

# Contraceptive Use

## in Eastern Europe and Central Asia



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**UNFPA in Eastern Europe and Central Asia**  
**United Nations Population Fund**

Istanbul, Türkiye

[eecaro@unfpa.org](mailto:eecaro@unfpa.org)

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# Executive summary

This report presents a comprehensive analysis of contraceptive use, preferences and barriers across 17 countries and territories in Eastern Europe and Central Asia. Drawing on quantitative and qualitative data, the study applies UNFPA's human rights-based approach to family planning to examine how policy environments, service delivery systems, individual experiences and community dynamics shape access to and the use of modern contraceptive methods.

The findings reveal persistent challenges in both low- and high-fertility settings. In low-fertility contexts, declining contraceptive demand is influenced not only by contraceptive preferences, availability and stockout of certain methods, or how family planning services are delivered, but also by demographic transitions, evolving fertility preferences and sociocultural norms. In high-fertility settings, less people-centred care was observed, often limiting autonomy and method choice. Across the region, misinformation, affordability barriers, provider bias and the limited availability of certain methods continue to undermine reproductive autonomy and equitable access to family planning.

Despite these challenges, the study identifies clear opportunities for progress. Across settings, women indicated high demand for reliable contraceptive options and emphasized the importance of informed, voluntary decision-making. However, gaps in training for health-care providers, commodity security and community-based interventions hinder the realization of these rights.

To address these barriers, the report offers a set of actionable recommendations aligned with UNFPA's holistic framework:<sup>1</sup>

- Community-based interventions should focus on transforming social norms, expanding comprehensive sexuality education and promoting informed, autonomous decision-making to ensure voluntary, equitable access to modern contraceptive methods.
- To create an enabling legal and policy environment for rights-based family planning, governments in the Eastern Europe and Central Asia region should prioritize family planning in national health and social protection strategies, strengthen supply chains and primary care services, and address structural barriers to improve access, quality and choice of contraceptive methods.
- Strengthening service delivery, provider training and task-sharing is essential in the region to ensure equitable, people-centred family planning, recognizing the pivotal role of health-care providers in shaping access and quality.
- Individual autonomy, informed choice, respectful care and individual empowerment should be placed at the heart of family planning policies and programmes in the region, ensuring equitable access free from coercion, stigma and discrimination.

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1. UNFPA, *The holistic framework for human rights-based family planning*, UNFPA Technical Brief (New York, 2023).

# Acknowledgements

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Furthermore, we would like to thank Ghent University's International Centre for Reproductive Health and the Academic Network for Sexual and Reproductive Health and Rights Policy (ANSER) for strengthening the scientific rigour of the study and contextualizing the findings and recommendations within current sexual and reproductive health policy frameworks.

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# 1. Introduction

“

*I guess I like withdrawal. My partner seems to know what he's doing.*  
(19-year-old woman without children, Prizren, Kosovo\*)

”

Access to reproductive health care, including family planning services, is a widely recognized fundamental human right, affirmed by the United Nations and human rights bodies, which includes the right to determine the number and spacing of children, the right to access information and services, and the right to make informed, voluntary decisions about one's reproductive health.<sup>2</sup> The 1994 International Conference on Population and Development marked a pivotal shift from demographic targets to a human-centred approach, presenting reproductive health and rights as fundamental. Yet more than 30 years later, persistent and emerging challenges continue to undermine these commitments. Declining fertility rates, an ageing population and complex migration dynamics continue to pose significant obstacles to achieving universal access to family planning across many regions, including in Eastern Europe and Central Asia.<sup>3</sup>

Although progress has been made globally in certain areas, such as the increased use of modern contraception,<sup>4</sup> universal access to contraception remains a challenge in Eastern Europe and Central Asia.<sup>5</sup> The prevalence of modern contraceptive use among all women of reproductive age in the region has increased only modestly since 1994, according to estimates of the United Nations Population Division. In only five countries or territories did modern contraceptive use increase by more than 10 per cent between 1994 and 2022, and in Kyrgyzstan the use of modern contraceptive methods even decreased from 31.5 per cent in 1994 to 24.1 per cent in 2022.<sup>6</sup> At the same time, the prevalence of the use of traditional contraceptive methods, such as fertility awareness-based methods or withdrawal, has not declined drastically in most places. In 11 countries and territories,

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\* Hereafter referred to in the context of United Nations Security Council Resolution 1244 (1999).

2. UNFPA, "Family planning". Available at <https://www.unfpa.org/family-planning> (accessed on 10 November 2025); WHO, "Family planning/contraception methods", 3 July 2025. Available at <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception> (accessed on 25 November 2025).
3. United Nations Economic Commission for Europe and UNFPA, *Fulfilling the Potential of Present and Future Generations: Report on ICPD Programme of Action Implementation in the UNECE Region* (Geneva, 2018). Available at <https://eeca.unfpa.org/sites/default/files/pub-pdf/ECE-WG.1-29.pdf> (accessed on 10 November 2025); UNFPA Regional Office for Eastern Europe and Central Asia, *Roadmap for Ending the Unmet Need for Family Planning in Eastern Europe and Central Asia by 2030* (Istanbul, 2024). Available at [https://eeca.unfpa.org/sites/default/files/pub-pdf/2024-03-05\\_roadmap\\_family\\_planning\\_a4\\_v7.pdf](https://eeca.unfpa.org/sites/default/files/pub-pdf/2024-03-05_roadmap_family_planning_a4_v7.pdf) (accessed on 10 November 2025).
4. United Nations Department of Economic and Social Affairs, "The New Landscape of Fertility and Family Planning 30 Years after Cairo and Beijing", UN DESA Policy Brief No. 172, 13 March 2025.
5. UNFPA Regional Office for Eastern Europe and Central Asia, *Family planning: Facts and trends in Eastern Europe and Central Asia* (Istanbul, 2019).
6. United Nations Population Division, Family Planning Data. Available at <https://www.un.org/development/desa/pd/data/family-planning-indicators> (accessed on 11 November 2025).

the decrease has been less than 10 per cent between 1994 and 2025. Only in Serbia (16.3 per cent) and North Macedonia (16.0 per cent) has the use of traditional methods declined by more than 15.0 per cent.

Family planning policies worldwide have historically emphasized contraception as a tool to prevent unintended pregnancies, reduce unsafe abortions and mitigate population growth.<sup>7</sup> Yet the demographic landscape is changing: more than half of all countries and territories today have fertility levels below the replacement threshold of 2.1 births per woman.<sup>8</sup> In low-fertility countries and territories, concerns about population decline have fuelled pronatalist narratives and, in some cases, restrictive policies that deprioritize contraceptive access or limit abortion rights.<sup>9</sup> Such framings risk undermining the very core of the sexual and reproductive health and rights agenda: ensuring that all individuals can decide freely and voluntarily whether to have children, when to have them and how many to have, free from discrimination, coercion or violence. Access to high-quality, affordable and acceptable contraceptive services remains as critical in low-fertility contexts as in high-fertility ones. It is not only a public health imperative but also a matter of human rights and gender equality, essential to enabling individuals and couples to realize their fertility intentions.<sup>10</sup>

These dynamics are particularly pronounced in Eastern Europe and Central Asia, a region that has undergone profound demographic transitions over the past three decades.<sup>11</sup> Most countries and territories in Eastern Europe now experience sustained below-replacement fertility, while Central Asian countries exhibit intermediate fertility levels.<sup>12</sup> This demographic divergence has significant implications for family planning priorities and approaches. In low-fertility settings, family planning may be deprioritized or even perceived as conflicting with national demographic goals, potentially leading to reduced investment in contraceptive services and weaker supply chains. This situation can limit individuals' ability to prevent unintended pregnancies and exercise full reproductive autonomy. Conversely, in higher-fertility contexts like parts of Central Asia, family planning programmes continue to face challenges related to unmet need, limited method choice and disparities in access.

Furthermore, evidence suggests that concerns regarding the negative demographic impact of family planning are misplaced. In low-fertility contexts, there is no empirical evidence to support the claim that increased access to modern contraception further drives down fertility rates. On the

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7. Bart C. J. M. Fauser and others, "Declining global fertility rates and the implications for family planning and family building: An IFFS consensus document based on a narrative review of the literature", *Human Reproduction Update*, vol. 30, No. 2 (2024), p. 153. Available at <https://doi.org/10.1093/HUMUPD/DMAD028> (accessed on 11 November 2025).
  8. Natalia V. Bhattacharjee and others, 'Global fertility in 204 countries and territories, 1950–2021, with forecasts to 2100: A comprehensive demographic analysis for the Global Burden of Disease Study 2021', *The Lancet*, vol. 403, No. 10440 (May 2024). Available at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(24\)00550-6/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)00550-6/fulltext) (accessed on 25 November 2025).
  9. Stuart Gietel-Basten, Anna Rotkirch and Tomáš Sobotka, "Changing the perspective on low birth rates: Why simplistic solutions won't work", *The BMJ*, vol. 379 (2022). Available at <https://doi.org/10.1136/BMJ-2022-072670> (accessed on 11 November 2025); Md Mizanur Rahman and others, "Reversing fertility decline in Japan with foreign pro-natalist policies, 1990–2035: A systematic review and secondary data analysis", *The Lancet Regional Health – Western Pacific*, vol. 59 (2025). Available at <https://doi.org/10.1016/j.lanwpc.2025.101596> (accessed on 11 November 2025).
  10. UNFPA, "Family planning".
  11. Bernd Rechel and Martin McKee, "Health reform in Central and Eastern Europe and the former Soviet Union", *The Lancet*, vol. 374 (2009). Available at [https://doi.org/10.1016/S0140-6736\(09\)61334-9](https://doi.org/10.1016/S0140-6736(09)61334-9) (accessed on 11 November 2025).
  12. Eurasian Research Institute, "UN population prospects: Case of Central Asia". Available at <https://www.eurasian-research.org/publication/un-population-prospects-case-of-central-asia/> (accessed on 24 September 2025).

contrary, robust family planning services are a cornerstone of demographic resilience. By enabling individuals—particularly women—to exercise full reproductive autonomy, family planning allows for better planning of pregnancies, which minimizes mistimed disruptions to education and career trajectories. This alignment of reproductive health with life goals is essential for strengthening human capital and closing persistent gaps in female labour force participation.<sup>13</sup>

The persistence of unmet need for modern contraception in Eastern Europe and Central Asia reflects both supply- and demand-side barriers. On the supply side, challenges are related to a shortage of available methods, limited provider training and outdated clinical protocols.<sup>14</sup> On the demand side, misinformation, sociocultural norms and structural inequalities continue to shape contraceptive choices. These barriers have historical roots. Prior to 1990, family planning services in Eastern Europe and Central Asia were typically found only in specialized health-care facilities, primarily in urban areas, and were predominantly provided by gynaecologists.<sup>15</sup> There was a limited choice of contraceptive methods, with frequent reliance on intrauterine devices (IUDs), leaving rural women with limited access to modern contraception. In addition, there was a reluctance among providers to prescribe hormonal contraception, often based on misconceptions about risks and side effects, which had a lasting influence on service provision and user perceptions. The integration of contraceptive services, counselling and referral to other health-care services took place only in the 2000s. However, this integration was limited, and a restricted choice of modern contraceptive methods persists in many countries and territories, as do misconceptions among providers and the public regarding hormonal contraception.<sup>16</sup>

This report offers a nuanced, evidence-based analysis of contraceptive use, user preferences and reasoning, and provider perspectives across 17 countries and territories in UNFPA's Eastern Europe and Central Asia region: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, the Republic of Moldova, Serbia, Tajikistan, Türkiye, Turkmenistan, Ukraine, Uzbekistan and Kosovo. The study explores both demand- and supply-side barriers to modern contraceptive use and examines how user and provider perspectives align or differ within contexts of low and intermediate fertility.

By sharing lived experiences, structural constraints and policy environments that shape reproductive decision-making in the region, this study contributes to a growing body of evidence that can inform human rights-based, context-sensitive and people-centred programming in the area of sexual and reproductive health and rights. A human rights-based approach to family planning is essential not only for achieving universal access to family planning but also for upholding commitments made at the International Conference on Population and Development and advancing the broader goals of health equity, gender equality and sustainable development.

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13. UNFPA Malaysia, *Ensuring Reproductive Rights and Choices: A Human Capital Perspective on Family Planning in Malaysia*, (Kuala Lumpur, 2023). Available at [https://malaysia.unfpa.org/sites/default/files/pub-pdf/full\\_report\\_lr\\_dec1\\_2.pdf](https://malaysia.unfpa.org/sites/default/files/pub-pdf/full_report_lr_dec1_2.pdf) (accessed on 11 November 2025).

14. UNFPA Regional Office for Eastern Europe and Central Asia, *Advancing contraceptive choices and supplies for universal access to family planning in Eastern Europe and Central Asia: UNFPA Regional Contraceptive Security Strategic Framework 2017-2021* (Istanbul, 2017). Available at [https://eeca.unfpa.org/sites/default/files/pub-pdf/EECA%20Regional%20Contraceptive%20Security%20Strategic%20Framework\\_Eng.pdf](https://eeca.unfpa.org/sites/default/files/pub-pdf/EECA%20Regional%20Contraceptive%20Security%20Strategic%20Framework_Eng.pdf) (accessed on 11 November 2025).

15. Ibid.

16. Ibid.

## 2. Methodology

### 2.1. Data collection

This study used a three-phased mixed-methods approach to examine the barriers to modern contraceptive use across the Eastern Europe and Central Asia region. The methodology was designed to build on existing data, identify knowledge gaps and validate findings through participatory approaches.

#### **Phase 1: Desk review and development of an explanatory conceptual framework (April–June 2023)**

During this phase, a desk review was conducted to synthesize existing evidence on contraceptive use in the Eastern Europe and Central Asia region. The desk review involved two components:

- First, the UNFPA Regional Office for Eastern Europe and Central Asia analysed data sets and reports, including national surveys, programmatic reports and statistical data.
- Second, a complementary literature review was conducted to gather further insights and identify gaps not covered in previously identified materials.

The findings from this comprehensive review informed the development of an explanatory conceptual framework, which served as the foundation for the study's subsequent phases.

#### **Phase 2: Online surveys (September 2023 – March 2024)**

Building on the insights from phase 1, the second phase aimed to address the identified data gaps through online surveys conducted across 17 countries and territories in the Eastern Europe and Central Asia region. Two surveys were developed to target different stakeholder groups: the general population of reproductive age (15–49 years) and health-care providers working in family planning services. The survey of the general population covered sociodemographic variables, as well as contraceptive use and non-use, contraceptive awareness, perceptions and sources of information about contraceptives. The survey of health-care providers covered sociodemographic variables, practice – including the frequency of contraceptive counselling and prescription – and awareness and training.

The surveys were available in 15 languages spoken in the region.<sup>17</sup> Prior to being fully rolled out, the surveys were piloted in local languages, with a small group of participants (17 for the general

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17. The survey was translated from English and made available to users in the following languages: Albanian, Azerbaijani, Bosnian, Croatian, Georgian, Kazakh, Kyrgyz, Macedonian, Romanian, Russian, Serbian (in both Cyrillic and Latin scripts), Tajik, Turkish, Ukrainian and Uzbek (in both Cyrillic and Latin scripts).

population survey and 6 for health-care providers) engaged to refine the wording and structure of the questions and to minimize ambiguity. Eligibility criteria for the general population survey included the following: respondents had to be between 18 and 49 years of age, reside in one of the 17 countries or territories included in the study, and provide informed consent. For the health-care provider survey, participants were required to be health-care professionals working in family planning services, reside in one of the study countries or territories, and provide informed consent.

To ensure broad and targeted dissemination, the International Centre for Reproductive Health partnered with regional actors such as the Eurasian Women's Network on AIDS, as well as digital platforms like the Amma pregnancy tracker, helping reach relevant populations as well as vulnerable and minority groups.

Vulnerable groups were defined as people living with HIV, persons with disabilities, sexual minorities, survivors of domestic violence, internally displaced persons and ethnic minorities, such as the Roma, Ashkali and Egyptian communities.

Sexual orientation was assessed using inclusive categories to ensure representation of LGBTQ+ populations. Respondents could identify as heterosexual, gay, lesbian, bisexual, asexual or other or select "I prefer not to answer" or "I don't know".<sup>18</sup> For the purposes of the analysis, the LGBTQ+ category includes all respondents who did not identify as heterosexual, including those who selected "other", "I don't know" or "I prefer not to answer".

The analysis included descriptive statistics as well as an assessment of differences in proportions.

### **Phase 3: Focus group discussions (April–September 2024)**

This final phase used focus group discussions to provide qualitative triangulation of the survey findings. To capture perspectives from both low- and high-fertility settings, a subset of the 17 countries and territories surveyed was selected for the discussions, with Albania and Kosovo representing low-fertility settings and Tajikistan representing high-fertility settings. The participants for each focus group were purposively sampled to reflect diverse sociodemographic backgrounds across rural and urban areas.

To ensure methodological consistency, a standardized moderator guide was developed (Annex A), and online training sessions were provided for all facilitators. The focus group discussions were organized by the respective UNFPA country offices and the UNFPA office in Kosovo in accordance with established ethical and methodological standards. The discussions that took place in Albania and Kosovo were transcribed, while the discussions that occurred in Tajikistan were documented as research notes containing summaries and key inputs from the research team. Subsequently, a qualitative thematic analysis was conducted using the software Nvivo 12. A concurrent mixed-methods approach was used, allowing qualitative insights to enrich and interpret the quantitative findings.

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18. In responding to the question "What is your sexual orientation?", participants in both surveys could choose from the following categories: prefer not to answer, heterosexual (a person who is sexually or romantically attracted exclusively to people of the other sex), gay (men who are sexually or romantically attracted to other men), lesbian (women who are sexually or romantically attracted to other women), bisexual (individuals who are sexually or romantically attracted to both men and women), asexual (individuals who do not feel sexual attraction to anyone), other, and I don't know.

## 2.2. Classification of low- and high-fertility countries and territories

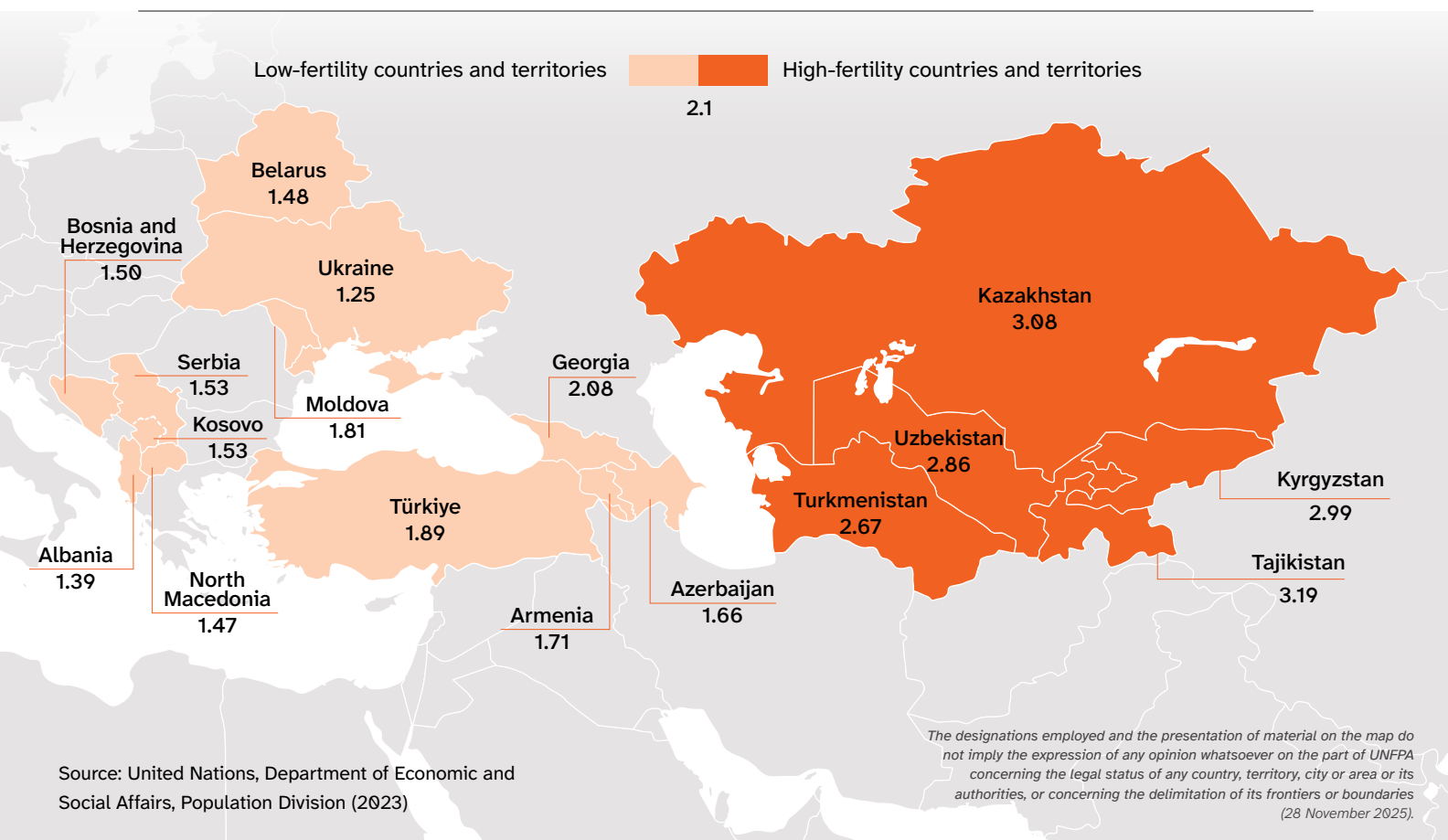
For the purposes of this study, the 17 countries and territories included were classified as low- or high-fertility settings based on their total fertility rate, using replacement-level fertility – approximately 2.1 children per woman – as the guiding benchmark.<sup>19</sup> This threshold represents the number of births needed, on average, to sustain a population in the long term, assuming constant mortality and no migration.<sup>20</sup> Countries and territories with a total fertility rate below 2.1 were categorized as low-fertility settings, while those with a rate at or above 2.1 were considered high-fertility settings. Using data from the United Nations Population Division,<sup>21</sup> countries and territories were classified as follows:

The low-fertility group included Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, North Macedonia, the Republic of Moldova, Serbia, Türkiye, Ukraine and Kosovo.

The high-fertility group included Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.

This classification provides an important analytical lens for understanding how the context shapes contraceptive use, fertility intentions and reproductive health service delivery.

Figure 1. Classification of countries and territories by fertility setting



19. Eurostat, Statistics Explained, 'Glossary: Replacement level'. Available at [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Replacement\\_Level](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Replacement_Level) (accessed on 10 September 2025).

20. J. Craig, "Replacement level fertility and future population growth", *Population Trends*, vol. 78 (Winter 1994). Available at <https://pubmed.ncbi.nlm.nih.gov/7834459/> (accessed on 11 November 2025).

21. United Nations Population Division, Family Planning Data.

## 2.3. Classification of contraceptive methods

There is no universally accepted definition of modern contraception, and interpretations vary depending on the source. The World Health Organization (WHO), for instance, emphasizes effectiveness and mechanisms of action but does not provide a specific definition within its classification system.<sup>22</sup>

To address these inconsistencies, the WHO Department of Reproductive Health and Research and the United States Agency for International Development convened a technical consultation in January 2015. The findings, published in 2016,<sup>23</sup> highlight the need for a clear and transparent framework to ensure consistency in categorizing contraceptive methods – particularly distinguishing between modern and traditional approaches. Notably, these terms do not always align with their historical or temporal meanings. For example, condoms have existed for centuries yet are classified as modern.<sup>24</sup> Similarly, the lactational amenorrhea method is classified as modern in Demographic and Health Surveys but as traditional in Multiple Indicator Cluster Surveys. Moreover, Festin and others propose that fertility awareness-based methods, such as the standard days method and the two-day method, should be categorized as modern, though this classification remains debated.<sup>25</sup>

For this report, we define modern methods as those methods that involve hormonal, barrier or surgical interventions. In contrast, natural methods are those that do not rely on any external mechanisms to prevent ovulation, block or damage sperm, or create a physical barrier between sperm and egg. For instance, since the lactational amenorrhea method does not employ an external mechanism, it is classified as a natural method in this report. Table 1 shows the classification used as the basis for this report, in line with WHO classifications.

**Table 1.** Classification of contraceptive methods

Modern methods	Natural methods
<ul style="list-style-type: none"> <li>• Oral contraceptives (pills)</li> <li>• Intrauterine device (IUD)</li> <li>• Emergency contraceptive pills</li> <li>• Cervical cap</li> <li>• Male condoms</li> <li>• Female condoms</li> <li>• Implant</li> </ul>	<ul style="list-style-type: none"> <li>• Diaphragm with spermicide</li> <li>• Patch</li> <li>• Spermicide</li> <li>• Vaginal ring</li> <li>• Female sterilization</li> <li>• Male sterilization (vasectomy)</li> </ul>
	<ul style="list-style-type: none"> <li>• Fertility awareness-based methods (standard days method, mucus method, basal temperature method, other)</li> <li>• Lactational amenorrhea method (while breastfeeding)</li> <li>• Periodic abstinence</li> <li>• Withdrawal</li> </ul>

Source: Unless indicated otherwise, all the figures and tables presented in this report were compiled by the authors.

22. World Health Organization (WHO), “Family planning/contraception methods”, 3 July 2025. Available at <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception> (accessed on 11 November 2025).

23. Mario Philip R. Festin and others, “Moving towards the goals of FP2020: Classifying contraceptives”, *Contraception*, vol. 94, No. 4 (October 2016). Available at <https://doi.org/10.1016/j.contraception.2016.05.015> (accessed on 11 November 2025).

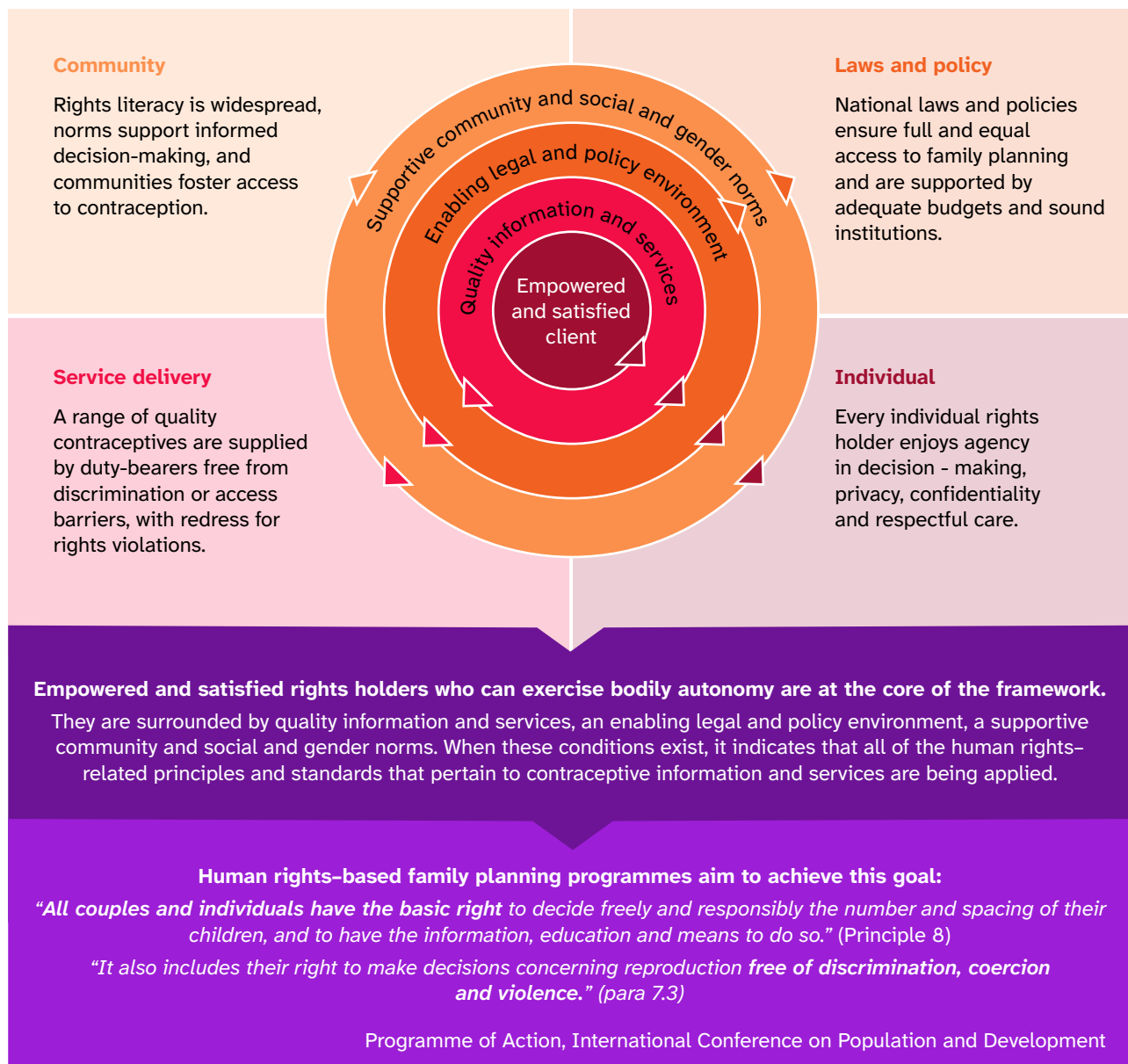
24. Jean-Jacques Amy and Michel Thiery, “The condom: A turbulent history”, *European Journal of Contraception and Reproductive Health Care*, vol. 20, No. 5 (2015). Available at <https://doi.org/10.3109/13625187.2015.1050716> (accessed on 11 November 2025).

25. Festin and others, “Moving towards the goals of FP2020: Classifying contraceptives”.

## 2.4. Analytical framework

UNFPA’s human rights–based approach to family planning<sup>26</sup> and holistic framework for human rights–based family planning<sup>27</sup> were used to guide the interpretation and discussion of the findings. The former offers practical guidance for assessing family planning programmes through a human rights lens, emphasizing the importance of delivering contraceptive services in ways that respect, protect and fulfil the rights of all individuals. Moreover, it illuminates how the legal and policy environment, systemic factors affecting people-centred service delivery and community dynamics interact to influence family planning outcomes.

Figure 2. Holistic framework for human rights–based family planning



Source: UNFPA, *The holistic framework for human rights-based family planning*, UNFPA Technical Brief (New York, 2023).

26. UNFPA, *Human rights-based approach to family planning*, UNFPA Support Tool (New York, 2024). Available at <https://www.unfpa.org/featured-publication/human-rights-based-approach-family-planning-support-tool> (accessed on 11 November 2025).

27. UNFPA, *The holistic framework for human rights-based family planning*.

## 3. Results

### 3.1. Sample description

A total of 3,953 individuals participated in the general population survey. After data cleaning and the exclusion of male and intersex respondents – due to their limited representation and concerns regarding the statistical robustness of subgroup analysis – this report focuses on the 3,265 completed responses from female participants. The highest number of respondents came from Ukraine (29.0 per cent), Bosnia and Herzegovina (12.6 per cent), Belarus (11.9 per cent) and Albania (11.7 per cent). The majority of responses (87.5 per cent) were from low-fertility settings, while 12.5 per cent were from high-fertility contexts.

The health-care provider survey yielded 1,261 respondents. The highest number of respondents came from Albania (39.8 per cent), followed by Kazakhstan (15.7 per cent) and Kosovo (12.4 per cent). After regrouping by fertility setting, 80.8 per cent of health-care providers were from low-fertility countries or territories, while 19.2 per cent were from high-fertility countries or territories.

**Table 2.** Respondents by country or territory, ranked from highest to lowest by number of respondents and by fertility setting

Country/territory	General population (n = 3,265)		Health-care providers (n = 1,261)	
	Number	%	Number	%
Ukraine	946	29.0%	137	10.9%
Bosnia and Herzegovina	410	12.6%	54	4.3%
Belarus	390	11.9%	-	-
Albania	382	11.7%	502	39.8%
Serbia	210	6.4%	28	2.2%
Kazakhstan	207	6.3%	198	15.7%
Türkiye	146	4.5%	88	7.0%
Georgia	137	4.2%	15	1.2%
Kosovo	127	3.9%	156	12.4%
Kyrgyzstan	109	3.3%	1	0.1%

Country/territory	General population (n = 3,265)		Health-care providers (n = 1,261)	
	Number	%	Number	%
Uzbekistan	72	2.2%	8	0.6%
North Macedonia	53	1.6%	18	1.4%
Republic of Moldova	30	0.9%	13	1.0%
Tajikistan	19	0.6%	33	2.6%
Azerbaijan	14	0.4%	7	0.6%
Armenia	11	0.3%	1	0.1%
Turkmenistan	2	0.1%	2	0.2%
<b>Low-fertility setting</b>	<b>2,856</b>	<b>87.5%</b>	<b>1,019</b>	<b>80.8%</b>
<b>High-fertility setting</b>	<b>409</b>	<b>12.5%</b>	<b>242</b>	<b>19.2%</b>

A total of 26 focus group discussions (Table 3) were conducted until data saturation. In Albania and Kosovo, a total of seven focus groups were held in each country or territory with women from the general population, women from vulnerable groups, men from the general population and health-care providers. In Tajikistan, 12 focus groups were conducted, with groups including women and men from the general population as well as health-care providers.

**Table 3.** Number of focus group discussions by country or territory, area and type of respondent

Country/territory	Women: general population	Women: vulnerable groups	Men: general population	Health-care providers
Albania	2	2	1	2
Tajikistan	4		4	4
Kosovo	2	2	1	2

### 3.1.1. General population

#### Sociodemographic characteristics of the general population

The average age of respondents from the general population sample was 29 years, and most (93.5 per cent) were born in the country or territory where they were living at the time of the survey (Table 4). Sexual orientation data showed that 8.5 per cent of the total sample identified as non-heterosexual. This proportion was higher for one subgroup in low-fertility settings, where 8.0 per cent of participants identified as bisexual, compared with 4.6 per cent in high-fertility settings.

Marital status also differed between settings. Overall, 46.8 per cent of respondents were married, with a higher proportion in high-fertility settings (68.9 per cent vs. 43.7 per cent). Conversely, a

higher proportion of respondents in low-fertility settings were either in a relationship (18.5 per cent) or single (34.7 per cent) than in high-fertility settings (6.4 per cent and 21.3 per cent, respectively).

Almost two thirds of the sample (66.4 per cent) had completed higher education (college or university), and only 1.0 per cent reported having no formal education or only basic schooling. The proportion of respondents with higher education was greater in low-fertility settings (67.5 per cent) compared with high-fertility settings (58.2 per cent), while those with intermediate education (secondary or advanced technical training) were more common in high-fertility settings (38.6 per cent vs. 28.9 per cent in low-fertility settings). This distribution may reflect participation patterns associated with greater educational resources, online connectivity and differences in dissemination channels.

Salaried employment was the primary source of income for 56.8 per cent of respondents, with higher representation in low-fertility settings (58.2 per cent) than in high-fertility settings (47.2 per cent). However, a higher proportion of respondents in low-fertility settings (28.3 per cent compared with 15.9% in high-fertility settings) also reported finding it difficult or very difficult to meet basic needs such as food and housing with their current financial resources. Overall, more than one quarter of the sample reported financial hardship (26.7 per cent), while a similar percentage of respondents (26.9 per cent) stated that it was easy or very easy to cover their basic needs. A larger proportion of respondents in high-fertility settings reported that it was neither easy nor difficult to cover their basic needs (57.9 per cent compared with 44.7 per cent).

**Table 4.** Respondents' sociodemographic characteristics

Variable	Categories	Low-fertility setting (n = 2,856) n (%)	High-fertility setting (n = 409) n (%)	Total (n = 3,265) n (%)
Age		29	28	29
Born in country or territory of residence	Yes	2,672 (93.6%)	380 (92.9%)	3,052 (93.5%)
	No	176 (6.2%)	26 (6.4%)	202 (6.2%)
	Unknown	8 (0.3%)	3 (0.7%)	11 (0.3%)
Sexual orientation	Heterosexual	2,397 (83.9%)	304 (74.3%)	2,701 (82.7%)
	Lesbian	11 (0.4%)	2 (0.5%)	13 (0.4%)
	Bisexual	229 (8.0%)	19 (4.6%)	248 (7.6%)
	Asexual	11 (0.4%)	6 (1.5%)	17 (0.5%)
	Unknown	208 (7.3%)	78 (19.1%)	286 (8.8%)
Civil status	Married	1,247 (43.7%)	282 (68.9%)	1,529 (46.8%)
	In a relationship	529 (18.5%)	26 (6.4%)	555 (17.0%)
	Single	990 (34.7%)	87 (21.3%)	1,077 (33.0%)
	Unknown	90 (3.2%)	14 (3.4%)	104 (3.2%)

Variable	Categories	Low-fertility setting (n = 2,856) n (%)	High-fertility setting (n = 409) n (%)	Total (n = 3,265) n (%)
Occupation	Salaried	1,663 (58.2%)	193 (47.2%)	1,856 (56.8%)
	Non-salaried	1,038 (36.3%)	174 (42.5%)	1,212 (37.1%)
	Unknown	155 (5.4%)	42 (10.3%)	197 (6.0%)
Education	High	1,929 (67.5%)	238 (58.2%)	2,167 (66.4%)
	Intermediate	824 (28.9%)	158 (38.6%)	982 (30.1%)
	None or basic	30 (1.1%)	3 (0.7%)	33 (1.0%)
	Unknown	73 (2.6%)	10 (2.4%)	83 (2.5%)
Economic status	Difficult or very difficult	807 (28.3%)	65 (15.9%)	872 (26.7%)
	Neither easy nor difficult	1,278 (44.7%)	237 (57.9%)	1,515 (46.4%)
	Easy or very easy	771 (27.0%)	107 (26.2%)	878 (26.9%)
Religious affiliation and practice	Yes, actively	291 (10.2%)	80 (19.6%)	371 (11.4%)
	Yes, but not actively	1,460 (51.1%)	232 (56.7%)	1,692 (51.8%)
	No	951 (33.3%)	65 (15.9%)	1,016 (31.1%)
	Unknown	154 (5.4%)	32 (7.8%)	186 (5.7%)
Member of a vulnerable group	Yes	535 (18.7%)	43 (10.5%)	578 (17.7%)
	No	2,321 (81.3%)	366 (89.5%)	2,687 (82.3%)
	Persons with disabilities	75 (2.6%)	5 (1.2%)	80 (2.5%)
	Living with HIV	152 (5.3%)	17 (4.2%)	169 (5.2%)
	Domestic violence	129 (4.5%)	13 (3.2%)	142 (4.3%)
	Internally displaced persons	137 (4.8%)	0	137 (4.2%)
	Sexual minorities	120 (4.2%)	6 (1.5%)	126 (3.9%)
	Roma	9 (0.3%)	0	9 (0.3%)
	Other	39 (1.4%)	8 (2.0%)	47 (1.4%)

Religious identification was common, with over 60.0 per cent of respondents describing themselves as religious. A significantly higher proportion in high-fertility settings stated that they were religious and practise their religion actively (19.6 per cent), while 56.7 per cent reported not practising actively, compared with 10.2 per cent and 51.1 per cent in low-fertility settings, respectively. Conversely, non-religious identification was higher in low-fertility settings, where one third of respondents reported no religious affiliation, compared with 15.9 per cent in high-fertility settings.

Out of the total sample, 578 respondents (17.7 per cent) identified as belonging to a vulnerable group, with a higher proportion coming from low-fertility settings (18.7 per cent) than high-fertility settings (10.5 per cent). Among the five vulnerable groups listed in the survey, 169 respondents (5.2 per cent) were living with HIV, 142 (4.3 per cent) had experienced domestic violence, and 137 (4.2 per cent) were internally displaced, the latter being reported only in low-fertility settings.

### **Sexual and reproductive characteristics of the general population**

A slightly higher proportion of individuals in high-fertility contexts reported currently having one or more sexual partners (82.4 per cent) compared with those in low-fertility settings (76.2 per cent) (Table 5). While the majority in both groups were sexually active or had been sexually active at the moment of the survey, a higher proportion of respondents in low-fertility settings reported never having had a sexual partner (12.1 per cent vs. 8.1 per cent). When asked whether they were currently in a steady sexual relationship, responses were similar across both groups, with 89.0 per cent on average being in a sexual relationship.

A significantly higher proportion of women in high-fertility settings – nearly half (45.7 per cent), compared with 14.5 per cent in low-fertility settings – reported being pregnant at the time of the survey. In terms of respondents' number of living children, a significantly higher proportion of respondents in low-fertility settings reported having no children (62.7 per cent compared with 46.5 per cent in high-fertility settings). Conversely, a significantly higher proportion of respondents in high-fertility settings reported having one child (25.2 per cent vs. 18.7 per cent), three children (8.1 per cent vs. 3.3 per cent) or four or more children (4.9 per cent vs. 1.0 per cent).

Differences were also statistically significant regarding fertility intentions. In high-fertility settings, the desire to have children was higher, with nearly 60.0 per cent expressing a wish to have a baby, compared with 32.4 per cent in low-fertility settings. More than half of respondents in low-fertility settings (53.2 per cent) stated that they did not want a child. Experiences of unwanted pregnancy were reported more frequently in high-fertility settings (21.8 per cent) than in low-fertility countries and territories (16.8 per cent), although the difference was not statistically significant. Among those who reported an unwanted pregnancy, 61.0 per cent attempted to terminate it, and 2.1 per cent reported that they had succeeded in doing so. When asked about the number of induced abortions, the proportion of respondents reporting three or more was higher in high-fertility settings (3.9 per cent compared with 1.4 per cent in low-fertility settings).

**Table 5.** Sexual and reproductive characteristics of respondents

Variable	Categories	Low-fertility setting n (%)	High-fertility setting n (%)	Total n (%)
		(n = 2,856)	(n = 409)	(n = 3,265)
Sexual partner	Currently have one or multiple sexual partners	2,176 (76.2%)	337 (82.4%)	2,513 (77.0%)
	No, but had one previously	333 (11.7%)	39 (9.5%)	372 (11.4%)
	No, I have never had one	347 (12.1%)	33 (8.1%)	380 (11.6%)
		(n = 2,176)	(n = 337)	(n = 2,513)
Steady sexual relationship	Yes	1,931 (88.7%)	301 (89.3%)	2,232 (88.8%)
	No	142 (6.5%)	24 (7.1%)	166 (6.6%)
	I am not sure	103 (4.7%)	12 (3.6%)	115 (4.6%)
		(n = 2,856)	(n = 409)	(n = 3,265)
Currently pregnant	Yes	414 (14.5%)	187 (45.7%)	601 (18.4%)
	No	2,337 (81.8%)	207 (50.6%)	2,544 (77.9%)
	Unknown	105 (3.7%)	15 (3.7%)	120 (3.7%)
Number of living children	0	1,791 (62.7%)	190 (46.5%)	1,981 (60.7%)
	1	534 (18.7%)	103 (25.2%)	637 (19.5%)
	2	407 (14.3%)	63 (15.4%)	470 (14.4%)
	3	95 (3.3%)	33 (8.1%)	128 (3.9%)
	> 4	29 (1.0%)	20 (4.9%)	49 (1.5%)
Want a baby	Yes	926 (32.4%)	242 (59.2%)	1,168 (35.8%)
	No	1,520 (53.2%)	129 (31.5%)	1,649 (50.5%)
	Don't know	410 (14.4%)	38 (9.3%)	448 (13.7%)
Experience of unwanted pregnancy	Yes	480 (16.8%)	89 (21.8%)	569 (17.4%)
	No	2,376 (83.2%)	320 (78.2%)	2,696 (82.6%)

Variable	Categories	Low-fertility setting n (%)	High-fertility setting n (%)	Total n (%)
		(n = 480)	(n = 89)	(n = 569)
Intention to induce abortion (among those experiencing an unwanted pregnancy)	Chose to give birth	146 (30.4%)	31 (34.8%)	177 (31.1%)
	Attempted to stop the pregnancy and succeeded	289 (60.2%)	46 (51.7%)	335 (58.9%)
	Attempted to stop the pregnancy but did not succeed	10 (2.1%)	2 (2.2%)	12 (2.1%)
	Other	35 (7.3%)	10 (11.2%)	45 (7.9%)
		(n = 2,856)	(n = 409)	(n = 3,265)
Number of successful induced abortions	1	188 (6.6%)	18 (4.4%)	206 (6.3%)
	2	57 (2.0%)	12 (2.9%)	69 (2.1%)
	> 3	39 (1.4%)	16 (3.9%)	55 (1.7%)
	No attempt	2,572 (90.1%)	363 (88.8%)	2,935 (89.9%)

### 3.1.2. Health-care providers

#### Sociodemographic characteristics of health-care providers

In both settings, the majority of health-care providers who responded were female (Table 6). In addition, a slightly higher proportion of women participated from high-fertility settings (90.1 per cent) compared with low-fertility settings (84.8 per cent). A very small number of participants did not specify their gender. Most respondents in both settings were born in the country or territory where the survey was administered, with no significant difference between the settings. Approximately 97.0 per cent of respondents from both low- and high-fertility settings were native-born.

A large proportion of the health-care provider sample, particularly in high-fertility settings (60.7 per cent), chose not to disclose their sexual orientation, compared with 17.3 per cent in low-fertility settings. Most respondents in both settings did not disclose their relationship status (97.0 per cent), and the proportions of those who identified as married or single were low, with no significant difference between the two groups. On the other hand, there was a significant difference between fertility settings ( $p < 0.001$ ) when it came to religious affiliation. Respondents from high-fertility settings were more likely to report being actively religious (31.4 per cent) than those from low-fertility settings (18.4 per cent). Meanwhile, over half of both groups identified as religious but not practising. Non-religious individuals were more common in low-fertility settings (17.0 per cent) than in high-fertility settings (9.5 per cent).

Economic status also differed between the two groups. Respondents in high-fertility settings were

more likely to describe their economic situation as “neither easy nor difficult” (62.4 per cent vs. 51.3 per cent), while a larger proportion in low-fertility settings reported experiencing financial difficulty (26.1 per cent vs. 19.0 per cent). The proportion of those reporting financial ease was similar in both groups.

**Table 6.** Health-care providers’ sociodemographic characteristics

Variable	Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
Age		42	42	42
Sex	Female	864 (84.8%)	218 (90.1%)	1,082 (85.8%)
	Male	146 (14.3%)	24 (9.9%)	170 (13.5%)
	Unknown	9 (0.9%)		9 (0.7%)
Born in country or territory of residence	Yes	984 (96.8%)	231 (95.5%)	1,215 (96.5%)
	No	32 (3.1%)	10 (4.1%)	42 (3.3%)
	Unknown	1 (0.1%)	1 (0.4%)	2 (0.2%)
Belong to LGBTQ+ group	Yes	37 (3.6%)	24 (9.9%)	61 (5.0%)
	No	806 (79.1%)	71 (29.3%)	877 (71.3%)
	Unknown	176 (17.3%)	147 (60.7%)	291 (23.7%)
Civil status	Married	24 (2.3%)	9 (3.7%)	33 (2.6%)
	Single	5 (0.5%)		5 (0.4%)
	Unknown	990 (97.1%)	233 (96.3%)	1,223 (97.1%)
Religious affiliation and practice	Yes, actively	188 (18.4%)	76 (31.4%)	264 (20.9%)
	Yes, but not actively	567 (55.6%)	122 (50.4%)	689 (54.6%)
	No	173 (17.0%)	23 (9.5%)	196 (15.5%)
	Unknown	91 (8.9%)	21 (8.7%)	112 (8.9%)
Economic status	Difficult or very difficult	266 (26.1%)	46 (19.0%)	312 (24.7%)
	Neither easy nor difficult	523 (51.3%)	151 (62.4%)	674 (53.4%)
	Easy or very easy	230 (22.6%)	45 (18.6%)	275 (21.8%)

## Professional characteristics of health-care providers

Regarding the composition of the health-care workforce providing contraceptive services, the majority of respondents in low-fertility settings (54.3 per cent) were health-care providers without a medical degree, meaning nurses, midwives, community health workers and physician assistants, compared with 49.6 per cent in high-fertility settings (Table 7). However, more doctors with a medical specialization (obstetrician/gynaecologists, paediatricians, doctors of internal medicine and emergency physicians) participated in the survey from high-fertility settings (34.3 per cent) than from low-fertility settings (21.5 per cent). Conversely, general medical doctors without a specialization (general practitioners and family doctors) made up a larger share of respondents in low-fertility settings (19.1 per cent), compared with only 2.9 per cent in high-fertility settings.

Moreover, the frequency in which health-care providers offer contraceptive counselling differed in the two subsets. When asked about how frequently they provide contraceptive counselling, a higher proportion of health-care providers in high-fertility settings (40.5 per cent) said they counsel patients on contraception on a daily basis than in low-fertility settings (20.2 per cent). In contrast, the health-care provider respondents in low-fertility settings offered contraceptive counselling on a weekly (17.2 per cent) or monthly (19.7 per cent) basis. Furthermore, in both low- and high-fertility settings, the largest proportion of providers reported rarely or never counselling patients on contraception (42.9 per cent in low-fertility settings and 41.7 per cent in high-fertility settings).

The frequency of prescribing contraception also varied between low- and high-fertility settings. In high-fertility settings, over a third of health-care providers (36.4 per cent) prescribed contraception daily, compared with only 10.9 per cent in low-fertility settings. Meanwhile, a large proportion of health-care providers in low-fertility settings rarely or never prescribed contraception (64.4 per cent), higher than the 43.0 per cent in high-fertility settings. Finally, IUD insertion practices were reported by nearly half of the health-care provider sample in high-fertility settings (46.7 per cent), compared with only 21.5 per cent in low-fertility settings.

**Table 7.** Professional characteristics of health-care provider respondents

Variable	Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
Speciality	Health-care provider but not a medical doctor	553 (54.3%)	120 (49.6%)	673 (53.4%)
	Medical doctor	195 (19.1%)	7 (2.9%)	202 (16.0%)
	Doctor with medical specialization	219 (21.5%)	83 (34.3%)	302 (23.9%)
	Other	52 (5.1%)	32 (13.2%)	84 (6.7%)
Frequency of contraceptive counselling	Daily	206 (20.2%)	98 (40.5%)	304 (24.1%)
	Weekly	175 (17.2%)	23 (9.5%)	198 (15.7%)
	Monthly	201 (19.7%)	20 (8.3%)	221 (17.5%)
	Rarely or never	437 (42.9%)	101 (41.7%)	538 (42.7%)

Variable	Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
Frequency of contraceptive prescription	Daily	111 (10.9%)	88 (36.4%)	199 (15.8%)
	Weekly	121 (11.9%)	25 (10.3%)	146 (11.6%)
	Monthly	131 (12.9%)	25 (10.3%)	156 (12.4%)
	Rarely or never	656 (64.4%)	104 (43.0%)	760 (60.3%)
IUD insertion	Yes	219 (21.5%)	113 (46.7%)	332 (26.3%)
	No	800 (78.5%)	129 (53.3%)	929 (73.7%)

## 3.2. Contraceptive use and choice

### 3.2.1. Contraceptive use among the general population and associated factors

Overall, 44.0 per cent of all respondents reported that they or their partners were currently using some form of contraception, while 56.0 per cent said they were not using any contraception (Table 8). Use of contraception was higher in low-fertility settings (45.6 per cent) compared with high-fertility settings (33.3 per cent). Among those currently using contraception (n = 1,437), the vast majority relied on modern methods (94.4 per cent), with similar patterns across settings: 94.1 per cent in low-fertility settings and 96.3 per cent in high-fertility settings. A small proportion reported using natural methods, with these methods appearing more common in low-fertility settings (4.5 per cent vs. 2.2 per cent for high-fertility settings).

Table 8. Overview of contraceptive use

Variable	Categories	Low-fertility setting (n = 2,856) n (%)	High-fertility setting (n = 409) n (%)	Total (n = 3,265) n (%)
Contraceptive use	Yes	1,301 (45.6%)	136 (33.3%)	1,437 (44.0%)
	No	1,555 (54.4%)	273 (66.7%)	1,828 (56.0%)
		(n = 1,301)	(n = 136)	(n = 1,437)
Contraceptive method by category	Modern method	1,224 (94.1%)	131 (96.3%)	1,355 (94.4%)
	Natural method	58 (4.5%)	3 (2.2%)	61 (4.2%)
	Other	19 (1.5%)	2 (1.5%)	21 (1.5%)
Main reason for contraceptive use	Preventing pregnancy	1,014 (77.9%)	115 (84.6%)	1,129 (78.7%)
	Preventing sexually transmitted infections	118 (9.1%)	10 (7.4%)	128 (8.9%)

Variable	Categories	Low-fertility setting (n = 2,856) n (%)	High-fertility setting (n = 409) n (%)	Total (n = 3,265) n (%)
Main reason for contraceptive use	Managing physical conditions	148 (11.4%)	7 (5.1%)	155 (10.6%)
	Unknown	21 (1.6%)	4 (2.9%)	25 (1.7%)
Place where method of contraception is typically obtained	Family physician or general practitioner	58 (4.5%)	15 (11.0%)	73 (5.3%)
	Pharmacy without a prescription	819 (63.0%)	92 (67.6%)	911 (63.6%)
	Health-care provider at a medical centre	160 (12.3%)	17 (12.5%)	177 (12.3%)
	Supermarket or drugstore, other shop or online	119 (9.1%)	3 (2.2%)	122 (8.2%)
	Unknown	145 (11.1%)	9 (6.6%)	154 (10.5%)
Ease or difficulty of obtaining method of contraception	Difficult or very difficult	47 (3.6%)	2 (1.5%)	49 (3.3%)
	Easy or very easy	1,254 (96.4%)	134 (98.5%)	1,388 (96.7%)

The focus group discussions shed further light on these practices. In Kosovo (low-fertility setting), most male participants stated that withdrawal was their preferred method, citing comfort, simplicity and mistrust of alternatives. A participant explained this as follows:

“

*It's our go-to method. I know it's not 100 per cent, but we're comfortable with it.*  
(Man, Prizren, Kosovo)

”

Similar views were shared in Albania, where many men described withdrawal as reliable for preventing pregnancy. One participant explained this as follows:

“

*I withdraw ... and my wife does not get pregnant.* (Man, Korçë, Albania)

”

Condom use, by contrast, was often framed in relation to mistrust or infidelity:

“

*With my fiancée, I don't use condoms because she is only mine and doesn't cheat.*  
(Man, Korçë, Albania)

”

In Tajikistan, the focus group discussions revealed that traditional methods such as withdrawal were more commonly used among older generations.

When asked about the main reason for contraceptive use, over three quarters (78.7 per cent) of respondents across both fertility settings cited pregnancy prevention (Table 8), with a higher proportion in high-fertility settings (84.6 per cent) than in low-fertility settings (77.9 per cent). A smaller proportion of respondents reported using contraception to prevent sexually transmitted infections (9.1 per cent in low-fertility settings vs. 7.4 per cent in high-fertility settings) or to address physical conditions (higher in low-fertility settings (11.4 per cent) than in high-fertility settings (5.1 per cent)).

In terms of access, pharmacies without a prescription were identified as the most common source in both settings (63.6 per cent) (Table 8). Reliance on formal health-care providers such as family physicians or medical centres as the source of commodities was less frequent, while use of non-medical outlets (e.g., supermarkets or online sources) was higher in low-fertility settings (9.1 per cent) than in high-fertility settings (2.2 per cent). Despite variation in sources and methods, the vast majority of survey respondents across both fertility contexts reported that obtaining their chosen method was “easy” or “very easy” (96.7 per cent).

In Albania, health-care providers described how recurrent stockouts not only restricted access but also undermined trust in the health system:

“

*I think that the lack of contraceptive methods is very important, because this way women lose confidence, and they stop coming because their method is not available anymore. There is a stockout of methods now.* (Health-care provider, Berat, Albania)

”

In Kosovo, health-care providers reported that contraceptive supply at the primary health-care level was frequently limited to condoms and oral contraceptives, with other modern methods either unavailable or inconsistently provided:

“

*I think the availability of oral contraceptives is there, but for other methods like IUDs or injectables, they're just not as accessible.* (Health-care provider, Prizren, Kosovo)

”

“

*Exactly. The only method I can give out right now is condoms, and that's it. Everything else is either unavailable or not something we can distribute.* (Health-care provider, Prizren, Kosovo)

”

Another health-care provider explained that sometimes these methods were also in short supply:

“

*Right now, we don't even have condoms available in the gynaecology unit. There's a shortage of contraceptive methods available for us to offer to our patients.* (Health-care provider, Prizren, Kosovo)

”

When it comes to methods currently used, the general population reported clear preferences, with notable variations between fertility settings. Male condoms were by far the most reported method across both settings (68.1 per cent) (Table 9). Oral contraceptive pills were the second most reported method, with higher use in low-fertility settings (22.5 per cent) compared with high-fertility settings (14.0 per cent). Withdrawal was also a frequently used method, especially in low-fertility contexts (14.5 per cent). By contrast, IUD use was almost three times as high in high-fertility settings (20.6 per cent) as in low-fertility settings (7.5 per cent), though overall prevalence in low-fertility settings remained in third place after condoms and pills. Other modern and natural methods were reported by much smaller proportions of respondents, pointing to a relatively limited method mix overall.

**Table 9.** Contraceptive use from the perspective of female respondents

Variable	Categories	Low-fertility setting (n = 1,301) n (%)	High-fertility setting (n = 136) n (%)	Total (n = 1,437) n (%)
<b>Main contraceptive methods that you are using or your partner is using</b>				
Modern methods	Oral contraceptives (pills)	293 (22.5%)	19 (14.0%)	312 (21.7%)
	Intrauterine device (IUD)	98 (7.5%)	28 (20.6%)	126 (8.8%)
	Emergency contraceptive pills	11 (0.8%)	2 (1.5%)	13 (0.9%)
	Cervical cap	3 (0.2%)		3 (0.2%)
	Male condoms	886 (68.1%)	93 (68.4%)	979 (68.1%)
	Female condoms	19 (1.5%)	2 (1.5%)	21 (1.5%)
	Implant	3 (0.2%)	1 (0.7%)	4 (0.3%)
	Injection			
	Diaphragm with spermicide	1 (0.1%)		1 (0.1%)
	Patch	1 (0.1%)		1 (0.1%)
	Spermicide	3 (0.2%)	1 (0.7%)	4 (0.3%)
	Vaginal ring	4 (0.3%)		4 (0.3%)
	Female sterilization	4 (0.3%)	1 (0.7%)	5 (0.3%)
	Male sterilization (vasectomy)	1 (0.1%)		1 (0.1%)
Natural methods	Fertility awareness-based methods (standard days method, mucus method, basal temperature method, other)	52 (4.0%)	5 (3.7%)	57 (4.0%)
	Lactational amenorrhea method (while breastfeeding)		2 (1.5%)	2 (0.1%)

Variable	Categories	Low-fertility setting (n = 1,301) n (%)	High-fertility setting (n = 136) n (%)	Total (n = 1,437) n (%)
	Periodic abstinence	17 (1.3%)		17 (1.2%)
	Withdrawal	188 (14.5%)	17 (12.5%)	205 (14.3%)
Other	Other	8 (0.6%)		8 (0.6%)
	I don't know	2 (0.2%)	2 (1.5%)	4 (0.3%)
	None of the above	12 (0.9%)		12 (0.8%)
<b>Main reason why you chose this contraceptive method</b>				
	High reliability and effectiveness	665 (51.1%)	74 (54.4%)	739 (51.4%)
	Affordability	264 (20.3%)	25 (18.4%)	289 (20.1%)
	Availability	64 (4.9%)	9 (6.6%)	73 (5.1%)
	Accessibility	390 (30.0%)	42 (30.9%)	432 (30.1%)
	Long experience of use	187 (14.4%)	23 (16.9%)	210 (14.6%)
	Good knowledge of the method	107 (8.2%)	13 (9.6%)	120 (8.4%)
	It is short-acting	56 (4.3%)	5 (3.7%)	61 (4.2%)
	It is long-acting	40 (3.1%)	12 (8.8%)	52 (3.6%)
	Invisibility	10 (0.8%)		10 (0.7%)
	Comfort	169 (13.0%)	19 (14.0%)	188 (13.1%)
	It is user-friendly	180 (13.8%)	19 (14.0%)	199 (13.8%)
	It has no/few side effects	177 (13.6%)	16 (11.8%)	193 (13.4%)
	It is non-invasive	130 (10.0%)	11 (8.1%)	141 (9.8%)
	It does not require intervention from a health-care provider	70 (5.4%)	4 (2.9%)	74 (5.1%)
	It was recommended by a health-care provider	115 (8.8%)	6 (4.4%)	121 (8.4%)
	It regulates menstruation	86 (6.6%)		86 (6.0%)
	Other people I know use it	14 (1.1%)	3 (2.2%)	17 (1.2%)
	It contains hormones	24 (1.8%)	1 (0.7%)	25 (1.7%)
	It is hormone-free	137 (10.5%)	4 (2.9%)	141 (9.8%)

Variable	Categories	Low-fertility setting (n = 1,301) n (%)	High-fertility setting (n = 136) n (%)	Total (n = 1,437) n (%)
	Other	11 (0.8%)		11 (0.8%)
	I don't know	18 (1.4%)	4 (2.9%)	22 (1.5%)
Decision on your contraceptive method (both users and non-users)				
		(n = 2,856)	(n = 409)	(n = 3,265)
	I can decide for myself	642 (22.5%)	30 (7.3%)	672 (20.6%)
	Both my partner and I	1,501 (52.6%)	280 (68.5%)	1,781 (54.5%)
	Partner	25 (0.9%)	4 (1.0%)	29 (0.9%)
	Health-care provider	585 (20.5%)	58 (14.2%)	643 (19.7%)
	Unknown	103 (3.6%)	37 (9.0%)	140 (4.3%)

Contraceptive use patterns varied by age, number of children and civil status (Table 10). Among non-users, younger respondents (18–26) were the most represented, accounting for nearly half of this group (49.2 per cent), with the proportion declining with age. A similar pattern was observed among users of modern methods, where 43.2 per cent were aged 18–26. In contrast, reliance on natural or unspecified methods was most common among respondents aged 27–35 (41.5 per cent). Parity was inversely associated with the type of method used: respondents without children accounted for the majority of both non-users (61.8 per cent) and users of modern methods (60.4 per cent). As the number of children increased, the percentage of modern-method users declined, while users of natural or unspecified methods were mainly women with no children, followed by women with one or two children (25.6 per cent each). This trend likely reflects the combined effects of age on contraceptive uptake. Patterns by civil status further highlighted differences in method choice. Married respondents comprised the largest share of both non-users (49.6 per cent) and users of natural or unspecified methods (63.4 per cent), while those in a relationship were somewhat more represented among users of modern contraception (22.0 per cent).



Single respondents accounted for roughly one third of both non-users (34.1 per cent) and modern-method users (32.1 per cent), suggesting that contraceptive use is not solely determined by marital status but may also be related to partnership dynamics and reproductive intentions.

Regarding contraceptive decision-making, more than half of survey respondents (54.5 per cent) reported that decisions were made jointly with their partners (Table 9). About one in five (20.6 per cent) said they mainly decided for themselves, while nearly another fifth (19.7 per cent) reported that health-care providers played the primary role. Situations where the respondent's partner was the main decision maker were uncommon (0.9 per cent).

The qualitative findings, however, revealed that these patterns often coexisted with gendered power dynamics, which influence method choice. In some focus group discussions in both Albania and Kosovo, men emphasized reliance on withdrawal and rejected condom use, framing condoms as unnecessary within marriage or equating their use with infidelity. Such accounts illustrate how male preferences can override notions of joint decision-making and constrain women's contraceptive options.

**Table 10.** Type of contraception by age, parity and civil status (female respondents)

Variable	Categories	Not using (n = 1,828) n (%)	Modern (n = 1,355) n (%)	Natural/unknow (n = 82) n (%)
Age	18–26	899 (49.2%)	585 (43.2%)	23 (28.0%)
	27–35	548 (30.0%)	440 (32.5%)	34 (41.5%)
	36–49	381 (20.8%)	330 (24.4%)	25 (30.5%)
Children	0	1,129 (61.8%)	818 (60.4%)	34 (41.5%)
	1	380 (20.8%)	236 (17.4%)	21 (25.6%)
	2	230 (12.6%)	219 (16.2%)	21 (25.6%)
	3	60 (3.3%)	62 (4.6%)	6 (7.3%)
	> 4	29 (1.6%)	20 (1.5%)	0
Civil status	Married	907 (49.6%)	570 (42.1%)	52 (63.4%)
	In a relationship	248 (13.6%)	298 (22.0%)	9 (11.0%)
	Single	624 (34.1%)	435 (32.1%)	18 (22.0%)
	Unknown	49 (2.7%)	52 (3.8%)	3 (3.7%)

Patterns of autonomy also differed across fertility settings, with some alignment between user and provider perspectives. In low-fertility settings, nearly one in four women (22.5 per cent) said they made decisions on their own, compared with just 7.3 per cent in high-fertility settings. Focus group discussions supported this distinction. In Kosovo, mainly women stressed the ideal of shared decision-making:

“

*It should primarily be the couple who decides together. Most of us agree that both partners should communicate and make this decision together, as it affects both of them.*  
(Woman, Fushë, Kosovo)

”

“

*Women decide together with their husbands; they don't make the decision alone.*  
(Woman, Fushë, Kosovo)

”

For both women and men in high-fertility settings, the husband retains ultimate authority:

“

*But a woman will be afraid to decide for herself such a method as sterilization. It will be her husband who decides.* (Man, Gafurovsky, Tajikistan)

”

“

*The decision on the method of contraception and the number of children is left to the man.*  
(Man, Kushonien, Tajikistan)

”

“

*Men often perceive women who grew up during the civil conflict as lacking education and knowledge about essential family planning issues.* (Man, Kushonien, Tajikistan)

”

“

*My husband didn't allow me to use contraception until our son was born.*  
(Woman, Nurabad, Tajikistan)

”

“

*First, there is a discussion (mandatory) with the husband about the use of contraception, then with the mother-in-law; thus, the decision is made first of all by the husband, agreed with the mother-in-law.* (Man, Gafurovsky, Tajikistan)

”

Among health-care providers, the most common response regarding decision-making was that decisions are made jointly by the provider and the patient (40.9 per cent) (Table 11). Still, nearly a quarter of health-care providers (22.8 per cent) believed that patients make decisions autonomously, closely aligning with women's reports from low-fertility settings.

When asked about the reasons for choosing a method, both women (Table 9) and health-care providers (Table 11) highlighted effectiveness and reliability as the most important factors. Over half of respondents in both groups (51.4 per cent) identified these factors as the primary reasons for their choice or recommendation. Accessibility, affordability, comfort and user-friendliness were also commonly cited, although with varying emphasis. Women often pointed to affordability (20.1 per cent), accessibility (30.1 per cent), long experience with the method (14.6 per cent) and hormone-free options (9.8 per cent) as key considerations. Providers, while echoing the importance of effectiveness, placed stronger emphasis on affordability (30.4 per cent), especially in low-fertility settings, and on long-acting methods (11.6 per cent), which were mentioned much less frequently by women in low-fertility settings (3.1 per cent).

**Table 11.** Contraceptive use from the perspective of health-care providers

Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
<b>Who makes the choice on contraceptive method?</b>			
Patient	217 (21.3%)	70 (28.9%)	287 (22.8%)
Both patient and partner	150 (14.7%)	25 (10.3%)	175 (13.9%)
Partner	8 (0.8%)		8 (0.6%)
Health-care provider and patient	438 (43.0%)	78 (32.2%)	516 (40.9%)
Health-care provider	191 (18.7%)	52 (21.5%)	243 (19.3%)
Unknown	15 (1.5%)	17 (7.0%)	32 (2.5%)
<b>Main reason influencing patients' selection of a particular contraceptive method</b>			
High reliability and effectiveness	522 (51.2%)	126 (52.1%)	648 (51.4%)
Affordability	343 (33.7%)	40 (16.5%)	383 (30.4%)
Availability	78 (7.7%)	7 (2.9%)	85 (6.7%)
Accessibility	243 (23.8%)	35 (14.5%)	278 (22.0%)
It is short-acting	40 (3.9%)	8 (3.3%)	48 (3.8%)
It is long-acting	96 (9.4%)	50 (20.7%)	146 (11.6%)
Invisibility	34 (3.3%)	4 (1.7%)	38 (3.0%)
Comfort	118 (11.6%)	18 (7.4%)	136 (10.8%)
It is user-friendly	126 (12.4%)	14 (5.8%)	140 (11.1%)

Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
It has no/few side effects	70 (6.9%)	10 (4.1%)	80 (6.3%)
It is non-invasive	27 (2.6%)	1 (0.4%)	80 (6.3%)
It does not require intervention from a health-care provider	31 (3.0%)	5 (2.1%)	36 (2.9%)
It regulates menstruation	23 (2.3%)	2 (0.8%)	25 (2.0%)
It is hormone-free	29 (2.8%)	10 (4.1%)	39 (3.1%)
It protects against sexually transmitted infections	84 (8.2%)	8 (3.3%)	92 (7.3%)
It complies with my religion	7 (0.7%)	2 (0.8%)	9 (0.7%)
It is the one my partner approved	42 (4.1%)	3 (1.2%)	45 (3.6%)
Other		13 (5.4%)	13 (1.0%)
I don't know	78 (7.7%)	34 (14.0%)	112 (8.9%)

Qualitative data further illustrated concerns regarding cost. For example, young men in Tajikistan expressed concerns about the affordability of contraceptive pills:

“

*These methods cost a lot, especially the pill.* (Man, Dushanbe, Tajikistan)

”

### 3.2.2 Health-care providers' perception of eligibility for contraceptive methods across subgroups

The data reveals notable variations in how health-care providers recommend contraceptive methods across different subgroups. For instance, health-care providers were more likely to select “It is the choice of the patient” for subgroups perceived as more experienced, such as women with one child (50 per cent) or married women – for example, married 18-year-old women (45.6 per cent) compared with unmarried 18-year-old women (34.5 per cent) (Table B4).

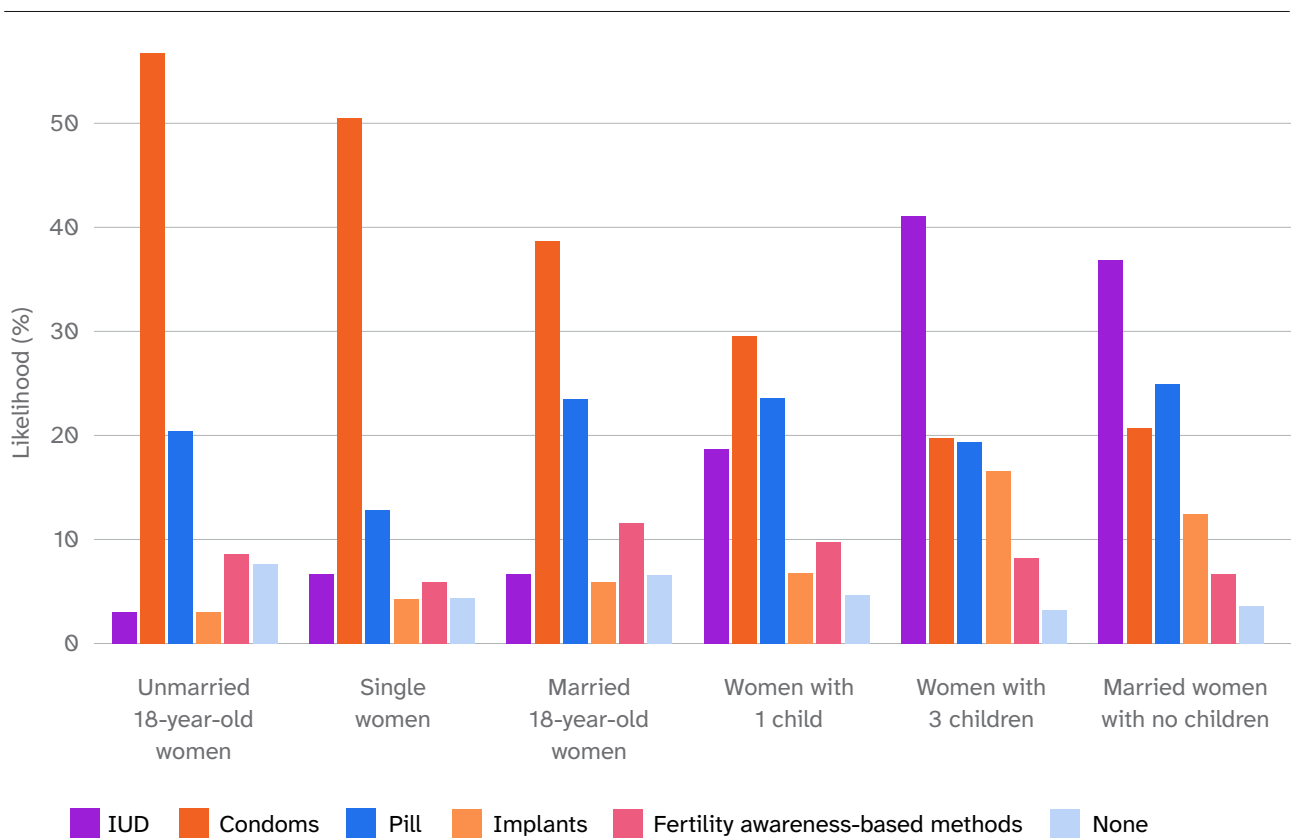
Method-specific trends were observed for certain groups:

- IUDs were most recommended for women with three children (40.8 per cent) and for women with one child (18.7 per cent), while this method was 38.2 per cent less likely to be recommended to unmarried 18-year-old women, and single women without a steady partner were 32.0 per cent less likely to be considered eligible for this method.
- Condoms were widely considered acceptable for younger and unmarried patients, with high approval rates for unmarried 18-year-old women (56.7 per cent) and single women without a steady partner (50.8 per cent) – groups often perceived as having temporary or non-

monogamous relationships. In contrast, providers were less likely to recommend condoms for women with three children (31.0 per cent), indicating a tendency to shift towards long-acting methods for higher-parity patients.

- The contraceptive pill showed a more balanced distribution, but providers were again more likely to recommend it to women with one child (23.4 per cent) and married 18-year-old women (23.5 per cent) than to married women who do not want to have children (1.2 per cent) or single women without a steady partner (12.5 per cent).
- Implants were strongly associated with patients who had either higher parity or clear reproductive preferences. They were most frequently recommended to women with three children (16.6 per cent) and married women who do not want to have children (12.0 per cent), but they were rarely considered suitable for unmarried 18-year-old women (14.0 per cent) or single women without a steady partner (12.7 per cent).
- Fertility awareness-based methods were not strongly preferred for any subgroup, but they were slightly more accepted for married or older patients, such as married 18-year-old women (11.2 per cent) and women with one child (9.6 per cent).
- Selecting “none” – indicating that none of the methods listed were appropriate – was rare across the board but slightly more likely for unmarried 18-year-old women (7.3 per cent) and married women who did not want to have children (3.0 per cent).

**Figure 3.** Likelihood that a particular method will be recommended, by subgroup



Source: Compiled by the authors based on the study data.

### 3.3. Contraceptive non-use among the population

Among respondents who were not currently using contraceptives, the most frequently cited reason was that they were pregnant, particularly in high-fertility settings (50.2 per cent compared with 25.6 per cent in low-fertility settings) (Table 12). In low-fertility settings, the second most frequent reason was not being regularly sexually active (22.1 per cent), which was also mentioned in high-fertility settings but to a lesser extent (11.4 per cent).

Another important reason for non-use, especially in low-fertility settings, was reluctance to use hormonal methods, reported by 19.7 per cent of respondents (Table 12). This hesitancy, which was also present, though less prominent, in high-fertility settings (10.3 per cent), echoes findings from the qualitative phase of the study. Related concerns, such as fear of side effects (11.2 per cent in low-fertility settings vs. 6.7 per cent in high-fertility settings), underscored that physiological and psychological discomforts, whether real or perceived, remain major barriers to consistent contraceptive uptake. Additionally, 12.3 per cent in both settings mentioned reduced sexual pleasure as a reason for non-use, reflecting a persistent perception that contraception interferes with sexual spontaneity or satisfaction. A small proportion of respondents also cited distrust in modern contraceptive methods (2.6 per cent), partner opposition (1.9 per cent), religious objections (0.7 per cent) or stigmas around contraception (0.2 per cent).

Qualitative findings underscored that concerns about side effects were widespread across both high- and low-fertility settings, although the nature and intensity of those concerns varied. In Tajikistan (a high-fertility context), many women described experiences of pain, bleeding and fear of long-term health impacts:

“

*Some women express concerns that contraceptive pills can be harmful, particularly to digestive health. (Woman, Dushanbe, Tajikistan)*

”

“

*My sister also received an implant but experienced pain in her arm for a month, felt generally unwell, and had to have the implant removed. (Woman, Nurabad, Tajikistan)*

”

Also, infertility and cancer were often mentioned, particularly in the context of implants and IUDs:

“

*There are barriers to using IUDs: they can fall out, cause pain, lead to bleeding and longer periods, and there is a risk of developing cancer. (Woman, Nurabad, Tajikistan)*

”

In Albania and Kosovo (low-fertility contexts), fear of side effects was also prominent, especially regarding hormonal methods such as the pill and IUDs. The fear was a result of an adverse experience which caused women to stop using the method in question or to no longer consider it as an option for contraception. Moreover, across both urban and rural areas, women voiced anxiety about trying new methods, and several reported discontinuations due to unwanted effects:

“

*I've heard about [the IUD], but I'm scared to try it. (Woman, Pristina, Kosovo)*

”

“

*I used Yasmin contraceptive [pills] for about six months. ... I started feeling bloating, and so I stopped [using] them. (Woman, Tirana, Albania)*

”

**Table 12.** Reasons for not using contraceptives among the general population

Categories	Low-fertility setting (n = 1,421) n (%)	High-fertility setting (n = 252) n (%)	Total (n = 1,673) n (%)
I am pregnant	398 (28.0%)	137 (54.4%)	535 (32.0%)
I am not (regularly) sexually active	343 (24.2%)	31 (12.3%)	374 (22.4%)
I don't want to use hormones	307 (21.6%)	28 (11.1%)	335 (20.0%)
It makes sex less pleasurable	179 (12.6%)	26 (10.3%)	205 (12.3%)
I am scared of the side effects	159 (11.2%)	17 (6.7%)	176 (10.5%)
I don't trust modern contraception	39 (2.7%)	4 (1.6%)	43 (2.6%)
I don't know what the best method is for me / my partner	36 (2.5%)	5 (2.0%)	41 (2.5%)
My partner objects	24 (1.7%)	8 (3.2%)	32 (1.9%)
I am infertile or my partner is infertile; we are not able to have children	24 (1.7%)	5 (2.0%)	29 (1.7%)
I can't afford it	18 (1.3%)	2 (0.8%)	20 (1.2%)
I don't have information or access to counselling about it	10 (0.7%)	4 (1.6%)	14 (0.8%)
I have been sterilized, or my partner has been sterilized	12 (0.8%)	1 (0.4%)	13 (0.8%)
My religion forbids it	11 (0.7%)		11 (0.7%)
I don't know how to use them	6 (0.4%)	1 (0.4%)	7 (0.4%)
There are stigma and taboos about contraceptives in my country or territory	4 (0.3%)		4 (0.2%)
I don't know where to get contraceptives	1 (0.1%)	1 (0.4%)	2 (0.1%)
Other	78 (5.5%)	8 (3.2%)	86 (5.1%)
Prefer not to answer	156 (11.0%)	26 (10.3%)	182 (10.9%)

Although only a small proportion of survey respondents explicitly cited religion or their partner's objection as reasons for not using contraception, the qualitative findings provide a far more nuanced view of these influences. Across low-fertility settings, religious and cultural norms, as well as gendered expectations, emerged as powerful undercurrents shaping contraception-related attitudes and behaviours, often overruling women's individual preferences. In Albania and Kosovo, religion and culture were often invoked indirectly, through references to family expectations, stigma or traditional gender roles. Several participants described contraception as a taboo subject, especially within Roma, Ashkali and Egyptian communities:

“

*It's a taboo word in our country; I have learned about it since elementary school, but it's taboo. (Roma woman, Fushë, Kosovo)*

”

“

*I've heard about it, but it's not something I would ever consider using. (Woman, Pristina, Kosovo)*

”

This cultural silence limits access to accurate information, and for many women, fear of being judged outweighs the perceived benefits of contraceptive use. Even when religion was not explicitly named, participants repeatedly referenced “God's will” or divine timing as central to fertility decisions:

“

*We have made children willingly, as God has given us. (Man, Korçë, Albania)*

”

“

*I have pushed away the man, or rather he knows how to withdraw. Then these are the works of God. (Roma woman, Korçë, Albania)*

”

Men's accounts reinforced the idea that family honour, tradition and male decision-making continue to frame reproductive choices.

“

*Well, religion can definitely play a role for some people, especially in rural areas. Like, I've heard that in some communities, people are really restricted by their religious beliefs when it comes to contraception or even abortion. But honestly, I think family has the biggest influence. In Kosovo, it's still kind of a taboo to talk about contraception openly. (Man, Prizren, Kosovo)*

”

One woman in Pristina stated this as follows:

“

*In some cases, the decision to use or not use contraceptive methods is more of a personal decision, but family and religion also play a role. (Woman, Pristina, Kosovo)*

”

Finally, focus group discussions in Tajikistan highlighted the persistence of misinformation as a key factor influencing non-use of modern contraception. In several cases, decisions not to use modern methods were based on advice received from health-care providers or on practices perceived as common knowledge within the community.

“

*After having two abortions, a doctor taught her a method for post-coital washing, which she used throughout her sexual life. (Woman, Nurabad, Tajikistan)*

”

“

*Women mentioned a method known as ‘interrupted sexual intercourse’. ... They expressed that traditional methods are generally safer, cost-effective and easily accessible.*

*(Woman, Kushonien, Tajikistan)*

”

### 3.4. Contraceptive non-use from the perspective of health-care providers

From the perspective of health-care providers, patients face a range of perceived barriers to contraceptive use, with several notable differences between low- and high-fertility settings. The reason cited most frequently by health-care providers was that patients lack sufficient information or counselling about contraception. This reason was reported by over a third of providers in low-fertility settings (35.3 per cent) but by fewer in high-fertility settings (18.6 per cent) ( $p < 0.001$ ) (Table 13). Health-care providers also frequently noted that patients are afraid of side effects, with this concern more commonly raised in low-fertility settings (27.8 per cent) than in high-fertility ones (13.2 per cent) ( $p < 0.001$ ).

In the focus group discussion in Berat, Albania, many health-care providers confirmed that fear of side effects, particularly weight gain, menstrual irregularities, bloating and even breast cancer, discourages women from using contraceptives. Some health-care providers even shared negative personal experiences with hormonal contraceptives, which may inadvertently reinforce patients’ fears.

“

*They don’t use pills because women do not have confidence. They are afraid of gaining weight, they are afraid of side effects, and they are afraid of disrupting their cycle. (Health-care provider, Berat, Albania)*

”

“

*The population thinks that contraceptives are bad for [their] health, so there are rumours about the methods. I think hormonal contraceptives [cause] side effects. I have personally used them for health reasons, and they have [caused] side effects.*

*In fact, contraceptives make you gain a lot of weight.*

*(Health-care provider, Berat, Albania)*

”

“

*I am personally against hormonal contraceptive methods. I have read that they cause breast cancer. ... Nature has given us everything to work by itself. Why take things from outside?* (Health-care provider, Berat, Albania)

”

“

*And I personally used them for health reasons. I used them for three months, and they [caused] me a lot of bloating and weight gain. I think that contraceptives [cause] weight gain if I use them for many years, more than five years.*

(Health-care provider, Berat, Albania)

”

On average, one in three health-care providers said their patients do not want to use hormonal methods (34.7 per cent in low-fertility settings vs. 30.2 per cent in high-fertility settings), suggesting that this perception is widespread among the populations they serve. Other commonly mentioned concerns (reported at similar rates across both settings) included beliefs that contraception may cause infertility (13.3 per cent) or be associated with cancer (12.1 per cent).

Cost was perceived to be a more significant barrier in low-fertility settings, where 13.7 per cent of health-care providers said their patients could not afford contraception, compared with just 4.5 per cent in high-fertility areas ( $p < 0.001$ ). Meanwhile, objection by other family members was cited more often by providers in high-fertility settings (5.4 per cent) than in low-fertility settings (0.7 per cent) ( $p < 0.001$ ), suggesting stronger familial or cultural pressures in those contexts.

Less frequently, health-care providers reported that their patients were hesitant because they do not know how to use contraception, do not trust modern methods or do not know where to obtain contraception, with no statistically significant differences between settings. The belief that contraception makes sex less pleasurable was mentioned equally in both contexts (6.2 per cent).

Finally, the “Other” category, which may reflect context-specific or unlisted reasons, was selected more by health-care providers in high-fertility settings (15.7 per cent) than in low-fertility settings (3.4 per cent) ( $p < 0.001$ ), suggesting additional barriers.

One striking finding is the disconnect between health-care providers’ perceptions and the concerns reported by contraceptive users themselves. Many health-care providers tended to minimize or dismiss the role of stigma, religion or male resistance in shaping contraceptive behaviour, contrasting sharply with the qualitative narratives from women and men in the community:

“

*I think, in some cases, people might hesitate because they think it's not socially acceptable to use certain methods, but it's rare. I haven't noticed much of an influence from family or religious beliefs [on] these decisions.*

(Health-care provider, Prizren, Kosovo)

”

“

*I haven't seen any major cultural or religious barriers either. Patients usually make their decisions based on what they've been told or what they know. I think if they had access to more education, it would help remove any doubts.*

(Health-care provider, Prizren, Kosovo)

”

“

*That's true. I don't think there's a significant religious or cultural factor that stops people from using contraceptives. It's more about their understanding of the methods and the availability of them.*

(Health-care provider, Prizren, Kosovo)

”

**Table 13.** Health-care providers' perspectives on the main reasons why patients may be hesitant to use contraception, by fertility setting

Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
They may be associated with cancer	125 (12.3%)	27 (11.2%)	152 (12.1%)
They have the potential to cause infertility	130 (12.8%)	38 (15.7%)	168 (13.3%)
They cannot afford it	140 (13.7%)	11 (4.5%)	151 (12.0%)
They don't have enough information or counselling about it	360 (35.3%)	45 (18.6%)	405 (32.1%)
They do not want to use hormones	354 (34.7%)	73 (30.2%)	427 (33.9%)
They do not know how to use them	84 (8.2%)	13 (5.4%)	97 (7.7%)
They do not know where to get them	26 (2.6%)	2 (0.8%)	28 (2.2%)
They do not know what the best method for them is	168 (16.5%)	34 (14.0%)	202 (16.0%)
It is inconvenient to use them	27 (2.6%)	8 (3.3%)	35 (2.8%)
Their partner objects	91 (8.9%)	26 (10.7%)	117 (9.3%)
Another family member objects	7 (0.7%)	13 (5.4%)	20 (1.6%)
They are scared of the side effects	283 (27.8%)	32 (13.2%)	315 (25.0%)
They do not trust modern contraception	24 (2.4%)	7 (2.9%)	31 (2.5%)
They make sex less pleasurable	63 (6.2%)	15 (6.2%)	78 (6.2%)
Traditional values present challenges to sexual education in their country or territory	36 (3.5%)	3 (1.2%)	39 (3.1%)

Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
There is stigma and taboos surrounding contraceptives in their country or territory	33 (3.2%)	6 (2.5%)	39 (3.1%)
Their religion forbids it	25 (2.5%)	7 (2.9%)	32 (2.5%)
Other	35 (3.4%)	38 (15.7%)	73 (5.8%)

### 3.5. Awareness and knowledge of contraceptive methods among women

Awareness and knowledge of contraceptive methods varied markedly by fertility context. Across the 18 listed methods (14 modern and 4 natural), respondents in low-fertility settings consistently reported greater familiarity than those in high-fertility settings (Table 14).

Male condoms were the most widely recognized method in both settings, with 84.6 per cent of respondents in low-fertility settings and 77.0 per cent in high-fertility settings stating they knew the method well. Oral contraceptive pills followed (75.5 per cent vs. 55.7 per cent, respectively). IUDs were more commonly known in high-fertility settings (56.0 per cent) than in low-fertility settings (48.1 per cent).

Awareness of emergency contraceptive pills was notably higher in low-fertility settings (55.3 per cent) than in high-fertility settings (30.6 per cent). Likewise, familiarity with methods like the vaginal ring, the contraceptive patch, spermicide and the diaphragm was lower in high-fertility areas. Permanent methods such as female sterilization (34.7 per cent in low-fertility settings vs. 19.6 per cent in high-fertility settings) and vasectomy (39.4 per cent in low-fertility settings vs. 22.5 per cent in high-fertility settings) also showed stark contrasts, with greater recognition in low-fertility settings.

The qualitative findings revealed that for men familiarity with certain methods was often partial, superficial or inaccurate. For example, in the focus group discussions with men in Kosovo (a low-fertility setting), none of the participants reported knowing about the female condom, the vaginal ring, fertility awareness-based methods, spermicide, periodic abstinence or the lactational amenorrhoea method. For many methods, participants described only vague awareness: they had heard the names but did not know how the methods were used or where to obtain them.

Male sterilization was particularly stigmatized and poorly understood across both fertility contexts. Among men in Prizren, Kosovo, the method was almost uniformly rejected:

“

*I've heard about it, but no way I'd consider it. It's too permanent.* (Man, Prizren, Kosovo)

”

“

*I've heard of it, but it sounds too extreme for me. I wouldn't even think about it.*  
(Man, Prizren, Kosovo)

”

In Tajikistan (a high-fertility setting), male participants were even less familiar with the concept of vasectomy. According to researchers' notes, some were visibly surprised to learn such a method existed.

According to the survey, respondents in low-fertility settings expressed familiarity with natural methods. For example, 46.0 per cent were aware of the withdrawal method, compared with 31.1 per cent in high-fertility settings. Similarly, fertility awareness-based methods (e.g., standard days, basal body temperature, mucus method) were known to 31.0 of respondents in low-fertility settings but only 14.9 per cent in high-fertility areas.

A small proportion of participants selected "I don't know" (2.9 per cent in low-fertility settings vs. 5.9 per cent in high-fertility settings), and almost no respondents indicated being unfamiliar with any method.

Disaggregating results by use of contraception revealed key trends (Table B2). Users of modern methods consistently reported the highest levels of knowledge. For example, 91.3 per cent of modern-method users reported being very familiar with male condoms, and 77.9 per cent reported the same for oral contraceptive pills. Non-users reported less knowledge, although they remained relatively familiar with common methods such as male condoms (78.6 per cent) and oral pills (69.6 per cent).

Natural-method users displayed a unique knowledge profile. They were less familiar with some modern methods but highly knowledgeable about natural ones. For example, 78.7 per cent were familiar with withdrawal, and 60.7 per cent knew about fertility awareness-based methods, figures notably higher than among both modern-method users and non-users. This finding suggests a link between method use and perceived understanding.

Notably, even among natural-method users, awareness of some modern methods remained relatively high: 23.0 per cent for spermicide, 18.0 per cent for the diaphragm and 42.6 per cent for female sterilization. Only 0.4 per cent of modern-method users reported not knowing any method, compared with 3.3 per cent among natural-method users.

**Table 14.** Knowledge of contraceptive method, by fertility setting

Variable	Categories	Low-fertility setting (n = 1,301) n (%)	High-fertility setting (n = 136) n (%)	Total (n = 1,437) n (%)
Main contraceptive methods that you are using or your partner is using				
Modern methods	Oral contraceptives (pills)	2,156 (75.5%)	228 (55.7%)	2384 (73.0%)
	Intrauterine device (IUD)	1,374 (48.1%)	229 (56.0%)	1,603 (49.1%)
	Emergency contraceptive pills	1,578 (55.3%)	125 (30.6%)	1,703 (52.2%)
	Cervical cap	345 (12.1%)	24 (5.9%)	369 (11.3%)
	Male condoms	2,417 (84.6%)	315 (77.0%)	2,732 (83.7%)
	Female condoms	923 (32.3%)	92 (22.5%)	1,015 (31.1%)

Variable	Categories	Low-fertility setting (n = 1,301) n (%)	High-fertility setting (n = 136) n (%)	Total (n = 1,437) n (%)
Modern methods	Implant	361 (12.6%)	43 (10.5%)	404 (12.4%)
	Injection	381 (13.3%)	46 (11.2%)	427 (13.1%)
	Diaphragm with spermicide	294 (10.3%)	12 (2.9%)	306 (9.4%)
	Patch	368 (12.9%)	32 (7.8%)	400 (12.3%)
	Spermicide	310 (10.9%)	17 (4.2%)	327 (10.0%)
	Vaginal ring	481 (16.8%)	43 (10.5%)	524 (16.0%)
	Female sterilization	991 (34.7%)	80 (19.6%)	1,071 (32.8%)
	Male sterilization (vasectomy)	1,124 (39.4%)	92 (22.5%)	1,216 (37.2%)
Natural methods	Fertility awareness-based methods (standard days method, mucus method, basal temperature method, other)	886 (31.0%)	61 (14.9%)	947 (29.0%)
	Lactational amenorrhea method (while breastfeeding)	386 (13.5%)	50 (12.2%)	436 (13.4%)
	Periodic abstinence	509 (17.8%)	38 (9.3%)	547 (16.8%)
	Withdrawal	1,314 (46.0%)	127 (31.1%)	1,441 (44.1%)
Other	Other	38 (1.3%)	1 (0.2%)	39 (1.2%)
	I don't know	84 (2.9%)	24 (5.9%)	108 (3.3%)
	None of the above			

### 3.5.1. Perception of method reliability among female respondents

When asked to select the methods respondents believed to be the most effective in preventing pregnancy, regardless of their actual use, modern methods – mainly male condoms (51.9 per cent) and oral contraceptives (42.9 per cent), followed by more permanent methods such as male (33.5 per cent) and female (29.0) sterilization – were the most trusted overall. However, perceptions varied notably by fertility setting, current contraceptive use and familiarity with specific methods.

Male condoms were the most widely endorsed method overall, considered reliable by 52.9 per cent of respondents in low-fertility settings and 44.7 per cent in high-fertility settings. WHO categorizes them as only “moderately effective” with typical use, meaning that about 13 out of every 100 women who use them may experience an unintended pregnancy each year. Nevertheless, confidence in male condoms appears higher, possibly due to their wide availability and familiarity (Figure 4).

Oral contraceptive pills were the second most commonly cited method, with 44.7 per cent endorsement in low-fertility settings and 30.3 per cent in high-fertility settings. Along with male condoms, they were among the methods that respondents reported knowing most about. Although pills are highly effective when used exactly as prescribed (0.3 per cent failure rate), typical use results in a 7.0 per cent failure rate. Despite this failure rate, they remain the most effective method under typical use conditions among commonly used methods.

IUDs were one of the few methods identified as reliable more frequently in high-fertility settings (32.3 per cent) than in low-fertility settings (28.5 per cent), suggesting possible differences in health-care provider emphasis across regions and possibly in the availability of this method in clinics. Long-term surgical methods like male and female sterilization were also seen as highly reliable, with more respondents in low-fertility settings endorsing these methods (35.3 per cent and 30.6 per cent, respectively) compared with those in high-fertility settings (21.0 per cent and 18.3 per cent, respectively).

Less commonly selected methods included the vaginal ring, the patch, spermicides and the diaphragm with spermicide, each endorsed by fewer than 3.5 per cent of respondents. The lower perceived reliability of these methods likely reflects both limited awareness and their comparatively limited effectiveness under typical use.

Among natural methods, withdrawal was the most frequently cited, considered reliable by 4.8 per cent of respondents in both settings. Other fertility awareness-based methods, such as standard days, the mucus method and the basal temperature method, were rarely selected (3.0 per cent in low-fertility settings vs. 2.2 per cent in high-fertility settings). These methods are less effective as typically used, with failure rates ranging from 12.0 per cent to 23.0 per cent, yet they continue to hold some perceived value, particularly among users of natural contraception.

A notable proportion of respondents, particularly in high-fertility settings, expressed uncertainty about contraceptive reliability: 15.2 per cent selected “I don’t know”, compared with 9.2 per cent in low-fertility settings. This difference may reflect gaps in contraceptive education or limited exposure to modern family planning services.

Finally, very few respondents believed that none of the listed methods were reliable – just 2.3 per cent in low-fertility settings and 2.9 per cent in high-fertility settings – suggesting that most participants trust at least one method to prevent pregnancy.

Perceptions of the reliability of various contraceptive methods are shaped not only by broader contextual factors such as the fertility setting but also by individuals’ personal experiences with



Photo: UNFPA Tajikistan/Nozim Kalandarov

contraception. When examining responses by current contraceptive use (as shown in Table B3), a more nuanced picture of trust in various methods emerged.

Users of modern methods consistently report the highest confidence in the reliability of those same methods. Pills, IUDs, male condoms and sterilization are particularly well regarded among this group. For instance, nearly half of modern-method users (49.5 per cent) consider oral contraceptives reliable, compared with just 37.9 per cent of non-users. Similarly, 59.3 per cent of modern-method users trust male condoms, while only 46.8 per cent of non-users do.

In contrast, individuals who currently use natural methods present a more complex perspective. While many natural-method users still acknowledge the reliability of certain modern options – for example, 42.6 per cent endorse pills, and 41.0 per cent endorse IUDs – they are also much more likely than others to express trust in natural methods themselves. For instance, 14.8 per cent of natural-method users believe withdrawal is a reliable method, compared with 5.6 per cent of non-users and only 3.4 per cent of modern-method users. A similar pattern can be observed for fertility awareness-based methods, which are seen as more reliable by natural-method users than by other respondents.

Non-users of contraception, on the other hand, are marked by higher levels of uncertainty and scepticism. They are more likely to respond “I don’t know” (13.9 per cent) when asked about method reliability – almost three times the rate of modern-method users (5.1 per cent). They are also more likely to report that “none of the above” methods are reliable (3.6 per cent vs. 0.7 per cent) ( $p < 0.001$ ). These findings highlight a significant information or trust gap among those not currently using any form of contraception.

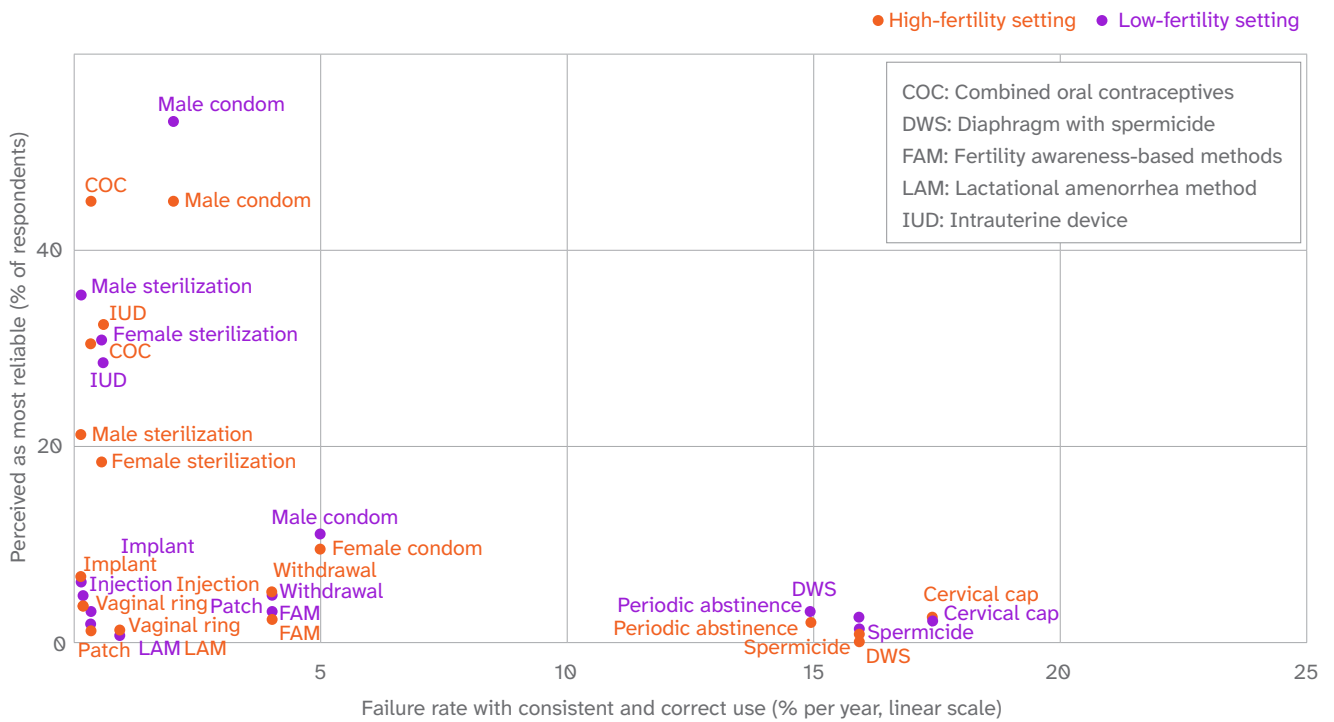
Permanent methods like sterilization are also perceived differently depending on contraceptive use. While male and female sterilization are widely recognized for their high effectiveness in WHO guidance,<sup>28</sup> only 25–28 per cent of non-users consider these methods reliable, compared with 33–40 per cent of modern-method users and over 47 per cent of natural-method users (Table B5). Across all user groups, less commonly known or newer methods, such as implants, patches, the vaginal ring and emergency contraception, are recognized as reliable by relatively small numbers of respondents, though they are slightly more likely to be considered reliable by current users of modern methods.

Overall, respondents’ perceptions of reliability align reasonably well with the technical effectiveness of most methods. However, notable exceptions emerge for the male condom and the contraceptive pill: both are widely perceived as highly reliable, yet their actual effectiveness under typical use is comparatively lower (Figure 4).

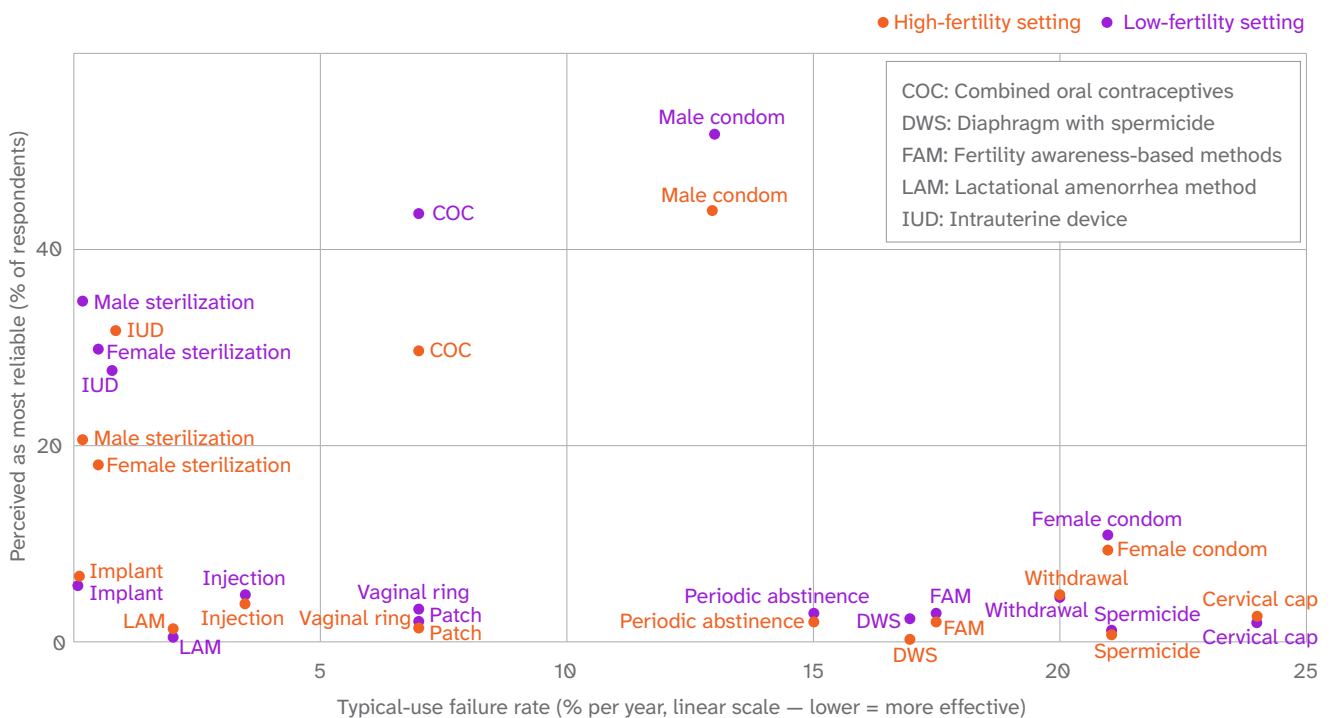
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28. WHO Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, *Family Planning: A Global Handbook for Providers*, 3rd ed. (Geneva and Baltimore, 2018).

**Figure 4.** Perceived reliability vs. effectiveness with correct and consistent use of contraceptive method, by fertility setting



**Figure 5.** Perceived reliability vs. actual effectiveness of contraceptive method, by fertility setting



Note: Data on contraceptive effectiveness was retrieved from WHO Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, *Family Planning: A Global Handbook for Providers*, 3rd ed. (Geneva and Baltimore, 2018), p. 460.

The survey also explored beliefs and misconceptions about contraception. Table 15 presents responses from individuals by fertility setting. Overall, the data reveals that many respondents reject widely held myths, although certain misconceptions persist across both contexts.

A significant proportion of respondents agreed that their doctor should decide which method is best for them, with slightly more agreement in low-fertility settings (33.9 per cent) than in high-fertility settings (30.6 per cent). This finding might indicate greater reliance on health-care providers for contraceptive guidance. Similarly, a substantial number of respondents in low-fertility settings (34.0 per cent) correctly acknowledged that forgetting to take the contraceptive pill once can influence its effectiveness, though only 17.8 per cent in high-fertility settings agreed.

Some persistent myths were endorsed by a minority of respondents. For instance, 14.0 per cent of respondents in low-fertility settings and 10.5 per cent in high-fertility settings believed that contraceptives cause weight gain. The belief that long-term contraceptive use reduces future fertility was held by 12.1 per cent of respondents in low-fertility settings and 13.0 per cent in high-fertility settings. Similarly, around 9.0 per cent of respondents across both settings believed that using contraceptives reduces sexual pleasure. A small percentage of participants agreed with myths such as the idea that “a woman cannot get pregnant if the man does not ejaculate inside her” (10.4 per cent in low-fertility settings vs. 7.8 per cent in high-fertility settings), or “you cannot get [sexually transmitted infections] if you have only one partner” (4.8 per cent vs. 9.0 per cent). The notion that contraceptive use is solely the responsibility of women was more prevalent in high-fertility settings (7.6 per cent) than in low-fertility settings (4.2 per cent), suggesting more traditional gender views in those contexts.

Moreover, nearly a third of respondents (30.0 per cent) did not agree with any of the listed statements, with this figure slightly higher in high-fertility settings (33.0 per cent) than in low-fertility settings (29.6 per cent).

**Table 15.** Beliefs and misconceptions about contraception, by fertility setting

Categories	Low-fertility setting (n = 2,856) n (%)	High-fertility setting (n = 409) n (%)	Total (n = 3,265) n (%)
Contraceptive methods encourage a promiscuous sex life	208 (7.3%)	32 (7.8%)	240 (7.4%)
Use of contraceptives is solely the responsibility of women	120 (4.2%)	31 (7.6%)	151 (4.6%)
My partner needs to approve of my use of contraceptive methods	291 (10.2%)	26 (6.4%)	317 (9.7%)
My doctor should decide which method is best for me	967 (33.9%)	125 (30.6%)	1,092 (33.4%)
Forgetting to take the contraceptive pill once can influence its effectiveness in preventing pregnancy	970 (34.0%)	73 (17.8%)	1,043 (31.9%)
I cannot get sexually transmitted infections, because I have one partner	137 (4.8%)	37 (9.0%)	174 (5.3%)

Categories	Low-fertility setting (n = 2,856) n (%)	High-fertility setting (n = 409) n (%)	Total (n = 3,265) n (%)
A woman cannot get pregnant if the man does not ejaculate while inside her	296 (10.4%)	32 (7.8%)	328 (10.0%)
You gain weight from using contraceptives	401 (14.0%)	43 (10.5%)	444 (13.6%)
Contraceptives cause cancer	111 (3.9%)	6 (1.5%)	117 (3.6%)
Washing after sex can prevent pregnancy	41 (1.4%)	8 (2.0%)	49 (1.5%)
If a woman takes contraceptives for a long period, this reduces her ability to have children in the future	346 (12.1%)	53 (13.0%)	399 (12.2%)
Using contraceptives reduces sexual pleasure	262 (9.2%)	39 (9.5%)	301 (9.2%)
I do not agree with any of the above statements	844 (29.6%)	135 (33.0%)	979 (30.0%)

### 3.6. Barriers to contraceptive access, use and provision

The survey explored self-reported barriers to accessing and using contraceptive methods. Across all settings, the most frequently reported barrier to contraceptive access and use was a lack of knowledge about contraceptives, cited by nearly one third of respondents (29.7 per cent). This finding highlights persistent informational gaps that may undermine effective contraceptive decision-making, despite increased global efforts to promote family planning education. The high cost of contraceptives was the second most common barrier, affecting 24.3 per cent of respondents overall. Other barriers, while less prevalent, were nonetheless notable. Approximately 13.6 per cent of respondents identified sociocultural taboos around contraceptive use for unmarried individuals, and 12.0 per cent cited the requirement for a doctor's prescription as an obstacle. A similar proportion (11.7 per cent) reported not knowing where to obtain contraceptives, pointing to persistent gaps in service visibility and navigability.

Analysis by setting shows that lack of knowledge was especially pronounced in low-fertility settings (30.9 per cent) compared with high-fertility settings (21.0 per cent). The high cost of contraceptives was the second most frequently cited barrier overall (24.3 per cent), again more commonly reported in low-fertility settings (25.4 per cent) than in high-fertility settings (16.9 per cent). Several other barriers were mentioned more often in low-fertility settings, including taboos around contraceptive use for unmarried people (14.6 per cent vs. 6.6 per cent in high-fertility settings), the requirement for a doctor's prescription (12.7 per cent vs. 7.6 per cent), lack of knowledge about where to obtain contraceptives (12.1 per cent vs. 8.8 per cent), judgmental attitudes on the part of health-care providers (6.0 per cent vs. 2.0 per cent) and social pressure not to use contraceptives (7.8 per cent

vs. 3.4 per cent). Conversely, a higher proportion of respondents in high-fertility settings (48.9 per cent) reported that none of the listed factors were barriers, compared with 40.7 per cent in low-fertility settings. Some barriers, such as religious opposition (8.0 per cent overall) and lack of knowledge among health-care providers (6.8 per cent), were reported at similar but slightly lower rates in high-fertility settings.

**Table 16.** Self-reported barriers to contraceptive access and use, by fertility setting

Categories	Low-fertility setting (n = 2,856) n (%)	High-fertility setting (n = 409) n (%)	Total (n = 3,265) n (%)
The cost of contraceptives in my country or territory is too high	726 (25.4%)	69 (16.9%)	795 (24.3%)
A doctor's prescription is needed	362 (12.7%)	31 (7.6%)	393 (12.0%)
Lack of knowledge about where to get contraceptives	346 (12.1%)	36 (8.8%)	382 (11.7%)
There is a lack of knowledge about contraceptives in my country or territory	883 (30.9%)	86 (21.0%)	969 (29.7%)
Contraceptives for unmarried people are a taboo in my country or territory	416 (14.6%)	27 (6.6%)	443 (13.6%)
Health-care providers are judgmental towards the use of contraceptives; they recommend not using them	171 (6.0%)	8 (2.0%)	179 (5.5%)
Health-care providers in my country or territory lack knowledge about contraceptives	203 (7.1%)	18 (4.4%)	221 (6.8%)
Contraceptives are often out of stock in my country or territory	78 (2.7%)	7 (1.7%)	85 (2.6%)
There is social pressure not to use contraceptives in my country or territory	222 (7.8%)	14 (3.4%)	236 (7.2%)
Religious leaders discourage the use of contraceptives	241 (8.4%)	19 (4.6%)	260 (8.0%)
Other	140 (4.9%)	32 (7.8%)	172 (5.3%)
None of the above are barriers in my country or territory	1,163 (40.7%)	200 (48.9%)	1,363 (41.7%)

The survey of health-care providers sought to identify key factors that may deter them from offering contraceptives to patients. The results, presented in Table 17, highlight a range of provider-reported barriers, including systemic, attitudinal and informational factors that influence contraceptive provision.

Across all settings, the most commonly cited deterrent was lack of health coverage for contraceptives, reported by nearly a quarter of respondents (24.0 per cent). Other frequently mentioned reasons included the patient being too young (13.5 per cent), concerns about potential infertility (8.3 per cent), social stigma surrounding contraceptive use (8.3 per cent) and beliefs that contraceptives may be harmful (8.0 per cent). A smaller but notable proportion of providers also identified the civil status of the patient (8.0 per cent), religious opposition by the patient (8.9 per cent) or lack of confidence in managing side effects (8.8 per cent) as barriers. Distrust in modern contraception was reported by 4.1 per cent of providers overall, and knowledge gaps were mentioned by 4.8 per cent. Less commonly cited reasons included stockouts of contraceptives (5.1 per cent), concerns about cancer (5.6 per cent) and personal religious opposition (0.8 per cent). About 16.0 per cent of providers selected “other”, and 18.1 per cent chose “prefer not to answer”, suggesting that some barriers may not have been captured by the listed options.

When comparing by fertility setting, key differences emerge. Lack of health coverage (with no specifications of provider or facility characteristics) was the leading deterrent in both groups but was more prevalent in low-fertility settings (27.0 per cent) compared with high-fertility settings (11.6 per cent) ( $p < 0.001$ ), underscoring the potentially systemic nature of access barriers. Similarly, lack of confidence in managing side effects was reported nearly twice as often by providers in low-fertility areas (9.8 per cent) than in high-fertility ones (4.5 per cent) ( $p = 0.008$ ).

Concerns related to patient age were more commonly reported in low-fertility settings (15.0 per cent) than in high-fertility ones (7.0 per cent) ( $p < 0.001$ ), indicating that they refrain from offering contraceptives because the patient is “too young”. The patient’s number of children also appeared to influence provider decisions more in low-fertility settings (11.9 per cent) than in high-fertility settings (7.0 per cent).

Conversely, distrust in modern contraception was more common in high-fertility settings (7.9 per cent) than in low-fertility settings (3.2 per cent) ( $p = 0.003$ ), pointing to possible attitudinal resistance among providers in those contexts. Reports of social stigma as a deterrent were also higher in low-fertility settings (9.2 per cent) compared with high-fertility settings (4.5 per cent). There were no significant differences across settings regarding other factors, such as religious objections, civil status, concerns about harm or infertility and stockouts, but they were still mentioned as barriers.



Photo: UNFPA Tajikistan

**Table 17.** Main reasons reported by health-care providers for not offering contraceptives, by fertility setting

Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
There is no health coverage for contraceptives in my country or territory	275 (27.0%)	28 (11.6%)	303 (24.0%)
I don't trust modern contraception	33 (3.2%)	19 (7.9%)	52 (4.1%)
My patient is too young	153 (15.0%)	17 (7.0%)	170 (13.5%)
Modern contraceptives may be harmful	85 (8.3%)	16 (6.6%)	101 (8.0%)
Contraceptives may cause infertility	81 (7.9%)	24 (9.9%)	105 (8.3%)
The number of children my patient has	121 (11.9%)	17 (7.0%)	138 (10.9%)
The patient's civil status (unmarried, single)	80 (7.9%)	21 (8.7%)	101 (8.0%)
Contraceptives may cause cancer	58 (5.7%)	12 (5.0%)	70 (5.6%)
There are stockouts of contraceptives in my country or territory	55 (5.4%)	9 (3.7%)	64 (5.1%)
There is social stigma surrounding contraceptives	94 (9.2%)	11 (4.5%)	105 (8.3%)
My patients' religion forbids it	97 (9.5%)	15 (6.2%)	112 (8.9%)
My religion forbids it	9 (0.9%)	1 (0.4%)	10 (0.8%)
My knowledge of contraception is not comprehensive	47 (4.6%)	14 (5.8%)	61 (4.8%)
I am not confident that I can manage the side effects, if there are any	100 (9.8%)	11 (4.5%)	111 (8.8%)
Other	149 (14.6%)	51 (21.1%)	200 (15.9%)
Prefer not to answer	168 (16.5%)	60 (24.8%)	228 (18.1%)

A comparison of users and providers revealed areas of overlap as well as important disconnects. While some areas of alignment are evident – particularly around structural and financial constraints – significant discrepancies emerge around perceptions of stigma, provider attitudes and knowledge gaps.

A clear point of convergence between both groups is the recognition of financial barriers. Among providers, the lack of health coverage for contraceptives was the most cited reason for not offering certain methods (24.0 per cent overall, 27.0 per cent in low-fertility settings). A similar pattern was found among users, with 24.3 per cent overall (25.4 per cent in low-fertility settings) identifying the high cost of contraceptives as a major barrier to access.

Informational barriers, however, were perceived more acutely by users than by providers. Nearly a third of users (29.7 per cent) reported a lack of knowledge about contraceptives in their country or territory, and 11.7 per cent were unsure of where to obtain them. In contrast, only 4.8 per cent of health-care providers acknowledged that their knowledge of contraception was not comprehensive, and 8.8 per cent expressed a lack of confidence in managing side effects.

Differences are even more pronounced in relation to stigma and social norms. For example, 13.6 per cent of users mentioned that contraceptive use is taboo for unmarried individuals, and 7.2 per cent referred to social pressure not to use contraceptives. Notably, 6.0 per cent reported judgmental attitudes on the part of health-care providers themselves. While providers did acknowledge some barriers related to social context – 8.0 per cent cited civil status, and 8.3 per cent identified social stigma – very few admitted to holding judgmental attitudes or restrictive personal beliefs.

Religious and cultural opposition to contraception was reported by both groups but with some variation. Eight per cent of users stated that religious leaders discourage contraceptive use, while 8.9 per cent of providers said their patients' religious beliefs may deter use. Only 0.8 per cent of providers cited their own religion as a barrier, pointing to a possible reluctance to acknowledge the influence of personal beliefs on professional conduct. Supply-related issues, such as contraceptive stockouts, were infrequently reported by both users (2.6 per cent) and providers (5.1 per cent).

Importantly, the analysis reveals consistent differences between low- and high-fertility settings. Users in low-fertility settings reported more barriers overall, including cost, stigma and informational gaps. This finding may reflect greater awareness of rights, higher expectations or more critical assessments of health-care systems in these contexts. Similarly, health-care providers in low-fertility settings were more likely to cite a wider range of deterrents, such as lack of health coverage, patients' age or number of children, and their own lack of confidence in managing side effects, than those in high-fertility settings.

### **3.7. Sources of information on contraceptives and training**

#### **3.7.1. Sources of information**

When asked about the primary source of information about contraceptives for the female population in general, respondents across both low- and high-fertility settings most commonly cited the Internet and media. The Internet was mentioned by nearly 60.0 per cent of respondents overall, slightly more frequently in low-fertility settings (59.9 per cent) than in high-fertility settings (52.6 per cent). Media also played a notable role, especially in low-fertility settings, where 27.2 per cent of respondents identified it as their main source of information, compared with 14.9 per cent in high-fertility settings. The use of these sources was more prevalent among respondents under the age of 30, highlighting potential generational differences in access to and trust in digital and mass communication platforms.

Gynaecologists were the second most frequently reported source of information about contraceptives, cited by 40.4 per cent of respondents in both low- and high-fertility settings. This source was also common among younger participants but was mentioned less frequently by older respondents.

Friends and family members were also common sources, particularly in low-fertility settings, although to a lesser extent than health-care professionals or digital sources. Notably, sexuality

education in schools was cited by 14.5 per cent of respondents in low-fertility settings but by only 5.4 per cent in high-fertility settings, pointing to possible disparities in comprehensive sexuality education programmes in these settings. Less commonly reported sources included community health workers, other health-care providers and colleagues at work.

Notably, the proportion of respondents citing their partners was slightly higher in high-fertility settings (10.0 per cent) compared with low-fertility settings (8.0 per cent), though overall this source remained relatively uncommon. High-fertility settings also had a higher proportion of respondents reporting no source of information about contraception at all (6.8 per cent vs. 2.8 per cent), underscoring potential gaps in information dissemination and access.

Qualitative findings provided further context about how men, in particular, learned about contraceptive methods. In Dushanbe, the capital of Tajikistan, many participants reported relying primarily on the Internet for information:

“

*We check online. You can find everything if you want.* (Man, Dushanbe, Tajikistan)

”

By contrast, in more rural areas such as Gafurov and Kushonien, informal networks and peer communication during migration played a much larger role:

“

*Most of us learned about condoms from friends.* (Man, Gafurov, Tajikistan)

”

“

*Men receive insights from peers during migration.* (Man, Kushonien, Tajikistan)

”

Similarly, in Albania, men described acquiring information informally, often in social settings like cafés and bars:

“

*Yes, I have heard it from old people and elders who come to my bar. Since I have a bar, they come and drink coffee there, and we also have these conversations.*

(Man, Korçë, Albania)

”

However, knowledge was far from universal. In the same focus group, a researcher noted that seven out of nine participants had never heard of family planning.

Survey data further indicated that populations in low-fertility settings rely more heavily on digital and formal channels, such as gynaecologists and other health-care providers, while those in high-fertility settings show less engagement with these sources. The only categories where respondents in high-fertility settings reported slightly higher rates were partners (10 per cent vs. 8 per cent in low-fertility settings) and no sources of contraceptive information at all (6.8 per cent in high-fertility settings vs. 2.8 per cent in low-fertility settings). These findings point to potential gaps in information dissemination in high-fertility contexts and underscore the importance of strengthening

school-based programmes. This finding is further reflected in disparities in foundational training: a large majority of health-care providers in high-fertility settings (76 per cent, compared with 14.3 per cent in low-fertility settings) reported that contraceptive methods were not included in their basic medical education (Table 19).

**Table 18.** Sources of information, by fertility setting

Categories	Low-fertility setting (n = 2,856) n (%)	High-fertility setting (n = 409) n (%)	Total (n = 3,265) n (%)
Friends	688 (24.1%)	87 (21.3%)	775 (23.7%)
Family members	303 (10.6%)	34 (8.3%)	337 (10.3%)
Neighbours	2 (0.1%)	2 (0.5%)	4 (0.1%)
Media	777 (27.2%)	61 (14.9%)	838 (25.7%)
Sexuality education at school	415 (14.5%)	22 (5.4%)	437 (13.4%)
Gynaecologist	1,153 (40.4%)	165 (40.3%)	1,318 (40.4%)
Community health worker	141 (4.9%)	14 (3.4%)	155 (4.7%)
Other health-care provider	159 (5.6%)	13 (3.2%)	172 (5.3%)
Internet	1,712 (59.9%)	215 (52.6%)	1,927 (59.0%)
In the workplace / from a colleague	121 (4.2%)	14 (3.4%)	135 (4.1%)
Partner	228 (8.0%)	41 (10.0%)	269 (8.2%)
Other	113 (4.0%)	15 (3.7%)	128 (3.9%)
None	80 (2.8%)	28 (6.8%)	108 (3.3%)
I am not confident that I can manage the side effects, if there are any	100 (9.8%)	11 (4.5%)	111 (8.8%)
Other	149 (14.6%)	51 (21.1%)	200 (15.9%)
Prefer not to answer	168 (16.5%)	60 (24.8%)	228 (18.1%)

### 3.7.2. Training of health-care providers

Regarding the training background of health-care providers in both low- and high-fertility settings, there are notable disparities in both foundational and method-specific contraceptive training. A large majority of health-care providers in low-fertility settings (83.9 per cent) reported that contraceptive methods were part of their basic medical education, compared with only 18.2% in high-fertility settings ( $p < 0.001$ ). When asked about additional training after their initial studies, about two thirds (62.9 per cent) of health-care providers overall reported having received further instruction, with no significant differences between settings.

However, more detailed questions revealed that, overall, health-care provider respondents in high-

fertility settings had more recent method-specific training compared with those in low-fertility settings. In low-fertility settings, the majority of providers (61.3 per cent vs. 44.2 per cent in high-fertility settings) reported not having received training in any of the following methods: female sterilization, vasectomy, implants or IUDs. Moreover, health-care providers in high-fertility settings were more likely to have received training on implants (14.5 per cent vs. 8.6 per cent in low-fertility settings) and IUDs (41.7 per cent in high-fertility settings vs. 31.3 per cent in low-fertility settings).

Health-care providers in high-fertility settings were more likely to have received recent training in specific contraceptive methods than their counterparts in low-fertility settings. Nearly one third (29.3 per cent) of health-care providers in these high-fertility settings reported having been trained within the past two years, compared with only 14.1 per cent in low-fertility settings ( $p < 0.001$ ). In contrast, more than 60.0 per cent of providers in low-fertility settings reported not remembering when they had last received such training – highlighting a notable gap in training in these contexts.

A similar pattern emerged when providers were asked about their most recent training on contraception more broadly. Health-care providers in high-fertility settings were again more likely to have received training in the previous two years (35.5 per cent vs. 23.8 per cent) ( $p < 0.001$ ). In both settings, however, nearly one third of providers reported that they did not recall ever receiving training on contraception at all.

**Table 19.** Training of health-care providers on contraceptive methods

Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
Was the topic of contraceptive methods included in your basic medical study/training programme?			
Yes	855 (83.9%)	184 (76.0%)	1,039 (82.4%)
No	146 (14.3%)	44 (18.2%)	190 (15.1%)
Other	18 (1.8%)	14 (5.8%)	32 (2.5%)
Did you have any additional training on contraceptive methods after your initial studies/training?			
Yes	639 (62.7%)	154 (63.6%)	793 (62.9%)
No	370 (36.3%)	79 (32.6%)	449 (35.6%)
Other	10 (1.0%)	9 (3.7%)	19 (1.5%)
Did you receive specific training in any of the following methods?			
Female sterilization	164 (16.1%)	43 (17.8%)	207 (16.4%)
Vasectomy	64 (6.3%)	6 (2.5%)	70 (5.6%)
Insertion and removal of implants	88 (8.6%)	35 (14.5%)	123 (9.8%)
Insertion and removal of intrauterine devices (IUDs)	319 (31.3%)	101 (41.7%)	420 (33.3%)
None of the above	625 (61.3%)	107 (44.2%)	732 (58.0%)

Categories	Low-fertility setting (n = 1,019) n (%)	High-fertility setting (n = 242) n (%)	Total (n = 1,261) n (%)
<b>When was your last training in this method or these methods?</b>			
During the past two years	144 (14.1%)	71 (29.3%)	215 (17.0%)
2-5 years ago	122 (12.0%)	28 (11.6%)	150 (11.9%)
5-10 years ago	81 (7.9%)	19 (7.9%)	100 (7.9%)
10-15 years ago	20 (2.0%)	8 (3.3%)	28 (2.2%)
More than 15 years ago	27 (2.6%)	9 (3.7%)	36 (2.9%)
Unknown	625 (61.3%)	107 (44.2%)	732 (58.0%)
<b>When was the last training on contraception that you attended?</b>			
During the past two years	243 (23.8%)	86 (35.5%)	329 (26.1%)
2-5 years ago	258 (25.3%)	40 (16.5%)	298 (23.6%)
5-10 years ago	144 (14.1%)	23 (9.5%)	167 (13.2%)
10-15 years ago	48 (4.7%)	8 (3.3%)	56 (4.4%)
More than 15 years ago	45 (4.4%)	7 (2.9%)	52 (4.1%)
I don't recall receiving contraceptive training	281 (27.6%)	78 (32.2%)	359 (28.5%)

## 4. Discussion

This study presents an analysis of contraceptive use, perceptions and barriers across 17 countries and territories in Eastern Europe and Central Asia. The discussion that follows is structured around the four programmatic levels of UNFPA's holistic framework for human rights-based family planning, moving from the broader community level, through laws, policy and service delivery to the individual level.

### Supportive community and social and gender norms

The study findings highlight the strong influence of community dynamics and deeply rooted gender norms on contraceptive behaviours and outcomes across Eastern Europe and Central Asia. Awareness of modern contraceptive methods was generally widespread among women respondents, particularly in low-fertility contexts, even when actual use remained limited. Across both settings, 83.7 per cent of women knew what condoms looked like and how to use them, 73.0 per cent were familiar with contraceptive pills, and just over half (52.2 per cent) were aware of IUDs. Moreover, awareness extended beyond the methods most commonly used. For instance, while spermicides were used by only 0.3 per cent of women, 23.0 per cent reported being very familiar with them; diaphragms were used by just 0.1 per cent of women, yet 18.0 per cent were familiar with them; and although only 0.3 per cent of respondents reported having been sterilized, 42.6 per cent indicated awareness of the method.

By contrast, the qualitative analysis suggested that, most of the time, men's knowledge could be characterized as partial, superficial or inaccurate, with some men completely unaware of certain methods. Many reported relying primarily on natural methods, such as withdrawal, while condom use was frequently avoided due to social stigma associating it with infidelity.

Despite this limited knowledge, men's role in contraceptive decision-making was significant. More than half of women (54.5 per cent) reported making decisions jointly with their partners, while only 22.5 per cent in low-fertility settings and 7.3 per cent in high-fertility settings reported making decisions on their contraceptive method independently. In high-fertility settings, the qualitative analysis also showed that the influence of family and partner approval was strong; women described needing permission from their partners to access contraception. Such dynamics pose a threat to sexual and reproductive health and rights, especially when men dominate or strongly influence decisions but lack a comprehensive understanding of contraceptive options.

Global studies confirm that men's knowledge of both female and male contraceptive methods

is considerably lower than women's.<sup>29</sup> Other research highlights how cultural norms and social stigma restrict women's autonomy in family planning, representing a major barrier to sexual and reproductive health outcomes.<sup>30</sup>

These findings show how male preferences can override joint decision-making and limit women's contraceptive choices, underscoring the need to increase men's knowledge of contraceptive methods and to engage them more actively in sexual and reproductive health education, both to improve method uptake and to strengthen women's autonomy in reproductive decision-making.<sup>31</sup>

### Enabling legal and policy environment: Gaps in structural support for rights-based family planning

While the survey did not directly assess national laws or policy frameworks, several indicators point to structural limitations that undermine the realization of reproductive rights.

Globally, the prevalence of contraceptive methods varies considerably. Short-acting methods remain the most widely used in five of the eight world regions, including Europe, whereas permanent or long-acting reversible methods dominate in Asia and Oceania.<sup>32</sup> In Central Asia, Uzbekistan stands out with the second-highest prevalence of IUD use globally, with 36.9 per cent of women reporting using this method.<sup>33</sup>

The choice of certain methods depends not only on personal preferences but also on their availability and accessibility. In the survey, the most important factors influencing method choice in Eastern Europe and Central Asia, after effectiveness and reliability, were accessibility (30.0 per cent in low-fertility settings and 30.9 per cent in high-fertility settings) and affordability (20.3 per cent and 18.4 per cent, respectively). Qualitative data from Albania and Kosovo further illustrated these structural barriers. Frequent stockouts and the restricted availability of certain methods at primary health-care facilities in both Albania and Kosovo revealed persistent gaps in contraceptive security and supply chain management. In Kosovo, health-care providers reported that contraceptive supplies at the primary health-care level were often limited to condoms and oral contraceptives, with other modern methods either unavailable or inconsistently stocked.

Research has consistently shown that greater availability of contraceptive methods leads to

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29. Arik V. Marcell and others, "Males' awareness of female and male contraception methods, information, outreach, and acquisition locations in Abidjan, Côte d'Ivoire, Nairobi, Kenya, and Lagos, Nigeria", *Journal of Adolescent Health*, vol. 71, No. 3 (2022). Available at <https://doi.org/10.1016/J.JADOHEALTH.2022.03.013> (accessed on 13 November 2025); Olivia Moumne and others, "Qualitative exploration of contraceptive knowledge in men and women", *Southern Medical Journal*, vol. 117, No. 12 (2024). Available at <https://doi.org/10.14423/SMJ.0000000000001762> (accessed on 13 November 2025).

30. Maggie Ikinue Baigry and others, "Barriers and enablers to young people accessing sexual and reproductive health services in Pacific Island countries and territories: A scoping review", *PLOS ONE*, vol. 18, No. 1 (2023). Available at <https://doi.org/10.1371/JOURNAL.PONE.0280667> (accessed on 13 November 2025); Hajar Ouahid and others, "The influence of gender norms on women's sexual and reproductive health outcomes: A systematic review", *BMC Women's Health*, vol. 25, No. 1 (2025), p. 224. Available at <https://doi.org/10.1186/S12905-025-03768-2> (accessed on 13 November 2025).

31. Kim Jonas and others, "Rumours, myths, and misperceptions as barriers to contraceptive use among adolescent girls and young women in South Africa", *Frontiers in Reproductive Health*, vol. 4 (September 2022). Available at <https://www.frontiersin.org/journals/reproductive-health/articles/10.3389/frph.2022.960089/full> (accessed on 13 November 2025); Olivia Moumne and others, "Qualitative exploration of contraceptive knowledge in men and women".

32. United Nations Department of Economic and Social Affairs, *World family planning 2022: Meeting the changing needs for family planning – Contraceptive use by age and method* (New York, 2022).

33. United Nations Department of Economic and Social Affairs, *Contraceptive use by method 2019: Data booklet* (New York, 2019). Available at [https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2020/Jan/un\\_2019\\_contraceptiveusebymethod\\_databooklet.pdf](https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2020/Jan/un_2019_contraceptiveusebymethod_databooklet.pdf) (accessed on 13 November 2025).

higher uptake across populations. Expanding the range of available options enables individuals to select a method that best meets their needs, preferences and circumstances, thereby increasing overall contraceptive prevalence.<sup>34</sup> The percentage distribution of total contraceptive use across various methods, known as method mix, captures both supply factors (such as the availability and affordability of methods) and demand factors (such as people's preferences).<sup>35</sup> The United Nations, for instance, attributes changes in method mix over time to a combination of factors: national health policies, reforms in health-care systems, the development of new contraceptive technologies and evolving access to different methods. Governments at all levels have therefore played a strong and visible role in shaping contraceptive landscapes by promoting and legitimizing the use of specific methods as well as family planning and reproductive health-care services.<sup>36</sup>

Evidence shows that no single ideal method mix applies universally; in contexts where one method predominates, expanding the range of available methods increases overall contraceptive use.<sup>37</sup> Findings from this study confirm that, in the Eastern Europe and Central Asia region, stockouts and the limited availability of certain methods compromise reproductive rights and limit effective contraceptive use. Family planning programmes in place should pay special attention to the groups that are most in need.<sup>38</sup>

To address these challenges, there is an urgent need to reposition family planning not as a driver of population decline, but as a strategic tool for governments to navigate demographic change and build robust human capital. Rather than viewing reproductive rights and national demographic goals as opposing forces, a modern understanding of family planning should recognize it as a prerequisite for demographic resilience. By ensuring that individuals can plan their families without fear of economic or educational penalization, governments can mitigate the "shocks" of unplanned pregnancies that often lead to school dropouts or the withdrawal of women from the labour market.

When family planning is integrated into a broader framework of family support policies—such as paid parental leave, affordable childcare, and flexible work—it empowers citizens to bridge the gap between their desired and actual number of children.<sup>39</sup> In this light, investing in a diverse contraceptive method mix and securing supply chains is an investment in a more productive, gender-equal, and economically stable society. Transitioning from a focus on demographic targets to a focus on human capital ensures that even in low-fertility settings, the emphasis remains on the quality of life, autonomy, and the long-term potential of every individual.

Following a rights-based approach, family planning programming should not be contingent on a country's or territory's fertility context. The implementation of pronatalist policies aimed at reversing

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34. Annie Haakenstad and others, "Measuring contraceptive method mix, prevalence, and demand satisfied by age and marital status in 204 countries and territories, 1970–2019: A systematic analysis for the Global Burden of Disease Study 2019", *The Lancet*, vol. 400, No. 10348 (July 2022). Available at [https://doi.org/10.1016/S0140-6736\(22\)00936-9](https://doi.org/10.1016/S0140-6736(22)00936-9) (accessed on 13 November 2025).

35. Jane T. Bertrand and others, "Contraceptive method mix: Updates and implications", *Global Health, Science and Practice*, vol. 8, No. 4 (December 2020). Available at <https://doi.org/10.9745/GHSP-D-20-00229> (accessed on 13 November 2025).

36. United Nations, Department of Economic and Social Affairs, *Contraceptive use by method 2019: Data booklet*.

37. Bertrand and others, "Contraceptive method mix: Updates and implications"; John Ross and John Stover, "Use of modern contraception increases when more methods become available: Analysis of evidence from 1982–2009", *Global Health, Science and Practice*, vol. 1, No. 2 (August 2013), p. 203. Available at <https://doi.org/10.9745/GHSP-D-13-00010> (accessed on 13 November 2025).

38. Haakenstad and others, "Measuring contraceptive method mix, prevalence, and demand satisfied by age and marital status in 204 countries and territories, 1970–2019: A systematic analysis for the Global Burden of Disease Study 2019".

39. UNFPA Malaysia, *Ensuring Reproductive Rights and Choices: A Human Capital Perspective on Family Planning in Malaysia*, (Kuala Lumpur, 2023). Available at [https://malaysia.unfpa.org/sites/default/files/pub-pdf/full\\_report\\_lr\\_dec1\\_2.pdf](https://malaysia.unfpa.org/sites/default/files/pub-pdf/full_report_lr_dec1_2.pdf) (accessed on 11 November 2025).

population decline has been shown to produce only modest increases in birth rates and rarely achieves replacement-level fertility.<sup>40</sup> Moreover, low fertility does not necessarily signify economic decline but rather underscores the need for thoughtful planning that promotes opportunity, autonomy and gender equality. In addition, several low-fertility settings have deprioritized policies that aim to increase universal access to family planning, removed sexuality education from school curricula or pursued restrictive abortion laws. These actions represent a regression in reproductive rights and autonomy and risk undermining fundamental human rights and freedoms.<sup>41</sup>

In Eastern Europe and Central Asia, health system transformations after the fall of the Berlin Wall further reshaped contraceptive access. Extensive health reforms, characterized by the expansion of private providers and a reduction in the size of the hospital sector, resulted in limited availability of contraception through public channels and an increasing reliance on pharmacies.<sup>42</sup> In the current study, respondents across both fertility settings reported relying primarily on pharmacies to obtain contraceptives, with limited engagement with formal health-care services. Pharmacies that did not require a prescription were identified as the most common source of contraceptives, particularly in high-fertility settings (67.7 per cent) but also, to a lesser extent, in low-fertility settings (62.9 per cent). Within this context, contraceptive provision has become increasingly fragmented, with weakly structured and publicly supported distribution mechanisms.

These findings reveal that gaps in service delivery are not only operational but also deeply structural. When contraceptive access depends primarily on pharmacies rather than integrated public health services, equity and quality of care are compromised. Women and couples are left to navigate availability, cost and information barriers on their own – conditions that contradict the principles of rights-based family planning. Addressing these challenges requires stronger policy frameworks, sustained investment in contraceptive security and the reinforcement of public systems capable of ensuring informed choice and universal access.

### **Quality of information and services: Gaps in method mix, provider training and rights-based delivery**

Access to comprehensive, unbiased, non-judgmental and scientifically accurate information on modern contraceptive methods is a critical component of sexual and reproductive health.<sup>43</sup> Yet, limited access to such information remains a significant barrier in the Eastern Europe and Central Asia region.<sup>44</sup> The survey showed that the Internet and media were the most frequently cited sources of contraceptive information among women. Reliance on informal networks and peer communication was more common in high-fertility settings, while 6.8 per cent of respondents in these settings reported having no source of contraceptive information at all. School-based sexuality education was also found to be limited, with only 5.4 per cent of respondents in low-fertility settings

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40. Family Planning 2030, “Beyond the numbers: Reframing the dialogue on fertility and population”, 5 September 2025. Available at <https://www.fp2030.org/news/beyond-the-numbers-reframing-the-dialogue-on-fertility-and-population/> (accessed on 13 November 2025).

41. UNFPA Regional Office for Eastern Europe and Central Asia, *Roadmap for Ending the Unmet Need for Family Planning in Eastern Europe and Central Asia by 2030*.

42. Rechel and McKee, “Health reform in Central and Eastern Europe and the former Soviet Union”.

43. WHO, *Quality of care in contraceptive information and services, based on human rights standards: A checklist for health care providers* (Geneva, 2017).

44. Baigry and others, “Barriers and enablers to young people accessing sexual and reproductive health services in Pacific Island countries and territories: A scoping review”.

and 14.5 per cent in high-fertility settings reporting exposure to it, highlighting systemic gaps in comprehensive sexuality education.

In addition to these information gaps, provider-related barriers further constrain individuals' contraceptive choices. These barriers are often compounded by provider bias in determining method eligibility.<sup>45</sup> Globally, such bias has been shown to play a significant role in shaping both access to and choice of contraception.<sup>46</sup> In the Eastern Europe and Central Asia region, provider bias manifests through judgments about certain population groups, contraceptive methods and contraception in general. Rather than offering patients a full range of options, some physicians prescribe specific methods for what they perceive as a particular type of woman. For example, IUDs are often prescribed only for women who already have children, while oral contraceptives are sometimes withheld from Roma women based on prejudiced assumptions that they are unable to take a pill daily.<sup>47</sup> Comparable patterns have been observed in other regions. In China, for example, some health-care providers have reported adhering to traditional beliefs against premarital sex, leading them to discourage or deny IUD use for nulliparous women.<sup>48</sup> Similar patterns have been documented in sub-Saharan Africa. In Tanzania and Burkina Faso, for example, unmarried patients reported receiving poorer treatment from providers compared with their married peers, while nulliparous patients experienced lower-quality contraceptive counselling than parous clients.<sup>49</sup> Other research has highlighted provider resistance to the removal of long-acting reversible contraceptives, revealing how biases can limit women's ability to discontinue use and make fully autonomous reproductive decisions.<sup>50</sup> Similarly, in this study, both survey and qualitative data revealed that health-care providers' knowledge and attitudes sometimes contributed to misinformation or hesitancy. In the focus group discussions, some providers expressed personal doubts about hormonal contraception, citing unfounded associations with cancer or infertility. These misconceptions can undermine patients' confidence and reinforce widespread fears about side effects or infertility, concerns that were particularly prominent in low-fertility settings.

The study also uncovered marked disparities in health-care provider training. Health-care providers in high-fertility settings were less likely to have received contraceptive training during their basic medical education (18.2 per cent vs. 83.9 per cent in low-fertility settings), although they were more

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45. Julie Solo and Mario Festin, "Provider bias in family planning services: A review of its meaning and manifestations", *Global Health: Science and Practice*, vol. 7, No. 3 (September 2019), p. 371. Available at <https://doi.org/10.9745/GHSP-D-19-00130> (accessed on 13 November 2025).

46. Ibid.

47. UNFPA Regional Office for Eastern Europe and Central Asia and International Planned Parenthood Federation European Network, *Key factors influencing contraceptive use in Eastern Europe and Central Asia: Findings from a qualitative study in 7 countries and recommendations for improving access to modern contraception in the region* (Istanbul and Brussels, 2012).

48. Ziliang Wang and others, "Attitudes and practices related to intrauterine devices for nulliparous women among Chinese health care providers", *Reproductive Health*, vol. 16, No. 1 (2019). Available at <https://doi.org/10.1186/s12978-019-0678-9> (accessed on 15 November 2025).

49. Alexandra Wollum and others, "Characterizing provider bias in contraceptive care in Tanzania and Burkina Faso: A mixed-methods study", *Social Science and Medicine*, vol. 348 (May 2024). Available at <https://doi.org/10.1016/j.socscimed.2024.116826> (accessed on 15 November 2025).

50. Laura E. Britton and others, "'When it comes to time of removal, nothing is straightforward': A qualitative study of experiences with barriers to removal of long-acting reversible contraception in Western Kenya", *Contraception: X*, vol. 3 (2021). Available at <https://doi.org/10.1016/j.conx.2021.100063> (accessed 13 November 2025); Leigh Senderowicz, "'I was obligated to accept': A qualitative exploration of contraceptive coercion", *Social Science and Medicine*, vol. 239 (October 2019). Available at <https://doi.org/10.1016/j.socscimed.2019.112531> (accessed on 15 November 2025).

likely to have received more recent, method-specific training – for example, on IUD insertion (41.7 per cent in high-fertility settings compared with 31.3 per cent in low-fertility settings). Evidence from other contexts supports the positive impact of such training. In Brazil, theoretical and practical training for health-care providers has been shown to clarify doubts and promote higher uptake of contraceptive implants.<sup>51</sup> In the United States, providers who participated in in-service training and demonstration projects showed improved perceptions, knowledge and behaviour regarding the use of emergency contraception.<sup>52</sup> These findings underscore the continuing need for comprehensive, rights-based provider training to ensure accurate information, non-judgmental counselling and equitable service delivery.

### **Empowered and satisfied clients: Persistent gaps in autonomy, choice and respectful care**

Information gaps and provider biases continue to shape contraceptive behaviours and choices. Users of natural methods showed strong knowledge of those methods, suggesting that their choice is not necessarily driven by a lack of awareness but often by a deliberate rejection of hormonal or clinical options, frequently due to perceived health risks or concerns about side effects. This finding underscores the need for nuanced communication strategies that acknowledge users' concerns while addressing misinformation and promoting evidence-based understanding of contraceptive safety and efficacy.

Qualitative data further revealed that contraceptive services are not consistently delivered in culturally sensitive or respectful ways. Unmarried youth and marginalized groups, including sexual minorities and internally displaced persons, reported stigma and discomfort when seeking contraception. This finding echoes other research that shows how health workers' values and preferences for contraceptive methods undermine both the acceptability and emotional safety of services.<sup>53</sup>

These findings point to persistent gaps in ensuring people's autonomy, informed choice and respectful care, key principles of rights-based family planning.<sup>54</sup> When individuals lack accurate information, face stigma from providers or encounter judgmental attitudes, their ability to make voluntary and informed decisions about contraception is compromised. Addressing these barriers requires strengthening client-centred care and creating enabling environments that promote privacy, empathy and inclusion across all population groups.

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51. Mariane N. De Nadai and others, "Practical training of health care providers in insertion of contraceptive implants: Findings from two Brazilian centres", *The European Journal of Contraception and Reproductive Health Care: The Official Journal of the European Society of Contraception*, vol. 26, No. 6 (2021). Available at <https://doi.org/10.1080/13625187.2021.1942448> (accessed on 13 November 2025).

52. Linda J. Beckman and others, "Changes in providers' views and practices about emergency contraception with education", *Obstetrics and Gynecology*, vol. 97, No. 6 (June 2001). Available at [https://doi.org/10.1016/S0029-7844\(01\)01365-5](https://doi.org/10.1016/S0029-7844(01)01365-5) (accessed on 13 November 2025).

53. Komol S. Soin and others, "Health workers' values and preferences regarding contraceptive methods globally: A systematic review", *Contraception*, vol. 111 (July 2022), p. 61. Available at <https://doi.org/10.1016/J.CONTRACEPTION.2022.04.012> (accessed on 13 November 2025).

54. Karen Hardee and Sandra Jordan, "Advancing rights-based family planning from 2020 to 2030", *Open Access Journal of Contraception*, vol. 12 (2021), p. 157. Available at <https://doi.org/10.2147/OAJC.S324678> (accessed on 13 November 2025).

## 5. Recommendations

The findings of this study point to an urgent need for a multilayered, human rights-based response to address the barriers to contraceptive use in the Eastern Europe and Central Asia region. To address these barriers, coordinated action at multiple levels – at the level of both the community and individuals, as well as the level of policies, laws and health systems – is needed.

### Community-level interventions

Community efforts must prioritize transforming social norms, expanding comprehensive sexuality education and fostering informed, autonomous decision-making for all individuals, as these steps are essential to creating an enabling environment for voluntary, informed and equitable access to modern contraceptive methods.

Community-based interventions play a vital role in changing social norms by engaging key influencers and stakeholders, including religious leaders, educators, parents and youth, to promote accurate information about contraception and challenge stigma and misconceptions. These actors shape community attitudes and behaviours and are crucial to fostering supportive environments for reproductive health and rights. By shifting collective beliefs and expectations, such interventions help dismantle barriers to contraceptive access and use. Evidence from community group engagement initiatives shows that when women and girls derive social and economic status by participating in collective decision-making structures, their empowerment and autonomy increase and challenge harmful social practices that impact their reproductive and sexual health.<sup>55</sup>

In addition, intergenerational knowledge gaps in reproductive health must be addressed through the integration of reproductive literacy into schools, health systems and community programmes. Embedding comprehensive, age-appropriate and culturally sensitive sexuality education across these platforms will equip future generations with the knowledge and confidence to make informed reproductive choices. Sexuality education programmes should start at an early age and focus on sexuality through a holistic approach (going beyond risk reduction). They have the potential to increase knowledge about contraception, strengthen self-efficacy in its use and foster more positive attitudes towards sexuality.<sup>56</sup>

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55. Family Planning High Impact Practices, “Promoting healthy couples’ communication to improve reproductive health outcomes”. Available at <https://www.fphighimpactpractices.org/briefs/couple-communication/> (accessed on 6 October 2025).

56. Sonia Barriuso-Ortega, María Fernández-Hawrylak and Davinia Heras-Sevilla, “Sex education in adolescence: A systematic review of programmes and meta-analysis”, *Children and Youth Services Review*, vol. 166 (November 2024). Available at <https://doi.org/10.1016/J.CHILDYOUTH.2024.107926> (accessed on 13 November 2025); Rachel Niland, Clodagh Flinn and Finiki Nearchou, “Assessing the role of school-based sex education in sexual health behaviours: A systematic review”, *Cogent Psychology*, vol. 11, No. 1 (2024). Available at <https://doi.org/10.1080/23311908.2024.2309752> (accessed on 13 November 2025).

Promoting shared responsibility for contraception is equally critical to fostering informed, autonomous decision-making. Interventions should actively engage men and boys in reproductive decision-making in ways that affirm human rights, respect women's autonomy and reduce the disproportionate burden currently placed on women. Normalizing male participation in family planning can foster more equitable partnerships and improve health outcomes. High-impact practices, a set of evidence-based, global-standard family planning interventions, offer valuable guidance. For example, couples' communication programmes have demonstrated effectiveness in transforming social norms and improving reproductive health outcomes, as they can have a positive influence on the uptake of modern contraception and help couples achieve their fertility intentions.<sup>57</sup>



Photo: UNFPA/Tajikistan/Nozim Kalandarov

### Policy and enabling environment

To create an enabling legal and policy environment, governments in the Eastern Europe and Central Asia region should embrace family planning as a human right, and, at the same time, as a key tool for building human capital and addressing demographic change. To create an enabling legal and policy environment, governments should adopt a comprehensive approach that explicitly prioritizes family planning in national health strategies and social protection frameworks. This approach includes strengthening supply chains to prevent stockouts, ensuring contraceptive commodity security, reinforcing the role of primary health-care facilities in contraceptive provision, and securing sustainable domestic financing for contraceptive procurement and delivery. Governments should also address challenges arising from reduced donor support by ensuring universal health coverage and prioritizing access to the full range of essential sexual and reproductive health and rights services. These include all nine essential service areas: (1) comprehensive sexuality education; (2) counselling and services for sexual health and well-being; (3) counselling and services for modern contraceptives; (4) abortion care to the full extent of the law and comprehensive post-abortion care; (5) antenatal, childbirth and postnatal care; (6) counselling, diagnosis and treatment services for infertility; (7) prevention and treatment of HIV and other sexually transmitted infections; (8) detecting, preventing and managing reproductive cancers; and (9) detecting, preventing and managing sexual and gender-based violence.<sup>58</sup> Addressing persistent structural and system-level barriers is essential to improving access to, quality of and choice in contraceptive services.

57. Family Planning High Impact Practices, "Promoting healthy couples' communication to improve reproductive health outcomes".

58. UNFPA, *Sexual and reproductive health and rights: An essential element of universal health coverage – Background document for the Nairobi Summit on ICPD25 – Accelerating the promise* (New York, 2019). Available at [https://www.unfpa.org/sites/default/files/pub-pdf/UF\\_SupplementAndUniversalAccess\\_30-online.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/UF_SupplementAndUniversalAccess_30-online.pdf) (accessed on 13 November 2025).

Governments should therefore implement supportive, non-coercive policies that prioritize reproductive autonomy, gender equality and social infrastructure rather than imposing mandates that restrict individual rights. Family planning should be explicitly recognized as a public good within national health strategies, ideally through the development of a comprehensive strategy on sexual and reproductive health and rights with clear targets, budgets and accountability mechanisms. Such a strategy should include securing sustainable domestic financing for contraceptive procurement and delivery, integrating contraceptives into essential-medicines lists and incorporating them into universal health coverage benefit packages.

Governments should focus on ensuring an essential package of sexual and reproductive health interventions that includes a choice of safe and effective contraceptive methods and the provision of accurate information and counselling, including comprehensive, evidence-based sexuality education.<sup>59</sup> To reduce dependence on user fees and external aid, countries and territories should improve domestic tax policies and administration, relying more on tax revenues to finance social protection and health services. Successful approaches include subsidizing target populations and creating large insurance pools to protect against health-related financial risks. Countries and territories that have expanded government health insurance coverage and benefits have succeeded in reducing out-of-pocket household expenditures while increasing public investment in health.<sup>60</sup>

Contraceptive commodity security must be prioritized to ensure the availability and accessibility of contraceptive methods at all levels of care. Frequent stockouts and limited method availability indicate weaknesses in logistics and procurement systems. To effectively eliminate the unmet need for family planning, countries and territories in Eastern Europe and Central Asia should prioritize strengthening the resilience of their supply chains to ensure that essential commodities reach those who need them. It is recommended that governments and partners address persistent weaknesses in supply systems, such as inaccurate forecasting, inefficient ordering procedures and inadequate distribution networks.

Finally, high reliance on pharmacies and limited engagement with formal health-care systems suggest gaps in service integration. Policymakers should strengthen the role of primary health-care facilities in contraceptive provision and ensure that pharmacies operate within regulated frameworks that guarantee quality, affordability and counselling standards. Out-of-pocket payments represent a threat, particularly for individuals without health coverage. Governments should implement targeted subsidies and social protection mechanisms to ensure equitable access to contraceptives for low-income and marginalized groups.

### **Service delivery: Providers as catalysts of rights-based care**

Health-care providers play a pivotal role in shaping the quality and accessibility of family planning services. In the Eastern Europe and Central Asia region, strengthening service delivery and provider training and introducing task-sharing are essential to advancing equitable, people-centred care.

The findings highlight an urgent need to strengthen the quality of service delivery across the region. Governments and programme implementers should prioritize expanding rights-

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59. Ann M. Starrs and others, "Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission", *The Lancet*, vol. 391, No. 10140 (2018). Available at [https://doi.org/10.1016/S0140-6736\(18\)30293-9](https://doi.org/10.1016/S0140-6736(18)30293-9) (accessed on 13 November 2025).

60. Ibid.

based, people-centred counselling at all service delivery points, especially targeting youth and marginalized populations.

Provider-related barriers must also be addressed to ensure equitable and high-quality service provision. To counteract these barriers, comprehensive, rights-based training should be institutionalized for health-care providers within both pre-service and in-service education. Digital innovations can play a pivotal role in achieving this goal. For instance, Virtual Contraceptive Consultation, an online learning platform developed by UNFPA's Regional Office for Eastern Europe and Central Asia in collaboration with the East European Institute for Reproductive Health, provides a scalable, evidence-based model for strengthening provider capacity.<sup>61</sup>

Moreover, training programmes should be standardized and include modules on contraceptive eligibility, side-effect management, method-specific technical skills, up-to-date information on contraceptive safety and effectiveness, and guidance on delivering non-judgmental, culturally sensitive counselling that prioritizes people's autonomy.

Mid-level providers should be formally integrated into family planning service delivery models through task-sharing policies, especially in settings where clinical contact is limited. Such integration would help expand access to counselling and method provision while maintaining quality and informed choice. Policies that promote task-sharing improve access in underserved areas.

### **Individuals' empowerment and access**

The findings underscore the urgent need to place people's autonomy, informed choice and respectful care at the centre of family planning policies and programmes in the Eastern Europe and Central Asia region. A rights-based approach requires not only ensuring the availability of contraceptive methods but also creating an environment in which individuals can make decisions free from coercion, stigma and discrimination.

Demand-side interventions are needed to overcome misinformation, fear of side effects and social stigma. Public health communication strategies must be evidence-based, empathetic and tailored to user concerns.

Comprehensive sexuality education must be expanded, both in schools and through community outreach, to equip adolescents and young adults with the knowledge and confidence to make informed reproductive decisions throughout their lives. Special attention should be given to reaching marginalized populations, including LGBTQ+ individuals, people living with HIV, displaced persons and survivors of gender-based violence, ensuring that services are inclusive, confidential and non-discriminatory.

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61. UNFPA Regional Office for Eastern Europe and Central Asia, *Virtual Contraceptive Consultation (ViC)* (Istanbul, 2016). Available at <https://eeca.unfpa.org/en/publications/virtual-contraceptive-consultation-vic> (accessed on 13 November 2025).

# Bibliography

- Amy, Jean-Jacques, and Michel Thiery. The condom: A turbulent history. *European Journal of Contraception and Reproductive Health Care*, vol. 20, No. 5 (2015).
- Baigry, Maggie Ikinue, and others. Barriers and enablers to young people accessing sexual and reproductive health services in Pacific Island countries and territories: A scoping review. *PLOS ONE*, vol. 18, No. 1 (2023).
- Barriuso-Ortega, Sonia, María Fernández-Hawrylak and Davinia Heras-Sevilla. Sex education in adolescence: A systematic review of programmes and meta-analysis. *Children and Youth Services Review*, vol. 166 (November 2024).
- Beckman, Linda J., and others. Changes in providers' views and practices about emergency contraception with education. *Obstetrics and Gynecology*, vol. 97, No. 6 (June 2001).
- Bertrand, Jane T., and others. Contraceptive method mix: Updates and implications. *Global Health, Science and Practice*, vol. 8, No. 4 (December 2020).
- Britton, Laura E., and others. "When it comes to time of removal, nothing is straightforward": A qualitative study of experiences with barriers to removal of long-acting reversible contraception in Western Kenya. *Contraception: X*, vol. 3 (2021).
- Craig, J. Replacement level fertility and future population growth. *Population Trends*, vol. 78 (Winter 1994).
- De Nadai, Mariane N., and others. Practical training of health care providers in insertion of contraceptive implants: Findings from two Brazilian centres. *The European Journal of Contraception and Reproductive Health Care: The Official Journal of the European Society of Contraception*, vol. 26, No. 6 (2021).
- Eurasian Research Institute. UN population prospects: Case of Central Asia.
- Eurostat. Statistics Explained. Glossary: Replacement level.
- Family Planning 2030. Beyond the numbers: Reframing the dialogue on fertility and population, 5 September 2025.
- Family Planning High Impact Practices. Promoting healthy couples' communication to improve reproductive health outcomes.
- Fauser, Bart C. J. M., and others. Declining global fertility rates and the implications for family planning and family building: An IFFS consensus document based on a narrative review of the literature. *Human Reproduction Update*, vol. 30, No. 2 (2024).

- Festin, Mario Philip R., and others. Moving towards the goals of FP2020: Classifying contraceptives. *Contraception*, vol. 94, No. 4 (October 2016).
- Gietel-Basten, Stuart, Anna Rotkirch and Tomáš Sobotka. Changing the perspective on low birth rates: Why simplistic solutions won't work. *The BMJ*, vol. 379 (2022).
- Haakenstad, Annie, and others. Measuring contraceptive method mix, prevalence, and demand satisfied by age and marital status in 204 countries and territories, 1970–2019: A systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, vol. 400, No. 10348 (July 2022).
- Hardee, Karen, and Sandra Jordan. Advancing rights-based family planning from 2020 to 2030. *Open Access Journal of Contraception*, vol. 12 (2021).
- Jonas, Kim, and others. Rumours, myths, and misperceptions as barriers to contraceptive use among adolescent girls and young women in South Africa. *Frontiers in Reproductive Health*, vol. 4 (September 2022).
- Marcell, Arik V., and others. Males' awareness of female and male contraception methods, information, outreach, and acquisition locations in Abidjan, Côte d'Ivoire, Nairobi, Kenya, and Lagos, Nigeria. *Journal of Adolescent Health*, vol. 71, No. 3 (2022).
- Moumne, Olivia, and others. Qualitative exploration of contraceptive knowledge in men and women. *Southern Medical Journal*, vol. 117, No. 12 (2024).
- Niland, Rachel, Clodagh Flinn and Finiki Nearchou. Assessing the role of school-based sex education in sexual health behaviours: A systematic review. *Cogent Psychology*, vol. 11, No. 1 (2024).
- Ouahid, Hajar, and others. The influence of gender norms on women's sexual and reproductive health outcomes: A systematic review. *BMC Women's Health*, vol. 25, No. 1 (2025).
- Rahman, Md Mizanur, and others. Reversing fertility decline in Japan with foreign pro-natalist policies, 1990–2035: A systematic review and secondary data analysis. *The Lancet Regional Health – Western Pacific*, vol. 59 (2025).
- Rechel, Bernd, and Martin McKee. Health reform in Central and Eastern Europe and the former Soviet Union. *The Lancet*, vol. 374 (2009).
- Senderowicz, Leigh. "I was obligated to accept": A qualitative exploration of contraceptive coercion. *Social Science and Medicine*, vol. 239 (October 2019).
- Soin, Komol S., and others. Health workers' values and preferences regarding contraceptive methods globally: A systematic review. *Contraception*, vol. 111 (July 2022).
- Solo, Julie, and Mario Festin. Provider bias in family planning services: A review of its meaning and manifestations. *Global Health: Science and Practice*, vol. 7, No. 3 (September 2019).
- Starrs, Ann M., and others. Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. *The Lancet*, vol. 391, No. 10140 (2018).
- UNFPA. Family planning.  
 \_\_\_\_\_. *The holistic framework for human rights-based family planning*. UNFPA Technical Brief. New York, 2023.

- \_\_\_\_\_. *Human rights-based approach to family planning*. UNFPA Support Tool. New York, 2024.
- \_\_\_\_\_. *Sexual and reproductive health and rights: An essential element of universal health coverage – Background document for the Nairobi Summit on ICPD25 – Accelerating the promise*. New York, 2019.
- UNFPA Malaysia. *Ensuring Reproductive Rights and Choices: A Human Capital Perspective on Family Planning in Malaysia*. Kuala Lumpur, 2023.
- UNFPA Regional Office for Eastern Europe and Central Asia. *Advancing contraceptive choices and supplies for universal access to family planning in Eastern Europe and Central Asia: UNFPA Regional Contraceptive Security Strategic Framework 2017-2021*. Istanbul, 2017.
- \_\_\_\_\_. *Family planning: Facts and trends in Eastern Europe and Central Asia*. Istanbul, 2019.
- \_\_\_\_\_. *Roadmap for Ending the Unmet Need for Family Planning in Eastern Europe and Central Asia by 2030*. Istanbul, 2024.
- \_\_\_\_\_. *Virtual Contraceptive Consultation (ViC)*. Istanbul, 2016.
- UNFPA Regional Office for Eastern Europe and Central Asia and International Planned Parenthood Federation European Network. *Key factors influencing contraceptive use in Eastern Europe and Central Asia: Findings from a qualitative study in 7 countries and recommendations for improving access to modern contraception in the region*. Istanbul and Brussels, 2012.
- United Nations Department of Economic and Social Affairs. *Contraceptive use by method 2019: Data booklet*. New York, 2019.
- \_\_\_\_\_. *The New Landscape of Fertility and Family Planning 30 Years after Cairo and Beijing*. UN DESA Policy Brief No. 172, 13 March 2025.
- \_\_\_\_\_. *World family planning 2022: Meeting the changing needs for family planning – Contraceptive use by age and method*. New York, 2022.
- United Nations Economic Commission for Europe and UNFPA. *Fulfilling the Potential of Present and Future Generations: Report on ICPD Programme of Action Implementation in the UNECE Region*. Geneva, 2018.
- United Nations Population Division. *Family Planning Data*.
- Wang, Ziliang, and others. Attitudes and practices related to intrauterine devices for nulliparous women among Chinese health care providers. *Reproductive Health*, vol. 16, No. 1 (2019).
- Wollum, Alexandra, and others. Characterizing provider bias in contraceptive care in Tanzania and Burkina Faso: A mixed-methods study. *Social Science and Medicine*, vol. 348 (May 2024).
- World Health Organization (WHO). *Family planning/contraception methods*, 3 July 2025.
- \_\_\_\_\_. *Quality of care in contraceptive information and services, based on human rights standards: A checklist for health care providers*. Geneva, 2017.
- WHO Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs. *Family Planning: A Global Handbook for Providers*, 3rd ed. Geneva and Baltimore, 2018.

# Annex A. Standard operating procedures for the focus group discussions

A. Preparation	
To do: Complete informed-consent forms and distribute questionnaire	
Essential items: Informed-consent forms and questionnaires	
Informed consent	<p>Link to informed-consent form (digital version)  <a href="#">general population</a> / <a href="#">health-care professionals</a></p> <p>A printed copy for every participant to sign before the start of the focus group.</p> <p>The group facilitator gives a brief explanation to the participants and invites them to ask questions if they need more information.</p> <p>NOTE: This is a general informed-consent form as used in Europe. Please adapt the information to your context.</p>
Questionnaire	<p>Link to questionnaire (digital version):  <a href="#">general population</a> / <a href="#">health-care professionals</a></p> <p>Every participant fills in the questionnaire.</p> <p>The group facilitator gives a brief explanation to the participants and invites them to ask questions if they need more information.</p> <p>NOTE: These questions and the answer categories provided are used in the quantitative part of this study. We will provide an English version in Word with the possibility for translation.</p>
<p><i>Both forms will be collected before the start of the discussion and stored with the transcripts of the focus groups. These documents will also be submitted to the ANSER Network for further analysis and processing.</i></p>	

B. Introduction	
<p>To do: (1) Introduce UNFPA and the current research. (2) Get permission to make an audio recording. (3) Set ground rules.</p> <p>Essential items: (Optional) Lined paper to put on the table or on the wall</p>	
Brief introduction to the research (example)	Welcome to the UNFPA focus group on contraception use.
About UNFPA	<p><b>Brief introduction to UNFPA</b></p> <p>UNFPA is the part of the United Nations that focuses on sexual and reproductive health care worldwide. Our goal is to create a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. To achieve these goals, we strive to end unmet need for family planning, preventable maternal death, and gender-based violence and harmful practices, including child marriage and female genital mutilation by 2030.</p>
Research / Purpose of the research	<p><b>Research context</b></p> <p>Research by the United Nations shows that there are significant regional differences in access to and use of contraception, including in Eastern Europe and Central Asia. To better understand why this is the case, we have developed a study on contraceptive use in this region. We aim to explore the reasons why people do or do not use contraception, focusing on both the demand side (the users) and the supply side (health-care workers).</p>
Research process	<p>This focus group represents the third phase of this study. The first phase involved a literature review, where we examined the scientific literature to identify the factors that influence people's decisions on whether to use contraception. The second phase consisted of an online questionnaire on this topic, which was distributed to both the general population and health-care professionals. In this third phase, we would like to delve deeper into the results of the questionnaire by engaging in discussions with groups of people.</p>
About focus group discussions	<p>We are conducting this study using focus groups. In a focus group, we bring together a group of people to discuss a specific topic. In this case, the focus is on contraception and the reasons for using or not using it. Through a series of questions, we invite participants to engage in conversation and debate with one another.</p>
Optional: About recording	<p>These discussions will be recorded so that we can listen to them later and transcribe them. The transcribed conversations will then be translated into English and further analysed by our research partner in Belgium.</p>
Optional: Asking permission to make an audio recording of the conversation	<p>Before we proceed, I would like to ask if you agree to have this conversation recorded. We assure you that these recordings will be used only for the purposes of this research and will be destroyed after the study is completed. In the transcribed texts, any references to you, other participants or individuals in your environment will be removed. References to any organizations will also be deleted. This is to ensure that your privacy is fully protected.</p>

B. Introduction	
About recording	<p>After feedback from local partners, we agreed that the audio recording would be optional. The reason for this is the potential resistance from participants to being recorded or the possibility that participants might provide more socially desirable responses if they are being recorded. To avoid this form of bias, we decided to leave the decision to record or not to the local facilitators. However, it was agreed that the facilitators would take detailed field notes on the focus group in order to gather qualitative data.</p>
Setting ground rules	<p>Before we begin the actual discussion, we would like to point out a few rules to ensure that everyone feels safe and comfortable participating in the conversation. (The list is indicative.)</p> <p><b>Confidentiality:</b> What is shared in this group stays in this group. Please respect the privacy of others and do not share any information or opinions expressed here outside of this discussion.</p> <p><b>Respectful communication:</b> Everyone's opinions and experiences are valid. Please be respectful and considerate when others are speaking, even if you disagree with their views.</p> <p><b>One speaker at a time:</b> To ensure that everyone is heard, please allow one person to speak at a time. Avoid interrupting others, and feel free to contribute when it is your turn.</p> <p><b>Honesty and openness:</b> We encourage you to share your honest opinions and experiences. This is a safe space for open discussion, and your insights are valuable.</p> <p><b>No judgment:</b> This is a nonjudgmental space. There are no right or wrong answers, and all perspectives are welcome.</p> <p><b>Stay on topic:</b> Please keep the discussion focused on the topic of contraceptives. If the conversation strays, the moderator will help guide it back.</p> <p><b>Participation is voluntary:</b> You are encouraged to participate, but you are not required to answer every question. If you feel uncomfortable at any point, you may choose to pass or withdraw from the discussion.</p> <p><b>Recording consent (optional):</b> Remember that this session is being recorded for research purposes. If you are uncomfortable with this at any point, please let the moderator know.</p>
Optional	<p>You can ensure that the established rules are visible to the participants so they can be referred to during the discussions.</p>

C. Breaking the ice	
To do: Get to know each other	
Essential items: Nothing	
Purpose	By asking a simple question, the participants are given an opportunity to get to know each other. Additionally, the topic is introduced via a straightforward question. It is important that everyone answers this question, including the facilitators of the group.
General population	Q. Could you briefly introduce yourself, including who you are, your age, what kind of work you do, whether you have children, and share the first word that comes to mind when you think about the topic of contraception?
Health-care professionals	Q. Could you briefly introduce yourself, including who you are, your age, your profession, your professional experience with contraception, and share the first word that comes to mind when you think about the topic of contraception?
Optional	The “first words” can be written on a flip chart or whiteboard.  (A photograph of resulting word cloud can support you when taking notes.)

D. Gathering general knowledge	
To do: Post-it exercise	
Essential items: (1) A4 sheets of paper with a drawing, picture or text of the different methods of contraception; (2) Tape, Post-it notes, pens, etc. in four different colours	
General population	<p>This brief exercise introduces the topic to the participants.</p> <p>Each participant receives Post-it notes, tape, pens, etc. in four different colours. Distribute A4 sheets of paper around the room, each showing a different method of contraception (through photos, drawings, etc.). Ask the participants to label each method of contraception with a sticker based on the following criteria:</p> <p><b>Red:</b> Unknown, never heard of it</p> <p><b>Orange:</b> Heard of it but never used it</p> <p><b>Yellow:</b> Heard of it, used it in the past but no longer use it</p> <p><b>Green:</b> Currently using it</p> <p>Afterward, invite the participants to share more about their choices.</p>
Prompts	<p>Reason for choosing method</p> <p>Reason for not choosing method</p> <p>Reason for no longer using method</p>
Important topics	<p>Barriers to / facilitators of the use of modern contraception</p> <p>Price, availability, reliability of the method</p> <p>Perceived quality and side effects of the method</p> <p>Who decides on the use of contraception? Personal autonomy</p>

D. Gathering general knowledge	
Important topics	<p>Influence of religion, socioeconomic factors, family and friends, attitudes of health-care professionals</p> <p>Experiences of the participants: ease of use, comfort</p> <p>Why choose a natural method of contraception like withdrawal, periodic abstinence, the lactational amenorrhea method?</p>
Health-care professionals	<p>Provide each participant with five Post-it notes.</p> <p>Ask the participants to number them from 1 to 5.</p> <p>Distribute A4 sheets of paper around the room, each showing a different form of contraception (using photos, drawings, etc.).</p> <p>Ask the participants to label the five forms of contraception that their patients use most frequently.</p>
Prompts	<p>Reason for the popularity of a certain method</p> <p>Reason for the lack of popularity of a certain method</p>
Important topics	<p>Barriers to / facilitators of the use of modern contraception</p> <p>Price, availability, reliability of the method</p> <p>Perceived quality and side effects of the method</p> <p>Who decides on the use of contraception? Personal autonomy</p> <p>Influence of religion, socioeconomic factors, family and friends, attitudes of health-care professionals</p> <p>Experiences of the participants: ease of use, comfort</p> <p>Why choose a natural method of contraception like withdrawal, periodic abstinence, the lactational amenorrhea method?</p> <p>Unmet need?</p>
Materials	File with drawings of different methods of contraception

E. Why participants use / do not use various methods of contraception	
<p>To do: Conduct a guided discussion (10–15 minutes)</p> <p>Essential items: A flip board, a large piece of paper or a whiteboard with two columns, labelled “Use” and “Do not use” or “Prescribe” and “Do not prescribe”</p>	
General population	<p>What are your main reasons for using or not using methods of contraception? (Note the topics on the board.)</p>
Prompts	<p>Why address this reason?</p> <p>Agree/disagree</p> <p>Invite participants to share their ideas.</p> <p>If the participants are cautious or timid about sharing their ideas, you can invite someone to share their ideas.</p>

**E. Why participants use / do not use various methods of contraception**

<p>Important topics</p>	<p>Barriers to / facilitators of the use of modern contraception</p> <p>Price, availability, reliability of the method</p> <p>Perceived quality and side effects of the method</p> <p>Who decides on the use of contraception? Personal autonomy</p> <p>Influence of religion, socio-economic factors, family and friends, attitudes of health-care professionals</p> <p>Experiences of the participants: ease of use, comfort</p> <p>Why choose a natural method of contraception like withdrawal, periodic abstinence, the lactational amenorrhea method?</p>
<p>Health-care professionals</p>	<p>What are your three main reasons for NOT prescribing contraception to someone?</p> <p>What are your three main reasons for prescribing contraception to someone?</p> <p>(Note down the topics on the board.)</p>
<p>Prompts</p>	<p>Why address this reason?</p> <p>Agree/disagree</p> <p>Invite participants to share their ideas.</p> <p>If the participants are cautious or timid about sharing their ideas, you can invite someone to share their ideas</p>
<p>Important topics</p>	<p>Barriers to / facilitators of the use of modern contraception</p> <p>Price, availability, reliability of the method</p> <p>Perceived quality and side effects of the method</p> <p>Who decides on the use of contraception? Personal autonomy</p> <p>Influence of religion, socioeconomic factors, family and friends, attitudes of health-care professionals</p> <p>Experiences of the participants: ease of use, comfort</p> <p>Why choose a natural method of contraception like withdrawal, periodic abstinence, the lactational amenorrhea method?</p>

**F. What is the perfect method?**

To do: Mind dump on the perfect method of contraception

Essential items: Nothing

<p>Purpose</p>	<p>This exercise follows up on the previous one. After participants have shared their motivations for choosing or not choosing contraception or a particular method, we want to explore what is necessary or important for them in a specific form of contraception. We will not distinguish between modern and natural methods here but instead will focus on the needs and expectations people have regarding contraception. Everyone, including those who do not use contraception, will participate in this exercise, as their choice may be linked to barriers. This exercise also aims to uncover topics that may not have been addressed in the previous exercises.</p>
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F. What is the perfect method?	
General population	What does the perfect method of contraception look like according to you? What characteristics does it have, how is it used, and how does it work? Also consider aspects like price, where it can be obtained and other relevant factors.
Health-care professionals	What does the perfect method of contraception look like for your patients? What characteristics would it have, how would it be used and how would it work? Also consider factors such as price, availability and other relevant aspects.
Prompts	<p>Why address this reason?</p> <p>Agree/disagree</p> <p>Invite participants to share their ideas.</p> <p>If the participants are cautious or timid about sharing their ideas, you can invite someone to share their ideas.</p>
Important topics	<p>Barriers to / facilitators of the use of modern contraception</p> <p>Price, availability, reliability of the method</p> <p>Perceived quality and side effects of the method</p> <p>Who decides on the use of contraception? Personal autonomy</p> <p>Influence of religion, socioeconomic factors, family and friends, attitudes of health-care professionals</p> <p>Experiences of the participants: ease of use, comfort</p> <p>Why choose a natural method of contraception like withdrawal, periodic abstinence, the lactational amenorrhea method?</p>

G. Closing
<p>To do: Get to know each other</p> <p>Essential items: None</p>

## Annex B. Contraceptive use, awareness and provider attitudes across population subgroups

**Table B1.** Logistic regression of sociodemographic factors on the use of contraceptives

Sociodemographic factors	B	S.E.	Sig.	Exp(B)
Age	0.016	0.005	0.003	1.016
Fertility setting (Ref.: Low)	-0.262	0.118	0.027	0.769
Born in the country or territory you are living in? (Ref.: No)	0.480	0.154	0.002	1.617
Gender (Ref.: Women)			0.433	
Man	0.020	0.302	0.947	1.020
Agender	-20.505	14,548.977	0.999	0.000
Cisgender	0.649	0.716	0.364	1.914
Non-binary	0.097	0.827	0.907	1.102
Unknown	-0.627	0.315	0.047	0.534
Sexual orientation (Ref.: hetero)			0.000	
Lesbian	-2.637	1.057	0.013	0.072
Bisexual	0.170	0.147	0.248	1.185
Asexual	-0.384	0.556	0.490	0.681
Unknown	-0.661	0.151	0.000	0.516
Are you religious? (Ref.: No)	-0.270	0.078	0.001	0.764
Civil status (Ref.: Married)			0.000	
In a relationship	0.624	0.109	0.000	1.867
single	0.191	0.090	0.034	1.211
Unknown	0.747	0.215	0.001	2.110
Education (Ref. High)			0.009	
Intermediate	-0.208	0.086	0.016	0.813
None or basic	-0.459	0.386	0.234	0.632
Unknown	-0.674	0.267	0.012	0.510

Sociodemographic factors	B	S.E.	Sig.	Exp(B)
Receive a salary (Ref. No)	0.115	0.086	0.182	1.122
Economic status (Ref.: Difficult)			0.025	
Neither easy nor difficult	0.239	0.092	0.009	1.270
Easy	0.231	0.106	0.029	1.260
Belong to a vulnerable group (Ref. No)	0.314	0.105	0.003	1.369
Constant	-1.297	0.249	0.000	0.273
Dependent variable: Do you use contraceptives?				
N	3,265			
% Correct predicted	59.80%			

**Table B2.** Knowledge of contraceptive method, by type of methods used

Variable	Categories	Non-users	Users of modern methods	Users of natural methods	Total
Which contraceptive methods do you know well? (Knowing well means knowing what the method looks like and/or how it is used.)					
Modern methods	Oral contraceptives (pills)	1,273 (69.6%)	1,056 (77.9%)	43 (70.5%)	2,384 (73.0%)
	Intrauterine device (IUD)	889 (48.6%)	673 (49.7%)	36 (59.0%)	1,603 (49.1%)
	Emergency contraceptive pills	890 (48.7%)	769 (56.8%)	38 (62.3%)	1,703 (52.2%)
	Cervical cap	206 (11.3%)	158 (11.7%)	5 (8.2%)	369 (11.3%)
	Male condoms	1,436 (78.6%)	1,237 (91.3%)	49 (80.3%)	2,732 (83.7%)
	Female condoms	553 (30.3%)	442 (32.6%)	16 (26.2%)	1,015 (31.1%)
	Implant	198 (10.8%)	194 (14.3%)	11 (18.0%)	404 (12.4%)
	Injection	228 (12.5%)	188 (13.9%)	11 (18.0%)	427 (13.1%)
	Diaphragm with spermicide	156 (8.5%)	139 (10.3%)	11 (18.0%)	306 (9.4%)
	Patch	213 (11.7%)	176 (13.0%)	10 (16.4%)	400 (12.3%)
	Spermicide	154 (8.4%)	158 (11.7%)	14 (23.0%)	327 (10.0%)
	Vaginal ring	291 (15.9%)	220 (16.2%)	11 (18.0%)	524 (16.0%)
	Female sterilization	582 (31.8%)	462 (34.1%)	26 (42.6%)	1,071 (32.8%)
	Male sterilization (vasectomy)	634 (34.7%)	553 (40.8%)	27 (44.3%)	1,216 (37.2%)

Variable	Categories	Non-users	Users of modern methods	Users of natural methods	Total
Natural methods	Fertility awareness-based methods (standard days method, mucus method, basal temperature method, other)	528 (28.9%)	377 (27.8%)	37 (60.7%)	947 (29.0%)
	Lactational amenorrhea method (while breastfeeding)	236 (12.9%)	184 (13.6%)	16 (26.2%)	436 (13.4%)
	Periodic abstinence	276 (15.1%)	250 (18.5%)	18 (29.5%)	547 (16.8%)
	Withdrawal	768 (42.0%)	619 (45.7%)	48 (78.7%)	1441 (44.1%)
Other	Other	28 (1.5%)	9 (0.7%)		39 (1.2%)
	I don't know	99 (5.4%)	6 (0.4%)	2 (3.3%)	108 (3.3%)

**Table B3.** Perceived reliability of contraceptive methods, by current contraceptive use

Variable	Categories	Non-users	Users of modern methods	Users of natural methods	Total
According to you, which of the following methods are the most reliable in preventing pregnancy?					
Modern methods	Oral contraceptives (pills)	693 (37.9%)	671 (49.5%)	26 (42.6%)	1,400 (42.9%)
	Intrauterine device (IUD)	467 (25.5%)	450 (33.2%)	25 (41.0%)	945 (28.9%)
	Emergency contraceptive pills	150 (8.2%)	120 (8.9%)	11 (18.0%)	282 (8.6%)
	Cervical cap	43 (2.4%)	21 (1.5%)	4 (6.6%)	68 (2.1%)
	Male condoms	856 (46.8%)	804 (59.3%)	27 (44.3%)	1,694 (51.9%)
	Female condoms	195 (10.7%)	150 (11.1%)	7 (11.5%)	354 (10.8%)
	Implant	85 (4.6%)	106 (7.8%)	11 (18.0%)	202 (6.2%)
	Injection	67 (3.7%)	75 (5.5%)	5 (8.2%)	147 (4.5%)
	Diaphragm with spermicide	26 (1.4%)	43 (3.2%)	3 (4.9%)	72 (2.2%)
	Patch	29 (1.6%)	39 (2.9%)	2 (3.3%)	70 (2.1%)
	Spermicide	20 (1.1%)	16 (1.2%)	2 (3.3%)	38 (1.2%)
	Vaginal ring	45 (2.5%)	52 (3.8%)	1 (4.6%)	99 (3.0%)
	Female sterilization	460 (25.2%)	457 (33.7%)	29 (47.5%)	948 (29.0%)
	Male sterilization (vasectomy)	520 (28.4%)	538 (39.7%)	32 (52.5%)	1,095 (33.5%)

Variable	Categories	Non-users	Users of modern methods	Users of natural methods	Total
Natural methods	Fertility awareness-based methods (standard days method, mucus method, basal temperature method, other)	54 (3.0%)	32 (2.4%)	8 (13.1%)	95 (2.9%)
	Lactational amenorrhea method (while breastfeeding)	11 (0.6%)	8 (0.6%)	1 (1.6%)	20 (0.6%)
	Periodic abstinence	50 (2.7%)	37 (2.7%)	5 (8.2%)	92 (2.8%)
	Withdrawal	102 (5.6%)	46 (3.4%)	9 (14.8%)	157 (4.8%)
Other	Other	44 (2.4%)	29 (2.1%)		76 (2.3%)
	I don't know	254 (13.9%)	69 (5.1%)	2 (3.3%)	326 (10.0%)
	None of the above	66 (3.6%)	9 (0.7%)	1 (1.6%)	77 (2.4%)

**Table B4.** Health-care providers' perceptions of contraceptive method eligibility across subgroups

Categories	Individuals with limited income	Migrants	Single women without a steady partner	Married women who do not want to have children	Unmarried 18-year-old women	Married 18-year-old women	Women with 1 child	Women with 3 children
It is the choice of the patient								
Individuals with limited income	<b>47.1%</b>	<b>-0.6%</b>	<b>4.3%</b>	<b>6.0%</b>	<b>12.6%</b>	1.5%	-2.9%	3.0%
Migrants	<b>0.6%</b>	<b>47.7%</b>	<b>4.9%</b>	<b>6.6%</b>	<b>13.2%</b>	2.1%	-2.3%	3.6%
Single women without a steady partner	<b>-4.3%</b>	<b>-4.9%</b>	<b>42.8%</b>	1.7%	<b>8.3%</b>	-2.8%	<b>-7.2%</b>	-1.3%
Married women who do not want to have children	<b>-6.0%</b>	<b>-6.6%</b>	-1.7%	<b>41.1%</b>	<b>6.6%</b>	<b>-4.5%</b>	<b>-8.9%</b>	-3.0%
Unmarried 18-year-old women	<b>-12.6%</b>	<b>-13.2%</b>	<b>-8.3%</b>	<b>-6.6%</b>	<b>34.5%</b>	<b>-11.1%</b>	<b>-15.5%</b>	<b>-9.6%</b>
Married 18-year-old women	-1.5%	-2.1%	2.8%	<b>4.5%</b>	<b>11.1%</b>	<b>45.6%</b>	<b>-4.4%</b>	1.5%
Women with 1 child	2.9%	2.3%	<b>7.2%</b>	<b>8.9%</b>	<b>15.5%</b>	<b>4.4%</b>	<b>50.0%</b>	<b>5.9%</b>
Women with 3 children	-3.0%	-3.6%	1.3%	3.0%	<b>9.6%</b>	-1.5%	<b>-5.9%</b>	<b>44.1%</b>

Categories	Individuals with limited income	Migrants	Single women without a steady partner	Married women who do not want to have children	Unmarried 18-year-old women	Married 18-year-old women	Women with 1 child	Women with 3 children
<b>IUD</b>								
Individuals with limited income	<b>26.5%</b>	<b>8.9%</b>	<b>17.7%</b>	<b>-10.2%</b>	<b>23.9%</b>	<b>20.0%</b>	<b>7.8%</b>	<b>-14.3%</b>
Migrants	<b>-8.9%</b>	<b>17.6%</b>	<b>8.8%</b>	<b>-19.1%</b>	<b>15.0%</b>	<b>11.1%</b>	-1.1%	<b>-23.2%</b>
Single women without a steady partner	<b>-17.7%</b>	<b>-8.8%</b>	<b>8.8%</b>	<b>-27.9%</b>	<b>6.2%</b>	2.3%	<b>-9.9%</b>	<b>-32.0%</b>
Married women who do not want to have children	<b>10.2%</b>	<b>19.1%</b>	<b>27.9%</b>	<b>36.7%</b>	<b>34.1%</b>	<b>30.2%</b>	<b>18.0%</b>	-4.1%
Unmarried 18-year-old women	<b>-23.9%</b>	<b>-15.0%</b>	<b>-6.2%</b>	<b>-34.1%</b>	<b>2.6%</b>	<b>-3.9%</b>	<b>-16.1%</b>	<b>-38.2%</b>
Married 18-year-old women	<b>-20.0%</b>	<b>-11.1%</b>	-2.3%	<b>-30.2%</b>	<b>3.9%</b>	<b>6.5%</b>	<b>-12.2%</b>	<b>-34.3%</b>
Women with 1 child	<b>-7.8%</b>	1.1%	<b>9.9%</b>	<b>-18.0%</b>	<b>16.1%</b>	<b>12.2%</b>	<b>18.7%</b>	<b>-22.1%</b>
Women with 3 children	<b>14.3%</b>	<b>23.2%</b>	<b>32.0%</b>	4.1%	<b>38.2%</b>	<b>34.3%</b>	<b>22.1%</b>	<b>40.8%</b>
<b>Condoms</b>								
Individuals with limited income	<b>34.2%</b>	<b>-7.6%</b>	<b>-16.6%</b>	<b>13.8%</b>	<b>-22.5%</b>	-4.5%	4.5%	<b>14.4%</b>
Migrants	<b>7.6%</b>	<b>41.8%</b>	<b>-9.0%</b>	<b>21.4%</b>	<b>-14.9%</b>	3.1%	<b>12.1%</b>	<b>22.0%</b>
Single women without a steady partner	<b>16.6%</b>	<b>9.0%</b>	<b>50.8%</b>	<b>30.4%</b>	<b>-5.9%</b>	<b>12.1%</b>	<b>21.1%</b>	<b>31.0%</b>
Married women who do not want to have children	<b>-13.8%</b>	<b>-21.4%</b>	<b>-30.4%</b>	<b>20.4%</b>	<b>-36.3%</b>	<b>-18.3%</b>	<b>-9.3%</b>	0.6%
Unmarried 18-year-old women	<b>22.5%</b>	<b>14.9%</b>	<b>5.9%</b>	<b>36.3%</b>	<b>56.7%</b>	<b>18.0%</b>	<b>27.0%</b>	<b>36.9%</b>
Married 18-year-old women	4.5%	-3.1%	<b>-12.1%</b>	<b>18.3%</b>	-18.0%	<b>38.7%</b>	<b>9.0%</b>	<b>18.9%</b>
Women with 1 child	-4.5%	<b>-12.1%</b>	<b>-21.1%</b>	<b>9.3%</b>	<b>-27.0%</b>	<b>-9.0%</b>	<b>29.7%</b>	<b>9.9%</b>
Women with 3 children	<b>-14.4%</b>	<b>-22.0%</b>	<b>-31.0%</b>	-0.6%	<b>-36.9%</b>	<b>-18.9%</b>	<b>-9.9%</b>	<b>19.8%</b>
<b>Contraceptive pills</b>								
Individuals with limited income	15.0%	2.3%	2.5%	<b>-9.7%</b>	<b>-5.3%</b>	<b>-8.5%</b>	<b>-8.4%</b>	-4.3%

Categories	Individuals with limited income	Migrants	Single women without a steady partner	Married women who do not want to have children	Unmarried 18-year-old women	Married 18-year-old women	Women with 1 child	Women with 3 children
Migrants	-2.3%	12.7%	0.2%	<b>-12.0%</b>	<b>-7.6%</b>	<b>-10.8%</b>	<b>-10.7%</b>	<b>-6.6%</b>
Single women without a steady partner	-2.5%	-0.2%	12.5%	<b>-12.2%</b>	<b>-7.8%</b>	<b>-11.0%</b>	<b>-10.9%</b>	<b>-6.8%</b>
Married women who do not want to have children	<b>9.7%</b>	<b>12.0%</b>	<b>12.2%</b>	24.7%	<b>4.4%</b>	1.2%	1.3%	<b>5.4%</b>
Unmarried 18-year-old women	<b>5.3%</b>	<b>7.6%</b>	<b>7.8%</b>	<b>-4.4%</b>	20.3%	-3.2%	-3.1%	<b>1.0%</b>
Married 18-year-old women	<b>8.5%</b>	<b>10.8%</b>	<b>11.0%</b>	-1.2%	3.2%	23.5%	0.1%	<b>4.2%</b>
Women with 1 child	<b>8.4%</b>	<b>10.7%</b>	<b>10.9%</b>	-1.3%	3.1%	-0.1%	23.4%	<b>4.1%</b>
Women with 3 children	4.3%	<b>6.6%</b>	<b>6.8%</b>	<b>-5.4%</b>	<b>-1.0%</b>	<b>-4.2%</b>	<b>-4.1%</b>	19.3%
<b>Implants</b>								
Individuals with limited income	5.4%	-1.0%	1.5%	<b>-11.9%</b>	<b>2.8%</b>	0.1%	-0.8%	<b>-11.2%</b>
Migrants	1.0%	6.4%	<b>2.5%</b>	<b>-10.9%</b>	<b>3.8%</b>	1.1%	0.2%	<b>-10.2%</b>
Single women without a steady partner	-1.5%	<b>-2.5%</b>	3.9%	<b>-13.4%</b>	1.3%	-1.4%	-2.3%	<b>-12.7%</b>
Married women who do not want to have children	<b>11.9%</b>	<b>10.9%</b>	<b>13.4%</b>	17.3%	<b>14.7%</b>	<b>12.0%</b>	<b>11.1%</b>	0.7%
Unmarried 18-year-old women	<b>-2.8%</b>	<b>-3.8%</b>	-1.3%	<b>-14.7%</b>	2.6%	<b>-2.7%</b>	<b>-3.6%</b>	<b>-14.0%</b>
Married 18-year-old women	-0.1%	-1.1%	1.4%	<b>-12.0%</b>	<b>2.7%</b>	5.3%	-0.9%	<b>-11.3%</b>
Women with 1 child	0.8%	-0.2%	2.3%	<b>-11.1%</b>	<b>3.6%</b>	0.9%	6.2%	<b>-10.4%</b>
Women with 3 children	<b>11.2%</b>	<b>10.2%</b>	<b>12.7%</b>	-0.7%	<b>14.0%</b>	<b>11.3%</b>	<b>10.4%</b>	16.6%
<b>Fertility awareness-based methods</b>								
Individuals with limited income	9.6%	<b>3.2%</b>	<b>3.9%</b>	<b>3.4%</b>	1.4%	-1.6%	0.0%	1.8%
Migrants	<b>-3.2%</b>	6.4%	0.7%	0.2%	-1.8%	<b>-4.8%</b>	<b>-3.2%</b>	-1.4%
Single women without a steady partner	<b>-3.9%</b>	-0.7%	5.7%	-0.5%	-2.5%	<b>-5.5%</b>	<b>-3.9%</b>	-2.1%

Categories	Individuals with limited income	Migrants	Single women without a steady partner	Married women who do not want to have children	Unmarried 18-year-old women	Married 18-year-old women	Women with 1 child	Women with 3 children
Married women who do not want to have children	<b>-3.4%</b>	-0.2%	0.5%	6.2%	-2.0%	<b>-5.0%</b>	<b>-3.4%</b>	-1.6%
Unmarried 18-year-old women	-1.4%	1.8%	2.5%	2.0%	8.2%	<b>-3.0%</b>	-1.4%	0.4%
Married 18-year-old women	1.6%	<b>4.8%</b>	<b>5.5%</b>	<b>5.0%</b>	<b>3.0%</b>	11.2%	1.6%	<b>3.4%</b>
Women with 1 child	0.0%	<b>3.2%</b>	<b>3.9%</b>	<b>3.4%</b>	1.4%	-1.6%	9.6%	1.8%
Women with 3 children	-1.8%	1.4%	2.1%	1.6%	-0.4%	<b>-3.4%</b>	-1.8%	7.8%
None								
Individuals with limited income	3.2%	-1.4%	-1.0%	0.2%	<b>-4.1%</b>	<b>-3.1%</b>	-1.3%	0.4%
Migrants	1.4%	4.6%	0.4%	1.6%	<b>-2.7%</b>	-1.7%	0.1%	1.8%
Single women without a steady partner	1.0%	-0.4%	4.2%	1.2%	<b>-3.1%</b>	-2.1%	-0.3%	1.4%
Married women who do not want to have children	-0.2%	-1.6%	-1.2%	3.0%	<b>-4.3%</b>	<b>-3.3%</b>	-1.5%	0.2%
Unmarried 18-year-old women	<b>4.1%</b>	<b>2.7%</b>	<b>3.1%</b>	<b>4.3%</b>	7.3%	1.0%	<b>2.8%</b>	<b>4.5%</b>
Married 18-year-old women	<b>3.1%</b>	1.7%	2.1%	<b>3.3%</b>	-1.0%	6.3%	1.8%	<b>3.5%</b>
Women with 1 child	1.3%	-0.1%	0.3%	1.5%	<b>-2.8%</b>	-1.8%	4.5%	1.7%
Woman with 3 children	-0.4%	-1.8%	-1.4%	-0.2%	<b>-4.5%</b>	<b>-3.5%</b>	-1.7%	2.8%
* Negative percentages indicate a lower likelihood of being eligible for certain methods compared with the reference group.								
** Bold numbers indicate statistically significant differences.								

**Table B5.** Scores for perceived reliability of contraceptive method, by fertility setting

Variable	Categories	Low-fertility setting	High-fertility setting	Total	Contraceptive effectiveness:	
					Consistent and correct use*	As commonly used*
In your opinion, which of the following methods are the most reliable in preventing pregnancy?						
Modern methods	Oral contraceptives (pills)	1,276 (44.7%)	124 (30.3%)	1,400 (42.9%)	0.3	7
	Intrauterine device (IUD)	813 (28.5%)	132 (32.3%)	945 (28.9%)	0.5–0.6	0.7–0.8
	Emergency contraceptive pills	261 (9.1%)	21 (5.1%)	282 (8.6%)		
	Cervical cap	58 (2.0%)	10 (2.4%)	68 (2.1%)	9–26	16–32
	Male condoms	1,511 (52.9%)	183 (44.7%)	1,694 (51.9%)	2	13
	Female condoms	315 (11.0%)	39 (9.5%)	354 (10.8%)	5	21
	Implant	175 (6.1%)	27 (6.6%)	202 (6.2%)	0.1	0.1
	Injection	132 (4.6%)	15 (3.7%)	147 (4.5%)	0.05–0.2	3–4
	Diaphragm with spermicide	71 (2.5%)	1 (0.2%)	72 (2.2%)	16	17
	Patch	64 (2.2%)	6 (1.5%)	70 (2.1%)	0.3	7
	Spermicide	35 (1.2%)	3 (0.7%)	38 (1.2%)	16	21
	Vaginal ring	93 (3.3%)	6 (1.5%)	99 (3.0%)	0.3	7
	Female sterilization	873 (30.6%)	75 (18.3%)	948 (29.0%)	0.5	0.5
	Male sterilization (vasectomy)	1009 (35.3%)	86 (21.0%)	1,095 (33.5%)	0.1	0.15
	Natural methods	Fertility awareness-based methods (standard days method, mucus method, basal temperature method, other)	86 (3.0%)	9 (2.2%)	95 (2.9%)	3–5
Lactational amenorrhea method (while breastfeeding)		15 (0.5%)	5 (1.2%)	20 (0.6%)	0.9	2

Variable	Categories	Low-fertility setting	High-fertility setting	Total	Contraceptive effectiveness:	
					Consistent and correct use*	As commonly used*
Natural methods	Periodic abstinence	84 (2.9%)	8 (2.0%)	92 (2.8%)		15a
	Withdrawal	137 (4.8%)	20 (4.9%)	157 (4.8%)	4	20
Other	Other	69 (2.4%)	7 (1.7%)	76 (2.3%)	76 (2.3%)	
	I don't know	264 (9.2%)	62 (15.2%)	326 (10.0%)	326 (10.0%)	
	None of the above	65 (2.3%)	12 (2.9%)	77 (2.4%)	77 (2.4%)	

\* WHO Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, *Family Planning: A Global Handbook for Providers*, 3rd ed. (Geneva and Baltimore, 2018), p. 460.



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