How to plan research in the area of sexual and reproductive health-

- specific research methods to be used, the role of population studies and other methods"

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Definitions

- In 1995 at the World Conference on Women in Bejing from 4th-15th September1995 Reproductive Health was defined as follows:
- „Reproductive health implies that, apart from the absence of disease or infirmity people have the ability to reproduce, to regulate their fertility and to practice and enjoy sexual relationships. It further implies that reproduction is carried to a successful outcome through infant and child survival, growth and healthy development.
- It finally implies that women go safely through pregnancy and childbirth, that fertility regulation can be achieved without health hazards and that people are safe in having sex.“

Definitions

The World Health Organisation has further developed the concept:

- “Sexual and reproductive health of women within the framework of WHO has been described “as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, as reproductive health addresses the reproductive processes, functions and system at all stages of life. ***Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so”.***
- …….Implicit in this are the right of men and women ***to be informed of and to have access*** to safe, effective, affordable and acceptable methods of ***fertility regulation of their choice,*** and the right of ***access to appropriate health care services*** that will enable women to go ***safely through pregnancy and childbirth*** and provide couples with the ***best chance of having a healthy infant***.

Sexual Health

WHO further elaborated on the concept of sexual health in particular

- " Furthermore a central aspect of being human throughout life encompasses sex, ***gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction***. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. ***Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors***." *(WHO, 2006a)*

The elements of sexual and reproductive health. How to measure or evaluate? Indicators

- ability to reproduce, to regulate their fertility
- ***the capability to reproduce and the freedom to decide if, when and how often to do so".***

Fertility rate
Prevalence of unwanted pregnancies
Prevalence of contraceptive use
Type of use Modern methods

Prevalence of infertility in women

Percentage of obstetric and gynaecological admissions owing to abortion

The elements of sexual and reproductive health. How to measure or evaluate? Indicators

the right of men and women ***to be informed of and to have access*** to safe, effective, affordable and acceptable methods of ***fertility regulation of their choice***

Accessibility,
Availability of methods
Services
Counselling

Prevalence of HIV infection in pregnant women
17 Knowledge of HIV-related preventive practices

The elements of sexual and reproductive health. How to measure or evaluate? Indicators

access to appropriate health care services that will enable women to go ***safely through pregnancy and childbirth*** and provide couples with the ***best chance of having a healthy infant***.

Maternal mortality ratio

Prevalence of low birth weight

Perinatal mortality rate

Prevalence of anemia in women

Prevalence of positive syphilis serology in pregnant women

Antenatal care coverage
Births attended by skilled health personnel
Availability of basic essential obstetric care
Availability of comprehensive essential obstetric care

The elements of sexual and reproductive health. How to measure or evaluate? Indicators

able to have a responsible, satisfying and safe sex life

Prevalence of positive syphilis serology in pregnant women

Prevalence of STI

Prevalence of HIV infection in pregnant women
17 Knowledge of HIV-related preventive practices

The elements of sexual and reproductive health. How to measure or evaluate? Indicators

able to have a responsible, satisfying and safe sex life

……central aspect of being human throughout life encompasses sex, ***gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction***

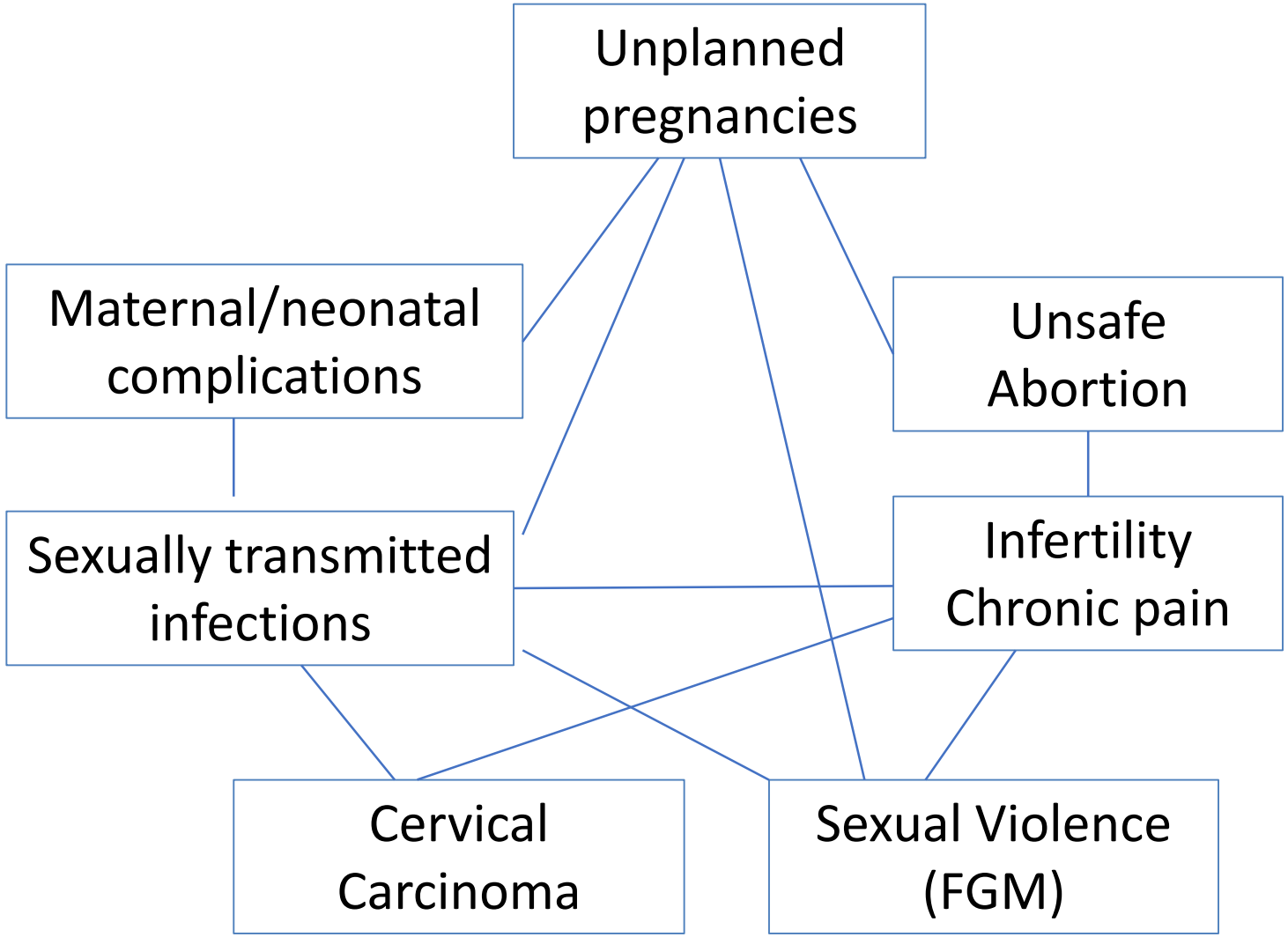
Reported prevalence of women with genital mutilation

????????

Indicators of sexual and reproductive health

1 Total fertility rate
2 Contraceptive prevalence
3 Maternal mortality ratio
4 Antenatal care coverage
5 Births attended by skilled health personnel
6 Availability of basic essential obstetric care
7 Availability of comprehensive essential obstetric care
8 Perinatal mortality rate
9 Prevalence of low birth weight
10 Prevalence of positive syphilis serology in pregnant women
11 Prevalence of anemia in women
12 Percentage of obstetric and gynaecological admissions owing to abortion
13 Reported prevalence of women with genital mutilation
14 Prevalence of infertility in women
15 Reported incidence of urethritis in men
16 Prevalence of HIV infection in pregnant women
17 Knowledge of HIV-related preventive practices

Associations and Interaction of different elements of SRH



The interconnection of the different fields

- Unintended pregnancies in adolescent girls (family planning, high risk groups) increase obstetrical complications and the health risks of the new born baby.
- Increased incidence of the Sexually Transmitted Diseases increases the risk of obstetrical complications and infertility
- Unwanted pregnancies may lead to abortion under unsafe conditions thus contributing to maternal death and/or infertility
- Sexual violence leads to unwanted pregnancies, negative mental and sexual health consequences for women and girls
- Female genital mutilation can lead to obstetrical complications and ill psychosexual health
- Lack of access to screening and early detection of malignant diseases like cervical carcinoma leads to preventable death, infertility etc.
- Lack of access to contraception leads to unintended pregnancies with negative medical, obstetrical, neonatal and psychosocial outcome.

What types of studies do we have?

Quantitative Research

- Surveys
- National statistics

- Cross Sectional
- Case Control
- Cohort
- Clinical trials

Qualitative Research

What is an Indicator?

- **Health indicators** *measure* certain characteristics of a population to describe the health of a population
  - Commonest example is Life expectancy
- A survey methodology is used to gather information preferably for the entire population when possible
- Perform a statistical analysis
- Health indicators are used to guide health care policy
- Essential for resource allocation
- Various organizations exist to identify, collect, measure, share and analyse data. E.g
  - Health Metrics Network
  - Institute for Health Metrics and Evaluation
  - http://phcperformanceinitiative.org/

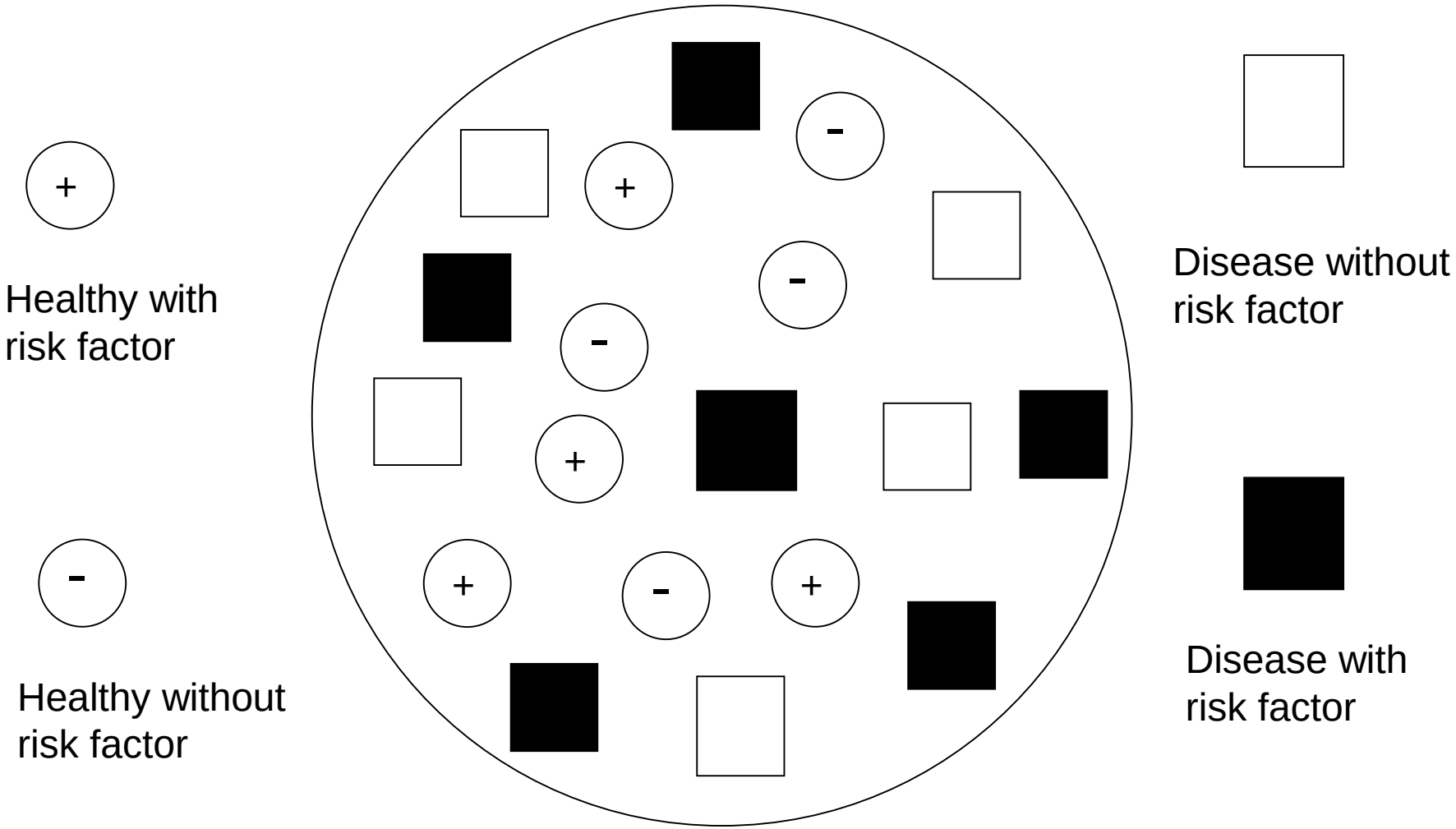
Types of Studies

- Descriptive Studies
  - Regional Survey
    - Frequencies, Rates, Ratios
  - National Statistics
    - Frequencies, Rates, Ratios
  - Global Statistics
    - Frequencies, Rates, Ratios
- Comparative Studies
  - Between Countries
  - Between Continents
  - Between Social Strata

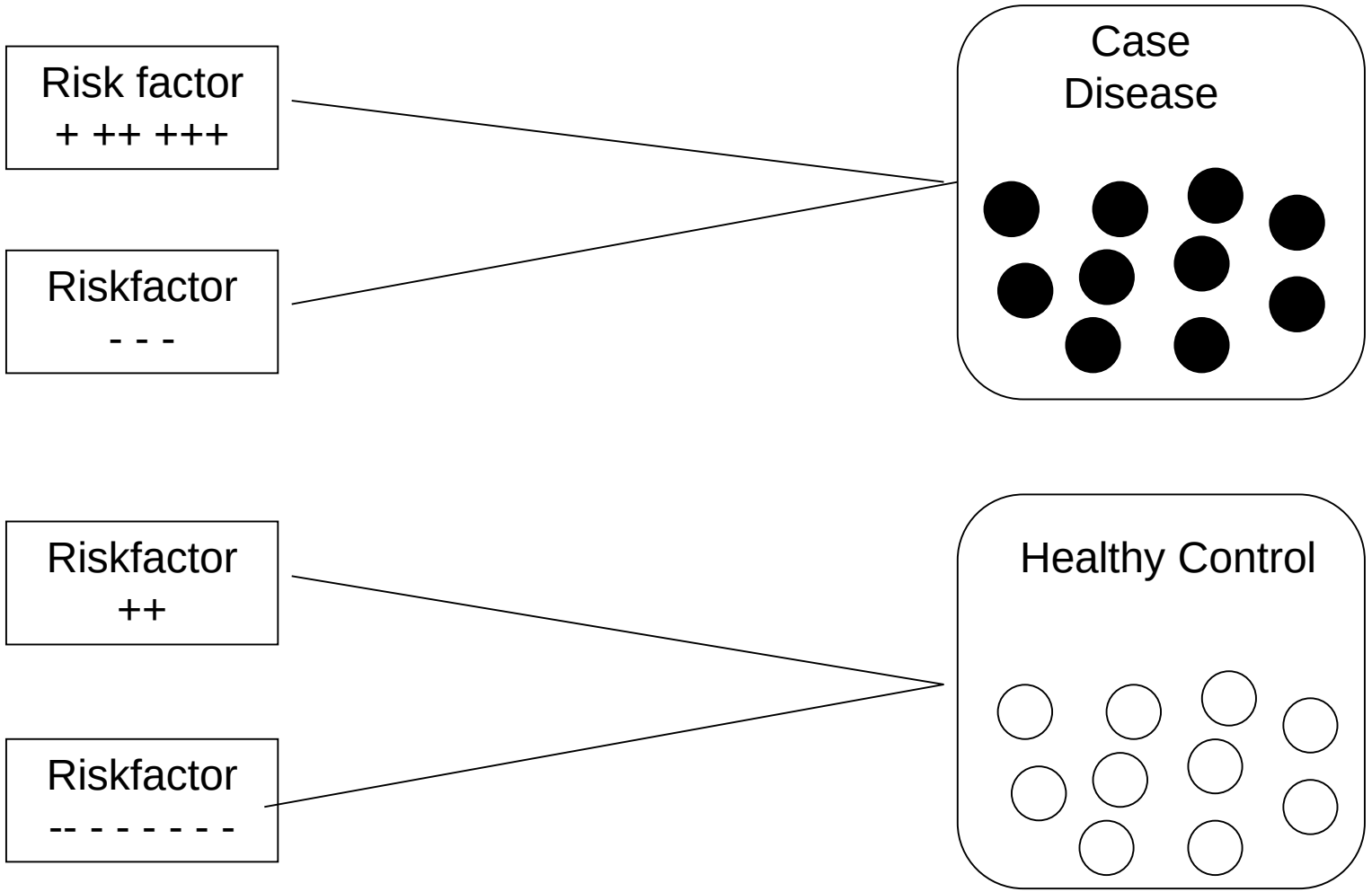
The methodological challenge

Sample/Population/ Representability
Data Collection
Quality of Data Collection
Control and Checking

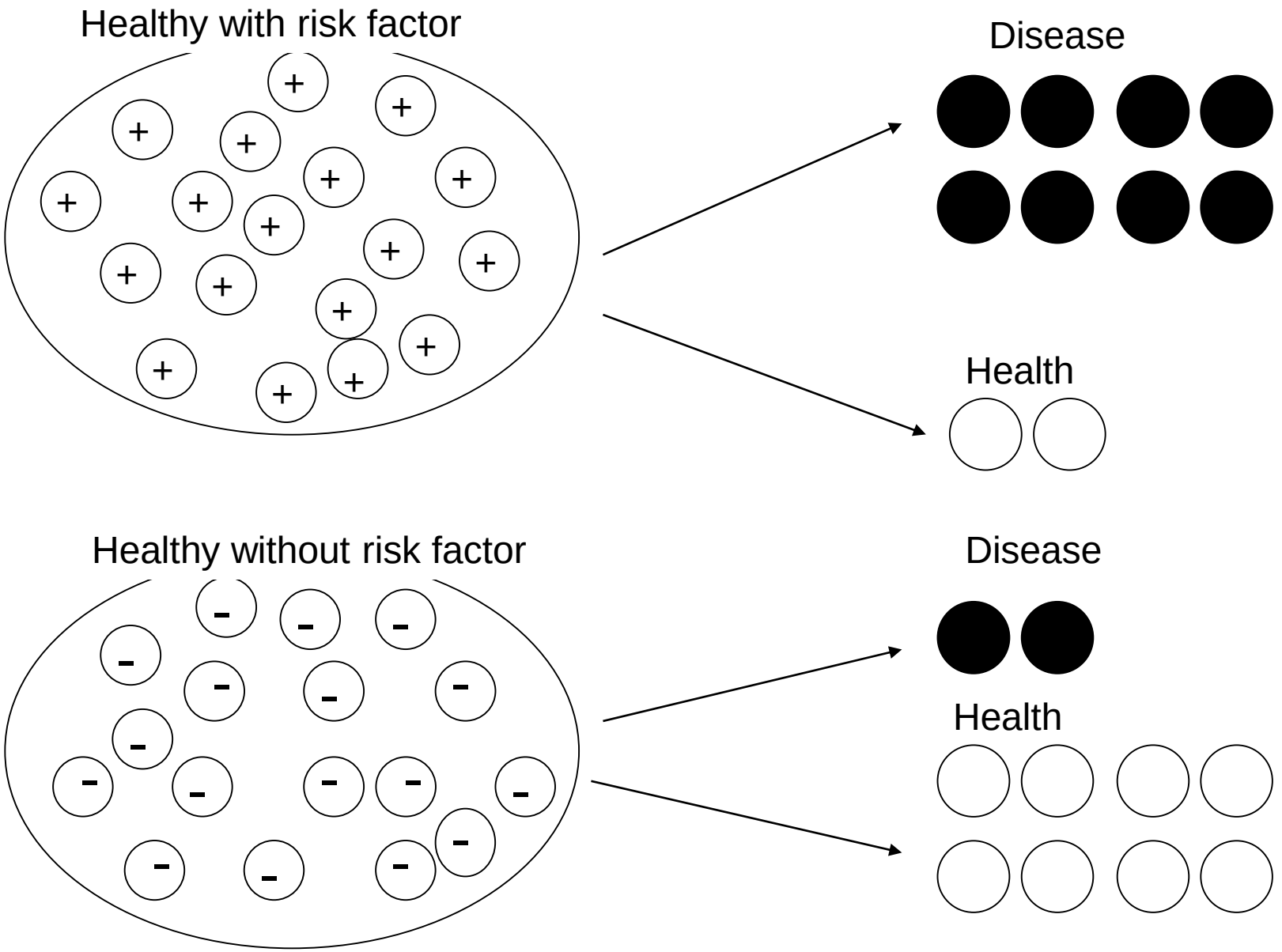
Cross Sectional – Prevalence study



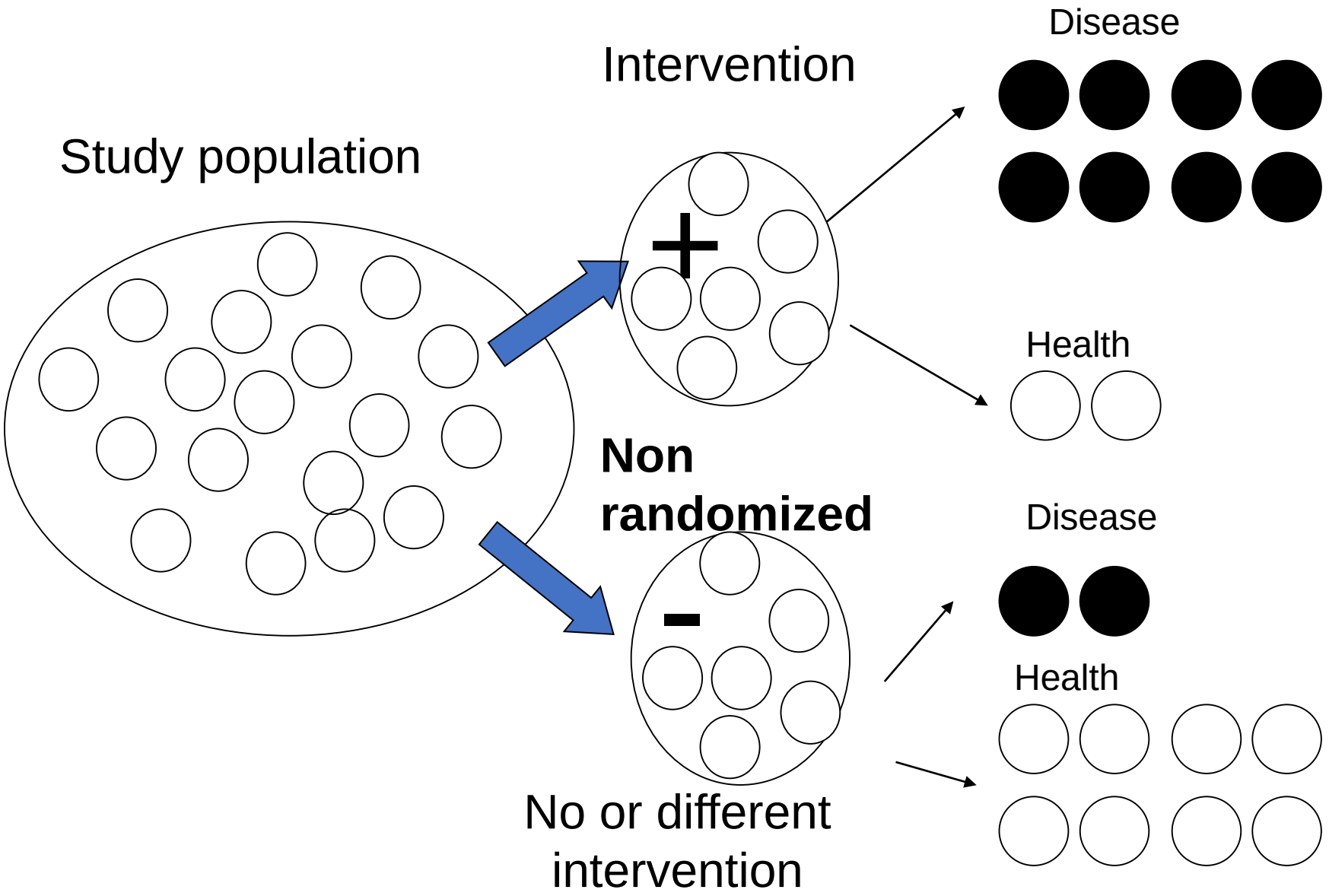
Case Control



Cohort Study



Clinical Trials



Qualitative research is a type of social science **research** that collects and works with non-numerical data and that seeks to interpret meaning from these data that help understand social life through the **study** of targeted populations or places.

Four major **types of qualitative research** design are the most commonly used. They are: 1) phenomenology 2) ethnography 3) grounded theory **4**) case **study**

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QUALITATIVE RESEARCH DESIGNS: A CONCEPTUAL FRAMEWORK. PK Astalin

Phenomenology

But what is it actually like to live with back pain?
What are the effects on peoples‟ lives? What problems does it cause? A phenomenological study might explore, for example, the effect that back pain has on sufferers‟ relationships with other people by describing the strain it can cause in marriages or the effect on children of having a disabled parent.
……wherever is a gap in our understanding and that clarification or explanation will be needed there the phenomenological research can begin in a systematic way with the full confident.
Phenomenological research will not necessarily provide definitive explanations but it does raise awareness and increases insight about the phenomena.

Ethnography

The social science that studies the origins and social relationships of human beings is known as anthropology. Ethnography is a branch of anthropology that provides scientific description of individual human societies. The term means “portrait of a people” and it is a methodology for descriptive studies of cultures and peoples. According to Van Maanen, "ethnography fieldwork usually means living with and living like those who are studied.

Grounded Theory

During their research into illness and dying, Glaser and Strauss developed grounded theory procedures, written in their book The Discovery of Grounded Theory (1967). To move away from the traditional scientific method, Glaser and Strauss suggested gathering data through systematic methodological procedures and developing theories from research that is grounded in the data.

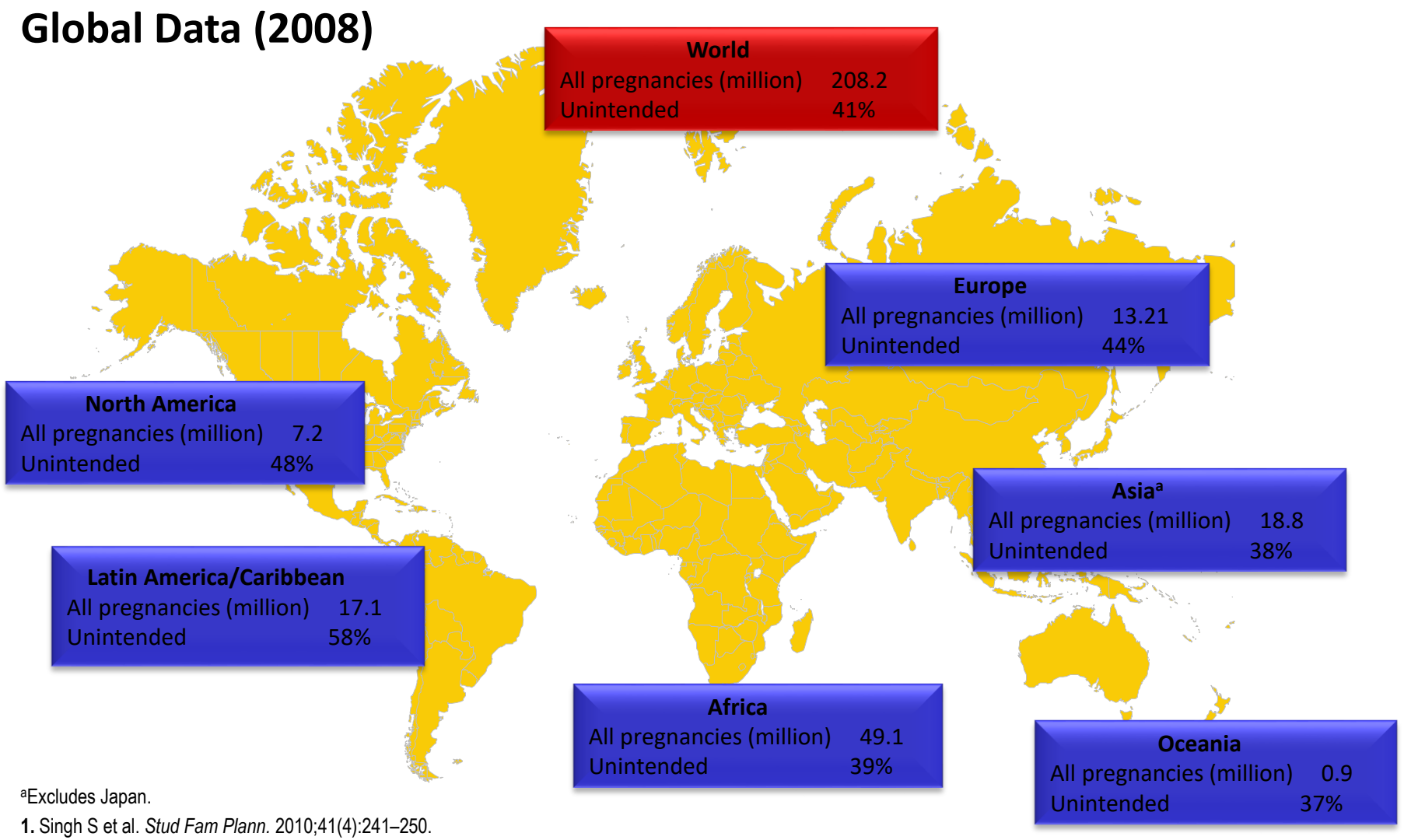
In grounded theory, the researcher does not commence the process of research with a predetermined theory in mind, the formulation of theories stem from the data that allows one to explain how people experience and respond to events.
The main feature of Grounded theory research is the development of new theory through the collection and analysis of data about a phenomenon. It goes beyond phenomenology because the explanations that emerge are genuinely new knowledge and are used to develop new theories about a phenomenon. In health care settings, the new theories can be applied enabling us to approach existing problems in a new way. For example, our approaches to health promotion or the provision of care.

A researcher collecting data through semi structured interviews may gradually develop an interview schedule in the latter stages of a research project which looks very different to the original schedule used in the first interview. New theory begins its conception as the researcher recognizes new ideas and themes emerging from what people have said or from events which have been observed. Memos form in the researcher's consciousness as raw data is reviewed. Hypotheses about the relationship between various ideas or categories are tested out and construct formed leading to new concepts or understandings. In this sense the theory is grounded in the data.

Surveys and global statistics of SRH

- Unplanned pregnancies
- Abortion
- STI
- Sexual Violence

Globally, Substantial Proportions of Pregnancies Continue to Be Unintended[1]



[a]Excludes Japan.

1. Singh S et al. *Stud Fam Plann.* 2010;41(4):241–250.

What is the impact of unintended pregnancies on the health of women

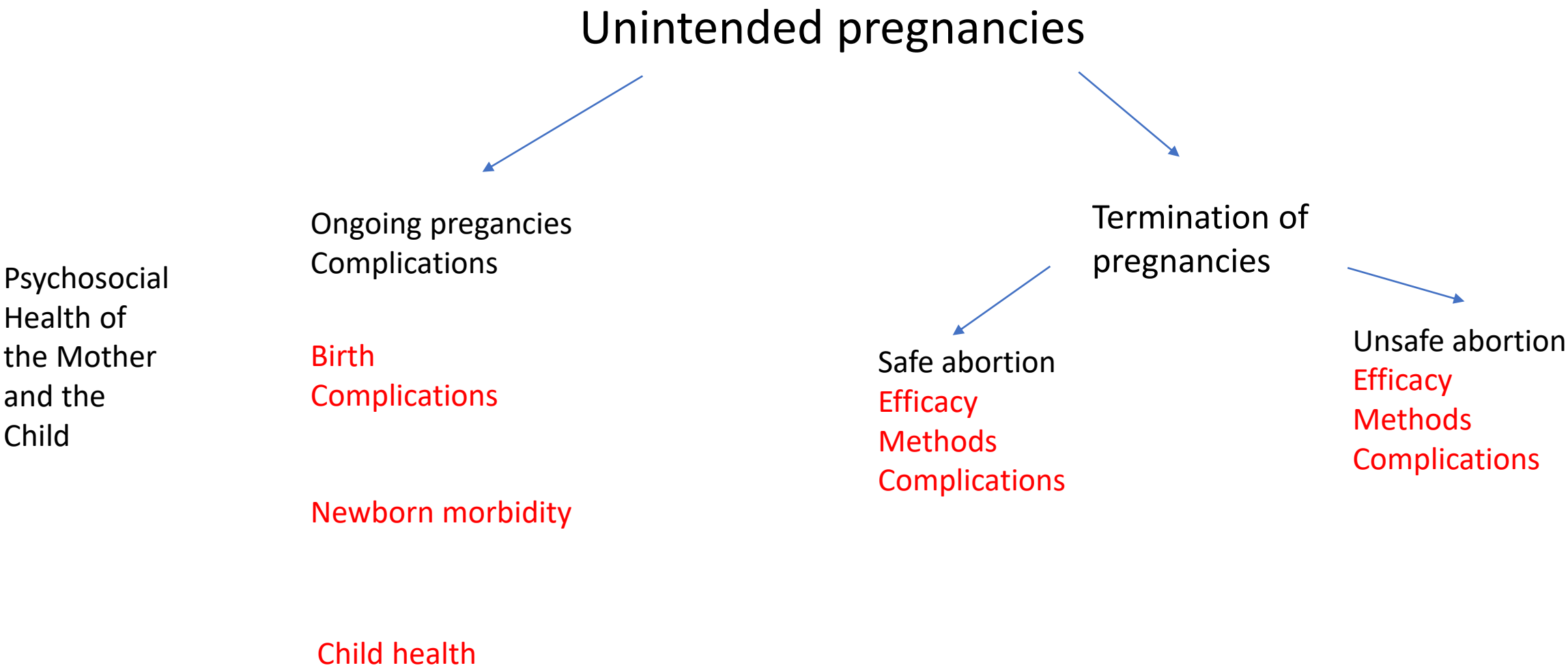
health burden

Follow up studies in women with unintended pregnancies

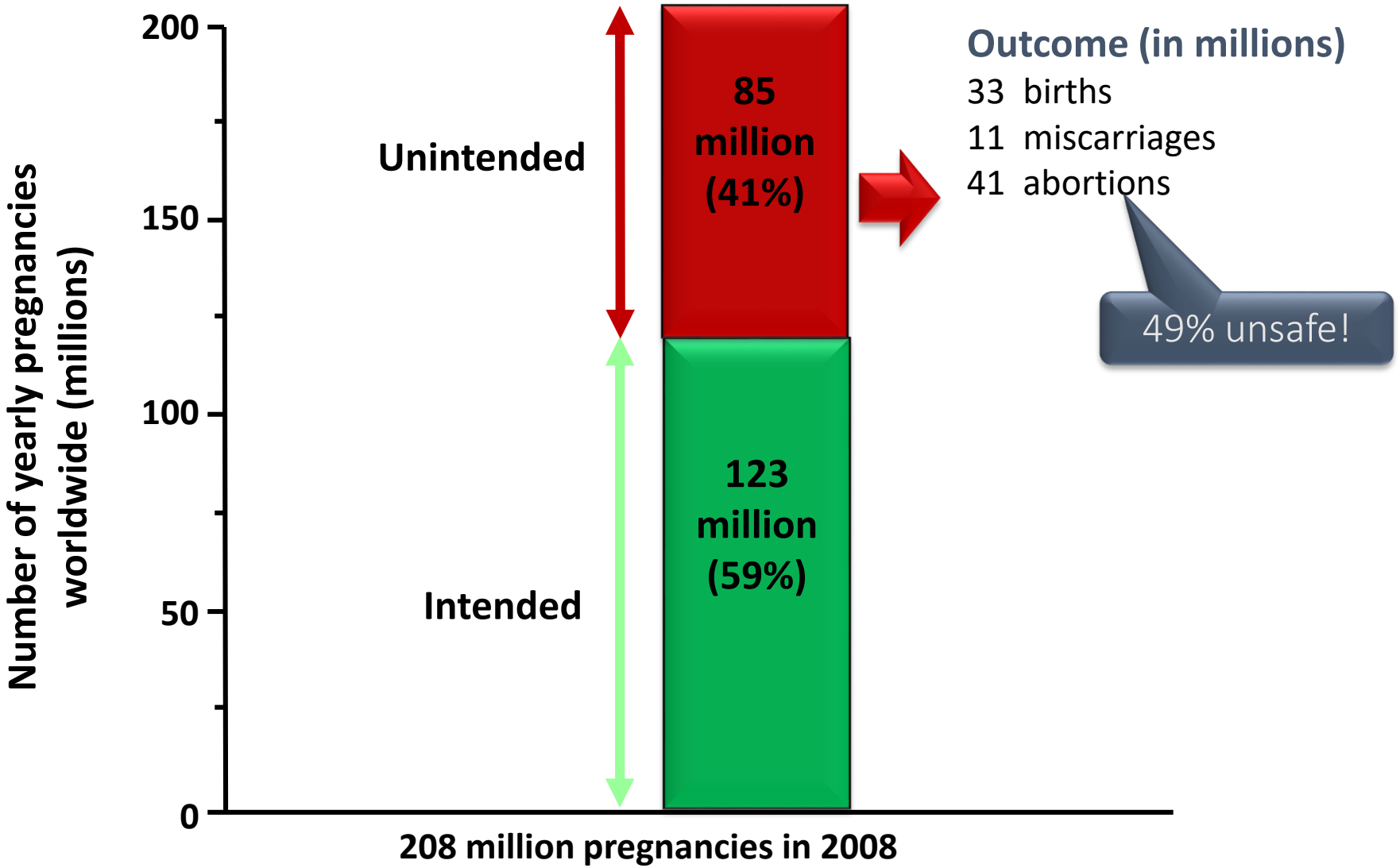
Somatic health outcome for women
Psychosocial outcome for women

Somatic health outcome or newborns
Psychosocial outcome for children

Study design. Cohort



Unintended Pregnancies Remain an Issue



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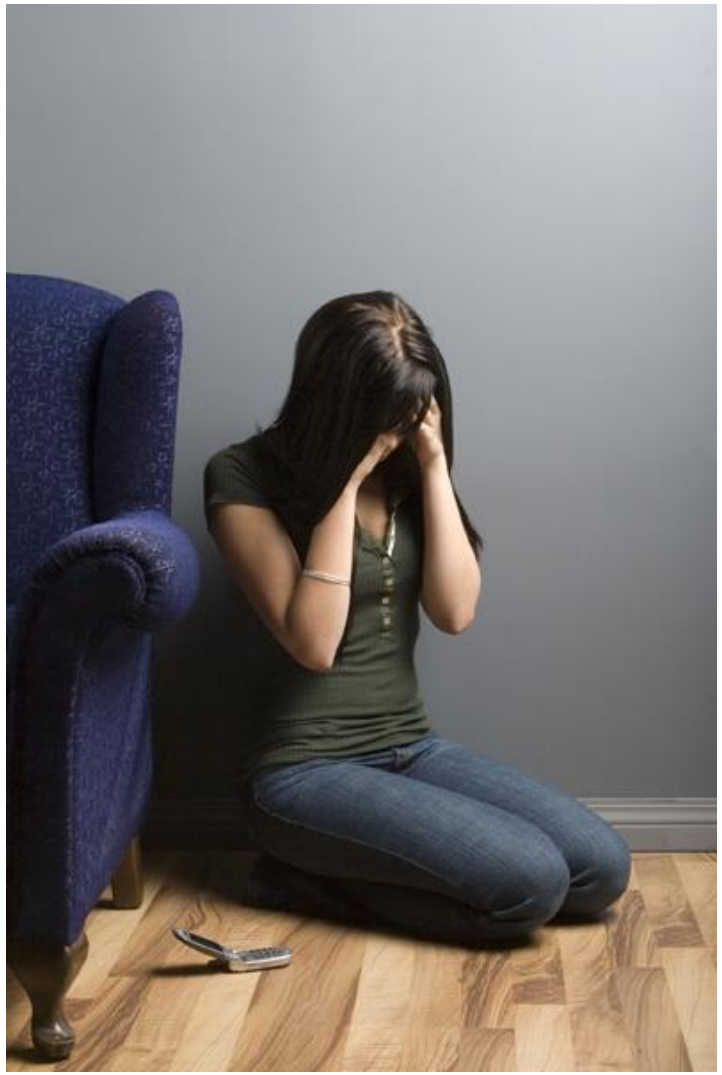


Unintended Pregnancies:
Individual Consequences

- Limit economic growth/ increase poverty
- Increase social burden
- Associated with high maternal mortality and morbidity
- High infant mortality and negative impact on child health and development

Estimated Safe and Unsafe Abortion Rates* Worldwide

	2008			
	Total	Safe	Unsafe	% Unsafe
Region and subregion				
World	28	14	14	49%
Developed countries	24	22	1	6%
Excluding eastern Europe	17	17	<0·5	<0·5%
Developing countries	29	13	16	56%
Excluding China	29	8	22	74%
Estimates by region and subregion				
Africa	29	1	28	97%
Eastern Africa	38	2	36	96%
Middle Africa	36	<0·5	36	100%
Northern Africa	18	<0·5	18	98%
Southern Africa	15	7	9	58%
Western Africa	28	<0·5	28	100%
Asia	28	17	11	40%
Eastern Asia	28	28	<0·5	<0·5%
South-central Asia	26	9	17	65%
Southeastern Asia	36	14	22	61%
Western Asia	26	11	16	60%
Europe	27	25	2	9%
Eastern Europe	43	38	5	13%
Northern Europe	17	17	<0·5	<0·5%
Southern Europe	18	18	<0·5	<0·5%
Western Europe	12	12	<0·5	<0·5%

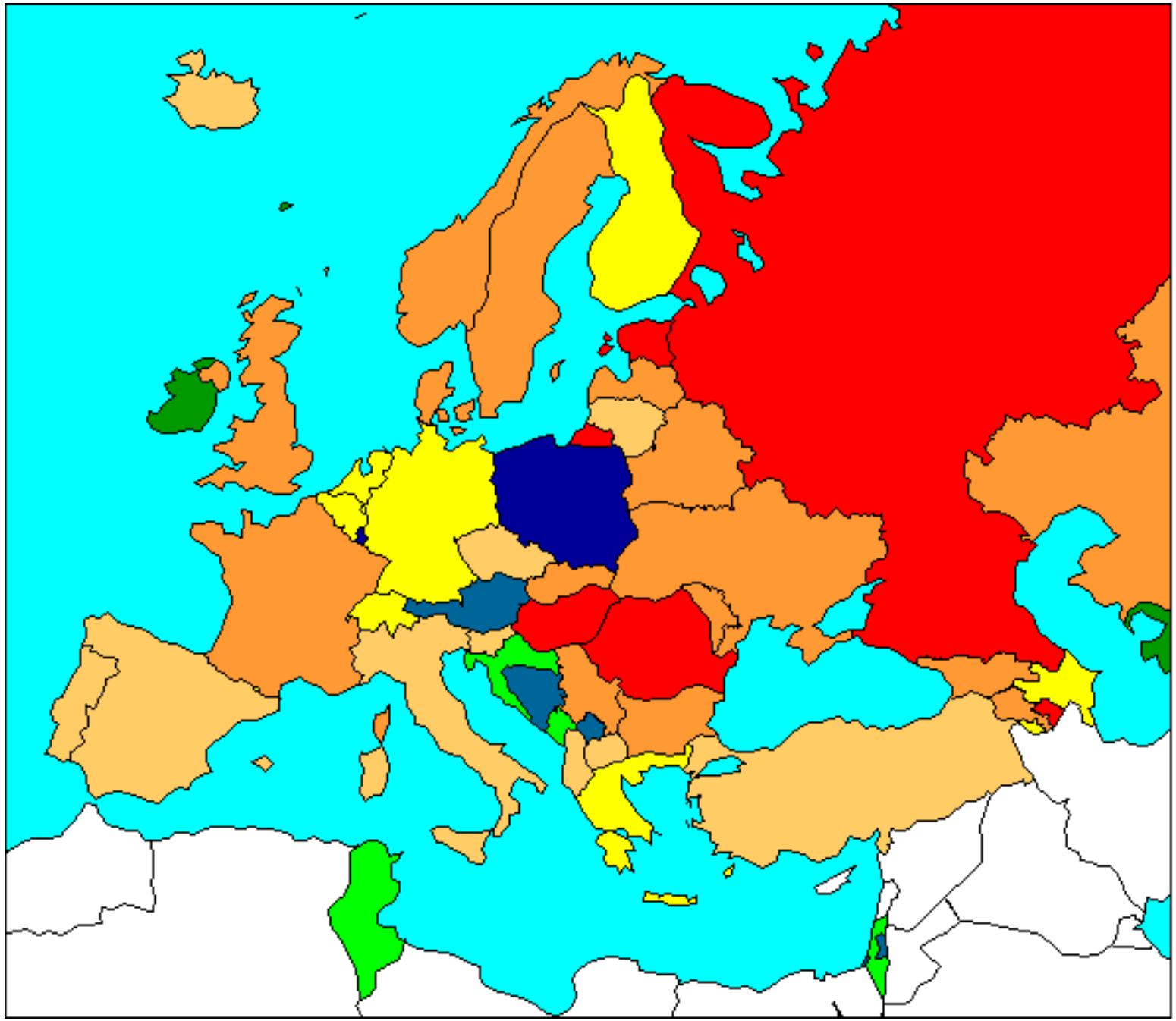
*Abortions per 1000 women aged 15–44 years.

Sedgh G et al. *Lancet*. 2012;379:625–632.

Global and regional estimates of induced abortion, 1990–1994 and 2010–2014

World and region	No. of abortions (millions)		Abortion rate†	
	1990–1994	2010–2014	1990–1994	2010–2014
World	**50.4**	**56.3**	**40**	**35**
Developed countries	11.8	6.7*	46	27*
Developing countries	38.6	49.6*	39	37
Africa	4.6	8.3*	33	34
Asia	31.5	35.8	41	36
Europe	8.2	4.4	52	30*
Latin America and the Caribbean	4.4	6.5*	40	44
Northern America	1.6	1.2	25	17*
Oceania	0.1	0.1	20	19

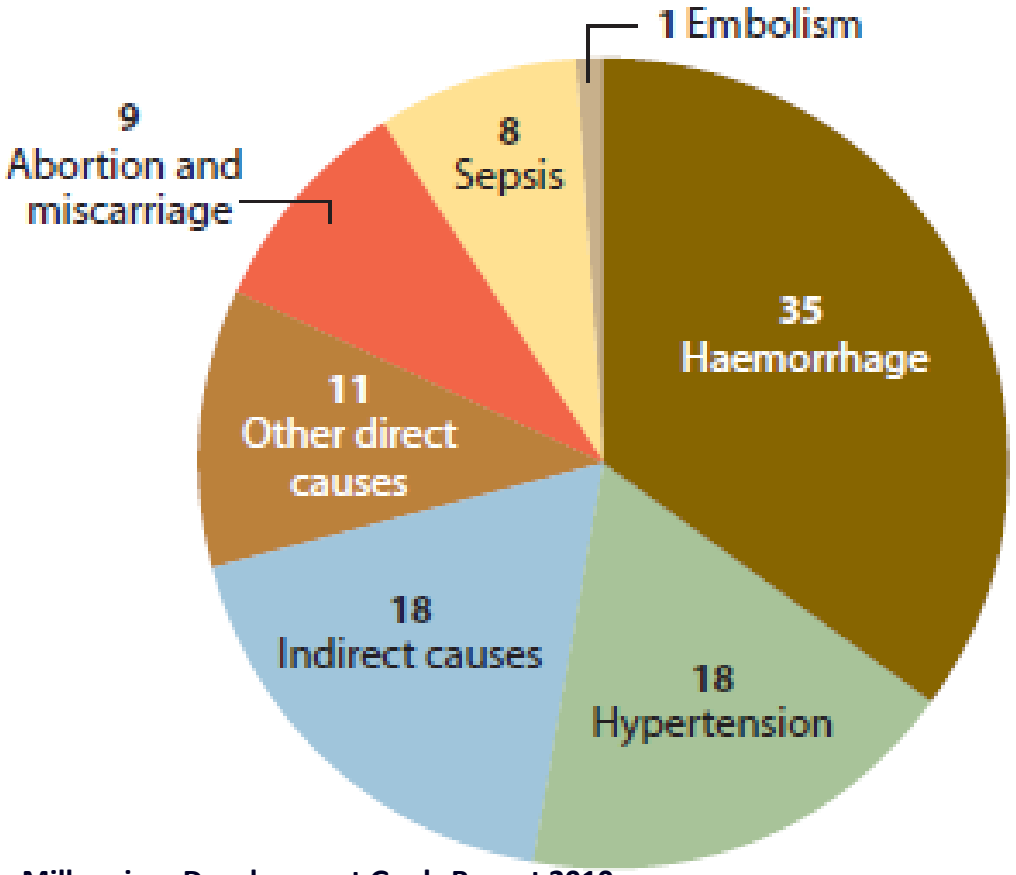
*Difference between 2010–2014 and 1990–1994 was statistically significant. †Abortions per 1,000 women aged 15–44.
SOURCE: Sedgh G et al., Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends, *The Lancet,* 2016, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30380-4/abstract.



Europe: percentage of pregnancies aborted by country, most recent data

50.0 - 87.5 %
30.0 - 49.9 %
20.0 - 29.9 %
15.0 - 19.9 %
11.0 - 14.9 %
8.0 - 10.9 %
5.0 - 7.9 %
2.0 - 4.9 %
0.0 - 1.9 %

Causes of Maternal Death

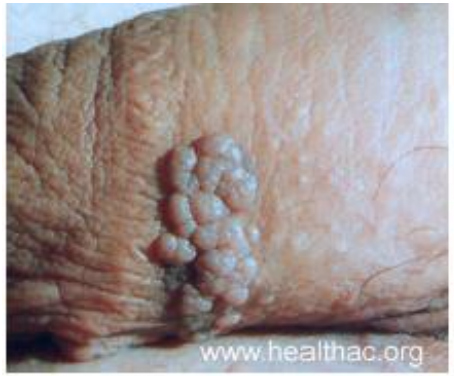


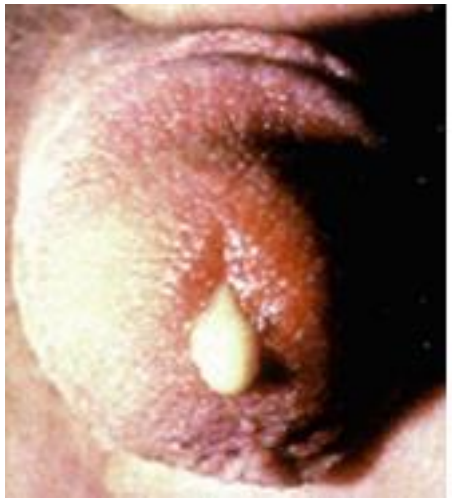
The Millennium Development Goals Report 2010

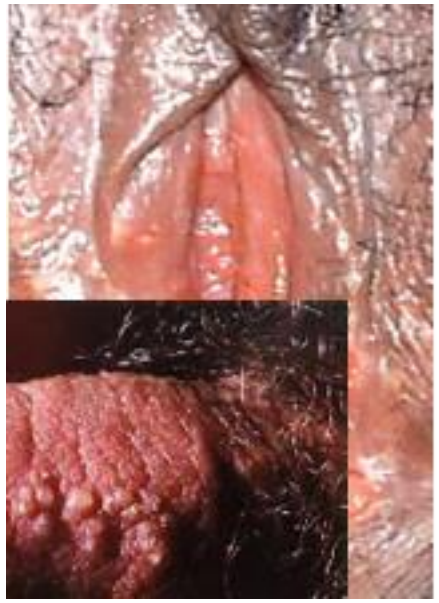
The vast majority of these deaths are avoidable

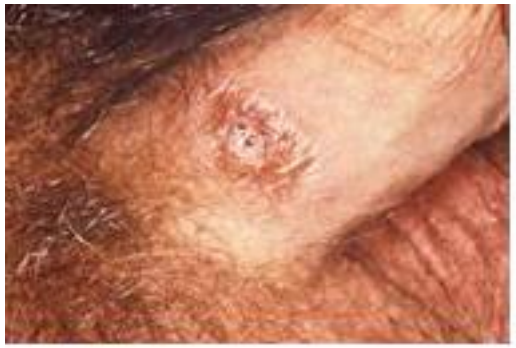
http://www.un.org/millenniumgoals/pdf/MDG Report 2010

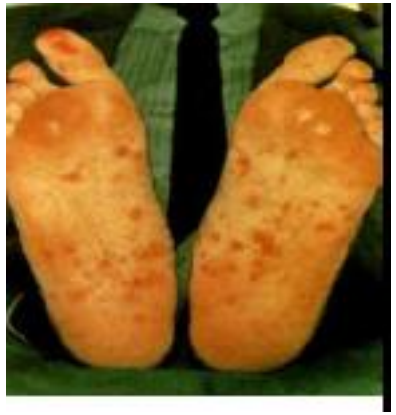
Sexually transmitted infections


www.healthac.org









Sexually transmitted infections

More than 1 million STIs are acquired every day.
Each year, there are estimated 357 million new infections with 1 of 4 STIs: chlamydia (131 million), gonorrhoea (78 million), syphilis (5.6 million) and trichomoniasis (143 million).
More than 500 million people are living with genital HSV (herpes) infection.
At any point in time, more than 290 million women have an HPV infection, one of the most common STIs.

Sexually transmitted infections

STIs can have serious consequences beyond the immediate impact of the infection itself.
STIs like herpes and syphilis can increase the risk of HIV acquisition three-fold or more.

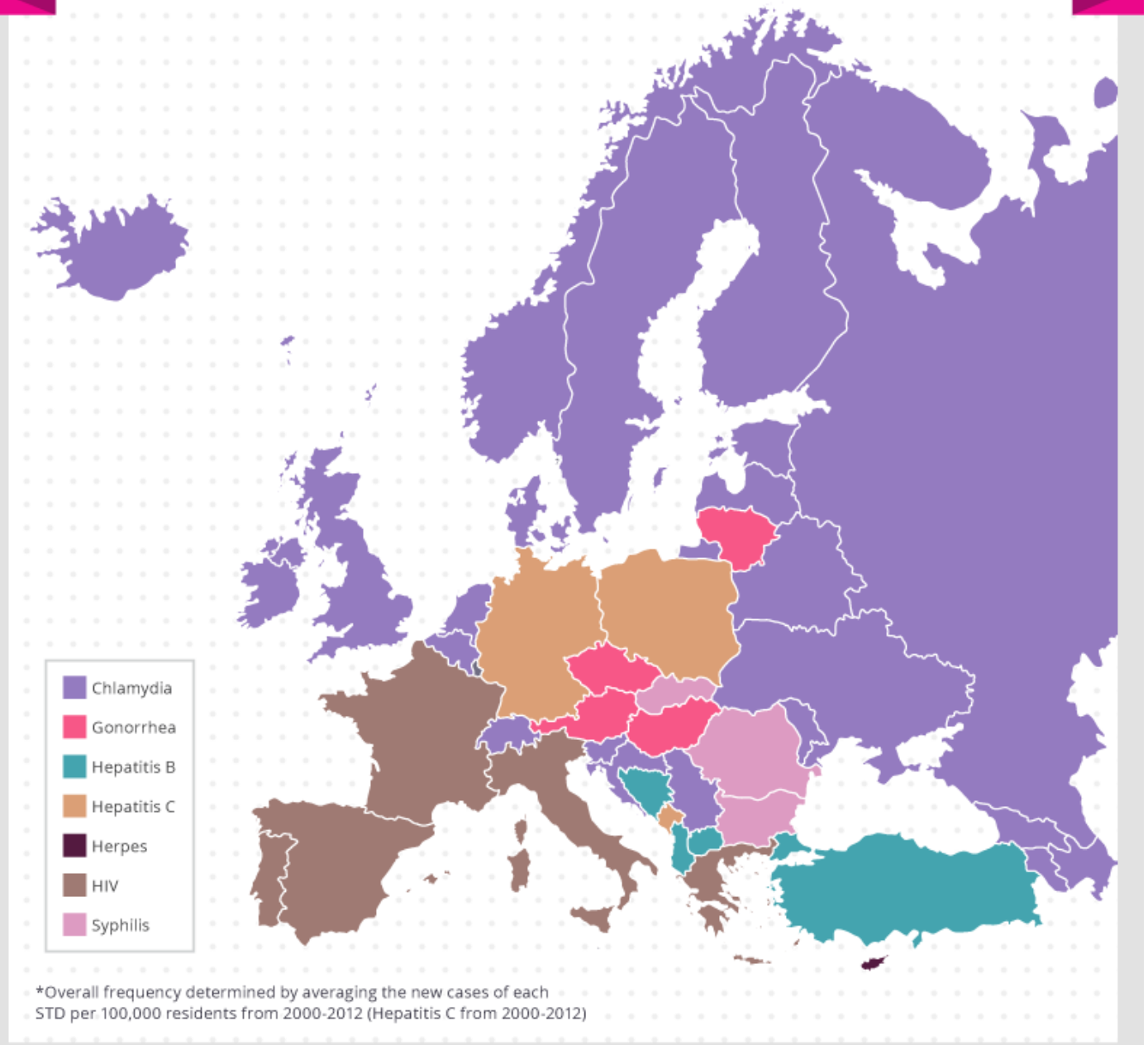
Mother-to-child transmission of STIs can result in stillbirth, neonatal death, low-birth-weight and prematurity, sepsis, pneumonia, neonatal conjunctivitis, and congenital deformities.
Over 900 000 pregnant women were infected with syphilis resulting in approximately 350 000 adverse birth outcomes including stillbirth in 2012[2].

Sexually transmitted infections

HPV infection causes 528 000 cases of cervical cancer and 266 000 cervical cancer deaths each year.

STIs such as gonorrhoea and chlamydia are major causes of pelvic inflammatory disease (PID) and infertility in women.

STDs With the Most New Cases



*Overall frequency determined by averaging the new cases of each STD per 100,000 residents from 2000-2012 (Hepatitis C from 2000-2012)

What is the impact of STIs on the health of women

health burden

STI

symptomatic **asymptomatic** **curable** **non curable**

Associated diseases

Course of the disease

Quality of life Study

Cohort studies

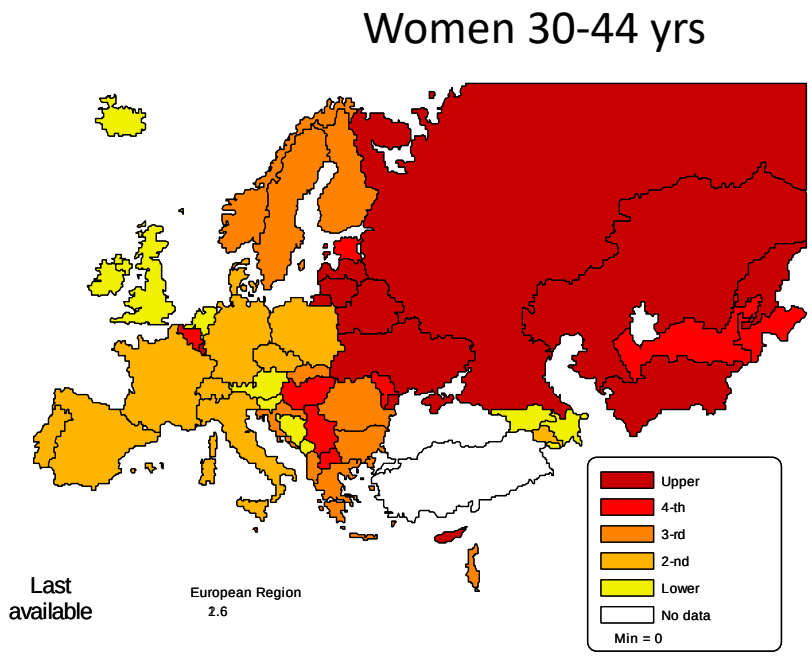
Longterm outcome

Case control studies

(Sexual) Violence against women

Mortality

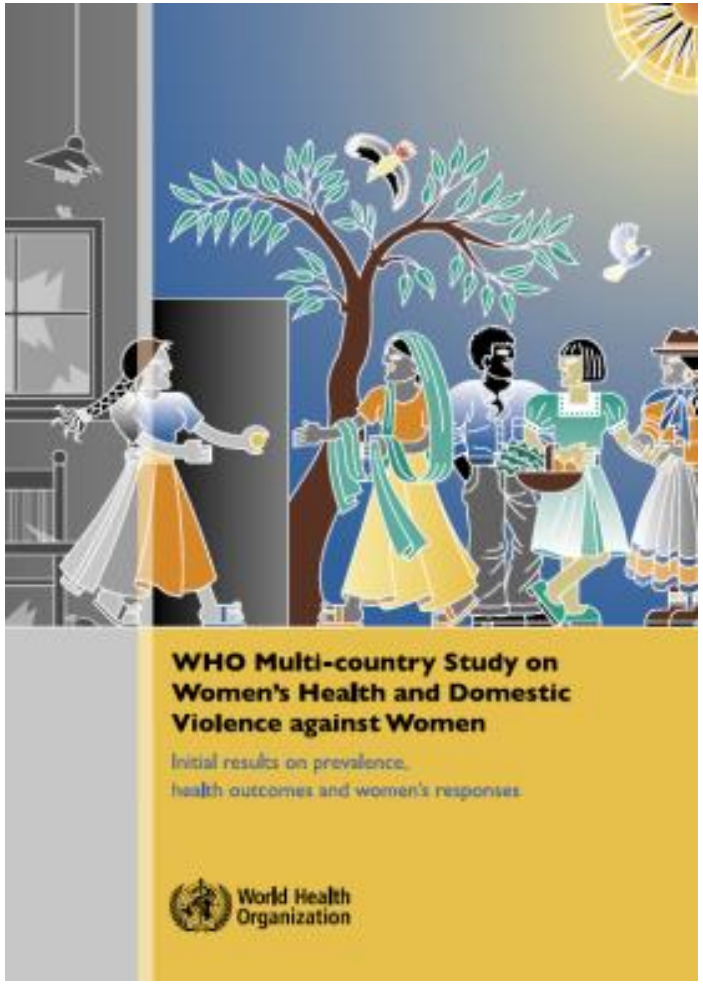
- 8649 homicides in women aged 15-59 in the WHO European Region (GBD 2008)
  - 978 in EU
- Half of the women are killed by their partner or ex partner
- 85% in den low-and middle-income countries (LMIC), 15% in den high-income countries (HIC)
- Rate ratio LMIC/HIC= 6.072



Source: WHO HFA MDB, January 2013

Homicides are the tip of the iceberg and prevalence rates are much higher

- ***WHO multi-country study on women's health and domestic violence against women:*** lifetime prevalence rates of violence by an intimate partner: from 15% (Japan) to 70% (rural Ethiopia and Peru).
- Most sites reported rates of between 29% and 62%.
- Surveys from diverse European countries: 5-45%
- Variation suggests that violence is preventable



Impact of Sexual Violence

- What would you study
- How would you study

Examples

Switzerland

Switzerland					
Maternal and Perinatal Health					[Switzerland]
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Antenatal care coverage (1+ visits) (%)	...		Low birthweight prevalence (%)	6	1999
Antenatal care coverage (4+ visits) (%)	...		Perinatal mortality rate (per 1000)	6	2000
MDG Births attended by skilled health personnel (%)	...		MDG Maternal mortality ratio (per 100 000) [Lower estimate-upper estimate]	7 [4-9]	2000
Availability of basic essential obstetric care (per 500 000)	...		Number of maternal deaths	5	2000
Availability of comprehensive essential obstetric care (per 500 000)	...		Lifetime risk of maternal death (1 in)	7,900	2000
			Proportion of maternal deaths (%)	...	
Family Planning and Fertility					[Switzerland]
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Total fertility rate	1.4	2000-05	MDG Contraceptive prevalence (any method) (%)	82.0 (p)	1994-95
Prevalence of infertility in women (15-49) (%)	...		Contraceptive prevalence (modern methods) (%)	77.5 (p)	1994-95
Sexually Transmitted Infections / Reproductive Tract Infections (STI / RTI) including HIV / AIDS					[Switzerland]
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Prevalence of positive syphilis serology in pregnant women (15-24) (%)	...		MDG HIV prevalence in pregnant women (15-24) (%)	...	
Reported incidence of urethritis in men (15-49) (%)	...		MDG Men (15-24) with comprehensive correct knowledge of HIV/AIDS (%)	...	
Proportion of adults (15-49) living with HIV/AIDS (%)	0.4	2005	MDG Women (15-24) with comprehensive correct	...	

Turkey

Turkey					
Maternal and Perinatal Health				[Turkey]	
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Antenatal care coverage (1+ visits) (%)	67	1998	Low birthweight prevalence (%)	16	1998
Antenatal care coverage (4+ visits) (%)	42	1998	Perinatal mortality rate (per 1000)	36	2000
MDG Births attended by skilled health personnel (%)	83.0	2003	MDG Maternal mortality ratio (per 100 000) [Lower estimate-upper estimate]	70 [18-130]	2000
Availability of basic essential obstetric care (per 500 000)	...		Number of maternal deaths	1000	2000
Availability of comprehensive essential obstetric care (per 500 000)	...		Lifetime risk of maternal death (1 in)	480	2000
			Proportion of maternal deaths (%)	5	2000
Family Planning and Fertility				[Turkey]	
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Total fertility rate	2.5	2000-05	MDG Contraceptive prevalence (any method) (%)	63.9	1998
Prevalence of infertility in women (15-49) (%)	...		Contraceptive prevalence (modern methods) (%)	37.7	1998
Sexually Transmitted Infections / Reproductive Tract Infections (STI / RTI) including HIV / AIDS				[Turkey]	
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Prevalence of positive syphilis serology in pregnant women (15-24) (%)	...		MDG HIV prevalence in pregnant women (15-24) (%)	...	
Reported incidence of urethritis in men (15-49) (%)	...		MDG Men (15-24) with comprehensive correct knowledge of HIV/AIDS (%)	...	
Proportion of adults (15-49) living with HIV/AIDS (%) [Lower estimate-upper estimate]	... [< 0.2]	2005	MDG Women (15-24) with comprehensive correct knowledge of HIV/AIDS (%)	...	

Italy

Italy					
Maternal and Perinatal Health					[Italy]
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Antenatal care coverage (1+ visits) (%)	...		Low birthweight prevalence (%)	6	1998
Antenatal care coverage (4+ visits) (%)	...		Perinatal mortality rate (per 1000)	6	2000
MDG Births attended by skilled health personnel (%)	...		MDG Maternal mortality ratio (per 100 000) [Lower estimate-upper estimate]	5 [4-7]	2000
Availability of basic essential obstetric care (per 500 000)	...		Number of maternal deaths	25	2000
Availability of comprehensive essential obstetric care (per 500 000)	...		Lifetime risk of maternal death (1 in)	13,900	2000
			Proportion of maternal deaths (%)	...	
Family Planning and Fertility					[Italy]
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Total fertility rate	1.3	2000-05	MDG Contraceptive prevalence (any method) (%)	60.2 (p)	1995-96
Prevalence of infertility in women (15-49) (%)	...		Contraceptive prevalence (modern methods) (%)	38.9 (p)	1995-96
Sexually Transmitted Infections / Reproductive Tract Infections (STI / RTI) including HIV / AIDS					[Italy]
Indicator	*Estimate*	*Year*	*Indicator*	*Estimate*	*Year*
Prevalence of positive syphilis serology in pregnant women (15-24) (%)	...		MDG HIV prevalence in pregnant women (15-24) (%)	...	
Reported incidence of urethritis in men (15-49) (%)	...		MDG Men (15-24) with comprehensive correct knowledge of HIV/AIDS (%)	...	
Proportion of adults (15-49) living with HIV/AIDS (%) [Lower estimate-upper estimate]	0.5 [0.3-0.9]	2005	MDG Women (15-24) with comprehensive correct knowledge of HIV/AIDS (%)	...	

Some indicators of reproductive and sexual health

Table 1. Pregnancy rate, abortion rate and birthrate, by category		
Category	Pregnancy rate	Abortion rate and birthrate
Very low	<20.0	<10.0
Low	20.0-39.9	10.0-19.9
Moderate	40.0-69.9	20.0-34.9
High	70.0-99.9	35.0-49.9
Very high	>=100.0	>=50.0

Table 2. Rates of adolescent birth, abortion and pregnancy per year (per 1,000 women aged 15-19) and abortion ratio (per 100 pregnancies), by developed country, for the most recent year available

Country	Birthrate	Abortion rate	Pregnancy rate	Abortion ratio
Germany	12.5	3.6	16.1	23.0
Greece	13.0	u	u	u
Hungary	29.5	29.6	59.1	50.3
Iceland	22.1	21.2	43.3	51.1
Ireland	15.0	4.2*	19.2*	21.9*
Israel	18.0	9.8†	27.9†	35.3†
Italy	6.9	5.1*	12.0*	42.9*
Latvia	**25.5**	**29.0**	**54.5**	**47.6**
Lithuania	**36.7**	**u**	**u**	**u**

*Abortion data are less than 80% complete. †Abortions are for women younger than 20, not just 15-19. ‡Birth data are for women younger than 20, not just 15-19; abortions are those for residents only. § Abortion rates reflect abortions obtained by Northern Ireland residents in England and Wales. **Data are from the 1993 National Fertility Survey. ††Abortion data are from Soskomstat. The totals are higher than those from the Ministry of Health. ‡‡Abortion rate includes abortions obtained by Scotland residents in England and Wales. *Notes:* The abortion ratio is the proportion of pregnancies (excluding miscarriages) that are resolved as abortions. The most recent year is 1995, with the following exceptions: 1996—Austria, Bulgaria, Croatia, the Czech Republic, Estonia, Finland, Hungary, Iceland, Latvia, Lithuania, Moldova, Norway, Poland, Portugal, Slovenia, Sweden, Switzerland and the United States; 1994—Australia and Georgia; 1992—the Netherlands; and 1990—Albania and Bosnia and Herzegovina. All data reflect "age in completed years." The following adjustments were made when age was defined as "age attained during year": abortion data—Finland, France, Germany, Iceland and Norway; birth data—France and Germany. u=unavailable.

Table 2. Rates of adolescent birth, abortion and pregnancy per year (per 1,000 women aged 15-19) and abortion ratio (per 100 pregnancies), by developed country, for the most recent year available

Country	Birthrate	Abortion rate	Pregnancy rate	Abortion ratio
Portugal	20.9	u	u	u
Romania**	**42.0**	**32.0***	**74.0***	**42.9***
Russian Federation††	45.6	56.1*	101.7*	56.1*
Scotland‡‡	27.1	14.5	41.6	37.2
Slovak Republic	32.3	11.1	43.3	25.5
Slovenia	9.3	10.6	19.9	49.2
Spain	7.8	4.5*	12.3*	36.7*
Sweden	7.7	17.2	24.9	69.6
Switzerland	**5.7**	u	u	u
Ukraine	**54.3**	u	u	u
Yugoslavia (Federal Rep.)	**32.1**	u	u	u

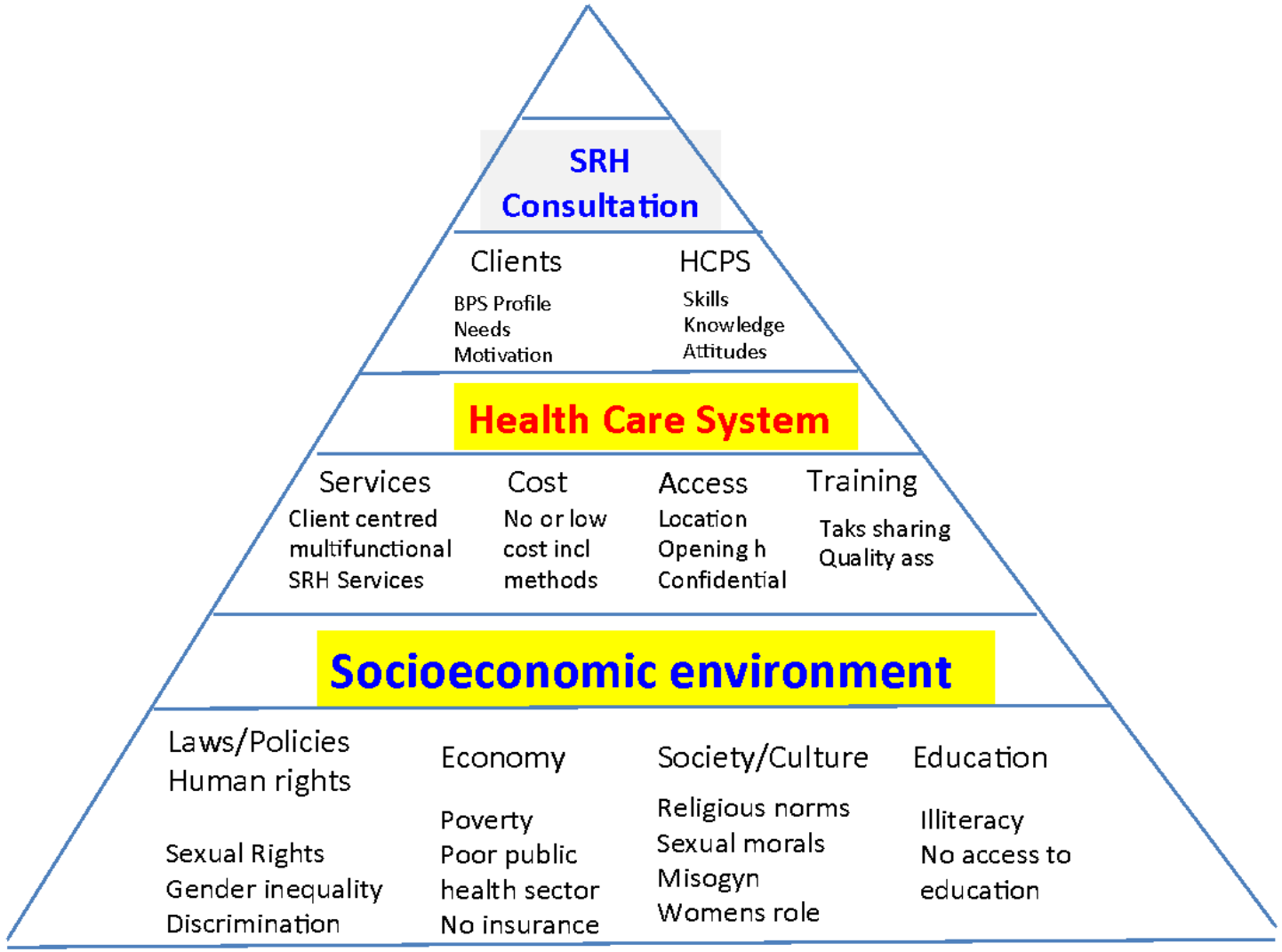
*Abortion data are less than 80% complete. †Abortions are for women younger than 20, not just 15-19. ‡Birth data are for women younger than 20, not just 15-19; abortions are those for residents only. § Abortion rates reflect abortions obtained by Northern Ireland residents in England and Wales. **Data are from the 1993 National Fertility Survey. ††Abortion data are from Soskomstat. The totals are higher than those from the Ministry of Health. ‡‡Abortion rate includes abortions obtained by Scotland residents in England and Wales. *Notes:* The abortion ratio is the proportion of pregnancies (excluding miscarriages) that are resolved as abortions. The most recent year is 1995, with the following exceptions: 1996—Austria, Bulgaria, Croatia, the Czech Republic, Estonia, Finland, Hungary, Iceland, Latvia, Lithuania, Moldova, Norway, Poland, Portugal, Slovenia, Sweden, Switzerland and the United States; 1994—Australia and Georgia; 1992—the Netherlands; and 1990—Albania and Bosnia and Herzegovina. All data reflect "age in completed years." The following adjustments were made when age was defined as "age attained during year": abortion data—Finland, France, Germany, Iceland and Norway; birth data—France and Germany. u=unavailable.

Table 1. Shortlist of indicators for global monitoring of reproductive health

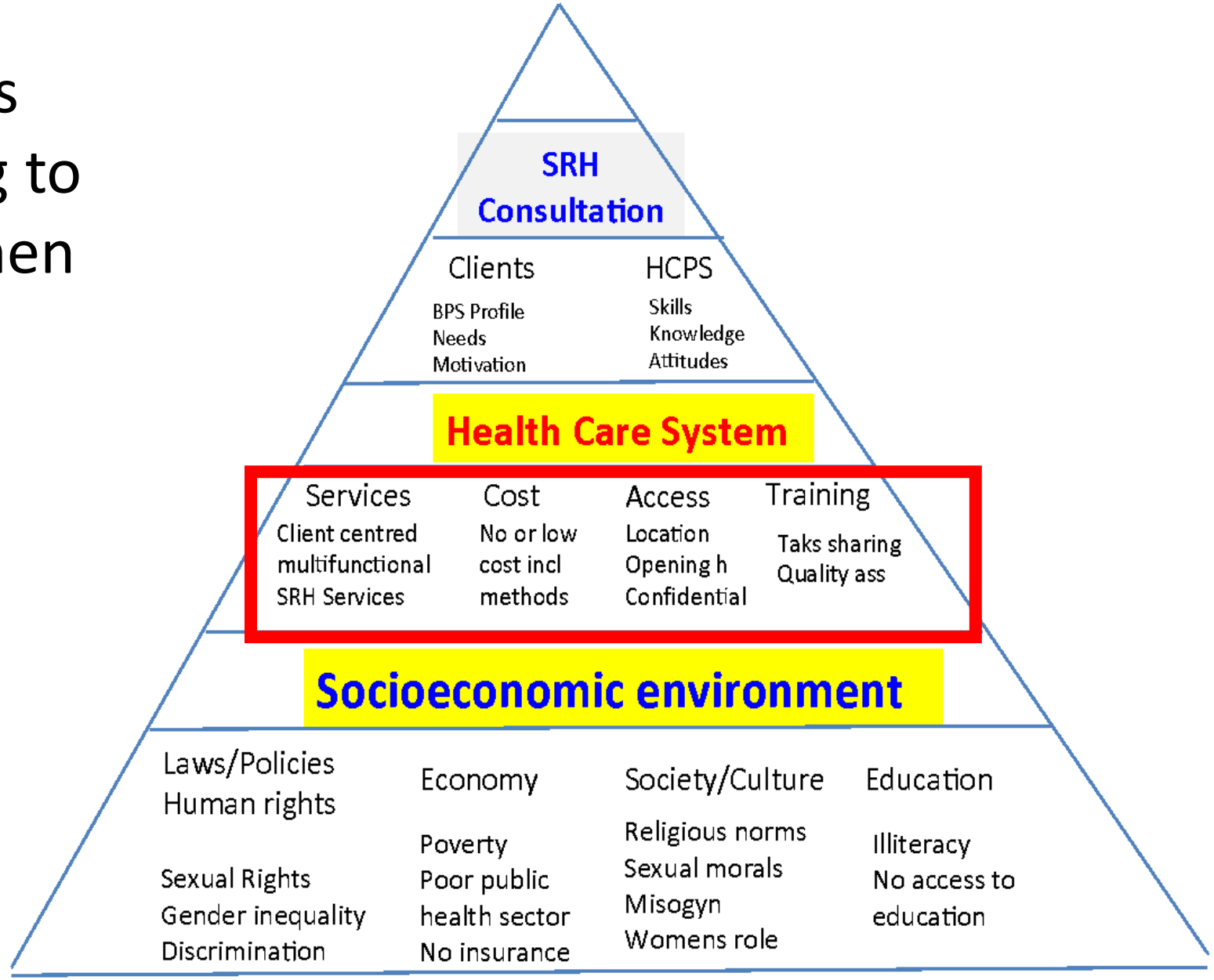
1	Total fertility rate
2	Contraceptive prevalence
3	Maternal mortality ratio
4	Antenatal care coverage
5	Births attended by skilled health personnel
6	Availability of basic essential obstetric care
7	Availability of comprehensive essential obstetric care
8	Perinatal mortality rate
9	Prevalence of low birth weight
10	Prevalence of positive syphilis serology in pregnant women
11	Prevalence of anaemia in women
12	Percentage of obstetric and gynaecological admissions owing to abortion
13	Reported prevalence of women with genital mutilation
14	Prevalence of infertility in women
15	Reported incidence of urethritis in men
16	Prevalence of HIV infection in pregnant women
17	Knowledge of HIV-related preventive practices

1) Demographic data (Total fertility rate),
2) Prevalence Data (Contraception, Anemia, Syphilis serology in pregnant women, Prevalence of low birth weight, Prevalence of women with FGM, Prevalence of Infertility, Prevalence of HIV infection in pregnant women);
3) Rates and Ratios (Maternal Mortality Ratio, Perinatal Mortality Rate);
4) **Data about services and knowledge (Antenatal Care coverage, Births attended by skilled health personnel, availability of comprehensive essential obstetric care, knowledge of HIV related preventive practices)**

The next step: Looking into the macro and microfactors contributing to SRH

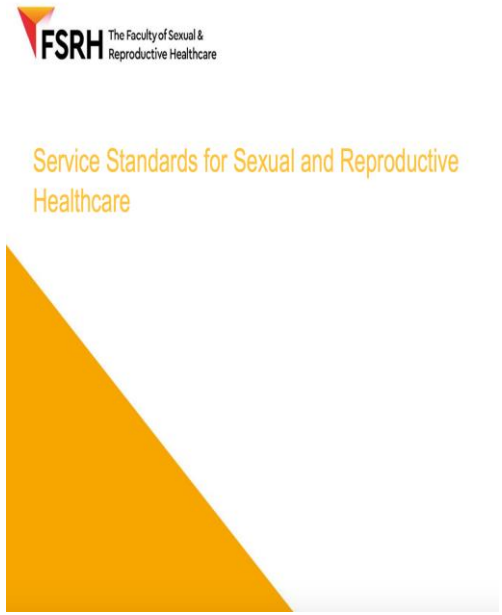


Macro and Microfactors contributing to SRH of women



Standards of Care

- WHO
- FSRH
- EBCOG
- CDC
- UNFPA



Patient Focus

Accessibility

Environment

Process

Staffing &Competence

Training standards

Contraception and Sexual Health

1. Patient Focus

1.1. The contraceptive needs of each individual should be assessed taking into account her/his priorities, values and attitudes, her/his biological and medical condition and psychosocial profiles.

1.2. All women and men have the right to evidence-based information on all available contraceptive method. Myths and misconceptions should be dispelled to ensure informed choice.

1.3. Both women and men should have the opportunity to address sexual health problems (screening for sexually transmitted infections, violence, sexual dysfunction etc.), in view of the close link between contraception and sexual health.

1.4 Multi-agency partnership approach would support the development of integrated sexual and reproductive healthcare services including psychological evaluation and counselling.

Contraception and Sexual Health

2. Accessibility

2.1. All services should be easily accessible, (five day service) and be complemented by the provision of emergency contraception out of hours and at weekends.

2.2. All services should provide information in different languages, according to the population they serve.

2.3 All services should have a wide range of contraceptive methods available.

2.4 All services should have antibiotics, emergency contraception and post-exposure HIV prophylaxis available.

2.5 All services should have on-site urine tests for pregnancy and access to trans-vaginal ultrasound scanning.

2.6 All services should have access to referral for safe termination of pregnancy within national legislation.

Contraception and Sexual Health

3. Environment

3.1. All services should have a designated reception area, constantly staffed during working hours.

3.2 The service should provide a setting allowing for appropriate privacy and confidentiality.

3.3 All services should have a link with providers of termination of pregnancy, outpatient and emergency gynaecology, sexually transmitted infections, urology and social services.

Contraception and Sexual Health

4. Process

4.1 History taking and clinical examination are essential. Gynaecological examination and genital examination of men may be indicated.

4.2 All services should provide counselling on evidence-based efficacy, advantages and disadvantages of the available methods of hormonal, non-hormonal, including long acting and permanent contraception as well as on sexual health.

4.3 Medical eligibility criteria as described for contraception by WHO should be applied.

4.4 Both men and women should be informed of sexually transmitted infections (STI) and the additional protection that male condoms afford. Information on the different condoms type and instruction on their use should be given. This should include advice on what to do if a condom bursts or slips off. The need for emergency contraception and STI protection should be emphasised.

Contraception and Sexual Health

4. Process

4.5 Services should provide counselling regarding vasectomy and female sterilisation and an appropriate referral process should be established.

4.6 All services should provide balanced and detailed educational materials regarding the different methods.

4.7 The insertion and removal of Intra Uterine Contraceptive Devices (IUDs) and implants should be performed by well-trained health care professionals.

4.8 Protocols for the use of emergency contraception should be followed.

4.9 There should be an integrated outreach programme in the community.

4.10 All services should offer, or offer referral for, screening, diagnostic tests and treatment of STIs (including for HIV positive women or men).

Contraception and Sexual Health

5. Staffing and Competence

5.1 All services should have a lead clinician with an interest and expertise in contraception and sexual health.

5.2 Staff members should be trained to perform female and male genital examinations, pap smears, STI screening and ultrasound scanning when indicated.

5.3. Staff members should be able to insert and remove IUDs and implants.

5.4 All staff members should be formally trained in contraceptive and sexual health counselling.

5.5 All staff members should be able to educate, inform and counsel women and men of all sexual orientations and those from migrant or ethnic groups in a non-judgemental and empathic way.

Contraception and Sexual Health

6. Training Standards

6.1 Doctors in training in Obstetrics and Gynaecology should have access to contraceptive services to fulfil the requirements of the EBCOG curriculum.

6.2 Doctors in training should maintain a log book to demonstrate their competence in various aspects of contraception counselling and care and communicating their benefits.

6.3 Doctors providing the service should be trained and achieve competence in counselling, insertion and removal of IUDs and implants.

6.4 Regular training in communication skills, cultural/gender awareness, equality and diversity and in safeguarding children and vulnerable adults should be provided.

Contraception Helicopter View

Governance

Who is the leader ? Who are the leaders ?

National policy

The woman /the man who needs contraception

Quality of care

Who provides care ?
Workforce → **Which professionals take care of her**

SRH Information → **Where does she get information from**

Services → **Availability, Accessibility, Quality of services**

Medicines, Products → **What methods are available**

Finances → **Who pays how much**

Abortion Helicopter View

Governance
Who is the leader ? Who are the leaders ?
National policy

The woman who needs abortion

Who provides care
Workforce → **Which professionals take care of her**

SRH Information → **Where does she get information from**

Services → **Availability,**
Accessibility,
Quality of services

Medicines, Products → **What methods are available**

Finances → **Who pays how much**

STI Care Helicopter View

The woman/man who needs protection or treatment for STI

Governance
Who is the leader ? Who are the leaders ?
National policy

Who provides care Workforce	→	**Which professionals take care of her**
SRH Information	→	**Where does she get information from**
Services	→	**Availability, Accessibility, Quality of services**
Medicines, Products	→	**What methods are available**
Finances	→	**Who pays how much**

Contraception Helicopter View

The woman who suffers from sexual violence

Governance
Who is the leader ? Who are the leaders ?
National policy

Who provides care Workforce	→	**Which professionals take care of her**
SRH Information	→	**Where does she get information from**
Services	→	**Availability, Accessibility, Quality of services**
Medicines, Products	→	**What methods are available**
Finances	→	**Who pays how much**

Contraception Helicopter View

The woman who suffers from sexual dysfunction

Governance
Who is the leader ? Who are the leaders ?
National policy

Who provides care
Workforce → **Which professionals take care of her**

SRH Information → **Where does she get information from**

Services → **Availability, Accessibility, Quality of services**

Medicines, Products → **What methods are available**

Finances → **Who pays how much**

Contraception Helicopter View

Governance
Who is the leader ? Who are the leaders ?
National policy

Young women and young men need sexuality education

Who provides sexuality education Workforce → **Which professionals take care of her**

SRH Information → **Where does she get information from**

Services → **Availability, Accessibility, Quality of services**

Medicines, Products → **What methods are available**

Finances → **Who pays how much**

What type studies

- Quantitative Studies
- How many women have access
- How many services per population
- ……

Case studies
Personal histories

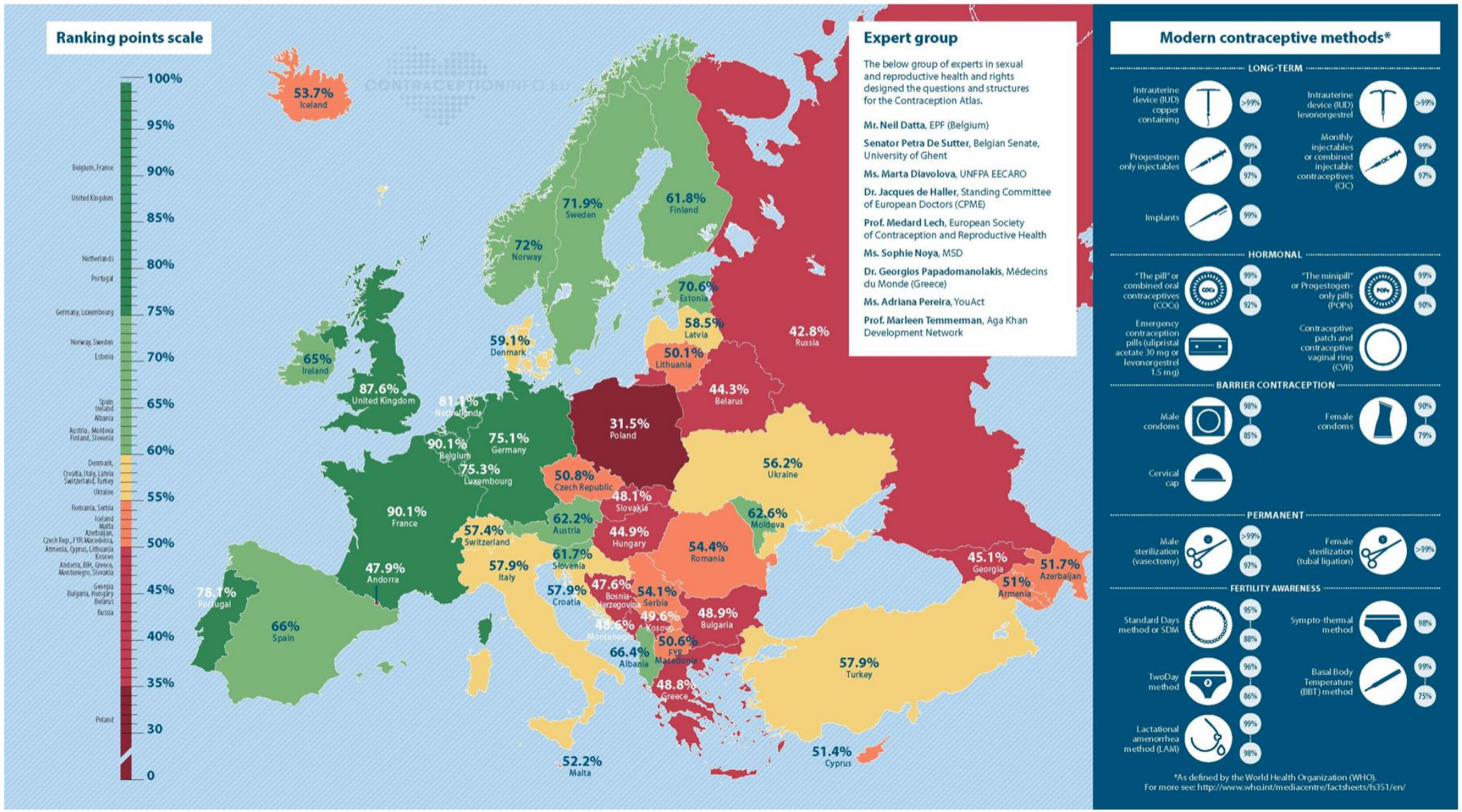
CONTRACEPTIONATLAS

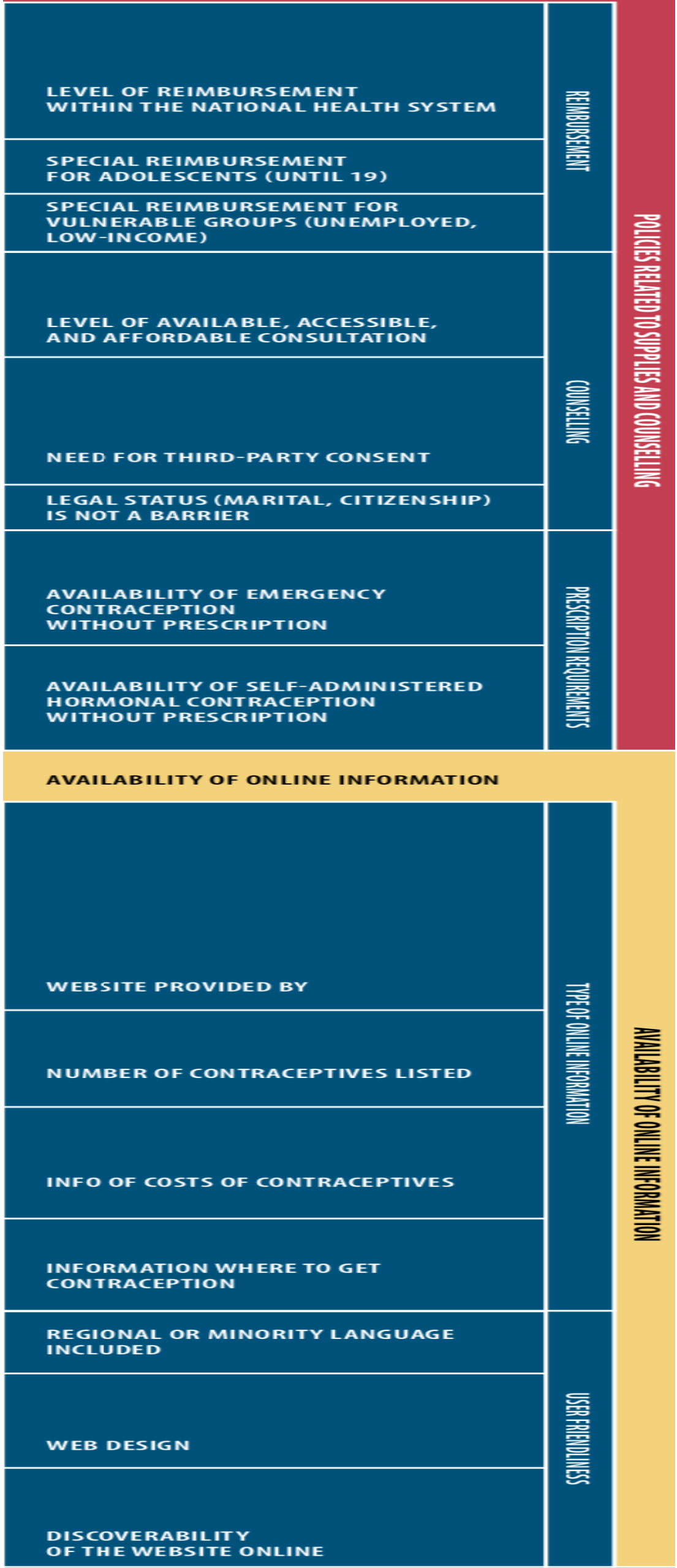
Tracking government policies on access to contraceptive supplies, family planning counselling and the provision of online information on contraception.

February 2019

CONTRACEPTIONINFO.EU

For more information, please visit contraceptioninfo.eu




POLICIES RELATED TO SUPPLIES AND COUNSELLING
REIMBURSEMENT
LEVEL OF REIMBURSEMENT WITHIN THE NATIONAL HEALTH SYSTEM
SPECIAL REIMBURSEMENT FOR ADOLESCENTS (UNTIL 19)
SPECIAL REIMBURSEMENT FOR VULNERABLE GROUPS (UNEMPLOYED, LOW-INCOME)
COUNSELLING
LEVEL OF AVAILABLE, ACCESSIBLE, AND AFFORDABLE CONSULTATION
NEED FOR THIRD-PARTY CONSENT
LEGAL STATUS (MARITAL, CITIZENSHIP) IS NOT A BARRIER
PRESCRIPTION REQUIREMENTS
AVAILABILITY OF EMERGENCY CONTRACEPTION WITHOUT PRESCRIPTION
AVAILABILITY OF SELF-ADMINISTERED HORMONAL CONTRACEPTION WITHOUT PRESCRIPTION
AVAILABILITY OF ONLINE INFORMATION
AVAILABILITY OF ONLINE INFORMATION
TYPE OF ONLINE INFORMATION
WEBSITE PROVIDED BY
NUMBER OF CONTRACEPTIVES LISTED
INFO OF COSTS OF CONTRACEPTIVES
INFORMATION WHERE TO GET CONTRACEPTION
USER FRIENDLINESS
REGIONAL OR MINORITY LANGUAGE INCLUDED
WEB DESIGN
DISCOVERABILITY OF THE WEBSITE ONLINE

COUNTRIES IN ALPHABETICAL ORDER	RANKING INDEX OF COUNTRIES TRACKING NATIONAL POLICIES, INFORMATION PROVISION, SUPPLIES AND COUNSELLING ON CONTRACEPTIVE METHODS	POLICIES RELATED TO SUPPLIES AND COUNSELLING	REIMBURSEMENT			COUNSELLING			PRESCRIPTION REQUIREMENTS		AVAILABILITY OF ONLINE INFORMATION	TYPE OF ONLINE INFORMATION				USER FRIENDLINESS			COUNTRIES IN ALPHABETICAL ORDER
			LEVEL OF REIMBURSEMENT WITHIN THE NATIONAL HEALTH SYSTEM	SPECIAL REIMBURSEMENT FOR ADOLESCENTS (UNTIL 19)	SPECIAL REIMBURSEMENT FOR VULNERABLE GROUPS (UNEMPLOYED, LOW-INCOME)	LEVEL OF AVAILABLE, ACCESSIBLE, AND AFFORDABLE CONSULTATION	NEED FOR THIRD-PARTY CONSENT	LEGAL STATUS (MARITAL, CITIZENSHIP) IS NOT A BARRIER	AVAILABILITY OF EMERGENCY CONTRACEPTION WITHOUT PRESCRIPTION	AVAILABILITY OF SELF-ADMINISTERED HORMONAL CONTRACEPTION WITHOUT PRESCRIPTION		WEBSITE PROVIDED BY	NUMBER OF CONTRACEPTIVES LISTED	INFO OF COSTS OF CONTRACEPTIVES	INFORMATION WHERE TO GET CONTRACEPTION	REGIONAL OR MINORITY LANGUAGE INCLUDED	WEB DESIGN	DISCOVERABILITY OF THE WEBSITE ONLINE	
Albania	66.4%	77.7%	Superior to other	Yes	Yes	Superior to other	No	Yes	Yes (illegal)	No	45.8%	Non-gov't supported websites	Excellent	Not available	Not available	No	Excellent	Excellent	Albania
Andorra	47.9%	51%	Similar to other	No	Yes	Similar to other	Yes (direct consent)	No	Yes (legal)	No	42.1%	Gov't supported integrated website	Good	Not available	Excellent	No	Good	Insufficient	Andorra
Armenia	51%	58.7%	No reimbursement	No	Yes	Similar to other	Yes (direct consent)	Yes	Yes (legal)	Yes (legal)	36.9%	Gov't supported integrated website	Weak	Insufficient	Good	Yes	Good	Not available	Armenia
Austria	62.2%	43,1%	No reimbursement	No	No	No reimbursement	No	Yes	Yes (legal)	No	97.1%	Gov't supported integrated website	Excellent	Excellent	Excellent	Yes	Excellent	Excellent	Austria
Azerbaijan	51.7%	60.3%	No reimbursement	No	No	Similar to other	No	Yes	Yes (legal)	Yes (legal)	36%	Other online resources	Good	Not available	Not available	No	Good	Excellent	Azerbaijan
Belarus	44.3%	41.7%	No reimbursement	No	No	Superior to other	No	No	Yes (legal)	No	49%	Non-gov't supported websites	Weak	Good	Insufficient	No	Good	Good	Belarus
Belgium*	90.1%	84.8%	Similar to other	Yes	Yes	Superior to other	No	Yes	Yes (legal)	No	100%	Gov't supported standalone website	Excellent	Excellent	Excellent	Yes	Excellent	Excellent	Belgium*
Bosnia-Herzegovina	47.6%	48%	No reimbursement	No	No	No reimbursement	No	Yes	Yes (illegal)	No	46.9%	Gov't supported standalone website	Good	Not available	Not available	Yes	Excellent	Excellent	Bosnia-Herzegovina
Bulgaria	45.2%	41.8%	No reimbursement	No	No	No reimbursement	Yes (indirect consent)	Yes	Yes (legal)	Yes (illegal)	51.5%	Gov't supported integrated website	Good	Insufficient	Insufficient	No	Insufficient	Excellent	Bulgaria
Croatia	57.9%	73.6%	Similar to other	No	No	Similar to other	No	Yes	Yes (legal)	Yes (legal)	29%	Non-gov't supported websites	Insufficient	Insufficient	Insufficient	No	Insufficient	Insufficient	Croatia
Cyprus	51.4%	49.8%	No reimbursement	No	No	Similar to other	No	Yes	Yes (legal)	No	54.5%	Non-gov't supported websites	Good	Insufficient	Good	Yes	Insufficient	Excellent	Cyprus
Czech Republic	50.8%	49.8%	No reimbursement	No	No	Similar to other	No	Yes	Yes (legal)	No	52.7%	Non-gov't supported websites	Excellent	Not available	Good	Yes	Good	Excellent	Czech Republic
Denmark	59.1%	61.2%	No reimbursement	No	Yes	Superior to other	No	Yes	Yes (legal)	No	55.1%	Gov't supported integrated website	Excellent	Insufficient	Insufficient	Yes	Good	Good	Denmark
Estonia	70.6%	67.9%	Less than other	Yes	No	Similar to other	No	Yes	Yes (legal)	No	75.5%	Gov't supported standalone website	Excellent	Insufficient	Excellent	Yes	Excellent	Excellent	Estonia
Finland*	61.8%	62.4%	No reimbursement	Yes	No	Superior to other	No	Yes	Yes (legal)	No	60.7%	Non-gov't supported websites	Excellent	Insufficient	Insufficient	Yes	Excellent	Excellent	Finland*
France	90.1%	84.8%	Similar to other	Yes	Yes	Superior to other	No	Yes	Yes (legal)	No	100%	Gov't supported standalone website	Excellent	Excellent	Excellent	Yes	Excellent	Excellent	France
FYR Macedonia	50.6%	53.7%	No reimbursement	No	No	No reimbursement	No	Yes	Yes (legal)	Yes (legal)	44.9%	Non-gov't supported websites	Good	Insufficient	Insufficient	No	Good	Good	FYR Macedonia
Georgia	45.8%	47.1%	No reimbursement	No	No	Less than other	No	Yes	Yes (legal)	No	43.5%	Other online resources	Excellent	Not available	Not available	Yes	Good	Excellent	Georgia
Germany*	75.1%	62.4%	No reimbursement	Yes	No	Superior to other	No	Yes	Yes (legal)	No	98.5%	Gov't supported standalone website	Excellent	Excellent	Excellent	No	Excellent	Excellent	Germany*
Greece	48.8%	48.5%	No reimbursement	No	No	Similar to other	Yes (indirect consent)	Yes	Yes (legal)	Yes (illegal)	49.5%	Non-gov't supported websites	Excellent	Not available	Insufficient	No	Excellent	Excellent	Greece
Hungary	44.9%	38%	No reimbursement	No	No	Similar to other	No	Yes	Yes (illegal)	No	57.4%	Non-gov't supported websites	Good	Insufficient	Good	No	Excellent	Excellent	Hungary
Iceland	53.7%	49.8%	No reimbursement	No	No	Similar to other	No	Yes	Yes (legal)	No	60.7%	Non-gov't supported websites	Excellent	Insufficient	Insufficient	Yes	Excellent	Excellent	Iceland
Ireland	65%	60.1%	Less than other	No	Yes	No reimbursement	No	Yes	Yes (legal)	No	74%	Gov't supported standalone website	Excellent	Insufficient	Excellent	No	Excellent	Excellent	Ireland
Italy*	57.9%	52.1%	No reimbursement	No	No	Superior to other	No	Yes	Yes (legal)	No	68.4%	Non-gov't supported websites	Excellent	Insufficient	Excellent	No	Excellent	Excellent	Italy*
Kosovo**	49.6%	53.7%	No reimbursement	No	No	No reimbursement	No	Yes	Yes (legal)	Yes (legal)	42.2%	Gov't supported integrated website	Good	Insufficient	Insufficient	Yes	Insufficient	Insufficient	Kosovo**
Latvia	58.5%	57.7%	Less than other	No	No	Similar to other	No	Yes	Yes (legal)	No	60.1%	Non-gov't supported websites	Excellent	Not available	Excellent	Yes	Excellent	Excellent	Latvia
Lithuania	50.1%	43.6%	No reimbursement	No	No	Similar to other	Yes (indirect consent)	Yes	Yes (legal)	No	62.1%	Non-gov't supported websites	Weak	Good	Excellent	Yes	Excellent	Good	Lithuania
Luxembourg	75.3%	79.3%	Less than other	Yes	Yes	Superior to other	No	Yes	Yes (legal)	No	68.1%	Gov't supported standalone website	Excellent	Insufficient	Good	Yes	Good	Excellent	Luxembourg
Malta	52.2%	49.8%	No reimbursement	No	No	Similar to other	No	Yes	Yes (legal)	No	56.6%	Gov't supported standalone website	Excellent	Not available	Insufficient	Yes	Excellent	Excellent	Malta
Moldova	62.6%	68.9%	No reimbursement	Yes	Yes	Similar to other	Yes (direct consent)	Yes	Yes (legal)	Yes (legal)	50.9%	Non-gov't supported websites	Excellent	Insufficient	Insufficient	No	Good	Good	Moldova
Montenegro	48.6%	53.7%	No reimbursement	No	No	No reimbursement	No	Yes	Yes (legal)	Yes (legal)	39.5%	Non-gov't supported websites	Good	Insufficient	Insufficient	Yes	Insufficient	Insufficient	Montenegro
Netherlands	81.1%	75.7%	Similar to other	Yes	No	Superior to other	No	Yes	Yes (legal)	No	91.1%	Gov't supported integrated website	Good	Excellent	Excellent	Yes	Excellent	Excellent	Netherlands
Norway	72%	62.4%	No reimbursement	Yes	No	Superior to other	No	Yes	Yes (legal)	No	89.7%	Gov't supported integrated website	Excellent	Excellent	Good	No	Good	Excellent	Norway
Poland	31.5%	25%	Less than other	No	No	Similar to other	Yes (direct consent)	Yes	No	No	43.4%	Non-gov't supported websites	Excellent	Not available	Not available	No	Good	Excellent	Poland
Portugal	78.7%	89.5%	Superior to other	Yes	Yes	Superior to other	No	Yes	Yes (legal)	No	59%	Non-gov't supported websites	Excellent	Insufficient	Good	Yes	Excellent	Good	Portugal
Romania	54.4%	52.1%	No reimbursement	No	No	Superior to other	No	Yes	Yes (legal)	No	58.6%	Non-gov't supported websites	Excellent	Not available	Excellent	No	Excellent	Excellent	Romania
Russia	42.8%	42.9%	No reimbursement	No	No	Similar to other	No	Yes	Yes (illegal)	Yes (illegal)	42.6%	Other online resources	Excellent	Insufficient	Insufficient	No	Insufficient	Insufficient	Russia
Serbia	54.1%	62.5%	Less than other	No	No	Similar to other	No	Yes	Yes (legal)	Yes (illegal)	38.7%	Non-gov't supported websites	Excellent	Not available	Insufficient	No	Excellent	Insufficient	Serbia
Slovakia	48.1%	39.1%	No reimbursement	No	No	Similar to other	Yes (direct consent)	Yes	Yes (legal)	No	64.4%	Non-gov't supported websites	Good	Good	Insufficient	No	Excellent	Excellent	Slovakia
Slovenia	61.7%	63.1%	Similar to other	No	No	Similar to other	No	Yes	Yes (legal)	No	59.2%	Gov't supported standalone website	Excellent	Not available	Good	No	Excellent	Excellent	Slovenia
Spain*	66%	63.1%	Similar to other	No	No	Similar to other	No	Yes	Yes (legal)	No	71.3%	Non-gov't supported websites	Excellent	Good	Excellent	No	Good	Good	Spain*
Sweden	71.9%	75.7%	Similar to other	Yes	No	Superior to other	No	Yes	Yes (legal)	No	64.9%	Non-gov't supported websites	Excellent	Insufficient	Good	Yes	Excellent	Excellent	Sweden
Switzerland*	57.4%	52.1%	No reimbursement	No	No	Superior to other	No	Yes	Yes (legal)	No	67.2%	Gov't supported standalone website	Excellent	Insufficient	Excellent	Yes	Good	Good	Switzerland*
Turkey	57.9%	52.5%	Similar to other	No	No	Similar to other	Yes (direct consent)	No	Yes (legal)	Yes (legal)	67.7%	Non-gov't supported websites	Good	Good	Excellent	No	Excellent	Good	Turkey
Ukraine	56.2%	53.1%	No reimbursement	No	Yes	Similar to other	Yes (direct consent)	Yes	Yes (legal)	Yes (illegal)	61.8%	Non-gov't supported websites	Good	Good	Good	Yes	Good	Good	Ukraine
United Kingdom	87.6%	82.4%	Similar to other	Yes	Yes	Similar to other	No	Yes	Yes (legal)	No	97.1%	Gov't supported integrated website	Excellent	Excellent	Excellent	Yes	Excellent	Excellent	United Kingdom

*Belgium, Finland, Germany, Italy, Spain and Switzerland have decentralised political systems and therefore circumstances may vary between regions. **Under UNSCR 1244/99

Belgium
France
UK
Germany
Netherlands
Portugal
Luxembourg

Norway
Sweden
Estonia
Spain
Ireland
Albania
Austria
Moldova
Finland
Slovenia

Denmark
Croatia
Italy
Latvia
Switzerland
Turkey
Ukraine

Romania
Serbia
Iceland
Malta
Azerbaijan
Czech Rep.
FYROM
Armenia
Cyprus
Lithuania

Kosovo
Andorra
BIH
Greece
Montenegro
Slovakia
Georgia
Bulgaria
Hungary
Belarus
Russia

Poland

#CONTRACEPTIONATLAS 2019

European governments must do more to **improve access to contraception**

EPF
European Parliamentary Forum for Sexual & Reproductive Rights

Belgium, France and the UK score top for third year running

- General reimbursement schemes (including long-term contraception)
- Special arrangements for young and vulnerable groups
- Government supported websites

But they too must do better to improve access for all

Most improved countries: Albania, Andorra, Finland & Greece

Most declined countries: Poland & Kosovo

11 Web winners

These countries have very good or excellent government supported websites

7 Reimbursers

These countries provide special reimbursement for young people and vulnerable groups

43%

of pregnancies in Europe are unintended

69%

of European women use contraception

LARC offer unique advantages

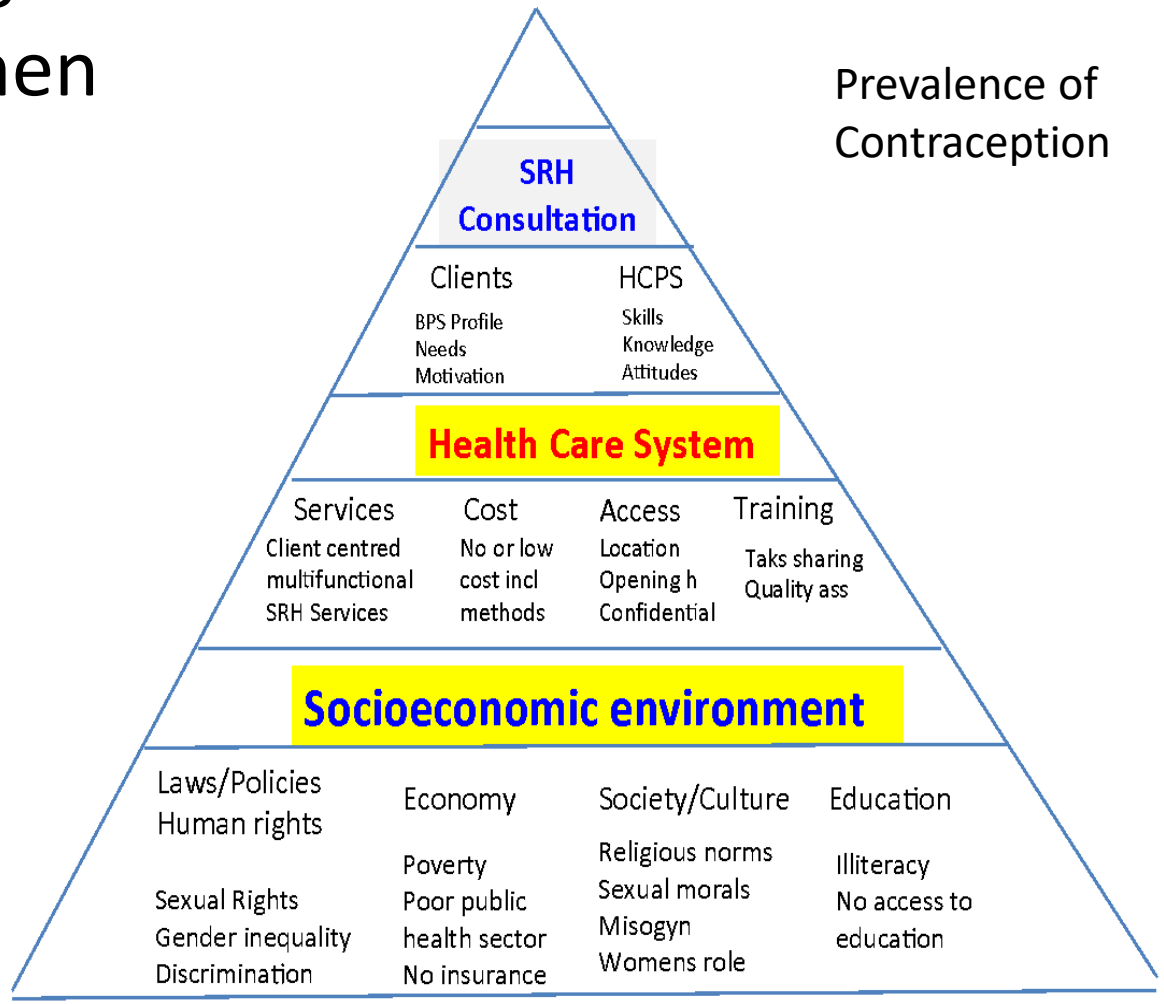
Long-acting reversible contraceptives (LARC) such as subdermal contraceptive implants, injections and IUDs are **less prone to failure** and show **higher satisfaction rates** than other contraceptive methods

CONTRACEPTIONINFO.EU

#ContraceptionAtlas ContraceptionInfo.eu

Macro and Micro factors contributing to SRH of women

Association Studies



Prevalence of Contraception

Laws Policies
No Cost

Service hours

?

IPPF International Planned Parenthood Federation
European Network

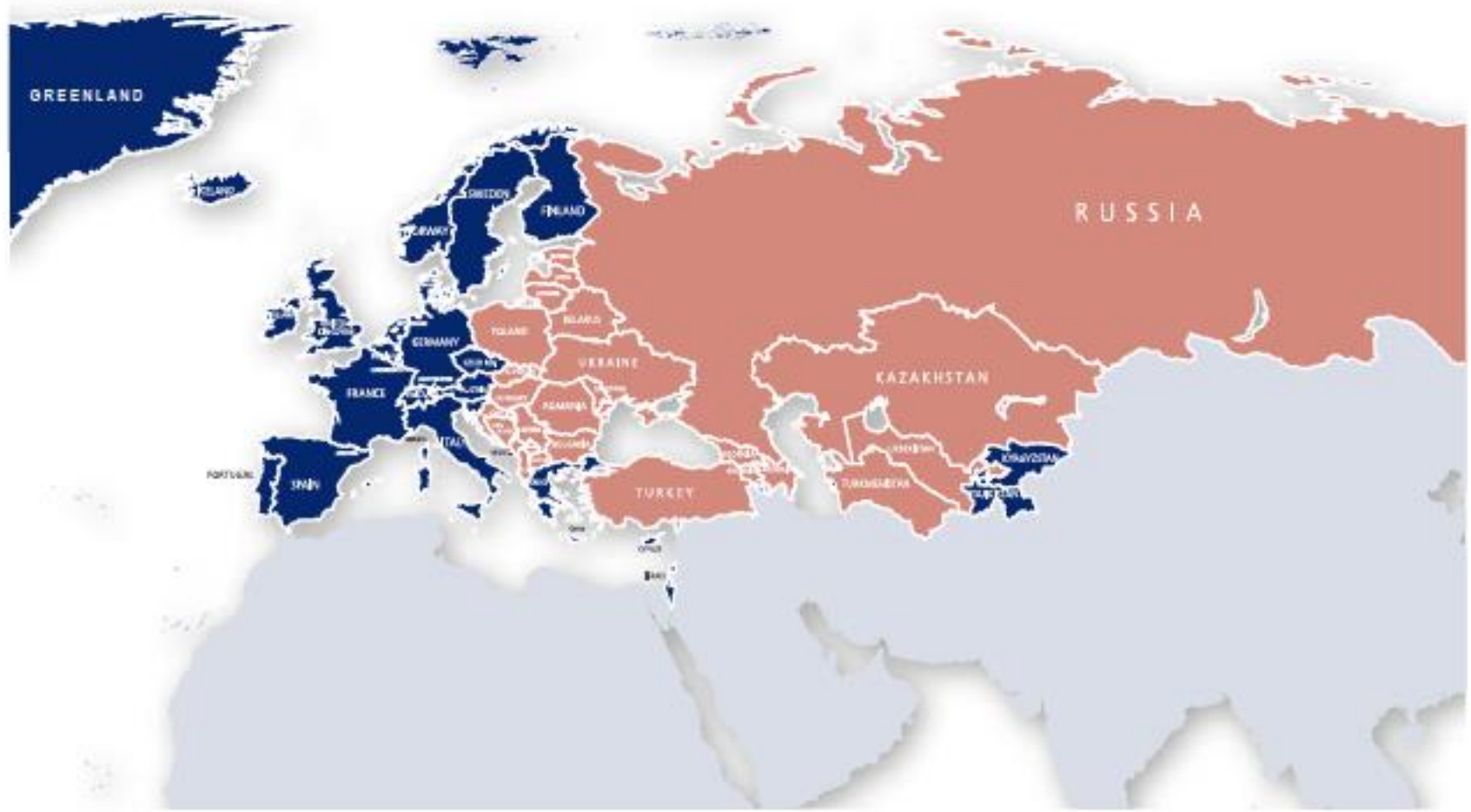
UNFPA

KEY FACTORS INFLUENCING CONTRACEPTIVE USE
in seven Middle-Income Countries of Eastern Europe and Central Asia

Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia -Findings from a Qualitative Study

Conducted in Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, the Republic of Macedonia and Serbia

Recommendations for Improving Access to Modern Contraception in the Region



Middle-Income Countries in Europe and Central Asia

ACCESS TO MODERN CONTRACEPTIVE CHOICE IN EASTERN EUROPE AND CENTRAL ASIA

Factors Influencing Contraceptive Behaviour, Demand And Access

A qualitative study[v] conducted by the IPPF European Network in seven countries across Eastern Europe and Central Asia (Armenia, Bulgaria, Azerbaijan, Bosnia & Herzegovina, Kazakhstan, Republic of Macedonia, and Serbia) identified seven cross-country factors influencing contraceptive behaviour, demand and access:

1. **The (lack of) COMMITMENT BY POLICYMAKERS AND GOVERNMENT actors to contraceptive security.** Even where policies exist, they are generally not accompanied by implementation plans and/or adequate funding.

2. **Widespread misinformation and DISTRUST towards modern (hormonal) methods of contraception**, fuelled by misinformation and myths. This distrust cuts across geographic, economic, and ethnic lines.

3. **YOUNG PEOPLE face particular barriers limiting their access to family planning**. These include lack of information, the cost of services, and particularly the lack of confidentiality and 'youth friendly' services.

4. **SERVICE PROVIDERS**, viewed by (potential) clients as a trustworthy source of information and service for family planning, do not always pass on correct, up-to-date information on FP and are thus a major source of misinformation, often confirming myths.

5. **A limited RANGE OF MODERN CONTRACEPTION METHODS is available on the market** in the countries studied, with choice restricted mainly to condoms, pills and intrauterine devices. Supply chain issues resulting in frequent stock-outs exacerbate this situation.

6. **AFFORDABILITY** is a top-factor for pockets of populations and segments of society. There are also factors adding to the cost, such as unnecessary tests and services.

7. **EXPECTATIONS with regards to sex and sexuality and gender power dynamics** are another key factor influencing contraceptive choice in the countries analysed.

Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia -Findings from a Qualitative Study

Conducted in Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, the Republic of Macedonia and Serbia

Recommendations for Improving Access to Modern Contraception in the Region

- INADEQUATE KNOWLEDGE, ATTITUDES AND AVAILABILITY OF SERVICE PROVIDERS
  - Gynaecologists are the only ones allowed to provide contraceptive services
  - Gynaecologists are misinformed and not well trained in contraception
  - Expensive unnecessary tests and wrong contraindications limit access for women to modern contraceptives
  - There is a considerable lack of interest and motivation to inform women properly and a lack of counseling skills leading to non information and non adherence

Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia -Findings from a Qualitative Study

Conducted in Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, the Republic of Macedonia and Serbia

Recommendations for Improving Access to Modern Contraception in the Region

- A LACK OF GOVERNMENT COMMITMENT TO CONTRACEPTIVE SECURITY
  - No policies and programs regarding family planning
  - Even in countries where policies and programs are present there is no or very little commitment

Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia -Findings from a Qualitative Study

Conducted in Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, the Republic of Macedonia and Serbia

Recommendations for Improving Access to Modern Contraception in the Region

- SOCIAL NORMS AND EXPECTATIONS REGARDING SEX AND SEXUALITY
  - Strict norms and patterns of sexual and reproductive behavior
  - Taboos around sexuality preventing women from getting the necessary information to make reproductive decisions in their interest
  - Gender based violence
  - Discrimination towards those women and men who do not comply with the norms (minorities)

Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia -Findings from a Qualitative Study

Conducted in Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, the Republic of Macedonia and Serbia

Recommendations for Improving Access to Modern Contraception in the Region

- PERCEPTION OF MODERN CONTRACEPTION AS HARMFUL
  - Safety concerns based on myths and misinformation keep women away from the use of modern contraceptives
  - The evidence based approach of modern medicine acts in favor of non science based traditional methods
  - Withdrawal is regarded as the safest natural method without taking into account the lack of efficacy

Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia -Findings from a Qualitative Study

Conducted in Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, the Republic of Macedonia and Serbia

Recommendations for Improving Access to Modern Contraception in the Region

- COST
  - One factor but not a determining factor
  - Lack of accessibility for the poorest, adolescents, housewives depending on the money of the husband
  - Rural women must add the cost of travel

Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia -Findings from a Qualitative Study

Conducted in Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, the Republic of Macedonia and Serbia

Recommendations for Improving Access to Modern Contraception in the Region

- LIMITED RANGE OF CONTRACEPTIVE METHODS RESTRICTING CLIENT CHOICE
  - Limited availability on the market
  - Lack of good supply chains (out of stock situation) especially in small pharmacies in the countries

Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia - Findings from a Qualitative Study

Conducted in Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Kazakhstan, the Republic of Macedonia and Serbia

Recommendations for Improving Access to Modern Contraception in the Region

YOUNG PEOPLE face particular barriers limiting their access to family planning.

lack of information,

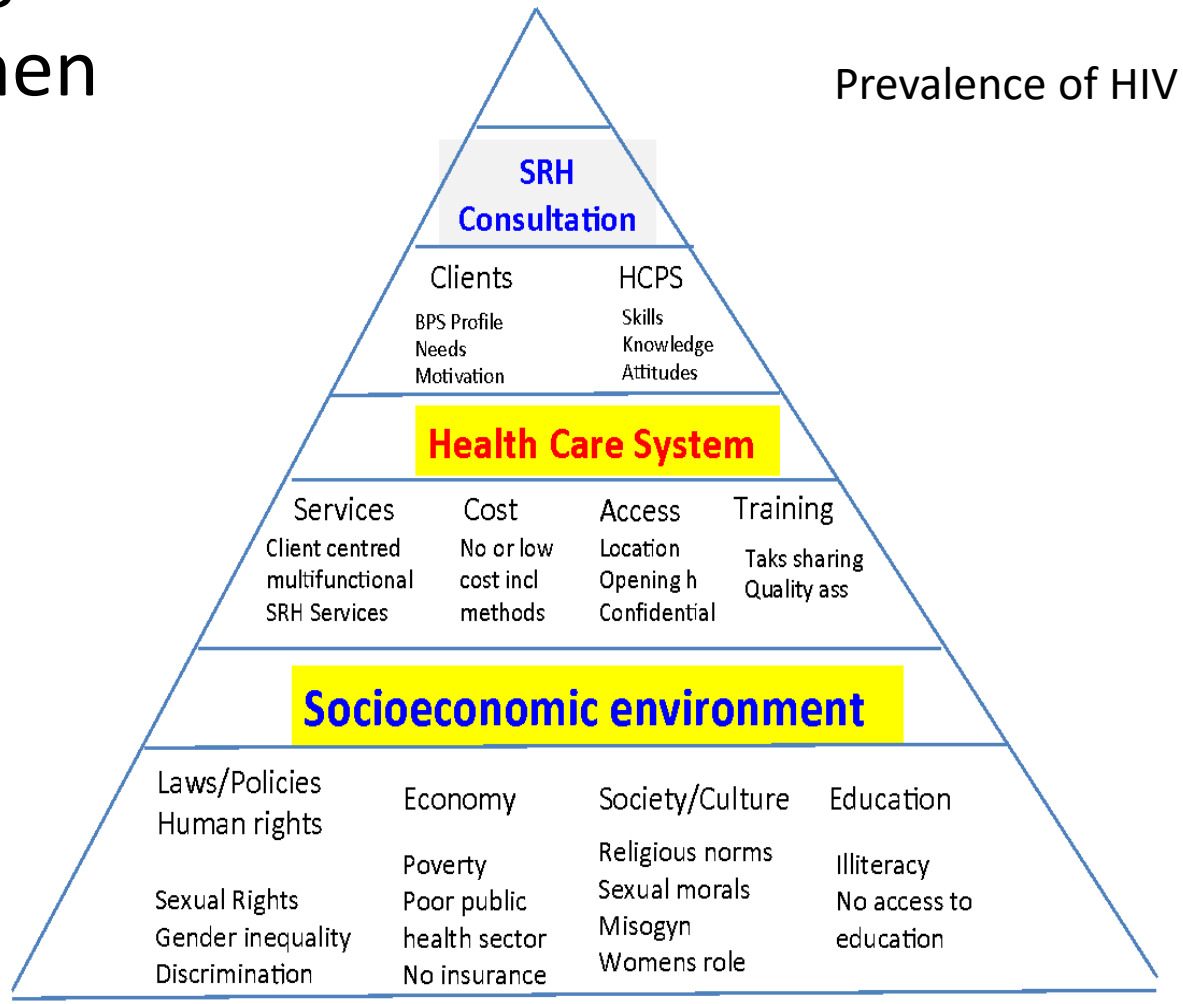
the cost of services,

lack of confidentiality and ‘youth friendly’ services.

Macro and Micro factors contributing to SRH of women

Typical title
Contributing factors

Association Studies



Prevalence of HIV

Characteristics of clients

Service Provision

Attitude and Training of HCP

Sexual Education Media

Next step

Intervention, Implementation studies

What helps maintain, improve, reestablish SRH

Principles of Preventive Medicine

Primary Prevention → **Maintenance and Promotion of Health**

Prevention of the occurrence of diseases

Secondary Prevention → **Detection and Therapy of clinically latent or early stage disease**

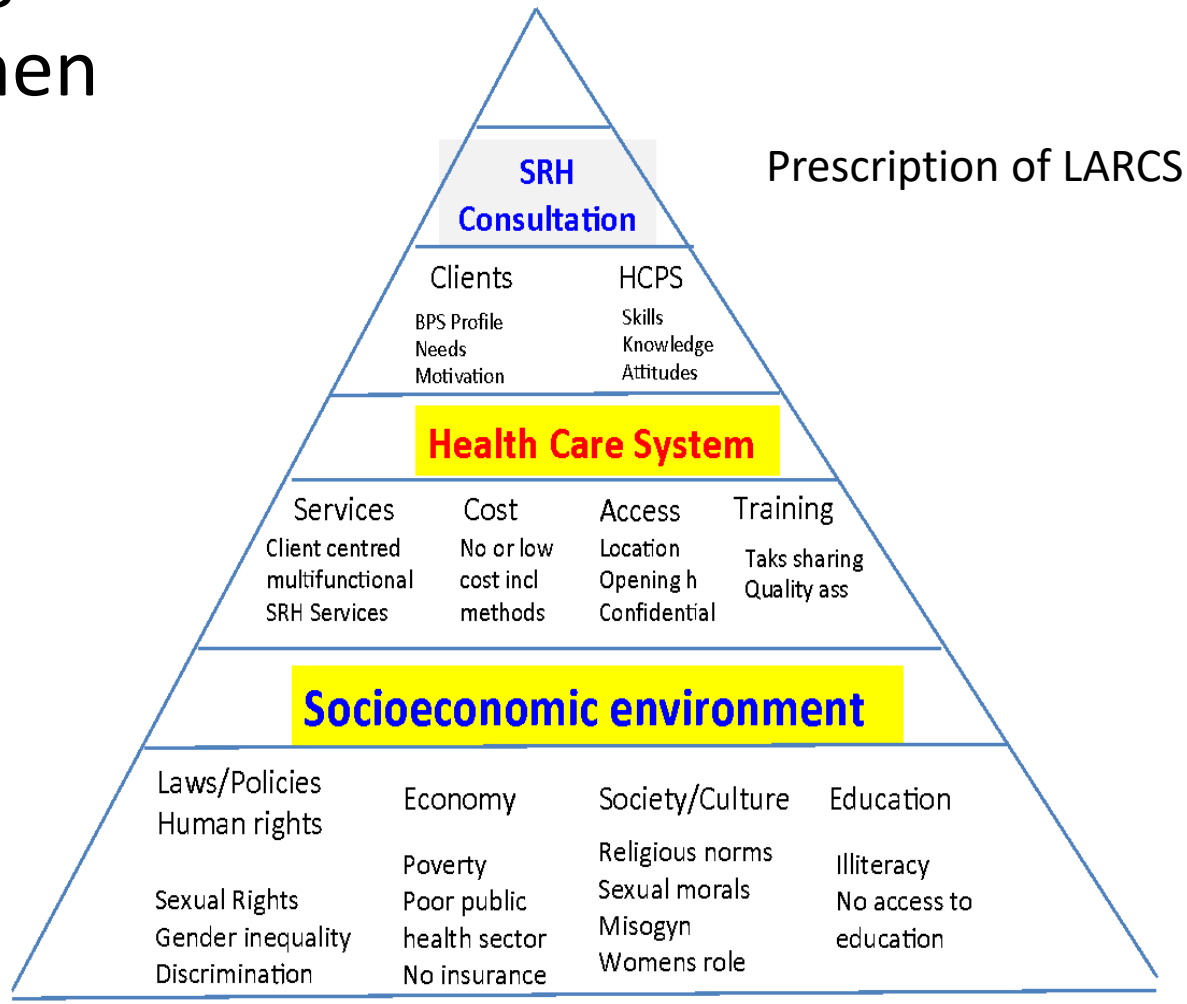
Prevention of disease spreading

Tertiary Prevention → **Efficient therapy of disease; Prevention of further complications, Rehabilitation**

Macro and Micro factors contributing to SRH of women

Typical title
Contributing factors

Intervention and Implementation Studies



Prescription of LARCS

Reduction of unwanted pregnancies

Service Provision

Attitude and Training of HCP

Sexual Education Media

The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception

Gina M. Secura, PhD, MPH; Jenifer E. Allsworth, PhD; Tessa Madden, MD, MPH; Jennifer L. Mullersman, BSN; Jeffrey F. Peipert, MD, PhD

OBJECTIVE: To introduce and promote the use of long-acting reversible methods of contraception (LARC; intrauterine contraceptives and subdermal implant) by removing financial and knowledge barriers.

STUDY DESIGN: The Contraceptive CHOICE Project is a prospective cohort study of 10,000 women 14-45 years who want to avoid pregnancy for at least 1 year and are initiating a new form of reversible contraception. Women screened for this study are read a script regarding long-acting reversible methods of contraception to increase awareness of these options. Participants choose their contraceptive method that is provided at no cost. We report the contraceptive choice and baseline characteristics of the first 2500 women enrolled August 2007 through December 2008.

RESULTS: Sixty-seven percent of women enrolled (95% confidence interval, 65.3–69.0) chose long-acting methods. Fifty-six percent selected intrauterine contraception and 11% selected the subdermal implant.

CONCLUSION: Once financial barriers were removed and long-acting reversible methods of contraception were introduced to all potential participants as a first-line contraceptive option, two-thirds chose long-acting reversible methods of contraception.

Cite this article as: Secura GM, Allsworth JE, Madden T, et al. The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception. Am J Obstet Gynecol 2010;203:115.e1-7.

The Choice project: LARC prevents unintended pregnancies

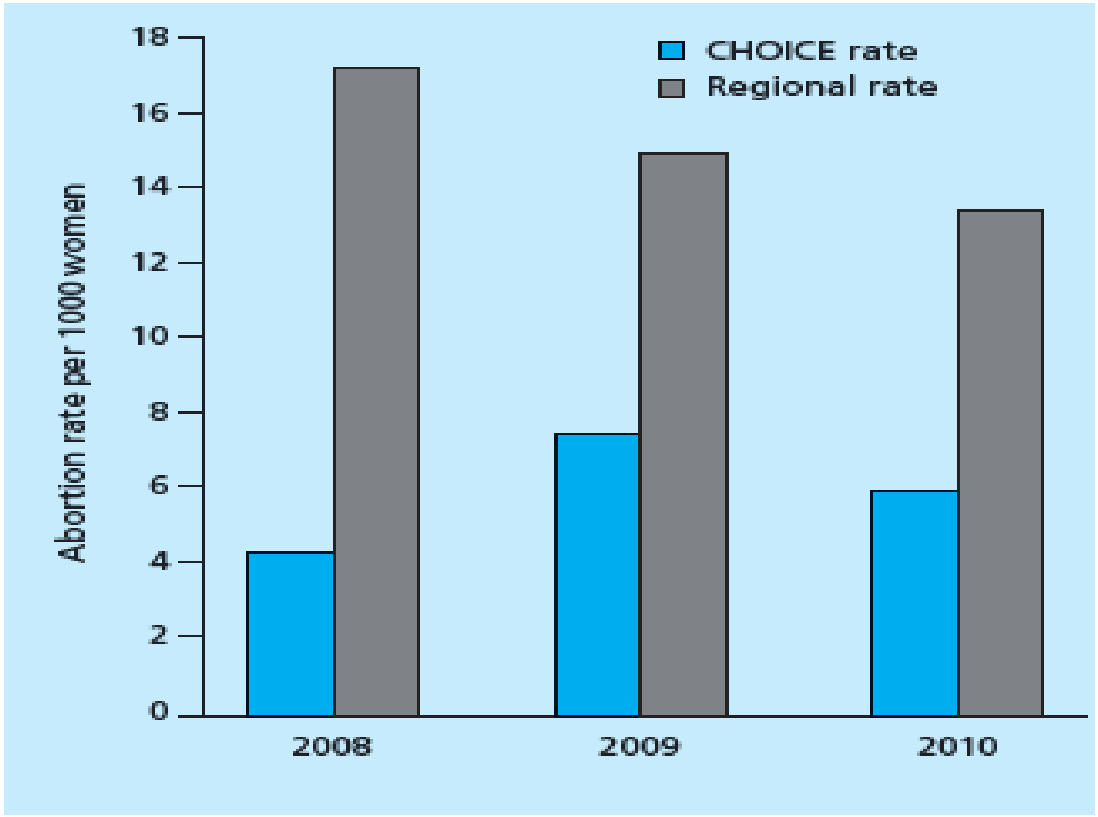
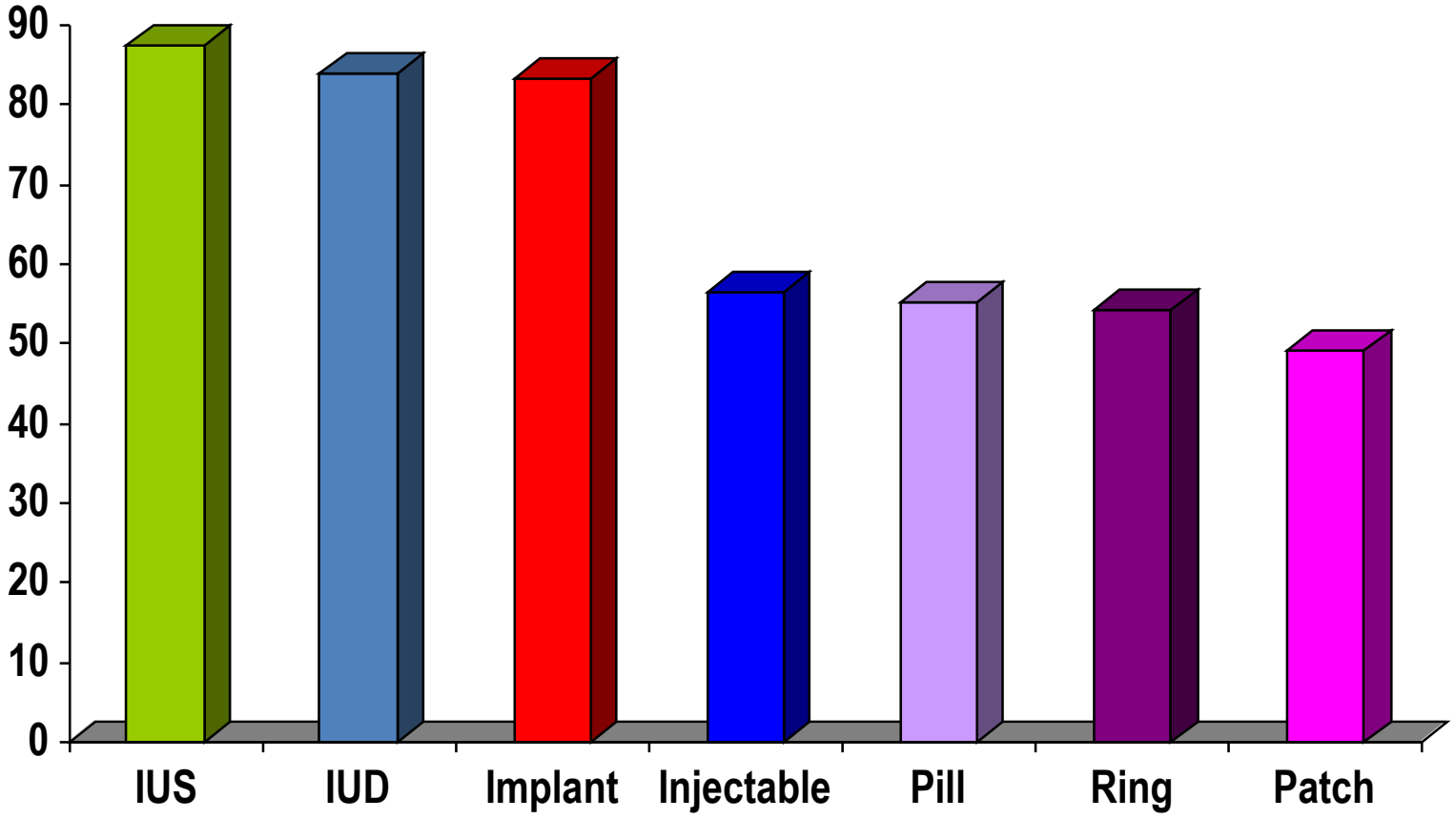


Figure 3: Abortion rates among women aged 15–44 years enrolled in the Contraceptive CHOICE Project compared with regional rates. Data taken from [26].

Contraceptive continuation rates in the CHOICE project at 12 months

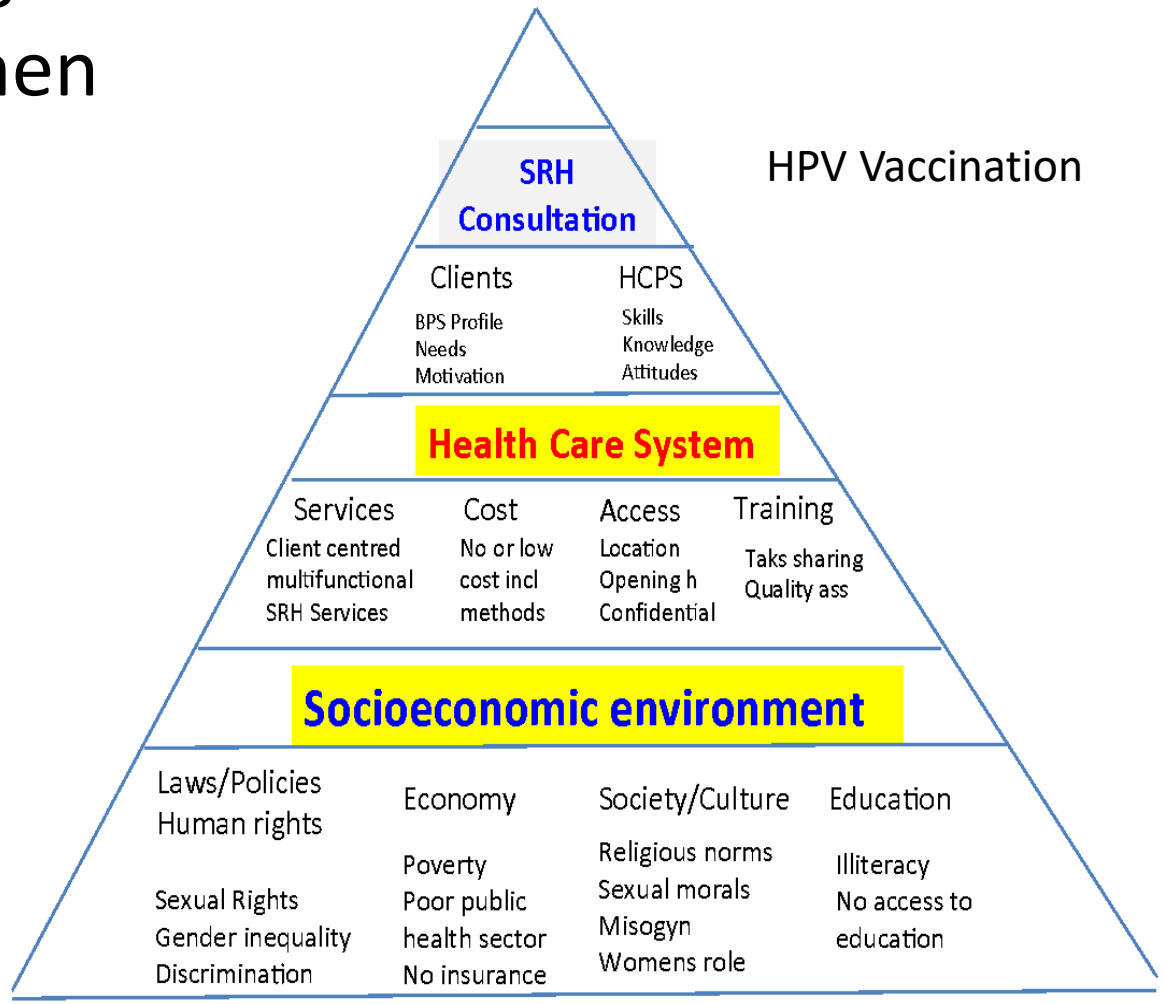


1. Peipert JF et al. *Obstet Gynecol*. 2011;117(5):1105–1113.

Macro and Micro factors contributing to SRH of women

Typical title
Contributing factors

Intervention and Implementation Studies



HPV Vaccination

Reduction of cases of Cerv Ca

Service Provision

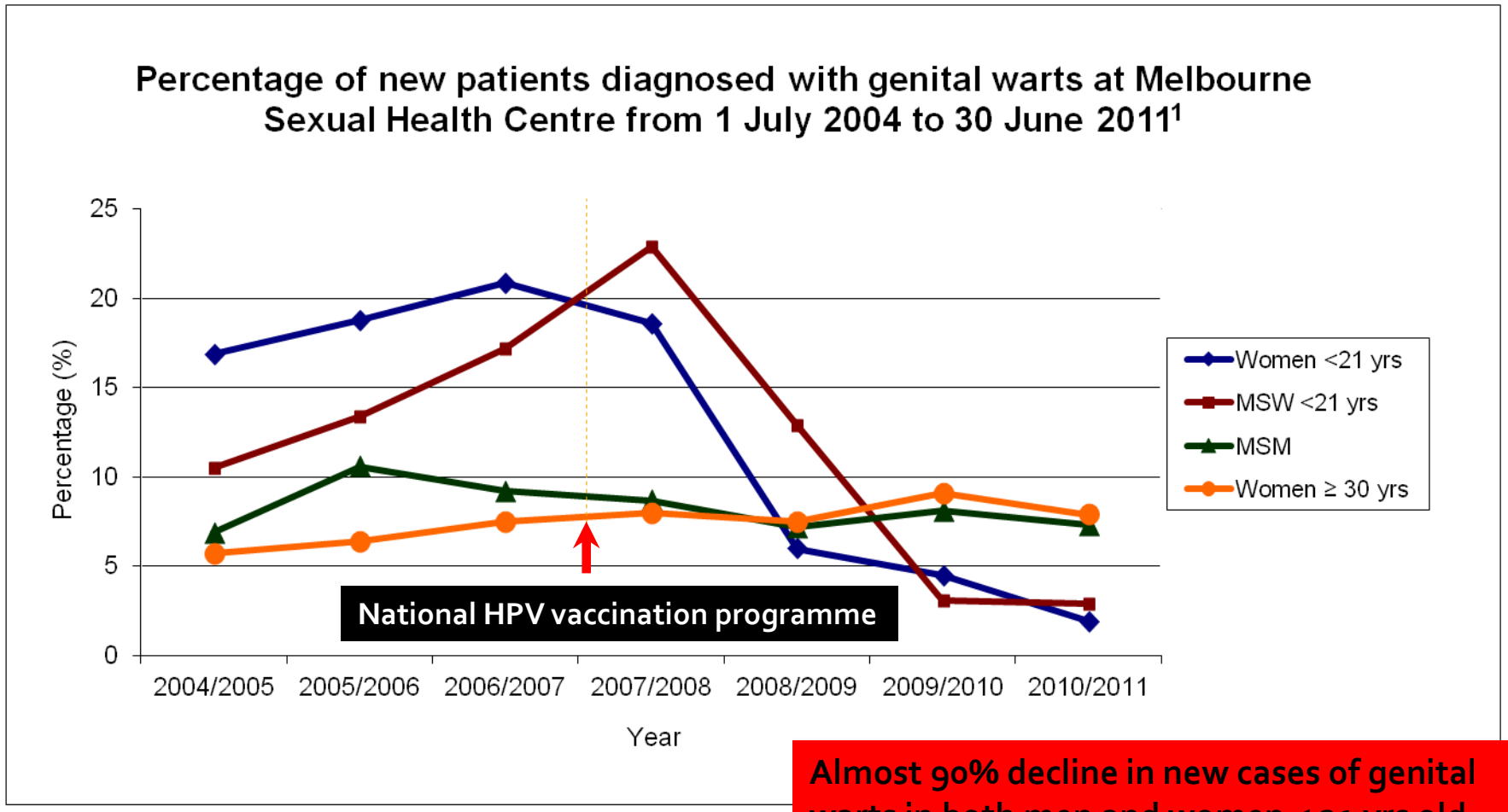
Attitude and Training of HCP

Sexual Education Media

The Australian National HPV vaccination program

- Funded by federal government, delivered by States and Territories
- quadrivalent HPV vaccine used.
- >7 million doses quadrivalent HPV vaccine distributed
- Commenced in April/July 2007 12-26 year old females
  12-13 yrs ongoing cohort 13-26 catch up
- School based 12-18 year olds
  GP/clinic based 18-26 year olds
- Overall coverage 70-80%

Australia: Near disappearance of genital warts after commencement of national HPV program

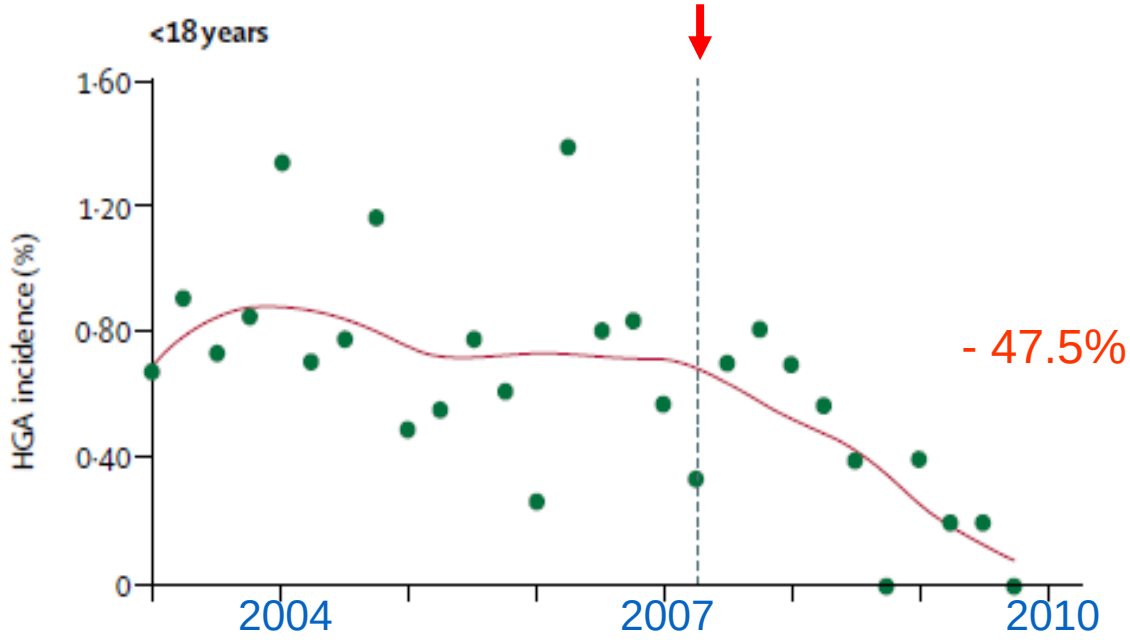


Almost 90% decline in new cases of genital warts in both men and women < 21 yrs old

1. Read et.al., *Sex Transm Infect 2011*; 87:544e547. doi:10.1136/sextrans-2011-050234

Start of vaccination programme (mid-2007)

Incidence of HGA/100 women tested in a 3 month period



- 47.5% p=0.003

A relative reduction of ~50% of high grade abnormalities (HGA) was observed in women <18 years, post vaccination vs. pre vaccination, less than 3 years after the introduction and the trend continues.

Similar early trends have been observed in the US.

Brotherton J et al. Lancet 2011

Program Development

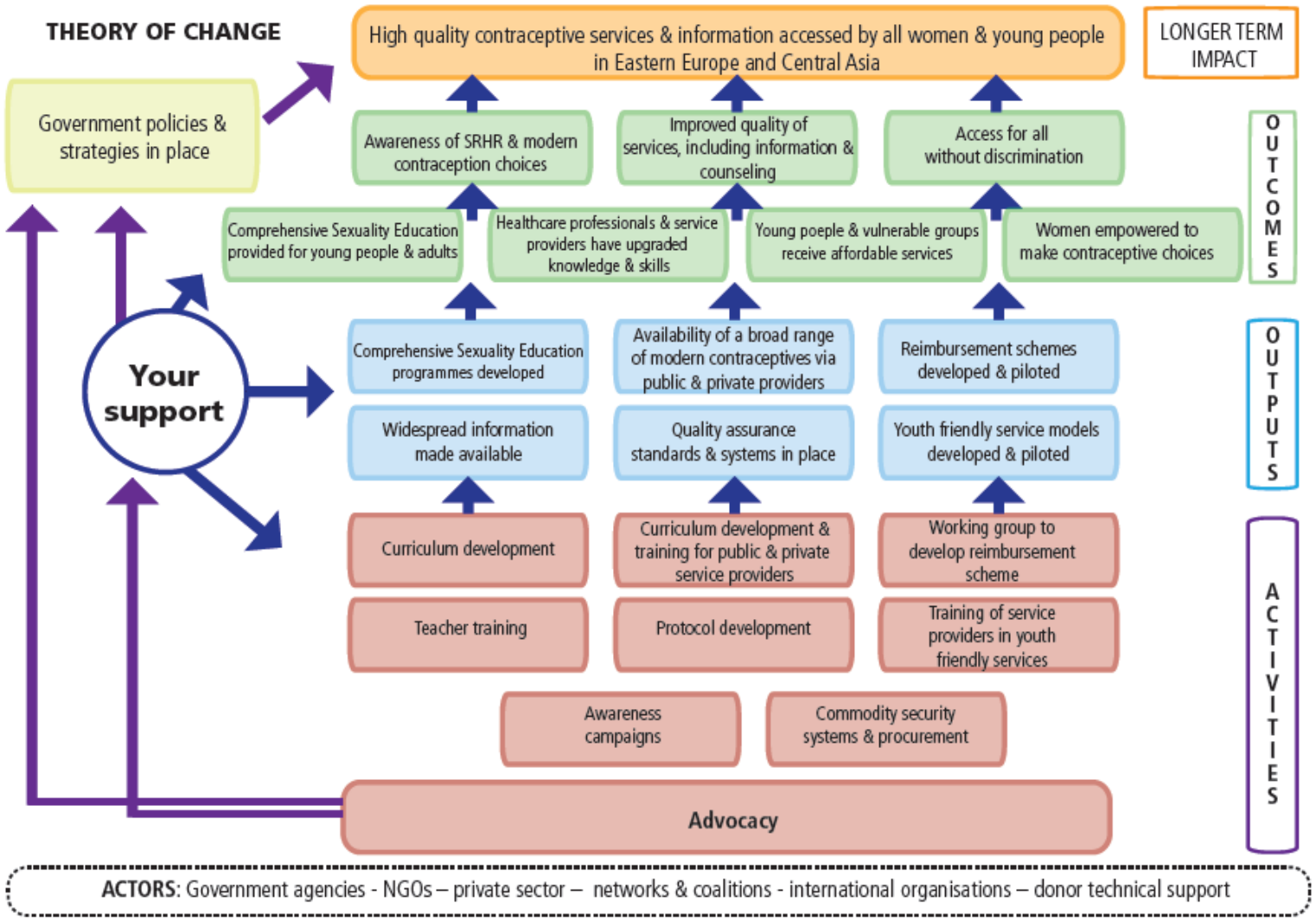
Based on empirical data including intervention studies a model of best care is developed

Then implemented

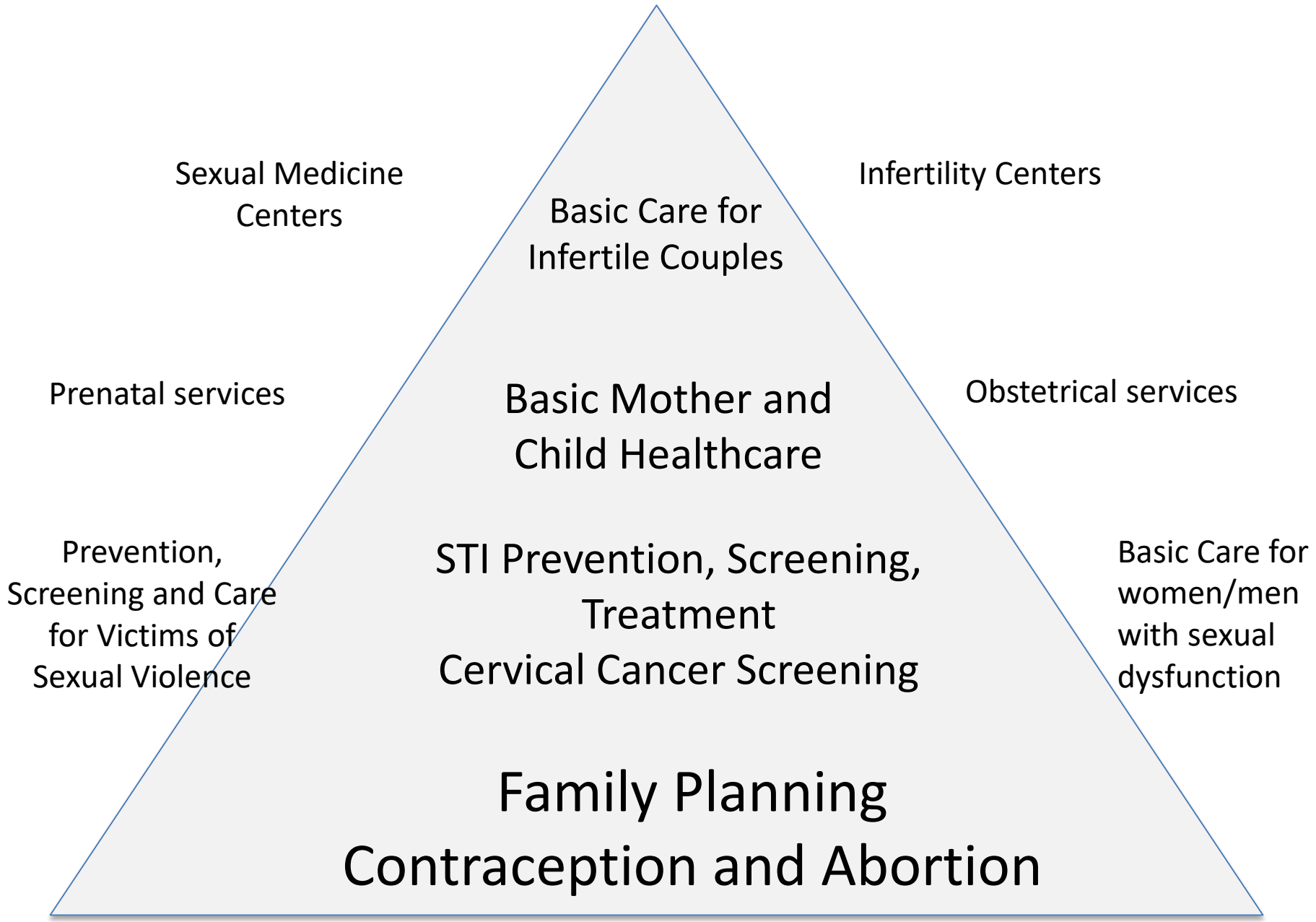
Then monitored and evaluated

IPPF
European Network
From choice, a world of possibilities
January 2016

ACCESS TO MODERN CONTRACEPTIVE CHOICE IN EASTERN EUROPE AND CENTRAL ASIA



The Comprehensive SRH Service



Planning and Implementing an Essential Package of Sexual and Reproductive Health Services

Guidance for Integrating Family Planning and STI/RTI with other Reproductive Health and Primary Health Services

Katherine Williams, Charlotte Warren, and Ian Askew
October 2010

UNFPA

Population Council
RESEARCH THAT MAKES A DIFFERENCE

Integrated comprehensive SRH Services

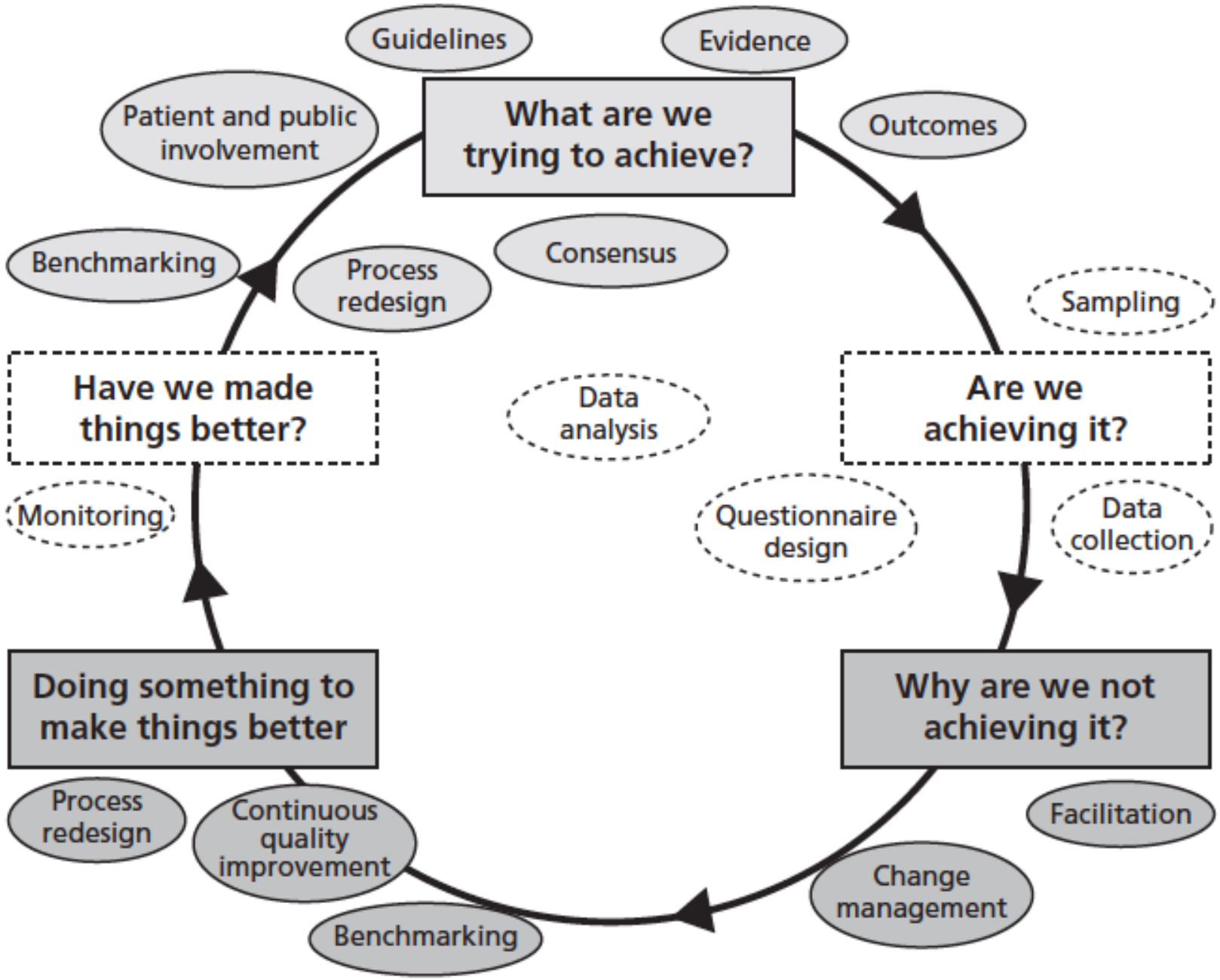
Good SRH services for all women in a society

Prevents unplanned pregnancies **Prevents (unsafe) abortion**	Costs for abortion Costs for complications in pregnancy Costs for neb
Prevents, detects early STI **Prevents complications of STI** **Prevents Infertility**	Cost for treatment of PID and Infertility and chronic pain
Prevents detects early malignant uterine disease	Cost for treatment of advanced disease like Cervival Cancer

Integrated SRH Services

Good integrated SRH services for all women (men) in a society

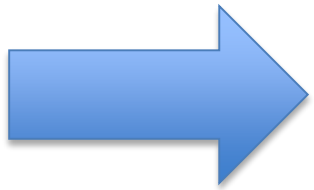
Responds to sexual problems and sexual dysfunction; Dysfunctional couple	**Cost for family disruption, couple separation, Cost for mental disorder**
Detects and responds to sexual violence Prevents psychiatric morbidity	**Cost for diagnosis and treatment of mental heath disorders**
Prevents complication of unsafe abortion	**Cost for medical complications of unsafe abortion**


Guidelines
Evidence
Patient and public involvement
What are we trying to achieve?
Outcomes
Benchmarking
Process redesign
Consensus
Sampling
Have we made things better?
Data analysis
Are we achieving it?
Monitoring
Questionnaire design
Data collection
Doing something to make things better
Why are we not achieving it?
Process redesign
Continuous quality improvement
Facilitation
Change management
Benchmarking

5 domains of evaluation and monitoring Setting up an Audit

The blocks

- Governance
- Health Workforce
- Information
- Financing
- Medical Technologies
- Service Deliveries



What to evaluate ?

- **Organisational Strategy**
- **Program Management**
- **Data Collection and Management**
- **Provision of Services**

Collaboration Targets

- WHO
- UK Faculty SRH
- CDC
- National Societies
- University Institutions (Public Health, Social Medicine)
- Private Institutions, NGOs
- International Societies (EBCOG, FIGO, ISGE, ISSM etc


by 2020 we want all governments to...
1 establish by 2015 a new international development framework that includes sexual and reproductive health and rights as essential priorities
2 increase access to sexual and reproductive health and rights in order to close the gap between the top and bottom wealth quintiles by 50% by the year 2020
3 eliminate all forms of discrimination against women and girls to achieve de facto equality of opportunity for both women and men by the year 2020
4 recognize sexual rights and reproductive rights as human rights by the year 2020
5 engage young people in all policy decisions affecting their lives
6 provide comprehensive and integrated sexual and reproductive health and HIV services within public, private and not-for-profit health systems by the year 2020
7 reduce by at least 50% the current unmet need[i] for family planning by the year 2020
8 make comprehensive sexuality education available to all by 2020
9 reduce maternal mortality due to unsafe abortion by 75% by the year 2020
10 allocate sufficient resources to make all nine targets achievable by 2020