

ABSTRACTS EXAMPLES

Example 1: Research abstracts

Title: Resumption to Menstrual Cycle, Sexual Behavior and Postpartum Contraceptive use in India

Significance/background:

One of the key components of effective postpartum care is the provision of contraception to help women space or limit subsequent pregnancies. Postpartum period usually refers to an interval between six to eight weeks after childbirth during which the mother is expected to return to her pre-pregnancy state. New mothers are encouraged to use contraception immediately after postpartum amenorrhea to avoid unintended pregnancies and delay subsequent birth. Usually, the risk of an unintended pregnancy is generally high during the postpartum period since women become fertile at least 14 days before the start of her menstruation. On the other hand, the timing of menstruation is closely associated with the intensity of breastfeeding and it varies across different cultures. The risk to immediate postpartum conception, therefore, depends on whether a woman is still breastfeeding, abstaining from sexual relations or using effective methods of contraception. However, the relationship between contraceptive initiation and resumption of menstruation and sexual behavior is not systematically explored at the population level, especially in India where postpartum contraceptive use remains low.

Main question/hypothesis:

This research uses population representative contraceptive calendar data from India to examine the association between resumption of menstruation and sexual behavior and contraceptive initiation in the extended post-partum period. Specifically, the paper assesses the association between resumption of menses and sexual behavior on the initiation of postpartum contraception. The paper also assesses the continuation of the temporary methods.

Methodology/ Research:

The nationally representative contraceptive calendar data from the third round of the Indian National Family Health Survey (NFHS-3) was used for the analysis. The survey collected a wide range of health, demographic, and socioeconomic data. A total of 124,385 women were interviewed including 93,089 ever-married women aged 15–49 years from 109,041 households. The analysis for this study is based on 26,665 women who had a birth in the 13 to 60 months preceding the survey. NFHS-3 collected specific reproductive health and contraceptive history data for the 60 months preceding the interview date. Contraceptive use preceding and following each reproductive (pregnancy) outcome were recorded in a monthly calendar format. This provides us with the opportunity to analyze the timing and duration of contraceptive use before and after each reproductive event within the 60 months observation period. Multinomial logistic regression was used to examine the effect of resumption of menstruation and sexual relations on the odds of postpartum contraceptive use, adjusting for demographic and socioeconomic variables. Proportional hazard models were used to examine the propensity of postpartum contraceptive method discontinuation and factors that were associated with the discontinuation of modern or traditional temporary methods.

Results/key findings:

The results suggest that by the first month following the last birth, 20% of women had started menstruating, by the second month 30% and by 11th month 67% were reported to be in the menstrual state. At the same time, 20% of women had already resumed their sexual relations by the first month following a birth and by second month 42% and by the 11th month 92% percent had resumed sexual relations. When initiation of contraception is concerned, except for the first month, more than half who had resumed sexual relations had not initiated postpartum contraception. For example, by the first month only 13% initiated contraception while 20% resumed sexual relations. By second month, only about 18% initiated contraception while 42% resumed sexual relations. By 12th month the vast majority of women had resumed sexual relations but only 43% initiated a method. About 45% of the women adopted postpartum contraception anytime during the 12 months following the last birth with large variation across the six regions in India. The association between resumption of menstruation and sexual behavior and postpartum contraceptive use is further confirmed in the multivariate analysis after controlling for confounding variables. The discontinuation rates of temporary methods initiated during the last 12 months following the birth of last child suggests that overall, the discontinuation rates were the highest amongst users of oral pills and condoms and the lowest amongst users of IUD and traditional methods. One in four women discontinued oral pills within the first 24 months.

Knowledge contribution:

This study is the first of its kind in India to establish statistical association between postpartum resumption of menstruation and sexual relations, and postpartum contraceptive initiation in the extended post-partum period. Postpartum contraceptive use is generally low in India. Only one in two women initiates a method during the 12 months in the extended postpartum period and over two fifth of these use a permanent method. The majority of women who resumed sexual relations before their menstrual cycle did not use any contraception. Strengthening institutional birth care is an effective strategy to promote postpartum contraception, especially in public health facilities where contraceptive services are mostly widely available. Effective family planning counseling and provision of long-term contraception with follow-up mechanisms can encourage postpartum contraceptive uptake and reduce method discontinuation. Moreover, it is important to ensure that women are adequately informed about method choices, associated potential side effects, indications and contraindications as well as information about the relationship between postpartum resumption of menstrual patterns and amenorrhea, and conception risks. Community-based targeted behavior change communication involving family planning service providers is yet another strategy to promote and sustain postpartum contraceptive use. Finally, as envisaged within the Janani Suraksha Yojana, there are opportunities to integrate postnatal services with family planning counseling and follow-up services for enhancing the health and wellbeing of women and children.

Example 2: Program abstracts

Title: Prevention of sexual transmission of Ebola Viral Disease

Significance/background:

There is no formal evidence on sexual transmission of the Ebola virus. However, sexual transmission from convalescent patients cannot be ruled out. There is evidence that live Ebola virus can be isolated in seminal fluids of convalescent men for 82 days after onset of symptoms. Ebola RNA has been detected by RT-PCR in semen of one patient up to day 101 after symptom onset. There is no evidence of live Ebola virus in vaginal secretions: only Ebola RNA have been detected in the vaginal secretions of a woman on the 33rd day after symptom onset. Whether these traces found in vaginal secretions represent live virus, and if so, for how long it would remain in vaginal secretions, is not known (WHO, 4th April, 2015).

In Sierra Leone, there have been alleged cases of Ebola infection from survivor partners through sexual intercourse, but none of these has been scientifically proven. Nonetheless, because the risk of sexual transmission of the virus cannot be ruled out, men and women who recover from Ebola Viral Disease (EVD) are advised to abstain from all types of sex for at least three months after onset of symptoms or use condoms for protection.

Program intervention/activity tested:

For greater prevention of Ebola transmission to partners, Ebola Survivors are encouraged to use condoms correctly and consistently for all sexual acts (including anal- and oral sex) beyond 3 months. Invariably, the use of condoms would also provide multiple protection from sexually transmitted infections including HIV and unwanted or unplanned pregnancies. Even though the primary aim is Ebola prevention, an opportunity is created for condom promotion which has traditionally been used for dual protection of STIs and family planning. The consistency in condom utilization may develop a practice of protection, outside the main target of Ebola prevention.

Methodology Program/Best Practice:

In Sierra Leone, since the EVD outbreak, UNFPA, together with WHO, UNICEF, The Ministry of Social Welfare Gender and Children's Affairs, and other partners are working together in raising public awareness about preventing sexual transmission of Ebola. It is also ensured that the principle of non-stigmatization and non-isolation of Ebola survivors is upheld.

The National Social Mobilization Pillar, in collaboration with the Social Mobilization Action Consortium (SMAC), developed a consolidated message guide for Ebola Communication, including special messages on the possibility of sexual transmission of Ebola. Social Mobilization teams and Ebola Contact Tracers were trained to educate the public about Ebola transmission and prevention mechanisms, including sexual transmission of Ebola.

UNFPA works with its key Implementing Partner on Condom Programming (National HIV/AIDS Secretariat) to provide condoms at twelve Ebola treatment centres in Bo, Bombali, Portloko, Kenema, Kailahun and Moyamba districts; and the Western Area. At least ninety condoms are included in Ebola survivor discharge packages. Counseling and IEC materials on condom use are also shared with survivors.

Results/key findings:

Research on abstinence from sex and condom use among Ebola Survivors is yet to be undertaken to evaluate efforts made on service provision and sensitization on prevention against sexual transmission of Ebola. However, with regards to activities undertaken on condom distribution and demand creation, these are the findings:

- Development and Dissemination of Media Messages/Social Mobilization
- The key messages provided in the message guide for Ebola communication are as follows:
 - Ebola survivors cannot spread the virus to others through casual contact. Although the virus may be absent from blood and most other body fluids, the virus can stay in semen and in vaginal fluids for 3 months or longer.
 - Scientists continue to study Ebola and whether or not it can be spread through sex, and if so, for how long.
 - As a safety measure, Ebola survivors (both men and women) should not have any sexual contact (oral, vaginal, or anal) for at least three months. If they do have sex, they should use a condom every time. Condoms may help prevent the spread of disease to sexual partners.
 - Radio and Television programmes as well as social media carry messages on possible sexual transmission of Ebola and prevention methods.
 - Door-to-door and small group outreach sensitizations are conducted by Social Mobilization teams and Contact Tracers.
 - Provision of condoms and counseling to Ebola Survivors
 - By the end of 2014, a total of 1,135 Survivors were counseled and received 158796 condoms.
 - Group counseling was provided to Survivors

Program implications/lessons:

The experiences of programme implementation can be transferred from one programme to another, whilst continuing to maintain the benefits of the previous. This has been clearly evident in condom use in EVD prevention, whilst the prevention of STIs and unwanted/unplanned pregnancies is equally maintained. The utilization of sexual reproductive health commodities can be expanded. Partnership and collaboration are essential for effective programming. Sexual and reproductive health is a major challenge during emergencies and requires innovative approaches within the context of existing situations. Clustering or formation of groups with similar identities creates an easier entry point to targeted populations. Guidelines on communication on specific interventions are essential for harmonization/uniformity and consistency in information dissemination.

Example 3: Advocacy & Accountability

Title: Socioeconomic status and abortion tourism in Mexico City: Implications for equity

Significance/background:

Unsafe abortion is a problem the world over, causing approximately 47,000 maternal deaths per year. The vast majority of these deaths take place in settings where access to abortion is legally restricted. When practiced safely and openly, abortion has a case-fatality rate well below 1/100,000 procedures. In Mexico, where abortion is criminalized but clandestine abortions are common, the case-fatality rate rises to 48/100,000, placing a substantial burden on women's health and causing hundreds of preventable deaths.

In 2007, the municipal government of Mexico City legalized abortion through 12 weeks of gestation within city limits. Both medical and surgical abortions are available at city public health clinics, city-run hospitals, as well as private providers. Known by its Spanish name, Interrupción Legal del Embarazo (ILE), the procedure is provided free of charge in at the primary-care facilities.

This unusual situation has created an "island" of free, safe, high-quality abortion care in a "sea" of legal restrictions and dangerous, clandestine methods in the rest of Mexico. There are no restrictions on who is allowed to access abortion in Mexico City's clinics, however the costs and logistical challenges of travel from other states may pose a substantial barrier to poor women.

Main question/hypothesis:

Hypothesis: Due to travel costs and other logistical challenges, women of lower socioeconomic status (SES) from outside of Mexico City face substantial barriers to taking advantage of safe abortion services in Mexico City, even though the services themselves are free. Low SES women from inside Mexico City, in contrast, face fewer barriers, and can more easily avail themselves of safe abortion services.

Thus, among women accessing abortion care in Mexico City's primary health centers, the average SES of women from outside Mexico City is higher than that of women from within Mexico City.

Methodology/ Research:

Since 2013, the Mexico City Secretariat of Health has used electronic medical records for all abortions performed at the primary-care level. Routine data on patients are collected regarding socio-demographic characteristics, reproductive history, abortion procedures, and post-abortion family planning. A complete dataset of all women seeking abortion services since this system was introduced was compiled in early 2015, with a total of 22,732 observations. Using years of education as a proxy for overall socioeconomic status as the dependent variable, a series of linear regression models are used to explore the differences in education by place of origin. Place of origin is categorized into four groups: women from Mexico City proper, women from the metropolitan area, women from the surrounding border states, and women from the rest of the Mexico, as a way to provide sensitivity to travel time and costs. Data from the 2010 Mexican Census is used to normalize years of education in one set of models, to control for pre-existing urban/rural disparities in educational attainment. A number of covariates are controlled for, including age, marital status, gravidity, and number of previous abortions, among others.

Results/key findings:

Findings strongly suggest that there are indeed significant differences in educational level between women coming from outside Mexico City and those coming from within Mexico City to access abortion services at public primary-care facilities.

Crude data on educational attainment provide evidence that the distribution of education attainment among abortion seekers diverges from that of the general population, and that these differences vary by geographic group. In the rest of Mexico, for example, 8% of the general population has no schooling, compared to only 1% of abortion seekers. 10% of the general population of women of reproductive age has post-secondary education in the rest of Mexico, compared to 35% of abortion seekers from this region who do. These data indicate that women coming into Mexico City for abortions are generally better educated than the general population.

These crude data are complemented by the regression models, which show that abortion seekers coming from the rest of Mexico have, on average 1.4 more years of education than those from within Mexico City. Controlling for covariates, this becomes 0.91 years. When normalized with census data, the estimates of education difference between these groups becomes 4.93 years (unadjusted) and 3.24 years (adjusted). All of these values are significant at alpha level 0.05.

Knowledge contribution:

This analysis does not, on its own, provide sufficient evidence for a causal claim that poorer, less educated women from outside Mexico City are being left behind, since theoretically, these women could simply have less need for abortion than their urban counterparts, or their better-educated counterparts. Yet, when viewed in conjunction with the vast body of evidence that shows that unsafe abortion in Mexico is strongly associated with poverty and low education, this theory seems unlikely. Much more likely is that, while the 2007 Mexico City law has helped both low and high SES women within Mexico City, as well as high SES women from outside Mexico City, the group that is still being left behind is low SES women from outside Mexico City. Unsurprisingly, it is this group of already marginalized women who are unable to take advantage of the safe abortion loophole provided by the Mexico City law, and who are left to confront the dangers of clandestine abortion in their own communities.

This study is the first of its kind to explore the effects of a law like Mexico City's, not only on the community it was directly intended to benefit (residents of the capital city, in this case), but also "spillover effect" on surrounding communities. This analysis shows that, while the Mexico City law was an important first step, it is not enough to ensure access to safe abortion services among those who need them most.

Acknowledgment:

These abstracts were extracted from the publically available 2016 International Conference on Family Planning program and are only provided as examples for learning purpose.