Removing medical, social, cultural and religious barriers to effective and safe contraception

12th Seminar of the European Society of Contraception and Reproductive Health

Dan Panorama, Tel Aviv, Israel, 2 - 4 September 2015

www.escrh.eu

Final programme and book of abstracts

More information

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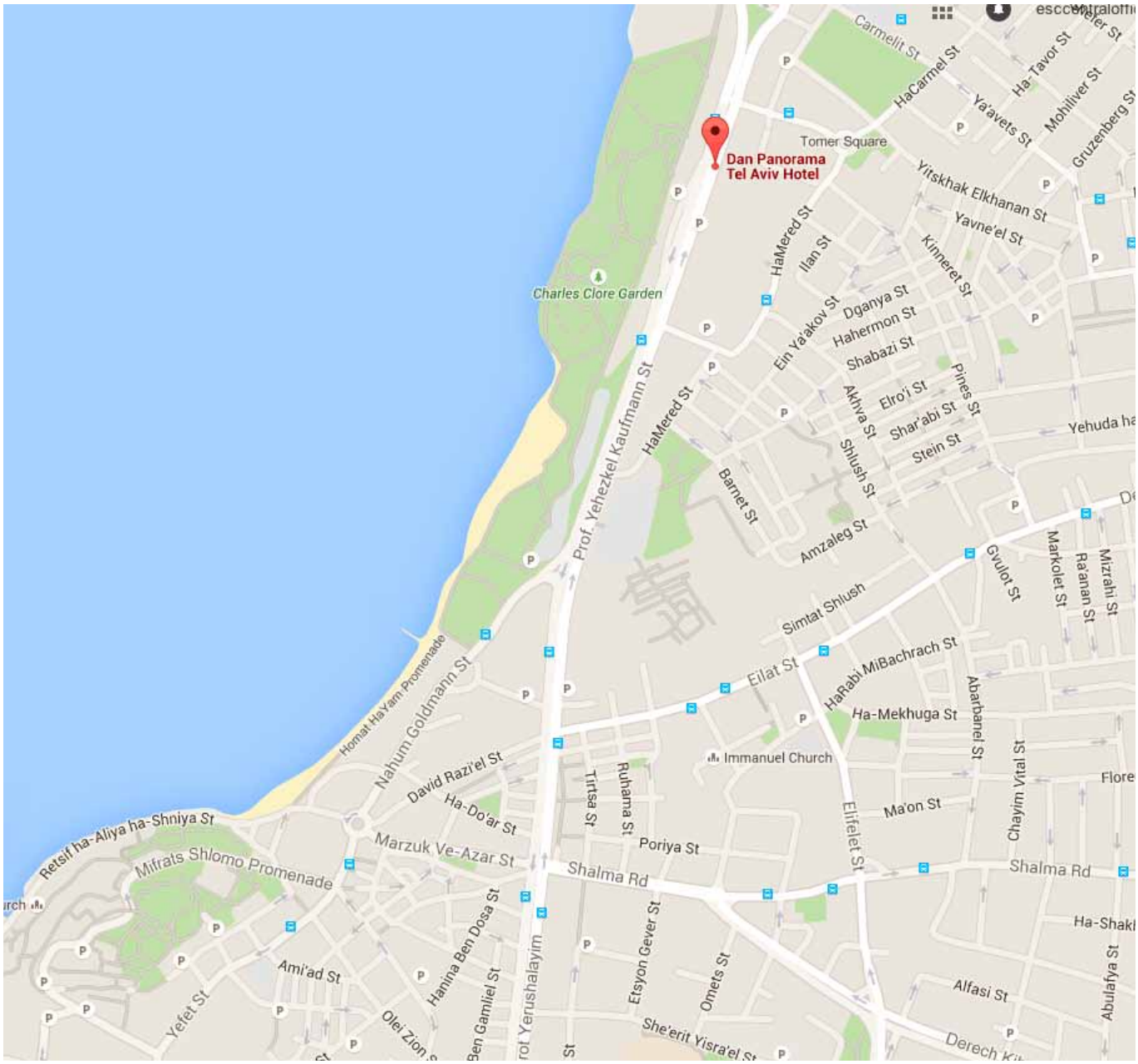

General information

Tel Aviv

Ever since the establishment of the State of Israel, Tel Aviv, Israel's largest city, has served as the financial, entertainment, and cultural center of the country. Founded in 1909 and built on the sand dunes that stretch northward from the old city of Jaffa, Tel Aviv lies on a beautiful beach strip of the Mediterranean.
Tel Aviv abounds with hotels, museums, galleries, theatres and entertainment venues, markets, shopping malls, restaurants, bars and outdoor cafes, all bustling with nonstop active day and night.
Typical of so much of Israel, Tel Aviv juxtaposes the old and the new. The old port of Jaffa, with its colorful artists' quarter and flea market, reflects the special atmosphere of ancient times, while the modern hotels, skyscrapers and busy shopping malls, portray the brisk vibrant city life.
A modern cultural center, Tel Aviv, boasts many fine art galleries, entertainment centers and museums like the multi-media at the Jewish Diaspora Museum. The world famous Israel Philharmonic Orchestra performs at the Mann Auditorium, next to Israel's Habima National Theater. The Golda Meir Center for Performing Arts is home to Israel opera, dance companies, theater companies and concerts, and the Suzanne Dellal Dance Center, situated in the old Neve Zedek Quarter of the city, offers exciting programs. Apart from the open air markets and shopping malls, popular street shopping areas like the bohemian Sheinkin Street and Neve Zedek, portray the newest trends in fashion and styles.

Lunch / dinner

If you have ordered a lunch and/or dinner, you will find this mentioned on the back of your badge. The seminar dinner will take place in the Blue Rooster Restaurant (Ha'Tarnagol Hakahol, 10 Nisim Aloni St, Tel Aviv), Thursday, 3 September 2015. The bus will leave from the entrance of the Dan Panorama Tel Aviv Hotel at 19:30 for the Blue Rooster Restaurant. Please remember to take your badge with you!
Dinner tickets can still be purchased on site till 12:00, Thursday, 3 September.

Evaluation

The Seminar Organiser would be very grateful if you would take a few minutes to complete the evaluation form available here: www.escrh.eu/seminar-evaluation
We will also send you this link after the Seminar.

Do not hesitate to contact the information and registration desk should you have any other question.

Wishing you a pleasant stay in Tel Aviv!

Daniel Seidman
Seminar Organiser

Amos Ber
Seminar Organiser

Kristina Gemzell-Danielsson
ESC President

Scientific Programme

Wednesday, 2 September 2015

16:00 - 18:30 **Registration**

18:30 - 19:00 **Welcome address**
K. Gemzell Danielsson (Sweden), ESC President
D. Seidman & A. Ber (Israel), Seminar Organisers

19:00 - 19:30 **A tribute to Carl Djerassi** (October 29, 1923 - January 30, 2015)
D. Serfaty (France)

19:30 **Get together**

Thursday, 3 September 2015

08:30 - 09:30 **Registration**

09:30 - 10:00 **Free Communication Session I**
Chairs: E. Arisi (Italy) - A. Yeshaya (Israel) - A. Brzezinski (Israel)
- It's a long way from the clinic to the bedroom - M. Schonbrun (Israel)
- Cultural Barriers to contraceptive: Israel as a case study - M. Rozenfeld (Israel)
- Birth control in Romani women in the Czech republic - T. Binder (Czech Republic)

10:00 - 11:00 **Scientific Session I: What are the cultural barriers for contraception in Europe today?**
Chairs: G. Bartfai (Hungary) - E. Lunenfeld (Israel) - J. Bornstein (Israel)
- Intrauterine contraception (IUC) for adolescents: a Northern European trend only? - K. Gemzell Danielsson (Sweden)
- Poor acceptability of oral contraceptive pills (OCPs) from Japan to Russia: who is to blame? - D. Seidman (Israel)
- Who is afraid of permanent contraception of women and men? - S. Skouby (Denmark)

11:00 - 11:30 **Opening Ceremony**
- Israeli Minister of Health
- K. Gemzell Danielsson (Sweden), ESC President
- E. Lunenfeld, President of Israeli OB/Gyn Association
- D. Seidman, President of Israeli Society of Contraception

11:30 - 12:00 Coffee Break & Visit the Exhibition

12:00 - 13:30 **Scientific Session II: How can we use better understanding of religious beliefs to promote contraceptive use?**
Chairs: B. Pinter (Slovenia) - F. Azem (Israel) - A. Shushan (Israel)
Religious concerns regarding the use of contraception
- Christian - M. Hakim (Israel)
- Moslem - A. Kubba (UK)
- Jewish - H. Katan (Israel)

13:30 - 14:30 Lunch Break

14:30 - 16:30 **Scientific Session III: Contraceptive choices for special medical conditions**
Chairs: P. Patroclou (Cyprus) - A. Ber (Israel) - D. Samuel (Israel)
- Obesity - L. Shulman (USA)
- Diabetes - A. Ber (Israel)
- Migraine - G. Merki (Switzerland)
- SLE, thrombophilia - A. Gompel (France)
- Congenital heart disease - N. Porat (Israel)
- Post organ transplantation - A. Yeshaya (Israel)

16:30 - 17:00 Coffee Break & Visit the Exhibition

17:00 - 19:00 **IUS hands on training workshop with the newest simulator**

20:00 **Seminar Dinner (**Payable option)

Friday, 4 September 2015

08:00 - 08:30 **Registration**

08:30 - 09:00 **Debate: OTC: the way to go in contraception?**
Chairs: M. Merckx (Belgium) - M. Hallak (Israel) - J. Lessing (Israel)
Pro - A. Kubba (UK)
Con - J. Bitzer (Switzerland)

09:00 - 09:30 **Free Communication Session II**
Chairs: S. Ozalp (Turkey) - N. Porat (Israel) - R. Orvieto (Israel)
- Barriers in access to modern contraceptive in Central and Eastern Europe - K. Kacpura (Poland)
- Determinants of the reliable contraceptive use: a nationwide cross-sectional survey in Hungary - M. Vanya (Hungary)
- The effect of hormonal contraceptive with anti-androgenic progestin on female sexual function - L. Čiaplinskienė (Lithuania)

09:30 - 10:30 **Scientific Session IV: Do social and economic factors still play a role in gaining access to contraception?**
Chairs: I. Sivin (USA) - D. Seidman (Israel) - D. Mansour-Schwake (Israel)
- Cost-effectiveness of school-based sexuality education - K. Haldre (Estonia)
- Does the price of contraception still serve as a barrier to its widespread use? - R. Lertxundi (Spain)
- Dr. Google and the pill: Fear of side-effects when choosing contraceptives? - L. Shulman (USA)

10:30 - 11:00 Brunch Break

11:00 - 12:00 **Workshop: Prevention of STDs, HPV vaccination, HIV prophylaxis, HSV, Chlamydia**
Chairs: B. Zilaitiene (Lithuania) - M. Zloczover (Israel) - I. Fainstien (Israel)
G. Donders (Belgium) - B. Frey Tirri (Switzerland) - P. Greenhouse (UK)

12:00 - 13:00 **Workshop: Contraception and the cycle of life**
Chairs: V. Prilepskaya (Russia) - L. Erofeeva (Russia) - I. Wolman (Israel)
- Is it appropriate to use OCPs in adolescents for non-contraceptive indications? - D. Apter (Finland)
- LARCs, Condoms or OCPs for the nulliparous? - R. Beerthuizen (the Netherlands)
- OCPs until the menopause: when should we STOP? - M. Lech (Poland)

13:00 **Closing Session**

Abstracts

Opening

A tribute to Carl Djerassi*
D. Serfaty (France)

Born on 29 October 1923 in Vienna, Carl DJERASSI died peacefully at home on 30 January 2015. He was considered often to be “the father of the pill” because his 1951 synthesis of norethisterone, the initial step in the development of oral contraceptives. Having an Austrian mother and a Bulgarian father, both medical doctors, and Jewish, Djerassi fled Vienna in 1938 due to the Nazi Anschluss and arrived in New York on December 1939. The thesis for his doctoral degree at the University of Wisconsin in 1945 was on the synthesis of estrogens from androgens.

Having rapidly managed to synthesise not only cortisone but also estrone and estradiol, in 1951, his focus switched to the synthesis of oral progestogens. The application for the patent for the production of norethisterone as an orally active formulation was submitted in November 1951 and the related scientific article published in 1952. Djerassi’s academic career began at Wayne State University in Detroit in January 1952, 3 months after his synthesis of norethisterone. Norethisterone continue today to be the mainstay for the progestogen component of oral contraceptives and, moreover, most other progestogens used for contraception resulted from minor chemical modifications. Today, norethisterone continues to be on the 19th WHO Model List of Essential Medicines (April 2015). Gregory Pincus, John Rock and Carl Djerassi have been perceived often, each, as the “father of the pill”, but Carl Djerassi preferred to be known as the “mother of the pill”.

Why Djerassi did not receive a Nobel Prize, mainly as chemist?
May he rest in peace. He worked for the good of humanity.

*This abstract is taken from an article of Edouard LINDSAY “Carl DJERASSI “father of the pill” and “renaissance man” (J Fam Plann Reprod Health Care, 2015; 41:158) and refers to the book written by Carl DJERASSI “The pill, Pigmy chimps and Degas horse” Editions Basic Books (Harper Collins Publishers Inc, 1992)

Free communication session I

It’s a long way from the clinic to the bedroom
Michal Schonbrun, MPH, CHES, Reproductive Health Education Specialist
Joanne Zack BA, BSW, Family Planning Counselor & Sexual Health Educator, formerly the National Director of “Open Door” Counseling Centers, Israel Family Planning Association

In spite of increasing access to contraception and increasing choices in contraceptive methods, almost 50% of pregnancies are unintended due to inconsistent, incorrect or non-use. Though ambivalence about becoming pregnant plays a role, the objective of this presentation is to examine the barriers in physician-client communication that contribute to the high rate of unintended pregnancy. It is the presenters’ contention that the western medical model does not sufficiently take into consideration the client’s personal and cultural values and priorities and subsequently the contraceptive method chosen is often a short-lived mismatch for the woman or couple.

This presentation will attempt to balance the weight given by the medical community in the decision making process to a contraceptive's effectiveness and efficacy with the unique needs and desires of the client. From the client's perspective, life style considerations, health status, relationship needs, maturity, importance of pleasure in the sexual encounter, interpersonal control and power issues are some examples of potential barriers which directly affect both the choice of method and its correct and consistent use.
On the physician's side, a different set of barriers may be present: time constraints for counselling, a focus on (theoretical) statistical efficacy, simplicity and convenience, underestimating client fears regarding method safety and side effects, discomfort discussing sexuality and intimate relationships, personal bias, and the influence of pharmaceutical companies which are a primary source of information and support for prescribing hormonal methods over all others.
The research and our combined observations and experience in the field suggest that a more client-centered approach to contraceptive counseling will ensure greater adherence to and satisfaction with a given contraceptive method, thereby diminishing the possibility of an unintended pregnancy.
Research has shown that the more a client/patient participates in decisions regarding their health care, the greater the chances that the patient will adhere to the treatment plan which consequently will lead to a better outcome. There is every reason to assume that the same principle applies to choosing a contraceptive method and preventing an unintended pregnancy.
Not only do women want to participate in the decision-making process but they want and expect to be listened to and to decide with their medical provider which contraceptive method is "best" for them. Clinicians need to devote more time and energy to listening to client's concerns and understanding "the price" she is willing to pay from the method of choice. It is imperative that the physician address, in a non-judgmental fashion, a client's personal values, within the cultural context in which she lives, even if it means discussing methods which the physician may not be accustomed to nor recommend.
Participants in this session will gain insight into the non-medical barriers which impact motivation and method satisfaction for preventing pregnancy, and learn about evidence-based communication models which can improve the communication between medical provider and the woman or couple seeking a contraceptive.

Cultural barriers to contraceptive: Israel as a case study

Michal Rozenfeld, Sharon Orshalimy
"Open Door" Tel Aviv, Israeli Family Planning Association

Objective: Much has been written in the medical literature about enabling access to sexual health services in order to encourage women and girls to use ongoing contraception (World Health Organization, 2010; United Nations Population Fund; 2011). However, there are still many barriers to this access in Israel. Israel is a diverse, multicultural society, integrating religious conservatism, pro-natalist agenda (Remennick, 2001) and liberal discourses. Additionally, Israel is undergoing a slow process of privatization of the universal health care that has been its core of the health system in Israel since it was established. In this situation, full and regular access to contraception and family planning services, are not available to all the women and girls who want it.
Design & methods: This lecture will discuss the unique barriers facing women and girls in Israel regarding the ongoing use of contraception, based on my experience over the past five years at the Tel Aviv "Open Door" youth friendly, sexual health and counseling center. The cultural barriers I will elaborate on are: Shame and stigma; religion; and gender inequality. I will also address the legal barriers that are an outcome of the cultural aspects of sexual health in Israeli society.
Results: My discussion of shame and stigma will address the social norms and sexual practices among youth in Israel, focusing on sexual stigma, the shame in being sexually active and embarrassment on the part of adolescents to involve a meaningful adult in decision making (Bayer, 2008).
Religion will refer to the major influence of religion in Israeli society, focusing on two main discourses that are mainstream in this culture: The commandment to be "fruitful and multiply" and the discourse of absten-

tion that encourages young people to remain virgins until marriage in religious communities and until a certain age in other communities (Srikanthan, 2007). Gender inequality will address how the social power structure between men and women in Israel is embedded in the sexual practices and norms of contraception use, particularly on condom use.
Conclusion: This lecture will discuss these barriers and suggest effective solutions such as comprehensive gender awareness sexuality education, training health professionals and refuting myths regarding reproductive health and religion, for encouraging young people to use contraception on a regular basis, in order to maintain their sexual and reproductive health.
Bibliography:

- Bayer, R. Stigma and the ethics of public health: not can we but should we. Social science & medicine 67, 2008 (463 – 472). Elsevier.
- Developing sexual health programs: a framework for action. Geneva: World Health Organization; 2010.
  Gavy, N, McPHILLIPS, K, & DOHERTY, M (2001). ‘’IF IT’S NOT ON, IT’S NOT ON’’−OR IS IT?: Discursive Constraints on Women’s Condom Use. Gender & Society, 15, 917 - 934.
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- Remenick, L. (2001). Childless in the land of imperative motherhood: Stigma and Coping among infertile Israeli women. Sex Roles, 431(11/12), 821–841.
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Birth control in Romani women in the Czech republic

Binder T., Šrytrová AE., Pošarova A., Prajka L., Alt J.
Dep.OB/GYN Masaryk´s Hospital and University J.A.Purkyně, Ústí nad Labem, Czech Republic

Objective: The goal of the study was to find out what is the attitude of Romani women to contraception; whether the barriers to a broader use of current contraceptive methods in this population are of cultural or only social nature; and if the Romani women have enough understandable information about individual methods.
Design and methods: Between 2012 and 2014, a total of 516 Romani women from the Northwest Region of the Czech Republic were asked to fill out a questionnaire with the help of medical assistants, of which 186 women refused to cooperate and 330 participated in the survey.
Results: All 330 women (100%) wished to have 3 or more children and considered the age of 18-20 years optimal for delivery of the first child.
A total of 109 (33%) women do not care about contraception at all and in view of 287 women (87%) contraception is their partners´ business. None of the respondents had IUD. Fifteen women (4.5%) were using hormonal contraception (birth control pills), 10 women (3%) depot progesterone injections and 100% of women with 3 and more children prefer tubal sterilisation. A total of 205 women (62.1%) were not actively offered any birth control method by their gynaecologist.
Conclusions: The barriers to a broader usage of modern birth control methods are both of a cultural and socioeconomic nature. Roma are a socially excluded ethnic group in the Czech society. They have never integrated into the majority society and refuse to accept changes in their lifestyle. Their value hierarchy is quite different, placing the greatest value on enjoying the life in whatever form, their extended families and children, with work and education ranking among the lowest priorities. Due to poor education and their lifestyle, more than 65% of the Roma live in ghettos, are unemployed and rely only on social allowances. The model of a traditional Roma family is strictly patriarchal, when women are absolutely submitted to their partner in any circumstances. The youngest woman is an outsider of the family and her position grows only with the number of delivered children. Children also bring higher social allowances. Another factor that plays an important role in the social situation of the Roma is money.

Charges for contraception are an additional barrier to their broader use. Taking a birth control pill every day is for a majority of Romani women quite unacceptable as they are not able to follow this scheme. IUD insertion seems to them a very painful procedure and because it is known that they have a low pain threshold, they refuse it. On the other hand if a Romani woman has 3 or more children and the current pregnancy is terminated by the caesarean section, they usually agree with tubal sterilisation.

Scientific Session I: What are the cultural barriers for contraception in Europe today?

Intrauterine contraception (IUC) for adolescents: a Northern European trend only?

K. Gemzell Danielsson (Sweden)

The contraceptive method mix varies greatly across countries with the Nordic countries being world leading in the uptake of the intrauterine levonorgestrel releasing system (LNG-IUS). The advantages of intrauterine contraception (IUC) also for young and nulliparous women are increasingly being recognised although several barriers to their use remains to be removed by evidence based practise. Long acting reversible contraceptive methods includes the subdermal contraceptive implants, and intrauterine contraception. While the efficacy of short or mid-acting contraceptive methods are highly dependent on the user and tend to have a lower effectiveness in young women, LARCs are equally effective in all age groups. Its contraceptive efficacy is independent of the user and offers long-term application. The contraceptive efficacy of LARCs is comparable to that of female sterilisation but it is completely and rapidly reversible with no impact on future fertility. In addition to being highly effective contraceptive methods, the LNG-IUSs offer several additional non-contraceptive benefits that include: reduced blood loss, prevention of anaemia, increase in serum ferritin and iron levels, and reduction of dysmenorrhoea as well as prevention of endometrial cancer. LARCs have proven to be the most cost-effective contraceptive methods. Despite this, there are several myths that unfortunately create barriers to the use of IUC and exclude young and nulliparous women from the use of highly effective and acceptable contraceptive methods. Emerging data on the use of IUC and especially the LNG-IUS in young and nulliparous women are reassuring and should be used to update local guidelines and current practise also beyond the Nordic countries.

Poor acceptability of oral contraceptive pills from Japan to Russia: who is to blame?

D.S. Seidman (Israel)

Oral contraceptive pills (OCPs) are considered among the most effective and safe forms of contraception. With the wide spread of global knowledge one would expect that the use of OCPs would be similar throughout the developed world. However, in spite of limited other options available for women at need for highly effective reversible contraception, OCPs are still shunned in many countries. It is surprising to acknowledge the huge variability in the use of OCPs around the world, from over a third of the young women in North Europe to just a few percent in Japan and Russia. It seems that invisible cultural barriers exist in some countries, although it is not clear if the dominant bias against OCPs use reflects physicians' attitudes or the general patient population beliefs.

In order to try to assess whether the apparent patient cultural objection to the use of OCPs can change over time we took advantage of a unique model, investigating OCPs use among women immigrating from to Israel from the Former Soviet Union (FSU) countries. Since 1990 and up to the beginning of 1996 more than 600,000 Jews emigrated from FSU countries. These immigrants currently compose over 10% of the Israeli population. Our hypothesis was that the well-known "melting pot" effect, prevalent among the much

welcomed FSU immigrants, may have changed the incidence of OCPs pill use among these women, from the extremely low rate currently prevalent in FSU countries to the significantly higher OCPs use rates typical among Israeli born young women.
We undertook a phone survey that included 300 women aged 16-40 from the general Israeli population and 205 women aged 16-40 who were born in the FSU or their parents were born in the FSU and immigrated to Israel after 1990. The survey's maximal error range ± 3.5% with a statistical significance of 95%. We found that FSU women have lower rates of regular use of contraception (55% vs. 42%, $P<0.05$). This difference was found less likely to be due to religious concerns and more frequently associated with fear of side effects. Concern with side effects was also more commonly given as a reason for stopping regular contraception use by FSU women. Among women regularly using contraception a similar proportion of FSU and Israeli women had used OCPs, 70% and 66%, respectively. FSU women who so far avoided the use of OCPs were more likely to note: fear of side effects, concern with using hormones and having heard that the pills were dangerous.
We conclude that a "melting pot" effect has apparently occurred; since FSU immigrants have a high rate of OCPs use similar to that found among Israeli born young women. FSU women seemed to be well aware of the effectiveness and availability of OCPs. The current low prevalence of OCPs use in FSU countries may be influenced by better communication of its safety and ease of use. Changing views among physicians may be crucial when attempting to improve the use of OCPs in low prevalence countries.

Who is afraid of permanent contraception of women and men?

S. Skouby (Denmark)

Globally, permanent contraception (PC) represents the leading method of family planning for women, particular for those over age 35. With traditional procedures its failure rate is 1 in 200 with complications occurring in <1% of procedures. Although permanent methods are widely available worldwide, they are marginalized and stigmatized in some countries and highly restricted in others. Concerns about reversibility and side effects limit access in some more developed countries, while inadequate availability of surgical facilities and trained personnel presents a significant barrier to use in many developing nations. Hysteroscopic sterilization is a newer outpatient based technique, which does not require a general anaesthetic and eliminates many of the operative risks of a laparoscopic procedure. It is as effective as laparoscopic sterilization but significantly more difficult to reverse. Its availability is still limited, but of note novel approaches to nonsurgical permanent contraception (NSPC) for women that are low cost and require no incision or hysteroscope/surgical equipment could improve access to, and the acceptability of PC.
Also the no-scalpel vasectomy technique for male sterilization has lower complications rate and faster recovery time than conventional vasectomy with similar failure rates (1 in 2000). However, women's and providers' perceptions of NSPC are linked to the conceptualized risk and effectiveness. Although perceptions maybe generally favorable, confirmation of safety and effectiveness are required for a new approach to be accepted. Cultural background and present life situation have a great impact on the attitude toward and acceptance of PC, thus influencing the final choice. Detailed counselling about this topic is essential and should be improved. On a global scale reasons for PC differ significantly by race and region. This fact suggests that stratified reproduction has not ended and that the patterns and consequences of PC continue to vary. Long Acting Reversible Contraception (LARC) methods are all equally or even more effective compared to traditional female sterilization and comparable to vasectomy, so they should be discussed as alternatives especially before pre-surgical counseling. All verbal counseling should be backed up with comprehensive written information on PC, NSPC and LARC presented in a format that is easy to understand Regret after PC is more common in patients who are under 30 years and in men who have no children. Between 5 and 10% of couples may regret the procedure and 2% of men and 1% of women request reversal. Success rates of reversal of PC are variable. Success rates for females are range from 50 to 60% and for males between 30 and 80% depending on the PC method.

Scientific Session II: How can we use better understanding of religious beliefs to promote contraceptive use?

Christianity

M. Hakim (Israel) - E. Saba (USA)

Christianity strongly adheres to Biblical verses that emphasize the importance and value of children. Most denominations of Christianity see children as a gift given by God. So, does contraception represent a form of denying or preventing this gift? In my presentation, I will discuss the Christian views on contraception, specifically exploring the differences existing among major denominations, and between clergy and congregation.

The major denominations of Christianity encompass Catholicism, Eastern Orthodoxy and Protestantism. All three branches agree in strongly opposing sexual activity in unmarried individuals but differ in their views on contraceptive use for married couples.

The Catholic Church provides the strictest rulings over contraception. Children are “arrows in the hands of a warrior… Blessed is the man who fills his quiver with them”. According to Catholicism, the primary purpose of intercourse is procreation. Thus, contraception directly conflicts with this purpose, allowing for sexual gratification without the fulfillment of the creation of new life. The Catholic Church prescribes the dated partially successful methods of natural family planning as means for child prevention. The current-day Pope made headlines when he remarked that modern Catholics “should not breed like rabbits.” Still, even despite these remarks, he has affirmed the Church’s views, defining each child as “a treasure,” and citing natural family planning via abstinence and the rhythm method as the only acceptable methods of contraception. The Catholic Church’s views on abortion and termination of pregnancy are also strict, with no exceptions given to victims of rape or incest, or in cases of potential maternal mortality.

The Eastern Orthodox views on contraceptive use are more complex than the Catholic Church’s, and provides a more flexible acceptance of contraceptive use. As the Orthodox Church witnesses marriage as the consummation of man and woman into one being, sexual intercourse is not restricted to the purpose of procreation, but rather as a means of unity. Thus, on the whole, modern theologians do not deny use of contraceptives, although they do differentiate use of contraceptives based upon type. Namely, temporary forms of contraception such as condoms are acceptable, but permanent forms of contraception are inappropriate except in exceptional cases. Today’s Protestant Church differs from the Catholic and Orthodox churches, and generally provides the most flexible approach to modern social issues, including the acceptance of contraceptive use. While Protestantism serves as an umbrella for myriad sub-denominations, they have historically supported contraceptive use for married women. While the Protestant Church has strongly opposed sexual activity and contraceptive use for unmarried women, it has generally provided acceptable reasons for contraception for married women.

Despite having the strictest views concerning contraception, birth rates among Catholics compare to birth-rates among other more flexible Christian groups. The facts reveal that promoting contraceptive use in the modern era is a reality despite conflicting religious doctrine. Looking forward, medical professionals must reconcile their respect for the patient’s religious ideals with care for the patient’s wellbeing. Only then can a suitable solution to the ever unresolved barrier for effective contraception be attained.

Moslem

A. Kubba (UK)

Islam is a religion for Millions worldwide. It is also a way of life. Muslim societies are culturally heterogeneous. The flexibility/relative freedom in interpretation of Islamic teaching means that cultural, social and

political drivers operate under the banner of religion. There are positive as well as negative forces playing a role in attitudes to contraception, sexuality and reproductive rights. We need to understand them to be able to influence them. I will review the topic and suggest ways of addressing the need for contraception in Muslim societies.

Jewish
H. Katan (Israel)

Jewish law puts a major emphasis on the commandment written in GENESIS – be fruitful and multiply but part of that involves enabling the couple to bring up the children in happiness, ensuring the mother's good health. The Rav will be posed with the following questions involving the use of contraception by religious couples- Is it permissible to use contraceptives? For how long is it possible? And what measures are permissible and advisable in their specific circumstances. Jewish law might pose restrictions regarding unnecessary spill of seed' by use of barrier methods, especially the male condom. Another issue is irregular spotting due to the use of an intrauterine device causing difficulties in the laws of purity. A similar issue could rise with the use of oral contraceptive pills. My lecture will cover the medical- halachic aspects of contraceptives from the perspective raised above.

Scientific Session III: Contraceptive choices for special medical conditions

Obesity
L.P. Shulman (USA)

Obesity, usually defined as a BMI (body mass index) of 30 or greater, has become increasing problem in the developed and developing world being associated with a reduced life expectancy as result of a considerable increased risk for cardiovascular disease, diabetes and some malignancies along with orthopædic and pulmonary morbidities.
Estimates of the percentage of reproductive-aged women in North America who are obese ranges from 25 – 60% depending on the specific demographic and racial/ethnic characteristics of the cohort being evaluated. While obese women have lower fertility than nonobese women, they are still exposed to pregnancy with an increased risk for obstetrical-related morbidity and mortality than nonobese women, especially if that pregnancy is unplanned. This presentation will present current information on the effectiveness and risks associated with a variety of reversible and nonreversible contraceptives when used by obese women and compare and contrast those characteristics to the use of such methods by nonobese women. In addition, the controversies surrounding the use of combination oral contraceptives by obese women and the potential of contraceptives to facilitate changes in weight will be presented. Finally, this presentation will include current "best practices" in the counseling and care of obese women seeking contraception.

Diabetes
A. Ber (Israel)

Over 10% of women older than twenty suffer from diabetes. The rate of Type 2 diabetes in children and adolescents is increasing due to more obese children, less physical activity and their exposure to diabetes in utero. Studies show also an increase in type I diabetes. Almost half of worldwide pregnancies are unplanned.

This is crucial factor in diabetic women where pregnancies that occur without glycemic control are associated with increased rate of major malformations, increased miscarriage rate, and high neonatal morbidity and mortality. Thus the role of doctors is to provide young patients with good contraception and stress the need to plan future pregnancies even to young patients that don't have any plans to do so in the near future. Though not enough evidence is available to prove that hormonal contraceptives does not influence glucose and fat metabolism in women with diabetes mellitus it seems that the rise seen in fasting glucose levels may not be clinically important and the use in non smoking otherwise healthy women under 35 who show no evidence of hypertension, nephropathy, retinopathy, or other vascular diseases is safe.
Among women with Diabetes limited evidence suggests that Progesterone only pills or injectables have effect on control (HbA1c levels), homeostatic markers or lipid profile.
The Levonorgestrel-releasing IUS (LNG-IUS) seems to have no impact on glycemic control and may offer long-term health benefits over oral contraceptives and should be preferred in women in their forties and/or with metabolic risk factors for cardiovascular diseases and type 2 diabetes mellitus
Looking at the UK and WHO eligibility criteria for contraceptive use we can conclude that in diabetic women with no vascular disease all hormonal methods can be used, though except the LNG IUS, they are less recommended in obese patients.
In women with vascular disease Progestogen-only pill, Progestogen-only implant and the LNG-IUS can be safely used.

Migraine

G. Merki (Switzerland)

Migraine affects about 18% of women in Western European countries. Migraine with aura (MA) and migraine without aura (MO) may increase vascular risks, especially the risk for stroke in younger women. Use of combined hormonal contraceptives (CHC) multiplies the risk for stroke in female migraineurs. Furthermore epidemiological and clinical data suggest that CHCs may initiate or even worsen existing migraines. A significant number of women with migraine has to face the choice of reliable contraception during their fertile life. Newer studies indicate that in contrast to CHC progestagen – only contraceptives are not associated with an increased risk for cardiovascular events, especially stroke. In addition three recent studies indicate that the progestin-only pill desogestrel 75µg may even improve migraine headaches. The positive effects are observed in both MA and MO.
Moreover quality of life improved significantly in migraineurs three months after initiating desogestrel 75µg. Because in premenopausal women estrogen withdrawal is frequently involved in migraine attacks maintenance of stable estrogen levels seems to be important. One of the underlying mechanisms of migraine improvement with POCs therefore may be the continuous use and suppression of ovulation. Other mechanisms under investigation in animal models are the suppression of cortical spreading depression.

SLE, thrombophilia

A. Gompel (France)

The choice of contraception can be limited in patients with diseases which can be worsenned by estrogens. Systemic lupus erythematosus is an heterogeneous disease which can present mild to very severe symmptoms. It is much more frequent in women than in men and is recognized as an estrogen modulated disease, through activation of autoimmunity. In addition it is assoicated to an increase risk of arteraila nd venous thrombosis especially when associated with antihospholipids. Thrombophilia are alos asocaited with an increased risk of thrombosis. Both conditions are thus contrindications to combines estrogen progestin contraception. Long acting progestin containing contraception, such as implant and the bioactive IUD, has certainly provided significant help for these patients. More efficient thant the low dose progestin only pill (POP) they can be used in most of the cases. However they are not allways well tolerated, there are some potential contraindications because of increasing risk of functional ovarian cysts in women with

strong anticoagulation. More potent antigonadotropic progestin can be of interest but oustide of France, only injectable medroxyprogesterone acetate or norethisterone (at 10mg) are available. Both are associated with an elevated risk of thrombotic disease. In France, two pregnane derivatives are available , chlormadinone acetate and cyproterone acetate. We have a long term experience with these two progestins which will be presented. The benefits/tolerance balance of each method in women with SLE or thrombophilia will be presented and discussed.

Congenital heart disease

N. Porat (Israel)

The number of young women with congenital cardiac disease seeking contraceptive advise has increased over the past years. The improved surgical techniques and medications by which these girls were treated allowed them to conduct normal life and reach the point which sexual behavior and contraception need to be addressed. Decision as to the recommended method of contraception should take into consideration many relevant factors: medical history, medications used, risks for thrombosis and any other important information delivered by the cardiologist. The woman's preferred method, future fertility and sexual behavior are additional factors in the this process. Each contraceptive method carries certain risks and benefits which will be discussed in regard to this special group of patients.

Post organ transplantation

A. Yeshaya (Israel)

Women of reproductive age account for more than one-third of all solid-organ transplant recipients and are advised against becoming pregnant for 1 to 2 years after their surgeries. These women are at risk for unplanned pregnancy because fertility can return as soon as 1 month after transplantation. Pregnancy is contraindicated in this population and carries risk greater then general population and should be timed with regards to medication regimen and organ function. Therefore, unplanned pregnancy is high in these patients. Healthcare providers should incorporate contraceptive and fertility counseling as part of routine care for women with solid organ transplants. These women needs highly effective contraception methods that should be adapted to their medical condition and to the medical treatment including anti-coagulant therapy that they receive. The preferable contraception method and the previous data will be discussed. There is a large range of contraceptive options, varying in drug formulation and route of delivery. Modern studies have shown the safety of IUD and historical concerns of infection. Women with history of solid organ transplantation can be safely offered with wide range of contraceptive options, to suit their individualized needs.

Debate: OTC: the way to go in contraception?

Pro

A. Kubba (UK)

Access to contraception is key to increasing uptake, facilitating continuation and reducing mistimed conceptions. It applies to women in developed as well as developing communities. It is a reproductive health right. For many, sex 'just happens'. The ideal state is for women [and men] to be 'contracepted' all the time until they decide to reproduce. Regulations, protocols and guidelines drive traditional service provision but women want us to help them to have autonomy in choice and access. Self triage in many medical conditions is becoming popular and millions 'doing it'. I will show that for healthy women seeking contraception, OTC is the way to putting women in the driving seat where they belong!

Con
J. Bitzer (Switzerland)

There are two major arguments which can be brought forward regarding the issue of providing contraception over the counter without medical counselling and consultation.
1) Contraception is a health maintaining and health promoting endeavour which for many women has to be maintained over decades. During this period decisions about method have to be made, the methods have to be used in an appropriate way, compliance and continuation has to be maintained across different phases of life with many possible physical, psychological and social changes. To make this project successful it is important that the woman be educated, counselled and accompanied by a specially trained person who can help her to come decisions in her best health interest, to recognize risks in the context of methods and to empower women with knowledge and skills. Over the counter will leave her more or less alone relying either on the internet with contradictory information or friends with possible personal biases.
2) The contraceptive consultation is probably the most effective single preventive consultation in ob/gyn. It allows for gynaecologic check-up, screening for premalignant and malignant diseases, screening for STIs, general health behaviour and screening for health behaviour risk, life style education and counselling. It is thus an important window of opportunity to provide promote women´s health which should not be given up and abandoned.

Free communication session II

Barriers in access to modern contraceptive in Central and Eastern Europe
Krystyna Kacpura, Executive Director, Federation for Women and Family Planning, Poland

Despite access to contraception being declared a human right in numerous international agreements, the contraceptive usage rates remain low in many regions throughout the world. Recent studies have shown that many countries in Eastern Europe have a contraceptive usage rate below 50 %.
The use of modern contraceptive methods is notably low, partly due to high reliance on traditional methods such as withdrawal and on abortion in the event of unwanted pregnancies. Accordingly, countries in the CEE region have the highest abortion rates in the world. Modern contraceptive methods are available to women who know of its existence and of its correct use. Access is however uneven among women throughout the region, and strongly dependent on level of income as well as other factors. While overall cost is not a major determining factor across society in the low usage of modern contraception, it is a barrier for some groups of women. These women are the poorest, the unemployed, the uneducated, the uninsured, the young with no access to cash, women living in rural areas as well as adolescents and housewives who depend financially on their relatives. The cost of unnecessary exams required by physicians in order to prescribe contraception puts contraception even further out of reach for underprivileged women. Lack of confidentiality is one of the most important factor affecting access to contraception, as talking about sex, sexuality and contraception is still stigmatised to a large extent within certain areas throughout the CEE region. Findings have shown that conservative policies exist in each country of the region. In some societies strict patterns of sexual and reproductive behaviour are being promoted. These patterns affect all matters that are linked with sexual and reproductive health, and make it impossible to talk openly about anything related to sex and sexuality.
Several reports have shown that women with lower or no education living in rural areas have less access to contraception than their wealthier and educated counterparts in urban areas. The taboo connected with sexual and reproductive health keeps women from getting the information they need to make conscious contraceptive decisions. Women who vary from the prescribed norms often face consequences such as

stigma. Many women therefore do not want to be observed purchasing contraception in pharmacies. This is especially the case for women living in rural areas where they cannot be anonymous.
Continuously, some groups of women face substantial barriers in accessing contraceptive methods. The high unmet need for contraception reflects a failure of state parties to fulfil their obligations by eliminating the barriers that prevent women from access. As long as contraceptives are not subsidised for women who cannot afford them, it is not freely accessible to all. As long as sexual and reproductive health matters are being stigmatised the low contraceptive usage rates will remain low. In order to make it available to all groups of women, states must therefore ensure that costs and taboo are not hindering them from access.

Determinants of the reliable contraceptive use: a nationwide cross-sectional survey in Hungary

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Objective: The purpose of this study was to investigate the contraceptive practice and sociodemographic determinants of employment of contraceptive methods among sexually active women.
Design and methods: A randomly selected representative sample of 4542 women aged 15-49 years from the Hungarian population participated in a prospective web-based and postal questionnaire survey. Women completed self-report questionnaires on sociodemographic characteristics, contraceptive practice and sexual activity between June and July 2015. Study population comprised sexually active women in the last three months, so pregnant women, women in the first postpartum year, women with impaired fertility and those who wanted to be pregnant were not included in the analysis. The contraceptive methods used by the women in the past 3 months were of interest. Oral contraceptives, intrauterine devices, male/female sterilization, vaginal ring, plaster, implant and injection were regarded as reliable methods, while barrier methods, periodic abstinence, withdrawal, spermicides, vaginal douche or no method were considered less reliable methods based upon the Pearl index.
Factors associated with the use of reliable contraceptives were studied. Multiple logistic regression analysis was applied to evaluate the factors influencing the contraceptive practice of women in reproductive age. Informed consent was obtained by email or written form via post.
Results: The mean age of the women was 29.4 years (± 8), and 77% reported urban residents. The rate of use of reliable methods (hormonal contraceptives, intrauterine devices or sterilization) was 43%, while no method was used by 4.7% of the participants. Most women were married or lived in a long-term relationship (74.9%). Slightly more than half the women self-identified as secondary educated (59%) and one third was higher educated. A majority of women had ≤10 sexual partners during their lifetime (84.4%) and the vast majority (96.2%) had only one partner at a time. They had stable sexual partnership (91.1%) predominantly and almost one tenth claimed that they had only occasional partner (8.9%). Eighty-nine per cent reported weekly or more often than sexual activity and 10.5 % had monthly sexual activity. Over half of the women (54.5%) had delivered at least one baby, and 25% had had at least one previous abortion. Future child wish was claimed by more than half of the participants (59%). Nearly half of the respondents lived in a good or average financial situation. Average age at first sexual intercourse was 17 years.
Logistic regression indicated that high income was favourable for the choice of modern contraceptive methods (adjusted odds ratio (AOR): 1.1), like the increased sexual frequency (AOR:1.1). The number of lifetime partners (AOR:0.99) and sexarche (AOR:0.94) was correlated inversely with the use of reliable contraceptives. Previous abortion (AOR:1.4) or delivery (AOR:1.58) was correlated significantly with an increased chance of reliable method use. Women with future child wish are significantly less prone to the use of reliable methods (AOR:0.70).

Conclusion: To the best of our knowledge, this is the first large scale representative report describing the contraceptive preferences in Hungary as a result of complex interplay between sociodemographic and sexual characteristics.

The effect of hormonal contraceptive with anti-androgenic progestin on female sexual function

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Objective: to investigate the effects of a COCs containing a progestin with anti-androgenic profile (0.03 mg of ethinylestradiol/ 3 mg of drospirenon) in a continuous-regimen on female's sexual function.
Design & methods: in presented prospective, randomized single institution study 80 healthy women with a permanent partner and active sexual life were randomized over two groups according to computer randomize function for 3 cycles. A COC containing 0.03 mg of ethinylestradiol/ 3 mg of drospirenon (EE/DRSP) was administered for the study group (n=40). The control group (n=40) used natural family planning methods and barrier contraception methods (NFPM/BCM). All study participants were asked to fill out a set of validated questionnaires, including the Female Sexual function Index (FSFI) and Dyadic Adjustment Scale (DAS). The main outcome of interest was the changes of total FSFI scores between baseline and cycle 3. Secondary outcomes included the changes of all the FSFI domains, the total DAS scores and all the DAS domains over 3 study cycles.
Results: the difference (δ) in mean baseline to 3 months change in sexual function between hormonal contraception method users and non-hormonal contraception method users was significant in arousal (δ = -0.49 ± SD 1.07 vs δ = -0.53 ± SD 1.47; p = 0.03) and total FSFI scores (δ = 9.56 ± SD 8.50 vs δ = -0.80 ± SD 4.01; p<0.001) of COC users. The use of COCs was found to have no impact on couple's adjustment. No changes of DAS differences (δ) were observed between NFPM/BCM and COC users, p>0.05. Hormonal contraception increased the likelihood of worse sexual function in terms of arousal (OR 2.85; 95% PI 1.01-8.04; p=0.04) and the total FSFI score (OR 2.01; 95% PI 1.27-3.19; p=0.003) even after adjusting for the subject's age (Arousal OR 3.72; 95% PI 1.09-12.66; p=0.04 and the total FSFI score OR 2.03; 95% PI 1.23-3.35; p=0.006) and education level (Arousal OR 3.08; 95% PI 1.08-8.76; p=0.04 and the total FSFI score OR 2.04; 95% PI 1.26-3.30; p=0.004).
Conclusion: the current study found evidence that COCs containing anti-androgenic progestin appeared to be associated with negative effect on female's sexual function.

Scientific Session IV: Do social and economic factors still play a role in gaining access to contraception?

Cost-effectiveness of school-based sexuality education

K. Haldre (Estonia)

Major socio-economic changes took place in Estonia immediately after the country regained its independence from Soviet occupation in 1991, including changes in heath care and education. In 1996 a new school curriculum was introduced in Estonia including for the first time mandatory sexuality education lessons integrated in a compulsory subject Human and Civil Studies. The Human Studies curriculum addresses sexuality explicitly with an emphasis on improving knowledge and building skills.
First youth counselling services addressing sexual health matters in a holistic way were set up in 1991–1992 and have resulted in 15 counselling centres by 2015. Both individual counselling and health education lectures/discussion groups, mainly for schoolchildren, are provided by the centers.
In 2011 the results of 12 population-based surveys and information from the national databases of health indicators were examined to determine whether changes occurred in young people's sexuality-related knowledge and behaviour during 1992–2009. Teenage fertility rates and abortion rates started to decrease immediately after modern contraceptives, sexuality education/information and youth-friendly services became available. The surveys on knowledge and behaviour showed that knowledge had improved, condom and modern contraceptive use had increased. A study was undertaken by Radboud University (Netherlands), commissioned by UNESCO, to determine the cost of offering sexuality education, compared with the savings from poor reproductive health outcomes averted. The sexual health outcomes were grouped together into health events, i.e., unwanted pregnancies, STIs, and HIV infections. The study on cost-effectiveness showed that sexuality education was highly cost effective. The cost of averting one health event ranged between 555 USD and 1,664 USD, depending on the scenario used.
Introduction of mandatory school-based sexuality education, in combination with youth-friendly sexual health services, led to an increase in contraceptive use, improved health outcomes, and savings for the government of Estonia.
The full report of the 2011 UNESCO "Cost and cost-effectiveness analysis of school-based sexuality education programmes in six countries" can be found:
http://unesdoc.unesco.org/images/0021/002116/211604e.pdf
The authors of the analysis carried out in Estonia are: Kai Part, Kai Haldre, Eva Palm, Raul-Allan Kiivet (University of Tartu, Estonia), Jari Kempers (Qalys Health Economics, The Netherlands), Rob Baltussen, Evert Ketting (Radboud University Nijmegen Medical Center, The Netherlands).

Does the price of contraception still serve as a barrier to its widespread use?

R. Lertxundi (Spain)

Nearly half the pregnancies that occur each year in the developed world are unintended, according to the Guttmacher Institut [1]. Unintended pregnancies result as well in considerable economic cost on society. The cost of one Medicare-covered birth in the USA (including prenatal care, delivery, post-partum care, and infant care for one year) was $12.613 in 2008 according to the Guttmacher Institut. The national per-client cost for contraceptive care the same year was $ 257.
General approach
As part of this issue contraceptive price has to be considered as one of the main elements to be taken into account when we are talking about demand stimulation. So the degree to which price influences contraceptive demand and use is a critical issue which should be considered in evaluating the appropriate balance between public and private roles in contraceptive supply.

To what extent is price a barrier to contraception access and how can this information be used to advise the policy debate?

Different opinions

Almost all the authors highlight the importance of contraceptives price but there is no general agreement: cost and access are found not to be important factors as it is shown in the survey carried out in Spain in 2014 [2] where only 2% of women mentioned the price factor as decisive. However specific studies such as CHOICE [3] in 2010 state clearly that removal of economic and financial barriers and the free cost establishment, determine the contraceptive method choice.

John D. Rockefeller

"Socioeconomic Development is the Best Contraceptive". This speech, explained at 1974 UN Population Conference in Bucarest still resonates today. Over the last three decades much energy has been spent over the relative importance of socioeconomic characteristics and service availability in predicting person's reproductive behaviour. The real equity issue is whether the differences in contraceptive use among the poor and the rich are explained by their different socioeconomic situations[4].

Gender equity

Where women have restricted access to money, their demand for contraception may be constrained. The interventions to improve their access to contraceptives give them more control on reproduction decisions. Female controlled methods are particularly important here [5]

Lewis 1986 [6]

- A small increase in prices generally does not produce a large fall in demand.
- A large increase in prices is usually associated with a large fall in demand.
- Reducing prices almost always leads to an increase in uptake.
- In some circumstances small increases in price (from free to a low charge) can increase demand because of the association of cost with value quality.

Public policies, donor organizations and individual fees [7]

The ones above are the three main funding sources for family planning programmes. Increasing users' fees is controversial, because the family planning demand is sensitive to price changes; it specially has a great impact on the ability of the poor people to buy goods and services, including contraceptive methods. Another big issue is the difference among countries and world areas.Just by having a look at Western Europe, a relatively homogeneous area, we can see that there are huge differences, as indicated in this article "Evaluation on the effect of contraceptive prices on demand in eight Western European countries [8].

Conclusions

All forms of contraception have been proved to be cost-effective compared to no method. Removing the cost barrier may be a critical step in increasing the use of highly effective contraceptive methods. Other studies find that continued public sector supply of contraceptives to the poorest women protects them. Of particular importance is how to balance Public Health needs and the resources available (income levels and potential demand) of private sector development. Of course where viable private markets are not present, governments will need to play the major role in ensuring access to contraceptives.

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Dr. Google and the pill: fear of side-effects when choosing contraceptives?
L.P. Shulman (USA)

Providing accurate and personalized counseling to women seeking contraception remains a universal challenge to health care providers and to society-at-large. Successful contraception and reduced rates of unplanned and unintended pregnancies are closely linked to women who have been well apprised of their options as well as the usage characteristics and risks of these methods. The increasing use of the internet not only provided an easily accessible source of information on contraception and a variety of health-related issues, it also allowed for a variety of resources to provide information on this and other topics. However, it appears that despite the availability of internet-based information for over a decade, women may not be any better informed of the risks, benefits and applications of contraception. This presentation will highlight the apparently inaccurate nature of much of the contraceptive information on the internet as well as the great concern of context. Specifically, even when information presented is accurate, is the information presented in a manner that allows the reader to understand the context of benefits and risks and thus facilitate a truly informed decision? This presentation will assess the ongoing role of the internet in the development of counseling programs, including interactive programs, to optimize the process by which women and couples initiate contraception.

Workshop: Prevention of STDs, HPV vaccination, HIV prophylaxis, HSV, Chlamydia

How much “safer” is Oral Sex?
P. Greenhouse (UK)

The generation who commenced sexual activity around the start of the AIDS era – those born between about 1968-1978 – were taught to stick to one partner, use condoms meticulously and that “Oral Sex is Safer Sex”. As a consequence (in the UK at least) they had:

1. Much higher teenage pregnancy rates – as their chosen first-line contraceptive method was condom rather than the OC pill used by the previous generation
2. Lower recorded rates of gonorrhoea, syphilis & chlamydia than any generation before or since
3. Higher rates of genital herpes
4. Greatest risks of suffering venerophobia – during their teenage years and for the rest of their lives
5. A misplaced presumption that oral sex was relatively safe

There is no doubt that oral sex risk of HIV transmission is vanishingly small even for performing fellatio with ejaculation in the mouth, with only a few case reports in the thirty years since HIV tests became available. Transmission probably occurs only at the very peak of seroconversion viraemia, which may last less than a week. This false sense of ‘security’ means nowadays that – among those who use condoms for all and any vaginal or rectal sex – oral sex is the principal route of STI acquisition and infection at multiple body sites. Genital herpes rates rose substantially in the early HIV years and HSV-1 acquired from oral cold sores is now the predominant cause (~80%) of genital herpes in the under 20 age group.

This is due to a dynamic balance between reducing oral herpes infection from better hygiene & smaller family size, and a larger pool of susceptible, unexposed individuals. The only group of individuals regularly using condoms for fellatio are female sex workers (FSW) in the Western world: This explains the accelerated development of antibiotic resistant gonorrhoea in homosexual men (MSM) and Asian FSW, as drug concentration is suboptimal in the pharynx and there gonococci can more easily acquire genetic resistance from similar commensal organisms. Amongst heterosexuals not involved in sex work or pornography, pharyngeal rates of gonorrhoea and chlamydia remain very low, but multi-site testing is now becoming the norm for those with higher risks.
The most sinister STI-related consequence of oral sex is an increased risk of oropharyngeal cancer which predominantly affects heterosexual men (MSW) in their 40s and 50s rather than MSM or women. This is due to far greater HPV viral shedding concentration, and thus transmission, from vulva-to-mouth than penis-to-mouth. Non-smoking MSW are also at significant risk as there are two HPV-16 pharyngeal cancer pathways, one of which is not dependent on smoking immunosuppression.
The only way to reduce oral sex-related STIs – and to prevent the emergence of untreatable gonorrhoea – is to mount a vigorous condom-for-all-fellatio campaign amongst MSM and all heterosexuals, which is unlikely to succeed as the fear of HIV acquisition has receded. No practical protection is available for dedicated cunnilinguists, other than universal HPV vaccination.

Vaginal flora factors influencing transmission risk

G. Donders (Belgium)

Women with a healthy lactobacillus dominant microflora are better protected against potential invading pathogens than women with disrupted microflora. Although antibacterial protection against C trachomatis and N gonorrhea seems somewhat more logical as a result of competition for nutrition, acidification and production of bacteriocins, it is less clear what the mechanism is to protect against viral infections like HSV-2 and HIV. Also it is not clear whether some normal (common) flora types and lactobacillary species are more protective than others. The potential use of probiotics is discussed.

Progress on vaccines

B. Frey Tirri (Switzerland)

Vaccines are available for the prevention of some infections that are sexually transmitted. These are immunizations for hepatitis A, hepatitis B and human papillomavirus (HPV). There are also great efforts in developing vaccines for HSV-1/2, HIV and chlamydia trachomatis.
Particularly in the field of the HPV vaccine new results with a high impact not only for the individual health of women and men but also for the screening will be shown and discussed.

Workshop: Contraception and the cycle of life

Is it appropriate to use OCPS in adolescents for non-contraceptive indications?

D. Apter (Finland)

Age as such is no contraindication for any contraceptive method. According to WHO medical eligibility criteria, combined and progestin-only contraceptive pills can be used from menarche onwards.
Contraceptive strategies need to include prevention of both sexually transmitted infections and pregnancies. Knowledge about various contraceptive methods and a desire to use protection are essential for successful contraception. Comprehensive sexuality education has been found to improve contraceptive use.

WHO and BZgA recently produced the “Standards for Sexuality Education in Europe” providing good framework. The first option is usually condoms backed-up by emergency contraception if needed. Ulipristal acetate has a higher efficacy than levonorgestrel. When the relationship becomes more stable and longer, there is a switch to oral contraceptives or other hormonal contraception. Condom use should not be stopped before it is reasonable certain that the partner is STI-negative. Breast, pelvic and genital examination, and routine laboratory tests are not necessary before starting hormonal contraception. Good counselling is most essential. In addition to OC, both the patch and the vaginal ring have become popular among adolescents. Other alternatives, particularly long acting reversible contraceptives should also be considered as they have better efficacy. Both implants and IUD can be used by adolescents. Where reliable modern methods are widely used, the need of abortion is low.
OCPS provide many non-contraceptive benefits and can also be used for such indications. They effectively reduce menstrual pain and bleeding. OCPS can be used to provide a regular bleeding pattern. The time of the menstrual bleeding can be regulated as whished. Many women who have PMS or PMDD report an improvement in their symptoms while they are taking birth control pills. Some preparations reduce acne, which might be a problem for many adolescents. Also hirsutism can be treated with certain OCPS. So it is appropriate to use OCPS in adolescents also for non-contraceptive indications.

LARCs, Condoms or OCPs for the nulliparous?

R. Beerthuizen (the Netherlands)

Oral contraceptive pills (OCPs) are the most frequently used modern methods of contraception worldwide especially in the younger age groups. However pills are not the safest option in protecting against pregnancy. With perfect use the Pearl Index (PI) is around 0.5, but in daily practice the PI ranges from 0.2 to 10. Missing pills especially during the weeks around the stopweek are the most important reason for unplanned pregnancy. In an international survey of over 12,000 women it was shown that 78% of all users of OCPs missed pills every year ranging from 1 to more than 12 times on a yearly basis. Long acting reversible contraceptives (LARCs) have been used for a long time by multiparous women only, because of a lot of myths and misunderstandings around LARCs such as cause of infertility after pelvic infection. The lack of regular menstrual bleeding in case of using LARCs should be unhealthy. Besides that LARCs are at the start more expensive than OCPs and are not available everywhere. Removing three key barriers: costs, poor education and access to LARC methods resulted in the CHOICE project with over 9,000 participating women in 75% of the participants to choose a LARC method. After follow-up of three years continuation rates were higher in the LARC groups as pregnancy rates turned out to be more than 10 times in the non-LARC group compared to the LARC group. In this study no differences have been found between multiparous and nulliparous participants. Using LARC methods did not increase risky sexual behaviour. Return of fertility after stopping LARC methods is not different in nulliparous women compared to multiparous women as well as women using non-LARC methods. Condoms are especially meant to protect against sexually transmitted infections (STIs). Double protection is needed in case of risky sexual contacts using LARCs and OCPs as well. Using condoms as protection against pregnancy without backing up with a modern method of contraception leads to a higher percentage of unplanned pregnancy mostly by slipping, breakage or too late application of the condom. In conclusion: LARCs are the most effective modern methods of contraception and should also be offered during counseling of nulliparous women.

OCPs until the menopause: when should we STOP?

M. Lech (Poland), L. Ostrowska (Poland)

Background: The family planning is very important issue in the life-course of contemporary men and women, regardless where they live and their social status.

All men and women represent various needs for contraception in their reproductive history. Initially this is a problem of not having children too early. But, as it is known from the several studies, fear of pregnancy in women in their later ages is almost the same as in adolescents.
As the fertility is the gift given us not till the end of our lives, the contraception used by women in their postmenopause is rather matter of habit and the psychological issue than the physical needs.
Content: sexual activity and behaviour in premenopause and postmenopause period, risku of unwanted pregnancy and STI in premenopuase, option for contraception in premenopause, health risk of hormonal contraception in pre- and postmenopause, non-contraceptive benefits of hormonal contraception in pre- and postmenopause etc.
Conclusions: there is no simple answer when particulary to stop hormonal contraception in women who have used to take this method for a very long period of their lives. Although prolonged use of hormonal contraceptives shouldn't be treated as hormonal replacement treatment (HRT) in postmenopause women, just because there are better alternatives

Poster presentations

The abortion culture issue in Serbia

Katarina Sedlecky, Family Planning Centre, Institute for Mother and Child Health Care of Serbia, Belgrade, Serbia
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Introduction: The problem of a large number of abortions in Serbia for the first time was pointed out in 1935 at the National congress of physicians. This problem is still not resolved. According to the Westoff method, the estimated total induced abortion rate in Serbia was 2.29 in 2000, 2.75 in 2005 and 2.80 in 2010. The above-mentioned rate is between 1.5 and 2 times higher than the total fertility rate and is among the highest in Europe.
Objective: The 'abortion culture' is referring to the widespread and deep-rooted view that abortion is a 'normal' way of dealing with medical and socioeconomic hardships in personal and family life. The aims of this paper are: (i) to identify the most important factors of the abortion problem in Serbia; (ii) to indirectly estimate whether the term 'abortion culture' can be applied to the population of Serbia.
Design & methods: The analysis included both current legal, policy and regulatory environment of family planning, and the actual situation, estimated on the basis of numerous research findings conducted in Serbia since 1990, that were focused on young people, women and men in need, as well as health care providers. In addition, five interviews with key informants have been carried out.
Results: Several important factors opt for traditional birth control and high rates of induced abortion in Serbia. Key factors are unrecognised need to include sexual and reproductive health (SRH) education in the school system and insufficient respective training of gynaecologists who are entitled to provide contraception. Lack of full range of contraceptive methods and the fact that contraceptive guidance are not widely used are also notable causes of low prevalence of modern contraception use. On political and social level, the impact of conservative birth control and induced abortions on bellow-replacement fertility of the Serbian population are not acknowledged.
The consequences are insufficient knowledge of modern contraception, coupled with social and medical taboos surrounding it, a belief that modern contraceptive methods are harmful, and a number of psychological barriers, including those that arise from the partner relationships. Attitudes of gynaecologists towards modern contraception tend to be negative and their contraceptive behaviour don't differ significantly from the rest of the population.

Despite the fact that in the last 10 years the Serbian Government had adopted various health strategies and the Pronatalist Strategy, such a legal framework does not exist in relation to SRH.
Conclusion: Identified macro and micro factors of traditional birth control in Serbia confirm the existence of the abortion culture on the political, educational, health care and individual levels. The abortion culture obstructs the adoption of a modern concept of family planning. All results indicate that the abortion problem will persist in Serbia in the years to come.

Criteria for safe contraception use and nonuse and predictable factors for safe contraception use in Latvia (*)

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Objective. To find out reasons due to which (of all possible aspects- psychological, social, religious, health, education, etc.) the population of reproductive age in Latvia insufficiently use safe contraception.
Design and methods. This is a randomized, stratified qualitative study- an anonymous survey of 3102 respondents (males and females) from 6 main cities of Latvia.The study is going to have 3 phases- 1. Development of theoretical background, structure and pionts of survey in Latvian and Russian. 2. Checking of survey pionts in the empirical research for detection of revident validity, psychometric analysis of pionts, adoption of the first and second level decisions on the pionts to be included in survey. 3. Implementation of study- testing of Latvian and Russian respondents.
Results. Development of survey was started in September of 2013 by initial determination of basic factors which influence forming perception of contraception. Six basic factors were determined:
1. Awareness of contraception; 2. Obtaining information about contraception in a family; 3. Obtaining information about contraception at school; 4. Communication on the contraception subject with friends; 5. Conversations about contraception with partner; 6. Attitude towards contraception in the context of religion.
From July to December 2014, the final survey was carried out.
Conclusion. As evidenced by statitically significant indicators:

1. Recommendations of health care professionals (doctors) play a significant role in choice of contraception.
2. The education system to a great extent forms the basic stance towards contraception in one's perception.
3. The choice of contraception methods is determined by the price of contraceptives.
4. In communication on contraception issues a negative attitude towards hormonal contraception is being formed in a wider circle of people.
5. Communication within personal partnership facilitates more positive perception of contraception.
6. On its turn, communication in wider circles of family and friends facilitates more negative attitude towards hormonal contraception.
7. There are no statistically significant differences in any of indicators between the Russian and the Latvian audience.
8. Respondents are not sufficiently informed about types of hormonal contraception.

(*) ESC granted project.

Exhibitors

The organisers wish to acknowledge the following companies that have assisted towards the success of the seminar by actively participating in the exhibition

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