

# Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia



Findings from a Qualitative Study in 7 Countries and Recommendations  
for Improving Access to Modern Contraception in the Region

## Acknowledgements

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# 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<sup>1</sup> and Serbia

**Recommendations** for Improving Access  
to Modern Contraception in the Region



<sup>1</sup> UN technical reference « The Former Yugoslav Republic of Macedonia”

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# FOREWORD

*The International Planned Parenthood Federation European Network Regional Office (IPPF ENRO) and six IPPF Member Associations in Eastern Europe and Central Asia as well as a partner organization in Azerbaijan worked together with the United Nations Population Fund Eastern Europe and Central Asia Regional Office (UNFPA EECARO) to conduct a study on factors influencing access to, and utilization of, modern contraception in seven middle income countries in the EECA region: Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Macedonia<sup>2</sup>, Serbia and Kazakhstan.*

*An important goal of this joint-initiative was to present the findings of the study to a meeting of high-level government officials from other countries in the region. The participants at the meeting in Brussels confirmed that the seven key-factors of contraceptive use which were identified in the study are common across Eastern Europe and Central Asia.*

*This publication does not only detail the seven factors which are responsible for the alarmingly low rates of contraceptive prevalence across the region, it also offers recommendations on how to address them.*

*One key aspect of the study is the focus on the client perspective and his/her reasons for (not) using modern methods of contraception. This qualitative analysis was made possible through focus-group discussions with certain groups of the population, as well as through interviews with key informants from a variety of groups including service providers, governments, donors and pharmaceutical companies.*

*The seven key-factors and other issues that hamper contraceptive use across the countries of the region are carefully outlined in the following pages; and even more thoroughly detailed for each country in the form of annexes. These are included in a CD-Rom on the inside back cover of this publication.*

*Any efforts to increase contraceptive security and to guarantee the right to sexual and reproductive health for women and men should take into consideration the people's perspective and the barriers they face.*

*According to the recommendations, it is important that governments implement (or develop) national evidence-based sexual and reproductive health strategies with a strong component on family planning/contraception, as well as an adequate regulatory framework and sufficient budgets.*

*Government officials and policy makers should work hand in hand with all stakeholders to address the issues that may hinder the demand for contraceptives and contraceptive security, such as the perception of modern contraceptives as being harmful; the lack of youth-friendly and high-quality services and access to comprehensive sexuality education; the affordability and availability of contraceptives, as well as gender power dynamics that all contribute to the popularity of traditional methods of contraception and the recourse to a potentially unsafe abortion in case of an unwanted pregnancy.*

*We hope that these recommendations will help governments and other stakeholders to ensure reproductive health commodity security. This will improve the health of women and men, enabling them to make informed decisions to obtain and use quality contraceptives of their choice for both family planning and the prevention of sexually transmitted infections, including HIV/AIDS.*



**Vicky Claeys,**  
Regional Director  
IPPF European Network



**Werner Haug,**  
Director, UNFPA Regional Office  
for Eastern Europe and Central Asia

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<sup>2</sup> UN technical reference « The Former Yugoslav Republic of Macedonia »

# LIST OF ABBREVIATIONS

<b>AMD</b>	Armenian Dram
<b>BiH</b>	Bosnia and Herzegovina
<b>BGN</b>	Bulgarian Lev
<b>FG</b>	Focus Group
<b>FGD</b>	Focus Group Discussion
<b>FP</b>	Family Planning
<b>HIV/AIDS</b>	Human immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
<b>IPPF EN</b>	International Planned Parenthood Federation European Network
<b>ICPD</b>	International Conference on Population and Development
<b>IUD</b>	Intra-Uterine Device
<b>LMIS</b>	Logistics Management and Information System
<b>MA</b>	Member Association
<b>MDGs</b>	Millennium Development Goals
<b>MICs</b>	Middle-Income Countries
<b>NGOs</b>	Non-Governmental Organizations
<b>RH</b>	Reproductive Health
<b>RHCS</b>	Reproductive Health Commodity Security
<b>SRH</b>	Sexual and Reproductive Health
<b>STI</b>	Sexually Transmitted Infection
<b>UNFPA</b>	United Nations Fund for Population Assistance
<b>UNFPA EECA</b>	United Nations Population Fund, Eastern Europe and Central Asia
<b>USAID</b>	United States Assistance for International Development
<b>USD</b>	United States Dollar
<b>WHO</b>	World Health Organization

# Executive Summary

Modern contraceptive use is alarmingly low in many countries of Eastern Europe and Central Asia. This report provides the results of a study conducted in 7 middle-income countries (Armenia, Azerbaijan, Bosnia-Herzegovina, Bulgaria, Kazakhstan, The Republic of Macedonia and Serbia) that aimed to explore the reasons for these low rates. The study focused on perspective of the client and his/her reasons for using/not using modern methods of contraception.

In each country, 10 focus group discussions were organized with: rural single women and men (2), rural married women and men (2), urban single women and men (2), urban married women and men (2) and vulnerable groups in society such as Roma, or other as relevant (2). Single women and men belonged in most cases to the age group under 25 (though not exclusively). Semi-structured interviews with key community and health informants and with donors, pharmaceutical companies, key institutions and policymakers (up to 25 per country) were also held.

The study identified key cross-country factors influencing contraceptive behavior, demand and access:

1. An overarching factor is the (lack of) **commitment of policymakers and government** actors to contraceptive security
2. In general, there is huge misinformation and **distrust** towards modern (hormonal) methods of contraception, fuelled by misinformation and myths.
3. **Young people** face particular barriers limiting their access to FP.
4. **The provider**, viewed by (potential) clients as a trustworthy source of information and service for family planning, is not always passing on correct and up-to-date information on FP, thus being a major source of misinformation- often confirming myths.
5. A limited **range of modern methods of contraception** is available on the market in these countries. It is mainly limited to condoms, pills and IUDs.
6. **Affordability** was a factor particularly present in Kazakhstan, where modern methods of contraceptives are relatively expensive. In other countries, it was a top-factor for pockets of populations and segments of society. There are also factors adding on to cost, such as unnecessary tests and services.
7. **Expectations regarding sex and sexuality and gender power dynamics** were another important factor that influences contraceptive choice in these countries

Detailed country-specific reports can be found in the annexes to this cross-country report.

On 6-7 June 2012, more than 25 high level government officials from 16 countries in Eastern Europe and Central Asia met in Brussels with representatives from the United Nations Population Fund, Eastern Europe and Central Asia (UNFPA EECA) and the International Planned Parenthood Federation European Network (IPPF EN). At the meeting, the study findings were presented and ways to improve reproductive health commodity security in the region were discussed.

All government officials present at the meeting endorsed specific recommendations to address each of the above identified factors. These recommendations can be found on pages 25-27 of this report.

# Study Background and Rationale

Middle-Income Countries (MICs) are those countries that fall into the middle-income range established for the World Bank's World Development Indicators Report. Middle-Income Countries are home to 64% of the world's extremely poor<sup>3</sup>, and are found in all geographical regions. They cover a wide range of income levels, with the highest income Middle-Income Country having a per capita income 10 times that of the lowest.

While recognizing that Gross National Income (GNI) does not by itself constitute or measure welfare or success in development, the Gross National Income as a broad measure is considered to be the best single indicator of economic capacity and progress. According to the World Bank's classification, which is widely used by the United Nations system, Middle-Income Countries are countries with a Gross National Income per capita ranging from \$995 to \$12,195. Among them, the lower Middle-Income Countries' Gross National Income per capita range is from \$995 - \$3,945 while for upper Middle-Income Countries it is from \$3,945 - \$12,195.

In the Europe and Central Asia region, the World Bank ranks 17 countries as Middle-Income. The 7 countries that were part of this study are all Middle-Income. Armenia has a lower-Middle-Income economy, while the other countries belong to the upper-Middle-Income economy category.

## **RATIONALE AND JUSTIFICATION OF FOCUS ON MIDDLE-INCOME COUNTRIES**

Despite the Middle-Income Countries' economic growth and development, income gains are often accompanied by persistent poverty, inequality, social and economic exclusion of certain populations, as well as great variations between and within countries in terms of achieving the International Conference on Population and Development (ICPD) goals. There is a big diversity among Middle-Income Countries, which goes beyond their income status and refers to the achievement of the International Conference of Population and Development (ICPD) goals and the Millennium Development Goals (MDGs), the stage of their demographic transition and population size, the level of human development, poverty, inequality, and other dimensions. In the short and medium term, the reversal of the country income status is highly probable due to the Middle-Income Countries' vulnerability to external financial/economic shocks, political conflicts, natural disasters and other environmental challenges. The lack of institutional capacity and the lack of an enabling and supportive environment in many Middle-Income Countries also jeopardizes economic and political reforms and entails in some cases continuous inefficiency in policy implementation and programme delivery<sup>4</sup>.

In a number of Middle-Income Countries, insufficient resources are devoted to health care services. Reproductive health, including the Reproductive Health Commodity Security policy sphere struggles to compete for resources with other public health issues. In Middle-Income Countries, progress towards

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<sup>3</sup> *Development Cooperation with Middle-Income Countries*, Report of the Secretary-General, UN 64th General Assembly, 5 August 2009, A/64/253, p.4.

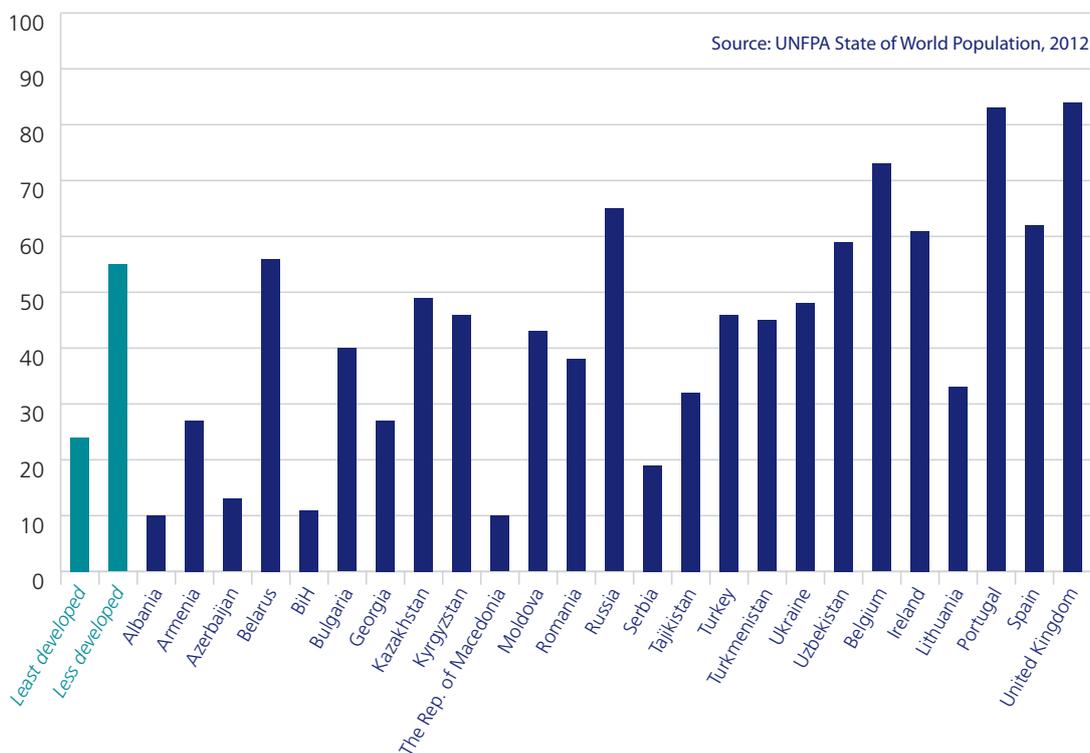
<sup>4</sup> *UNFPA Strategy towards Middle-Income Countries*, February 2010, p. 2

achieving universal access to sexual and reproductive health (Millennium Development Goal 5, target b) is lacking behind compared to other Millennium Development Goals. Access to Sexual and Reproductive Health services and Reproductive Health Commodities is challenged by political, economic and structural changes, including health sector reform. As a result, Reproductive Health indicators show a widening gap in the contraceptive prevalence rate among different socio-economic groups, an increasing unmet need for modern contraception, a very low level of modern contraceptives usage, and a continuing high rate of abortion. Due to inefficiencies in the health sector (inadequate Sexual and Reproductive Health policies, a lack of funding and health resources, poor Logistical Management Information Systems), there are reduced options for modern contraceptives for users and potential users due to recurrent stockouts or overstocks, weak inventory controls and logistic management systems, and/or the absence of Reproductive Health commodities [particularly contraceptives] on national essential commodities lists. With regard to staffing, there is a shortage of qualified health personnel and extensive technical training needs among existing health personnel. This is exacerbated by a high turnover of health service providers due, in many cases, to the decentralisation of health systems following health sector reform, the privatization of health services and the existence of multiple, non-integrated service systems.

## CONTRACEPTIVE USAGE AND REPRODUCTIVE HEALTH COMMODITY SECURITY IN THE REGION

Usage rates for modern methods of contraception are alarmingly low in many countries of the Eastern Europe-Central Asia region. In five countries of the region (Albania, Azerbaijan, Bosnia and Herzegovina, The Republic of Macedonia and Serbia) this rate is below the average of 22% for the least developed countries<sup>5</sup> and in another 11 countries it is lower than the average of 55% for the less developed regions<sup>6</sup>.

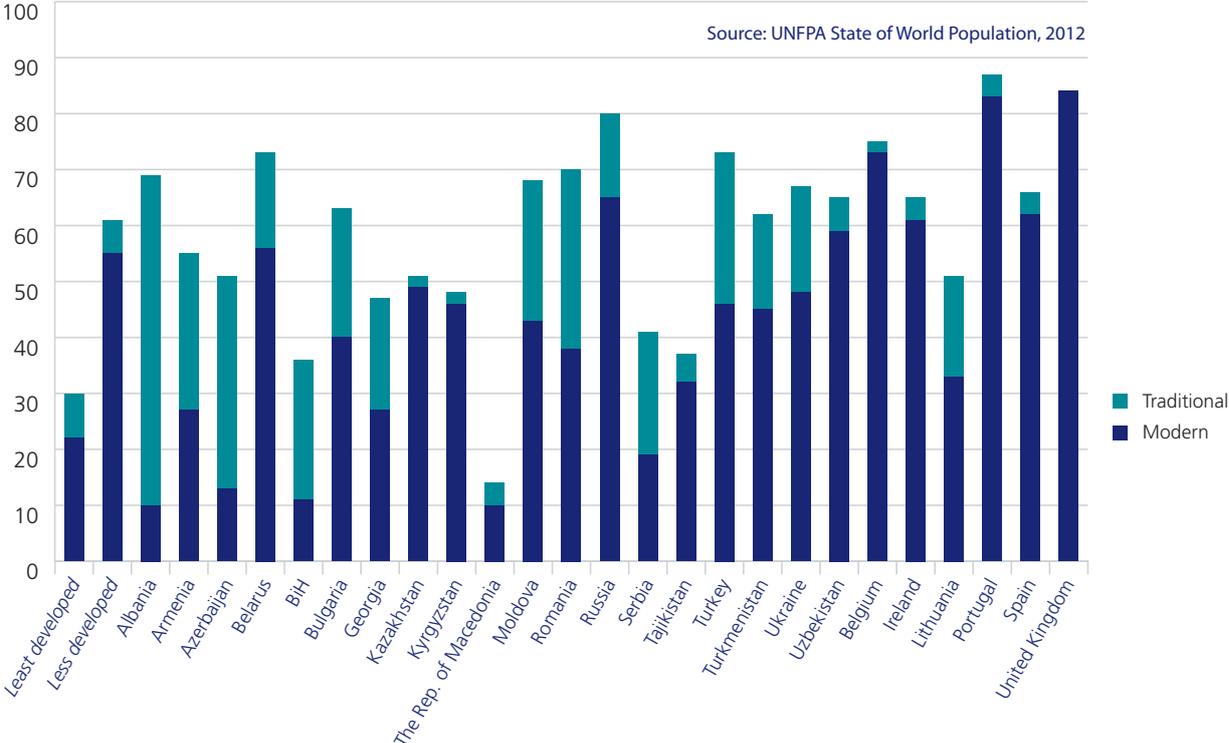
**Table 1: Contraceptive Prevalence, Modern Methods of Contraception**



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<sup>5</sup> State of the World Population Report, 2012  
<sup>6</sup> idem

However, if traditional methods of contraception are included (see table below) in the calculations of contraceptive prevalence, the figures change quite dramatically: in many countries a large proportion of women are trying to avoid pregnancy using traditional methods. In Albania, for example, 59% of women rely on traditional methods of contraception to delay a pregnancy while only 10% use modern methods. It is worth noting that these are national-level figures and do not illustrate the often vast differences between rural and urban areas.

**Table 2: Contraceptive Prevalence, Modern + Traditional Methods**



Study findings suggest that women do not use modern methods of contraception for several reasons: incorrect information, poor counselling, high cost, and crucially, a lack of choice and unreliable supply of contraceptives. Furthermore, the region has the highest abortion rates in the world. When comparing abortion rates with contraceptive prevalence, the figures show that, with the notable exception of Kazakhstan, in the countries with high abortion rates, a very high percentage of women who are trying to delay or prevent pregnancy are not using a reliable method of contraception. This figure is alarmingly high in many countries, including EU Member States such as Bulgaria and Romania<sup>7</sup>.

<sup>7</sup> Based on data from WHO, 2010

In order to document existing reproductive health commodity security systems, budgeting and national capacities in the Eastern Europe-Central Asia region, UNFPA conducted a desk review in 2009<sup>8</sup>. This review found the following:

**Reproductive Health Commodity Security** is achieved when all individuals can obtain and use affordable, quality contraceptives and other reproductive health commodities of their choice whenever they need them.

- Only three countries in Eastern Europe (Moldova, Albania and Turkey) have national action plans in place to address Reproductive Health Commodity Security.
- While the provision of obstetric drugs is covered largely by governments or health insurance funds, there is a lack of funding for contraceptives. Only five of the seventeen MICs in Eastern Europe and Central Asia have national budgets covering a portion of contraceptives supply and insurance programs often do not cover contraceptive costs. In most of Eastern Europe MICs contraceptives are provided through the private sector therein increasing inequities in RHCS.
- Six out of the seventeen Middle-Income Countries (35%) reported an improvement. In eight countries, Reproductive Health Commodity Security is assessed as being unchanged (47%). In only one country, Turkey, Reproductive Health Commodity Security was assessed as potentially getting worse. Two countries from the region were unable to provide a Reproductive Health Commodity Security assessment.

## STUDY PURPOSE AND METHODOLOGY

The objective of this analysis has been to gather and analyze data on factors influencing access to and utilization of modern family planning methods with particular attention to vulnerable populations in seven selected middle-income countries in Eastern Europe and Central Asia. Analysis findings supplement a review by UNFPA of reproductive health commodity security (RHCS) in the region and will contribute to the establishment of country client-centered family planning and Reproductive Health Commodity Security strategies.

The study is a qualitative analysis of behavioral patterns and cultural norms that are influencing contraceptive access and utilization in seven selected countries across the Eastern Europe and Central Asian region: Armenia, Bosnia and Herzegovina, Bulgaria, The Republic of Macedonia, Serbia, Azerbaijan and Kazakhstan. Detailed data on patterns and determinants of utilization of family planning (FP) methods and RHCS of the population has been gathered, including information on supply factors that promote or hinder contraceptive usage. The analysis involved a desk review of key reports and documents on behavior and culture related to contraceptive use in the region and ten focus group discussions with various communities in each country. In each of these countries, usage rates of modern methods of contraception and reliance on traditional methods of contraception are close to similar across society. Therefore, focus groups were held with representatives from all groups in society in each country: rural single women and men (2), rural married women and men (2), urban single women and men (2), urban married women and men (2) and vulnerable groups in society such as Roma, or other as relevant (2). Single women and men belonged in most cases to the age group under 25 (though not exclusively).

8 UNFPA, *Review of Existing Reproductive Health Commodity Security Systems, Budgeting and National Capacities, and Progress Achieved with Family Planning Service Provision in the Eastern Europe and Central Asia Region*, August 2009, 213 p.

Key informant interviews were held with persons having particular insight into specific social groups in their country or into their country's reproductive health services delivery system. Interviews with policy-makers, international organizations, donors, pharmaceutical companies and key government institutions were held to learn more about existing relationships, power structures and decision-making in relation to Reproductive Health Commodity Security.

This report presents major cross-country findings and outlines key recommendations for action. Findings from each of the country studies are presented in the annexes to this report.

# Key Cross-Country Findings

Representatives of each of the IPPF EN Member Associations (MAs) and the partner from Azerbaijan participating in the seven-country assessment met in Istanbul in December 2011 to discuss the study findings. The Member Associations and the partner organization identified seven priority issues that hamper contraceptive security across the countries included in this review. These cross-country priority issues are:

- 1. Government and Policy Makers' Commitment**
- 2. Perception of Modern Methods of Contraception as harmful**
- 3. Difficulties for young people in accessing contraceptive services**
- 4. Knowledge, Attitudes, Skills and Range of Service Providers**
- 5. Range of Modern Methods of Contraception available**
- 6. Affordability of Modern Methods of Contraception**
- 7. Social Norms and Expectations regarding Sex and Sexuality and Gender Power Dynamics**

These seven priority issues are discussed below; a more detailed discussion of these and other issues specific to each country can be found in the country reports in the annexes.

## **1. GOVERNMENT AND POLICY MAKERS' COMMITMENT**

As the UNFPA 2009 review of reproductive health and contraceptive security in the region highlighted RHCS policies and programme issues, the focus of this assessment has been on the social, cultural and service factors that influence contraceptive usage. Interviews with national policy-makers, program officials and donor organizations however indicated that a lack of government commitment is a critical obstacle to advances in reproductive health contraceptive security in each of the seven countries of the study. Even in the countries where policies and programs are in place, those policies and programs are not being implemented accordingly. Adequate funding is not allocated nor implementation plans developed in order to translate the plans that are on paper into real activities and action.

Government leaders' concern about the low demographic growth in the region is one factor contributing to the lack of commitment to RHCS. The situation is further exacerbated by the polarization of the demographic situation and minority issues in political discussions.

## 2. PERCEPTION OF MODERN METHODS OF CONTRACEPTION AS HARMFUL

The safety of modern contraception methods is a major concern to men and women in every country of this study, cutting across ethnic, economic and geographic lines. The perception of modern contraceptives being harmful to health is widely held and is present among both rural and urban population, all ethnic groups, young and older generations, high- and low-educated, married and unmarried, etc. It may be a remnant of the experiences with high-dose contraceptive pills of the Soviet period passed down generation to generation that now seems to be reinforced by the new focus on natural products and the 'healthy is natural' movement<sup>9</sup>. Unnatural equals unhealthy in many of the countries and modern contraception is unnatural, with some methods considered more unnatural than others. Hormones are especially suspect and oral contraception was categorized as harmful to a woman's health in fifty of the seventy focus groups conducted during this study. In seven of the remaining twenty focus groups, participants reported that community opinions about the pill were mixed: while some in their communities have no concerns about the safety of oral contraception, others continue to believe that the pill is not good for women<sup>10</sup>. Only thirteen of the seventy focus groups put oral contraception into the safe category with no reservations whatsoever. Groups categorizing the pill as 'not harmful' tended to be male groups. When groups were aware of other hormone-based methods— injection, Norplant, etc.—these methods were also placed in the harmful grouping. Being hormone-free however does not earn a healthy rating for a contraceptive. Thirty-four of the seventy focus groups also indicated that their communities believe the IUD is harmful for a woman's health; only sixteen groups categorized the IUD in the "all think it is safe" grouping<sup>11</sup>.

**"My friend told me that hair growth may occur on the face of women who use hormonal contraceptive pills ..."**

**SINGLE, RURAL WOMAN IN ARMENIA**

Fears seem to be a mix of known side effects of certain contraceptives that can be managed with support from a health care worker and outlandish consequences that have no basis in reality. Comments that illustrate the level of concern regarding the safety of modern contraception were numerous. (see quotes in text box).

**"There is no modern method that is not harmful"**

**RURAL MAN IN THE REPUBLIC OF MACEDONIA**

**"Everyone agrees that hormones are harmful. This affects the choice of contraceptive method. In general all methods might be dangerous"**

**GIRL IN SOFIA, BULGARIA**

**"Contraception is not 'natural' for women."**

**ROMA WOMAN IN SERBIA**

**"The IUD can only damage the genital parts, not the whole body, which is the case with pills since they are swallowed."**

**ALBANIAN MAN IN THE REPUBLIC OF MACEDONIA**

Based on the findings of this study, there is little doubt that concerns about safety contribute significantly to the non-use of modern contraception in the region.

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<sup>9</sup> USAID Fact Sheet. 2008. Family Planning in Europe and Eurasia.

[http://www.usaid.gov/locations/europe\\_eurasia/health/technical\\_elements/family\\_planning.html](http://www.usaid.gov/locations/europe_eurasia/health/technical_elements/family_planning.html)

<sup>10</sup> Focus group participants were asked to consider what women and men in their community think about contraception.

The responses are usually a mix of their own personal opinions and that of those they know.

<sup>11</sup> The IUD can be hormone-free or hormone-based. However, in these countries, IUDs are usually hormone-free.

Findings also suggest that the safety factor contributes to the popularity of withdrawal in the countries of the region. Withdrawal it seems is often not the method of choice, but rather of default. Just as with safety concerns about modern contraception, use of withdrawal cuts across contextual, social and economic distinctions in almost all of the study countries<sup>12</sup>. While virtually all know that withdrawal is not reliable, it is considered by many to be the safest method of contraception from a health perspective and the safety factor clearly trumps the reliability factor. Withdrawal also has other advantages; it is free, takes no preparation, is always available and does not take away from the spontaneity of sex. These study findings concur with periodic research in the Balkans since the early 1990s that found withdrawal coupled with induced abortion to be affirmed by society<sup>13</sup>. Withdrawal *“has been used for centuries”*<sup>14</sup> and is considered ‘normal’ for married couples and singles in long-term relationships; when it fails, abortion has been, and is still, the response.

**“Everything is poison and chemistry. The best is withdrawal”**

ROMA MAN IN THE REPUBLIC OF MACEDONIA

Data from focus groups in Serbia also suggest there may be a gender factor operating as well. Comments of Serbian men during focus groups suggest a kind of male 'bravado' associated with withdrawal, one in which men are proud of their prowess, their skill in mastering their sexual performance, their ability to take care of their woman.

**“ [Withdrawal] is like a constant process of baby-making, men feel potent.”**

URBAN MARRIED MAN WITH CHILDREN, FGD 9, SERBIA

Performing withdrawal correctly seems to be one aspect of being a good lover in Serbia. According to Serbian men, *“there are different ways of doing [withdrawal], and if not getting your girlfriend pregnant is your objective, there is a way to do it right.”* Those who use this method effectively are ‘holders of a special knowledge’ on how to perform withdrawal correctly and they are sexually-skilled enough to put their special knowledge into practice: using withdrawal successfully seems to be a source of pride for Serbian men. Consistent with this notion is the comment of a community key informant saying that when an unplanned pregnancy does occur and abortion is necessary, some men are concerned that they have failed as lovers because they allowed such a thing to happen<sup>15</sup>.

For Serbian women, on the other hand, the use of withdrawal with a partner seems to serve as an indicator of commitment within a relationship; it denotes an important level of trust and intimacy between the man and the woman. Being in a relationship where withdrawal is used then is positive for a woman; the perceived commitment linked to the use of withdrawal provides a sense of security for her future. A key health sector informant added that withdrawal is *“a way the female partner, by accepting the method, can show trust in the man”*<sup>16</sup>. Furthermore, it seems to be both recognized and accepted by the woman that in some cases pregnancy will occur when withdrawal is used. As the woman feels she is in a real and enduring relationship, it is ‘okay’ to become pregnant as she and her child will be provided for.

While these discussions were specific to Serbia, comments in other focus groups suggest that similar gender dynamics may be contributing to the popularity of withdrawal in other Balkan countries. Moreover, even where sexual bravado linked to withdrawal is not a factor, withdrawal is clearly the man’s method: men

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<sup>12</sup> With the clear distinction of Kazakhstan: Kazakhs generally do not use traditional methods of family planning.  
<sup>13</sup> Rasevic, Mirjana and Katarina Sedlecky. The Abortion Issue in Serbia. The European Journal of Contraception and Reproductive Health Care. 2009;14:6,385-390.  
<sup>14</sup> Quote from an Albanian man in Gradec, Macedonia (FGD 4)  
<sup>15</sup> Other men, she continued on to say, just blame the woman for not using any form of contraception.  
<sup>16</sup> Interview with Dr. Ivan Cukic, Director of the Department of Gynecology at the Institute of Protection of Student Health, Belgrade, Serbia.

hear about it from other men, men propose it, men control it, and men perform it. Most men tend to be out of the picture when it comes to other methods of contraception: rural men due to ignorance and not meddling in what is seen as “women’s matters”<sup>17</sup>; urban men because, as concluded by the lead Serbian FG facilitator, “contraception is the responsibility of the woman”.

Even though “it has been used for centuries”—according to a man of Albanian origin from The Republic of Macedonia - and “everybody knows it”—according to a Bulgarian man—not all men like withdrawal. Some say it is “not easy to use for both the man and the woman”, and an Azerbaijani group of women from a low-income area concluded that withdrawal is “not pleasant for the man and makes them nervous”.

**“I believe in myself, and I have enough experience so there is no need to use a condom...”**

YOUNG SINGLE URBAN MAN, FGD 10, SERBIA

**“All men think it [withdrawal] is a good method.**

**But it is like a punishment for the man. It is a sacrifice of pleasure to avoid pregnancy.**

**It is like you need to run 1000 meters and in the last 200 meters you break a leg.”**

A MACEDONIAN MAN OF ALBANIAN ORIGIN

Focus group participants were probed about their community’s knowledge about contraceptive methods. We learned that concerns about harmfulness of modern contraceptive methods are present in all countries cutting across geographical, economic and ethnic lines; but this is not the case when asked about knowledge and access to information about modern contraception: groups of population have different levels of knowledge and access to information on contraceptive methods.

In Bulgaria, key informants were in agreement that differences in knowledge about modern contraception and access to information are rather along the lines of social status, income level and place of residence. Neither ethnicity nor religion seems to play a large role.

In Bosnia and Herzegovina, a key informant spoke of knowledge about contraception being lower in rural areas, rural youth and young adults knowing less about methods, in particular where they can be obtained. In The Republic of Macedonia, married Albanian women from rural areas in general seem to be less informed about family planning. Whereas the group of married and single middle-income women from the capital Skopje seemed to be the most well-informed about the contraceptives available in The Republic of Macedonia, their use, their advantages and disadvantages. Focus group findings in The Republic of Macedonia confirm some of the findings in other countries, namely that urban women know more about modern contraceptives and how they work than rural women. As well, many young single women seemed to be better informed than older married women. In The Republic of Macedonia, this was especially the case within Albanian and Roma community where young single women are better informed than older married women. Age differences among women were especially evident in rural areas where it is believed young girls have easier access to information through internet and newspapers.

Serbian women seem to be relatively well-informed about the contraceptive methods available, their usage and where to obtain them. The findings in Serbia however also suggest that rural men know very little about contraception. Roma women, both urban and rural, also tend to be less aware than other women and know only a few basic methods of contraception. Rural single men, most from Muslim families originally from Kosovo, were by far the least informed of all the focus groups as well as being very shy to talk about sexual matters. Single rural women seemed to have significantly more access to information about contraception

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17 Quote from a Serbian rural man (FGD 4)

than married women in the same community. Urban groups have a high level of access to information. In Armenia, urban parents with limited income, rural women with migrant husbands and young people with only primary and secondary education tend to have less knowledge about modern contraception. Married men and women in urban areas seem to know more about the pill and IUD than both rural and urban singles, and married men and women in rural areas.

In Azerbaijan, contrary to other countries in this study, male groups were generally better informed than female groups. IUDs, male condoms and pills are the most commonly known contraceptives and were named by all groups regardless of marital status, education and residency.

In Kazakhstan, those living in rural areas have less access to information. From all focus group discussions held in Kazakhstan, the rural married women from South Kazakhstan had the least knowledge of the range of existing contraceptive methods. They seemed to be more interested in learning about family planning than answering questions. Pockets of less access to information may exist within large cities also, especially among recent rural migrants who would still retain many of their rural characteristics and are yet not acclimated to the urban setting and ways of coping. Being from a Kazakh traditional family may also be a factor in access to information about contraception.

In general, we may conclude that those living in urban areas have greater knowledge and access to information than those living in medium-sized cities; residents in medium-sized cities have more knowledge and access to information than those in rural areas. Young people have more information than older people. Women tend to know more than men (except for Azerbaijan). Sometimes, also marital status makes a difference. This tendency was apparent in all countries. In some countries, there were some differences along ethnic lines as well – however, it was not always clear whether ethnicity or other factors (income, place of residence, marital status, other) were predominant.

Finally, it is interesting to note also that while many women turn to abortion when an unplanned pregnancy occurs and abortion is accepted by society across the study countries, it seems that many men and women do not take abortion lightly and, as well, consider abortion as harmful to health as modern contraception. Opinions are mixed however and, for many, abortion is just a part of life.

Following quotes from different focus groups illustrate these mixed opinions about abortion:

**“Abortion is the most harmful method of contraception.”**

ALBANIAN WOMEN IN MACEDONIA

**“The result is most important. So if the abortion is the solution, why not?”**

YOUNG RURAL MEN IN BULGARIA

### 3. YOUNG PEOPLE

While it is not possible to draw firm, all encompassing conclusions from the study findings concerning the contraceptive knowledge, attitudes and behaviors of young people across the seven countries, certain tendencies were apparent. Young people tend to have better access to information than older generations. Urban youth and young adults tend to have better information than rural youth and young adults. Young women tend to know more about modern contraception than young men, and girlfriends are often a key source of contraception for young men. And, in many places, young women are as comfortable – sometimes more comfortable – talking about sexual matters as young men<sup>18</sup>.

The level of knowledge and experience with sexual matters of young people seems to vary greatly within each country and is often not what one would expect. Young girls in what is considered a very traditional community in The Republic of Macedonia are clearly sexually active and very conversant about sex and sexual pleasure. Young men in Bosnia and Herzegovina are too shy to ask about contraception and young men in many of the countries too embarrassed to ask for condoms in a pharmacy. Male university students in Azerbaijan, where men are thought to be ‘macho’, make unexpected feminist-leaning statements. Very young girls in one neighbourhood of Sofia, Bulgaria, change sexual partners frequently and brag about their sexual exploits on the web while slightly older girls in a neighbourhood not that far away are still talking about the importance of being virgins.

The one constant for many of the young people across the region seems to be change–changing values, changing sexual practices, changing expectations, changing information coming in from all over the world. Internet, social media sites, mobile telephone networks and satellite channels seem to be at the hub of much of the change for many young people across the region<sup>19</sup>. A surplus of information is now readily available at one’s fingertips, both good and bad. Young people in Kazakhstan are watching Californication, a very sexually-explicit US cable show that features adultery and promiscuity. Men in several countries spoke of first hearing about condoms and vasectomies and learning about sex from watching porn movies: *“My sexuality education started with watching erotic video-films.”*

Factual information is also available. *“Young people are mostly on the internet. Today you can find information about anything you want. It’s the same for contraception. You will find information about each method. Often however, the accuracy and their understanding of the information they have is limited.”* A Sarajevo pharmacist explained: *“We think that a young person knows a lot about contraception, but when you start to talk with them, you will find that they are uninformed. Even if they have some information,*

**“We have completely opposite situations [in our country], either very traditional norms about sexuality or girls’ behaviour without any limits whatsoever...”**

KEY INFORMANT IN BOSNIA-HERZEGOVINA

On getting partners to use condoms:

**“Many boys say they don’t use ‘such things’ – the reaction of 3 of the girls in such cases – take my pants and go!”**

10TH GRADE GIRLS IN SOPHIA, BULGARIA

**“When an aptek [pharmacy] worker is a woman, she looks and smiles if you buy condoms.”**

YOUNG SINGLE MAN IN AZERBAIJAN

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<sup>18</sup> Note that there are exceptions to every one of these tendencies.

<sup>19</sup> But not all: many of the study participants in Kazakhstan, for example, did not have access to internet, and some rural groups seemed to be out of the loop of information.

*for the most part they don't understand it."* FG participants in other countries also cautioned that while youth can get a lot of information about sexual matters on the internet, information is not knowledge. They often do not know how to use a method correctly, or where contraceptive methods are available.

Access to services, in terms of both cost but mostly in terms of confidentiality, is a major issue for young people and contraception across the seven countries and study findings confirmed the continuing need for youth-friendly services.

**"Sometimes you wait until all people leave the pharmacy, then you point your finger at the condom and ask to buy 'that product'."**

**YOUNG SINGLE MAN IN KAZAKHSTAN**

Unfortunately, young people in several of the seven countries also confirmed the need for improving existing youth-friendly services. According to focus group participants and key informants, physicians in youth counselling services are often not friendly. Examples included physicians always asking the age of the young person before talking about sex or scolding the young person for having sex at such a young age.

#### 4. KNOWLEDGE, ATTITUDES, SKILLS AND RANGE OF SERVICE PROVIDERS

Across the seven countries in the study, physicians were mentioned as the most trusted source of information on contraception by the focus group participants:

Unfortunately though, the quality of information provided by some physicians is not always as reliable. Doctors—both gynaecologists and general practitioners—often do not provide any information on contraceptive methods to their clients and, when they do, the information they provide is at times incorrect. It was clear from focus groups and from views expressed by physician key informants that provider bias and misinformation is an issue in each of the seven countries of this study.

Study results suggest that many gynaecologists base their professional advice on misinformation, outdated information and on their own personal opinions of modern contraceptives rather than on the latest, sound, evidence-based medicine. A 2008 Serbian study supports these findings. Six out of ten members of the Gynaecology and Obstetrics Section of the Serbian Medical Society responding to a survey reported that they or their partner had one or more abortions; almost four out of ten said they usually used withdrawal or no contraceptive method at all; one out of two was unwilling to prescribe oral contraceptives to girls younger than 18 years of age; and more than three out of four advised women against the use of oral contraception for more than two years. Study respondents in the Serbian study also expressed a range of other irrational concerns about the use of modern

**“I have never received information about family planning from a physician, but I believe that this information would be the most reliable.”**

URBAN POOR MARRIED WOMAN IN ARMENIA

**“The reliable source of information on sexual and reproductive health matters is the physician.”**

YOUNG SINGLE MEN IN SOUTH KAZAKHSTAN

**“The most important thing for a sexually-active woman is a good, professional gynaecologist.”**

YOUNG, URBAN MARRIED WOMAN IN SERBIA

**“Youth aged between 15 and 20 should know that it is for them better to use barrier contraceptive methods. Hormonal contraception is better only from an age of 20 onwards, because of the development of young people.”**

A GENERAL PRACTITIONER WORKING WITH ADOLESCENTS IN SARAJEVO, BIH

contraceptives<sup>20</sup>.

Indication of misinformation among physicians in this study came from focus groups and from key informant interviews. The physicians themselves are not aware that their opinions and information on contraception are not based on latest evidence; on the contrary, they are convinced that their information is correct.

Provider bias includes judgements about certain groups within the community, about certain contraceptive methods, and about contraception in general. For example, rather than offering women a choice of contraception, some physicians tend to prescribe certain contraception for a certain ‘type’ of women. IUDs are prescribed only to women

**“I’m not very fond of oral contraception. As for the IUD, we are speaking about a foreign body...”**

MACEDONIAN GENERAL PRACTITIONER

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<sup>20</sup> Sedlecky, Katarina and Mirjana Rasevic. Are Serbian gynecologists in line with modern family planning? The European Journal of Contraception and Reproductive Health Care 2008 13:2, 158-163.

who already have children. Oral contraception is not prescribed to Roma as Roma women are believed incapable of taking a pill every day. In FGs, participants named their source of information for each contraceptive method. Their responses support the finding that physicians focus on certain contraceptives and not others, and are clearly not giving women a choice of a range of contraceptive methods.

**“Pills can be dangerous because of hormones. Withdrawal is safe for women and for men.**

**However it affects the nervous system. The psyche gets disturbed.”**

KAZAKH HEALTH CARE PROVIDERS

Requiring a range of expensive and unnecessary tests before prescribing a modern method of birth control is also widespread. *“In Breza there is not even one gynaecologist who does not require a hormonal test before prescribing contraceptive pills.”* This is the statement of a Bosnian pharmacist but it describes a situation common in many of the countries: physicians unaware, or not in agreement, with standard international protocols who require a range of preliminary tests for hormonal contraception or prior to IUD insertion. These practices significantly increase the cost of contraception – and needlessly – reinforce the myth that there is something inherently risky about modern family planning methods.

Income and profit also complicate the provision of SRH services and can dissuade a provider from promoting contraceptive to clients. A Bulgarian pharmacist pointed out that *“most gynaecologists do not have an interest in prescribing contraceptives. [...] It is a very common practice to perform vacuum aspirations in gynaecologist office. This is a very profitable activity. If a gynaecologist performs ten vacuum aspirations per month, he makes around BGN 2000 (1000 Euro).”*

Opportunity for profit is a factor that enters into the SRH equation for providers in many of the study countries; it determines both which services and products are offered and where they are offered. Primary health care reforms across the region followed by privatization of gynaecological health care has increased client costs for SRH services in many places and, as well, affected the number of providers in certain places. For example, the gynecologist in Panagyurishte, Bulgaria, said that the number of the specialists had decreased significantly in his area due to the weak local economy and the inability of clients to pay for gynecological services. The profit factor also affects the supply of contraception: there is more money to be made with a product that is in demand than a product that a client must be convinced to use, with a product with a higher profit margin than a product with a small mark-up (vacuum aspiration versus prescribing contraception), and where there are more potential clients (urban versus rural). This commercial aspect of service provision needs to be taken into account in planning for services that can be maintained over time.

Exacerbating the situation in many countries are policies that limit the types of providers allowed to prescribe contraception. Often only a gynecologist can prescribe contraception. This is an issue because the number of gynecologists is often very limited, they are often concentrated in large urban areas, and they often work at secondary and tertiary health facilities with little connection to communities. Widening the range of providers enabled to offer contraception has been shown to improve contraceptive access, particularly where resources are most limited<sup>21</sup>. Allowing general practitioners, whose numbers are greater and who are usually working closer to the population to provide family planning services, would quickly multiply the sites for family planning in the region and increase access significantly<sup>22</sup>.

21 Welsh MH; Stanback; Shelton J. “Access to modern contraception” in Best Practice & Research Clinical Obstetrics & Gynecology. Vol 20:3, P 323-338, June 2006. [http://www.bestpracticeobgyn.com/article/51521-6934\(05\)0901707/abstract](http://www.bestpracticeobgyn.com/article/51521-6934(05)0901707/abstract)

22 Many countries, including nearby Turkey, have increased both access and quality of family planning services by allowing paramedical workers to work in family planning service provision.

Study findings across the seven countries also indicate that counseling – an essential component of quality family planning services that is key to achieving contraceptive security – is rarely, if ever provided. Providers lack the skills; have poor motivation or no time to counsel women. Comments of physicians in Azerbaijan reveal the scope of the challenge in regards to counseling. Physicians who had developed their counseling skills and incorporated counseling into their practices during a recent USAID project were no longer providing counseling in their practices. When asked why, their response was: *“Counseling is an international agency ‘deal’, not ours”*.

The below case illustrates what the consequences were for a woman in Azerbaijan who never received any information or counselling from any doctor about contraception:

**AZERBAIJAN:** Sada is 39 years old. She has been married for 17 years and has two daughters, 12 and 13 years old. For the last 12 years, she says, she has been pregnant two or three times per year. She does not remember how many abortions she has had, but knows it is certainly over twenty-five. Not once did a doctor suggest that she uses contraception. She had heard about condoms and spermicides from her friends though and tried them; her husband was opposed, so she stopped. Two years ago she became pregnant just two months after her last abortion. When she returned to the same doctor for yet another abortion, the doctor felt sorry for her, suggested she uses contraception, and inserted an IUD right after the abortion. Since then, Sada is happy. She had some bleeding for the first few months, but she did not worry as the gynecologist had explained the possible side effects to her. Sada is now comfortable and content with her family planning method.

## 5. RANGE OF MODERN METHODS OF CONTRACEPTION AVAILABLE

The availability of a broad range of methods has been shown to increase contraceptive use<sup>23</sup>. It ups the chances that people can choose, obtain, and use the contraceptive method that is right for them. Results of this study suggest that the limited range of contraceptives available on the market as well as supply chain issues causing frequent stock outs are factors in non-use of modern contraception in several countries of this study.

In Kazakhstan, a range of methods is often available in the private sector, but injections, spermicides and the contraceptive patch are hard to find, even in private pharmacies. A particular concern in Kazakhstan is that pharmaceutical companies control the types of contraceptives that are available on the market. And, even when a range of brands are available, clients often request the more expensive western brands thinking that they are of better quality.

To a certain extent these factors are also present in other countries according to both key informant and policy-level interviews. In many places, there is concern that the prescriptive behaviours of some service providers are unduly influenced by pharmaceutical companies through the provision of incentives. A Kazakhstan midwife aptly explained this phenomenon as follows: “doctors prescribe unimaginatively”, adding “*to be honest, prescription depends on who paid the doctors for advertising.*”

The commercial sustainability of the contraceptive market is a factor in contraceptive availability. While in many of the countries pharmacies are widespread, small pharmacies often do not stock many, or at times any, contraceptives. The situation is related to insufficient demand for contraception and the pharmacists’ unwillingness to invest money in contraceptive products. A key informant in Bulgaria explains: “*If there is no demand, then it makes no sense to ensure that contraceptives remain available. It is nonsense to invest BGN 200 if the turnover per day is BGN 50.*” With only limited capital available, it is logical for the pharmacist to stock what he knows he will be able to sell.

Note that key informants in Bulgaria strongly recommend that rather than increasing the range of methods available in the country, the focus be on increasing the number of service sites. They also recommend that rather than adding new contraceptives to the method mix – female condoms, etc. – that more kinds of a contraceptive method be added – IUDs that are appropriate for different profiles of women, for example.

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<sup>23</sup> John Ross et al., “Contraceptive Method Choice in Developing Countries,” *International Family Planning Perspectives* 28, no. 1 (2001): 32-40; and Tara M. Sullivan et al., “Skewed Contraceptive Method Mix: Why it Happens, Why it Matters,” *Journal of Biosocial Science* 38, no. 4 (2006): 501-521.

## 6. AFFORDABILITY OF MODERN CONTRACEPTION

In Kazakhstan, cost is a key factor in use/non-use of modern contraception according to study findings. Some contraceptives – IUD and injections for example – are expensive to purchase and require the additional expense of a doctor’s visit. And women usually don’t have the money to buy pills on a regular basis. Even among bank workers who have steady and relatively good salaries, cost of contraception – pills, injectables, IUD and spermicides were specifically mentioned – can be a problem. The cost issue was confirmed by a key informant midwife in Almaty: *“Our women pay attention first of all to cost. Even if a woman understands there are better methods available, she will choose the cheapest.”* She went on to say that while pills are expensive, the IUD is extremely expensive, *“beyond all imaginable limits.”*

Kazakhstan policy-makers and donors consider the affordability of contraception as a significant challenge to contraceptive security, explaining that the state pharmacy committee sets prices for the benefit of the private pharmaceutical sector rather than for the benefit of the client. In practice the private sector is fully free to dictate both the range of contraceptives that are on the market and their prices. There are no subsidies or insurance benefits for contraceptives. On the plus side, there is a national network of pharmacies –“Hippocrat” – that provides consumers the lowest prices in the country for all medical products. It is suggested that this model be explored for contraceptive distribution. An interview was also held with a pharmaceutical company using a different profit strategy that proposes profit by selling less expensive products through broader coverage to more clients. The company is in the process of registering in Kazakhstan and to introduce products manufactured in China. Provided the products adhere to international quality standards, this is a model that could be explored in other countries of the region also.

Cost is a factor in the other countries of the study also, but not the determining factor in use or non-use of modern contraception for the most according to study results. In no country is it the only factor. And in many places, even when it is a factor, it is not seen by either FG participants or most key informants as an obstacle that cannot be overcome. That said however, from the perspective of policy-makers and donors, contraceptives not covered by national insurance funds is one of the key factors determining lack of accessibility.

In both Bosnia and Herzegovina and Armenia, the cost issue came up fairly frequently in study discussions. A well-informed pharmacist in Bosnia and Herzegovina maintains that cost does have a major influence on access in most parts of Bosnia and Herzegovina, saying *“people know that prices for contraceptives are high, so they don’t bother to ask”*. He considers the cost of contraception as one of the reasons for withdrawal being so prevalent. An NGO representative drew attention to the cost of contraception being a particular factor for the young since they don’t work and usually don’t have enough cash to purchase pills every month.

In Armenia, cost of contraception has a strong influence on choice of method according to information gathered during focus groups. Many couples are unable to afford modern contraceptive methods, nor surgical and medical abortion.

“The minimum salary in Armenia is around 30,000 AMD [less than 100 USD]. For regular use of a condom, a man having a regular sexual life has to spend at least 3000 AMD a month.

The cost of an early abortion varies from 12,000 to 18,000 AMD.

There are many people in Armenia who have no job or income and are financially dependent on relatives living abroad. They attend public health facilities only in emergency cases.

I have no other comments.”

A MALE FOCUS GROUP PARTICIPANT, ARMENIA

The Armenian man (text box) speaks for many across the seven countries. While overall cost is not a major determining factor across society in the non-use of modern contraception, it is an obstacle for some – the poorest, the unemployed, the uninsured, the young with no access to cash, the housewives dependent on money from their husbands or mother-in-laws. The cost of unnecessary exams required by physicians in order to prescribe contraception puts contraception ever further out of reach for those most-at-risk in society.

In Armenia, withdrawal often seems to be the method of default with regards to cost also: people use it because they have no other choice. *“I don’t like withdrawal and prefer to use a condom, which is possible to get sometimes from the clinic for free. But they are not always available.”*<sup>24</sup> In particular, modern methods are not affordable for low-income couples, those in rural areas and sexually-active young people who depend financially on their parents or other relatives. Rural women must add on costs for travel to get contraceptives and related clinic visits. Many therefore prefer withdrawal and in the case of its failure, Misoprostol, which can be purchased from pharmacies without a prescription and is cheaper than either medical or surgical abortion. *“I take four tablets of Cytotec each time my period is late. One tablet costs me 300 AMD; this is much cheaper and easier than surgical abortion.”*<sup>25</sup>

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<sup>24</sup> Quote from a young Armenian urban married and unemployed woman (FGD 3)  
<sup>25</sup> Quote from a young Armenian urban married and unemployed woman (FGD 3)

## 7. SOCIAL NORMS AND EXPECTATIONS REGARDING SEX AND SEXUALITY AND GENDER POWER DYNAMICS

Confidentiality is one of the most important criteria for access as talking about sex, sexuality and contraception is still a taboo within certain groups and in certain places. Findings suggest that pockets of conservatism exist within each country of the study where it is not possible to talk openly about anything related to sex and sexuality and society dictates strict patterns of sexual and reproductive behaviour. These taboos keep women from getting the information they need to make sound contraceptive decisions and those who vary from the prescribed norms often face consequences. Many women therefore do not want to be seen visiting a facility known to provide sexual health and contraception services, nor do they want to be observed purchasing contraception in a pharmacy. For this reason, many small-town and rural residents prefer accessing facilities in nearby cities, or the next town over where they will not be recognized.

Within certain groups prescribed gender roles and tradition limit contraceptive use. For example, in Armenia a young bride must be a virgin and is expected to become pregnant soon after marriage. If she does not have a child within a reasonable time period, her husband could seek a divorce. In South Kazakhstan, a key informant estimated that eight out of ten women live according to traditional ways. This was very apparent in focus groups; the study team had a very hard time getting the women to say anything at all. For most of these women, their entire lives are controlled by the husband and his mother. In particular the mother-in-law has control over the young woman's reproductive life; the young woman would not be making the decision about contraception. In other places across the region, a husband may not want his wife to learn about reproduction and contraception in fear that it may "open her eyes" and affect her morals. And it is not uncommon that the use of contraception by a married woman would make the husband suspect that she is unfaithful.

Gender power dynamics were apparent in focus group discussions across countries. Often the criterion for a "good" contraceptive was that a method could be used without the knowledge of the husband. Cases of gender violence associated with contraception were also mentioned at times.

While some men want complete control over contraception, the opposite seems to be more often the case: men taking no interest whatsoever, leaving all the responsibility to the woman.

Religion has not been a factor in most countries as both of the two main established religions in the region – Orthodox Christianity and Islam – are not opposed to contraception. Evangelical Christianity however is growing in many countries in the region, and while the beliefs vary, many evangelicals are opposed to contraception. Religious opposition to contraception may increase.

**"Nothing will change even if we have a pharmacy in the village.**

**People then will be afraid that the pharmacist will tell everyone who bought condoms and who did not.**

**Whoever did will be scolded by the village since they will be labelled as promiscuous."**

**"No I cannot use contraception without asking my husband.**

**I do not want to get beaten afterwards."**

**TURKISH-ROMA RURAL WOMAN IN BULGARIA**

# Recommendations

On 6-7 June 2012, more than 25 high level government officials from 16 countries in Eastern Europe and Central Asia met in Brussels with representatives from the United Nations Population Fund, Eastern Europe and Central Asia (UNFPA EECA) and the International Planned Parenthood Federation European Network (IPPF EN) to discuss ways to overcome the barriers to access modern methods of contraception as identified through this study.

The meeting was organized by the IPPF European Network Regional Office as part of its 2012 work plan with the UNFPA EECA Regional Office.

The government officials present at the meeting endorsed the following specific recommendations to improve reproductive health commodity security in the region:

## **Reproductive Health Commodity Security**

is achieved when all individuals can obtain and use affordable, quality contraceptives and other reproductive health commodities of their choice whenever they need them.

### **1. Governments and policy makers should commit to:**

- Ensure the implementation of (or development of) a national sexual and reproductive health law and strategy with a strong component on family planning/contraception
  - With budgets allocated
  - Based on evidence
- Increase and allocate the necessary budget for family planning, based on a cost-benefit analysis
- Coordinate efforts of all stakeholders from different sectors (NGOs, private and public sector) with a clear division of roles and responsibilities

In order to effectively increase access to family planning and contraceptives, a national sexual and reproductive health law and strategy should address both the low demand and limited supply of modern contraceptives. Therefore, all of the below listed 7 key factors influencing contraceptive use and access should be addressed:

### **2. Perception of modern methods of contraception as harmful**

- Increase the awareness of the population addressing the myths and misinformation related to modern contraceptives
  - Using tailored and innovative strategies for vulnerable groups<sup>26</sup>
  - Using recent information based on evidence

### 3. Contraceptive security for young people

- Introduce policies that improve young people's demand and access to modern contraceptive methods (e.g. reduced age of consent<sup>27</sup>, lower cost of / free contraceptives, ensure confidentiality of services, introduction of alternative distribution channels for contraceptives)
- Ensure access of all young people to age-appropriate comprehensive sexuality education in and out of school
  - Based on internationally agreed sexuality education standards (e.g. World Health Organization - WHO)
  - Including monitoring and evaluation of its implementation
- Ensure that existing health services are youth-friendly and comprehensive
  - Meeting their sexual and reproductive health needs
  - E.g. by integrating existing youth-friendly services into the primary health care system
  - Introducing evidence-based standards for youth friendly services

### 4. Attitudes, knowledge, skills and range of service providers

- Endorse internationally agreed clinical protocols and guidelines (WHO) on family planning and reproductive health
- Expand the type of service providers eligible to provide family planning/contraceptive services
- Build the capacity of service providers (through pre- and post-graduate education, for instance through the use of modern technology such as distance learning modules)
- Monitor and evaluate the quality of contraceptive services (including counseling) provided by service providers
- Health system mechanisms should address the motivational issues of service providers
  - By certification and qualification based on regular monitoring and evaluation

### 5. Range of methods available

- Introduce the WHO eligibility criteria for contraceptives and international standards, including for voluntary sterilization nation-wide
- Strengthen supply-chain management<sup>28</sup> of reproductive health/family planning commodities
  - Logistical management information system
  - Monitoring and evaluation system
  - Collaboration/coordination with different actors (from public and private sector) led by the government
- Introduce simplified procedures and reduce related costs for registration and importation of a wide range of modern contraceptives

.....  
<sup>26</sup> Each country should have its specific list of vulnerable people

<sup>27</sup> Age is the most commonly used indicator for determining young people's capacity to exercise their rights and make autonomous decisions. This uniform approach is rigid and does not take into account the different rates at which young people develop and grow. A preferred model is where age limits are set, but young people have the right to demonstrate their competency before the set age (e.g. jurisdictions such as England, New Zealand and Sweden). For example, in New Zealand, the legal age for consent to medical treatment is 16, but young people under that age can consent to treatment if they demonstrate competency. Source: IPPF Keys to youth-friendly services: Understanding capacity to consent May 2012, 8p.

<sup>28</sup> «All actions related to planning and monitoring of implementation by all companies/ organizations, which are involved into production and distribution of commodities: producers, providers, distributors, etc. In short: the path from manufacturing of commodities till clients/ users

## 6. Affordability of contraception

- Include a broad range of modern contraceptive methods in the government essential drug list and insurance coverage, prioritizing vulnerable groups<sup>29</sup>
- Introduce sustainable financing mechanisms (such as the total market approach)
  - Government funding should prioritize the affordability of contraceptives for vulnerable populations

## 7. Social norms, expectations and gender power dynamics

- Develop and implement community development and women empowerment programmes (such as WHO IFC Programme) as part of broader strategies aimed to increase access to family planning
- Ensure that sexuality education programmes in and out of school are comprehensive and thus include education on gender, rights and sexuality.
- Increase the use of condoms as a family planning method through its promotion as dual protection (protection from unintended pregnancy and STIs)<sup>30</sup>
- Involve men and address the needs of men in family planning efforts

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<sup>29</sup> Each country should have its specific list of vulnerable people

<sup>30</sup> There is a stigma on condom use – as it is perceived mostly as an STI prevention method. Therefore, the condom as a family planning method needs to be promoted.







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համահայկան արտիստիցի



БЪЛГАРСКА  
АСОЦИАЦИЯ  
ПО СЕМЕЙНО  
ПЛАНИРАНЕ  
И СЕКСУАЛНО  
ЗДРАВЕ



KMPA  
Kazakhstan Association  
on Sexual & Reproductive  
Health



X. E. P. A.  
Kazakhstan Association on Sexual & Reproductive Health

SRH SERBIA

