ideas42

ADVANCING ACCESS AND AUTONOMY

Cross-cutting insights from behavioral science to strengthen family planning and reproductive health programs and services

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Executive summary

Many millions of women and families experience health, financial, and social consequences from unintended pregnancies, despite large investments in programming and significant strides to improve service availability. Behavioral science offers a unique set of tools to make further progress on this challenge, drawing insights from a range of disciplines that help explain human behavior and building on those insights to test and iteratively refine program improvements. It opens opportunities to smooth pathways to access contraceptive services while also centering the needs and priorities of women, families, and communities. Through 17 projects that span almost a decade, ideas42 has worked to understand the many behavioral factors that contribute to unintended pregnancies. Together with our partner organizations and with health workers, community members, and other stakeholders in family planning and reproductive health (FP/RH) programs and services, we've researched, innovated, and learned a great deal along the way. Six cross-cutting insights have emerged through this behavioral science research and design work. These insights suggest ways that we all—as program designers, implementors, policymakers, and other stakeholders in the FP/RH sector—can improve programs and services for the humans who deliver, use, and are impacted by them.

1. ***Identity & Norms.*** Social and gender norms shape identities while also guiding and constraining individual behavior. However, ***identity—and its effect on choices—is not singular or static.*** We can harness untapped opportunities for contraceptive use to align with, rather than challenge or undermine, core aspects of an individual's identity and the norms of their community. We can also equip individuals and communities to challenge and reshape norms that are misaligned with their goals.
2. ***Ambiguity.*** Diffuse responsibilities and discomfort combine to make conversations about childbearing and contraception rare even when decision making is shared. ***Even if programming reaches diverse audiences, those audiences aren't always connected with each other in conversation.*** We can create spaces for open communication and joint decision making to surface existing alignments and to increase alignment over time. Where preferences and priorities diverge, we can elevate the agency of those who are most impacted.
3. ***Attention.*** Distractions and competing priorities mean that ***family planning often falls outside of the "tunnel" of the here and now.*** By noticing what else competes for a client's or health worker's attention and how moments for action are perceived, we can better ensure that women are able to fully consider the family planning options available to them and to follow through on their intentions.
4. ***Risk Perception.*** Quirks in the way our brains process information and assess risk, likelihood, and causality lead myths and misinformation to be particularly durable and influential. By drilling down to ***where myths originate and what perpetuates them,*** we can target evidence-informed behavioral approaches to more effectively counter misconceptions and to reduce their disproportionate impact on choices.
5. ***Choice Architecture.*** The order, timing, volume, type, and framing of information clients are offered influences whether they use contraception and which method they choose. ***No approach is truly neutral,*** and we can improve counseling to fit the practical realities of health facilities while also guiding clients to make active, autonomous choices and to be well-informed about any method they choose to adopt.
6. ***Frictions.*** For many clients, the process to adopt and use a contraceptive method is rife with frictions. Some, like transportation costs or inconvenient service hours, are easy to spot. Others are less obvious, and ***many have a far greater impact than might be expected.*** By unpacking when, where, and how frictions arise and understanding which exert a disproportionate effect, we can reduce the barriers and burdens—both recognizable and obscured—to accessing services.

Together, we can continue to use the power of behavioral science to understand challenges more deeply and to build bold new solutions that accelerate progress toward the parallel aims of improving access and respecting agency and autonomy.

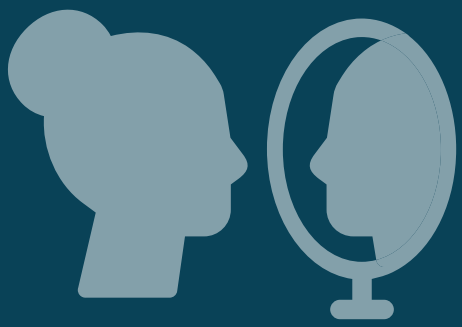
Introduction

Unintended pregnancy is a persistent global challenge with health, financial, and social consequences for women, families, and communities. The challenge is particularly acute in low-and middle income countries (LMICs), where despite significant strides in increasing the availability of contraceptive services,[1] 49% (111 million) of all pregnancies each year are unintended.[2] Social and behavioral factors are important components of the continued challenge, and programming focused principally on changing behavior has proven effective in increasing uptake of contraceptive services.[3,4] While the global health sector continues to tackle the behavioral drivers of unintended pregnancy, it also increasingly recognizes the importance of centering the needs and priorities of women, families, and communities.[5,6,7] It is clearer than ever that efforts to respond to the challenge of unintended pregnancy must support women and families to chart their own path forward to achieve their goals.

How can we tackle these dual challenges of smoothing pathways to contraceptive use while respecting agency and autonomy? Behavioral science offers tools to deepen our understanding of how women, families, and health workers approach choices about contraception, drawing from and building upon research in psychology, neuroscience, economics, and other disciplines.[8,9]

For almost a decade, ideas42 has used behavioral science to understand and address behavioral factors that contribute to unintended pregnancies. Through 17 research and design projects in nine LMICs across Africa and Asia, we have conducted in-depth qualitative research to unpack the reasons why women, men, youth, and health workers choose and act as they do. Together with our partners and with community members, we've built upon these insights to strengthen reproductive health programming to help women and their families make choices and access services at pivotal moments and in ways aligned with their goals and priorities. Through these design processes, we've learned from prospective users and recipients of the solutions about their needs, perspectives, and challenges. While every context and every individual is unique, powerful cross-cutting insights have begun to emerge through this work, which may have broader relevance within and outside the specific settings where our research occurred.

In the sections that follow, we synthesize six such cross-cutting insights from our behavioral science research and design work. Each section offers a brief introduction to behavioral science concepts—related to ***identity and norms, ambiguity, attention, risk perception, choice architecture,*** and ***frictions***—that have informed our work. We summarize common threads emerging from our interviews, observations, and collaborative design work across contexts. For each topic, we present suggestions for how programs can respond to these challenges to expand choices and reduce unintended pregnancies. Some suggestions are quick wins—opportunities to make modest adjustments to how information is presented or services are offered that may yield substantial gains, for example by correcting misconceptions or illuminating where the priorities of women and their partners are more aligned than they might have guessed. Others require larger changes—reimagining service delivery, investing substantially and differently in health workers' skills and women's options, and challenging existing power structures. We end with a call to action for those who shape sexual and reproductive health policy and programming to take advantage of the quick wins where they are available while also working with women and communities to address the more fundamental behavioral reasons that programs and services fall short.



1 IDENTITY AND NORMS

In many settings, the ability to bear children is central to a woman's identity as a wife, mother, and community member. Male identity is often strongly linked to a role as a provider and head of household. While desired family size may vary within couples, across communities, and between countries, these identities often reinforce a desire to begin bearing children at an early age, to have more children, and to avoid doing anything perceived to jeopardize fertility.

Research has demonstrated that identity—and its effect on choices—is not singular or static. Each person has multiple identities, for example as a spouse, a daughter, an adherent to her faith, and an agriculture worker. Which of these identities is most present in her mind at a given moment can influence her choices. Moreover, the specific actions or attributes most strongly linked to a particular identity may differ across communities and may change over time.[8,10] Identities are frequently shaped by social and gender norms, which guide and constrain individual behavior.

Insights about choices and identity from our behavioral diagnosis research suggest that there are often opportunities for contraceptive use to better align with, rather than challenge or undermine, core aspects of an individual's identity and the norms of their community.

Where motherhood is central to women's identities, any perceived threat to fertility may bring an unacceptable risk. Fertility is core to many women's identities, and social norms often reinforce motherhood as central to a woman's worth. At the same time, persistent myths falsely link contraceptives to infertility. Where preserving fertility is of paramount importance, even a risk viewed as very remote can easily lead women to avoid contraceptives. This suggests that demonstrating repeatedly and unambiguously that women who have used contraceptive methods remain fertile is critical to offer reassurance that family planning (FP) is consistent with women's goals. It also suggests that many women may demand a very high standard of proof that FP protects fertility, a dynamic we expand upon further in Insight 4.

> *"People say that if you use the implant that you can't have any more children."*
> – YOUNG WOMAN

Where women have other strongly held identities instead of or in addition to motherhood, perceived threats to fertility may sway their decisions less. For example, women who identify as breadwinners also take seriously risks that interfere with their ability to work. For adolescent girls who identify strongly as students, threats to their ability to remain in school are influential. In both cases, the risk of an unintended pregnancy that may imperil these other identities can offset concerns about risk to fertility. This suggests that, where other identities are important to women, reminding them of those identities may help them to consider their options in light of all their priorities for themselves, their families, and their futures.

> *"Because I'm a single mother, I have to take care of my daughter. That's why I'm here [working]."*
> – WOMAN

Social sanctions for not having children or having too few children are highly visible. Women commonly recount stories of other women being abandoned by their husbands or losing status if they fail to have children. Women also reflect on their experiences of gaining social status after giving birth and of seeing women with many children garner respect in their communities. These visible consequences reinforce norms that favor large families, early pregnancy, and closely spaced births. This suggests that demonstrating in a similarly vivid manner how FP use is consistent with good motherhood and with desired family size may help to assuage concerns about the possible social costs. It also suggests there is value in equipping individuals and communities with the skills and platforms to challenge and reshape norms that negatively impact them.

"Living in this world, the benefit is having a baby."
– WOMAN

Pregnancy is a means to signal fertility, often the only signal available to a woman. Once a young woman is married, she often feels pressure to become pregnant to cement her role as a wife and mother and demonstrate her fertility. While becoming pregnant before marriage often engenders strong social sanctions, in some settings and for some young women, it can prove fertility and lead to a desired marriage proposal. This suggests that if a young woman has access to another way to signal her fertility and secure the future she wants for herself, she might feel more confident choosing to use FP to delay her first pregnancy.

"[If the girl] wants the boy and the boy doesn't want to marry her, she might get pregnant to have the boy change his mind."
– YOUNG WOMAN

Large families can lead men to feel more secure as partners and providers, for reasons that vary across families and contexts. It's common for men to desire larger families than their wives do. Large families can serve as a signal of social status, cementing a man's role as a provider and authority figure in his household and community. In settings where men fear abandonment, they may view pregnancy and childbearing as a way to reinforce control within their families. A wife with many children or a wife who is currently pregnant may be less willing and able to abandon her husband for another partner. This suggests that if a man's sense of security in his partnership, household, and community can be bolstered through other means, he may feel more content to space his children or to have a smaller family.

"Men with more children are the 'men of the stars'."
– WOMAN

"If a woman gives birth to a lot of children she won't be having time to go out, and she wouldn't leave him for another man … that's why they want them to have more babies as much as they can, so she won't leave them for a better life."
– WOMAN

There are limits to the status benefits from having large families. In many communities, both women and men view large families as a signal of, and sometimes a path toward, high status. However, they also note that large families have high status only to the extent they are well cared for. When a family struggles to cover the costs of caring well for many children or children who are spaced closely together, the status benefits of a large family are undermined. Men with many children sometimes reflect that they didn't fully anticipate the costs of their children in advance, in some cases expressing a desire for a smaller family than they have. Others reflect that they previously felt they should have many children because some might not survive, recounting experiences earlier in their lives when child mortality rates were higher. This suggests that helping families, and in particular men, to fully consider the future implications of the number and spacing of their children may support them to make choices that are better aligned with their goals.

"I was one of 18 siblings, and 10 of them died. I thought that some children would die. It was a huge mistake to have this many children."
– MAN

Health workers' identities as women and mothers sometimes outweigh their clinical identities, influencing the role they feel they can and should play in offering FP services. Often, health workers are embedded in communities where public discourse associates FP use, especially among young and unmarried women, with promiscuity and prostitution. The social relationships health workers have with clients, their families, or others like them in the community can also feel at odds with providing comprehensive FP counseling and services, especially to young, unmarried, or nulliparous women. In some cases, health workers actively oppose FP use by these women. Often, however, health workers' personal identities exert a subtler influence; though they remain willing to provide services if requested, they may discuss FP less openly, recommend only certain methods, or recommend FP only as a less desirable alternative to abstinence. Health workers may receive training or messages to the contrary, but those messages aren't strong enough to outweigh the ubiquitous contrary cues from the environments where they live and work. This suggests that if identity as a community member and mother can be reconciled with identity as a clinician, health workers may feel more confident that by providing comprehensive FP counseling and services to all clients they are acting appropriately, both as community members and as clinicians.

> *"The advice that I give to those who are not yet married is to preserve themselves. I would love to tell them to abstain from sex, but to preserve themselves is about using condoms."*
> —COMMUNITY HEALTH WORKER

2 AMBIGUITY

Multiple other people play a role in women's choices about childbearing and contraceptive use, including partners, parents, in-laws, and health workers. Despite the important and sometimes determinative role these other people play, open conversations rarely occur, and when they do, critical topics are not always discussed. In some cases, the preferences or guidance of these other influencers or decision-makers may conflict with a woman's preferences. Sometimes, however, there may be greater alignment than either party expects—alignment that is obscured by a lack of open communication.

Behavioral science research suggests that people are tempted to avoid situations that present ambiguous outcomes; sometimes even to the extent of choosing a path that is objectively worse to avoid the ambiguity.[11] Conversations with partners, parents, or health workers are a source of information for women, but these conversations appear risky or frightening when women feel uncertain about what reaction they will receive. Often, people avoid confronting information that could be useful (like a medical diagnosis or a partner's stance on contraceptive use) because the prospect of knowing is frightening.[12] In other cases, a diffusion of responsibility means that one person fails to initiate a conversation because they assume another person will or should be the one to do so.

We've learned from our behavioral diagnosis research about the conversations women, families, and health workers have and do not have about childbearing and contraception. These insights suggest opportunities to encourage more open communication to discuss and consider FP together. Where preferences and priorities diverge, they also suggest avenues to elevate the agency of those who are most impacted by decisions.

Male partners are often viewed as deciders, but don't initiate conversations. While men frequently desire large families or hold negative views about contraceptive use, they often express openness to discuss, consider, or learn more. In many LMIC contexts, both men and women expect that men will weigh in or have the final say on decisions about having children or using FP. Often, however, it is not clear who in the couple should or can bring up a conversation about childbearing or FP. A woman may feel uncomfortable raising the topic if it appears outside of her control, while a man may assume that his partner will broach the subject if she wants to. As a result, conversations about FP are rare, leaving both men and women unsure of what their partners think and how they might react. The uncertainty creates a further temptation to avoid the topic entirely. If men and women can be made to feel assured and confident in broaching the topic with one another or have ways to learn what their partner thinks that feel safe to them, alignments in their preferences may more readily come to light. Open conversations may also lead preferences to align more closely over time. Where preferences about family size and contraceptive use diverge between women and their partners, efforts to elevate women's agency and autonomy will help them to take greater control over choices that impact their health and well-being.

> *"Families do not discuss when to have children."*
> —MAN

> *"[My husband's other wife] has four children, so I think he wants me to have that many."*
> —WOMAN

Silence on the topic is readily interpreted as opposition. Women who have not discussed FP with their partners or other family members often assume they disapprove and would react negatively should the woman bring it up. Women cite fears that partners or parents may react in anger or violence upon discovering they are interested in using FP. As a result, they may avoid conversations to prevent any chance of a negative reaction, even if they think an extreme reaction is unlikely and even when doing so means accepting a risk of an unintended pregnancy and its financial, health, and social costs.

"[I] never considered [FP] because my husband never wanted it. Some husbands say 'If I hear you use FP, I will send you home!'"
—WOMAN

"I chose [FP] secretly because my husband does not help with the babies."
—WOMAN

Another result of presumed (or actual) disapproval is for women to use FP in secret. Doing so introduces complexity, hassles, and risk, making it more likely that she will not access services, feel restricted in which method she can use, or discontinue FP use (see Insight 6). Women who choose not to disclose to partners or other family members that they are using FP should not be pressured to do so. However, there is value in making it easier and less risky for women to understand the perspectives of people whose views have consequences for them. With clearer information about where others stand on the topic, women may be better positioned to make choices and have conversations that are consistent with their own needs, preferences, and goals. Creating avenues, as noted above, for individuals and communities to question and reshape harmful norms can reduce the risks of using FP or of expressing a desire to do so.

Health workers' assumptions about who needs and wants FP influence when and how proactively they discuss it with clients. Health workers play a critical role in starting and guiding discussions about FP, but do not raise the topic with all clients. Health workers sometimes assume that some clients do not need information or will respond negatively if they bring up FP, especially men and clients who are young, unmarried, have few children, or appear healthy. When there are constraints on method supply or on health workers' time, they sometimes prioritize offering FP to clients they view as most deserving or in greatest need: married women with many children. In some cases, health workers refuse services or actively discourage other clients from using FP. In other cases, they fail to raise the topic, although they would be willing to provide FP counseling and services if requested.

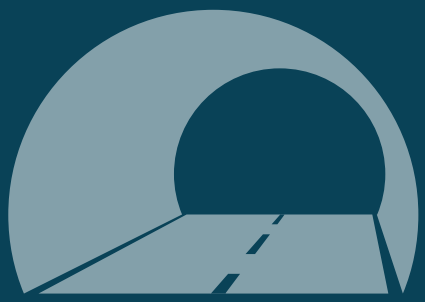
"If a youth wants to use family planning, the midwife will ask them questions to know why. If they convince her, she can maybe let them use family planning."
—YOUNG WOMAN

"[The facility] does not invite men to learn about family planning… I am interested in learning."
—MAN

"Men are very rushed and don't want to listen, only rush. [They] say 'why are you making me wait to get my services?'"
—HEALTH WORKER

As with partners and other family members, women sometimes interpret a health worker's silence as a signal that the health worker does not think the time is right or thinks she should not use FP. Clients' hesitancy to bring up the topic is compounded by the fact that in many LMIC settings, women are not accustomed to proactively ask questions of health workers, but instead defer to health workers as experts. This suggests that more opportunities for FP counseling may emerge if health workers are prompted to raise the topic consistently, even with clients they think are unlikely to choose FP. If clients can be assured of a positive response, they may also feel more comfortable proactively asking about FP. Providing other avenues for women and men to receive reliable and understandable information can also ensure that their ability to learn about and consider FP does not hinge so completely on a conversation with a health worker.

3 ATTENTION



Sometimes, a general interest or openness to using FP does not translate into a concrete choice to take up a method. In other instances, a woman may intend to use FP but never take the steps needed to follow through. Especially when women and health workers must attend to multiple health needs, decisions, and services in a single visit, it's easy for divided attention, distractions, and competing priorities to get in the way.

Behavioral science research has repeatedly demonstrated that all people have limited capacity to attend to multiple topics or tasks at a time.[13] The needs that appear most urgent in a given moment tend to capture attention, sometimes to the detriment of things that are equally or even more important but that fall outside the "tunnel" of those most urgent issues.[14] Even if a person notices and attends to one of these non-urgent details, they can easily feel tempted to delay action when there's no apparent deadline or when the best moment to act feels unclear.[15]

Our behavioral diagnosis research suggests that by noticing what else competes for a woman's or health worker's attention and how moments for action are perceived, we can better ensure that women are able to fully consider their FP options and follow through on their intentions.

Clients often receive information about FP during health visits when they—and health workers—are likely to prioritize other topics. Clients who visit a health facility to receive services other than FP understandably focus their attention on the primary reason for their visit. Health workers similarly focus on the needs that appear most urgent, particularly in busy environments when other clients are waiting. Sometimes, services are labeled with a name (such as Immunization Day) that further reinforces the emphasis on a single service, for both clients and health workers. In other cases, the visit is connected to a momentous or stressful occasion such as preparing for childbirth or accessing an abortion, which can feel incongruous with discussing FP, both for clients and for health workers. The result is that sometimes FP is not discussed at all or discussed in only a cursory manner. At other times, women feel unprepared to make a decision at the time the topic is broached. This suggests that integrated services may be most successful if health workers can view and describe FP as connected to the primary purpose of a client's visit. It also suggests that information and counseling over multiple visits may be needed for some clients to feel comfortable and prepared to make an informed choice, especially when that counseling is provided alongside other health services.

"Even when we discuss FP during antenatal care or other times, women forget or say 'you didn't tell me.'"
—HEALTH WORKER

"FP is all about women's health. The maternity ward takes care of women's health… So [at immunization] they don't talk about it."
—HEALTH WORKER

"I want to get the cleaning [abortion] and make sure it's taken care of… then I'll come back for family planning."
—WOMAN

Women who do not adopt a method when offered sometimes feel the window of opportunity has passed. Some women who learn about FP during another health visit think that they must start using FP in that moment or never. When coupled with divided attention that makes it difficult to deliver, receive, and absorb counseling, women can feel they have missed their chance. This suggests that explicitly communicating to clients that they are welcome to return later for FP services may help to ensure that they view this as an option. It also suggests that referrals, plan-making, and reminders may be necessary to support clients to act later when they are not ready to do so in the moment the topic is first broached.

When health workers wait to counsel until they think a client is ready for FP, they miss opportunities to ensure she is prepared to make a choice. Clients who are not at immediate risk of pregnancy because they are not yet sexually active, are currently pregnant, or are exclusively breastfeeding, are generally not prioritized for FP counseling. But by waiting to discuss FP until the risk of becoming pregnant is imminent, clients miss out on opportunities to learn about, consider, and discuss options, often leaving a gap in protection. This suggests that offering information and counseling early and often and guiding clients to think ahead about when and how they will make a choice may support readiness to make that choice at the most opportune moment.

> *"They [health workers] didn't say anything about methods just said 'to come' for family planning at immunization."*
> —POSTPARTUM WOMAN

4

RISK PERCEPTION

Fears of side effects and health consequences of contraceptive methods—in particular, the fear that FP may jeopardize fertility—are widespread. For many women and men, fears about false consequences are a primary driver of hesitancy to use FP and have persisted even with intensive efforts to combat them.

Behavioral science research offers clues about why concerns rooted in misconceptions are so influential and so hard to counter. Vivid examples that come easily to mind can lead a person to overestimate the likelihood of a negative event.[16] Then, they tend to notice and interpret the evidence around them in a way that reinforces that belief, and to miss or discount evidence that might counter it.[17] Even evidence that corrects a misconception can further reinforce it, simply by making the false information more familiar.[18] When what a person perceives to be at stake (in this case, fertility) is of paramount importance, even misconceptions that are not strongly held or risks that appear remote can exert a powerful influence on their choices.[19]

Our behavioral diagnosis research has illustrated how these tendencies influence risk perceptions, and how perceptions shape preferences and decisions, revealing opportunities to counter misconceptions and to reduce their disproportionate impact on choices. These insights also underscore the importance of continued investment to improve the available options to ensure each client has access to a method that suits her needs, priorities, and preferences.

Vivid examples of negative consequences are widely shared and easy to recall, even when they are partially or entirely false. For many people, family members and peers rather than health workers are the first and most influential source of information about FP. Stories of women who have experienced significant side effects and or have struggled to conceive after using FP are widely shared, and nearly all community members can cite an example of someone who is said to have had a negative experience. These negative experiences are often not actually attributable to FP, but nonetheless influence choices. Good experiences with FP—when users don't experience side effects and when they are able to conceive quickly after using FP—are rarely discussed and less likely to be recalled. The result is that negative experiences appear more common than they are. This suggests that if similarly vivid, personal, and memorable success stories of FP use can be widely shared and discussed within communities, those positive stories will come more easily to mind and exert a counterbalancing effect on perceptions of risk.

> *"[My sister in-law has a] 7-year old child but up to now, they are unsuccessfully trying to get another child. She took the pills then some people argued that they were the cause."*
> —YOUNG WOMAN

Women interpret common side effects from FP as dangerous when they connect them to deep-seated fears about infertility or birth defects. Contraceptive methods have possible side effects that range from innocuous to uncomfortable and in some cases dangerous if left

> *"The biggest thing is fear of side effects; their minds are fixed."*
> —HEALTH WORKER

unattended. For most FP users, side effects do not pose a significant risk. However, real side effects such as changes in monthly bleeding are often interpreted as a sign of a more serious concern rooted in myths and misconceptions about FP. Women and men sometimes express hesitancy about FP because of side effects or discontinue use after experiencing side effects, when their primary concerns are much deeper fears that FP will jeopardize fertility or the health of their future children. This suggests that to assuage concerns, it is necessary to support women to understand and address the side effects they experience, but also to weaken the perceived links between side effects and deeper concerns.

> *"The biggest worry is having … delay in pregnancy."*
> —MAN

Sometimes, other health issues are mistakenly perceived to be connected to FP. Difficult living and working conditions and weak health systems limit women's ability to understand and address the causes of health concerns unrelated to FP. The choice to discontinue FP generally remains within a woman's control when other actions may not be. This may make it tempting for a woman to attribute the issues she experiences to her FP method. It suggests that increasing women's agency and resources to address other health issues may decrease the likelihood that those health issues are mistakenly attributed to FP use. In many cases, this may point to a need for expansive investments to improve comprehensive health care, increase food security, and otherwise allow women to take control of broader aspects of their health and well-being.

> *"Many of the women that come [here] for FP do not have the opportunity to change their health status by taking medicine or getting procedures because they are poor and unable to seek treatment. One client wanted her IUD removed because she was feeling numbness in her legs."*
> —HEALTH WORKER

Even when health workers try hard to address clients' concerns, they struggle to combat misconceptions and sometimes inadvertently reinforce fears. Sometimes, health workers are influenced by the same fears and misconceptions that clients and community members experience, which leads them to perpetuate myths. Perhaps more often, they are aware of the misconceptions and try hard to dispel them but struggle to do so effectively. Some of their efforts to address concerns and counter misconceptions may backfire. For example, repeating a myth (even in the context of explaining that it is false) can unintentionally entrench false beliefs. When health workers avoid recommending methods that they know clients are concerned about, they may reinforce the notion that many people are concerned and signal that there is something questionable about those methods. This suggests that equipping health workers not only with correct information about FP, but also with tools and tactics to counter misconceptions, will enable them to address clients' concerns more effectively.

> *"[Clients'] minds are fixed. How can you change it?"*
> —HEALTH WORKER

Clients sometimes choose fertility awareness methods in response to fears of using other methods without being prepared to use them effectively. The standard days method, two-day method, lactational amenorrhea, and other fertility awareness methods are often viewed as the most suitable option for avoiding pregnancy by those who have misgivings about other methods. These methods can be appropriate, reliable options for many women.[20] However, they are sometimes chosen without a complete understanding of how to use them correctly. For example, some women rely on counting days while misunderstanding which are the fertile days in their cycle or rely on breastfeeding without knowing that protection is reduced after the baby begins eating solid foods. Sometimes, women choose fertility awareness methods without being fully prepared to use them effectively—they

> *"I don't need to use contraception because I'm counting my days … They showed us [how] at school … I don't remember much."*
> —YOUNG WOMAN

may, for example, overestimate their own ability to abstain from sex or their ability to negotiate with their partners to abstain or use a condom on certain days. Supporting women to understand how these methods work and to consider what is required to use them correctly will help them make more informed choices about which method best suits their needs. For those who choose a fertility awareness method, understandable explanations will also prepare them use the method effectively. The challenges inherent in using these methods effectively also underscore the value of continuing to invest to expand method options and facilitate self-care.

> *"If they are correctly breastfed, they can wait till three years [to become pregnant again]."*
> —POSTPARTUM WOMAN

5 CHOICE ARCHITECTURE

Counseling from a trained health worker is critical to ensure that clients can make a free and informed choice about FP and understand how the method they choose works and how it may affect their bodies. In practice, however, counseling does not always translate to greater understanding or to choices that are aligned with clients' needs and preferences.

A robust literature on choice architecture shows that the order, timing, and volume of information a woman receives will shape the choices she makes and how she later feels about those choices.[21] Detailed information may help ensure she fully understands her options, but information overload can lead to confusion and paralysis.[22] An unnecessarily large number of options can also, paradoxically, lead a person to feel less satisfied with what they ultimately choose.[23] Actively guiding choices with more curated information and structured decision-making processes may preserve free and informed choice more effectively than simply providing a large quantity of information. Even when an effort is made to present information in the most impartial way, it's impossible to be truly neutral. Certain details tend to stick out, including those presented first[24] and most recently[25] or those that support an option that was previously chosen.[26]

Our behavioral diagnosis research illuminates how counseling influences clients' perceptions of their options and the choices they make. These insights suggest opportunities to improve counseling so it guides clients to fully consider their options, to make active choices about which method best suits their needs, and to be well-informed about any method they choose to adopt.

Information is often difficult to digest and not easily comparable between methods. When they receive FP counseling, clients are often presented with large volumes of information about 10 or more different methods, one after the other. They hear about medical eligibility, the method's total duration, how it is administered and used, and all potential side effects with instructions on mitigating those side effects. The large volume of information, the medicalized nature of method descriptions, and the fact that each method is discussed separately make it challenging for clients to compare methods based on the features that are most important to them. Information that is critical to making an informed choice is mixed with information that may be most relevant after a woman has selected her preferred method.

> *"When they come, we present the methods and explain. It is she herself who makes the choice.…We don't tell her that's what's good for you, it's not good for you."*
> —HEALTHCARE SUPERVISOR

Some health workers view their role in FP counseling as informing rather than guiding and hesitate to explicitly compare methods or make recommendations because they fear inhibiting choice. This approach may make it harder for clients to use the information they receive, leading them to fall back on a choice that is more familiar or to defer the decision about FP entirely. This suggests that counseling by actively guiding clients toward methods based on their needs and preferences may best support clients to choose a method that's right for them.

Mismatches between counseling protocol and the reality of practice sometimes tempt health workers to skip or truncate counseling. Health workers often note tensions between the in-depth counseling expected of them and the time constraints of their daily practice in a health facility. Without direction on what to prioritize and how to counsel effectively within these time constraints, a health worker can feel tempted to skip counseling entirely and simply ask the client which method she wants, give her the method she has used in the past, or advise on a single method the health worker thinks is most appropriate. In settings where one method is particularly common, health workers may assume a client will choose that method and that counseling on other options is superfluous, even though many clients might prefer a different option if they were better informed. This suggests that matching tools and protocol for FP counseling to the constraints health workers face may increase the likelihood that counseling is consistently offered even when time is limited.

"Most of the woman when they came, they already have the method in their mind."
—HEALTH WORKER

"With the new married couple, if they come then [they're told] about the pill, condom. If they have one child, they get implant. If they have 2 children, then [they're told] about ligation or IUD. So it depends on the tenure of the couple."
—HEALTH WORKER

When all potential side effects are disclosed without conveying the likelihood that they may be experienced, side effects can play a disproportionate role in decisions. While clients need to know about potential side effects to make an informed choice, the prominence given to side effects in FP counseling and the way they are discussed can lead clients to think they are more likely or more serious than they are. This may exacerbate fears and lead clients to eliminate options that are well suited to their needs. Counseling tools typically list side effects for each method and health workers take seriously their responsibility to disclose the risk of side effects, including those that are uncommon. However, clients rarely receive information about how likely side effects are to occur. When counseling does touch on the likelihood of side effects, it generally communicates the probability that a side effect will be experienced rather than the (often much greater) likelihood that it will not be experienced. When coupled with vivid stories from friends and neighbors about side effects and risks (see Insight 4), this can lead clients to assume certain methods come with a near certainty of serious side effects. This suggests that finding accessible, understandable ways to depict a client's likely experience using a method will help her to better weigh any risks of side effects against other considerations that are also important to her.

"The implants and the IUD are good because they are of long term but the only problem is that it has so many side effects… so it is better to use the method which is not giving you any problems."
—WOMAN

A method's maximum duration features prominently in FP counseling, leading both clients and health workers to exclude relevant methods. The maximum duration a method can be used is often a primary feature considered by both health workers and clients to determine whether a particular method is appropriate. A method's duration is highlighted in counseling and is frequently used as a shorthand name for the method. The possibility of switching or stopping a method before its full duration is rarely emphasized and sometimes not mentioned at all. In some cases, health workers discourage or refuse early removal of methods. Women who know or suspect that they may want to become pregnant before the end of that period assume that the method is not right for them.

"We inform that we have three types of family planning: the three years family planning, the three months Depo family planning, and there is the 28 days or the pill one."
—COMMUNITY HEALTH WORKER

Young, unmarried women often face the added complication that they are not certain when they will get married but know they will be expected to become pregnant soon after they do. Taking up a method they perceive to come with a fixed duration (especially one of several years) may feel risky in the face of this uncertainty. This suggests that emphasizing other features of FP methods and reinforcing—for both health workers and clients—that methods may be used for a shorter period of time will help to broaden clients' choice set.

> *"They proposed to me to use the [injectable], for the three months. Because she's so young we can't use a one or two years or five years method."*
> —MOTHER OF A YOUNG WOMAN

Health workers tend to overestimate clients' readiness to make an informed choice after group counseling. Group counseling sessions can be an efficient and unintimidating way to expose many prospective clients to information about FP. Health workers frequently view group counseling as sufficient to prepare clients to make an informed choice. Sometimes, however, clients need in the in-depth, one-on-one conversations to absorb the information and make a decision. During group counseling, especially in a hectic public space, clients' attention may be divided. They may feel uncomfortable asking questions and voicing concerns, or they may feel overwhelmed by the amount of information and unsure of how to approach the choice. When busy health workers assume that clients already have the information they need, they're tempted to start consultations by asking clients which method they would like. This suggests that helping health workers reflect on what a client may realistically be expected to absorb from group counseling, reinforcing the additive value of one-on-one discussion, and supporting health workers to have conversations effectively within their time constraints may help ensure that clients receive the counseling needed to make a truly informed choice.

> *"I would say no [we could not ask questions after counseling] because at that time the doctor was busy with other people."*
> —WOMAN

6 FRICTIONS

Even with a strong intention, a lot can get in the way of accessing or continuing to use FP.

Behavioral science literature is rife with examples of how small hassles can exert a disproportionate effect on behavior, even when a person wants and intends to do something. Hassles can lead a person to procrastinate, putting off inconvenient, uncomfortable, or unpleasant steps, especially when there is not a clear deadline.[27] Though they sometimes seem like mere inconveniences, complexity or unanticipated steps can intimidate, leading a person to question whether she can and should follow through.[28] Where intentions are not strong or where barriers such as those described in the sections above make it particularly challenging to access FP, the impact of these frictions is likely to be particularly large.

Our behavioral diagnosis research has illuminated many different hassles women must surmount to access FP services. Some are easy to spot, while others are less obvious. Some have a far greater impact than might be expected. Understanding where and how these frictions arise uncovers opportunities to smooth the path to access services and continue using FP for women who choose to do so.

The path to taking up a method is not always easy or clear. A woman who chooses to use FP must often take many different steps to follow through. These steps can include determining the days and hours when services are available, finding someone to cover her daily activities, finding transport to the health facility and the money to pay for it, waiting an unknown period of time to be seen by a health worker, engaging in a discussion with the health worker that she finds uncomfortable, choosing a method, and returning later or visiting another facility if her preferred method is unavailable, among many others. Each one of these steps presents an opportunity for her plans to be derailed: she may lack the resources to complete it, feel frustrated or confused about what to do next, or delay steps that she expects to be unpleasant. Reducing the number and complexity of steps a client must complete will make it more likely that she can follow through on her intentions. While it may not be possible to eliminate hassles entirely, offering a clear, relatable picture of what the process will entail will help clients persist in the face of inconveniences.

> *"I came for the coil [IUD]. I arrived early because I did not want to wait long, but I waited three hours. I got the injection because I walked here alone, far from my house and the nurse worried that I might struggle in my walk back as I am alone."*
> —POSTPARTUM WOMAN

Sustained use of short acting methods presents additional hassles. Clients who choose oral contraceptives must remember to take a pill every day. Injections require repeated visits to the health facility, as do refills of oral contraceptives. The window of time when these visits can occur is often narrow, and missing it can lead to extra steps such as a pregnancy test and possible scolding from a health worker. Community-based distribution of contraceptive methods offers a

> *"It is a thing of remembering [to take the pill]. Sometimes I remember to have it; sometimes I forget to take it."*
> —WOMAN

promising avenue to reduce some of the challenges that impede sustained use, while user-friendly reminders can further support women to consistently use their chosen FP method.

Using FP in secret further complicates the process. If a client decides that her best option is to use FP in secret, she must take extra steps to ensure no one she knows sees her accessing services. She might feel she can only visit the health facility at certain times or that she must avoid the facility nearest her home. A desire to maintain secrecy also contributes to some women's choice of injectable contraceptives over long acting methods, although injectables come with the additional hassles of remembering when her next injection is due and visiting the facility in secret to get it. This suggests that making it easier to access FP services discreetly may help to overcome the additional challenges faced by these clients. It also reinforces the value of supporting couples to align on their preferences whenever possible so that FP can be used openly, as discussed in Insight 2.

> *"The Muslim girls will come [to the facility] at night…who don't want people to know."*
> —HEALTH WORKER

For those who have not used FP before, it's easy to overestimate unpleasantness and social risks. Young clients, in particular, often express uncertainty about how health workers will treat them and how likely it is that if they visit a facility their neighbors and families will find out. Because peers who use FP often do so in secret, examples of positive experiences are not readily available to assuage their concerns. This suggests that encouraging clients (especially young clients) to share their experiences with peers and offering visible signals that clients are welcome and will be treated well may help to make the process of visiting a facility less daunting. These positive signals must, of course, be matched with actual good treatment for clients when they access services.

> *"If it was me, and I was married, I could go see my aunt [the midwife] [for family planning]. But if not married, I wouldn't go see my aunt. I would go somewhere where no one knew me."*
> —YOUNG WOMAN

The path forward

Programs and services aiming to help women and families avoid unintended pregnancies should be designed from the perspectives and experiences of the individuals and communities they seek to reach. While understanding the rich cultural, contextual, and individual differences that shape behavior is valuable, programs and services can build upon behavioral insights that have emerged across settings. The table on the next page summarizes the implications for program, services, and policy design that follow from the insights described in this paper.

INSIGHT	DESIGN AIMS
Identity and norms 	▸ Demonstrate repeatedly and unambiguously that FP use does not threaten fertility ▸ Amplify identities consistent with FP use ▸ Convey vivid, salient narratives linking FP use to good parenting and desired family size ▸ Offer means to signal fertility that aren't pregnancy ▸ Bolster men's security in their roles in households and communities in ways that don't rely on large families or frequent pregnancy ▸ Cue people to consider future implications of decisions about childbearing and contraception ▸ Build skills and platforms for individuals and communities to challenge and reshape norms that negatively impact them ▸ Guide health workers to reconcile their identities as a community members and clinicians
Ambiguity 	▸ Generate opportunities to safely broach uncomfortable topics with partners ▸ Open avenues to for women to understand the perspectives of people whose views have consequences for them ▸ Elevate women's agency and autonomy in decisions about FP ▸ Motivate, remind, and encourage health workers to consistently offer FP counseling ▸ Reassure women of a positive response from health workers if they raise the topic ▸ Furnish alternatives to facility-based health workers for reliable and understandable information
Attention 	▸ Describe services in ways that emphasize connections between FP and other health needs ▸ Inform and counsel early and often, including before a client may feel ready to take up a method ▸ Enable clients to decide and act when they are ready, through referrals, planning, and reminders
Risk perception 	▸ Show personal, memorable, and vivid success stories of FP use ▸ Support FP users to understand and address side effects ▸ Increase accessibility of resources for other health issues that may be mistakenly attributed to FP ▸ Correct misconceptions and weaken perceived links between side effects and deeper concerns ▸ Illuminate and prompt reflection on what is needed to use fertility awareness methods effectively
Choice architecture 	▸ Match counseling tools and protocol to health workers' constraints ▸ Depict the likelihood of experiencing side effects in accessible, understandable ways ▸ Feature aspects of methods other than maximum duration in method descriptions ▸ Prompt health workers to reflect on the additive value of one-on-one conversations after group counseling
Frictions 	▸ Simplify and smooth the process of accessing services ▸ Illustrate clearly what the process of taking up a method will entail ▸ Expand access to community-based method distribution and self-care ▸ Afford means to access services discreetly ▸ Signal that clients are welcome and will be treated well

Program designers, implementors, policymakers, and other stakeholders in the FP/RH sector can improve programs and services for the humans who deliver, use, and are impacted by them. We encourage stakeholders to consider whether and how their programs, services, and policies can achieve these aims. There are opportunities for relatively quick wins, such as adjusting counseling tools, integrating reminders, or changing the words used to describe services. Others require attention to the larger root causes of unintended pregnancies, such as norms, biases, and power imbalances. Tackling these challenges through bold new solutions requires close collaboration with the women, men, communities, and health workers who receive and deliver programs to ensure all families can chart their own path forward. Together, we can continue to use the power of behavioral science to understand challenges more deeply and build bold new solutions to accelerate progress toward the parallel aims of improving access while respecting agency and autonomy.

About ideas42

ideas42 is a non-profit that uses insights from human behavior—why people do what they do—to help improve lives, build better systems, and drive social change. For more than a decade, we've been at the forefront of applying behavioral science in the real world. Our efforts have so far extended to 50 countries as we've partnered with governments, foundations, NGOs, private enterprises, and a wide array of public institutions—in short, anyone who wants to make a positive difference in peoples' lives.

Contact the ideas42 Global Health Team at gh@ideas42.org to learn more.

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