MINISTERUL SĂNĂTĂȚII
AL REPUBLICII MOLDOVA

UNFPA

pas
we act today for tomorrow's future!

RESEARCH REPORT

Factors influencing the use of contraceptive methods among vulnerable groups in the Republic of Moldova

QUALITATIVE STUDY

CONTENTS

RESEARCH REPORT

Factors influencing the use of contraceptive methods among vulnerable groups in the Republic of Moldova

QUALITATIVE STUDY

Chisinau, 2024

CONTENTS

Acknowledgments

The qualitative study of factors influencing the use of contraceptive methods among vulnerable groups in the Republic of Moldova has been conducted by the Center of Sociological Investigations and Marketing (CBS-Research) at the request of the Center for Health Policies and Studies (PAS Center), in coordination with the Ministry of Health of the Republic of Moldova and with the support of the United Nations Population Fund (UNFPA).

The research report reflects the views of the authors and does not necessarily represent the views of UNFPA or any other affiliated organization.

The translation from Romanian into English of the Report was performed by translators from BISCONSULT SRL, translation agency, who took full responsibility for the accuracy of the translation.

We are thanking the PAS Center team for providing relevant information and support during the research. We are also deeply grateful to the partners who gave us access to respondents from certain vulnerable groups of population: NGO *"Motivation"*, Public Association *"Everyone contributes to change"*, Public Association *"Positive Initiative"*, Regional Social Center *"Renaissance"*, residential centers for adults with disabilities.

We appreciate all respondents from the interviewed vulnerable groups, as well as specialists from the national health system who participated in the study: obstetricians-gynecologists, family doctors, nurses, specialists from youth-friendly health centers (YFHC). We thank everyone for their time, involvement, openness, trust and the valuable information provided during group discussions and in-depth interviews.

We express our gratitude to the experts who reviewed the report and contributed to its completion.

Contents

Authors

Natalia Vladicescu, study coordinator, sociologist at CBS-Research

Patricia Vieru, sociologist at CBS-Research

Tatiana Mărgărint, PhD, university lecturer, Department of Philosophy and Anthropology, State University of Moldova (USM), researcher at CBS-Research

Corina Iliadi-Tulbure, DMedSc, associate professor, Department of Obstetrics and Gynecology**,** Nicolae Testemitanu State University of Medicine and Pharmacy (USMF)

Tatiana Cotelnic-Harea, program coordinator, PAS Center

Design: Imprint Plus SRL, bd. Renasterii Nationale, 14, of. 3

Cover picture: @UNFPAMoldova/2023

Abbreviations

LPA	Local Public Administration
NHIC	National Health Insurance Company
IUD	intrauterine device
IDI	in-depth interview
STIs	sexually transmitted infections
FG	focus group
NGO	Non-governmental organization
PAS	Center for Health Policies and Studies
RM	Republic of Moldova
GGS	Generations and Gender Survey
UNFPA	United Nations Population Fund
USMF	Nicolae Testemitanu State University of Medicine and Pharmacy
PHC	Primary health care
YFHC	Youth-friendly health center

Study background

The research was carried out by the Center of Sociological Investigations and Marketing CBS-Research at the request of the Center for Health Policies and Studies (PAS Center), the qualitative study being carried out in coordination with the Ministry of Health of the Republic of Moldova, with the support of the United Nations Population Fund (UNFPA).

Couples, women and men from Moldova have the right to decide whether or not they want a child / children, when and how many children to have, but not all have the information and capacity to make such decisions. Only 38.1% of all women of reproductive age use modern contraception methods.[1] Limited access to the wide range of modern contraception methods often leads to unplanned pregnancies, as well as medical and social vulnerabilities. According to the Order of the Ministry of Health, Labor and Social Protection no. 555 of 16.06.2020 on providing vulnerable population groups of reproductive age with contraceptives, there are 12 categories of population that can benefit from modern contraception methods free of charge.

According to the National Program on Sexual and Reproductive Health and Rights for the years 2018-2022 and the draft of the new policy paper developed for the period 2024-2027, systemic measures have been taken to ensure the 12 vulnerable population groups with a wide range of contraceptives provided free of charge at primary health care (PHC) level. Eligible beneficiaries of contraceptives at PHC level are people who belong to the following categories of vulnerable population groups:

1. Teenagers and young people up to 24 years of age;
2. Women in the obstetric risk group;
3. Women in the somatic risk group (suffering from chronic diseases with risk for pregnancy and childbirth);
4. Women who have had an abortion on demand over the past year;
5. HIV-positive people and people in groups at high risk of HIV infection;
6. Victims/survivors of sexual abuse, for emergency contraception;

[1] GGS 2020

7. Victims/survivors of human trafficking;
8. Survivors of emergency situations, humanitarian crisis or public health emergencies, persons with refugee status, beneficiaries of humanitarian protection in the Republic of Moldova, asylum seekers, stateless persons, immigrants;
9. Persons with disabilities, including persons with disabilities in residential institutions;
10. Persons with mental health problems, registered with a psychiatrist or family doctor;
11. Users of narcotic drugs and other psychoactive substances, registered with a substance abuse professional;
12. People with low or no income.

According to the data of the Generations and Gender Survey (GGS) 2020, the rate of use of modern contraception methods among all women of reproductive age (15-49 years) in the Republic of Moldova is only 38.1%. Moreover, out of all women of reproductive age, 16.9% have an unmet need for family planning. The GGS results also indicate that the most popular modern contraception methods used in the Republic of Moldova among all women of reproductive age are male condoms (19.4%), intrauterine devices (8.1%), contraceptive pills (4.8%), and female sterilization (3.9%).

Methodology

The qualitative study included 11 focus groups (FG) with people from vulnerable groups that can benefit from modern contraceptives distributed free of charge within primary health care in Moldova (see Annex, Table 1), in accordance with the provisions of the Regulation on ensuring people of reproductive age from vulnerable population groups with contraceptives (hereinafter – Regulation), developed under the provisions of Law no. 411/1995 on health care and Law no. 138/2012 on reproductive health. Also, 37 in-depth interviews (IDIs) were conducted, of which 10 IDIs with respondents from vulnerable categories and their family members and 27 with family planning service providers (see Annex, Table 2).

Purpose of the study. The qualitative sociological study aimed at researching perceptions, attitudes, behaviors regarding contraception in the context of determining the factors that influence the use of contraception methods among vulnerable groups in Moldova. The results of this study will contribute to establishing the necessary measures and solutions for removing the identified barriers, so that women/men/couples from vulnerable categories appeal for family planning services when needed and obtain modern contraception offered free of charge at the primary health care level.

Research tools. The interview guides were prepared by a team made of sociologists, an obstetrician-gynecologist and a representative of civil society. They included key themes and were also adapted to each category of vulnerable groups, as well as to service providers. Subsequently, the research tools were consulted on 21 May 2024 in a meeting with representatives of civil society providing services to vulnerable categories, with representatives of academia and other relevant actors. The research tools were approved by the Ethics Committee.

Selection of respondents. The *snowball* method and convenience sampling[2] were used to select participants for group discussions. Respondents from all over the country, except the territory on the left bank of the Dniester, participated in the study. The basic criteria for selection was being part of vulnerable groups that can benefit from modern contraceptives distributed free of charge within primary health care in Moldova. Participants in the following group discussions were selected through the network of interviewers: teenagers and young people aged

[2] For groups selected through NGOs and/or representatives of institutions providing services for them (HIV-positive women, drug users, people in residential institutions).

16-24; women at obstetric risk and women in the somatic risk group (suffering from chronic diseases with risk for pregnancy and childbirth); survivors of emergency situations (refugees from Ukraine); and women/men with low or no incomes. Through civil society and service providers, the following categories were recruited: HIV-positive women; women with disabilities, including persons with disabilities in residential institutions; people using narcotic drugs and other psychoactive substances; women with mental health problems in institutional care.

The criteria of heterogeneity of groups recruited through interviewers was respected due to the selection of respondents by residence environment (rural and urban) and geographical distribution: 30% South, 30% North, 40% Center. Also, in two groups – teenagers/young people aged 16-24 and people with low or no incomes – two group discussions were conducted in each, one focus group with women and one with men. For the other target groups, group discussions were conducted with women. With the exception of the teenager and youth groups, the other focus groups included people aged 18 to 49.

In the selection of the interviewed health service providers, a theoretical sampling based on quotas was used. Also, in their selection, the distribution per regions of the country (Center, North, South) was taken into account, and in the case of family doctors, the area in which they work was also taken into account, so that half of the family doctors interviewed are from rural areas and half from urban areas. Their work experience was also taken into account, so as to include both young specialists with experience up to 5 years and doctors with vast experience.

Data collection. Group discussions were conducted both with physical presence and online through the ZOOM platform. The decision on how to proceed was taken jointly with the persons involved in recruitment, at the suggestion of persons from target groups. Individual interviews, including those with service providers, were conducted face-to-face, online or by telephone. Discussions were mostly conducted in Romanian, and people were encouraged to respond in the language that was most convenient for them. In three focus groups discussions were in Russian, and individual interviews were conducted in the language chosen by the respondents. Data were triangulated, so that any new information was addressed in other discussions and interviews, and topics were validated if they were repeated/ confirmed in multiple sources.

Data were collected between July and August 2024.

Data analysis and interpretation. For the analysis of data, the thematic framework approach was used, developed on the basis of the research objectives and the main questions from interview guides. The key themes and sub-themes of this study were presented in the form of analysis, including quotations from respondents. In addition to the analysis of the collected qualitative data, the report

also includes a chapter presenting scientific information aimed at combating myths related to contraception methods.

Ethical principles. The National Committee for Ethical Review of Clinical Study analyzed the study documents at its meeting on 29 May 2024 and concluded that the study complied with ethical standards. In the data collection process, all study participants, including service providers, were guaranteed anonymity and confidentiality. Participation in the study was voluntary, but among doctors, including employees of YFHCs, some refused to participate because they did not have the permission of their superiors and/or had not received an order to this effect from the Ministry of Health. Some public institutions requested a confirmation letter from the PAS Center on the conduct of the study. In the data analysis process, details that could allow the identification of study participants were excluded.

Study limits:

- The findings of the qualitative study present an in-depth understanding of the attitudes, behaviors and practices of couples, women, and men interviewed within the 12 vulnerable groups of population eligible for free contraception and cannot be generalized to the entire population of reproductive age in the country.
- Since the data were collected *face to face*, online, and by the telephone, they had both advantages and disadvantages. The online collection of information allowed the participation of various categories of people, who connected online without being constrained by the need to travel to a specific place. It is worth mentioning, however, that when the research team collects information on site, it also makes observations, which is difficult to do remotely.
- The recruitment of some categories of respondents was difficult (victims/survivors of sexual abuse), given the sensitivity of the topic, and some of the men refused to participate arguing that it is a topic dedicated to women. Access to women victims/survivors of sexual abuse, those who had an abortion, persons with chronic diseases or obstetric risk was limited, given that this is a confidential information.
- Some respondents, including middle-aged women (35-49 years old) found it difficult to speak about sexual relations and contraception because they had not previously discussed these topics with anyone and still feel *"embarrassed"* or *"guilty"* to address them.

1

CONTRACEPTION – PERCEPTIONS, ATTITUDES

1.1 Opinions and perceptions of contraception methods

1.1.1 Contraception methods

The interviewed participants from vulnerable groups were asked to mention the contraception methods they know in order to prevent an unplanned pregnancy, and then the advantages and disadvantages of these methods from the respondents' perspective were discussed. Below are the main findings for each method mentioned.

- **Withdrawal method (coitus interruptus)**

The withdrawal method **(coitus interruptus)** is the most known and popular method of contraception, which prevailed in all group discussions regardless of the category interviewed – *"He has to withdraw on time, giving up ejaculation inside, to prevent an unwanted pregnancy."*

Some respondents noted that this method is not effective. Several study participants pointed out that the use of coitus interruptus causes stress in the couple and does not allow relaxation during sexual intercourse. A few of the women believe that the interruption of sexual intercourse can have consequences for the sexual and reproductive health of men – *"I know that withdrawal is not good at all, because it can cause problems to the genitals in men."*

- **Calendar method**

The calendar method is perceived by respondents as suitable for women with a regular menstrual cycle and risky for those who have an irregular menstrual cycle. Contraception methods based on the recognition of the fertile period (including the calendar method) are less effective and are not recommended by service

providers, but are still used by some women. They use the calendar method in combination with the withdrawal method and/or male condom, and, where appropriate, other methods (spermicide suppositories, emergency contraceptive pills).

> *"Another method I used was the calendar method. There is quite a comfortable telephone app that tells you your fertile days. On days when the risk of getting pregnant is high, we use a condom."* (F, 37 years old, urban, 6 FG)

- **Male condom** [3*]

In group discussions, but also in individual interviews, in different contexts it was mentioned that *"the best way is to use a condom".* When used correctly, at every sexual contact, in addition to having a high degree of protection against an unplanned pregnancy, condoms also protect you from sexually transmitted infections (STIs). It was also mentioned that this method is accessible – *"they are sold even in the market", "they are distributed free of charge, you only have to want to use them."*

However, some respondents and health service providers pointed out that condom use is mainly preferred in sexual relations with casual partners and primarily among young people. At the same time, respondents mentioned that for couples who have stable sexual relations it is not a preferred method, as there are situations in which sexual intercourse happens without a condom anyway. Some men pointed out that condoms are for casual relations, considering that in a couple/family they should not be used because they reduce the intensity of sensations during sexual contact / reduce pleasure – *"The man does not feel the same pleasure."* Thus, some men insist on having sex without a condom, opting for other methods of protection against an unplanned pregnancy.

> *"Some guys say that they are not satisfied with a condom and somehow influence the girls to take those pills."* (M, 21 years old, rural)

> *"They use condoms when they go for 'prey', for something casual, but in the family I think they should not be used. The woman better knows how to protect herself. And she protects herself when pregnancy can happen [combining the calendar method with the withdrawal method]."* (M, 49 years old, rural, 10FG)

[3] * In this report, we refer to the male condom, if not specified otherwise

- **Intrauterine device (IUD)**

Among respondents the idea persists that IUDs are intended for women who have already given birth and who do not want a pregnancy in the next 3-5 years.

> *"The IUD is allowed only if you have given birth and depending on what the protection objective is, that is, it is good to consult with your gynecologist to know what term you put it for."* (F, 32 years old, urban, 4FG)

The IUD has been mentioned by respondents as a method used frequently after the occurrence of an unplanned pregnancy, regardless of whether the woman/couple chose to terminate the pregnancy or to give birth to the child and then use this method of contraception.

The IUD is appreciated as a "time-tested" method [with high efficiency proven in time]. The interviewed health service providers find it to be more appropriate for vulnerable groups, given that after insertion of the IUD by healthcare professionals, no further action by users/clients is required, unlike oral contraceptives that require adherence and discipline. This aspect has also been confirmed by some women, who said that, once inserted, the IUD is more convenient and economical compared to other contraception methods (birth control pills, condom).

> *"The pill is good, but the likelihood is high that you can forget to take it or you are not at home and left the pills at home. With the condom, it is the same. First, it is expensive, and second, you can forget about it or not have it at hand at that moment, because you forgot to buy it. If you get an IUD, you are sure everything is going be okay."* (IDI, F, 46 years old, rural)

On the other hand, in several group discussions there were people who spoke out against the IUD, believing that it can cause cancer. This is also one of the main concerns for women who are considering this option of contraception.

> *"Why am I against the IUD? I am against it because I've heard, I know people who say that the IUD can lead to cancer in women. My mother died because of this. All the doctors were saying that it was because of the IUD, this was the beginning, the cause."* (M, 33 years old, urban, 10FG)

- **Oral contraceptives**

Some of the women and men interviewed about the use of oral contraceptives expressed reluctance due to concerns about the risks associated with them: hormonal disorders, weight gain, infertility, etc. While women who have already given birth are more concerned about the change in weight/weight gain, considered to be influenced by the use of combined oral contraceptives, then the interviewed young women and men are concerned about fertility being affected as a result of the use of birth control pills. Another challenge is the way oral contraceptives are used, women being worried not to forget to take them, as in this case they lose efficiency and thus the risk of becoming pregnant increases, in their opinion.

> *"The degree of infertility in women increases due to these pills. Thus, if they start their sex life at a very early age, the use of these contraceptives will create a habit of the body to stop producing that number of eggs, decreasing the likelihood of conceiving a child at the desired time."* (M, 23 years old, rural, 1FG)

> *"I didn't want to depend on some pills that were to be taken at a certain hour, which somehow stresses you out if you forget. In addition, I heard they are hormonal, from which you can gain weight."* (F, 35 years old, urban, 4FG)

Respondents from vulnerable groups noted that the use of oral contraceptives can affect the physical and emotional health of the woman. There is reluctance and concern about possible hormonal disorders following the use of oral contraceptives. They also believe that stopping taking birth control pills is a difficult process with side effects (increased hairiness, changed voice, acne, etc.). Some women said that even the doctors they consulted expressed reluctance about the use of contraceptives.

> *"They are directly related to the health of the girl, since these pills work on a hormonal basis. As a result, the girl can have complaints such as pains, mood swings, insomnia."* (M, 16 years old, urban, 1FG)

> *"Regarding birth control pills, doctors say that once you stop taking them, all kinds of problems arise, such as pimples and change of voice, and it really is so. I have friends who experienced these things firsthand."* (F, 37 years old, urban, 6FG)

Women who have been using contraceptive pills for a longer period of time and those who have been informed and advised by health care professionals about contraception listed some advantages of using oral contraceptives, such as *"stress-free sexual relations"*, *"anti-acne treatment"*. There are also perceptions that contraceptive pills could prevent early menopause, for which there is currently no conclusive data. Respondents believe that termination of pregnancy is much more harmful to health compared to the side effects of contraceptive pills.

> *"I think having an abortion is far more complicated than taking a pill and being protected. The most important thing is to take the pills regularly, not skip a day, and everything will be fine... As my gynecologist explained to me, after the age of 40 these contraceptives are taken not only for contraception purposes, but also to prolong the woman's fertile period. After 40, the female body is preparing for menopause, therefore, in order to prolong the period of our youth, contraceptives are also beneficial."* (F, 42 years old, urban, 3FG)

The greatest concern of the medical staff participating in the research regarding the use of oral contraceptives is their correct administration by women from vulnerable groups. In fact, this is also one of the basic concerns of women, what happens if they forget to take the pill, what to do in such situations and to what extent the risk of an unplanned pregnancy increases.

- **Emergency contraceptive pill**

Respondents from vulnerable groups heard about emergency contraception mainly from their peers, friends, colleagues. Some participants in the study heard about it from the media or the Internet, while medical professionals were mentioned very rarely. As a method of emergency contraception, only the pill was mentioned.

> *"The pill can help you within 72 hours. During this period after intercourse, if the woman takes the pill, there is still a chance that the problem will be resolved. Even if they protect themselves with condoms, but they are of a poor quality, situations may happen that they break, and in this case they resort to taking special pills. Therefore, we see that the pills are a bit safer for partners compared to condoms."* (M, 20 years old, rural)

Opinions about the term when emergency contraceptive pills should be taken are different: the most commonly mentioned term is 72 hours, while other women insist that it is 24 hours after unprotected sex.

> *"I talked to my friends, because I have no one else to talk to. We talked about contraception methods, and they told me about this 72-hour pill."* (F, 16 years old, urban, 2FG)

In all group discussions with women there were respondents who mentioned that they had used emergency contraceptive pills at least once, and there are women who use emergency contraceptive pills with some regularity "*as an additional form of protection against an unplanned pregnancy*". Other women noted that these pills cannot be used more often than once every 6 months, because they can cause significant hormonal disorders.

> *"I used emergency pills about once every three months, when I felt or was afraid that something might be wrong. Most of the time, though, we interrupted the act to make sure everything went well. In the worst case, we used a condom."* (F, 41 years old, rural, 3FG)

> *"The pill can be taken within 24 hours after sex, but it cannot be taken more often than once in six months. In addition, it certainly destroys the hormonal balance."* (F, 41 years old, urban, 8FG)

Some family doctors mentioned during the discussions that it would be good if they had emergency contraceptive pills available in stock so they could offer them to beneficiaries from vulnerable groups, as currently they are not available in the institutions where they work.

- **Female and male sterilization**

Tubal ligation is a method that some respondents know as a suitable method when you are sure that you do not want children anymore or when pregnancy can seriously endanger a woman's health. Vasectomy is a less known method among respondents, and in the opinion of some study participants it is reversible, which is not true. Both are invasive methods – *"For guys, there is a method that closes the ducts and does not allow to ejaculate the substance, but it requires surgery."* (M, 16 years old, urban)

In certain situations, such as when women have multiple unplanned pregnancies or when a new pregnancy poses increased risk to the woman's health and/or complicated course of pregnancies, some doctors recommend female sterilization. Some of the women mentioned that they do not accept this method of contraception for the reason that they may want another child, and other women are convinced that *tubal ligation* affects the sex life of the couple.

> *"After the third pregnancy, after the third loss, they kind of told me that we could tie the fallopian tubes, which I did not accept. Anyway, it affects sexual life to some extent. I did not agree to tie the fallopian tubes, and we use a condom and I also calculate the ovulation period. There were also cases when I took the pill within 72 hours to prevent some risks."* (F, 35 years old, urban, 4FG)

- **Spermicides**

Several women mentioned that some time ago they used spermicides in the form of suppositories applied before sex. Some women noted that they still occasionally use this method of contraception in combination with traditional methods (the withdrawal method and the calendar method).

> *"I like the calendar method and it suits me perfectly. I calculate the cycle, and in the first five days, in my case, I am infertile. There are also suppositories, which I use as well. They are applied 15-20 minutes before intercourse, and some of them also have an antibacterial effect."* (F, 46 years old, urban, 6FG)

- **Other contraception methods that women in the research heard about: implants and injectable contraceptives**

In the study, no respondents reported using any of these methods. But obstetricians-gynecologists noted that there are young women, mothers who prefer these methods because they are more convenient than contraceptive pills. At the same time, doctors mentioned that these contraception methods are not always available in medical institutions to be offered free of charge to women from vulnerable groups.

> *"Young women like the injection because it is good for women who breastfeed. This year we have them and can offer them; last year we did not have them. Why is it good? Women with small children are scatter-brained and do not sleep at night, giving them pills is*

> *sometimes a bit problematic. This way, she comes once and you give her an injection, and she comes back in 3 months, and thus she comes out of the breastfeeding period and becomes calmer."* (9IDI, gynecologist, YFHC)

- **Abstinence and acceptance of the number of children "given to you"**

Some young men and women are of the opinion that you should not have sex before marriage **–** ***"Sex life begins after marriage, so why bother with it beforehand?!"*** (M, 20 years old, rural, 1FG). And then, as many children as *"it is destined for you to have", "God gives to you"*, the woman will give birth to all of them and will raise them together with her partner.

> *"Now, I still do not protect myself. I don't know why, but we got to the conclusion that we would not protect ourselves. If God gives us another child, it will be a gift... we accept all of them."* (F, 32 years old, rural, 9FG)

> *"I have never used protection, and I do not see this need now. I live with my husband and see nothing to protect myself against. But yes, if God gives us more children, we will raise them."* (F, 42 years old, urban, 9FG)

> *"A woman who has 14 children, the 14th is one-year-old, but she does not want contraception – 'If God gives us another one, we will raise him.' Another woman with 4 children, she came to me not long ago, among the last examined, and I asked her, what about contraception? She said, 'No, if there are more children, fine,' but she takes care of them, they have funds to raise them, and they have all the comforts."* (5IDI, obstetrician-gynecologist)

In the research, some women with mental disabilities mentioned that they received the following message both from medical professionals and family members – "*It is best for you not to have sex*." The study found that people with mental disabilities face stigma and prejudice about their sexuality, both from family and some service providers.

Also, some couples give up an active sex life ("*It happens rarely"*) because they no longer want children, but they also refuse to use contraceptives. The reasons cited by couples were different: the fact that they did not find a contraception method suitable for them; lack of satisfaction / reduced sensations and sexual pleasure in

the case of condom use; installation of the IUD with problems (bleeding, pain, expulsion of the IUD, etc.); the belief that contraceptives seriously harm the physical and psycho-emotional health of the woman.

1.1.2 Uncertainties expressed regarding contraception methods

Some young women believe that it is best to use a condom, but it does not give you a 100% guarantee either, and it would be good to combine oral contraceptives with a condom.

> *"The condom, but still there is a very small percentage of risk, different situations happen and she can get pregnant anyway. But if they are not ready for this 1-2% risk either, they can go to the doctor for prescription of contraceptives and use both, and then that's it."* (F, 20 years old, rural, 2FG)

The study found that a large part of the interviewed persons (especially young men and women, but also other categories, such as rural women) heard something about some contraception methods, but are not sure of the information received. They mentioned: *"To prevent such incidents, there are also some pills"; "I also know there is IUD, but I don't know how well it helps"; "I don't know if it is a method, but there is interrupted sex"; "There are also some hormonal implants that are inserted intravenously or under the skin."* Many women mentioned that specialists usually discuss with them about the IUD and condom, and from the Internet and from the women around them they learn about other contraception methods, which arouses their curiosity and desire to learn more.

> *"I did not learn about contraceptive pills from the gynecologist, but from women on TikTok. Listening to what girls say (in the group discussion), I was intrigued and I will even further seek information on this topic. My family doctor told me there is an IUD with gold that is one of the most beneficial. As for the pills, no one recommended me."* (F, 42 years old, urban, 3FG)

> *"I have heard, for example, of some patches or hormone devices that are inserted under the skin, but I don't know how safe and harmless these methods are. I would like to hear the opinion of some doctors."* (F, 44 years old, rural, 6FG)

> *"I read in an article that there are injections that are given every three months, but I can't give any further details. I only found out there is such a method." (IDI, F, 46 years old, rural)*

Limited knowledge or erroneous perceptions were also noted in discussions about male contraception methods. The interviewees mentioned that they had heard about some of these methods, and also pointed out that apart from the condom, which is a widely used method, no one ever used other male contraception methods in a couple.

> *"I know there are contraception methods for men as well. I don't know whether it's a device, but there are some processes. It's a metal tube inserted into a man's penis or something."* (F, 20 years old, urban, 2FG)

The study found that the lack of information and/or limited knowledge about some contraception methods increase the degree of distrust in them and therefore increases the reluctance to use them.

> *"I didn't really know about contraceptive pills either, always having the fear that while they are good for something, they can affect something else. In my opinion, these pills can affect the hormonal balance of the woman. On the one hand you protect yourself, but on the other hand it can damage the liver, for example. There are women who can get pregnant even with the pill."* (F, 45 years old, urban, 3FG)

> *"From what I heard [in the focus group], I understand that oral contraceptives are not so bad as I initially thought. However, I would not use them anyway, but I would recommend them to a couple who do not want a pregnancy at the moment."* (F, 23 years old, urban, 3FG)

1.1.3 Perceptions of the safest / most reliable contraception methods

In all discussions with female respondents, situations were reported in which women in their entourage became pregnant despite using contraception methods such as oral contraceptives and intrauterine devices. Thus, respondents got the perception that the use of oral contraceptives is not effective, even if the majority of women mentioned that the recommendations on how to use them were not followed properly.

> *"An acquaintance gave birth while on contraceptives. She had toothache and went to fix it. There she had a checkup and found out that she was four months pregnant. Astonished, she could not believe it, because, as she said, she was protecting herself by taking pills. In the end, it was found that she wasn't taking them correctly, which caused the pregnancy, because they did not have the desired effect."* (F, 41 years old, rural, 3FG)

The interviewed medical professionals noted that one of the most frequently asked questions by their clients concerns the effectiveness of contraception methods in preventing an unplanned pregnancy.

1.1.4 Myths and stereotypes about preventing an unplanned pregnancy

The study identified several activities, actions [that have no scientific basis or may even be harmful to health] that respondents or people in their entourage do, believing that in this way they can prevent an unplanned pregnancy, including:

- **Hygiene / washing of genitals immediately after intercourse,** including with the use of chemicals – it is considered by some women to be an effective method of preventing an unplanned pregnancy, whether it is achieved only with the use of soap/shower gel or with the use of other chemicals, such as baking soda, potassium permanganate, diluted vinegar.
- **Urination immediately after intercourse** – a practice that is still used and recommended by women, especially women with a low level of education.
- **Hot shower and/or keeping feet in hot water** – a practice taken over from older women in the family, the effectiveness of which is questioned even by women who said that they practice it.
- **Vaginal douches (diluted vinegar, chamomile tea, lemon juice)** – several participants in the study mentioned that they had acquaintances or relatives who recommended such practices**,** which respondents consider outdated, as safe contraception methods are available now.

> *"One of my colleagues told me that a tablespoon of vinegar is added to 100 ml of boiled water and you should wash with this solution internally. I don't know, I haven't tried, and I think that these are some primitive methods, and now we are in the 21st century and something more innovative and new keeps appearing, which is better to use as contraception."* (F, 42 years old, urban, 3FG)

> *"My mother-in-law suggested to me as a method of contraception internal washing with water and vinegar or citric acid, but I did not try it, because nowadays there are so many affordable contraception methods."* (F, 44 years old, rural, 6FG)

- **Introduction of some products into the vagina (lemon slices, garlic, butter balls with citric acid)** – such practices have been noted as rarely used by some women, and other women in group discussions reacted by trying to combat them, pointing out that these methods can cause injuries and infections and are dangerous to the woman's health. Since safe contraception methods are currently available, these practices are largely rejected by women.

> *"I used and still use lemon slices, I told about it to other women, it really works."* (F, 45 years old, urban, 3FG)

> *"I had an acquaintance who used butter balls and citric acid as a substitute for contraceptive suppositories. I would not be ready to apply such experiments."* (F, 46 years old, urban, 6FG)

- **Consumption of some products:** milk with iodine, vitamin C in large quantities**.**

> *"I thought I was pregnant, and I drank milk with iodine, maybe my mother told me, or a woman advised me... It helped, I told about it to others."* (F, 27 years old, rural, 5FG)

> *"You can drink several vitamin C pills, I don't know how many exactly, but the method is not effective. I tried, but it didn't work."* (F, 49 years old, urban, 8FG)

- **Intense work, lifting weights** is a practice that women use as "emergency contraception", when they assume they might have an unplanned pregnancy after unprotected sex.

- **Abortion perceived as a method of contraception**

One aspect that is taken to the extreme refers to **abortion**: On the one hand, there are people who perceive any form of contraception as interference in *"God's will", "in fate"*, and are categorically against termination of pregnancy even in the initial

stage, and on the other hand, there are women who perceive abortion as a form of contraception – *"rather than using pills all the time or having an IUD, it is better to have an abortion if it happens and you don't want the baby."*

Several women, especially over 40 years old, mentioned that they had not used any method of contraception over time, and in the event of an unplanned and unwanted pregnancy, they resorted to abortion. Some women feel they have suffered the consequences of these abortions, being unable to conceive a child later, when they wanted to.

> *"We have never protected ourselves. At first, he did not accept a condom, so I had three abortions, and then I wanted children, but I couldn't get pregnant... At that time there were not so many contraception methods, or we didn't know about them. I wanted children, but when I got pregnant and saw my husband's behavior, I thought we'd get divorced and I couldn't decide to give birth."* (F, 41 years old, urban, 8FG)

Abortion was mentioned by some respondents as one of the methods of preventing an unplanned pregnancy. Moreover, the study identified several situations mentioned in the discussions, when women decided to take abortion pills without consulting a health care provider. In some situations, Moldovan women abroad ask their friends to send them these pills.

In several group discussions there were women who mentioned *that "abortion takes 5 years of a woman's life".* In the light of these beliefs, some women who said that for them the birth of a child / one more child was a challenge (for health and/or socioeconomic reasons) decided not to terminate the pregnancy.

At the same time, in religious groups and not only, the idea is promoted that **the use of contraception represents / is equivalent to a monthly abortion**, given that it prevents a child from being born.

> *"I am against abortion, all children must be accepted. By the way, the IUD, as the doctor explained to me, also has the effect of abortion. The egg, even if it has been fertilized, does not reach the uterus because it is removed."* (F, 44 years old, rural, 6FG)

> *"Last week, a woman told me that if she gets an IUD, ovulation occurs anyway, only that at the level of the uterus the embryo is killed and in fact it is a monthly abortion."* (4IDI, gynecologist)

- **No method of protection is effective** *"if you are destined to have another child", "such is your fate", "if you are meant to get pregnant, not even the condom or pills will help, that is fate, whatever will be, will be."* (F, 41 years old, rural, 5FG)

Some myths about contraception are transmitted by medical personnel, too – *"From my own experience, I know that in case the situation described above happens* [unprotected sex]*, internal washes are done with clean water, and if we have at hand, we also add chamomile".* The respondent who gave us this "advice" is a nurse in an educational institution, being interviewed as a representative of one of the vulnerable groups eligible to benefit from contraceptives offered free of charge at PHC level.

1.1.5 Perceptions in the context of service provision for various categories of beneficiaries

The interviewees, including some health service providers, mentioned during the discussions that for young women and/or women who have not yet given birth / have no children, the use of oral contraceptives and IUD is not recommended. It is assumed that these methods could later create fertility problems. On the other hand, the use of a condom or vaginal ring is recommended.

> *"There are also other types of contraception, such as pills, but in a young couple this method is not quite healthy. Even if it prevents pregnancy, it changes the hormonal status a lot, and in the future it could have consequences on fertility. I talked to a gynecologist in a private clinic about this."* (F, 19 years old, urban, 2FG)

> *"I don't know if the IUD is indicated for young people, who have not yet had children. There is controversy, but I'm not sure."* (F, 19 years old, urban, originally from rural, 2FG)

> *"Young girls are recommended one type of contraceptive ... [hormonal vaginal ring]. They release a certain amount of hormones to prevent pregnancy."* (F, 19 years old, urban, 2FG)

Doctors mentioned in the discussions the need of choosing contraceptives based on several criteria, mainly *the age of the woman, associated pathologies, and individual tolerance to various substances.*

1.2 Responsibility for preventing an unplanned pregnancy

A large part of the respondents believes that responsibility for preventing an unplanned pregnancy should be assumed by the couple, given that both partners participate in a consensual sexual act. However, the opinions of those who believe that only one of the partners should be responsible tend to tip the balance towards the opinion that the woman has more responsibility, since she is the one who carries the pregnancy and bears the consequences of an unplanned pregnancy.

Also, some respondents noted that women *"can control themselves"* better during intercourse and can thus interrupt the intercourse *"on time"* – *"You feel it and give him a push"*.

Most of the respondents emphasize that, first of all, the personal and professional life of the woman is most affected by a pregnancy and the appearance of a child. If this pregnancy is not planned or does not occur at the desired time and context, the consequences are more difficult for women to manage.

> *"We, women, have more responsibility, because he can tell you not to worry, he'll manage [withdrawal method]. It doesn't influence them so much if a pregnancy occurs; if the need arises, he marries, the child is born, and in half a year he says goodbye to you and finds another girl, and the woman remains alone. She can't complete university studies and find a job, as the child must grow until you can take him to kindergarten. That bothers me, and I take care."*
> (F, 20 years old, rural, 2FG)

Among the young people interviewed, it was found that teenage girls and young women consider that the responsibility lies to a greater extent on women, because they bear the consequences of an unwanted pregnancy, and boys think that men should assume responsibility, because *"he is responsible for ejaculation".* Hence, we can conclude that young people, too, frequently practice withdrawal as a method of contraception. Some women mentioned that in their family, the man was the one responsible for preventing an unplanned pregnancy, since they used withdrawal as a method of protection. This method of contraception was perceived as inappropriate, because it does not allow enjoying sexual intercourse / sexual experience. For both the woman and the man, the withdrawal method can generate stress and anxiety, due to the focus on the moment of withdrawal and the permanent fear of an unplanned pregnancy. Worry about the moment of ejaculation can also affect the pleasure of sexual intercourse.

> *"In our family, most often the husband took care of preventing an unwanted pregnancy. But now I'm sorry about that. Because we used the withdrawal method, our sex life was affected. Looking back, I think it was a very big mistake. I think this happened out of ignorance and misinformation."* (F, 47 years old, rural, 3FG)

Some of the women are convinced that in the case of using the withdrawal method to protect from an unplanned pregnancy, the responsibility lies with the man – *"If he does not let go, you will not get pregnant, he is more to blame."*

Buying condoms is most often the concern of the male partner. Although this topic has not been investigated directly, in different contexts it has been emphasized that the woman can request the use of a condom, but the responsibility to have it lies with the man.

> *"There is also this thing that we are women, and for this issue [condom] the man is more responsible. We may ask, but we don't go buy them."* (F, 19 years old, urban, 2FG)

The study found another pattern that was highlighted in several group discussions with reference to sexual intercourse – *"the man's pleasure", "wanted by the man", "they need sex more".*

> *"Both are responsible, because we are talking about a relationship. Even if most of the time the man is the initiator [of sexual intercourse], the responsibility falls on both."* (M, 21 years old, rural, 1FG)

Another aspect found in the study refers to the way women perceive the attitude of the man towards the concern of preventing an unplanned pregnancy. For some women, the partner's concern for contraception is a form of manifestation of love and of the fact that he cares about her health. But for other women "fear of a pregnancy" is evidence that the man has no feelings and does not want a child (one more child) from her.

> *"There have been times when I wanted without [condom], but he was so worried, he didn't accept it... It happened once that, when my partner returned from Germany, we did not use protection. He came the next day with a pill and told me to take it because he didn't want me to call him back and tell him I'm pregnant. I was offended, but I took it."* (F, 29 years old, urban, 8FG)

In the case of vulnerable categories, the interviewed doctors pointed out that for the prevention of unplanned pregnancies it would be good to involve more representatives from the community by organizing information sessions for members of the community, informing about the eligibility of groups to benefit from contraceptives at the family doctor. At the same time, some doctors do not see the equal involvement of female and male local leaders, a sign that responsibility for contraception is still more attributed to women in these categories, including by doctors – *"teachers and social workers need to be involved too. Well, the mayor is a man, we can't get him involved."*

2

PRACTICES AND BEHAVIORS RELATED TO THE USE OF CONTRACEPTION

2.1 Contraception methods used

The most used contraception methods mentioned by study participants were the withdrawal method and intrauterine devices, and for casual sexual relations, the condom. In most group discussions with women, except for the group discussion with women with mental disabilities in residential institutions, there was at least one respondent who mentioned using, or having used, oral contraceptives. In some cases, oral contraceptives were prescribed to balance certain hormonal disorders and/or in the treatment of severe acne.

The withdrawal method / ejaculation outside the vagina is perceived as the least offensive method for women's health. Although most of those who use it are aware that it is **not** an effective method, they assume/accept the significant risk of an unplanned pregnancy, and some study participants said it is not a method that gives you comfort. For the situations considered *"incidents"* (ejaculation in the vagina), they use pills for emergency contraception or traditional practices to prevent an unplanned pregnancy (various vaginal washes) that are in reality ineffective or even harmful to health.

> *"My husband and I also protect ourselves by withdrawal, but also by taking the morning-after pill, which I use about once every six months. I went to the gynecologist and explained the situation [unprotected intercourse], to which he gave me the name of the medicine, and I went to the pharmacy to buy it. I did not want the IUD, because after the second pregnancy, with the girl, I went from 50 kg to 100 kg. As far as I understood from other sources, too, with the IUD there is a high probability to gain weight. However, to feel safer, sometimes we also use a condom."* (F, 23 years old, urban, 3FG)

Regarding the **IUD**, female respondents mentioned some side effects or problems they faced, such as discomfort, menstrual cycle disorders, heavy bleeding. But the biggest problem regarding the IUD is that some women do not address in time for its removal and, respectively, they get pain and gynecological problems.

> *"I think I got myoma from the IUD, because I got one that's only good for 3 years, but I kept it for 8 years."* (F, 41 years old, rural, 3FG)

However, many women opt for the IUD, because it is considered a more convenient and effective method. Many of the interviewed women who used withdrawal as a method of protection and had an unplanned pregnancy subsequently opted for IUD as a method of contraception.

> *"When I was younger, I used the withdrawal method as well. This lasted until I became pregnant with my first child. Withdrawal really is not the best option. First, it is discomfort, you don't get any pleasure. Second, you must always be in a psycho-emotional strain. That's why I chose the safest and most comfortable method of contraception, the IUD."* (F, 45 years old, urban, 3FG)

Virtually all people who said that they use a **condom** as a method of contraception mentioned that it was not used for every intercourse, because either it was not at hand or available at the time, or they decided to use the calendar method plus the withdrawal method.

> *"I have a boyfriend. We talked about it and we both make sure everything is okay. He usually buys condoms... Exceptions also happen. In this case we resort to the withdrawal method."* (F, 20 years old, urban, 2FG)

Oral contraceptives were an optimal solution selected by women who mentioned that they had problems during the period of using IUD. They admitted that they heard mostly negative opinions from other women in their entourage (see reasons in Chapter 2.3 Barriers).

> *"Unfortunately, the IUD did not work for me and in about 8 months I removed it. One of the reasons that prompted me to do this was heavy bleeding. When I went to the doctor, he told me that this method did not suit me and it would be best for me to use birth control pills or the condom."* (F, 42 years old, urban, 3FG)

Some women who had used oral contraceptives gave them up because they experienced side effects. Most of the time they stopped taking them without consulting a specialist and without opting for another method of contraception.

> *"I was offered some contraceptive pills, but I refused, because I had taken them for about eight months last year, but it was very difficult to give them up. The menstrual cycle after that is different. It got to be longer, the density changed [consistency, flow]. In the first month, it lasted about two weeks. I started taking contraceptives not for contraception, but because I had severe acne. I consulted the dermatologist and gynecologist, and they decided to give me the weakest contraceptives."* (F, 20 years old, rural, 2FG)

The study also identified women, mostly from urban areas, who are satisfied with the use of oral contraceptives. They refute stereotypes that oral contraceptives make you gain weight.

> *"I have quite serious myopia and both births were by C-section. Recommended by the doctor, I decided that it would not be desirable to have another pregnancy, so as not to worsen the eyesight even more. Thus, as a method of contraception, I take pills. I have been taking these contraceptive pills since I was 38. Even if it is said everywhere that you get fat from them, that they are harmful to the body and cause other adverse reactions, I can say for sure that it is not quite so. Personally, I did not notice any changes in body mass and the state of my health... I can say that I am very pleased with them. You really live a simple, free life full of emotions, and I'm sorry I didn't use this method before."* (F, 42 years old, urban, 3FG)

Several female participants in the study who have health problems (such as diabetes, high blood pressure) or have given birth to several children mentioned that they were proposed to "have their tubes tied". Some women accepted voluntary **female sterilization as surgical contraception**, having mentioned that their last pregnancy was problematic and they don't want to put themselves and their children at risk.

> *"After the last birth, my fallopian tubes were sewn. For the reason that the last two children were born premature due to diabetes and so as not to have an unexpected pregnancy, we decided to have this procedure. I talked to the doctors and concluded that for my age, sugar is very*

high, causing a lot of problems. Thus, in order to avoid an unwanted pregnancy, so as not to make children suffer and not pose danger to my life, we decided to protect ourselves in this way." (F, 27 years old, rural, 3FG)

"The last pregnancy was very difficult, I was with high blood pressure... The doctors proposed strictly after the second pregnancy to have my tubes tied, but I refused. Seeing as I was struggling between life and death with my third pregnancy, it was already my decision to have the procedure." (F, 41 years old, rural, 3FG)

In several group discussions and interviews there were women who mentioned that they used medical abortion pills without a doctor's consultation. In two cases, pills for medical abortion were purchased in order to be sent to Moldovan women abroad.

One respondent mentioned that she was recommended to use pills for termination of pregnancy from veterinary pharmacies, which, according to those who recommended this, are much more effective – *"An acquaintance told me that she went to the pharmacy for animals and she drank those pills and had an abortion, had bleeding, the pregnancy did not go further... they are better, more effective."* (F, 27 years old, rural, 5FG)

Some women from residential centers for people with disabilities said that for them pregnancy is not *"something terrible, that you either have an abortion or you give birth"*, but they are much more concerned about the risk of getting a sexually transmitted infection. Thus, some people in the center are labeled as having a sexually transmitted infection and others avoid them.

*"It is not terrible if you get pregnant. But if he has syphilis or AIDS and you slept with him, because you didn't know and you got it, there are such cases here. Where are the doctors looking?! It's good that someone told me that one was like this and the other one was like this, but what if I didn't know he had syphilis or AIDS?!" (*F, 41 years old, 11FG)

The interviewed health service providers revealed that there is an improvement in the use of contraception. The reduction in teenage pregnancies and the number of abortions is evidence. At the same time, some obstetricians-gynecologists recognize that in certain cases, referring to vulnerable groups (women who abuse alcohol, who have several sexual partners and/or who neglect their children, women with

severe disabilities), they resort to IUD insertion without the woman's consent. The specialists understand perfectly that it is not an ethical practice, but they declare that they assume it in order to prevent an unplanned pregnancy and possibly the birth of children who will suffer, but these actions do not respect the sexual and reproductive rights of the beneficiaries.

> *"Sometimes if I see that the patient does not have an inflammatory process, I put the IUD without her consent, rather than let her have a child and ruin him or be with a heart defect... they often have genetic diseases, too. I tell them I put the IUD, and if they stop drinking, then I'll take it out. God forgive me, but I am forced to do this, too."* (4IDI, gynecologist, YFHC)

> *"The one who gave birth was from a socially vulnerable category: a single teenage mother. Right away we are trying to insert an IUD as soon as possible. Sometimes we do it in the maternity ward, right after she gives birth. We consult with the doctor, with the specialist in the in-patient facility; sometimes the woman did not know, although this is not correct, but something like that was done. If it was necessary, it had to be done... Or when they are admitted in the pediatric ward, if vulnerable mothers come with children of 3-5 months, with a bronchitis, pneumonia, then the head of the pediatric ward sent them to us for contraception.* (5IDI, gynecologist)

2.2 Decisions regarding contraception methods

The study found that there are some trends regarding the decision to use contraception methods:

- decision of the couple
- decision of the woman with consultation of an obstetrician-gynecologist
- decision of a third person in case of some teenagers, persons with mental disabilities under guardianship, or in the case of complex situations (abuse of drugs, alcohol, etc.)

Respondents who said it was the couple's decision pointed out that partners choose the best option for them to be protected from an unplanned pregnancy, but also to enjoy a harmonious sex life.

Respondents who believe that the decision primarily belongs to the woman argue that it is about her health, considering that most of the currently available contraception methods are intended for use by women.

In a few contexts, some women pointed out that their partners insist on having sex without a condom under the pretext that they *"don't feel the same pleasure".*

It was also noted in group discussions with key groups, although rarely, that men want children / another child, and it is women who choose to use contraceptives without informing their partner. Situations largely due to distrust in the current partner, violence.

The study also identified some situations in which the man is the one who insists on contraception to prevent an unplanned pregnancy, whether it is a family with several children or a relationship perceived as temporary.

Obstetricians-gynecologists mentioned that there are situations in which parents or guardians of persons with disabilities call for *support for contraception for these persons, especially in the case of a previous unplanned pregnancy.*

> *"There are people with mental problems who do not have relationships, do not go anywhere. There are others where the mother comes and says, 'She is healthy, put her an IUD because she doesn't understand. If you do it, I'll know she's not going to get pregnant.' Such people don't come themselves."* (5IDI, gynecologist, YFHC)

> *"The person who has guardianship or who is in charge of the disabled person. Depending on the degree of decision-making we also discuss with her. The method of giving it to someone without their will is excluded... In some situations, they are not able to make decisions."* (5IDI, gynecologist, YFHC)

The specialists of a temporary placement center for adults with disabilities mentioned that they *"find it difficult to manage contraception situations"*, as on the one hand they are responsible for the health and integrity of the people in the institution, and on the other hand they cannot decide or influence if the person does not consent to the use of a method of contraception.

Thus, in the center they have a woman who gave birth twice, and the children are placed in the Maternal Center. In this case, on the one hand, the woman does not give up the children, and on the other hand she, having mental health problems, is not allowed to stay with them in the Center. She still does not use any method of

contraception, and without her consent *"no action can be taken"*. Specialists say that people at the center were informed, influenced by representatives of NGOs and human rights activists to refuse to sign any agreement under the pretext that they could be deceived.

2.3 Barriers mentioned by respondents in the use of modern contraception methods

a) **Respondents do not know about the fact that they can benefit from different contraception methods for free** by contacting the family doctor. Some of the interviewed representatives of vulnerable groups also expressed reluctance to go to the family doctor for contraception.

b) **Concerns about unwanted effects** most commonly associated with oral contraceptives, called by respondents "hormonal pills". Thus, respondents mentioned the following potential undesirable effects:

- *Weight gain, obesity – most often mentioned by women;*
- *Hormonal disorders;*
- *Menstrual disorder – "it becomes more abundant and more painful";*
- *Infertility – especially mentioned by young men and women;*
- *Damage to the liver and digestive system;*
- *Malaise, including psycho-emotional sensitivity;*
- *Increased hairiness – "excess hair growth".*

> *"There may be some problems with infertility, especially on the female side. Medicinal substances can negatively influence the production of eggs by the female genital organs, becoming a serious problem, so when the woman will want to conceive a child, she won't be able to."* (M, 16 years old, urban, 1FG)

> *"Of the oral contraceptives taken by women, I can't name one that is harmless to the body, because they are on a hormonal basis and contribute to the increase in body mass, attacking the liver..."* (M, 20 years old, rural, 1FG)

> *"Some are afraid that they will gain weight, others are afraid that they will grow hair in the wrong places, others are afraid that their libido, or sexual attraction, will decrease, or something else... others are not allowed by their religion."* (8IDI, family doctor, urban)

Some respondents are convinced that they have undesirable effects because some women choose to use oral contraceptives without consulting a doctor, without any investigations (even if they are not required by specialists). Some women are convinced that if contraceptives are recommended according to eligibility criteria, they will not have side effects and certain aspects can be managed together with the obstetrician-gynecologist.

> *"I know from some friends that they had taken contraceptive pills and because of the hormones they were not feeling very well. If you go to the doctor and do some tests to be prescribed the right pills, I think there should be no such problems. But if you go to the pharmacy and ask for some contraceptives, in this case I think there may be problems."* (F, 16 years old, urban, 2FG)

c) Challenges regarding the use of IUD

> *"We have had some cases when we administered the IUD to women in the socially vulnerable group, they went home and with a finger removed the IUD because it irritated them, did not feel comfortable."* (7IDI, family doctor, rural)

d) Irregular sexual intercourse at long intervals. Migration of spouses/ partners abroad, which is a factor that requires specific counseling for choosing the method of contraception suitable for the situation.

e) Irregular use of condom – considered a good protection method, but not used at every sexual contact.

f) Limited knowledge of the broad spectrum of contraceptive methods available, advantages and disadvantages of each, which prevents the couple from making an informed decision and opting for the most appropriate option for their needs and preferences. As a consequence, they declare that the right method of contraception has not been identified.

> *"We pull out on time [withdrawal method], and then there is God's will. With the condom it is not so good, the feeling is wrong, and I don't want to take pills because I'm afraid of hormones, so this way is better. I don't want the IUD, either, it causes menstruation problems, that's why no."* (F, 27 years old, rural, 5FG)

g) **Lack of confidence in the effectiveness of contraception methods and the persistence of the idea that contraception methods do not provide guaranteed protection** – *"no method is safe".*

h) **Social norms and expectations and fear of being judged** – this is especially true for young people. Purchasing condoms or seeking them for free is a barrier difficult to overcome especially in smaller communities, where people know each other.

> *"I saw 14-15-year-old boys going to the pharmacy and buying condoms and the pharmacist looked at them very disapprovingly, as if they killed a man. Because of this many do not use them."* (F, 16 years old, urban, 2FG)

i) **Difficulties in becoming aware of risks/need for protection** – in residential centers for people with disabilities, changing partners is a widespread practice, and sexual relations are often unprotected. In some contexts, situations, the priority is to live the moment, and they think about possible consequences later.

j) **Alcohol consumption** affects the perception of risk, respectively diminishes the importance of using a method of contraception.

> *"Young people, when they meet, they only just meet and consume something, and then they care for nothing and they don't realize the consequences that may come. It's not that they don't know about contraception, but many mistakes are made while intoxicated."* (M, 39 years old, rural, 10FG)

k) **Cost of purchasing contraceptives –** the issue addressed mainly in the group discussion with men with low income. They mentioned the high costs for quality condoms, but also for other contraception methods (contraceptive pills, emergency contraception, IUDs, etc.).

l) **Insufficient knowledge of sexuality and contraception, which is manifested in the belief that *"I can't have children"*,** they will not get pregnant – there are women who are convinced that they have fertility problems and will not have a pregnancy and for this reason do not protect themselves. Even women who have had previous pregnancies/abortions believe that after 40 years the probability of a pregnancy is low, and if it happens, it will be terminated.

> *"I am not protecting myself currently, because I have the feeling that I will not be able to get pregnant again. In the previous relationship, no one was responsible for protection. Our contraception consisted of withdrawing, only, as a result, I got two miscarriages."*
> (F, 37 years old, urban, 8FG)

In the opinion of obstetricians-gynecologists, but also of specialists from YFHC, one of the biggest challenges is the limited access to family planning services and contraception in rural areas, especially for young people and socio-economically vulnerable people (people of this reproductive age group usually rarely or not at all address doctors, only when they have a health problem, and in these conditions they discuss the problem they addressed for, some of them being convinced that if they do not have health insurance they will have to pay for medical services). This is because of **the long distances to youth-friendly health centers and the lack of adequate information for these people –** *"In our district, YFHC services, including contraception services, are used more than in urban areas. But access for people in remote villages is a problem."* (6IDI, gynecologist, YFHC)

Religious motive is another argument invoked by some people who categorically refuse contraception. Doctors said they are some of the most difficult categories to be counseled and helped to make informed decisions about using any method of contraception if needed.

> *"There are some who do not accept for religious reasons. We have families with 13 children, 11 children, some are Jehovah's Witnesses, some are Baptists, who are categorically against any method of contraception from a religious point of view. They come with pregnancy and, respectively, as with anyone, after the 4th pregnancy, we ask how many more children she wants, 'How are you planning your future life?' With this category, it is useless trying to prove something, like with vaccination of children. Especially Jehovah's Witnesses, in recent years they have been coming to the maternity ward with an agreement drawn up by the lawyers, where they*

signed in advance that if life was in danger, blood or blood preparations cannot be used for religious reasons and that they take the risk if something happens." (2IDI, obstetrician-gynecologist, YFHC)

Family doctors, but also obstetricians-gynecologists, pointed out that another factor that causes some categories of women to give up the use of contraception refers to **socio-economic interests** – the one-time birth allowance and the child care allowance determine them to give birth. In some situations, women hope that if they have a certain number of children, they will be provided with a home.

"A beneficiary told me that she will receive 20 thousand lei, and she will also receive money for the child. This is something we have, too, in socially vulnerable families, where they should not have children because they only ruin them, or social assistance has work to do, placing them in some placement centers. We inserted them IUDs, but when they heard that the state offers them 20 thousand lei, they take the IUD out elsewhere." (4IDI, obstetrician-gynecologist, YFHC)

2.4 Challenges of health workers in providing contraception services

Family doctors **are very little involved in informing and recommending contraception methods** both in the opinion of service providers and of respondents from vulnerable groups. Some family doctors, but also obstetricians-gynecologists, **do not know which are the 12 vulnerable groups that can benefit from contraceptives offered at the level of primary health care.** Most health workers discuss contraception predominantly with women with many children and/or women who do not fulfill their parental responsibilities, women with risky behaviors (alcohol use, having several partners / unstable partners, etc.). Family doctors, both those working in rural areas and those in urban areas, say that they refer women to the obstetrician-gynecologist for the recommendation and choice of contraception method.

Not knowing all the categories that can benefit from free contraceptives, some health service providers intuitively indicate these categories as eligible for free contraceptives, but have the feeling that they violated something, because they know/mistakenly perceive that free contraceptives are intended only for socially and economically vulnerable categories.

"Women who have unplanned pregnancies seem to be better off, but they still deserve it, they had one abortion, they had a second abortion, for them this is a negative experience, too, they should also receive it. They don't want a pregnancy to begin with. We offer them, we don't look at the patient's vulnerability. If she addressed voluntarily, then we have to offer, we strive to include them, too." (2IDI, obstetrician-gynecologist)

According to some family doctors, **given the demographic situation in the country and the small number of births, they do not recommend couples methods of protection against an unplanned pregnancy; on the contrary, they encourage them to give birth to more children.** Some doctors say they only propose contraception methods to women who have had at least two births.

"Until the second pregnancy, it is not recommended, that is, after two births we recommend contraception methods, but before the second birth we don't recommend contraceptives... for the health of the mother and children, that is, it is undesirable to use contraceptives." (7IDI, family doctor, rural)

Contraceptives received for categories in key groups **do not necessarily reach them, or in some situations they expire** and additional procedures are needed for their return, destruction.

"The socially disadvantaged group is covered, that is, we are given [contraceptives] for them; for example, when we get 4 contraceptives, I mean 4 IUDs, and then they give us some more, they tell us to see who needs them, that is, we no longer look whether they are socially disadvantaged or not. We give them to everyone who wants. According to the law, we should not, but who needs the term of the IUD to expire without being used?! I mean, condoms are more often used in this socially disadvantaged group, that is, the more condoms we have, we give them all in the first month." (7IDI, family doctor, rural)

"Youth-friendly health centers have many contraceptives, especially emergency ones... which are free, and their term expires and no one uses them. Why?! Because 1,000 pills came [emergency pills], and a girl once in half a year uses it, but otherwise they use condoms, withdrawal, IUD, or other oral contraceptives. These emergency pills are for unpredictable cases." (3IDI, obstetrician-gynecologist)

Several family doctors revealed they are faced with having stock of oral contraceptives they have no one to give to – *"Sometimes there were too many contraceptives, we didn't even know who to give them to, to distribute them before the term expired."* **It is difficult to keep, monitor, and then manage expired stock**.

> *"We are allocated these drugs by invoice. We take 10 boxes of one kind, so many condoms, so many different kinds... We store them somewhere and worry that the term might expire and these preparations may not even be kept in the necessary conditions, properly, like in pharmacies. Not all family doctor's offices are equipped to store medicines. Until we find beneficiaries, the term expires or almost expires. Then there are some monitoring issues: How many did you give? How many are left? Who did you give it to? and so on. Very frequently we have situations with oral contraceptive pills whose term expires."* (2IDI, family doctor, rural)

3

SOURCES OF INFORMATION AND RESOURCE PEOPLE REGARDING CONTRACEPTION

The study found that persons' levels of information on contraception differed greatly. Being of a qualitative type, the research could not clearly identify any more informed groups, according to socio-demographic criteria (age, sex, rural/urban, education); however, it seems that people active in the community, who participate in activities organized by NGOs, and Russian speakers are better informed and approach the topic of sexual relations, including relations in the family, more easily.

Another aspect identified is that among young people, there are some who are very informed, who benefited from discussions with teachers, extracurricular activities, and some of them also addressed this topic in the family, and on the other hand there are young people who have not discussed the topic of contraception with anyone, or discussed it only with their peers. For these young people, the main source of information is the Internet. In general, the Internet is an important source for seeking information, for deepening the knowledge of young people and other respondents.

At the same time, some respondents pointed out that some information in the Internet is not truthful and we should pay attention to the source. It was exemplified that on the social network TikTok some people promote stereotypes about contraception and sex life. However, some young people mentioned that they prefer to read the opinions of people online rather than consult specialists, largely because they will be judged, but also because of the lack of availability of medical professionals to address these topics in a safe environment[4] – *"The opinions of people in the Internet are a source that I trust."*

[4] See the sub-chapters below.

3.1 Obstetricians-gynecologists

Obstetricians-gynecologists are the most important and reliable resource for choosing a method of contraception in the opinion of people from vulnerable groups and service providers. The vast majority of the interviewed family doctors pointed out that it is necessary to consult an obstetrician-gynecologist in order to choose a method of contraception. Family doctors do not feel ready in terms of knowledge, experience, and skills to consult and offer contraception to women, couples.

> *"I know the subject in general, but not well enough to be able to recommend contraceptives to a woman, for example, like I prescribe medication for other pathologies. It is a specific area, and we understand that there can be side effects. If a problem occurs, I have no idea what may occur. I refer the woman to the gynecologist to consult anyway, I don't recommend anything."* (2IDI, family doctor, rural)

Some female respondents pointed out that they prefer to address obstetricians-gynecologists in private clinics in order to benefit from a better attitude. Usually, these respondents were either verbally assaulted, bullied, or witnessed some inappropriate attitudes, behaviors in public medical institutions. This aspect was also mentioned in group discussions with refugee women from Ukraine, who noted that for qualitative medical services and a benevolent attitude on the part of the doctor, it is advisable to turn to private clinics.

> *"Speaking from experience, I can tell you that I went to the gynecologist to a public polyclinic twice, and twice she looked at me disapprovingly, as if I owed her something. The last time I went, before me was a pregnant 14-year-old girl, accompanied by her mother. After they left the office, she started talking so badly about her – that she doesn't think with her head, that she spreads her legs left and right."* (F, 20 years old, rural, 2FG)

> *"In discussion with other refugees who had addressed a gynecologist either on the basis of temporary protection or went for free consultations, they complained that they met a negligent attitude and failed to solve their problem. In order not to walk from one specialist to another, I turned from the beginning to a competent specialist at a private clinic."* (F, 27 years old, urban, 6FG)

HIV-positive women pointed out that they prefer to go to the obstetrician-gynecologist at the Toma Ciorba Clinical Hospital for Infectious Diseases, where they are treated with understanding and respect.

Some vocational education and training (VET) institutions have the practice of inviting specialists or of going to medical institutions for information activities regarding contraception. Young women sometimes perceive these information activities as having a connotation of reprimand, reproach.

> *"The gynecologist gave us girls a little lecture, to be careful, not to rush [to have sexual relations], told us about contraception methods, brought us several examples of various sexually transmitted infections."* (F, 16 years old, urban, 2FG)

Some of the interviewed obstetricians-gynecologists noted that with certain categories of respondents it is very difficult to communicate, they refuse any form of contraception or simply stop contacting the specialist and return when they are pregnant. In the opinion of specialists, in the case of some women contraception should be resorted to even if they do not give consent. Some family doctors mentioned that together with the obstetrician-gynecologist they sometimes decide to put the IUD without the consent of the person, in exceptional cases, considered critical (alcohol consumption, mental disabilities, etc.).

Some interviewed women confirmed that the obstetrician-gynecologist had proposed at least one method of contraception, but they refused for fear of side effects.

> *"She proposed to me once to put an IUD, when I came to have an abortion. I don't want to, because it increases menstruation and I don't want it, and at that we ended the topic."* (F, 27 years old, rural, 5FG)

Obstetricians-gynecologists in the consultation wards of hospitals cannot provide free contraceptives to vulnerable categories. They very rarely have certain types of contraceptives available, which they consider to be of worse quality and/or having a limited shelf life, close to expiration.

> *"I don't know about polyclinics, but we don't even have condoms for some manipulations. In the consultation ward, if a vulnerable patient comes, I don't have a contraceptive to offer... We only had from donations, humanitarian aid. We got a couple of bags of pills*

> *about to expire, with limited shelf life ... As about quality, the IUDs brought in as humanitarian aid, I wouldn't give them. They are of very poor quality, very difficult to install, very thick, very cheap. When they are installed, it is quite painful, and they tell each other their fears and what happens."* (4IDI, obstetrician-gynecologist)

3.2 Family doctors, nurses

The vast majority of respondents from vulnerable groups noted that the family doctor was not a resource they would turn to for questions about contraception. A large part of the respondents stressed that the family doctor is the last person they would turn to, or would not turn to him under any circumstances. Many women prefer to turn directly to the obstetrician-gynecologist.

> *"The person I would turn to lastly regarding contraceptives is the family doctor. I am of this opinion because some family doctors have their ideologies. So, they would not give me a professional consultation, but would impose their opinion, that you need to start a family, that there are risks, etc."* (M, 21 years old, rural, 1FG)

"If you say it would be good to have an IUD, she says, 'I already got an IUD.' We are not informed, they go themselves and have it. They prefer to go on their own." (4IDI, family doctor, urban)
The main reasons for this are:

- **Privacy concerns,** especially expressed by young people, but also by other categories interviewed

> *"They can go to their family doctor, but to keep their privacy, they can go directly to a pharmacy that works 24/24."* (M, 16 years old, urban, 1FG)

> *"I wouldn't be able to talk to the doctor. Maybe with someone closer, my sister, for example. Because there are situations when the family doctor talks about you when you walk out the door."* (F, 16 years old, urban, 2FG)

> *"At the level of family doctors, they are afraid [teenagers, young people], because they know your mom, your dad. They have no guarantee that the family doctor is their friend."* (4IDI, obstetrician-gynecologist)

- **Problematic relationship / poor communication with the family doctor**
- **Overburdening of the family doctor** due to multiple responsibilities – *"You can't tell much to the family doctor, because constantly someone opens the door, he has a lot of writing to do."*
- **Turnover of healthcare professionals in primary health care, especially in rural areas**
- **Perception that the family doctor is not as qualified as the obstetrician-gynecologist to provide contraception advice**
- **Awkwardness of discussing the topic of contraception with the family doctor** (out of shame, you must insist – *"If you ask, he tells you"*, etc.)
- **Perception that the family doctor is prejudiced and/or traditionalist** – *"He is old-fashioned."*
- **Gender-based preconceptions** – *"With a man, even a doctor, cannot discuss."*

> *"In our situation, family doctors were changed very often. One time there is one doctor, another time there is another doctor... We've never had a family doctor for more than a year, who is present and who you can address whenever you need to. There were also male family doctors, and I felt uncomfortable asking them any questions about my female health."* (F, 47 years old, rural, 3FG)

> *"Family doctors somehow know the information in general, in all areas. Thus, in order to receive information, you have to ask, and sometimes you feel uncomfortable asking that question. With a gynecologist it is different. The gynecologist sees your question in your eyes and gives you the information you need before you ask for it."* (F, 33 years old, rural, 3FG)

Several family doctors pointed out that they have neither the time nor the context to address the topic of contraception, except with women from socially vulnerable categories and young families, but the latter address mostly when they have infertility problems. Family doctors are mainly focused on providing consultations for people with health problems, but they also have many other responsibilities, such as monitoring pregnant women and small children, immunization of the population, etc.

Some family doctors pointed out that they have no public speaking skills and find it difficult or refuse when they are invited to talk about contraception or other topics in educational institutions or in work settings. In their opinion, these information sessions / conversations should be organized and conducted by specifically trained people, including those who have communication skills.

> *"When a husband and wife come to me, it is easy for me to talk, but when we are told to go to a school or somewhere else, I can't do it. I mean, I am no public speaker, but when I am face to face with a person, I can explain quite easily, no problem. When there are more people in the audience, I get confused."* (7IDI, family doctor, rural)

Also, some family doctors mentioned that they are not sufficiently trained and confident in their knowledge to offer advice on contraception methods, especially when it comes to prescribing oral contraceptives.

> *"Most of all I was asked about the pills, and there is a certain problem. I mean, we would like the treatment to be started by a gynecologist, the first visit to be to a gynecologist and he would prescribe it, recommend the exact contraceptive, of the medication type... We look for indications, contraindications, what pathology the patient is registered with, I mean, something like that... we have a fear. We don't want to harm anyone."* (7IDI, family doctor, rural)

Thus, some family doctors mentioned that both they and the patients are embarrassed to address the topic of sexual relations and contraception. These family doctors say they do not know how to address these topics. And they usually only talk to women from socially vulnerable categories who have children they neglect.

> *"They may also use the withdrawal method, but these are questions they are embarrassed about. I can't ask, 'How do you sleep with your husband, with a condom or something else?' Among them are those who are embarrassed and don't want to say... I'm not touching this topic."* (4IDI, family doctor, urban)

Most of the interviewed family doctors (7 out of 10) have participated in some training on contraception in the last 3 years. A large part of them mentioned the 3-day training conducted in Chisinau, but also trainings at district level or online. Those who have not recently attended any training cited various reasons, such as

the recent return from maternity leave, being on annual leave during the training period, and stigmatization of older specialists, priority to training being given to young people in some medical institutions.

> *"We are a bit stigmatized quite often with age, they don't really send us to training ... The protocol exists, but you know how it is, we have standardized protocol in family planning. But frankly, we don't have time to study it well. When there are classes, you obviously have the protocol and you start studying it and it's different."* (6IDI, family doctor, urban)

The interviewed family doctors mostly mentioned that they are open to training on contraception methods, especially since there are certain changes and they need to know the new trends in the field. But there are also doctors who pointed out that for family doctors there are other training priorities, like the management of chronic diseases and acute diseases, and contraception is a topic for obstetricians-gynecologists. Some family doctors noted that even in the process of studying the subject of contraception it is not given increased attention.

> *"Training would probably be helpful. Not that I feel the need – you see, my daily engagement with chronically and acutely ill patients is major and, frankly speaking, we don't get to family planning. Even when I was having my practical training, and wherever I was, not much attention was paid to it... We had very little discussion on contraception during the residency period, very little. Even when I had the obstetrics and gynecology course, practically we focused on births... There was, I think, an online lesson on contraception, where there were family doctors and gynecologists involved, and if you got it, it was okay, you didn't get it, it was still okay."* (5IDI, family doctor, rural)

Some family doctors pointed out that face-to-face training is more effective than online training, both because of the many interruptions that occur during virtual sessions, especially due to patients requiring consultations, and because of the lack of direct interaction between participants and trainers.

In conclusion, the topic of contraception methods is little addressed by family doctors. One of the reasons is that family doctors are overloaded with solving people's health problems. At the same time, counseling on contraception is perceived by them as a task for obstetricians-gynecologists.

> *"Free contraceptives are issued only by the gynecological office, and it also can tell which categories can benefit from them, but we mostly refer socially vulnerable families to it."* (1IDI, family doctor, urban)

Obstetricians-gynecologists, including those from YFHCs, also mentioned that the responsibilities of family doctors and the high workload represent a major barrier in taking an active and effective role in advising and providing contraceptives to vulnerable groups of the population, depending on the need, to prevent unplanned pregnancies. Although family doctors have/had training in the field, there are protocols, regulations in this regard, very little work is done in this regard. Usually, family doctors intervene after certain critical situations occur.

> *"Family doctors are very busy. Even though they have this information and presentation tools, they don't have time to discuss contraception. Patients go to the family doctor, who has lots of problems and thus forgets about us (YFHC). Family doctors are trained by us, but the problem is that if he has 40 patients waiting at the door, he clearly forgets about us."* (1IDI, obstetrician-gynecologist, YFHC)

3.3 Representatives of Youth-Friendly Health Centers (YFHC)

The vast majority of respondents who interacted with YFHC staff, whether they visited educational institutions or young people went to YFHC, remained satisfied with the way they provide information, services.

> *"I've been to a youth-friendly health center a few times. I know that specialists there provide psychological counseling, training on sex life absolutely free of charge, and there is even a gynecological office. In addition, there are groups of volunteers who go to schools and give lessons on protection during intercourse and its importance. I really liked it there. As evidenced by the name, they turned out to be very friendly."* (M, 21 years old, rural, 1FG)

> *"They provide great information support, both brochures and videos on sex life, contraception, methods of preventing an unwanted pregnancy or infection as a result of unprotected sexual intercourse. In addition, they have demonstration stands, where they explain*

> *step by step how to open correctly, how to apply, and what manipulations you need to do with a condom."* (M, 18 years old, urban, 1FG)

> *"There are youth-friendly clinics, where young people can address and will be consulted free of charge by a gynecologist or psychologist. As far as I know, they also offer free contraceptives. As for the pills, you need to run some tests to determine which one suits you."* (F, 20 years old, urban, 2FG)

Most young people know about the existence of these centers, but there were some teenagers, young people who said that they heard about the existence of YFHCs for the first time. The latter showed interest in the work of YFHCs. Some young people mentioned that the YFHC in their city is located in a secluded area with limited access to public transport, and it is difficult for young people to get there – *"In our city these places are not visited very much, because they are very far away, where there is no transport and not much population."* (F, 16 years old, urban, 2FG)

Young people from Balti seem to have the greatest connection with ATIS YFHC, they mentioned several activities carried out by this institution. Also, all interviewed specialists from Balti mentioned cooperation with this institution. The interviewed family doctor noted that all young people who seek a health certificate for enrolling in a new educational institution are required to visit the ATIS Center.

Also, some representatives from the YFHC visit women in the work setting and inform them that they can also benefit from YFHC services, including contraceptives distributed free of charge.

> *"A gynecologist once came to my workplace and informed us that we can get contraceptives from the health center [YFHC], but I trust only the recommendations of my gynecologist."* (F, 33 years old, rural, 3FG)

Some respondents are skeptical about the quality of health services provided free of charge, even if they know people who have had positive experiences in accessing these services.

> *"I have friends who often turn to Neovita for consultation and are satisfied. I, however, wasn't sure it would help me, maybe because it's free."* (F, 20 years old, urban, 2FG)

YFHC specialists noted that they have enough resources to provide a method of contraception for anyone who addresses them. Although teenagers and young people are the priority category for them in providing services, including free contraceptives, it was noted that other categories that address them are not refused, either. In the opinion of some specialists, practically anyone who addresses can be classified into a category that benefits from free contraception[5].

Family doctors, and especially gynecologists, appreciate the activities carried out by YFHCs. They believe that many information activities and services are offered for teenagers and young people up to 24 years of age. At the same time, it was mentioned that these services should be more accessible to young people from rural areas.

3.4 Other resource persons

- **Family members**

The topic of sexual relations and contraception still remains taboo for most families. Young men and women who consider their parents to be elderly would feel uncomfortable addressing these topics with them and would prefer to discuss with older brothers/sisters, although there is a perception among respondents aged over 30 that things have changed, and now parents discuss with their children. De facto, young people mentioned that they prefer not to discuss the topic of contraception with their parents, whether they are embarrassed or do not see this need, considering that the Internet provides them with the information they need. Very few respondents mentioned that they can have honest discussions with parents, and for the most part it was the parents who initiated discussions on these topics. Although some young men and women mentioned that they would not see a problem talking to their parents on this topic, they have not done it to this day.

> *"I don't see a problem in asking my parents any questions, because they are open to discussion, freethinking, and do not put any barriers to me. On the contrary, I believe that parents are happy when their child seeks information, thus avoiding serious problems in the future. I mean not only unwanted pregnancies, but also various diseases that are transmitted through unprotected sex."*
> (M, 18 years old, urban)

[5] YFHC/YK services in crisis conditions focus on the target population – teenagers and young people aged 10-24, and also young people in a state of vulnerability up to 35 years old https://neovita.md/wp-content/uploads/2023/07/Dispoz-nr.-905-d-din-30.12.22-YFHC-1.pdf

Several women mentioned that these topics were not discussed at all in their families and they are still difficult topics to address. Some girls were not prepared, informed about the menstrual cycle, and the prevention of pregnancy was approached by saying something like, "Take care, don't come with a child out of wedlock", or was generally not discussed.

> *"I tried to discuss with my mother such topics, already being adult, under 40. She said her mother had never even discussed about the cycle with her. Even I didn't know until it happened. The time came and it's dripping, and 'Mom, what does this mean?' Let alone telling me what a condom or contraceptive means, or that the time will come. Such were the times."* (F, 46 years old, rural, 7FG)

Some women noted that due to lack of sex education of their partners, for them sexual debut and sex life generally was not pleasure, but mostly *"a wife's duty", "you must, this is done in the family", "so he doesn't go to other women".* These situations contributed over time to the cooling in relations between partners. Thus, these women decided to talk to their children openly and/or guide them where they can seek information support.

> *"I teach my girls [daughters] to take all the best from life, from the years of youth, to communicate as a couple and not to limit themselves in terms of pleasures in a couple. It's really good now, you can find information where you want, and it will be presented in detail, step by step, and in an understandable manner."* (F, 47 years old, rural, 3FG)

- **Friends, peers**

Discussions about contraception take place between friends in a natural way and are usually related to contexts, concrete situations, personal experiences. They also discuss relationships with partners, how to convince the partner to use certain methods of protection against an unplanned pregnancy. The study also found that in many situations respondents trust friends/peers more than healthcare professionals.

Friends are an important source of information – *"I started taking birth control pills that my friend was using", "my friend told me that if you had an incident, there is the 72-hour pill."* It should be noted that at the same time they can misinform and perpetuate certain preconceptions and myths.

- **Teachers**

Several young people, both from rural and urban areas, mentioned that they discussed contraception and prevention of unplanned pregnancies and sexually transmitted infections during lessons with their class teacher and/or at lessons of biology, health education, and social studies. It should be mentioned that young people who talked with someone at school usually had several lessons in which they addressed this topic. There are also young people who mentioned that they did not discuss this topic in educational institutions at all.

- **Civil society representatives, peer educators**

For certain categories of women, the involvement of civil society and their services are very important. This is the case for HIV-positive women, who in some situations face stigma and discrimination in local medical institutions in the sector, and consulting an obstetrician-gynecologist recommended by an NGO increases their openness in referring to specialists, if they need. In the case of some people with disabilities, too, their participation in the sessions, information activities carried out by NGOs can be an important step in their sex education.

> *"Honestly, I'm embarrassed to hear the word sex. We lived in an orphanage where it was not talked about and we didn't have any connections with boys. It was 'Wow' for me. When I found out, I said to that doctor who teaches us, 'Stop talking, because I am embarrassed of this word. I can't hear it.' Because that is what they said, it is a shame to talk about it, that is how they influenced us there. And I was afraid, you know, when they said it. Now, I hear it easier, you know, it's like I'm starting to normalize with people, but until then I did not know and got informed from them, from Motivation [organization]."* (F, 32 years old, urban, 4FG)

4

ACCESSIBILITY OF CONTRACEPTION METHODS

The condom.
In the opinion of respondents, there are very accessible methods such as condom for men, which are offered free of charge in medical institutions of PHC, YFHCs, NGOs, and can also be purchased in stores and pharmacies. However, condoms are not so accessible for women.

A large part of the interviewed young people, but also respondents from specific categories, such as drug users or HIV-positive women, mentioned that they received free condoms from NGOs, youth-friendly health centers, or volunteer groups. Drug users have access to condoms and syringes from vending machines with condoms placed in different sectors of Chisinau municipality.

> *"In every city sector there are vending machines from which you can take condoms and syringes for free. Addicts get registered at the center and obtain the card for free."* (F, 23 years old, urban, 8FG)

Although the vast majority of respondents appreciate that condoms are distributed free of charge, most have doubts about their quality. Some have tried them and say they are too *"frail", "break easily",* or are *"small".* But there is also the preconception that whatever is offered for free is not qualitative and may be unsafe. It was also mentioned that condoms of unknown manufacturers are usually offered free of charge, which are not *"ones we know".* Thus, of those who received condoms for free, few mentioned that they used them; most said that they threw them away or gave them to other people. Among men there is also the preconception that condoms offered for free could be the source of some STIs.

> *"They were thrown away, because we got them from some activists walking down the road. Somehow they gave no sense of security, because I didn't know what they did with them, what their origin is, because I've never seen the manufacturing company that was indicated on the packaging... I don't trust condoms given free. I'd rather buy them from a pharmacy or a supermarket than use something I got for free."* (M, 20 years old, rural, 1FG)

> *"I have access to ATIS, so I can always go take absolutely for free. However, I don't do it, because I am afraid somehow. Even if they showed me that they are safe and good, I can't take them anyway. I'd rather go to a pharmacy, get that brand, and be sure that everything will be okay."* (M, 20 years old, urban, 1FG)

> *"My partner had a fear that condoms offered for free are infected with AIDS or other diseases."* (F, 23 years old, urban, 8FG)

Several respondents tried to counter the myth that free contraceptives are low-quality. Some noted that representatives of civil society, youth-friendly health centers who visited their educational institutions assured them that the distributed condoms were of good quality.

> *"On this subject I can say that when ATIS came to my school, the lady who presented contraceptive products stretched a condom very hard, proving to us that they can't break."* (M, 20 years old, urban, 1FG)

It has been observed that in general there is a preconception among people that everything that is free is of poor quality – *"I don't trust anything that comes for free"; "I will never take whatever is given for free* [referring to condoms]*. I better pay, but then I know that I get quality."*

For people from rural areas, "being the talk of the town" is a barrier to purchasing condoms or requesting them from the family doctor, even if they were available for free. Young women and some young men feel embarrassed to take condoms, even if they are distributed in educational institutions.

> *"Our people mostly buy condoms at gas stations or in the city, when they have the opportunity. I don't think young people would ask for them in the pharmacy in the village. The village is small, everyone knows each other and, for fear of being talked behind their backs,*

they prefer to buy from the city, where the flow of people is very high and the probability of being recognized is small." (M, 20 years old, rural, 1FG)

"A lady comes to our school and tells us about different things. She asks who wants free condoms. In our district there is a clinic and you can get them there. It's the youth-friendly health center. I've never taken free condoms." (F, 16 years old, rural, 2FG)

Other forms of contraception.

Accessibility of contraception methods that require consultation of a health service provider is perceived as strongly associated with the financial possibilities of the woman – *"If you have money, there is no problem."*

Theoretically, many female respondents said that they admit that there is the possibility of receiving contraceptives free of charge or with minimal costs, if they go to the family doctor, who in turn will refer them to an obstetrician-gynecologist. In practice, however, they believe it is still difficult for various reasons. Unmarried young women, women who do not have a stable partner, HIV-positive women, especially in rural areas, say that it is much better to address a known/recommended obstetrician-gynecologist or a private institution, as thus you will be treated kindly, will receive adequate consultation, and your privacy will be respected.

"We can go to the family doctor and he will give you a referral, if you don't have the money to go to a private clinic, where everything remains anonymous and they don't have to write in your medical records. There are also shy young women who feel bad when the doctor looks disapprovingly at them." (F, 20 years old, rural, 2FG)

The interviewed specialists pointed out that in order to propose oral contraceptives, the woman must be responsible and strictly follow the prescriptions, but many women from vulnerable groups do not have this c`ommitment. Another aspect noted by several specialists is the fact that people, especially young ones, are involved in the process of internal and external migration, and thus the use of some contraception methods is more difficult.

"People to whom we propose contraceptives have some fears, they hear that these substances contain hormones. And now, with the Internet [information from the Internet], they say there are heart attacks, something increases, blood pressure or what not... First of

all, they are not organized to take them – contraceptives require a certain rule to be followed, at the same hour, on certain 21 days as indicated. We often call them, I mean, three months pass and we call them, and they say they didn't take them, they took them only one month, then the husband left, then the husband returned, and so on. So, they are simply disorganized, this issue is not serious for them." (7IDI, family doctor, rural)

"With pills it's very difficult, you can't prescribe pills to absolutely everyone because you don't know how responsible they will be, whether they will or won't forget or mess up the pills, how long they will take them, whether they will take them regularly. For socially vulnerable groups – IUDs, but they must have a stable sex life in the couple, with only one partner who is not infected by anything. If she has a depraved sex life, the IUD is an additional cause of infection and other complications." (4IDI, obstetrician-gynecologist)

Most of the interviewed specialists believe that family planning services are accessible at national level, for both young people and adults. In particular, health professionals noted that contraceptives are provided free of charge to several categories of beneficiaries, including teenagers and socially vulnerable people. Specialists in YFHCs seem to be more informed about the 12 categories of population that can benefit from contraceptives distributed free of charge at PHC level. Some specialists pointed out that any person who addresses a gynecologist, regardless of socio-economic category, can benefit from free contraception – *"We are glad if a couple comes and asks us, and we give it to them, because it is available."* The challenge is low demand, or the contraceptives offered free of charge are not the ones they want (a certain brand of condoms, a certain brand of contraceptive pills, etc.).

"Anyone can request it. I mean, if a woman comes to ask the gynecologist for a method of contraception and she intuits, like, 'Can you offer anything?' If the gynecologist has it available, he can offer it." (1IDI, family doctor, urban)

5

Level of information in vulnerable groups regarding the free provision of contraceptives at the primary health care level

The vast majority of respondents are unaware that they could benefit from many other contraceptive methods, offered free of charge at the level of primary health care, apart from condoms. It should be mentioned that even some family doctors do not know all categories of people who can benefit from contraceptives free of charge; they usually name socio-vulnerable categories (people with low incomes, alcohol and drug users, etc.), families with many children, women perceived as having risky behavior (several partners, with sexually transmitted diseases, people living with HIV, etc.). In the study, a few exceptions were identified, when people from vulnerable groups were informed that they could benefit from free contraceptives, and a few of them accepted a certain method of contraception. The vast majority of those who received free contraception did so when recommended by the gynecologist.

> *"When I was at the gynecologist, he said, 'Look at the conditions others live in,' and suggested that I get an IUD, that my child is small, and who knows what will happen next. Now, the IUD is free up to 3 years [after giving birth], so I got one."* (F, 42 years old, urban, 5FG)

Other respondents chose, based on the recommendation of the gynecologist, to continue using the contraceptives they buy themselves, saying that thus they are more confident in the quality of the products they use. The idea persists that whatever is offered free of charge is of lower quality and is intended primarily for economically vulnerable people.

"For the reason that after the two births my myopia worsened, the family doctor informed me that at least twice a year I am obliged to go to the gynecologist... In addition, the doctor informed me that if I am registered in family planning, there I can get free contraceptives: condoms, IUD, or pills, depending on what they have in stock, or what I take. Unfortunately, what I take is not available at the family planning office. They offered me alternatives, but I refused and I prefer to buy the pills I'm 100% sure of. I discussed this topic with my gynecologist, but he recommended that if I have the possibility to buy them, it is best. I'm aware that whatever is available at the health center is intended for people that can't afford to purchase it." (F, 42 years old, urban, 3FG)

6

INTERINSTITUTIONAL COLLABORATION

The vast majority of the interviewed specialists noted a good collaboration between health professionals.

However, some obstetricians-gynecologists pointed out that family doctors give too little attention to prevention of an unplanned pregnancy, and for these reasons they act on consequences. It was also mentioned that some family doctors and even some obstetricians-gynecologists have certain stereotypes regarding modern contraceptives and instill in their patients concerns, fears regarding their use.

In the opinion of obstetricians-gynecologists, including those working in YFHCs, the role of family doctors is essential, because they know their patients well and patients interact more often with them, compared to specialized doctors. While some family doctors are involved in the distribution of contraceptives to vulnerable groups, according to their needs, especially in rural communities, others refuse to have/keep contraceptives in their offices because of privacy concerns, as doctors worry that beneficiaries could be judged by the rest of the community, but also because of the lack of conditions for storing contraceptives.

Specialists from YFHCs pointed out that collaboration with educational institutions is very important, and this collaboration mostly takes place. But there are exceptions, when teachers and/or parents oppose the sex education of teenagers, believing that it will lead them to start sex life early. Several studies carried out in this regard do not confirm this hypothesis[6].

In the opinion of the interviewed specialists, there are categories of women that require a special approach, such as patients with mental and/or somatic health

[6] https://unesdoc.unesco.org/ark:/48223/pf0000368231
https://moldova.unfpa.org/sites/default/files/pub-pdf/SexEd_Policy_Brief_No_1sm.pdf
https://moldova.unfpa.org/ro/publications/ghidul-tehnic-%C8%99i-programatic-interna%C8%9Bional-pentru-educa%C8%9Bia-sexual%C4%83-comprehensiv%C4%83

problems, those who abuse alcohol or drugs, requiring the involvement of other specialists and family members. In such cases, counseling and providing a method of contraception if beneficiaries need contraception is often difficult and requires the involvement of social workers, representatives of local public administration, and family members, relatives in order to inform persons from vulnerable groups about their eligibility to benefit from contraceptives provided free of charge at the level of primary health care.

Some obstetricians-gynecologists from YFHCs mentioned that it is important to have a connection and, at times, to insist that more community actors be involved in informing vulnerable groups about their eligibility to benefit from modern contraceptives when they need them, which are distributed free of charge in primary health care institutions, including YFHCs. This combination of efforts aims to ensure that every person from vulnerable groups knows their rights in order to exercise them according to their needs.

Obstetricians-gynecologists noted that there are results within YFHCs, where there is openness and active involvement from YFHC specialists by collaborating with other actors at the level of the territories served. They pointed out that if the beneficiaries are expected to come themselves to PHC institutions, including YFHCs, for health services, including contraception, especially vulnerable categories, then there will be no results.

> *"We cooperate with all the family doctors in the district and their team, with the district hospital. We have cooperation contracts with educational institutions, with the police inspectorate, with Novateca in the library, where we give lessons. We work with social workers in villages, because they know people from the socially vulnerable category."* (6IDI, obstetrician-gynecologist, YFHC)

In some cases, especially in the case of religious denominations or ethnic minorities, such as Roma, collaboration with community leaders and community mediators in the process of informing vulnerable groups is also necessary.

7

SUGGESTIONS AND RECOMMENDATIONS OF STUDY PARTICIPANTS

7.1 Sexual education and information

Sexual education is considered essential for the prevention of unplanned pregnancies and the correct use of contraception methods. The vast majority of respondents, regardless of gender, age, category interviewed, pointed out that **more information on contraception should be provided in schools**, starting with grades 6-8 and continuing in high school and subsequently at other levels of education (vocational school, college, university). Respondents noted that for some middle school students it may be too early to provide this information, but for others in high school it may be too late. Also, respondents mentioned that information should be transmitted by competent and open/unprejudiced persons, and the topics regarding contraception methods should be communicated according to age.

In the opinion of study participants, although in middle school some students may be embarrassed and amused when addressing these topics, they should be discussed anyway. Discussions on contraception topics in educational institutions subsequently contribute to a greater openness on the part of partners to communicate as a couple on this topic.

> *"It would be good to teach such lessons not only in gymnasiums, but also to continue in lyceums, colleges, or vocational schools. Personally, I was informed in more detail at the college, at lessons with our class teacher. I liked the friendly atmosphere that was created. All classmates were open, no one was embarrassed to ask if they had any questions. I believe that if the class teacher assumed such a responsibility, the necessary information would reach young people and nothing terrible would happen."* (M, 20 years old, urban, 1FG)

> *"However, I support the idea that children already in school be informed about contraception methods, hygiene, sexual behavior, and many other important things. I came to this conclusion after listening to the opinions of the women who said that no one informed them, which led to living a sex life with many gaps, disappointments, and regrets."* (F, 42 years old, urban, 3FG)

Opinions on who should talk to students about sex education and contraception are divided: on the one hand, some respondents believe that teachers are the ones whom students trust and they should communicate on these topics, and on the other hand, there are some who believe that trained people, doctors, volunteer peer educators should communicate on these topics, because not all teachers are open to discuss sexuality and contraception.

Some respondents noted that in schools not all children are ready for information on contraception, and it would be best to organize **information sessions for couples, in youth clubs or other safe spaces,** where they can openly address these topics and be properly informed.

> *"It would be beneficial to organize some clubs for young married women. Yes, we can educate young people in schools, but they have no idea what sex is and what the nuances are. I think that when you are married and you live with your husband, there should be some lessons for couples... Maybe when the couple applies for marriage, they could be informed by a sexologist, gynecologist about questions that may arise in the couple's life. In this way, young people would be more open with society and would not resort to experiments with their health, using outdated, archaic methods."* (F, 47 years old, rural, 3FG)

A number of respondents from vulnerable groups as well as health service providers pointed out that more attention should be paid to **online information for vulnerable groups**, given that virtually all categories of people of reproductive age have access to the Internet. Evidence-based information should be promoted intensively and presented in an attractive and understandable way. At the same time, some participants in the study mentioned that the distribution of leaflets is no longer such an efficient method of information, online resources being more accessible among the population.

> *"The time of leaflets is coming to an end, and they certainly reach a very small number of people. Information should be provided through social networks... I would do paid campaigns on social networks – as far as I see, women up to the age of 40 are all on social networks. If she was interested in this topic and it appeared 10 times, you can look for it, you can save it, you can take a screenshot, and when you get into a certain situation, know where to go."* (4IDI, obstetrician-gynecologist)

> *"It would be good to place advertisements on the Internet, on television, so information gets to them easier. People no longer read newspapers or leaflets, they are glued to their phones."* (1IDI, obstetrician-gynecologist, YFHC)

Another topic addressed was sexual debut without having elementary knowledge about the physiology of the reproductive organs or about sex life. Some women admitted that if they had the knowledge they have today, they would have had a different sex life with their partner/husband. For some women sexual intercourse was a constant stress, fear of becoming pregnant, or possibly the partner to *"manage"* ejaculation outside the vagina.

> *"If I got to be 19 again, when I started my sex life, I would do it differently. I think we weren't informed then, we were somehow living in ignorance. I had practically no knowledge. If for a woman this interrupted intercourse may be okay, then for a man it seems unfulfilled. I think that if we had any knowledge of contraceptive pills back then, the attraction and sex life between me and my husband would have been different, perhaps much better. All these years I had no pleasure from intercourse, always being tense lest the husband relax too much and ejaculate."* (F, 47 years old, rural, 3FG)

Several women pointed out that due to the lack of sex education of themselves and their partner, they did not experience orgasm, pleasure from sexual intercourse, they perceived it rather as a *"wife's duty"*. There are women with disabilities who suffered physically as a result of sexual intercourse. For them, sexual relations are associated with pain. One of the participants in the group discussion, living in a residential center, had a ruptured vagina with severe bleeding from an intercourse.

> *"Sexual relations are horrible. When he gets with his penis and you are a virgin, everything inside is closed, it hurts terribly. God I cried, I said I no longer wanted to see him. God, a surgery is better, because you don't feel thanks to anesthesia. When I was 35, I had my first sex, I was a virgin. I said, 'God, no, I'd rather die!' But that's how I lived with him."* (F, 41 years old, 11FG)

Some women still find it difficult to talk to anyone about sexual relations and contraception due to lack of information and limited knowledge, especially women without education and from vulnerable families. They come to the doctor only for termination of pregnancy, or they come late for pregnancy monitoring.

> *"My first child was a girl with ICP[7], and then I had two abortions because I was afraid that I would have another one like that... I was young, I don't know, I was afraid to tell my mother anything, and I was embarrassed to turn to doctors [for contraception], I was embarrassed. I would go when I was already pregnant."* (F, 42 years old, urban, 5FG)

In different contexts, several respondents mentioned that they were talked to at school or in the family after some cases occurred: pregnancy in a minor, sexual abuse, etc.

> *"When I finished the ninth grade, I had a classmate who got pregnant because she didn't know about all these things. If she had been informed, I think she could have avoided it. When it became known, our class teacher, who was also a biology teacher, gathered all the girls together and explained."* (F, 16 years old, rural, 2FG)

Specialists confirmed and exemplified several cases when parents "are late" talking with their children about protection from an unplanned pregnancy, considering it too early, and when an unplanned pregnancy occurs, they are surprised.

> *"They didn't talk to their little girl, because she was 13, they decided to talk at 18, but their little girl gave birth at 13. They found out when their girl was 30 weeks pregnant, the educator at the camp told them. She gave birth, because at 30 weeks' abortion is out of*

[7] Infantile cerebral palsy

> *the question. It was 2 years ago. Let's rely on educating parents, we shouldn't rely on school. School still doesn't do it, religion doesn't, but stands in the way, parents don't... At 12, most girls have menstruation, but they are not informed."* (4IDI, obstetrician-gynecologist)

One female respondent mentioned that until the age of 40, until she talked to an obstetrician-gynecologist, she did not know that it was not necessary to wash the inside of the vagina. She did her daily hygiene, including the vagina, and thought that this was the natural way.

> *"Until I was 40, I didn't know that I shouldn't wash inside because I could damage the vaginal flora... I thought it was pretty normal to wash with your finger as far as you can reach... I found out about this by chance, when I did a routine check-up at a gynecologist in Chisinau. In addition, I used to make aloe and honey tampons and put them inside. Following the check-up, it was found that I have erosion. So, this is the result of incorrect hygiene. Since then, I have not practiced this method." (F, 45 years old, urban, 3FG)*

Also, some of the interviewees directly expressed their interest and need for information on the following topics:

- **First sexual experience** – the interviewed young people are interested in topics such as the right age and person, the recommended period of getting to know the partner before having sexual relations, etc. – *"When is it right for a young woman to start sex life? After how long of relationship?"*
- **Effects of contraceptive pills** – the interviewed women need more information on the effectiveness, use, benefits, side effects, and health risks of using oral contraceptives: *"I would like to know more about birth control pills and how safe they are for health"; "What are the risks of using birth control pills?"*
- **Effectiveness and safety of contraception methods** – *"What is the safest method of contraception?", "What is the safest method of contraception for young people who are only starting sex life?"*
- **The most suitable method of contraception for young people** – *"What is the safest method of contraception for young people who are only starting sex life?"*
- **Hygiene of the genitals** – some female respondents pointed out that the topic of intimate hygiene is important to be discussed more openly and

frequently, with mothers/parents when a child is born, as well as later during visits to the doctor, in the context of obstetric-gynecological examinations.

- **Sexually transmitted infections (STIs)** – some women from economically vulnerable categories, but also people with mental disabilities, are concerned about the topic of STIs and methods of protection – *"How can you tell that he has a disease [STI]?"*
- **Menopause** – a topic that concerns premenopausal women and which in the opinion of some respondents is little discussed in society. Some doctors, in their opinion, are not ready to provide support to women to get through this period more easily **–** *"The woman is left alone", "The first gynecologist I turned to told me that insomnia and everything else are natural, and this is what all women go through, I am not the first and not the last, but the second one explained to me what is happening to my body, prescribed me drugs that helped me."* (F, 46 years old, rural, 7FG).

During interviews and group discussions with people from vulnerable groups and with health care providers, they came up with other proposals, suggestions in the context of providing family planning services and especially providing free contraceptives:

- **Offering contraceptives according to the model of compensated drugs** – fully compensated for vulnerable groups, and partially compensated for people from other categories. They should be taken from pharmacies based on the doctor's prescription and costs be covered subsequently by the National Health Insurance Company.

> *"The most effective way would be for these preparations to be compensated like the ones for hypertension, like any other preparation; and, well, maybe the family doctor should be able to prescribe them compensated, and then any woman, knowing that there are compensated contraceptives, could come and ask for a consultation and get from the pharmacy as much as she needs and what she needs."* (2IDI, rural, family doctor)

- **Ensuring a wider range of oral contraceptives and continuity of supply of certain pills.** It is important that once the woman gets used to one type of pills, she adheres to them, and it is problematic if you change her pill.

"The spectrum of pills should be wider. These pills should be prescribed by a gynecologist, because we have some criteria we are guided by... We used to have a good pill [combined oral contraceptive with estrogen dose 0.03 mg], very well tolerated by women, but now we don't have it, we need [combined oral contraceptive with estrogen dose of 0.02 mg]... for young girls – it was in stock, now it is not." (2IDI, obstetrician-gynecologist)

- **Practical application of agreements, regulations**. Some specialists pointed out that the provisions of the existing protocols and regulations, cooperation agreements are very good, but for the most part they remain only on paper. If more institutions were involved, more specialists joined their efforts, then the results would also be better.

"I would like these collaboration agreements with the police to work and bring street children, drug users into the center. They don't really work. We have agreements with everyone, with the probation office, with many institutions, but everyone does their own work." (3IDI, obstetrician-gynecologist, YFHC)

- **Carrying out preventive family planning activities** – several specialists pointed out that the mobilization of community actors is done when serious situations occur and not for their prevention.

"We want young people to come before marriage so that we can discuss some issues that may arise. It doesn't usually happen. It doesn't happen, and we don't look for them intentionally to call them. Basically, family planning services start working only when problems arise, but until then they are not in demand." (2IDI, family doctor, rural)

"I personally had a meeting with 8-grade girls after there was a pregnant girl in a class." (8IDI, family doctor, urban)

- **Providing support from other specialists (psychologist, social worker, etc.)** to guide them and to support vulnerable groups. For some women, planning a pregnancy is not a priority, either because of unhealthy lifestyle or the environment in which they live, particularly young women, but also other categories, such as victims of violence, people with disabilities. They will use a method of contraception if they have a reliable resource person to inform them, guide them on the eligibility of vulnerable groups for free contraceptives and how to obtain them.

DISCUSSION of myths about contraception and the use of methods that are ineffective and lacking scientific evidence or even harmful to health

MALE CONDOMS

- They are effective in preventing pregnancy and STIs, including HIV. When male condoms are used correctly at every sexual contact, about 2 pregnancies per 100 women whose partners use male condoms. In common use, however, about 13 pregnancies per 100 women whose partners use male condoms.
- They do not make a man sterile or impotent.
- They do not decrease the sexual desire of men.
- They do not cause a man to get sick by the fact that spermatozoa "go back".
- They cannot be lost in the woman's body.
- They do not cause the woman to get sick.
- They have no holes through which HIV can pass. They are not contaminated with HIV.
- They are not only used in extramarital relationships, but also by married couples.
- They do not cause cancer and do not contain carcinogenic chemicals.
- They do not break or slip frequently in case of correct use during sexual contacts.
- One does not use 2-3 condoms simultaneously for better protection. The use of 2-3 condoms simultaneously could increase the risk of their breakage.
- Latex allergy is not a common form of allergy.

COMBINED ORAL CONTRACEPTIVES (COCs)

- It is an effective method of contraception. When no mistakes are made in the use of pills, less than 1 pregnancy per 100 women during the first year of using COCs. With regular use, about 7 pregnancies per 100 women during the first year of using COCs.
- They do not cause the accumulation of hormones in the woman's body.
- It is not necessary to make a "pause" in use, it can lead to unwanted pregnancy. COCs can be safely used for many years without the need to periodically stop.
- They should be taken every day, regardless of whether or not the woman has sexual intercourse that day, preferably at the same time (to relieve some side effects and help women remember to take the pills consistently).
- The pill does not accumulate in the stomach; on the contrary, it dissolves daily.
- The woman is protected from unwanted pregnancy only as long as she takes the pills regularly.
- Women who stop using COCs can become pregnant just as quickly as women who stop using non-hormonal methods.
- They do not cause infertility in women after discontinuation of use.
- They do not stop the development of an already existing pregnancy. They do not produce abortion.
- They do not cause congenital abnormalities and will not harm the development of the fetus if the woman becomes pregnant while using hormonal contraceptives.
- Studies show that COCs typically do not influence weight. Most women do not gain or lose weight due to taking COCs. Weight changes naturally due to changes that occur during life and due to age. Because weight changes are so common, many women believe that these increases or decreases in weight are produced by COCs. However, studies show that COCs typically do not influence weight.
- They do not generally alter sexual mood and behavior. Some women who use COCs report these disorders. It is difficult to judge whether such changes are due to COCs or other causes.
- Both women who use COCs and women who do not use them may have breast cancer. It may have already been present before the use of COCs, but it was not detected earlier in COC users.
- There is no minimum or maximum age for COC use. It can be suitable for most women, from the onset of menstruation to menopause. There is no scientific

evidence available that would demonstrate a causal link between the use of COCs and the prevention of early menopause.

- No gynecological examination or other consultation is required before the woman starts using COCs; no follow-up consultation is required. It is desirable that before the initiation of any hormonal contraceptive method each woman have her blood pressure measured.
- COCs can also be used as emergency contraception pills after unprotected sex or if a method of contraception has failed, as soon as possible, but no later than 120 hours (5 days).

EMERGENCY CONTRACEPTION

- It can be used by women of any age, including teenage girls.
- It does not prevent or affect the implantation of an already fertilized egg; it does not produce abortion; it does not impact the course of pregnancy if the woman is already pregnant.
- It does not cause congenital abnormalities and does not harm the fetus if pregnancy sets in during use or if the woman is already pregnant.
- It is not dangerous for a woman's health.
- It does not promote risky sexual behavior.
- It does not cause infertility.
- If needed, the woman can use emergency contraceptive pills (ECPs) several times in a menstrual cycle. If a woman repeatedly resorts to ECPs, she needs to consider a regular family planning method.
- ECPs with Levonorgestrel can be used within the first 72 hours (3 days) after unprotected intercourse, and other methods of emergency contraception, such as COCs, intrauterine device, and Ulipristal acetate, can be used within the first 120 hours (5 days) after unprotected intercourse. The sooner they are taken after unprotected intercourse the more effective they are in preventing pregnancy.
- Women with HIV status who use or do not use antiretroviral therapy can safely use emergency contraception.
- The risk of ectopic pregnancy in case of failure of emergency contraception is not higher.

PROGESTOGEN-ONLY INJECTABLE CONTRACEPTIVES (POIC)

- They can stop monthly bleeding, but this is not harmful to a woman's health and can help prevent anemia. It is similar to the lack of menstruation during pregnancy. Blood does not accumulate in the woman's body.
- They do not stop the development of an already existing pregnancy (do not produce abortion).
- They do not cause developmental abnormalities in the fetus.
- They do not cause infertility. Women who stop using POIC wait on average about 4 months longer to get pregnant than women who used other methods.
- Women who are at risk of STIs, including HIV infection, can use POIC.
- A breastfeeding woman can safely use POIC starting from 6 weeks after childbirth. They are safe for mother and baby, and do not affect the production of breast milk.
- Women who use POIC gain weight on average 1-2 kg per year. Weight gain may be partly due to regular weight gain as you age.
- In general, it does not alter women's mood or libido.

IMPLANTS

- They are not harmful, although they cause lack of monthly vaginal bleeding. It is similar to the lack of menstruation during pregnancy. Blood does not accumulate in the woman's body.
- Regular, routine follow-up visits are not required.
- Their action stops after they are extracted. Hormones from implants do not remain in the woman's body.
- It is generally not recommended to keep implants longer than the duration of effective use. Implants as such are not dangerous, but as hormone levels in implants decrease, they become less effective.
- They do not stop the development of an already existing pregnancy.
- They do not cause developmental abnormalities in the fetus.
- They do not increase the risk of ectopic pregnancy.
- They do not cause infertility. Women who stop using implants can get pregnant just as quickly as women who stop non-hormonal methods.

- They do not cause cancer.
- They can be used by breastfeeding women, regardless of how much time has passed since birth.
- Some studies have found that the effectiveness of implants in obese women decreases slightly after ≥4 years of use. As a precaution, women who have a weight of ≥80 kg should request their replacement after 4 years, for greater efficiency.

INTRAUTERINE DEVICE (IUD)

- It can be used at any age, including by teenage girls.
- It can be used by women who gave birth and those who did not give birth.
- They do not increase the risk of infection with STIs, including HIV.
- It is not necessary to extract the IUD if the woman has a STI or is at an increased risk of STIs.
- If a woman gets a new STI after IUD insertion, she is not necessarily at risk of developing pelvic inflammatory disease. The woman can continue using the IUD while being treated for STIs.
- It does not increase the risk of miscarriage if the woman becomes pregnant after IUD extraction.
- It does not cause fetal abnormalities.
- It significantly decreases the risk of ectopic pregnancy.
- It does not cause infertility.
- There is no scientific evidence to suggest that the use of the IUD can cause the appearance of uterine myoma.
- They do not cause cancer. There is no scientific evidence to prove that IUDs cause cancer. On the contrary, some studies have shown that copper IUDs can even have a protective effect against certain types of cancer, such as endometrial cancer.
- It does not migrate to the heart or brain.
- It does not cause discomfort or pain to the woman or man during sexual intercourse.
- Weight change is a side effect reported by some users of the Levonorgestrel IUD – some women may notice slight weight gain, but it is often attributed to other factors, such as changes in lifestyle, diet, or age. Revision of the

diet may be recommended.

- In general, a woman who has not given birth can use the IUD, but she must understand that it is more likely that the IUD will be expelled because her uterus is smaller than the uterus of a woman who has given birth.
- The IUD should not be inserted only during menstruation, but at any time of the menstrual cycle, if it is known with a reasonable degree of certainty that the woman is not pregnant. IUD insertion during menstruation can be convenient because the woman is less likely to be pregnant and the insertion can be easier.
- It is not necessary for the woman to "have a break" if she has used the IUD for several years or after the IUD reaches the time of extraction. The extraction of the old IUD followed by the immediate insertion of a new IUD entails a much lower risk of infection than performing two separate procedures. The woman could also become pregnant during the "break" before the insertion of the new IUD.
- The duration of use of the IUD is between 3-5 years for the hormonal IUD and 12 years for the copper IUD.
- It is usually not necessary to routinely administer antibiotics before IUD insertion. Recent studies have shown that the risk of developing pelvic inflammatory disease is small, with or without antibiotics.
- It is important to take into account respect for fundamental human rights. Inserting an IUD without the woman's consent is a violation of fundamental human rights (the right to bodily autonomy and physical integrity, the right to informed consent, the right to privacy).

FEMALE STERILIZATION

- It does not cause physical weakness or pain.
- It does not imply surgical removal of the uterus, nor will it determine the need to do it.
- It does not cause hormonal disorders.
- It does not cause a disturbance in the characteristic of menstruation (more abundant or irregular bleeding) or other changes in the menstrual cycle.
- It does not cause changes in body mass, appetite, or physical appearance.
- It does not alter a woman's sexual behavior or libido.
- It does not increase the risk for ectopic pregnancy.

- It should not be offered only to women who have a certain number of children, are of a certain age, or are married.
- Generally, the woman who has resorted to surgical sterilization (permanent, irreversible method) should never again be worried that she might become pregnant.

VASECTOMY

- The ducts that carry the sperm produced in the testicles are blocked; the testicles are not removed.
- It does not decrease sexual desire.
- It does not affect sexual function. Erection has the same intensity and duration, including ejaculation.
- It does not cause changes in body mass, does not decrease masculinity or ability to work.
- It does not cause any diseases in the future (cancer, cardiovascular disease).
- It does not prevent STIs, including HIV.
- In the first 3 months after the procedure, it is necessary to use a method of contraception to prevent a pregnancy.
- Generally, vasectomy is a permanent (irreversible) method. Fertility does not return, because, in general, vasectomy cannot be stopped or reversed. The intervention should be considered as permanent. Restorative surgery is difficult, expensive, and, in most areas, not available. When performed, reversibility intervention is often not followed by the onset of pregnancy. Sometimes vasectomy fails, and the female partner may become pregnant.
- It should not be suggested only to men who have a certain number of children, are of a certain age, or are married.

SPERMICIDES

- They do not reduce vaginal secretions and do not cause women to bleed during intercourse.
- They do not cause cervical cancer or congenital abnormalities.
- They do not protect against STIs, including HIV.
- All women can safely use spermicides, except those who are at high risk for HIV infection or are HIV-positive.

- They do not alter the sexual desire of men or women and do not reduce sexual pleasure.
- They do not stop women's menstruation.

THE WITHDRAWAL METHOD (COITUS INTERRUPTUS)

It is one of the least effective methods – "better than nothing". Efficiency depends on the ability of the couple to use withdrawal at each sexual intercourse. In common use, about 20 pregnancies per 100 women whose partners use withdrawal. For both the woman and the man, interrupted sexual intercourse can generate stress and anxiety due to focusing on the moment of withdrawal and the fear of an unplanned pregnancy. In its turn, an unplanned and unwanted pregnancy can also be associated with other risks to a woman's health. In addition, worrying about the moment of ejaculation can affect the pleasure of sexual intercourse.

FINAL FINDINGS

No method of contraception is 100% effective in preventing pregnancy. The effectiveness of each method varies. The most effective contraception methods are implants, IUDs, female sterilization and vasectomy.

If a method has not worked in the past, there are alternatives that might be more suitable for the particular couple. Analyzing different options by consulting a doctor can help the couple find a solution that gives them more confidence.

Side effects may or may not be caused by the method of contraception. There are no signs of illness and they usually fade or disappear during the first few months of use. At the same time, side effects affect the satisfaction of the woman and the use of the method of contraception, that is why if the client reports side effects, the service provider offers advice and assistance, depending on the need.

CONCLUSIONS

Factors influencing the use of contraception among vulnerable groups

Study participants noted a wide range of contraception methods, traditional methods such as **the withdrawal method and calendar method** being frequently mentioned. They are perceived as the most harmless to a woman's health, but at the same time less effective than other contraception methods.

The withdrawal method is the best known and most used method, but it is perceived as ineffective and stressful for the couple. **The condom** is considered an affordable and effective method that also protects from sexually transmitted infections, but it is largely associated with casual relationships, and many men say that condom use reduces sexual pleasure.

In general, there is reluctance to use **hormone-based contraception methods** due to fears of side effects on health**. Oral contraceptives** are perceived as posing a number of major health risks to young women, one of which is impaired fertility. They are also frequently believed to contribute to women's weight gain and various physical and psycho-emotional health problems. **The IUD** is perceived as something time-tested, suitable for women who have given birth and want a convenient, long-lasting method of contraception, and the vital concern is the risk of developing cancer from its use.

Emergency contraception is known to respondents mainly from informal discussions with friends or colleagues, and the correct term of administration remains unclear for some women. Frequent use of emergency pills is considered to be associated with hormonal risks, and most women believe that they should not be used more often than once every 6 months.

Several respondents pointed out that **their knowledge of modern contraceptives is limited** and it often comes from unofficial sources, such as social networks or entourage. This contributes significantly to increased reluctance and mistrust in certain methods, such as oral contraceptives.

Several respondents questioned **the effectiveness of oral contraceptives and IUD in protecting from an unplanned pregnancy**, because they know cases

when women in their entourage became pregnant despite using these methods. The interviewed specialists pointed out that in these situations the main cause is the non-compliance with the correct method of administration/insertion, which establishes the perception that contraception methods are not completely safe.

The study found the existence of several **myths about contraception and the use of ineffective practices to prevent an unplanned pregnancy**, often transmitted from generation to generation. Some women still resort to such practices as vaginal douching, urination immediately after sexual intercourse, or introduction of foreign substances into the vagina, considered to be measures to prevent pregnancy. A positive aspect is that a significant share of women questions these methods.

Abortion is perceived by some respondents as a method of contraception, being considered an "emergency" solution when the contraception methods they used failed or no contraception was used, which is indicative of lack of awareness in the population about the difference between contraception and abortion. At the same time, there are women who completely reject the possibility of using contraception, especially due to religious beliefs, considering them an attempt to take the life of a possible child. Gaps in sex education and access to accurate information about contraception contribute to the perpetuation of myths and risky practices, emphasizing the need for broader information campaigns and specialized medical advice on contraception.

The study revealed several trends in **contraception decisions**, including: the decision of the couple, the individual decision of the woman with the consultation of a gynecologist and the influence of third parties, especially in the case of teenagers or people with mental disabilities. Respondents who believe that the decision belongs to the couple emphasize the importance of joint choice for a healthy sex life, and some women who say that the responsibility is theirs point out that most contraception methods and the consequences of an unplanned pregnancy primarily concern them. In some cases, the pressure of the partner to give up protection was mentioned, and in other cases, it was men who insisted on the use of contraception methods.

The woman's decision on contraception is essential, as it influences her physical health and emotional wellbeing, allowing her to have control over her own body, to plan her life according to personal needs and desires. At the same time, contraception is not just the woman's responsibility. Active involvement of men also contributes to a fairer distribution of responsibilities within the couple and, respectively, to combating gender stereotypes.

In the opinion of the interviewed specialists, women with mental health problems have difficulties in managing daily oral contraception, in which case long-term contraception methods, such as intrauterine devices (IUDs) or contraceptive

injections, are preferred. The involvement of family members and specialists is necessary if the woman needs support to choose and administer contraception, but this involvement must always be done with the consent of the woman and with respect for her reproductive rights.

Regarding **responsibility for preventing an unplanned pregnancy**, perceptions are divided. A large part of the respondents believe that responsibility lies with both partners, given that sexual intercourse is a joint decision. On the other hand, there are study participants, especially women, who believe that the woman bears greater responsibility, given that her personal and professional life is deeply affected by an unplanned pregnancy. Also, some respondents argue that men should take care of preventing pregnancy, especially in the context of using protection such as the withdrawal method or the condom. Although the woman may insist that the man use the condom, the responsibility to purchase it usually lies with the man.

Study participants use various contraception methods, the most common being the withdrawal method. Condoms and intrauterine devices are frequently used, and women who have received adequate counseling and support from doctors are generally satisfied with the use of oral contraceptives. Many women find that although methods such as the IUD and oral contraceptives are more effective, fears of side effects and associated discomfort influence their choice.

Barriers to the use of contraception are diverse and reflect aspects such as perceived side effects, attitudes regarding their effectiveness, the frequency of sexual relations, the type of protection method, socio-economic factors. Most often respondents mentioned **perceived side effects associated with hormone-based/ oral contraceptives**: weight gain, hormonal disorders, and infertility. **The use of IUD** also **causes concern** related to discomfort, bleeding, and risk of unplanned pregnancy.

Some women experience difficulties in **choosing the right method of contraception**, often due to concerns about possible side effects or lack of knowledge of available methods. The lack of information accentuates fears and lack of trust in modern contraceptives. This lack of trust is amplified by the perception that **no method provides guaranteed protection**, which perpetuates sexual relations without using a modern method of protection, mostly by resorting to the withdrawal method. **Irregular sexual relations**, including due to the migration of partners, limit the use of contraceptive methods and contribute to **non-consistent condom use**, although it is recognized as an effective method of protection in such cases.

Access to contraception is influenced by **social constraints and fear of being judged**, especially in rural communities, where stigma can prevent young people from purchasing contraceptives or going to their family doctor and obtaining them for free. **Socio-economic factors**, such as high costs of contraceptives, are an additional barrier, especially for low-income men, who either do not know they are eligible to receive contraceptives free of charge from their family doctor or do not go to their family doctor because of embarrassment/discomfort of discussing contraception. Added to these barriers is the lack of **risk awareness**, when some young people in the state of euphoria or some people under the influence do not realize the need for protection; **perceptions of fertility/infertility**, some women believe that they will not be able to get pregnant, so they do not feel the need to protect themselves. **Religious beliefs** can also be a significant obstacle to accepting the use of contraception, as well as **economic interests**, when some women/couples choose to have children in hopes of receiving financial aid or other benefits provided by the state.

There is a low involvement of family doctors in informing and recommending contraception methods to vulnerable groups of the population. The study found that there are **gaps in the knowledge of categories that can benefit from free contraceptives**, and many specialists, whether gynecologists or family doctors, focus predominantly on women with many children or those with risky behaviors. This restricted approach contributes to an inefficient distribution of contraceptives to eligible beneficiaries, as a result of which stocks of contraceptive pills / intrauterine devices expire, meaning there is need for a more effective strategy to ensure fair access to contraception for the categories covered by the current legislation.

The vast majority of respondents **does not consider the family doctor a resource for relevant information** about contraception, preferring to address obstetricians-gynecologists. Concerns about confidentiality, perception of a lack of special competence, the gender of the family doctor (male), and strained or distant relations contribute to this situation. Family doctors are also often overworked and lack the time to address the issue of contraception, which limits access to essential information about contraception for people of reproductive age, particularly from vulnerable groups.

Gynecologists are considered the most reliable source for choosing contraception methods. At the same time, some women prefer to turn to private clinics for quality medical services and a more empathetic attitude, after hearing about or having had unpleasant experiences in public institutions. Also, certain categories of women who are at risk of being subjected to stigmatization and discrimination (HIV-positive women, drug users, etc.) prefer to address gynecologists recommended by NGOs.

Young participants in the study who know about the services offered by **youth-friendly health centers (YFHC)**, as well as the interviewed specialists, highly appreciated their activity. They appreciate the useful information, the resources available, the way different activities are carried out, and the friendly approach of the staff. However, there are also some young people who do not know about the existence of these centers, especially those in areas with limited access to transport. Also, although the majority of young people are familiar with the services offered by YFHCs, some are skeptical about the quality of contraceptives offered for free because of the perception that what is offered for free is of low quality. YFHC specialists confirm that they have sufficient resources to provide contraception to all young people who request it, covering other categories of women who address them, too.

Sexual relations and contraception continue to be taboo topics in most families, young people avoid talking to their parents about these topics. Although some of them consider their parents open-minded, many prefer to turn to older brothers or sisters, adults in the extended family for information. Among respondents over 30 years old, there is a perception that things have changed in recent years and the topic of sexual relations is addressed in discussions between children and parents. However, the interviewed young people feel uncomfortable discussing these topics with their parents.

Discussions about contraception **between friends** happen in a natural way, often based on personal experiences. Friends become an important source of information, but there is a risk of misinformation, such as perpetuating myths. Young people tend to trust friends more than specialists, which can influence their choices in terms of contraception.

Many young people, including in rural areas, discussed contraception and the prevention of STIs with their class teacher, at lessons of biology or health education. However, there are also young people who never addressed these topics **at school.** Open discussions about contraception in educational institutions, institutions that promote and provide a complete and correct sex education, appropriate to the age and level of understanding of students, can facilitate communication between partners.

Some women have admitted that **the lack of sex education affected their sexual experiences**, generating anxiety and a distorted perception of intimate relations, thus highlighting the need for information and support sessions for young people. Sex education can provide young people with the knowledge to make informed decisions about their sex and relationship lives, helping to increase self-confidence and develop healthier relationships as a couple.

Respondents believe that **sex education is essential for preventing unplanned pregnancies** and stresses the need to introduce the subject of contraception in schools starting in middle school and continuing throughout high school, college, and university. It is important for **information to be transmitted by competent persons and online resources to be used more efficiently**, given their accessibility for all age categories. There is also need in a **more effective implementation of existing reproductive health agreements and regulations**, through active collaboration between institutions and specialists in different fields.

It is necessary to **ensure a wider range of free oral contraceptives and guarantee constant supply** with them to enhance the use of this method and maintain the women's adherence to it. The interviewed specialists suggested considering **the provision of contraceptives through a compensation system similar to that of compensated medication**, so that vulnerable groups receive free access and other categories receive partial compensation. Some specialists suggested the idea of offering contraceptives through pharmacies based on doctor's prescription.

Thus, the factors influencing the use of contraception among vulnerable groups can be arranged into the following groups:

Systemic factors

A. Health system

1. The highest appreciation for counseling and the provision of family planning services, including contraception methods, was given for the work of youth-friendly health centers both by service providers and by vulnerable groups who reported having benefited from their services.

2. Gaps in the knowledge by health workers of all categories that can benefit from free contraceptives, although only one family doctor among respondents did not receive training on contraception methods.

3. Limited knowledge of contraception methods on the part of family doctors and their distrust in their own skills of advising on the choice of a method of contraception, despite training and the resource materials received by them.

4. Insufficient effective communication skills for counseling on the subject of contraception among family doctors.

5. Overburdening of family doctors with many responsibilities causes discussions on the subject of contraception to be delayed; also, mistrust on the part of vulnerable groups in the preservation of confidentiality by the family doctor.

6. The lack of family doctors or their high turnover, especially in rural areas, does not allow establishing a relationship of trust with beneficiaries.

7. Gaps in knowledge regarding the estimation of the need for contraceptives for vulnerable groups, the management of stocks of contraceptives, including the lack of conditions for their storage in some cases, make the management of the supply chain of contraceptives be perceived by health professionals as a heavy burden.

8. Personal beliefs of doctors about certain contraception methods and the demographic situation.

9. Beliefs of family doctors that the subject of contraception is the task of obstetricians-gynecologists.

10. Lack of a human rights-based approach and need-based counseling, especially for people from certain vulnerable groups: people with disabilities, including mental health; people living with HIV and in groups at risk of HIV infection; etc.

11. Concentration of free distribution of contraceptives only through the family doctor. Some respondents mentioned the lack of free contraceptives in the offices of obstetricians-gynecologists, whom beneficiaries more often address for counseling, especially for women who apply for abortion.

12. Accessibility of contraception, especially for the rural population, either because of the lack of a family doctor or because of the people's distrust in the family doctor and the lack of communication between people and the family doctor.

13. Lack of contraceptives in the offices of obstetricians-gynecologists whom people address directly for counseling, including on family planning and choosing the method of contraception.

B. Education system

14. Health education being an optional discipline, not all students in the country can benefit from it.

15. Sexual education is taught within the framework of certain subjects in selective educational institutions and by staff who do not necessarily have the training to discuss this topic with teenagers.

Factors related to vulnerable groups and community

1. Limited knowledge or lack of knowledge about certain contraception methods: lack of confidence in the effectiveness of contraceptive methods; lack of proper information; previous negative experiences of the person or in their close environment; erroneous perception of one's own fertility.

2. Myths and superstitions about different contraception methods that circulate and perpetuate over time between generations: concerns about side effects from the use of oral contraceptives, IUD.

3. Social and behavioral factors: irregular sexual relations at long intervals, associated with the lack of counseling for choosing the right method of contraception; irregular use of condoms; alcohol consumption; costs of contraceptives associated with the belief that everything free is not qualitative; religious beliefs; economic interests for the poor (childbirth allowance).

4. Societal norms and expectations, including the fear of being judged, related to the purchase of condoms; the fear that the family doctor will not ensure confidentiality, especially in small communities; gender-related preconceptions in the case of male family doctors; the awkwardness to approach the subject of contraception with the family doctor.

5. Stigma and discrimination faced by people from certain specific groups: people with disabilities, including mental; people living with HIV and in groups at risk of HIV infection.

6. Lack of community involvement or low community involvement in information, education, acceptance and promotion activities related to the use of contraception, which otherwise could have turned it into a societal norm.

Recommendations

Proposed interventions at system level

1. Training of health workers through continuing medical education courses on topics such as:

   1.1. Counseling and recommending contraception methods in order to strengthen the status of a primary source of information, in particular for vulnerable groups, and to focus on questions arising from their existing experience;

1.2. Improving the quality of counseling by building effective counseling skills by learning techniques specially developed for this purpose, including with a focus on services in sexual and reproductive health;

1.3. Qualitative counseling on contraception methods, including for specific groups of population based on their needs: persons with disabilities, including intellectual disabilities, HIV-positive people and people from groups at high risk of HIV infection, etc.;

1.4. Recommendation of contraception methods according to the needs of beneficiaries;

1.5. Active identification of vulnerable groups eligible for free contraceptives (through interinstitutional collaboration and visits in the territory covered), estimation of contraceptive needs, management of drug stocks;

1.6. Ethical principles and human rights and respect for them in a doctor's work.

2. Widely promote and encourage the use of online training platforms on contraception (www.vic.eeirh.org/) that have secure and accredited information.

3. Strengthen the knowledge of family doctors and their team with regard to contraception, through:

3.1. Periodic organization of communication sessions with experts in the field of sexual and reproductive health, including obstetricians-gynecologists from youth-friendly health centers and reproductive health offices, with the exchange of opinions and good practices and answers to questions, so that family doctors improve their skills to provide accurate information and recommend contraception methods focused on the needs of the beneficiary;

3.2. Collaboration between obstetricians-gynecologists and family doctors through mentoring (on-site visits of gynecologists, online communication between gynecologists and family doctors, etc.) to improve family doctors' competences in the field of family planning, providing a continuous flow of information and recommendations centered on the needs of the beneficiary.

4. Diversify methods of distribution/handing out of contraceptives:

4.1. through obstetricians-gynecologists,

4.2. through pharmacies,

4.3. self-service vending machines for distributing condoms,

4.4. social workers,

4.5. nurses in schools, etc.

5. Develop the mechanism of ensuring the availability of contraceptives in institutions where safe abortion services are provided, so that they can be offered to women immediately after abortion.

6. Expand the use of telemedicine in counseling and provision of contraceptives in family planning and self-care to beneficiaries.

7. Develop and introduce the system of motivation of family doctors and their teams for providing family planning services and distributing contraceptives to vulnerable groups, according to their needs: quality indicators, bonus system, etc.

8. Introduce in the education programs of college and university students (medical, pedagogical) the module of family planning and contraception.

9. Extend the use of existing resources for health services, in particular mobile units within the YFHC network, so they can be used more actively and in more rural localities to ensure access to services for young people who live in communities and do not have access to health services in their locality or do not access them because they feel embarrassed or fear stigmatization.

Proposed interventions focused on the population and vulnerable groups

10. Extend the organization of information sessions, sex education campaigns in public institutions (schools, high schools, colleges, universities), focused on the importance of modern contraception and reliable sources, including by promoting the peer-to-peer concept.

11. Adjust school curricula in terms of sexual education, including on proper hygiene of the genitals and contraception, in particular with a view to the new adjustment of the school study plan and integrated school curricula.

12. Train teachers in the teaching of this subject to students according to their age.

13. Use the resources of YFHCs to train students in educational institutions.

14. Widely promote and encourage public use of online information platforms on contraception methods (https://sexplicatii.md/, YK app, etc.), which have reliable information for the population, including information about contraception methods, with a focus on informing about benefits, usage, risks, and YFHC contacts (telephone number, location, etc.).

15. Conduct community information and awareness sessions on family planning and contraception in order to combat myths about contraception, provide truthful information with the involvement of all interested partners (representatives of the media and the private sector, family planning experts, opinion makers – influencers, bloggers, vloggers, etc.):

    15.1. Develop parental education programs in order to encourage open discussion of contraception in the family, in community, and to combat/reduce the transmission of myths/misinformation;

    15.2. Carry out structured information sessions at community level with vulnerable groups based on truthful and scientifically proven information about contraception with subsequent referral for counseling and choice of contraception methods to the family doctor;

    15.3. Organize information campaigns for vulnerable groups on the possibility to obtain free contraceptives in the primary health care system;

    15.4. Develop information materials accessible to all persons (including persons with disabilities) or ensure open access to them (brochures, official websites, videos) in collaboration with experts in the field, in order to provide accurate and understandable information, combat myths, and answer questions and uncertainties;

    15.5. Organize an information campaign about the effectiveness of contraception offered free of charge to vulnerable groups and explain that free contraception products are as efficient as the ones sold in pharmacies and other distribution networks.

16. Create interinstitutional collaboration partnerships by developing clear guidelines for reference and cooperation between medical institutions, social assistance, civil society organizations in order to provide needs-based services to people from vulnerable groups, especially those with social and economic vulnerability, in order to meet their needs.

17. Involve civil society organizations that work with certain vulnerable groups in informing and educating people from vulnerable groups about contraception methods, and also in informing about their availability upon request at the family doctor.

ANNEX

Table 1. **Distribution of group discussions**

Cod	Category of respondents	No. of FGs	No. of respon-dents	Group features	Date
1FG	Teenage boys and young men, age 16-24	1	9	rural (4), urban (5) 2 young men live with their female partners, 1 alone and 6 with one or both parents.	10.08.2024
2FG	Teenage girls and young women, age 16-24	1	9	rural (4), urban (5) 1 young woman lives with her husband, 2 alone, 1 with her sister and 5 with their parents.	10.08.2024
3FG	Women at obstetric risk	1	7	Age: 23-47 rural (4), urban (3) 1 pregnant woman, the others have 2-3 children each.	11.08.2024
4FG	Women in the somatic risk group (suffering from chronic diseases with risk for pregnancy and childbirth)	1	7	Age: 25-42 rural (4), urban (3) 1 unmarried woman 2 pregnant women, having 1 and 2 more children, respec-tively 3 women – 3 children 1 woman – 4 children	11.08.2024
5FG	HIV-positive women and women in groups at high risk of HIV infection	1	8	rural (4), urban (4) most with secondary or professional education	28.08.2024
6FG	Survivors of emergency situations (refugees from Ukraine)	1	7	Only one respondent lives in a rural area. All respondents have children, between 1 child and 4 children. Only 2 respondents currently live with their husbands.	17.08.2024

7FG	Women with disabilities, including persons with disabilities in residential institutions	1	7	Age: 30-47 rural (3), urban (4) 3 persons live in couples, 4 live with parents or relatives/ friends	15.08.2024
8FG	Users of narcotic drugs and other psychoactive substances	1	10	Age: 23-49 All respondents live in urban areas, 2 persons live with their partners, 3 rent a home and live with their friends, the rest live with their immediate or extended family.	14.08.2024
9FG	Women with low or no income	1	10	Age: 19-47 rural (6), urban (4) 2 of the respondents with higher education, the rest with secondary or vocational education. 2 respondents without a partner at the moment 1 respondent has 4 and another one has 5 children, the rest have 2-3 or no children	18.08.2024
10FG	Men with low or no income	1	6	Age: 24-49 rural (3), urban (3) 1 unmarried 1 separated, 3 children 4 live with their wives and 1-2 children.	18.08.2024
11FG	Women with mental health problems in a placement center.	1	7	Age: 29-46 Most have lived in residential institutions since childhood, periodically changing institutions, including some who lived in sheltered housing. 2 persons have stable partners at the moment. 1 person has 1 child, 2 other people have had at least one pregnancy.	14.08.2024
	Total	**11 FGs**	**87**		

Table 2. **Distribution of in-depth interviews**

A. Key groups

	Category of respondents	No. of interviews
1	Women who have had an abortion on demand over the past year	3 IDIs
2	Victims / survivors of sexual abuse, for emergency contraception	1 IDI
3	Survivors of emergency situations, humanitarian crisis or public health emergencies, beneficiaries of humanitarian protection in Moldova, asylum seekers, stateless persons, migrants	2 IDIs
4	Family members of persons with mental health problems registered with a psychiatrist or family doctor	2 IDIs
5	Young woman	1 IDI
6	Person with mental disabilities	1 IDI
	Total	**10 IDIs**

B. Specialists

	Category of respondents	No. of interviews	Distribution/notes
1	Family doctors	10	Area: 5 respondents – rural; 5 respondents – urban Region: 3 respondents from the South Region; 4 respondents from the Center Region; 3 respondents from the North Region
2	Gynecologists	5	Region: 3 respondents from the North Region; 1 respondent from the Center Region; 1 respondent from the South Region
3	Gynecologists and midwives in YFHCs	10	Region: 3 respondents from the South Region; 4 respondents from the Center Region; 3 respondents from the North Region
4	Social workers	2	Region: 1 respondent from the North Region, 1 respondent from the Center Region
	Total	**27 IDIs**	

MINISTERUL SĂNĂTĂȚII
AL REPUBLICII MOLDOVA