible for different methods of contraceptives and I think unmarried girls and rape victims also need these. Rape victims need these to live in the society with respect and honour. We have seen many cases where some girls who did not know about these services were thrown out of their families after becoming pregnant and some of these needed abortions".*
>
> Block educator, Jammu and Kashmir

Method choices available and their sources

Both spacing and limiting methods were mentioned by respondents. They said that women have the choice to opt for Emergency contraceptives, Chhaya, Copper T (Intra-uterine Contraceptive Device or IUCD), Antara and also for sterilisation. Though respondents mentioned condom as a choice available to the couple, none of them talked about vasectomy.

Village level frontline health workers i.e. ASHA and ANMs were mentioned as the source for temporary methods like condoms or oral pills. For other methods such as Antara, IUCD government health centres such as Primary (PHCs) and Community Health Centres (CHCs). Other than that, chemists and private service providers were mentioned as sources of contraceptives specially for those who could afford to pay for these.

Women's preferences

While talking about preferred contraceptive methods, most responses from all stakeholder categories (both key informants and women) included condoms and pills. The stated reasons for this preference were ease of use and assured access at village level both with local ASHA or ANM or AWW and the chemists. Within these methods condoms were seen as more useful as they served dual purpose of contraception as well as prevention of infection and also had no side effects. Female sterilisation was quoted as the most appropriate and therefore preferred method once the family size was achieved.

According to respondents, preference for newer methods such as Antara and Chhaya was largely amongst those who were educated or based in urban settings. However, according to them few women in rural areas preferred these methods specially Antara because of uncertainty of consistent availability.

> *'Educated women prefer injection for convenience and less educated use oral pills which are easy to obtain'.*
>
> ANM, Haryana

Pathways for realising their needs, choices and preferences

Against this background of need, available choices and preferences, it is important to explore whether they are able to do so, how are their needs are met in reality.

Data from both key informant interviews and FGDs indicated that women's ability to meet their conrtaceptive needs is determined by contextual factors like education, economic status, number of surviving children and above all the decision making autonomy. Social-cultural, religious and familial barriers directly impact their decision about and ability to implement their choice. In some communities, diktats of religious leaders decide their reproductive decisions.

It became evident from the data obtained from all categories and from all stakeholders that most women cannot exercise their right to contraception. Their needs, choices and rights are not central to repdroductive decision making. Family, especially husbands and mothers-in-law play a critical role and often take decisions that are in direct conflict with what she needs and desires. Most women themselves accept this as fait accompli. They need and seek emotional, financial and physical support of their partner so that they make choices and decisions aligned to societal norms.

> *"No! Women don't have such rights. Generally, women want to limit family size with one or two children but their family members compel them to have another child with an expectation that the next child will be a male or female baby. I can say that there are no such rights for women in our rural areas. If we ask a simple thing, women immediately say I need to ask my husband's permission".*
>
> SHG member, Tamil Nadu

This is also to avoid any conflict at a later date arising out of any unexpected adverse outcome of their individual decisions.

> "*No, they need their husband's permission for all. Suppose she decides on her own, and has health complications, they will scold and quarrel with her. Even if a woman is working in the IT sector, she needs her husband/in-law's permission for everything*".
>
> NGO representative, Tamil Nadu

Some key informants differed from this view. According to them, family does not intervene in decision making or choices of women as long as they are not held responsible for the process and its outcomes.

> "*Mostly women are doing. Of course, they are telling to discuss with husband and mother-in-law but at the end choice is their only. In my knowledge actually there is no pressure from other side. Why should they bother about what are you using*?
>
> ANM, Odisha

In fact, in most instances where husbands are in agreement about use of a method, women ask them to buy contraceptives from open market.

> *"Women themselves do not openly ask for the method due to a sense of shame, embarrassment or guilt as these are mostly those who use condoms"*
>
> ASHA, Uttar Pradesh

Even if the family members agree to the woman's use of contraception, it is not necessary that her choice will prevail. It was mentioned by almost all interviewed doctors (qualified) and ANMs that while they do inform women about all available methods, they take detailed medical history of the clients before suggesting and providing any contraceptive method as there are strict eligibility criteria for each method.

> *"I tell them about newer methods also. I definitely take detailed history before advising any method as the suitability has to be considered"*.
>
> Gynaecologist, Punjab

> *"The most appropriate method of birth control depends on an individual's overall health, age group, frequency of or infection. Sexual activity, number of sexual partners, desire to have children in the future, and family history of certain diseases".*
>
> Medical officer, Haryana

Very few women go ahead with their own decisions and are able to exercise their choices even if these are in direct conflict of those of their families and the service providers.

> "*Only 5% of the women have a choice to decide about contraceptives or several children the rest only husband's decision*"
>
> ANM, Meghalaya.

So, what steps these women do women take when they do decide to go ahead with their decision and choice?

As a young womsn in the FGD in Meghalaya FGD said, "*These women have to do it secretly. They just meet the ASHA and use the method. If the husband finds out about say the pills, they say that these are vitamins given by ASHAs. It is always better to have mutual understanding on these issues so that they don't have to do it secretly. But what can they do? They do not share their decision or plan because there is no understanding at family level and they do not want to have fights at home*"

Women's experiences of seeking and using contraceptives

Stakeholders from various categories narrated the experiences shared by women. It is noteworthy that many sites and various stakeholders reported that women did not face much difficulty in accessing or using contraceptives.

> "*Non-availability of methods of choice leads a few of them to use EC pills as a precautionary measure. Some try to avoid sex which in few cases leads to fights/misunderstanding/ tension between husband and wife. Some others opt for less successful natural methods like withdrawal*."
>
> ASHA, Uttar Pradesh

> *"If the contraceptive of their choice is not available, we ask them to use natural method"*
>
> ASHA, Meghalya

Though according to almost all field workers, especially ASHAs most women continue with the method they adopted. They do so as even if they have problems, as support was available to them to address these.

> *"Women do not face much problems. If they have any issues, they call me and I help them. They get the method for free and it is easily accessible. They don't have any challenge".*
>
> ASHA, Odisha

Of those who spoke about continuation, almost all said that women want to limit number of children they have and also protect themselves against infections and their spouses / partner do not make any efforts to help them, they have no option but to continue with whichever method they use despite side effects. This was reported more so from the northern states of Punjab, Haryana and Jammu and Kashmir. NGO representatives from Jammu and Kashmir described continued use of methods as a case of absence of alternatives available to women of their State,

> *"Most the them continue use the contraceptives as they have to use it for family planning or protect themselves from STI and RTIs. They don't have options but to use them despite side effects".*

Another emerging reason was that poverty and lack of knowledge about contraceptive availability makes many to continue despite side effects - with whatever method they have been using as and when it is available. They are completely at the mercy of availability of these services and supplies at government facilities. Their continuation or discontinuation is not an informed, well thought out decision.

However, frontline workers also acknowledged that discontinuation of spacing methods is high. Reasons for discontinuation can be broadly categorized in three domains, namely, non-availability, inaccessibility and unacceptability. Women reported difficulty in accessing method of their choice (IUCD and injectable) if it required service provider's intervention. Unavailability of these at facility closest to their residence, distance between their residence and facility where these services were available, transport cost, absence of help to look after children prevented women from opting for these methods. Unacceptability was largely due to unanticipated side effects, non-availability of alternatives of choice and a host of misconceptions (IUCD causes uterine cancer, weight gain and long-term use of pills causing infertility) that continue to exist about the methods. Religious beliefs and pressure from husband and/or his family also played a role in discontinuation. Change of mind or desire to have another child was not mentioned very often by service providers.

Discontinuation, according to most respondents was more often of newer methods like Chhaya, Antara and LARCs. The reason mentioned was menstrual disturbances such as scanty menstruation, heavy flow and amenorrhoea for months, etc. In case of IUCD, the main reason for discontinuation or removal was insertion of IUCD without the woman's consent. It was strongly voiced by stakeholders from Tamil Nadu. Even when women specifically told the providers that they did not want and IUCD they were told that it was mandatory compliance with government directive to insert IUCD in women who had delivery at government institutions.

Respondents said that large scale discontinuation happened during the COVID-19 lockdown due to lack of supplies, unavailability of alternatives, restricted mobility and non-availability of health staff as well as some of these services. These issues were primarily in states other than Haryana. Doctors and ANMs reported that during lockdown, services at government centres were focussed on COVID-19 related issues and contraceptive services like sterilization, IUCD insertion, Antara injection that required provider's presence were temporarily halted. This was the time when women faced problems of availability and accessibility. A government health provider from Punjab voiced the difficulty in accessing and accepting the contraceptives and the outcomes of this situation,

> *"During lockdown our hospital was converted to a COVID facility for 4 months. Women could not approach us for contraceptive methods or even for problems they had with methods. The supply with ASHA was initially not affected. But later that also was affected. There may have been discontinuation of contraceptives for one or two months. There were unwanted pregnancies during that period which came to our notice when our OPD started. These women could not get abortion done, so they continued with the pregnancy. The number of pregnancies in this area increased during and after lockdown."*

Medical Officer, Punjab.

While the prevalent barriers to access and use continued, the pandemic added other roadblocks. Those who could afford purchasing methods or services at private sector, availed of those. However, according to ASHAs and ANMs such women were few in their area. As a government service provider in Uttar Pradesh summed up the scenario as,

> *"On the background of hesitancy in asking openly in absence of a separate room for contraceptive services, shortage during lockdown, no VHND in villages and closure of markets meant that women suffered. Men had returned home from outside and there was greater need for contraceptive methods but these were difficult to procure. Amongst those who could access but experienced side effects, access to formal service providers was impossible. So they too either discontinued or sought treatment from Jholachhaap (Quacks) providers or private doctors. Those who discontinued and had unwanted pregnancies, sought abortion from quacks because government health facility services were not available. Some went to private providers or used MTP kits available in the market".*

Medical Officer, Uttar Pradesh

Women from Haryana said that they did not face any problems in accessing or using contraceptives even during the COVID-19 lockdown. The providers also confirmed consistent availability of contraceptives in the State. The government health staff at the village level was cooperative and helped women even during lockdown.

> "*During lockdown we didn't face any problems. The supply was adequate. Many people who needed contraceptives came to us, despite the lockdown."*

MO, Haryana

While frontline workers from other states corroborated unavailability of methods during the lockdown, in Odisha, frontline workers claimed that they did not think access to methods was an issue as the need for contraceptives itself was actually lower during the pandemic!

'In joint families, in pandemic situation, the environment was completely different. With full family and stress of life there was very limited scope, interest and space for a husband and wife to enjoy their marital life. So, the use too was very rare'

ASHA, Odisha

Variations across socio-demographic and health system contexts

There are differences in terms of women's needs, use or non-use and discontinuation of use of contraceptives. Seconday data from National Family Health Survey (NFHS)-5, showed heterogeneous geographical variation in the choice of contraceptive methods. While condoms are reportedly the most commonly used method in the Study states in Northern and Western regions, those in North-Eastern and Eastern regions have a higher prevalence of use of oral pills (higher than that for the country as a whole).

In %	TFR	mCPR	Methods						
			Tubec-tomy	Vasec-tomy	Oral Pills	IUCD	Inject-able	Con-dom	ECPills
INDIA	1.99	58.5	36.3	0.2	4.3	2.7	0.4	13.6	0.1
Eastern region									
Odisha	1.82	47.2	24.4	0.2	**10.3**	2.3	0.4	8.7	0.1
Western region									
Gujarat	1.86	54.0	29.1	0.1	3.1	**4.2**	0.1	**16.8**	0.0
Maharashtra	1.71	**62.7**	**44.0**	0.1	1.9	2.2	0.2	**14.1**	0.1
Northern region									
Haryana	1.91	59.0	24.1	**0.7**	2.9	**5.0**	0.4	**24.6**	0.0
Jammu & Kashmir	1.41	53.5	21.6	**0.4**	**7.7**	**7.2**	**4.0**	11.6	0.2
Punjab	1.63	49.4	18.0	**0.5**	1.1	2.8	0.1	**26.6**	0.1
Uttar Pradesh	**2.35**	48.6	13.5	0.1	4.0	2.0	**0.9**	**27.1**	0.2
North-Eastern region									
Meghalaya	**2.91**	21.0	7.1	0.0	**6.0**	2.9	**0.7**	3.9	0.3
Southern region									
Tamil Nadu	1.76	**64.0**	**55.6**	0.1	0.4	**4.8**	0.1	2.6	0.0

*: Among women age 15-49 who experienced an episode of contraceptive use within the 5 years preceding the survey, the percentage of episodes discontinued within 12 months

**: unwanted pregnancy, contraceptive failure, last child too small, husband/mother in law did not want

More developed states known for better health systems and performance on health indicators and having reached replacement fertility such as Maharashtra and Tamil Nadu, had contraceptive prevalence rate for modern methods (mCPR) that was higher than national average. Interestingly, these were also the States where female sterilisation that required an interface with the health system, was more prevalent.

States with TFR higher than national average were also the States with low mCPR, low prevalence of sterilisation but relatively higher prevalence of injectables, a method availability of which has been reported to be irregular.

Of the states where study was undertaken, Meghalaya in the Northeast had significantly higher TFR and low mCPR. Respondents in their interviews and discussions did explain the reasons for this. Just about a fifth of the couples with woman in the reproductive age group used modern contraaceptives, with less than a tenth of them opting for female sterilisation and 6% opting for Oral pills. There is strong resistance to use contraceptives.

Meghalaya

All respondents talked about the stranglehold of religious beliefs as a formidable barrier to use of contraceptives. Children are seen as *God's gift to be accepted unconditionally and any attempt to prevent their birth as* a *"Homicide of a child".*

Many of them also mentioned that one prevalent fear among men was about access and use of contraceptives leading to infidelity and promiscuity among women. This was more so as many men migrate out to work in other States.

Women are apprehensive about the society labelling them as immoral and irresponsible,

"Some say that it is for the benefit of the women. She wants to have an easy lifestyle which is free of responsibilities. They take it in a negative way where a woman is seen as an ill-disciplined person". 22 year old young woman.

Among spacing methods, injectables and EC pills were used by very few. Despite the consistent promotion of IUCDs, use appeared to be poor. This was also the method that was most often discontinued. Misconceptions and coerced insertions made women discontinue the method.

All women in our study belonged to marginalised groups – adolescents, dalits, sex workers, rural or tribal women and women from minority community. These women had to face pressures at all level from spouse, marital family, community, religious leaders to the health system. As a result, their decisions and choices were almost never respected and this was a major determinant of the woman continuing with the method.

Respondents from Tamil Nadu across categories reported pressure from government staff on women to opt for IUCD after delivery at government institutions. Women and their families were told that this was the government directive. Misconceptions about IUCD exist and in absence of counselling about possibly heavier periods, women panic.

An NGO representative from Tamil Nadu explained the issues in using contraceptives in details. She said,

> *"From my interactions with the community, a few women reported that copper T would get inside the abdominal, stick with the intestines and lead to low appetite, body weakness. Few others report there are discomforts in sexual life. Some women think that it would lead to obesity and others said it could result in severe weight loss. These kinds of false information spread quickly in the community and consequently many users remove it with a suspicion that contraceptive could spoil their health."*

A whole range of side effects get associated with the method and spread like wild fire in the community leading to discontinuation even among those who otherwise do not have any problems but do not want to take any risk. While many of these women, soon after got the IUCD removed, they remained wary of going in for other method at the facility and were not capable of consistently affording a method from the private sector.

In Odisha and Uttar Pradesh, service providers were of the opinion that such decisive directives of the state government and decisions by service providers about method for the woman were necessary as women tend to have 'a casual and careless attitude towards contraception'. In fact, those from Uttar Pradesh said that counselling about methods and their side effects itself was responsible for disconituation. If women are counselled or informed about possible side effects, the minute they experience any unusual occurrence,they and their family members panic and discontinue the method.

In case of women in sex work, stigma associated with their work, provider biases and professional hazards – all have adverse impact on their continued use of contraceptives. At times, the clients entice these women by promising more money than their normal rates or by providing alcohol and tobacco to which many of them are addicted they do not use a condom. Many of them resultantly do not use the method. Providers while asking for all kinds of official documentations and official permissions, consistently humilate them with statements such as, "A prostitute can never be a mother" (*Randi kabhi ma nahi ban sakti*) while providing services. These experiences make these women reluctant to seek services from government facilities and they cannot afford private sector services. All this leads to inconsistent use.

Discussion and Conclusion

India is signatory to international agreements which recognise reproductive rights and the government has a constitutional obligation to respect the stipulations specified in these agreements. As early as 1994, Government of India signed the declaration of International Conference for Population Development, which in its Programme of Action explicitly endorses reproductive rights of couples and advocates for freedom to couples to decide the number and spacing of children[7]. Policies in the country such as the National Population Policy of 2000 have respected this commitment to voluntary and informed choice, individual consent and target free non-coercive contraceptive services[8]. Courts in India have upheld this right-based approach through their various judgments. In response to a Public Interest Litigation filed in 2020 in the Supreme court, the Government of India itself had re-iterated its commitment to individual reproductive rights and had said, "the family welfare program in India is voluntary in nature, which enables couples to decide the size of their family and adopt the family planning method best suited to them according to their choice without any compulsion"[9].

The National Family Health Survey 5 (2019-20) reports TFR below replacement fertility rate of 2.1 children per woman and a consistent improvement in mCPR and decline in TFR[10]. However, while these trends are desirable, numbers tend to conceal the ground realities. Coercive policies and insensitive programmes tend to affect marginalized populations disproportionately based on their literacy, caste, religion and socio-economic background.

From the views and experiences shared by respondents, it was clear that women irrespective of their demographic profile needed contraceptives, wanted those that they could procure and use easily, preferrably confidentially, without any side effects and as long as they wanted to. Reasons were not restricted to prevention of pregnancy but also included prevention of infections. Yet, meeting their needs was not easy.

Women can not decide the number of children or choose contraceptive. A host of socio-cultural and systemic factors come in the way of their meeting these needs. Patriarchy, joint family system, cultural norms, societal attitudes, lack of education and information about contraceptive methods and interspousal communication pose as an obstacle in the way of her any health related decision at every stage of

7 https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf

8 http://nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/national_population_policy_2000.pdf

9 https://theprint.in/health/india-unequivocally-against-forcing-family-planning-centre-tells-supreme-court/565499/

10 https://timesofindia.indiatimes.com/india/national-family-health-survey-indias-population-stabilising-as-total-fertility-rate-declines-across-states/articleshow/79738803.cms

her reproductive life span. At the systemic level, distance of facilities, inconvenient access at times, non-availability of methods and service providers are major deterrents for women to seek services especially at government facilities. At the programmatic level, the complete insensitivity to the socio-cultural factors, the implicit targets, service provision of service providers trained on biomedical model of service provision that is based on clinical criteria rather than the lived in reality of a woman and complete absence of explanation or counselling adds to women's inability to exercise deicisions and choices related to their reproductive health.

While thus women's access to contraceptive services is a challenge even under normal circumstances, especially for marginalised and vulnerable women, current health crisis due to the pandemic and the supply and service disruptions, further worsened the situation for them. Their health was a major casualty in the war against the pandemic. There was financial crunch and fear of infection impacted families negatively. Men, who otherwise were working elsewhere had returned home. Need for contraception went high but availability and accessibility were major obstacles. With most facilities functioning with a Covid1-9 management focus, diversion of the health system resources and caseload overwhelming the health system, even essential service have been relegated to the backseat. Many states had a moratorium on provision of contraceptive services such as IUCD and sterilisation that involve close human interaction. Supplies of oral contraceptive pills and condoms are in short supply due to the logistic difficulties posed by the stringent lockdown. Even otherwise women are known to lack the agency to convince their partners to use condoms. Under the circumstances, women, who bear the burden of contraception even otherwise, were either forced or use whatever contraceptive is available, face an unwanted pregnancy or opt for unsafe abortion services.

Data suggested that there should not only be 'awareness campaigns' for women in reproductive age group but should also be for husbands, their families and PRI members or community leaders who influence perceptions at community level. It also suggested that a 'different' model of awareness creation or training for service providers that goes beyond clinical details of methods and incorporates the 'human life and experiences' context for health needs and relevant decisions, should be designed. It is unfortunate that more than half a century of the programme, even today the same misconceptions prevail at community level and biases remain at provider level. The concepts of consent and counselling need to be clearly understood by providers. These should be countered with complete transperancy in complete information provision that includes support available in case of need.

Having experienced the gravity of situation during the COVID-19 pandemic, multiple stakeholder categories demanded that there should be a 24*7 helpline for contraceptive issues and grievance redressal and 24X7 depots for consistent supplies of contraceptives. These two additions would not only benefit women during normal circumstance but would also benefit women in times when mobility gets restricted and service becomes difficult to access.

As Emily Saurman writes in her article titled 'Improving access: modifying Penchansky and Thomas's Theory of Access', access is about enabling a patient in need to receive the right care, from the right provider, at the right time, in the right place, dependent on context.

Receiving the right care can further be understood as providing what is required by the client. In many instances we get to see the power imbalance between the provider and the client. Poverty, lack of information and the social context play a vital role and women end up getting what is given to them rather than what they actually want. Non-availability of providers in COVID-19 lockdown like situations compelled women to access services from persons who may not be qualified to provide the services. Further, due to non-availability of field level staff and contraceptive methods, women had to resort to natural methods which are not fool proof, some tried to avoid sex which led to tensions and fights between husband and wife, some women after having conceived, tried home remedies to abort the foetus.

Government of India has certainly made serious efforts to improve the programme. However, there are still many issues which need to be looked into for betterment of quality. Unmet needs continue to be an impediment. In the tightly knit fabric of Indian culture, continuous monitoring, evaluation and consequent rectification is needed if we have to attain the goal of making an impact on fertility level without compromising women's rights, decisions and choices. The need of the hour is to formulate a people centred programme that focuses on changing social norms, takes into account the needs of country's large population of young people and women who bear the brunt of contraception, is rooted in gender-inclusive socioeconomic policies, and invests in information and communication, strengthening of primary care facilities for service provision and meeting unmet need. Such a programme would have greater potential to impact not only on women's health by addressing morbidity and mortality due to unsafe behaviours borne out of lack of choices but also address the issue of population stabilization that currently drives the programme.

Annexure 1

Key Research Question

The research questions that will be explored would be as follows:

1. Which women need contraceptives? When and Why?
2. How do these women try to meet their contraceptive needs?
3. What are contraceptives are currently available and what are women's opinions about available contraceptives in the family planning programme / in India?
4. Which contraceptives are preferred and why?
5. What are women's experiences of seeking and using contraceptives? How does the health system respond to their needs?
6. What do women do when their needs are not met? What makes some of them uptake despite lack of willingness or continue despite side effects?
7. What are the implications in terms of obstetric health outcomes of the steps women take in absence of access to desired contraceptive services?
8. What can be done to address the difficulties individuals face in accessing these services?

Annexure 2 - Research Partners and Sample Size

#	Organization	State/ District	Key Informants				
			Doctors Public/ Private Unqualified	Field Level Workers ANM,ASHA, AWW	Chemists	NGO, CBO, SHG, PE	Others **
1	AAA	Gadchiroli, Maharashtra	4	2	2	2	
2	AHSAAN	J&K *	2	3	2	2	1
3	ARPAN	Rupnagar, Punjab	3	3	2	2	1
4	GADSS/	Ludhiyana, Punjab	3	2	2	2	1
5	GPS	Azamgad, UP	1+2***	2	2	2	1
6	ISRD	Panchkula, Haryana	2	3	2	3	-
7	Faith Foundation	Ri-Bhoi	-	5	1	2	2
8	RUWSEC	Chengalpattu Tamil Nadu	-	4	2	4	-
9	SAHAJ	Vadodara Gujarat	3	2	2	2	1
10	Sahayog	Odisha	1+1***	6	1		1
11	Saheli	Pune Maharashtra	2		2	5	1

* Sample was collected from the following districts: Bandipora, Baramulla, Budgam, Ganderbal, Kupwara, Shopian, Srinagar

** Category Others – Block Educator, Block Extension Educator, District BCC Coordinator, Health Education Officer, Government Servant, Veterinary Officer, Child Development Project Officer, Sarpanch (PRI Member). Counsellor

*** Unqualified Provider

About the FGD Sample.

Two FGDs were conducted at each research site with women in the age group of 18-24 years and 25 -45 years. All participants in both age groups were married. From all sites taken together a total of 87 women participated in the FGDs for the age group between 18 – 24 years and 87 women in the age group 25 – 45 years. In both groups, women's education ranged between none to graduation (seven graduates in both age groups). There were two diploma holders. Most women in both age groups were homemakers and were also reported as being involved in farming. Only 4-5 women were engaged in occupations like tailoring, employment in private sector one was employed as an Anganwadi Worker and one was employed in Maharashtra State Rural Livelihoods Mission as Internal Community Resource Person.

Annexure 3 - Informed Consent

Basic information

Namaskar. My name is _____. I am from *****. The study is conducted by CommonHealth, a rights-based, multi-state coalition of organizations and individuals that advocates for increased access to sexual and reproductive health services to improve health conditions of women and marginalized communities.

The purpose of this exploratory study is to systematically document women's perceptions and access to contraceptive services and their experiences with these services (including during COVID-19 pandemic).

For this, I would like to have your permission to discuss these issues. The information you provide us has the potential to help improve these services in your area during this period as well as in future health crisis situations. In view of the current restrictions on mobility and social distancing norm, the interview will be at a distance and in case of restrictions due to increased cases, will be telephonic requiring about 30-45 minutes.

All the data that we gather will be used for research purposes and as data for policy recommendations. Your identity will not be revealed anywhere. Only our research team will have access to the information you provide us. You can take your time to decide whether you want to participate or not in the study. If you decide to participate, you can withdraw from the study at any time, without assigning any reasons. The data collected from you till the point of withdrawal will not be used in the final analysis. You have the right to refuse to discuss any question if you feel uncomfortable about it. This will be without any consequences for you now or in the future and there is no penalty for refusing to take part. However, I do hope that you will give me permission for this good cause. You may ask me at any given point if you have any questions related to this issue. Even post interview, ifyou have questions, you can also contact: ******, Study team lead, Organisation **** (Contact number ****).

Do I have your consent to proceed? Please let me know. I will register your consent in the consent form. I will provide you with a copy of the signed form if you want.

Participant consent

I, _____, have understood the purpose of and topics to be covered during the interview. All of my questions have been answered. I understand that my participation is voluntary and that if I choose to refuse to participate, I understand that my refusal will not affect me or my career in any adverse manner, and there will be no adverse impact whatsoever to me for my refusal to participate. I also understand that I may withdraw my consent at any time, and I do not have to provide a reason to withdraw. I voluntarily agree to participate in this study.

Verification of Consent

The benefits, risks, and procedures for the research study have been explained to the respondent. Her questions have been answered. Oral consent of the participant is taken on ..... (date) in person/ telephonic conversation. She has agreed to participate.

_____Signature of interviewer _____Date (dd/mm/yyyy)

May I begin the interview?

Annexure 4 –
Guidelines for interview of key informants

A. Background information

1. Location
   a. State
   b. District
   c. Urban / Rural
   d. Containment zone at any stage during the pandemic: Yes/no

2. Respondent's profile
   a. Age
   b. Education
   c. Occupation
   d. Designation
   e. Years of service

B. Access to contraceptive

1. What are your views on available contraceptives? (Probe: especially for newer methods such as injectables/MPA, Chhaya pills, IUCDs)
2. What are your views on eligibility of women for different methods? Who should be considered eligible for these services? (Probe: For eligibility according to age, education, marital status, parity, types of delivery etc. Probe especially for newer methods such as injectables/MPA[11], Chhaya[12] pills and IUCDs)
3. Which women need contraceptives? Why?
4. What do these women do to meet this need? What proportion of these women access contraceptive services for spacing or preventing pregnancies? Where?
5. What method/s of contraception do women prefer? Why? (List the name of the contraceptives one by one and ask for what women like / dislike about it?)
6. Which method do they end up receiving / using? Why? What makes some of them uptake despite lack of willingness or continue despite side effects?
7. What are the source of their method?

11 MPA is given every 3 months by injection.

12 Chhaya or 'Saheli' tablet needs to be taken only twice a week for the first 3 months and then once a week.

8. What information and counseling service related to the method do they receive? (Probe for information and counseling about the contraceptives-benefits, side effects, follow up)
9. What is their experience of seeking contraceptive services? What challenges do they face in seeking the contraceptive? What challenges did they face during the lockdown? (Probe for accessing source, accessing supplies, unavailability and behaviour of health staff, cost of methods)
10. What challenges do/ did they face in using the contraceptive? What challenges did they face during the lockdown? (Probe for lack of information about correct use, side effects, difficulties in compliance, husband's support, any other)
11. What do women do in case they develop side effects? What did they do during the lockdown?
12. How many of these contraceptive users continue to use contraceptive? What makes some of them continue despite side effects?
13. How many discontue? Why? In what period after starting to use? (Probe for COVID-19 lockdown period also)
14. Do their contraceptive needs change over time? Why? (Probe for all methods including emergency contraceptive pills) (Probe for pre COVID-19 and during COVID-19 period)
15. What do women do if contraceptive of their choice / one which they were using is not accessible or if they discontinue use?
16. What steps do they take? Do these help meet their need? (Probe for COVID-19 lockdown period)
17. What are the reproductive health outcomes in women who discontinue use of contraceptives? (Probe for getting and continuing unintended pregnancy, termination of unintended pregnancy) (Probe for COVID-19 lockdown period)
18. What are your views on women's right to decide the number and spacing of her children?
19. What are your views on women's right to choose and decide on use of a contraceptive method?
20. What do you think about women's right to complete information about methods and counselling as a part of contraceptive services? Why? What are your views on woman's individual right to consent for use of a contraceptive method?

C. Recommendations

20. What are your suggestions to make contraceptive services accessible to the women at all times as well as during the covid pandemic / crisis such as this?

Annexure 5 –
Group Discussion Guide for Married Women in Reproductive Age Group

Informed Consent

Date of group discussion		
State		
District		
Village		
Name of the facility		
Number of participants		
Result of discussion	Completed	1
	Partially completed	2
	Refused	3

(Separate one for each participant)

Demographic information

	Name (Coded)	**Age**	**Education**	**Occupation**	**Vaccination status- # of COVID Vaccines taken**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

1. What are your views on available contraceptives? (Probe: especially for newer methods such as injectables/MPA, Chhaya pills, IUCDs)

2. What are your views on eligibility of women for different methods? Who should be considered eligible for these services? (Probe: For eligibility according to age, education, marital status, parity, types of delivery. Probe for newer methods such as injectables/MPA[13], Chhaya[14] pills and IUCDs)

3. What are the barriers to acceptance of contraceptive methods? (Probe: Barriers at individual, family and community level probe for gender and social determinants of acceptance) Can you describe some of the beliefs associated with use of certain methods? (Probe: especially for newer methods such as injectables/MPA, Chhaya pills, IUCDs)

4. Which women want to use contraceptives? Why? Which contraceptives do they prefer and why?

5. What do women do if contraceptive of their choice / one they were using, is not accessible?

6. How do women meet their contraceptive needs? How prevalent is the use of contraceptives? At what stage of their obstetric career?

7. Which method do they end up receiving / using? Why? What makes some of them uptake despite lack of willingness?

8. What is their husbands/ partner's role in use of contraceptive methods?

9. Do their contraceptive needs change over time? Why? (Probe for all methods including emergency contraceptive pills) (Probe for pre COVID-19 and during COVID-19 period)

10. What are women's experiences of use of different methods? How many of these contraceptive users continue to use contraceptive? (Probe: especially for newer methods such as injectables/MPA, Chhaya pills, IUCDs)

11. What do women do in case they develop side effects? What makes some women continue to use a method despite side effects? Which women continue to use? Why? (Probe: For age, education, marital status, parity, types of delivery)

12. What makes some women discontinue contraceptive usage? (Probe: especially for newer methods such as injectables/ MPA, Chhaya pills, IUCDs) Which women discontinue? (Probe: For age, education, marital status, parity, types of delivery)

---

13 MPA is given every 3 months by injection.

14 Chhaya or 'Saheli' tablet needs to be taken only twice a week for the first 3 months and then once a week.

13. What prevents some women from using contraceptives though they want to? (Probe for lack of awareness, misconceptions, opposition at family level, health system response, coercion)

14. What steps do they take? Do these help meet their need? (Probe for COVID-19 lockdown period)

15. What are the reproductive health outcomes in women who are either not able to access, use, are denied contraceptive services or who discontinue use of contraceptives? (Probe for getting and continuing unintended pregnancy, termination of unintended pregnancy) (Probe for COVID-19 lockdown period)

16. What challenges did women face during the lockdown? (Probe for accessing source, accessing supplies, unavailability and behaviour of health staff, cost of methods)

17. What are your views on women's right to decide the number and spacing of her children?

18. What are your views on women's right to choose and decide on use of a contraceptive method?

19. What do you think about women's right to complete information about methods and counselling as a part of contraceptive services? Why? What are your views on woman's individual right to consent for use of a contraceptive method?

20. What can be done to improve acceptance? (Probe: especially for newer methods such as injectables/MPA, Chhaya pills, IUCDs)

End the discussion with thanks and ask them if they have any questions. Keep your answers general.

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