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ADVANCING CONTRACEPTIVE CHOICE

Marleen Temmerman

Ensuring that family planning programmes are centred on rights is essential: the ability to plan for one's self, if and when, to have children is fundamental to the health of women and their families (1). However, unintended pregnancy, resulting from unmet need for contraception, continues to threaten the lives and well-being of women, girls and their families globally. The latest estimates are that 222 million women who are married or in union, have an unmet need for modern contraception and the need is greatest where the risks of maternal mortality are highest (2). In the least developed countries, 6 out of 10 individuals who do not want to get pregnant, or who want to delay the next pregnancy, are not using any modern method of contraception (2). Unmet need for contraception is highest among the most vulnerable elements in society: adolescents, the poor, those living in rural areas and urban slums, people living with HIV and internally displaced people.

The World Health Organization, Department of Reproductive Health and Research (WHO RHR), is collaborating with partners to accelerate access to high quality contraceptive information and services for all individuals. Multiple strategies and rapid scale up will be essential to reducing unmet need. Strengthening health system infrastructures to minimize stockouts and ensure a comprehensive method mix that enables choice, training providers in counseling and provision of long acting and permanent methods of contraception, ensuring that policy and programmes adequately support adolescents unique needs and research into new contraceptive methods are all needed.

At the same time, it remains critical that commitment to the rights based approach to family planning articulated in Cairo at the International Conference on Population and Development (ICPD) in 1994 is not compromised by the requirement to scale up rapidly. The 1994 ICPD articulated a clear vision about the relationships between population, development and individual well-being. The ICPD Programme of Action was remarkable in its recognition that reproductive health and rights, as well as women's empowerment and gender equality, are cornerstones of population and development programmes. The years since the ICPD have seen a large amount of conceptual work produced demanding and defining a rights-based approach to health services including family planning. The *"Every Woman, Every Child"* initiative based on the United Nation Secretary General's global strategy for maternal and child health and the subsequent creation of the Commission for Information and Accountability, further emphasized the importance of rights in improving health of women and children. Yet there is comparatively little practical guidance on how to implement rights based approaches from a programme design and management perspective.

Over the last year, the WHO RHR has been working to address this gap through development of a body of work to ensure accountability in reproductive health programmes. Accountability is central to ensuring that both human rights and health standards are respected, protected and fulfilled. Monitoring and evaluation can contribute to accountability by providing information on progress on the fulfillment of right to health obligations. However, despite an international commitment to public health policies and programmes that are based on human rights and rights principles, indicators for monitoring rights in health programmes have not been widely implemented. While human rights indicators have been used to monitor some specific issues related to health, and health indicators have been used to draw attention to some rights issues, a systematic, transparent system is needed for explicitly linking human rights and health concerns and then determining their combined impact on the effectiveness and outcomes of health policies and programmes (3).

An urgent need for indicators at the intersection of health and human rights exists. It is clear that to comprehensively monitor rights, a combination of policy, qualitative and quantitative indicators are needed. Furthermore, these indicators must have an explicit linkage to human rights standards that are grounded in international law. A WHO advisory group has developed a methodology for identifying and prioritizing existing health indicators for use in rights analyses and has extrapolated key human rights standards for monitoring. This information is forthcoming. Identification of areas where new indicators are needed, particularly to capture the experience of marginalized individuals, has been an essential component of this work. Over the next year, the WHO RHR will lead in developing new indicators to comprehensively monitor rights in reproductive health programmes.

Advancing the right to health is central to the WHO's mandate and choice with respect to contraception information and services is an integral component. Reproductive and sexual health information and services are essential to well-being and the attainment of individual rights. In collaboration with partners, the WHO is leading technical work to promote our collective accountability as a global community in fulfilling equitable access to information and services for all individuals.

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References

1. Dehlendorf C, Rodriques MI, Levy K et al. Disparities in family planning. *Am J Obstet Gynecol.* 2010; 202(3):214-20.
2. Singh JD, Darroch JE. *Adding it up: the costs and benefits of investing in family planning and newborn and maternal health. Estimates for 2012.* New York: Guttmacher Institute and UNFPA, 2012.
3. Gruskin S, Ferguson L. Using Indicators to determine the contribution of human rights to public health efforts. *Bull World Health Organ.* 2009;87(9):714-9.

FAMILY PLANNING PROGRAMMES: PAST, PRESENT AND FUTURE

It is now 50 years since modern contraception became available and the first national family planning (FP) programmes were launched. With half a century of experience behind us, what have we learned?

The most important lesson is that there is no longer any doubt that FP improves the lives of women and children; it improves the health of mothers by decreasing the numbers of high-risk pregnancies (too early in life, too close, too late in life) and the numbers of unsafe abortions; and it improves the health of children, as spacing births benefits the health of the newborn as well as that of his/her older sibling.

Additionally, with enough accumulated experience and evaluation, one can safely say that FP brings significant socio-economic benefits as well. The best evidence for this comes from the Matlab programme in Bangladesh. There, starting in 1977, a densely populated rural area of 173 000 population was divided into a control and an intervention area. The control area received regular FP services, while the intervention area received a wide choice of contraceptives, free services and supplies, home visits by FP workers, regular follow-up, multimedia communication, menstrual regulation services, outreach to husbands and religious and other leaders. Several decades later, this experience shows that in the intervention area, there was greater workforce participation of women, greater education of their children, greater asset accumulation and greater use of preventive health services (1).

The other lesson from the Matlab experience is that, to reap the benefits of FP, services need to be comprehensive and to meet the needs of their populations. Indeed, worldwide, over time one has witnessed a number of trends in the design of FP programmes, such as:

Target population: Whereas early on, programmes catered for married women after they had had their first child, it became clear that pregnancies to mothers who were too young for childbearing were risky, that in many countries social norms were changing with regard to marriage, and most importantly, that access to FP was acknowledged as a human right to be guaranteed to all individuals, regardless of age or status. Thus, increasingly, programmes diversified their approaches in order to serve nulliparous women and adolescents and focused their attention on previously neglected populations; these included populations who, too often, do not have access to health services such as the poor, migrants or refugees and also stigmatized groups such as HIV-positive women.

Services: In the mid-1970s, it was estimated that the world population had reached 4 billion and governments were alarmed to see that its rate of growth was increasing. In response, some of the large national programmes launched in the last decades of the 20th century had clear population goals. They set targets of contraceptive use aimed at decreasing population growth rather than improving women's health. This abuse of technology was exposed at the International Conference on Population and Development in 1994. In fact, history showed that coercion was very often counterproductive and that it was not needed. Where women have free access to family planning usage is high. However, if contraception is to be delivered for the benefit of women, it should be provided as one element of women's health. Sexually active women need access to sexual health counseling and care; to sexually transmitted infections (STI) services including those for HIV/AIDS and for cervical cancer screening; to pregnancy termination where it is legal and to post-abortion care; and those who have undergone female genital mutilation need counseling and care. In other words, contraception should not be a stand-alone service but it needs to be delivered within a holistic approach to women's health.

Contraceptive methods: Before the 1960s, contraceptive methods available included: diaphragms and condoms, traditional methods and early forms of intrauterine devices (IUDs). The 1960s saw the development of combined pills, injectables and copper IUDs, soon to be followed by implants and emergency contraceptive pills. Women's contraceptive needs vary according to their life stages, the society and religion they belong to, their social situation and other factors, so these developments allowed them to find methods that suited them better. Indeed, evidence shows that offering a choice of method leads to greater use of contraception (2).

In the late 1990s, new and improved methods were released on the market, namely: the combined patch and the combined vaginal ring, the levonorgestrel-releasing IUD, a new combined injectable and new generations of low-dose pills. For a variety of reasons, cost in most cases, many of these methods are not available in public sector FP programmes and remain out of reach of many women. Other needs of couples remain unmet, such as reversible methods for men. For example, other than condoms, multi-purpose technologies offering dual protection against pregnancy and STI/HIV, or pericoital methods, still represent a gap. Thus, there is still a great need for innovation for the development of diverse low-cost methods.

Settings: Early on, FP was dispensed in hospitals, dedicated clinics, or physicians' offices. Mobile clinics were set up to serve the more geographically dispersed rural populations. With time, programmes became aware of the need to develop a greater variety of delivery options to reach different segments of the population and accommodate their lifestyles. This has meant extending community-based distribution and provision at the doorstep, allowing pharmacies to provide contraceptives and making some methods available over-the-counter. It was also recognized that, too often, contraception was not made available to women coming to services for other reasons. To avoid missing these opportunities, an increasing number of countries are integrating FP with other services (i.e. antenatal care,

postpartum care, HIV/AIDS services and immunization).

Providers: Numerous studies in different settings have proven that midwives and nurse-midwives are equally competent, if not better than physicians, in providing counseling and services including IUD and implant insertions. However, many countries suffer from a severe shortage of such qualified health personnel. It is also the case that contraceptives have been extensively tested and are among the safest medications. Thus, increasingly, programmes are turning to community health workers to deliver contraception. Traditionally, they provided counseling, pills and condoms; it is now well accepted that, with training and supervision, they can safely administer injectables as well. The Ethiopian programme has even trained 15 000 rural community health extension workers (CHEWs) to insert implantable contraceptives, while leaving implant removal to services with higher-level personnel.

To ensure that FP practices rely on the best, most up-to-date evidence, at all levels of FP programmes, international guidelines were harmonized and developed for the various levels of service delivery and they are updated continuously (3, 4). Finally, evidence shows that there are still serious misconceptions and misinformation around contraception and that an important cadre of specialists needed by FP programmes are behaviour change and communication specialists, as well as, multi-media specialists so that different communication channels can be used to inform couples.

Management: Large national FP programmes of developing countries were set up with the assistance of multilateral and bilateral donors. While this was welcome, it created challenges in donor coordination and supply management. Over time, countries are putting in place: health information systems so that the management and distribution of commodities is demand-driven rather than supply-driven; quality control mechanisms to ensure that products are safe to use at their delivery point; and monitoring systems to ensure a continuous supply with minimal stockouts. Several countries are taking similar measures to regulate provision of FP by the private sector.

Financing: The world population has now exceeded 7 billion and the demand for contraception keeps expanding. Not only do more women manage to access FP programmes, but each year, new cohorts of young people join them with their own needs. Large national FP programmes were set up with a mix of public and private financial support and, in some cases, great dependence on international funding. Over time, international funds became diverted to other priorities and public sector programmes had to sharpen their policies and financing mechanisms. Some focus on serving the poorer segments of population through subsidized services, developing social marketing programmes for the less poor and leaving those who can afford it to be served by the private sector. Increasingly, countries reserve a line in their own budget for FP and seek creative ways to finance the needs of their population.

Governance: As mentioned above, FP programmes were set up at a time of great concern over excessive population growth. In many countries, the objective of population control dominated health goals to the extent that FP programmes were set up independently from the Ministry of Health and given ministerial status. The remarkable uptake of contraception that followed, on one hand, and the demand by women for attention to their own health, on the other, have led countries to modify their approach. The great majority signed the WHO's reproductive health strategy (5) which reaffirms family planning as a human right. To meet this commitment, countries need to put in place policies that fully support reproductive rights, which ensure fully informed consent and that respect the decisions of clients with respect to timing and use of contraception. They need to give greater attention to equity in access to information and care and to put in place accountability mechanisms.

In summary, FP programmes have evolved considerably since they were created. They can claim remarkable achievements and yet, in some countries, up to 40% of women of reproductive age, married or in union, still express an unmet need for family planning. Groups most underserved globally include adolescents, migrants, urban slum dwellers, refugees and women in the postpartum period. Clearly, FP programmes need to monitor the situation of the populations they serve regularly and continue to adapt to the needs of growing numbers of individuals and couples worldwide.

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References

1. Bongaarts J, Cleland J, Townsend JW et al. *Family planning programs for the 21st century. Rationale and design.* New York: The Population Council, 2011.
2. Jain AK. Fertility reduction and the quality of family planning services. *Studies in Family Planning* 1989; 20 (1):1-16.
3. *Planning: A Global Handbook for Providers (2011 update).* Baltimore and Geneva: CCP and WHO, 2011.
4. *A guide to family planning for community health workers and their clients.* Geneva: WHO, 2012.
5. *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets. Global strategy adopted by the 57th World Health Assembly.* Geneva: WHO, 2004.

DIFFERENCES IN USE OF FAMILY PLANNING IN THE EUROPEAN REGION

What can be done and what should be done to live healthier and better? This question is asked by many: parents when their children are born; adults, usually when they or those close to them are sick; and very often by public health experts at public health discussions and health systems meetings.

Background

In the WHO European Region health indicators, including those of sexual and reproductive health (SRH) and family planning (FP), have improved during the last decades. However, there are widespread health inequalities between countries and within societies. The economic crisis that started in 2007 has contributed to major challenges leading to increasing unemployment and the number of people living in poverty. The search for employment has meant that many individuals need to live and work outside their countries of origin, which has lead to increased migration and a mix of differing levels of health literacy and SRH values all over Europe.

These and many other factors influencing a healthy life are addressed in the new European health policy *"Health 2020: A European policy framework supporting action across government and society for health and well-being"* approved by all European Member States in 2012 (1). *"Improving health for all and reducing health inequalities"* is one of the strategic objectives of this policy and calls all countries to analyze, across the life course, the complex factors contributing to health and well-being, including SRH. The impact of health-related behaviours, such as tobacco and alcohol use, diet and physical activity, has recently been on the agenda of high-level meetings in the Region. Yet, even in 2013, the year when many countries and regions are evaluating achievement of the goals set by the International Conference on Population and Development in Cairo in 1994, FP is still on the "waiting list" as an agenda in the WHO European Region. While, several countries have prioritized access to information and quality FP services in the bilateral collaboration agreements with the WHO Regional Office for Europe, because FP is not among the direct causes of the loss of disability-adjusted life-years it remains thought of as less of a priority issue for the majority of countries in the Region. As a result, despite its direct link to improved SRH, including maternal and child health, FP data from many countries is lacking and data on contraceptive prevalence in most countries of the Region are not available (2).

Main data sources

What do we know about access to FP and contraceptive prevalence in the Region? The best data sources to answer this question come from the Demographic Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) that have been carried out in the Region in the 21st century and have included questions on FP and reproductive health. To date, of the 203 DHS carried out globally, 10 countries of the WHO European Region have been involved. In addition, in many of the eastern and central European countries where MICS have been performed, an increasing number of countries are also including data from the Roma communities (3, 4). While these surveys are our most reliable data source on contraception and FP, it is important to realize that questions related to SRH and FP vary from country to country and are often adapted to cultural traditions.

This article attempts to present the most recent available data on the subject. DHS data from the 1990's have not been included since it is felt that these data no longer reflect the current situation as much has changed over the last decade. Data from the 2006 MICS in Turkmenistan is restricted and thus, not available, and data from the Republic of Moldova, Ukraine (both MICS) and Kyrgyzstan and Tajikistan (both DHS) where surveys are ongoing are not yet available.

Gender

Information from more than 30 countries on 15-year-olds who used condoms or pills at their last intercourse has been well documented and analyzed (5). Data show large gender differences in rates of

Table 1. 15 year–olds who used a condom at last intercourse (5).

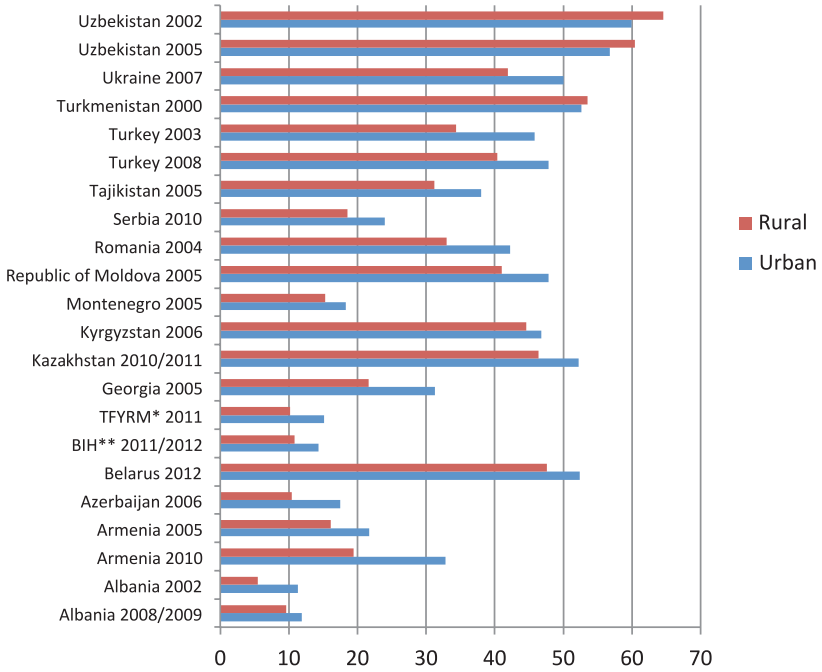
HBSC REGION	BOYS	GIRLS
Czech Republic	no data	no data
Denmark	no data	no data
Greenland	no data	no data
Russian Federation	no data	no data
Turkey	no data	no data
United States	no data	no data
Belgium (French)	no data	no data
Estonia	91%	89%
Luxembourg	90%	84%
Greece	87%	86%
France	90%	82%
Slovenia	85%	82%
Spain	81%	85%
Croatia	83%	81%
Switzerland	84%	80%
Portugal	80%	84%
Austria	86%	77%
Poland	78%	83%
Wales	83%	78%
Lithuania	77%	84%
Ukraine	82%	79%
Latvia	77%	84%
Germany	84%	75%
Italy	78%	78%
Hungary	79%	74%
Slovakia	77%	76%
TFYRM*	76%	-
Armenia	76%	-
Netherlands	75%	75%
Canada	75%	74%
Belgium (Flemish)	79%	69%
England	74%	73%
Ireland	70%	77%
Scotland	72%	70%
Romania	79%	61%
Finland	76%	63%
Norway	75%	63%
Iceland	71%	64%
Sweden	69%	58%

No data for Belgium (French), Czech Republic, Denmark, Greenland, Russian Federation, Turkey or United States.
Data not presented for girls in Armenia or TFYRM* as there were too few cases.

** The former Yugoslav Republic of Macedonia*

Gunta Lazdane

Table 2. Current use of any modern method of contraception by place of residence, percent of women age 15-49, country and year of study (3, 4).



*TFYRM = The former Yugoslav Republic of Macedonia ** BiH = Bosnia and Herzegovina

condom and pill use among adolescents (see Table 1). The prevalence of condom use was significantly higher among boys in one third of the survey countries, but in some countries (Ireland, Latvia, Lithuania, Poland, Portugal and Spain) girls report higher condom use. This difference may be related to access to information and condoms or having a partner from a different age group. Some countries, for example Germany, regularly carry out surveys on youth sexuality and can monitor the trends, as well as, factors influencing contraceptive use. In Germany, the difference between girls and boys who have not used contraception or have used "unsafe methods" during their recent sexual intercourse has decreased since 1980, when the first survey was carried out, from 14% of girls in 1980 to 3% in 2009 and from 19% to 4% of boys (6). These gender differences can also be seen in older age groups. Data from the 2007 DHS in Ukraine revealed that use of condoms at first sexual intercourse among men and women aged 15-49 was very similar (50.1% versus 45.4%) (3). This is in contrast to data from the 2008-2009 DHS in Albania which found that 19.3% of women aged 15-49 had used a condom at last sexual intercourse, compared to 49.7% of men (3).

Data on gender differences and FP remain difficult to capture, even from the DHS and MICS. For example, in some countries questions on FP are asked to both women and men aged 15-49, but in others FP questions are asked only to women. While DHS data from select countries (Albania 2008-9; Ukraine 2007; Azerbaijan 2006; Armenia 2005) do include information of having ever used contraception among women and men, men were asked only about use of male-oriented contraceptive methods, making it difficult to interpret or comment on male involvement in FP issues within relationships and to completely understand and/or analyze the gender role in FP (3).

The role of men in FP cannot be neglected, especially as there is strong evidence that male involvement increases uptake and use of FP. Fortunately, in the most recent DHS in Armenia (2010) there is a chapter on men's attitude toward FP. This chapter highlights the important role men have to play; 73% of men age 15-49 disagreed with the statement "Contraception is a woman's business" (3). Increasing male involvement was also found in the 2007 DHS from Ukraine where 93 percent of currently married women aged 15-49 reported that their husband knew about their use of contraception (3). Increasingly national reproductive health surveys (Ireland 2006; Latvia 2011; Germany 2011) are recognizing the importance of including both men and women in their surveys targeting SRH and FP and the inclusion of both sexes in the surveys reveal important similarities and differences among males and females when analyzed.

Place of residence

Analysis of the place of residence of current users of modern, effective methods of contraception is important for further development of the health systems approach to ensure access to information and modern contraceptives to those in need. In most countries where Reproductive Health Surveys (RHS), DHS and MICS have been carried out recently the difference of use of modern contraception in rural and urban settings is small with some exceptions (see Table 2). In fact, analysis of the trends in FP use in countries where surveys have been carried out more than once over the past 10-15 years illustrates where FP programs have targeted activities at the country level to attempt to decrease inequities that may have been present between rural and urban populations. For example, in Albania the percentage of modern contraceptive users remains small, but has increased in rural areas from 5.5% to 9.6% from 2002 to 2008-9, compared to urban settings which demonstrated only marginal changes – 11.3% versus 11.9- during the same time period (3).

Interestingly, in Turkmenistan and Uzbekistan modern contraception use is higher in rural than in urban regions. The same is also true of Uzbekistan where data from 2005 showed the unmet need

DIFFERENCES IN USE OF FAMILY PLANNING IN THE EUROPEAN REGION *(CONTINUED)*

Table 3. Current use of any modern method of contraception by education, percent of women age 15-49, country and year of study (3, 4).

Country/year of survey	Primary or less	Higher
Albania 2008/2009	8.6	17.5
Albania 2002	5.8	17.2
Armenia 2010	21.4	39.1
Armenia 2005	11.1	28.9
Azerbaijan 2006	12.7	24.5
Belarus 2012	46.3	55.2
BIH* 2011/2012	6	25.3
TFYRM** 2011	7.9	21.2
Georgia 2005	18.2	34.1
Kazakhstan 2010/2011	44.7	51.5
Kyrgyzstan 2006	40	48.1
Montenegro 2005	10.9	20.4
Republic of Moldova 2005	38.3	50.9
Romania 2004	21	54.5
Serbia 2010	10.2	32.9
Tajikistan 2005	15.8	46.3
Turkey 2008	35.3	55.3
Turkey 2003	29.9	52.2
Turkmenistan 2000	52.6	53.1
Ukraine 2007	43.2	50.3
Uzbekistan 2005	54.8	57.1
Uzbekistan 2002	58.7	61.5

Table 4. Current use of any modern method of contraception by wealth quintile, percent of women age 15-49, country and year of study (3, 4).

Country/year of survey	Lowest	Highest
Albania 2008/2009	10.5	14.2
Albania 2002	6.2	17.8
Armenia 2010	21.4	37.7
Armenia 2005	12.4	28.6
Azerbaijan 2006	11.1	20.9
Belarus 2012	43.8	56.5
BIH* 2011/2012	7	12
TFYRM** 2011	7.5	18.5
Georgia 2005	10.5	31.1
Kazakhstan 2010/2011	44.6	55
Kyrgyzstan 2006	47.3	48.5
Montenegro 2005	7.5	22.8
Republic of Moldova 2005	36.6	51.3
Romania 2004	22.8	48.5
Serbia 2010	10.5	31.1
Tajikistan 2005	25.9	39
Turkey 2008	38	54.3
Ukraine 2007	36	52.7
Uzbekistan 2005	60.9	56
Uzbekistan 2002	60.7	62

** BiH = Bosnia and Herzegovina*
*** TFYRM = The former Yugoslav Republic of Macedonia*

for contraception was higher in the urban population (3).

Education

The link between education and contraceptive use has also been well documented, with populations who have lower levels of education often having a lower propensity to use contraception.

Table 3 presents the difference in current use of modern contraception by educational status across the different countries in the Region. Significant variation is present. The largest difference is seen in Tajikistan where only 13.9% of women with primary or less education currently use modern contraception compared to 50.7% of women with higher education - a difference of 35% (3). The smallest difference is seen in Turkmenistan where 52.6% of women with primary or lower education use modern contraception, compared to 53.1% of women with higher education – a gap of less than 1% (3).

Wealth

In both the DHS and MICS one can find information on use of contraception in different groups by wealth quintile. Data summarized in Table 4 present the relationship between finances and FP in different countries of the Region. Household income greatly impacts the use of modern contraception in Armenia, Georgia, Republic of Moldova, Montenegro, Romania, Serbia, Turkey and Ukraine, where the difference between the lowest and highest wealth quintile for use of contraception is 15% and greater (3, 4). In some countries (Albania, Bosnia and Herzegovina and Kyrgyzstan) the difference is very low (3, 4). The relationship between wealth and FP is complex and requires more detailed study as the access to contraceptives in the European Region differs country from country – from free of charge contraception to a client provided by aid development partners (mainly UNFPA), too reimbursement of contraception by insurance, to free of charge for special population groups (young people, postpartum women, low-socio-economic status), all factors that influence the contraceptive prevalence and method mix.

Ethnic minority

FP is linked with cultural traditions and norms. Given the diversity of cultures that exist in Europe it is not surprising that variation in use of contraception would also be seen among different ethnicities in the Region.

The Federal Centre for Health Education (BZgA) in Cologne, Germany carried out a study "*Women's Lives – Family Planning and Migration Throughout Life*" that compared the current contraceptive practice of German, Turkish, eastern and south-eastern European women living in Germany. The study clearly demonstrated that ethnic background influences the choice of contraceptive method. For example pills were more often used by German women, the intrauterine device

Table 5. Percent of Roma women age 15-49 who are using any modern method of contraception, country and year of study (4).

Country/ year of survey	Rural	Urban	Primary education and lower	Higher education	Lowest wealth quintile	Highest wealth quintile
Bosnia and Herzegovina 2011/2012	NA	NA	4.9	18.2	5.9	7.5
Serbia 2011	6.5	4.5	3.8	10.7	4.8	9.5

(IUD) by women from eastern and south-eastern Europe and Turkish women more often used surgical contraception (7).

According to the 2011 MICS in The former Yugoslav Republic of Macedonia, the percentage of women aged 15-49 years who use a modern contraceptive method differs depending on the ethnicity of household head: 14.9% if the household head is Macedonian, 9.7% if Albanian and 8.8% if another nationality (4). In Montenegro, the difference between modern contraceptive use according to the ethnicity of the household head is also present, with the biggest difference being among Bosnian\Muslim (19.3%) and Albanian (14.6%) women (4).

The Roma population represents one of the most marginalized ethnic minorities in Europe, but comparable data on their SRH and FP needs has been lacking. The MICS in Bosnia and Herzegovina (2011/12) and in Serbia (2011) specifically included a section for the Roma, which is providing useful information about FP and this population. For example, in Bosnia and Herzegovina the language spoken in the household influences the use of modern contraception (5.1% Romanian language vs. 12.2% other languages) (4). When looking at other social determinants of health and their relationship with contraceptive use among Roma women, similar trends to those of non Roma women are seen, with lower use among those who are less educated and less wealthy (see Table 5) (4). In Serbia, while patterns of use may follow similar trends, access to FP differs, with a greater percentage of Roma women reporting unmet need for FP compared to non Roma women (10% versus 7%) (4).

Conclusions

More and more policy makers are focusing on strengthening high-quality people-centred health systems and tackling persisting health system barriers that continue to limit health promotion and availability of high quality services. Members States of the WHO European Region are starting this process by developing a "*Framework for Action towards People-Centred Coordinated/Integrated Health Services Delivery*" (8). The WHO Regional Office for Europe and other partners are supporting countries with policy options and specific recommendations for change, through an action-oriented approach to target areas for strengthening the coordination/integration of care. It is important to ensure that the Framework for Action includes FP, an important area of public health with impact on the health and well-being not only of the woman or couple, but also the health of the future generations.

In order to help shape the strategies and actions and track progress, it is essential that data on FP is available and comparable throughout the Region. Standardized questionnaires and indicators should be used when any survey on SRH and FP is taking place. These surveys should also involve both sexes, with questions targeted to men as well.

Furthermore, the role of social determinants of health such as place of residence, education, wealth and ethnic background differs from country to country and needs to be studied and monitored to ensure that developed SRH strategies, action plans and activities are targeting those most in need.

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References

1. *Health 2010. A European policy framework supporting action across government and society for health and well-being.* Copenhagen: WHO Regional Office for Europe, 2013.
2. *Social determinants of sexual and reproductive health. Informing future research and programme implementation.* Geneva: WHO, 2010.
3. Measure DHS [website]. (http://measuredhs.com/What-We-Do/Survey-Search.cfm, accessed 20 October 2013)
4. Monitoring the Situation of Children and Women [website]. UNICEF (http://www.childinfo.org/mics4_surveys.html , accessed 20 October 2013)
5. Currie C, Zanotti C, Morgan A et al., editors. *Social determinants of health and well-being among young people. Health behaviour in school-aged children (HBSC) study: International report from the 2009/2010 survey.* Copenhagen: WHO Regional Office for Europe; 2012
6. *Youth Sexuality. Repeat survey of 14 to 17-year-olds and their parents – current focus: migration – 2010.* Bundeszentrale für gesundheitliche Aufklärung; 2010 (http://publikationen.sexualaufklaerung.de/index.php?docid=2132 , accessed 19 October 2013).
7. *Women's lives - Family Planning and Migration Throughout Life. Interim results of a town-based study involving women with a Turkish, eastern European or south eastern European migration background.* Cologne: BzgA, 2008-2009.
8. *Roadmap. Strengthening people-centred health systems in the WHO European Region.* Copenhagen: WHO Regional Office for Europe, 2013.

EMERGENCY CONTRACEPTION IN EUROPE: EQUAL ACCESS FOR ALL?

Do all women in Europe have the same access to emergency contraception (EC)? If all national reproductive health policies are evidence-based, the response should be yes. Women in Germany or Hungary, for instance, would need to take the same steps as women in Scotland or Norway to obtain EC.

Reality, however, is a bit more complex. The truth is that, when in need of EC, Norwegian women are able to stop at the closest gas station or supermarket and buy EC pills. Scottish women just need to ask for EC pills at their local pharmacies and can get them for free. Both will be able to obtain EC pills fast and, thus, increase their chances of preventing pregnancy after an episode of unprotected intercourse. Women in Germany and Hungary, on the other hand, need to see a doctor, explain that they didn't use contraception, that the condom slipped, or that they missed a pill, and ask for a prescription for EC. Perhaps the pharmacists will have to give them a brief talk about being more responsible when they submit the prescription but will fail to remind them that EC pills will not protect them from pregnancy if they have further unprotected intercourse in the same cycle.

So the answer is no. It seems that, despite the fact that EC pills have been available in many European countries for more than 15 years, women across Europe do not have equal access to EC and, thus, to a second chance for preventing pregnancy.

Data on EC in Europe is scarce and, for the data that does exist, it is not clear where EC falls in the broader array of available contraception methods or how it fits into women's trajectories.

In order to assess different regulations, reimbursement policies and service delivery modalities for EC, the European Consortium for Emergency Contraception (ECEC) conducted a survey of key experts in 2012 and 2013 from 25 countries. While the ECEC plans to gather data from all of the 53 countries comprised in the WHO definition of the European Region, so far, data has been collected and validated on access policies and prescription statuses, cost and reimbursement policies, guidelines and common practices and use from the following countries: Albania, Austria, Belgium, Bulgaria, Denmark, Estonia, Finland, France, Germany, Hungary, Italy, Latvia, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, and the United Kingdom (1). The findings from the surveys are presented below.

What we know about EC access in Europe

Levonorgestrel-only emergency contraceptive pills (LNG ECPs), the most widely available EC method in the region, can be purchased directly at pharmacies in 19 countries (see Figure 1). In eight of these countries (Bulgaria, Denmark, Estonia, the Netherlands, Norway, Portugal, Romania, Slovakia and Sweden) the product is available over the counter, which means that no interaction is needed with the pharmacy staff to obtain EC. Despite the fact that LNG ECPs meet all the criteria for over the counter access (they have no potential for overdose or addiction, have very low toxicity, are of uniform dosage, have no major drug interactions or contraindications, pose no danger to an existing pregnancy and can correctly be self-administered) current regulations in Albania, Germany, Italy, Hungary and Poland still maintain that the user needs to first obtain a prescription from a health provider in order to buy LNG ECPs. This is also the case in Finland for women who are 15 years old or younger. In the Maltese islands, ECPs are not available and women need to resort to higher doses of regular oral contraceptive pills (termed the Yuzpe regime) if they need EC.

National reimbursement policies to reduce the out-of-pocket costs of LNG ECPs are only in place in Belgium, Finland, France, Germany, the Netherlands and the United Kingdom. However, LNG ECPs are provided free of charge to young people in at least family planning centres and youth clinics in Finland, France, Germany, Norway, Portugal, Spain, Sweden, Switzerland and the United Kingdom. Since 2008 LNG ECPs are also provided free of charge in all pharmacies in Scotland and Wales. In Finland, France, Norway and some parts of the United Kingdom, EC can be procured in schools. In France, Norway and the United Kingdom, systems to access LNG ECPs via the Internet have recently been developed and only in Norway and the Netherlands can LNG ECPs be obtained through mass

Figure 1. Legal status of LNG ECPs. Developed by Aline Bohet for the ECEC.

Cristina Puig

Jamie Bass

Text Box 1. Emergency contraception

Emergency contraception (EC), also known as *postcoital contraception or the morning after pill*, refers to contraceptive methods that women can use to prevent pregnancy after unprotected or inadequately protected sexual intercourse. Access to EC is essential for ensuring women's reproductive health.

Currently, there are three main types of EC methods available in Europe: Levonorgestrel-only EC pills (LNG ECPs), EC pills containing ulipristal acetate (UPA ECPs) and copper intrauterine devices (IUDs) inserted up to five days after intercourse.

EC can reduce the risk of pregnancy following an act of unprotected or inadequately protected intercourse by between 75% and 99%, depending on the method used. Insertion of a copper IUD is the most effective EC method, followed by UPA ECPs. LNG only EC pills reduce the risk of pregnancy by at least half and possibly by as much as 80% to 90% following an act of unprotected or inadequately protected intercourse (3).

Text Box 2. The European Consortium for Emergency Contraception

The European Consortium for Emergency Contraception (ECEC), established in 2012, is a network of organizations and individuals working in the field of EC research, service provision and advocacy within a broader sexual and reproductive health and rights approach. Our mission is to **expand knowledge about and access to EC in European countries** and to **promote the standardization of EC service delivery** in the European context.

Visit www.ec-ec.org for more information.

distribution channels like retailers and gas stations.

For now, a prescription is required to buy ulipristal acetate (UPA) ECPs in all countries where it is available (UPA is still not available at all in Albania, Estonia, Malta, Switzerland and Turkey). In Italy, health providers and required health authorities are increasingly confident about UPA's safety as long-term surveillance data is amassed. This is just another example of disparities in EC access policies, which may be partially explained by the fact that only eight countries have clinical guidelines exclusively devoted to EC (Denmark, Finland, France, Poland, Portugal, Spain, Sweden and the United Kingdom).

Can this picture get any more diverse? Apparently so. The availability of data on EC use and women's knowledge of EC also varies greatly by country. Aside from France and the United Kingdom, very few countries have conducted studies in the past decade to assess actual use. The countries that have recently conducted studies include: Spain, where in 2012 14.7% of women of reproductive age reported to have ever used EC; Germany, where in 2011 13% of women reported to have ever used EC; and Estonia, where in 2007 21% of women reported to have ever used EC. At the regional level, a recent study examining 7170 women's knowledge and use of EC in France, Germany, Italy, Spain and the United Kingdom found that the mean age of users was 28 years old and that 88% of women who used EC took it within the first 24 hours (2). This study also found that only 27% received information on EC from their health provider and while viewing the use of EC to be a responsible act, women still felt stigmatized and judged when seeking EC treatment (2). The vast majority of women wanted more information on EC.

Could guidelines help reduce inequalities?

The great diversity in service delivery modalities paints to a landscape of unequal access to EC options for European women. The gap is likely to increase with the presence of the new generation of EC pills, namely ulipristal acetate, becoming more available in many markets.

With the aim of promoting the harmonization of EC services in Europe, the ECEC is developing a guide that addresses key issues that should be included in any EC clinical guideline. We hope that such a tool will facilitate the task of developing or updating national EC guidelines based on the most updated research available.

When choices expand so should information to women

EC choices are expanding in Europe, as well as in other parts of the world. The promotion of the use of the copper IUD for EC and the introduction in 2010 of a new EC pill containing ulipristal acetate are generating new and passionate debates about best pathways for treatment and most cost-effective choices at the population level. While these discussions take place we should not forget that every woman seeking EC needs to be informed of the different methods available to her, their efficacy, adverse effects, interactions and eligibility requirements so she can truly exercise choice. Developing coherent national policies on sexual and reproductive health and rights, including access to EC, across Europe, would help ensure that women receive the information they need to make informed decisions and that no additional misunderstandings are created around this important contraceptive method.

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References

1. Data on which this article is based is available at http://www.ec-ec.org/emergency-contraception-in-europe/country-by-country-information-2/, retrieved on Oct 10th 2013.
2. Nappi Rosella (IT). *What do women know about pregnancy risk and emergency contraception? A European survey amongst 7170 women.* 10th Congress of the European Society of Gynecology, Friday September 20th.
3. *Medical and Service Delivery Guidelines*, 2012. Retrieved Oct 8 2013 from http://www.cecinfo.org/custom-content/uploads/2013/06/Medical-and-Service-Delivery-Guildelines-English-June-20131.pdf

IDENTIFYING AND OVERCOMING BARRIERS THAT ADOLESCENTS IN LOW AND MIDDLE INCOME COUNTRIES FACE IN OBTAINING AND USING CONTRACEPTION

Barriers

Adolescents – especially unmarried ones - in low and middle income countries (LMIC), face barriers in obtaining and using contraception (1). While adolescents experience many of the same barriers that adults do when it comes to obtaining contraceptives, some are specific to them.

In many poor communities of LMIC, contraceptive methods are not available to adults or to adolescents. Even when they are available, laws and policies exclude their provision to unmarried adolescents or to those under a certain age. Other access barriers include cost, health facilities that are difficult to reach and health workers who do not provide contraceptives even though there are no legal or medical restrictions to do so. Health workers in many places refuse to provide unmarried adolescents with contraceptive information and services because they do not approve of premarital sexual activity. Even when they do so, they limit the contraceptive methods they provide (to condoms only) wrongly believing that long acting hormonal methods and intrauterine devices are inappropriate for nulliparous women.

Even when contraception is available and obtainable for adolescents, they may not use it for a variety of reasons. In many places young married women are under pressure to conceive and bear children. Contraception is considered only after a first child is born. Also, the stigma surrounding contraception prevents use by adolescents who are not in stable relationships. Proposing the use of a condom or carrying one can lead to a woman being considered 'loose' in many places. Finally, even when adolescents are able to get modern contraceptive methods and to use them, they may not want to do so. Adolescents in many places have misconceptions about the immediate and long-term side effects of contraceptive methods on their health and their future ability to bear children. Due to the resulting fears and concerns they consider ineffective methods, such as withdrawal and traditional remedies, more acceptable. Furthermore, because of a poor understanding of how contraceptives methods work and how they should be used, they use them incorrectly.

Improving access and use

In 2011, the WHO issued guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries (2). These guidelines were based on reviews of published systematic reviews and of individual studies and the collective judgment of an expert panel. Increasing access to and use of contraception was one of the four outcomes to prevent early pregnancy. The studies that met the inclusion criteria for this outcome were conducted in a number of LMIC. Some focused exclusively on condom use, while others looked at hormonal contraceptives and emergency contraception (EC). Some examined the use of contraception as a primary outcome while others examined it as secondary to outcomes such as HIV prevention or changing knowledge and attitudes. Some focused on health system actions (such as over-the-counter or clinic provision of contraception) while others focused on actions directed at community leaders and members. Collectively, they demonstrated increases in contraceptive use (including condoms, hormonal contraceptives and EC) as a result of actions directed at multiple levels – laws and policies; individuals, families and communities; and health systems. The interventions discussed below are drawn from the WHO's guidelines.

MAKING LAWS AND POLICIES SUPPORTIVE: In many countries, laws and policies restrict the provision of contraception to unmarried adolescents or those below a certain age. Policy makers must intervene to reform these laws and policies to ensure that adolescents are able to obtain contraception information, counseling and services. Policy makers should also consider providing adolescents contraception at no or reduced cost (2).

MAKING SOCIAL AND GROUP NORMS SUPPORTIVE: In many societies premarital sexual activity is not considered acceptable and there is considerable resistance to the provision of contraceptive information and services to unmarried adolescents. To overcome this barrier, it is important to improve the understanding of influential community leaders and of the community at large on adolescents' needs for information and contraception, including the risks to their wellbeing of not responding to these needs (2).

In many places, social and group norms hinder discussion between couples about contraception. In addition, knowledge gaps and misconceptions prevent use or proper use of contraceptive methods. Mass media (radio and television programmes), peer-education and inter-personal communication and information education communication materials (such as posters and leaflets) have been used successfully to communicate health information to adolescents and to influence their norms. In recent years, the ways adolescents communicate have changed radically. Mobile phone technology, the Internet and social media are increasingly being used, even in LMIC. These technologies are potentially valuable for communicating contraceptive information and options to adolescents conveniently and confidentially (3).

IMPROVING KNOWLEDGE AND UNDERSTANDING: The evidence of the benefits of curriculum-based comprehensive sexuality education is strong. The most successful sexuality education programmes provide accurate and age-appropriate information and in addition, develop life skills and provide support to deal with thoughts, feelings and experiences that accompany sexual maturity (e.g. falling in love, refusing unwanted sex proposed by a friend firmly but without creating hostility). They are also linked to contraceptive provision and services (4).

Although policies requiring sexuality education for adolescents are in place in many countries, they are poorly imple-

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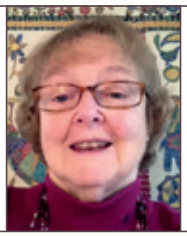

Nancy E. Williamson

Text Box 1. Components of adolescent friendly health services

To be considered adolescent-friendly, health services should be accessible, acceptable, equitable, appropriate and effective, as outlined below:

- Accessible: Adolescents ***are able to*** obtain the health services that are available.
- Acceptable: Adolescents ***are willing to*** obtain the health services that are available.
- Equitable: ***All adolescents, not just some groups of adolescents***, are able to obtain the health services that are available.
- Appropriate: ***The right health services (i.e. the ones they need)*** are provided to them.
- Effective: The ***right health services are provided in the right way*** and make a positive contribution to their health.

mented, if at all. Health and education policy makers and managers must ensure that curriculum-based sexuality education is widely and effectively implemented. Complementary efforts are needed to reach the many adolescents who are not in school.

IMPROVING ACCESS TO CONTRACEPTION: Adolescents in many places are unwilling to visit facilities providing contraception because they view them as unfriendly. There is growing evidence of the value of making health services adolescent friendly (see text box 1) (5).

To improve access to contraception, health facilities must be made easy to get to and welcoming, they must have unbroken stocks of a range of contraceptive methods and adolescents must be supported to choose the ones that meet their needs and preferences by empathetic and competent health workers.

Contraceptive education, counseling and provision could be integrated into other health services used by adolescents – including sexually transmitted infection management, HIV counseling and testing, comprehensive abortion care services and postpartum care. For many adolescents, contact with these services may be their first opportunity to have a face-to-face discussion about contraception with a competent person. Integration into postpartum services offers the opportunity to reach first-time mothers with information on birth spacing so they can delay a second pregnancy.

In making health services adolescent friendly, it is important to build on what already exists - modifying general health facilities and building the competencies and attitudes of existing health-service providers, rather than setting up new facilities and assigning some health-service providers exclusively for adolescents. Having said this, dedicated health facilities could be useful to reach marginalized groups of adolescents (such as sex workers) who may be reluctant to use a service-delivery point open to all.

Even if health facilities are adolescent-friendly, they are unlikely to attract all adolescents. Therefore, contraception should be provided through a variety of outlets. Outreach to adolescents in venues where they socialize can improve their access to contraceptive information and services – on the spot or through referral. Making pharmacies and shops adolescent friendly could greatly expand ready access to over-the-counter contraceptive methods. Some countries have begun to task-shift contraceptive services to community-level providers in response to shortages of qualified medical personnel (6). Adolescents could benefit from these efforts if confidentiality can be assured.

Summary

In summary, there is fairly good evidence, from research studies and small-scale and time limited projects, on effective ways of increasing access and use of contraception by adolescents. They include favourable laws and policies; multifaceted communication programmes directed at community leaders and members and at adolescents - that inform, educate and create supportive norms for the provision and use of contraception; accurate and age-appropriate curriculum based sexuality education; and the provision of a wide range of contraceptive methods through different adolescent-friendly outlets. The real challenge is to build on these small-scale and time-limited initiatives to build large scale and sustained programmes.

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References

1. Bankole A, Malarcher S. Removing barriers to adolescents' access to contraceptive information and services. *Stud Family Plann.* 2010. 41, 2, 117-124.
2. *WHO Guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries.* Geneva: WHO, 2011.
3. Guse K, Levine D, Martins S et al. Interventions using new digital media to improve adolescent sexual health: A systematic review. *J Adolescent Health*. 2012. 51 (6): 535-43.
4. Kirby DB, Laris BA, Rolleri LA. Sex and HIV education programs: their impact on sexual behaviors of young people throughout the world. *J Adolescent Health* 2007; 40(3): 206-17.
5. Quality Assessment Guidebook. *A guide to assessing health services for adolescent clients.* Geneva: WHO, 2009.
6. Janowitz B, Stanback J, Boyer B. Task sharing in family planning. *Stud Family Plann* 2012;41(1):57-62.

IMPACT OF THE MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE (MEC) WHEEL ON THE QUALITY OF FAMILY PLANNING: EXPERIENCES FROM SELECT COUNTRIES

The MEC wheel is based on the *Medical Eligibility Criteria for Contraceptive Use* (MEC), 3rd edition and its 2008 Update, one of WHO's evidence-based guidelines. This wheel contains the medical eligibility criteria for starting use of six common types of contraceptive methods and provides family planning providers with easily accessible information on what various contraceptive methods can be used safely and effectively by women presenting with known medical or physical conditions.

In this article four countries from the WHO European Region share their experience with the wheel and its impact on the quality of family planning (FP) in their country.

Uzbekistan

Since the introduction of health care system reforms in 1998, the issue of sexual and reproductive health (SRH) has become a key focus of national plans and actions. With a population of approximately 29.5 million, of which 50% is under the age of 25, SRH services are a major priority for health.

Different health conditions, common among women of fertile age in Uzbekistan, create serious barriers for health care providers in expanding the use of different modern contraceptives due to lack of access to information sources on evidence-based counseling. In spite of an increasing contraceptive prevalence rate (64.88%) in the country, 80% of modern contraceptive users still prefer intrauterine devices and there is still low demand and use of hormonal methods and injectable contraceptives. The situation can be partly explained by a lack of knowledge and skills of the health care providers, as well as, their limited access to the WHO sources published in the local language.

The UNFPA has played a key role in helping to address this issue. Being a main supplier of reproductive health commodities, in particular of modern contraceptives, the UNFPA, promotes an evidence based SRH programme nationwide and also supports training on integrated SRH services where FP, logistics and

Example of MEC wheel in local language from Uzbekistan

management and information systems for contraceptives are key aspects focused on for quality improvement. In collaboration with the WHO, a series of evidence based guidelines and quality improvement tools for FP were also introduced and implemented. More than 5000 health care providers improved their capacities in counseling, client oriented approaches to SRH and FP since the first guidelines on *"Medical Eligibility Criteria for Contraceptives Use"* and the *"Selected practice recommendations for contraceptive use"* were published by the WHO in 1996.

The UNFPA has also played a key role in the adaptation and provision of technical assistance in producing these guidelines in the local language, which was recognized by the Ministry of Health and a wide audience of health care professionals. Since the MEC Wheel was published by the WHO and the Russian version became available in Uzbekistan, a tangible increase in the demand for this tool was observed. However, the UNFPA monitoring missions to regions where the UNFPA-supported training for general practitioners and nurses took place showed that the rural health care providers made limited use of the Russian version due to language barriers. Thus, in 2013 the adaptation of the MEC Wheel into the Uzbek language was agreed upon and included in the UNFPA's annual work plan. The Uzbek version was prepared in close consultation with local experts and health care providers. The publication process fully conformed to the WHO copyright requirements and permission of the WHO's Department of Reproductive Health and Research was granted.

Seven thousand (7000) copies of the Uzbek version of the MEC Wheel were published and distributed during training for general practitioners and nurses in 2013. The training programme included the learning session on "how" and "who" can use the wheel. The Uzbek version is designed in the same format and instructions as explained in the 3rd edition by the WHO (2004 and 2008). Six methods of contraception and 19 health conditions can be considered when clients decide to begin using a method. Feedback received from health care providers shows that the tool helped them to increase the **quality of counseling** and to find answers to frequently raised questions by clients during follow-up visits. Furthermore, following the introduction of the MEC wheel into the local language **an increase in the proportion of hormonal method users and an increase in the number of clients preferring effective and safe methods** were documented in health records at rural practices.

Access to an Uzbek language source of the information and the possibility of using it in daily practice contributed substantially to increasing mid-level health care personnel's confidence in conducting FP counseling, which is crucial as such personnel still play a key role in the provision of FP services in the rural area.

Romania

Romanian editions of all the WHO evidence-based guidance documents, including the MEC wheel, were published and disseminated by the East European Institute for Reproductive Health (EEIRH). These evidence-based tools provided guidance to the National Family Planning Programme in the preparation of guidelines for service delivery of contraception and have been used by policy-makers, FP programme managers and the scientific community.

The Romanian Family Planning Programme has developed and implemented national policies and tools that incorporate WHO recommendations on current best practice. The WHO cornerstones were included in the Technical Norms of the National Family Planning Programme and embedded in the programme activities at three levels: training of the FP providers, provision of free-of-charge contraceptives and information, education and counseling and behaviour communication and change (IEC/BCC).

Curricula that included the WHO cornerstone information and MEC wheel were developed and accredited for Training of Trainers, basic FP training for primary health care providers (family physicians and nurses), FP specialists and post-abortion contraception. IEC/BCC activities featured key messages from the WHO cornerstones through posters, brochures, flyers and media was also targeted through a specific campaign including MEC and Standard Practice Recommendations presentation and distribution to media professionals.

The impact of the WHO cornerstones was documented by EEIRH through a survey which identified perceptions of physicians who received the WHO documents about: content and usefulness, impact on quality of services offered, dissemination process and suggestions that would improve further dissemination activities.

These activities have been made possible through a model partnership between the UN agencies (WHO, UNFPA, UNICEF), USAID/JSI and the Romanian Government and civil society.

Ukraine

The Together for Health (TfH) project (2005 – 2011), funded by the U.S. Agency for International Development (USAID) and implemented by JSI Research and Training Institute, Inc.(JSI), developed the reference manual "Family planning" and a basic five day in-service training curriculum in line with the latest international standards, recommendations and approaches. The main reference materials used were the *Medical Eligibility Criteria for Contraceptive Use* (WHO, 2004, 2009) and *FP: a Global Handbook for Providers* (WHO and USAID, 2007). It was used during trainings and other events for health providers.

TfH team together with local partners, national and local trainers identified challenges in the FP practices of trained health providers and their needs for additional training materials and job aids that would improve the quality of FP services, particularly primary health care providers. The MEC wheel was the most requested job aid by health care providers and partner organizations.

In the opinion of health providers

IMPACT OF THE MEDICAL ELIGIBILITY CRITERIA FOR CONTRACEPTIVE USE (MEC) WHEEL ON THE QUALITY OF FAMILY PLANNING: EXPERIENCES FROM SELECT COUNTRIES

(CONTINUED)

the MEC wheel is an easy to use tool in selecting the appropriate contraceptive method during the client's visit, taking into account medical criteria and the client's wants and needs.

To help providers apply the correct eligibility criteria when providing or prescribing contraceptives, TfH translated and printed the MEC wheel into Ukrainian. This was done under a formal cooperation agreement between WHO and John Snow International (JSI). Four thousand (4000) copies of the wheel were printed and it was used during trainings for primary health care providers, as well as, during other continuing medical education events, where the wheel was used as a tool to help providers follow the Medical Eligibility Criteria and remind them which clients were eligible/not eligible for the various contraceptive methods.

Health providers who participated in the clinical courses demonstrated substantial improvements in their knowledge, with average scores on pre-tests at the start of the training standing at 58% to 92% on post-tests at the end of the training. Women's satisfaction with the FP/RH services they received improved over time according to project surveys of women leaving project-assisted health facilities in seven regions. After about 20-24 months of project interventions, 68.9% said the quality of services was good, compared with only 54.7% before the project came - an increase of about 14%.

Kyrgyzstan

According to the results of the strategic assessment of unwanted pregnancy conducted by the Ministry of Health, the WHO and the UNFPA in 2011, the knowledge of health professionals and general population about FP and contraception was low with a lot of misconceptions.

In 2012, the UNFPA with the WHO experts carried out a training of trainers on FP for health care providers to establish oblast teams on FP among health care providers and strengthen their knowledge. This was part of the UNFPA's mandate to work closely with

Example of MEC wheel in local language from Kyrgyzstan

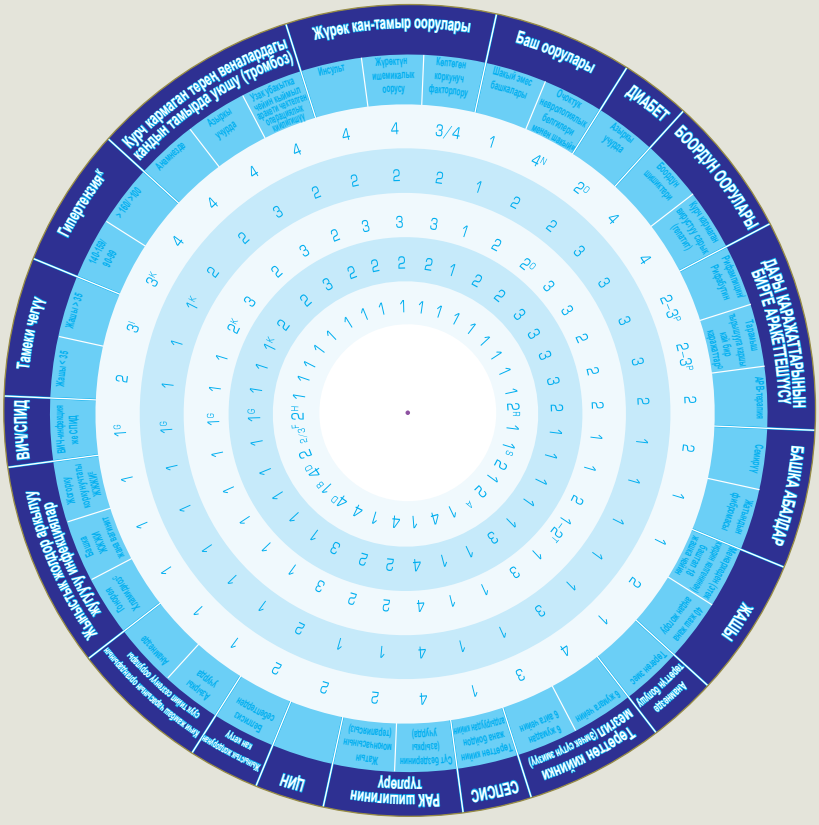
the Ministry of Health and other partners to strengthen knowledge and skills of health service providers in delivering good quality counseling and services to ensure a greater access to range of modern contraceptives. The *Medical Eligibility Criteria for Contraceptive Use* and *Practice Recommendations for Contraceptive Use* were guidelines used as one aspect of improving the quality of reproductive health care. The WHO MEC wheel became the most popular tool on the course and was used in various interactive training sessions. The decision making tools for health care providers and community also played a key role in enhancing the client's experience.

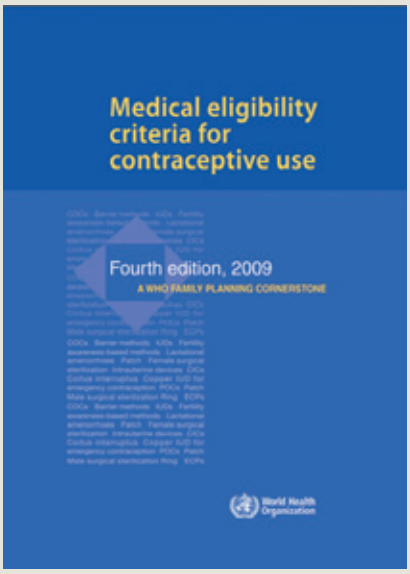
After the national training, the UNFPA supported implementation of the cascade training at the oblast and rayon level, followed by on-job monitoring of the knowledge and practical skills of local service providers in 2013. One of the achievements was the fact that doctors use the MEC wheel in the Kyrgyz language at the grassroots level.

"For us, service providers, this tool in the Kyrgyz Language is easy to use during the counseling on FP. For providers it is a 'cheat sheet'. Many participants of the monitoring noted that this tool can save time and there is confidence in the provision of the contraceptive," said the National Coordinator on FP, Dr. Elmira Maksutova. During the monitoring visits the doctors said that "we used to have this tool on hand in Russian, but we did not know how to use it."

Thus the MEC wheek in Kyrgyz and the conducted trainings at district levels for health care providers have enabled many to understand and get detailed instructions which has lead to an improved consulting process for both client and provider.

Example of MEC wheel in local language from Kyrgyzstan





Medical eligibility criteria for contraceptive use, WHO, 2010. Available in English, French and Spanish at: http://www.who.int/reproductive-health/publications/family_planning/9789241563888/en/index.html

MULTIPURPOSE PREVENTION TECHNOLOGIES

Sexually active women can be exposed to the risk of unintended pregnancy and sexually transmitted infections (STIs), including HIV. Condoms, both male and female, are currently the only methods that provide simultaneous protection against these risks. Condom use, either alone or in addition to another reliable contraceptive method, has increased substantially over the last 20 years, particularly among unmarried women, but condom use among married couples or stable partnerships has remained at very low rates. Both male and female condoms in particular need to be made available, accessible and promoted for correct and consistent use.

An alternative and novel approach focuses on the development of other multi-purpose prevention technologies, or MPTs. These new products are being developed to simultaneously address, but not be limited to, more than one sexual and reproductive health prevention need of women. As such these products reflect the needs of women within a life-course approach since the sexual and reproductive health needs and goals of women change and evolve over time.

Although the only approved products currently available are male or female condoms, with innovative designs and concepts, the development of other safe and effective MPTs is now not only technically feasible, but researchers worldwide are at various stages of product development. Current research is focused on promising innovations that include microbicides (delivered as gels, films, or tablets), as well as, vaginal rings and single sized diaphragms that release contraceptive products, and/or HIV preventive products and/or products to prevent a variety of STIs (see Figure 1).

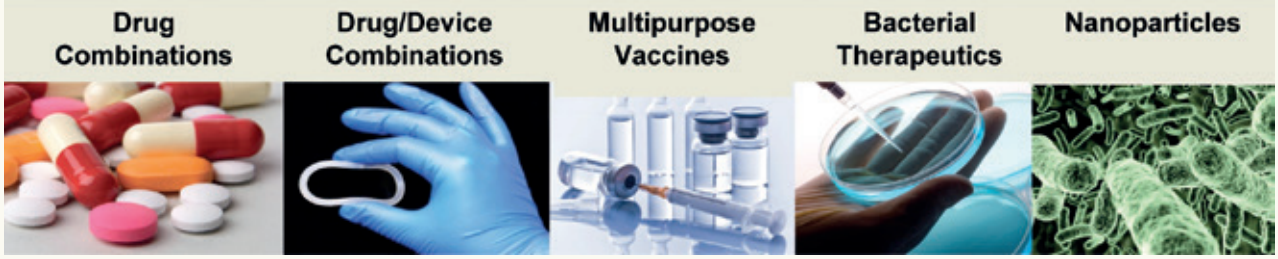
In theory, the combinations and possibilities for MPTs are diverse and will address the varying needs of women according to stage of life, socio-cultural norms and regions in which they live (see Figure 2). Ideally, a suite of MPT products and strategies will be available. For example, MPTs could range from coitally dependent use because of infrequent need to long lasting delivery methods that could provide more continuous protection. Additionally the range of products provides the potential for various combinations of indications such as contraception and HIV protection, HIV and herpes simplex virus (HSV) protection, and/or contraception and protection against other STIs, either viral or bacterial. At present, the contraceptive features women have to choose from are limited, therefore research into novel delivery mechanisms and products are important to support women's sexual and reproductive health choices.

The product most advanced in clinical testing is 1% tenofovir (TFV) gel for which there is evidence for impact against HIV and herpes simplex virus type 2 (HSV-2) infections from one trial and a confirmatory Phase 3 trial is currently underway in South Africa. Work to combine the active ingredient TFV with a contraceptive in a vaginal ring delivery system is being pursued by CONRAD (a leading organization in reproductive health research) and the University of Utah. Several approaches are also being pursued by the Population Council, including research on combined gels and ring technologies. The International Partnership for Microbicides (IPM) has recently launched an HIV prevention trial of its novel dapivirine-releasing vaginal ring and has started pre-clinical work to combine this with the contraceptive progestin levonorgestrel. With the recent success of the oral pre-exposure prophylaxis HIV prevention trials, a co-formulated combined oral contraceptive with the antiretrovirals tenofovir and emtricitabine can be envisaged. Long-acting injectable antiretrovirals for treatment of HIV infection are in early phases of development, but could also be envisaged in the long term, in combination with an injectable progestin contraceptive.

MPTs could achieve meaningful reductions in terms of cost of goods and lead to significant efficiencies in product delivery and access when compared to efforts necessary for delivery of multiple products targeting separate indications. The development of MPT products is technologically complex, expensive and risky, but also represents a powerful means of achieving high public health impact in at-risk populations around the world.

In many instances, the conceptual development of new MPTs builds upon proven, successful models. For instance, incorporating folic acid into common food items or iron supplementation into oral contraceptive pills have been effective ways to enable patients to benefit without extra effort on their part and to increase uptake of the product.

Figure 1: MPTs are in various stages of development (1).



Source: CAMI and the Initiative for Multipurpose Prevention Technologies ©2013 http://www.cami-health.org/resources

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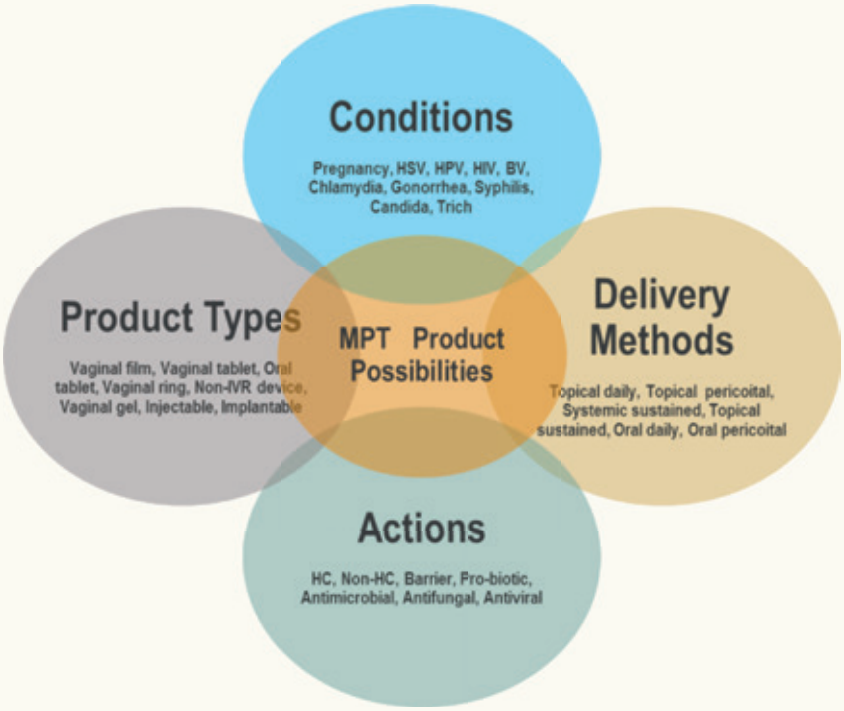
Figure 2: Promising combinations and possibilities for MPT product development and delivery.



Source: CAMI and the Initiative for Multipurpose Prevention Technologies ©2013 http://www.cami-health.org/resources

MPT Complexities and Challenges

The multidisciplinary approach of the MPT field creates several challenges including at regulatory and funding levels. While there has been progress in the areas of contraceptive research and HIV and STI prevention and treatment, donor proposals for research grants are often framed by health issues – in this instance reproductive health or HIV or other STIs. In addition, funding cycles will need to cover a multiple-year approach to address the complicated nature of MPT development, regulatory approval and introduction. This would reduce research 'silos', funding gaps and duplication of research efforts, while targeting funding to priority research. While large scale clinical trials of MPT products will require meaningful levels of financial support, more modest funding and in-kind support can make significant contributions to innovative basic science research, communication and advocacy efforts and understanding the potential market and demand issues that will be critical for MPT success. Increased collaboration and a widening of funding frameworks from single issues to a more comprehensive sexual and reproductive health framework will invigorate scientifically innovative and successful approaches for MPT development.

Regulatory issues also pose challenges, since MPTs involve more than one indication and have complex chemistry, manufacturing and controls requirements and demonstrations of efficacy. MPTs may also combine drugs, formulations or devices that are already approved or that have not yet been approved by a national regulatory authority. The regulatory review processes for such products may be complicated.

Despite biological, behavioural, and physiological linkages between the risk for unintended pregnancy and STIs and the evolving sexual and reproductive health goals and needs of women over time, health care remains siloed and strengthening linkages to provide a comprehensive approach to women's health will be critical to achieving international goals and targets in the coming years. MPTs provide an innovative approach to addressing the multiple sexual and reproductive health needs of women over time. The success of this new class of MPT products requires an integrated mix of expertise and advocacy, as well as, a sound evidence-based argument for their need and plausibility as a product category.

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THE BAROMETER OF WOMEN'S ACCESS TO MODERN CONTRACEPTIVE CHOICE IN 10 EUROPEAN UNION (EU) COUNTRIES

"Women's access to modern contraceptive choice is a crucial component of health, gender equality, employment and education which are at the same time the pillars and drivers of a prosperous and healthy society."

– Katarina Nevedalova, Member of the European Parliament

The International Planned Parenthood Federation European Network's (IPPF EN) landmark research study, ***"the Barometer of Women's Access to Modern Contraceptive Choice in 10 EU Countries,"*** launched in the European Parliament in June 2013, provides an overview of factors influencing access to contraceptive choice in Bulgaria, the Czech Republic, France, Germany, Italy, Lithuania, the Netherlands, Poland, Spain and Sweden. The study evaluates and rates countries on policy benchmarks including: policy making and strategy; general awareness; education for young people; education of healthcare processionals; individualized counseling; reimbursement; prevention of discrimination; and empowerment of women.

Results

IPPF EN Member Associations and national experts gathered information and ranked countries on each of the policy benchmarks. Figure 1 shows how each country scored on each benchmark in accordance with a rating system designed to enable comparisons within and between countries. The report presents key findings on both barriers and good practices and makes recommendations for improving access to modern contraceptive choice.

On **policy and strategy** for example, the study revealed that, of the countries studied, only Germany, the Netherlands and France have implemented comprehensive national policy frameworks on sexual and reproductive health and rights (SRHR). In contrast, in the Czech Republic, Lithuania and Italy, SRHR are practically absent from institutional agendas. Generally, SRHR policy measures are scattered and limited often lacking political attention and financial support. The level of stakeholder involvement varies significantly across countries and monitoring and evaluation of SRHR policies are poorly developed in almost all countries examined.

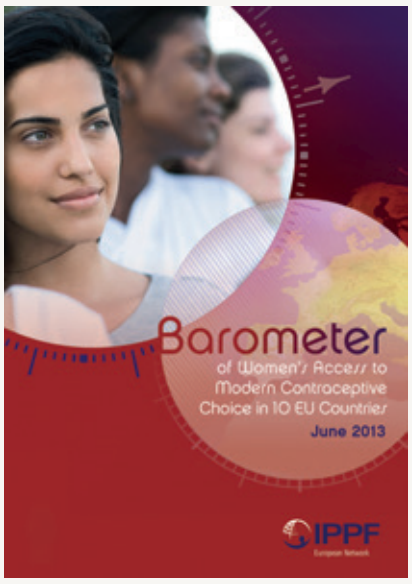
While all countries examined have developed national policies supporting gender equality and women's participation in professional and social lives, only in a few countries do these polices include a component on SRHR. For example, in Sweden and France, gender equality policies specifically address SRHR, including measures to improve access to modern contraceptive choice.

Comprehensive sexuality education is essential for empowering young people to make informed decisions and access services for their reproductive health. There is great variation in the quality of education received by young people in Europe.

Comprehensive sexuality education is mandatory in only half of the countries studied. France is the only country of those studied that provides comprehensive sexuality education based on specific content guidelines. Specific training courses for teachers are offered only in France, Germany, Spain and Sweden. Even in Sweden, *"the quality of sexuality education can differ substantially from one school to another,"* said Hans Olsson of the Swedish Association for Sexuality Education.

Religion is still a barrier in many countries, influencing individual teachers and influencing policy. *"Information about contraception cannot be presented as an acceptable alternative to abstinence,"* said a representative of the Ministry of Science and Education in Lithuania, which was the country with the lowest score on the comprehensive sexuality education benchmark.

Individualized counseling, another benchmark highlighted in the study, is critical for promoting access to contraceptive choice but in most countries studied, there is a lack of awareness of individualized counseling as a key component of sexual and reproductive health services and stakeholders called for improved availability and quality of services. Accessibility was rated as high only in the Netherlands. In Lithuania and the Czech Republic counseling is rarely provided and no quality standards exist. Of the 10 countries studied, only Denmark, Sweden and the Netherlands include training on individualized counseling in medical curricula and postgraduate programmes. *"There are still myths and lack of knowledge amongst healthcare professionals with regards to some modern contraceptive methods,"* said Lena Marions of the Obstetrics and Gynaecology department at Karolinska University Hospital in Stockholm.



Barometer of Women's Access to Modern Contraceptive Choice in 10 EU Countries, IPPF EN, 2013. Available in English at: http://www.ippfen.org/resources/barometer-womens-access-modern-contraceptive-choice

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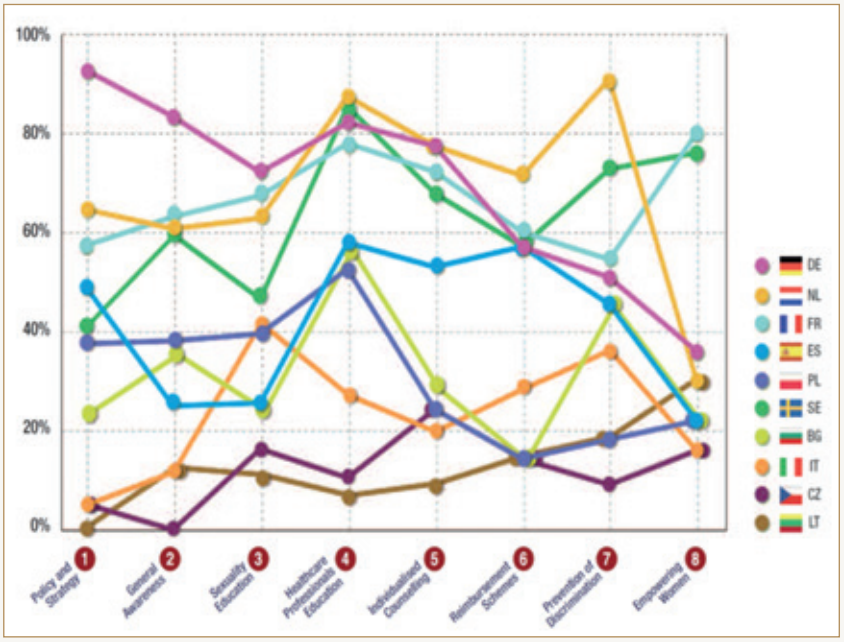
Figure 1. Overall Scoring by Policy Area and Country



The Barometer also highlighted that **financial constraints** are still a barrier for many people in Europe who want to access contraception. "*The biggest barrier, especially for people in difficult economic situations, is not access to healthcare but access to a choice of modern contraceptives tailored to their needs, as reimbursement for the wide range of modern contraceptives is limited due to the government's financial constraints,*" said Anna Korzan of the Society for Family Development in Poland. None of the countries studied offered full reimbursement of modern contraceptive methods and related health services and only half of them (Spain, France, Denmark, the Netherlands and Sweden) offered partial reimbursement. While stakeholders recognize that young people face significant financial barriers in accessing contraceptives, only Germany, the Netherlands, Sweden and France offer special reimbursement schemes for them. Austerity measures are beginning to make matters worse in some countries. "*The current budget cuts at national and regional level represent a new major obstacle for the effective implementation of policy measures to prevent unintended pregnancies,*" said Justa Montero of the Spanish IPPF Member Association, Federacion de Planificacion Familiar Estatal.

Conclusion and recommmendations

Comparing the status of different countries gives the opportunity to highlight good practices and specifies areas for further work. The report ***Barometer of Women's Access to Contraceptive Choice in 10 EU Countries*** (available on the web at: http://ippfen.org/news/barometer-womens-access-modern-contraceptive-choice), gave stakeholders in the countries covered a way to show how their country measured up in comparison with others and aided in stimulating dialogue about priority areas for work. The European Region has seen considerable progress on access to modern contraceptive choice and the prevention of unintended pregnancies and is home to many good policies and practices. However, considerable work is still needed to address existing gaps and prevent backtracking in countries facing austerity measures. In this regard the report makes a number of policy recommendations aimed to empower women and young adults to benefit from appropriate contraceptive methods and access quality sexual and reproductive healthcare and information with the advice and support from healthcare professionals:

- Develop targeted, comprehensive SRHR policy frameworks, in close collaboration with key stakeholders and the scientific community;
- Increase general awareness of modern contraceptive choice through public awareness campaigns;
- Establish mandatory sexuality education at schools, including information on modern contraceptive choice;
- Ensure the provision of individualized counseling and quality services on SRHR;
- Establish targeted measures to overcome inequalities in women's access to all methods of contraception;
- Work towards the prevention of discrimination and stigmatization around SRHR; and
- Ensure adequate policy integration and consistency by adopting targeted measures to improve access to contraceptive choice within broader employment, education and non-discrimination policies.

The Barometer on Women's Access to Modern Contraceptive Choice in 10 EU Countries was produced with support from Bayer HealthCare.

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KEY FACTORS INFLUENCING CONTRACEPTIVE USE: EXPERIENCE FROM 7 EASTERN EUROPEAN AND CENTRAL ASIAN COUNTRIES

Contraceptive prevalence* in the eastern European and central Asian Region

Controlling her fertility is a key priority for most women and the use of modern contraceptive methods is essential to achieving this aim. While the use of modern methods of contraception is quite high in western Europe, it is considerably lower in many other European countries (1). According to the 2012 United Nations Population Fund (UNFPA) *State of the world population report*, the United Kingdom and Portugal have the highest percentage of women relying on modern contraception (89% and 84% respectively) (1). In the least developed countries** in the world the average use of modern contraception stands at 28%. There are, however, seven countries in eastern Europe (Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, the Former Yugoslav Republic (TFYR) of Macedonia and Serbia) which have levels lower than this average and another 11 countries have a prevalence of modern contraceptive use that is lower than the average for less-developed regions*** which stands at 56% (see Figure 1).

The figures are even more dramatic if traditional methods of contraception are included in the calculations of contraceptive prevalence. In many countries, a large proportion of women try to avoid pregnancy but rely on traditional methods to do so. 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 they do not illustrate the vast differences between rural and urban areas in each country (see Figure 1).

The International Planned Parenthood Federation European Network (IPPF EN) and its member associations believe that women do not use modern methods of contraception for several reasons such as incorrect information, poor counseling, high costs and lack of choice. In an effort to gather evidence to gain a better understanding on the factors that influence women's access to and use of modern

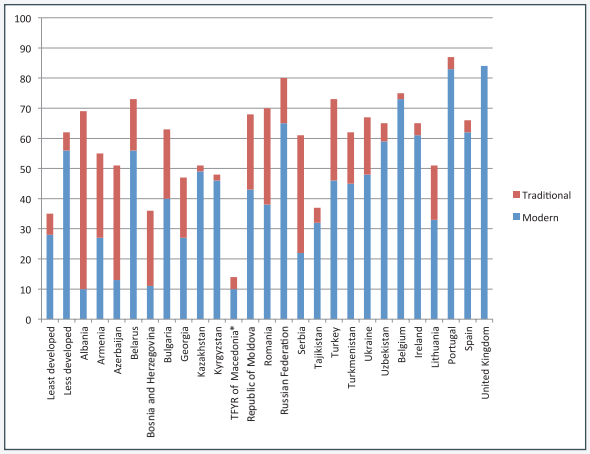

Figure 1: Contraceptive prevalence rates in selected European and central Asian countries, traditional and modern methods of contraception (1).

** TFYR of Macedonia = the former Yugoslav Republic of Macedonia*

methods of contraception, the IPPF EN member associations of Armenia, Bosnia and Herzegovina, Bulgaria, TFYR of Macedonia, Serbia and Kazakhstan and a partner organization in Azerbaijan, undertook in 2011 a qualitative analysis of behavioural patterns and cultural norms influencing contraceptive access and use. The study was conducted in collaboration with and funded by the UNFPA eastern European and central Asian Regional Office.

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

Seven key factors were found to influence contraceptive behaviour, demand and access:

- **An overarching factor is the lack of commitment of policy-makers and government agencies to contraceptive security.**
  Interviews with national policy-makers, institutions, programme officials and donors indicated that lack of government commitment is a critical obstacle to advances in contraceptive security in each of the seven countries in the study. Even in countries where policies and programmes are in place, there are no adequate funding or implementation plans to translate them into action.
- **In general, there is huge misinformation and distrust towards modern (hormonal) methods of contraception, fuelled by misinformation and myths.**
  Oral contraception was categorized as harmful to a woman's health in fifty of the seventy focus groups held during this study, cutting across ethnic, economic and geographic lines. Fear seems to be rooted in a mixture of known side-effects of certain contraceptives that can be managed with support from a health care worker and imagined consequences that have no basis in reality. There is little doubt that concerns about safety contribute significantly to the non-use of modern contraception across the whole Region. Findings also suggest that the safety factor contributes to the popularity of withdrawal in the countries of the Region. Withdrawal is often not the method of choice, but rather of default. Withdrawal is considered 'normal' for married couples and those in long-term relationships.
- **Young people face particular barriers limiting their access to contraception.**
  Certain tendencies regarding the contraceptive knowledge, attitudes and behaviour of young people were apparent. Young people's access to services is hampered by cost, but first and foremost by a lack of confiden-

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tiality and lack of youth-friendly services.

- **The provider, viewed by (potential) clients as a trustworthy source of information and service for family planning, is not always providing correct and up-to-date information on contraceptive methods and is thus often a major source of misinformation, often confirming rather than dispelling myths.**
  Study results suggest that many gynaecologists base their professional advice about modern contraceptives on misinformation, outdated information and on their own personal opinions rather than on evidence-based medicine. Demanding a range of expensive and unnecessary tests before prescribing a modern method of fertility control is also widespread. These practices increase the cost of contraception and reinforce the myth that there is something inherently risky about modern family planning methods. Primary health care reforms across the Region followed by privatization of gynaecological health care has increased client costs for services in many places and has also affected the number of providers in certain places. Exacerbating the situation in many countries are policies that limit the types of providers allowed to prescribe contraception. Often only a gynaecologist can prescribe contraception.

  Study findings across the seven countries indicate that counseling is rarely, if ever, provided. Providers lack the skills; have poor motivation or no time to counsel women on contraceptive choice.
- **A limited range of modern methods of contraception is available on the market in these countries. Choice is mainly limited to condoms, pills and intrauterine devices.**
  A 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. While pharmacies are often 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.
- **Affordability is a factor particularly present in Kazakhstan, where modern methods of contraceptives are relatively expensive.**
  In other countries, affordability is the main barrier for certain groups and segments of society. Other factors, such as unnecessary tests and services add to the cost.

  Cost, however, is not the determining factor in use or non-use of modern contraception and in no country is it the only factor. That said however, contraceptives not being covered by national insurance funds is one of the key factors determining lack of accessibility for the poorest, the unemployed, the uninsured, the young with no access to cash and the housewives dependent on money from their husbands or mother-in-laws. In particular, modern methods are unaffordable for low-income couples, those in rural areas and sexually active young people who depend financially on their parents or other relatives.
- **Societal expectations regarding sex and sexuality and gender power dynamics were another important factor that influence contraceptive choice.**
  Study findings suggest that pockets of conservatism exist within each surveyed country, 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 prevent women from receiving the information they need to make sound contraceptive decisions. Gender power dynamics were apparent in focus group discussions across the countries. Often the criterion for a "good" contraceptive was that a method could be used without the husband's knowledge.

The findings of this qualitative study were presented to high level government officials from 16 countries in eastern Europe and central Asia. The meeting aimed to promote the development of nationally owned reproductive health commodities security strategies and policies addressing the family planning needs of vulnerable populations, based on sharing of evidence, in order to accelerate the achievements of the ICPD Plan of Action and MDG 5b. The participants acknowledged the need for governments to increase and allocate the necessary budget for family planning and endorsed a set of recommendations addressing the 7 key factors identified in this study as influencing contraceptive use and access. The full set of recommendations, the study report and a summarizing factsheet can be accessed on the IPPF EN website: http://www.ippfen.org/en/Resources/Publications/Key+factors+influencing+contraceptive+use.htm

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Special notes:

*Contraceptive prevalence is the % of women of reproductive age using a method of contraception, composed of those who use modern or traditional methods.

**Least developed countries according to standard United Nations designation.

***Less developed regions comprise all regions of Africa, Latin America and the Caribbean, Asia (excluding Japan), Melanesia, Micronesia and Polynesia.

References

1. *State of the World Population 2012.* New York: UNFPA, 2012. Available at: www.unfpa.org/public/home/publications/pid/12511. Accessed 15 October 2013

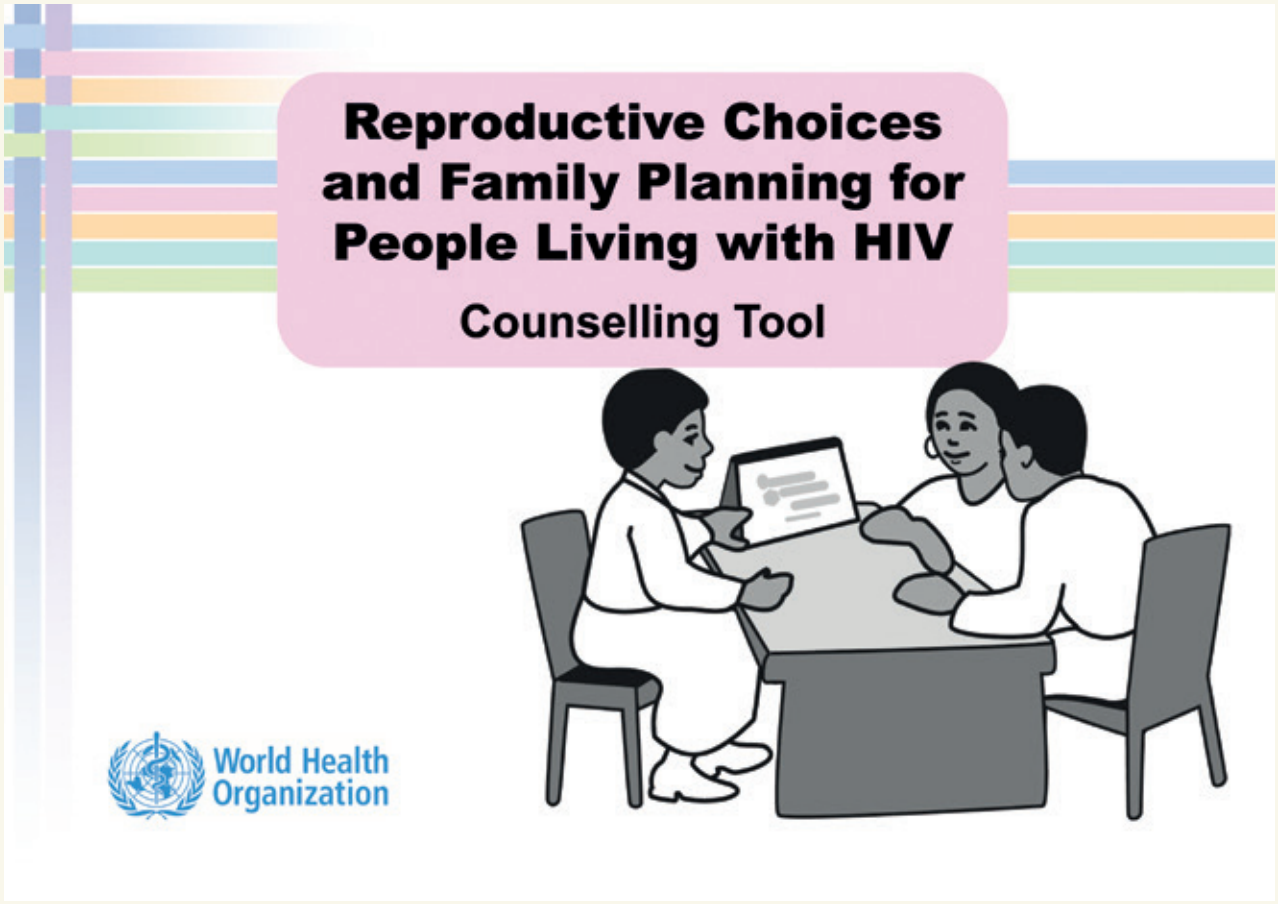
UNMET NEED FOR FAMILY PLANNING OF PEOPLE LIVING WITH HIV IN EUROPE: A NEGLECTED PUBLIC HEALTH ISSUE

In 2011, an estimated 34 million people worldwide were living with HIV(1). Over the last 20 years, significant improvements in the survival of HIV-infected patients treated with highly active antiretroviral therapy (HAART) have changed the perception of diagnosis of HIV from invariably fatal to a medically manageable chronic disease (2).

In resource-rich settings, people living with HIV (PLHIV) may live on average 35 additional years after their HIV diagnosis (3). In Europe, the prevalence of HIV and the proportion of women with newly acquired HIV continue to rise. In 2011, the estimated number of PLHIV in Europe was 2 300 000. In the same year, there were 27 963 new HIV infections officially reported among men and women in the European Union/European Economic Area region. As many as 75.8% of the new cases were aged between 20 and 49 years — the fertile age group, as defined by the official HIV/AIDS surveillance system adopted by the European Centre for Disease Prevention and Control (4). The HIV epidemic in Ukraine is the fastest growing in Europe, with 1.63% of the population estimated to be HIV positive (5). It has been suggested that owing to low access to, and uptake of, HIV testing and counseling in Europe, especially among the populations most at risk of infection and transmission, all HIV cases are not diagnosed (6).

In the context of the changed perspective of HIV as a medically manageable chronic disease, it is reasonable to expect that PLHIV will have sexual and reproductive aspirations just like the rest of the population. Of course, most infected people have a strong fear of transmitting HIV to the partner or child, as shown by a study in Denmark (7), but for that reason alone, many infected people will need sexual and reproductive health services, especially advice related to safe contraception. And, since the vast majority of PLHIV are of reproductive age, they will also need health-care services for safe planned, as well as, unintended pregnancies.

Preventing unintended pregnancies is a key goal of efforts to expand contraceptive use among women living with HIV. Several authors have highlighted the substantial contribution that family planning can make to reducing mother-



Reproductive choices and family planning for people living with HIV, Counselling tool, WHO, 2007.
Designed to help health care providers counsel PLHIV on family planning and sexual and reproductive health, this very useful tool also empowers PLHIV to make and exercise informed, appropriate decisions about their sexual and reproductive health and lives. Available in English, Spanish and French at: http://www.who.int/reproductivehealth/publications/family_planning/9241595132/en/index.html

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to-child transmission of HIV (MTCT) by decreasing the frequency of unintended pregnancies among women living with HIV (8, 9).

A study in Ukraine reported an unacceptably high proportion of the study population of post-natal HIV-positive women were using ineffective or unreliable methods of contraception, or none at all, and thus were at risk of future unintended pregnancy. The study also reported that use of oral contraceptives, injectable contraceptives and intrauterine devices (IUDs) was low and many reported lack of affordability as a key barrier to accessing family planning services (10).

Unintended pregnancy among HIV-infected women may elevate risk of both MTCT and infant abandonment, particularly by marginalized women (e.g. injection drug users, illegal migrants).

A recent United States-based study found rates as high as 86% of unplanned pregnancies among women living with HIV who conceived after their HIV diagnosis. Some western European studies have indicated that around half (51–58%) of pregnancies among HIV-infected women are unintended (11), whereas in a Russian survey of HIV-positive women, 54% of those who had recently completed their pregnancy reported that it was unintended (12).

Recently, a multicentre study of PLHIV consulting HIV outpatient-clinics in 13 European countries (Austria, Belgium, the Czech Republic, Germany, Greece, Hungary, Italy, Latvia, Poland, Portugal, Slovakia, Spain and the United Kingdom) (13) indicated that the proportion of women with an unmet need for family planning was much higher (28% not wanting to become pregnant) than that in the general population in Europe (less than 10% in most European countries). It also reported that almost one third of women who had become pregnant since their HIV diagnosis had had their pregnancy terminated. These findings strongly highlight the need for both adequate contraceptive provision to prevent abortions and for post abortion and post-partum contraceptive counseling to women living with HIV.

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References

1. *Global Report, UNAIDS Report on the Global AIDS Epidemic 2012.* New York: UNAIDS, 2012. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/20121120_UNAIDS_Global_Report_2012_with_annexes_en.pdf.
2. Lohse N, Hansen AB, Gerstoft J et al. Improved survival in HIV-infected persons: consequences and perspectives. *J Antimicrob Chemother* 2007;60: 461–3.
3. Finocchario-K, Essler S, Sweat MD et al. Understanding high fertility desires and intentions among a sample of urban women living with HIV in the United States. *AIDS Behav* 2010;14:1106–14 .
4. ECDC/WHO. HIV/AIDS Surveillance in Europe, 2011. Accessed 27 March 2013 from: http://www.ecdc.europa.eu/
5. *2008 Report on the Global AIDS Epidemic.* Geneva: UNAIDS, 2008.
6. WHO. Regional Office for Europe. http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/data-and-statistics
7. Laursen T, Kesmodel U, Højgaard A et al. Reproductive patterns and fertility wishes among HIV-infected patients: survey from six outpatient clinics in Denmark. *Int J Infect Dis* 2013;17: e851–e856.
8. Reynolds HW, Steiner MJ, Cates W: Contraception's proved potential to fight HIV. *Sex Transm Infect* 2005;81:184–185.
9. Sweat MD, O'Reilly KR, Schmid GP et al. Cost-effectiveness of nevirapine to prevent mother-to-child HIV transmission in eight African countries. *AIDS* 2004;18:1661–1671.
10. J. Saxton R, Malyuta I, Semenenko I et al. Previous reproductive history and post-natal family planning among HIV-infected women in Ukraine. *Hum Reprod* 2010;25 (9) 2366–2373.
11. Floridia M, Tamburrini E, Bucceri A et al. Pregnancy outcomes and antiretroviral treatment in a national cohort of pregnant women with HIV: overall rates and differences according to nationality. *BJOG* 2007;114:896–900.
12. Vartapetova N, Karpushkina A, Fullem A et al. Family planning needs of HIV-positive women in Russia: data of the Maternal and Child Health Initiative. WEPE0835. XVI International AIDS Conference, Toronto, Canada, 13–18 August, 2006.
13. Nöstlinger C, Desjardins F, Dec J. Child desire in women and men living with HIV attending HIV outpatient clinics: Evidence from a European multicentre study. *Eur J Contracep Repr* 2013;18:251–263.

RESOURCES

Task shifting to improve access to contraceptive methods, WHO, 2013.

A perfect summary for decision makers working to improve access to FP, outlining the WHO recommendations on the cadres ranging from lay health workers to mid-level providers that may be trained and supported to provide increased access to contraceptive methods safely. Available in English and French at:
http://www.who.int/reproductivehealth/publications/family_planning/task_shifting_access_contraceptives/en/index.html

Programming strategies for postpartum family planning, WHO, 2013.

Designed for programme planners and managers, this excellent resource outlines how to integrate FP into existing postpartum programmes as part of national strategies. Available in English at:
http://www.who.int/reproductivehealth/publications/family_planning/ppfp_strategies/en/index.html

Selected practice recommendations for contraceptive use, Second edition, WHO, 2004.

This guide provides guidance on how to provide contraceptives, with the goals of maximizing effectiveness and managing side effects and other problems. The 2008 update on the guideline summarizes changes made based on new evidence and is also available at the following link. Available in English, French, Arabic, Spanish, Romanian and Russian at:
http://www.who.int/reproductivehealth/publications/family_planning/9241562846index/en/index.html

Family planning: a global handbook for providers, 2011 Update, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, USAID and WHO, 2011.

An essential resource for health care providers providing FP, this handbook provides practical guidance on all major contraceptive methods to allow better care for all people. Available in Arabic, Chichewa, English, Farsi, French, Hindi, Portuguese, Romanian, Russian, Spanish, Tajik at:
http://www.who.int/reproductivehealth/publications/family_planning/9780978856304/en/index.html

State of World Population 2012. By Choice, Not By Chance: Family Planning, Human Rights and Development, UNFPA, 2012.

The 2012 report analyzes FP challenges, data and trends to understand who is denied access and why, emphasizing the social and economic impact of family planning as well as the costs and savings of making it available to everyone who needs it. Available in English, French, Russian, Arabic and Spanish at:
http://www.unfpa.org/public/publications/swps

Contraceptive Commodities for Women's Health. Key Data and Findings, UNFPA, 2012.

This report highlights the importance of improving access to contraceptive commodities to achieve reproductive health for all and provides a review of three contraceptive commodities that are considered to be overlooked or underutilized: the female condom, hormonal implants and emergency contraception. Available in English at:
http://www.unfpa.org/public/home/publications/pubs_rh

The Rights to Contraceptive Information and Services for Women and Adolescents. Briefing Paper, UNFPA and the Center for Reproductive Rights, 2011.

A practical guide, this briefing paper assesses the benefits of contraceptive access, lays out the human rights framework and provides an overview of how to apply a human rights-based approach to the provision of contraceptive information and services. Available in English at:
http://www.unfpa.org/public/home/publications/pid/7267

The Global Programme to Enhance Reproductive Health Commodity Security, Annual Report, 2012, UNFPA, 2012.

This annual report describes results and good practices in 46 countries of the UNFPA flagship thematic fund to achieve reproductive health commodity security and build global momentum in FP. Available in English at:
http://www.unfpa.org/public/home/publications/pubs_rh

Lisa Avery

Reducing Unmet Need for Family Planning. Evidence-based Strategies and Approaches, PATH and UNFPA, 2008.

A quick read, this publication offers clear suggestions for programme managers to address unmet need for family planning in the face of current political, financial and health-systems challenges. Available in Engish at:
https://www.unfpa.org/public/home/publications/pid/1386

From evidence to policy: expanding access to family planning, WHO and HRP, 2012.

Developed to inform the Family Planning Summit held in London in July 2012, this excellent series of policy briefs summarizes the latest evidence on family planning as a critical health and development issue and a key intervention for the survival of women and children. Available in English at:
http://www.who.int/reproductivehealth/publications/family_planning/policybriefs/en/index.html

The Lancet Series on Family Planning, The Lancet, 2012.

The new Lancet Series brings together the latest thinking and evidence on FP, showing how lack of access to FP carries a huge price, not only in terms of women's and children's health and survival but also in economic terms. Available in English at:
http://www.thelancet.com/series/family-planning

Women's Lives, Women's Voices: Empowering women to ensure family planning coverage, quality and equity, Report, CARE, 2012.

Launched prior to the London Family Planning Summit, this report provides an excellent overview of the current status and challenges facing FP and outlines strategic approaches that will help reduce the unmet need for FP globally. Available in English at:
http://www.care.org.au/document.doc?id=884

Revising unmet need for family planning, DHS Analytical Studies No. 25, Bradley SK, Croft T,Fishel J and Westof C, 2012.

Using data from 169 DHS conducted in 70 countries over the last 20 years, this report presents a new standard definition of unmet need that can be consistently applied over time and across countries and shows the impact of the revising the definition on estimated levels of unmet need. Available in English at:
http://www.measuredhs.com/publications/publication-as25-analytical-studies.cfm

Upcoming Events

13th Congress of the European Society of Contraception and Reproductive Health: Challenges in Sexual and Reproductive Health May 28–31, 2014 — Lisbon, Portugal

North American Forum on Family Planning October 10–13, 2014 — Miami, Florida

7th Asia Pacific Conference on Reproductive and Sexual Health and Rights
January 21–24, 2014 — Manila, Philippines

Useful websites

International Planned Parenthood Federation European Network (IPPF EN): www. ippfen.org
CONRAD: Leaders in Reproductive Health and HIV Prevention: www.conrad.org
European Consortium for Emergency Contraception: www.ec-ec.org
Center for Reproductive Rights: www.reproductiverights.org
Measure Evaluation: www.cpc.unc.edu/measure
UNFPA: www. unfpa.org
WHO Family Planning: www.who.int/topics/family_planning/en
CARE International: www.care-international.org

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