REPRODUCTIVE HEALTH OF THE POPULATION

2011
The study has been prepared in the framework of the project “Reproductive Health of the Population in Latvia”. The project is coordinated by the society “Papardes zieds”. Partners of cooperation – the World Health Organisation, the Ministry of Health of the Republic of Latvia, Latvian Association of Gynaecologists and Obstetricians. The project has been implemented with the funding from the World Health Organisation, Latvian Association of Gynaecologists and Obstetricians, European Society of Contraception and resources attracted by the society “Papardes zieds”. The project has been implemented in cooperation with an ESF co-funded project “Capacity building for interdisciplinary biosafety research”. (No.2009/0224/1DP/1.1.1.2.0/09/APIA/VIAA/055)

Author and editor
Aivita Putniņa

International scientific advisor, reviewer
Prof. Gunta Lazdāne

Reviewer
Anda Karnīte

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The study is not copyright protected, it can be used in full and partially without prior consent from the society “Papardes zieds” and its partners of cooperation, however, reference to the used source is mandatory.

The study in Latvian, questionnaire and data array for secondary analysis are available on the Internet: www.paparedszieds.lv

Advisor to the quantitative study
Māris Brants

 Implementer of the quantitative study
Research Centre SKDS

Proof-reader
Inguna Milgrāve
Reproductive health indicators characterise public health as a whole, since mother’s and father’s health has a significant impact upon child’s development both prior to birth and, especially, during the first year of life.

Being aware of the topicality of demographic situation, the government has set demographic issues, including reproductive health, as one of its priorities. In this context special attention should be paid to educating young people already in schools, since insufficiency of information is a direct cause of increasing numbers of unplanned pregnancies and induced abortions in the age group below 19, which can cause infertility later in life. Likewise, parents’ knowledge about the negative consequences of using addiction causing substances upon the health of the pregnant woman and the expected child, as well as about sexual tract infections, which can create risks to bringing pregnancy to full term and may facilitate hereditary disorders in the child. The growing maternal mortality indicators should be assessed, also from causes, which are not pregnancy linked, as well as the growing number of women, who have not registered their pregnancy and do not receive qualitaty care throughout their pregnancy.

It must be underscored that a number of state covered screening programs (for cervical and breast cancer) have been introduced in the framework of sexual and reproductive health policy developed by the Ministry of Health, that state covered vaccination of 12 years old girls against human papillomavirus causing cervical cancer has been launched, that “Public Health Strategy for 2011-2017” has been elaborated and approved, setting aims and lines of action for improving Latvian public health during the coming seven years, including the field of sexual and reproductive health.

To make the development and implementation of sexual and reproductive health policy more effective, health, education, welfare and gender equality aspects should be included in uniform intersectoral policy, by cooperation with other ministries, local governments and non-governmental sector, as well as with the World Health Organisation and the European Union institutions – to implement research projects and adopt best practice.

It is time to deal with issues of sexual and reproductive health in a strategic and complex manner, to implement the principle “health in all policies”, because these issues are in a most direct way linked with improvements in demographic situation and healthy development of the state.

Ingrida Circene
Minister for Health of the Republic of Latvia
FOREWORD

Sexual and reproductive health plays a significant role in the life of each individual and the society as a whole. For people it is linked with quality of life, love and developing relationships, family and children. Public health, in its turn, ensures the development of a nation.

For this reason states have confirmed in international documents that there is no future without reproductive health. Already in 1994 Cairo International Conference on Population and Development agreed on objectives and aims even up to 2015. The 21st century started with the defining of Millennium Development Goals, which have had direct impact upon policy documents and fields of actions for many states.

The European Regional Strategy in the Field of Sexual and Reproductive Health (2001) of the World Health Organisation (WHO) helped member states to adjust international documents to the specific situation in each state. More than 20 states in Europe have elaborated their national development programs, defining more accurately the possibilities for implementing the Regional Strategy in the country. In 2004 the World Health Assembly adopted the first global reproductive health strategy, which contains five priorities – maternal and perinatal health, family planning, prevention of unsafe abortion, sexually transmitted infections and HIV. This strategic document also contains ways, how to reach the set objectives, i.e., assessing the impact of various social conditions upon sexual and reproductive health.

Delegations of the Republic of Latvia have also participated in global and regional fora and conferences and agreed to the aims defined there. What progress has been made in implementing these political documents in Latvia? What is the population’s self-assessment of reproductive health? Has it been influenced by the changes in financial status and migration of the 21st century? The outcomes of the 2011 study of population sexual and reproductive health, supplemented by the data of 1998 and 2003 studies and official statistics, provide answers to these and many other questions.

Many developed European countries regularly conduct such surveys, but in countries, which cannot financially afford it, donors help to carry out Demographic and Household surveys. Even such significant information as contraception coverage, which is a target indicator for Millennium Development Goal 5B, can be obtained only with the help of a survey.

It is impossible to elaborate national policy in a concrete sector and to improve the quality of health care without information. The Republic of Latvia, being aware of it and joining the forces of the Ministry of Health (MH), Latvian Federation of Family Planning and Sexual Health and the support from the WHO Regional Office for Europe, in 2011 repeated reproductive health study, which included data and information from various sources of statistics, results of quantitative and qualitative analyses and experts’ assessment.

We would like to congratulate the Ministry of Health of the Republic of Latvia for the aptly chosen timing – the time, when the implementation of the Public Health Strategy for 2011–2017 should start, but the current financial situation of the state calls for careful consideration of each step and decision. This overview of population sexual and reproductive health will definitely help to take well-considered steps in the right direction.

Dr. Gunta Lazdāne,
Doctor of Medical Science
WHO Regional Office for Europe, Advisor in the Field of Sexual and Reproductive Health

Dr. Aiga Rūrāne
Head of WHO Country Office in Latvia
Indicators Characterising the Demographic Situation and Reproductive Health of Population in Latvia

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<td>Population (million)</td>
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<tr>
<td>Gender break-down of population (%)</td>
<td></td>
<td></td>
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<tr>
<td>Men</td>
<td>46.0</td>
<td>46.0</td>
<td>46.1</td>
</tr>
<tr>
<td>Women</td>
<td>54.0</td>
<td>54.0</td>
<td>53.9</td>
</tr>
<tr>
<td>Birth rate (per 1000 of population)</td>
<td>7.9</td>
<td>8.6</td>
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<tr>
<td>Mortality (per 1000 of population)</td>
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<td>13.4</td>
</tr>
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<td>Natural growth</td>
<td>-5.9</td>
<td>-5.3</td>
<td>-4.8</td>
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<td>Summary birth rate (average number of children in a woman's lifetime)</td>
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<tr>
<td>Average life-expectancy of newborns (in years)</td>
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<td>Both genders</td>
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<td>71.1</td>
<td>73.8</td>
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<td>Men</td>
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<tr>
<td>Women</td>
<td>75.6</td>
<td>76.8</td>
<td>78.4</td>
</tr>
<tr>
<td>Infant mortality (per 1000 live births)</td>
<td>15.6</td>
<td>9.9</td>
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<td>Maternal mortality (per 100 000 live births)</td>
<td>40.3</td>
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<tr>
<td>Number of induced abortions (per 1000 live births)</td>
<td>1225</td>
<td>734</td>
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<tr>
<td>Total health expenditure (% of gross domestic product)</td>
<td>3.9</td>
<td>3.5</td>
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INTRODUCTION

This is already the third study of the situation and policy in the field of population sexual and reproductive health conducted in Latvia. The previous points of reference were 1997 and 2003. The studies aimed not only to assess the situation and identify fields that call for urgent action the most, but also to provide recommendations for improving the situation. In difference to previous studies, this provides recommendations in the context of the already existing political initiatives, offering both instruments and indicators for measuring the effectiveness of action.

BOXED INFORMATION NO. 1.

Definition of sexual and reproductive health

Sexual health is a state of physical, mental and social well-being in relation to sexuality. It is not only a condition of absence of disease, dysfunction or disability. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. To ensure and maintain sexual health, the sexual rights of each person must be respected, safeguarded and observed. (WHO, 2006: 5)

Reproductive health is a state of complete physical, mental and social well-being in relation to the reproductive system, its functions and processes. Reproductive health means that people conduct responsible, satisfactory and safe sex life, that people are able to create descendants and to choose freely, whether, when and how frequently create them. This concept includes the rights of women and men to be informed about safe, effective, accessible and acceptable means of birth-control of their own choosing, as well as to receive appropriate health care services, which ensure the possibility of safe pregnancy and delivery, ensures to couples the best possibility for having a healthy child. (WHO, 1994, quoted in WHO Regional Office for Europe, 2001: 7).

International Context

During the reporting period global attention has been focused upon health education. In 2008 the United Nations Education, Science and Culture Organisation published a new action program for education in the field of sexuality in educational institutions, which was elaborated on the basis of UNESCO (2007) strategy in relation to situation with HIV/AIDS. New approach to sexual education at schools was developed in the framework of the program (UNESCO, 2009), case analyses (UNESCO, 2010) and an analysis of costs and cost effectiveness was performed (UNESCO, 2011).

The sexual health of the population of the World Health Organisation (WHO) European region is analysed mainly from the aspect of public health and quality of life, based upon “the positive attitude”, referred to above, towards sexuality and sexual relations of every individual. Children and adolescents are the main target group for improving sexual health. (WHO, BzGA, 2010: 5,7). The standards of sexual education, elaborated by the WHO Regional Office for Europe and WHO cooperation partner – Federal Health Education Centre (BzGA), Cologne [Köln], Germany, is the first step towards uniform principles of sexual education in the European Union (EU) and the whole European Region of the WHO, emphasizing the importance of comprehensive and consistent education, “encouraging [adolescents] to experience their sexuality and relationships in a fulfilling and responsible way” (ibidem: 5).

Latvian Context

During the last reporting period the relevance of sexual and reproductive health has been increasing in the context of demographic policy. Therefore significant part in it was dedicated to reproductive choices of population and changes in them. The study identifies changes in family structure – statistical data and the survey results show that inhabitants choose marriage as the foundation of family less often, delay having children and formation of permanent partnerships to a later period in life. The period of life from starting sexual relations to establishing a family and having children becomes longer, thus, prevention of unplanned, unwanted pregnancy and sexually transmitted infections becomes more important, especially if partners are changed frequently. The proportion of diagnosed cases of sexually transmitted chlamydia infections among young women is disturbing. The study identifies the impact of Latvian population migration upon sexual and reproductive health. Those inhabitants of Latvia, whose partners have been abroad for longer than three months, have a higher risk of casual relationships.

The study reveals gradual improvement in the health self-assessment of population. The differences in female and male health care habits, identified by the previous studies, have not changed significantly. At the same time respondents, who are better off, have better health self-assessment. The proportion of respondents with health insurance has decreased.
In 2004 Action Plan for the Implementation of the Strategy for Maternal and Child Health Care for 2004–2007 was approved, however, no significant improvements in the indicators of maternal and newborn health has been achieved. Latvia has high maternal mortality. Even though since the previous reporting period a slow trend of decreasing perinatal mortality indicator has been observed, its indicators in Latvia remain higher than the EU average. The envisaged measures for dealing with issues of infertility and medical fertilisation have not been implemented, now, following the adoption of Public Health Strategy for 2011–2017 (in September 1011), these issues have returned to the health policy agenda.

In 2009 organised breast and cervical cancer screening was launched in Latvia, attempting to detect the disease in as early stage as possible or completely prevent it in the case of cervical cancer, thus reducing the high mortality. On 1 September 2010 the vaccination of 12 years old girls against cervical cancer causing stems of human papillomavirus was started.

Situation in education has not improved since the previous reporting period. Health Education, which includes issues of sexual and reproductive health in its content, is an optional subject in secondary schools, and part of secondary school and all vocational school students do not acquire important knowledge on sexuality, developing relationships and prevention, envisaged in the subject standard of Health Education. One fifth of the surveyed 15–19 years old girls and one fourth of 15–19 years old boys assess their knowledge as insufficient or totally insufficient. No research has been carried out on the effectiveness and age-appropriateness of sexual education provided at school.

**Study Working Group**

The study was conducted by a working group, which was involved in the elaboration of research tools and data interpretation, as well as in the process of drafting recommendations. The working group members were: Inese Birzule, doctor, public health specialist; sociologist Māris Brants; Liga Kozloksa, the President of the Latvian Association of Rural General Practitioners; representatives from the Ministry of Health – Inga Šmate, Director of the Public Health Department, Ilze Straume, Head of the Health Promotion Unit; Sanita Kukliča, senior desk-officer of the Health Promotion Unit; Iveta Pudule, public health analyst from the National Health Service Data Analysis Department; Dace Rezeberga, the President of Latvian Association of Gynaecologists and Obstetricians; Aiga Rūrāne, the Head of WHO Country Office in Latvia; Gunta Lazdāne, advisor in the field of sexual and reproductive health of the WHO Regional Office for Europe; Aivita Putniņa, docent of the University of Latvia; representatives of society “Papardes zieds” Ivela Kelle and Anda Vaišļa. Sandra Falka, senior desk-officer of the National Centre for Education, as well as specialists from the Infectology Centre of Latvia were advisors to the working group.

**Research Methods**

**Survey**

The target group of the study are Latvian’s inhabitants of both genders in reproductive age (15–49 years). The study was conducted with stratified random sample at the respondents’ places of residence, ensuring stratification according to administrative territorial and ethnic features. Fieldwork was conducted from 27 February 2011 to 17 April 2011. Quotas were applied to the sample, ensuring at least 250 respondents in all gender and age groups: 15–19 years, 20–24 years, 25–29 years, 30–39 years and 40–49 years.

This system of quotas ensured the possibility to analyse each of the mentioned groups separately. When collecting respondents’ views from different groups, scale was applied to the data file, weighing according to region, ethnicity and age. The weighing was not applied according to gender, since general results regarding the totality of all respondents were never counted, only according to gender cross-section.

In view of the sensitive topic of the study, the basic method of survey was filling out questionnaires by respondents themselves in the interviewer’s presence. Only in some cases the questionnaires were filled out according to the classical interviewing scheme, when the interviewer puts questions to the respondent and records responses. After questionnaires were filled out, they were placed in envelopes and taken out only before inputting. The filling out of questionnaires by respondents themselves does not ensure as high quality as interviewing, thus in the course of analyses conflicting content, empty blocks of questionnaire and other shortcomings were encountered. The most problematic questionnaires were not included in the data array.

The questionnaire consisted of the following blocks of questions: questions about lifestyle; questions about health examinations and visiting doctors; questions about contraception; questions about various diseases (including HIV/AIDS, sexually transmitted infections); questions about sexual experience, about pregnancy;
about last pregnancy resulting in birth; and other questions, including questions on social demographic aspects.

Prior to data analysis a detailed data control process was conducted, including also logical verification. During the logical verification situations sometimes occurred, when the paper versions of the concrete questionnaires had to be analysed, in order to take a decision in each specific situation on introducing amendments to eliminate logical contradictions. In some cases, when the contradictions were unsolvable, questionnaires were deleted from the data array.

In general 2617 valid survey questionnaires were used in analysis (including 1313 female and 1304 male questionnaires). With the achieved sample the statistical error for total distribution of answers to any question, to which all respondents had to answer, in the gender section with 95% probability does not exceed 2.7% – i.e., repeating the study under identical circumstances 100 times, in 95 times out of these the answer, the proportion of which for one of the genders would be 50%, would fluctuate within the range from 47.3 to 52.7%.

Data were processed with the statistical data processing software SPSS and digital spread-sheet MS Excel. The questionnaire and the data array are available for secondary analysis from www.papardeszieds.lv.

**Focus Group Discussions and Interviews**

Similarly to the previous study, focus group discussion method was used for in-depth study of the group of youth. The study defines youth as women and men, aged 15–25, covering the definition of reproductive age (15–49 years) recommended in the Law on Youth and by WHO. The guidelines for discussions were changed, compared to the previous reporting period; expanding the range of included topics and including questions on sexual and reproductive health and sources of information; experience in relationship formation and application of acquired knowledge; use of contraceptive means and knowledge on contraception; family and family planning; as well as knowledge of and attitude towards the use of new biotechnologies – stem cells, technologies of artificial fertilisation (see: guidelines for focus group discussions appended to the report www.papardeszieds.lv). The focus group discussions were organised in cooperation with the project “Capacity building for interdisciplinary biosafety research” (No.2009/0224/1DP/1.1.1.2.0/09/APIA/VIAA/055), the report does not analyse all questions that were included.

Focus group discussions were conducted in January, February 2011. In total 5 focus group discussions were held in Riga and regions, including the total of 48 young people. The target group of the discussions were students of secondary schools and vocational schools, aged 16–20. Signed forms of informed consent were received from the parents of all those participants of the discussions below the age of 18. In setting up discussion groups gender factor was taken into consideration. One group had only female and one – only male participants. The other three focus groups were mixed.

In addition to the focus group discussions, the first and second year students of culture and social anthropology conducted interviews as part of the course Anthropology of the Body and Medicine, adjusted according to the guidelines for focus group interviews (see: interview guidelines appended to the report at www.papardeszieds.lv). Interviews with 4 men and 11 women aged 16–25 were selected as complying with the study requirements. The advantage of interviews is greater openness on the topic of sexual and reproductive behaviour, sensitive for public discussions.

Discussion and interview materials were processed using the qualitative data processing software Atlas.ti. Data coding allows drawing conclusions on the prevalence of an opinion according to the frequency of references and number of quotes. Quotes are used to illustrate and identify opinions in the study.

**Analysis of Policy Documents**


The analysis of documents allows a better positioning of the findings and recommendations of the Report in the policy process, thus promoting the effectiveness of the Report.

**Data from Other Studies**

Data from the Central Bureau of Statistics, the Infectology Centre of Latvia, the Centre of Health Economy and WHO Health for All database have been used in the study. The data from available studies have been used for
comparison.

The unpublished interim-results of the ESF funded project “Capacity building for interdisciplinary biosafety research” (see above) on infertility treatment in Latvia deserve special mentioning. Comparative analysis of the legal and ethical regulation, media analysis, as well as interviews with experts were conducted in the framework of the project. Signe Mežinska and Ilze Mileiko, who prepared the respective part of the Report, worked on this project component.

**Structure of the Study**

The Study consists of four Chapters. Chapter 1 reviews sexual and reproductive health in the context of family and partnerships, analysing trends in co-habitation, reproductive choice and sex life, as well as violence in relationships. Chapter 2 is dedicated to health maintenance habits – health self-assessment, health care habits and disease prevention, prevention of unwanted pregnancy and sexually transmitted diseases. This Chapter also provides an overview on pregnancy and birth care and its subjective assessment. Chapter 3 analyses trends of sexual and reproductive education in the target group of youth. This Chapter also reviews education policy in this field. Chapter 4 is dedicated to sexual and reproductive health policy and its effectiveness in Latvia.
Chapter 1

Sexual and Reproductive Health in Partnerships

Sexuality and reproductive abilities are realised in partnerships and simultaneously leave an impact upon them. They create environment, where sexual and reproductive health is realised, define reproductive trends in society and is the first stage for taking decisions on one’s own and partner’s health and family planning. This Chapter provides a brief description of the demographic situation and family relationships since the previous reporting period. Both statistic and survey data reveal changes in the family institution in Latvia – the time of having children is delayed, the significance of single marriage for life decreases and several partnerships throughout one’s lifetime are perceived as norm. These changes influence the economic stability of families and individual decisions on having children. Continuing the initiative of the World Health Organisation (WHO) to examine the interconnection between violence and health, the quality of relationships has been examined from the vantage point of violence. Since the previous reporting period domestic violence has entered the political agenda, however, surveys and statistical data do not yet show improvement in the situation.

1.1. Partnerships, Children and Family Planning

Examination of birth trends in the whole of the Baltic region (see Figure 1.1) shows the most dramatic decrease in the period affected by the economic recession is seen Latvia’s birth data. The analysis of the summary birth rate coefficient (the average number of children that a woman could give birth to in her lifetime, if the birth rate of the respective year would remain unchanged, per 1000 women aged 15–49), in accordance with the Central Statistical Bureau data, reveals a trend similar to the birth rate: it was increasing from 1997 to 2008, slightly decreasing in 2009, by 2010 reaching the level of 2002.

In 1990 all three Baltic States were in equal positions of departure as to the summary birth rate coefficient. Differing trends in the indicators of all three countries appeared in the second decade of independence – different family and demography policies were launched. Currently Estonia has the highest birth rate. At the same time, high birth rate in Estonia is not linked to stable marriages, since the highest proportion of children

Figure 1.1 Summary birth rate coefficient (the average number of children that a woman could give birth to in her lifetime, if the birth rate of the respective year would remain unchanged, per 1000 women aged 15–49), 1990–2009

Source: Central Statistical Bureau of the RL, database, Eurostat data.
born outside marriage in the Baltic States is observed there (see Figure 1.2).

The decrease in the summary birth rate coefficient, perhaps, was facilitated by the adverse social economic situation in the state, influencing not only the general standard of living among population, but also demographic and health indicators. The data of the Central Statistical Bureau shows that following a sustained and stable (since 1996) growth of the gross domestic product (GDP), GDP decline was observed in Latvia in 2008, which continued into 2009. The comparison of Eurostat data on Latvia and other EU member states shows that the unemployment level has also risen dramatically: in 2009 it was the second highest in the European Union – 17.1% (Spain 18.0%). In a survey, conducted by the Central Statistical Bureau (CSB) in 2010, 75% of households admitted that during last 12 months the economic situation had worsened (rural areas – 71%, cities – 76%). Estonia and Lithuania have managed to avoid an impact of recession, which started in 2008, upon birth indicators, which proves the great significance of state support in the reproductive choices among population.

Focusing upon Latvia’s situation and looking at the trends revealed by statistical data, in the field of family institution one can observe an increase in the proportion of concluded marriages from 2004 to 2008 (see Figure 1.3). Simultaneously it must be noted that the ratio of divorce compared to the number of concluded marriages slightly decreased during this period, creating an impression of growing stability of marriage. The lowest point – 478 divorces per 1000 concluded marriages was reached in 2007.

Growing birth rate and improved indicators of mar-
riage in Latvia coincided with the launching of consistent family policy – increasing the state family benefit, child-care benefit and later – parent benefit. This period is also linked with demographic factors: the young generation born during the baby boom of 1980s reached reproductive age. Most likely, both these factors influenced the birth rate and marriage indicators. The economic recessions since 2008 shows that the family policy has not been flexible enough to retain the positive trends in improving the demographic situation.

Simultaneously changes linked to transformation of family and household structure are observed in Latvia. Latvia has a high proportion of unmarried people: 40% of men and 31% of women aged 25 – 49 are not officially married (CSB, 2011). In 2010 44.1% of children were born to unmarried parents, to married parents, respectively, – 55.9%. For the last 7–8 years this indicator has not changed significantly, fluctuating within the range of a few percent points over the years. CSB data show that the number of children born to married parents decreased rapidly from 1995 to 2003, when it fell from 70.1% to 55. Survey data show that compared to the survey of 2003 the proportion of respondents indicating that they live in marriage has significantly decreased, but the number of respondents living in unregistered partnership or other types of households has increased.

To characterise partnerships it must be mentioned that the average age at first marriage is increasing (see Figure 1.4). CSB data show that since 1990 the average age of all persons getting married has increased by approximately 5 years. In 2010 it was 34.1 years among men and 31.4 years among women. Latvia has the third lowest average age in the EU.
when a woman has a child and the lowest summary birth rate coefficient, which indicates that women choose not to have more children over a comparatively longer reproductive period. (European Commission, 2011: 28). The choice of women in older reproductive age group to have one more child, when the previous ones have already been brought up, and the behaviour of young people, when planning their family, are important in this respect.

During focus group discussions and interviews, conducted as part of the study, young people, when discussing the role of the family, defined two kinds of opinion. Those participants of the study, of both genders, who wanted to have family and children in the future, considered that they could plan stable relationship, job and children, on average, after reaching the age of 26. The majority of young people were not planning a family and considered that they would be able to do that, if such a wish appeared.

“IF I'D FEEL SURE THAT EVERYTHING WOULD BE FINE, THEN I'D GET MARRIED, AND THEN I'D START THINKING ABOUT FAMILY, OF COURSE, I WOULD HAVE A JOB, A PLACE WHERE TO LIVE, BECAUSE I WOULD WANT MY CHILDREN AND WIFE TO HAVE A PLEASANT LIFE. NOT GETTING MARRIED, HAVING CHILDREN AND THEN START THINKING HOW TO GET BY.”

(Interview, 21 years old man.)

“I DON'T KNOW ABOUT MY FUTURE, THIS IS JUST A PERIOD LIKE THIS, WHEN I AM NOT THINKING ABOUT IT, OF COURSE, LIKE ANY GIRL, I'D LIKE A WEDDING, A BRIDAL DRESS AND SO ON, BUT WE'LL SEE. I'D LIKE A FAMILY AND CHILDREN ALSO, BUT I STILL THINK THAT I AM TOO YOUNG TO PLAN ANYTHING AT THE MOMENT. I THINK I'LL START THINKING ABOUT FAMILY FROM [THE AGE OF] 25, ONWARDS. YOU CAN BRING UP CHILDREN WITHOUT A SPOUSE, THOUGH, OF COURSE, IT'S Nicer AND MORE IDYLIC TO HAVE BOTH PARENTS, BUT TODAY LIVING IN A DIVORCED FAMILY IS REALLY THE norm NOW.”

(Interview, 21 years old woman.)

Young people treat unregistered partnerships liberally, perceiving registration as an unnecessary procedure and additional burden, for example, when getting divorced. The opinion that relationship should be based upon love, not mutual long-term responsibility, was identified also during the group discussions involving young people in the previous reporting period. The emphasis upon love and spontaneity of relationship changes the understanding of marriage as the basis for partnership and allows perceiving several permanent partnerships over one's lifetime as a norm.

Only few young people of both genders emphasised the importance of traditional co-habitation, and also in this case were postponing it for a later period of life.

“IT IS IMPORTANT FOR ME TO HAVE CO-HABITATION REGISTERED OR AT LEAST SOMEHOW MARKED; I HAVE THIS INNER FEELING THAT IT SHOULD BE LIKE THIS. THAT PEOPLE, WHO WANT TO BELIEVE IN MARRIAGE, FAMILY, VOWS, SHOULD GET MARRIED. LIKE IN AN INSTITUTION – THE FAMILY, PROVIDED BY MARRIAGE.”

(Interview, 22 years old woman.)

On the one hand, young people admitted the wish to have relationship, support and stability, but on the other hand – they did not wish to assume long-term commitments, seeing having children as a burden. The perception of the adult life, which young people have, stems from their own experience. The majority of young people refer to experience of divorce in their own or friends' families, normalising a divorced family.

“I DON'T THINK THAT I SHOULD IMPLEMENT SOME KIND OF CONCRETE PLANS NOW, TO LIVE THEM OUT LATER ON. I THINK THAT ONE MUST ACT NOW, LIVE, MEET WITH WHOMEVER ONE WANTS TO, LIKE THAT. I HAVE A BOYFRIEND NOW. I DON'T KNOW, EVERYTHING IS FINE NOW. BUT MY PARENTS ARE DIVORCED; PERHAPS THAT'S WHY I NEVER REALLY TRUST MARRIAGE. I HAVE NO FAITH IN IT, BUT THAT DOES NOT MEAN THAT I WOULD NOT WANT IT AT SOME POINT IN THE FUTURE. BUT IN ANY CASE I PLAN TO LIVE TOGETHER FOR AT LEAST SOME TIME, AND GET TO KNOW ALL ASPECTS. PROS AND CONS. AND ONLY THEN START THINKING, WHETHER INDEED. YOU CAN HAVE THAT MARRIAGE, TO LIVE TOGETHER NOW, PROPERLY, NOT MESSING AROUND.”

(A discussion of youth focus group, in Zemgale)

At the same time issues connected with the experience of the divorced family members are not sufficiently discussed in the family, school and the public sphere. Thus, a gap appears between the ideal family and the one experienced by young people. The majority of participants in the qualitative study deny the importance of marriage or of a single marriage in their life, young people emphasize the absence of the topic of relationships in discussions on sexuality and reproductive health conducted in educational institutions and mass media. As a young girl stated during an interview that she had never in her life experienced an ideal family, did not know what it meant and thus, could not build it herself.

The other reason, mentioned less frequently, emphasised by young people is the fast pace of living and the lack of stability in life in the future. The dynamism of life changes relationships, which young people orient to-
Figure 1.6 How many children would you like to have in your family? Answers provided by all respondents, % (women, n = 1313, men, n = 1304)

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>No children</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>1 child</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>2 children</td>
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<td>23%</td>
<td>21%</td>
</tr>
<tr>
<td>4 children and more</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>No response provided</td>
<td>4%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Figure 1.7 What circumstances hinder you (hindered, could hinder) to have the optimum number of children in the family? Female respondents, % (2003, n = 1251, 2011, n = 1313)

- Nothing hinders: 22%, 22%
- Instability in income: 37%, 39%
- I am too young: 15%, 16%
- Life conditions: 21%, 23%
- Instability at work: 16%, 18%
- Lack of a suitable partner: 16%, 18%
- Future career plans: 11%, 15%
- I am not ready for this kind of responsibility: 11%, 15%
- Instability in family: 11%, 15%
- Health problems: 11%, 14%
- I don’t want to make any commitments: 3%, 4%

Figure 1.8 What circumstances hinder you (hindered, could hinder) to have the optimum number of children in the family? Male respondents, % (2003, n = 1201, 2011, n = 1304)

- Nothing hinders: 22%, 27%
- Instability in income: 39%, 33%
- I am too young: 18%, 23%
- Life conditions: 22%, 23%
- Instability at work: 17%, 23%
- I am not ready for this kind of responsibility: 11%, 15%
- Lack of a suitable partner: 11%, 13%
- Future career plans: 11%, 11%
- Instability in family: 11%, 11%
- Health problems: 5%, 6%
- I don’t want to make any commitments: 4%, 9%
wards the present, trying to get fast returns on the investments made into relationships. The perception that young people have of relationships is essential in developing reproductive behaviour, starting with the time and motivation chosen to start building relationship, actions in case of unwanted pregnancy and/or sexually transmitted infections (STI) and, finally, with deliberate family planning. Thus, the issues of reproductive health and demographics cannot be treated in isolation from perceptions of relationships. Chapter 3 offers an in-depth analysis of this topic.

1.2. Desirable Number of Children in Family

The data of the Central Statistical Bureau for 2010 show that 48% of the children born in this year were the first children in their families (in 2009 this number is 50%). The proportion of second children among the newborns in 2010 was 35%, compared to 34% of the previous year. The perception of the desirable number of children in family has not changed significantly since the study of 2003. Most frequently the respondents want 2 children – this is the response provided by 53.5% of surveyed women and 48.3% of men. The next most popular choice is 3 children (23% of women and 21.3% of men). 13.5% of men and 11.6% of women would like to have a single child. Only 5% of women and 6.5% of men would want to have four and more children. The respondents’ financial status does not have a significant impact upon the choice of the preferable number of children. The survey shows that the stability of relationship influences the preferable number of children. Those female respondents, who live together with a spouse in marriage, on average would want to have more children than those living in unregistered partnership.

Marriage as a type of partnership is more frequently connected with children, and only 0.5% of married women and 1% of married men indicate that they do not want children. The proportion of such respondents is higher among unregistered couples – 3.5% and 3.2%, respectively. The responses provided by young people do not reveal a trend for increasing the preferable number of children in a family – only 23–25% of young women and 18.7–25.5% of young men, aged 15–19 and 20–24 would want to have three and more children in the future. In the age groups of thirty and forty years old 34% and 28.8% of female and 29.1% and 37.2% of male respondents, respectively, would want three and more children (see Figure 1.6).

In general, the obstacles to reaching the preferable number of children, identified in the survey of 2003, have not changed significantly. The most essential change is the growing sense of insecurity in the environment – absence of job and income stability. In 2003 and 2011 these reasons were mentioned by 18% and 39% of the female respondents, respectively, and 22% and 39% of the male respondents, but the current living conditions have become a less important factor, especially for women. The shift of emphasis in the responses shows that compared to the previous reporting period the present quality of life plays a less important role, but the significance of the long-term stability of the family increases.

Notable changes are observed in the assessment of the most appropriate age for having children, compared to 2003, in 2011 the number of respondents indicating that they were too young for having children has increased by 8% – in total 23% respondents. Statistical data also point to this trend of postponing having children, as well as the statements made during interviews and discussions with young people regarding the preferable child bearing age (see Figure 1.7, 1.8).

The majority of participants in the discussions perceived pregnancy of 15–20 years old adolescents as a mistake or
something that they have to justify in the company of their peers. Schools have become open to teenage pregnancies, and young people had encountered pregnant girls among their schoolmates. At the same time young people were to a certain extent distancing themselves from these cases during discussions. During one group discussion a case, when a pregnant girl, lacking her friends’ support, had been ridiculed by her peers and perceived as failure, was discussed. Participants of both genders were talking about fear of unwanted pregnancy during the discussions.

«The girls are the ones to feel anxious, if anything happens, if I become pregnant, a disease comes only after it. If I become pregnant, then my life is over, forget about studies, parents will drive you out of home. Perhaps I am mistaken, but some girls cope better with the fact that they have a disease than with being pregnant. Pregnancy is really something awful; your life is over.»

(Discussion in a focus group of adolescents, in Riga)

To a large extent societal pressure determines adolescents’ attitude towards pregnancy. Thus, responsibility in sexual relationship turns into an ambivalent concept. Young people, who participated in discussions, indicate, that, on the one hand, responsibility is linked with contraception: a young boy during a discussion among young people in Kurzeme said:

«It’s better to be responsible than to bring up a baby.»

but, on the other hand, bringing up children is perceived as a difficult, externally imposed task:

«The idea of children is not attractive for me, because I see it as huge responsibility… which I don’t want.»

(Interview, 21 years old woman)

The tension caused by the fear of pregnancy influences the relationships among young people and simultaneously creates a perception of having children as an event associated with negative experience.

1.3. Role of Men and Women in Partnership

As regards the traditional female and male roles, 68% of respondents of both genders do not agree that it is the sole duty of women to take care of children. It is noteworthy that 15–19 years old respondents of both genders, notwithstanding their more liberal attitude towards marriage mentioned above, are more conservative compared to other age groups and comparatively more frequently support the traditional role for women (33.5% of young women and 30.5% of young men in the respective age group compared to 29.3% of all women and 25.2% of all men). Religious affiliation and ties to a religious organisation did not significantly affect this view. 95.4% of women and 89.1% of men consider both partners to be responsible for pregnancy planning.

16.5% of women and 24.6% of men agree that a woman should be a virgin when getting married. The affiliation with a concrete denomination did not significantly influence the development of views, however, active participation in a religious organisation did. Thoes respondents, who attend a religious organisation more than once per month, in 48% of the cases agree to the view that women

<table>
<thead>
<tr>
<th>Age</th>
<th>Almost every day</th>
<th>Once a week</th>
<th>Once a month</th>
<th>Less frequently</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 19</td>
<td>11%</td>
<td>28%</td>
<td>3%</td>
<td>22%</td>
<td>6%</td>
</tr>
<tr>
<td>20 - 24</td>
<td>16%</td>
<td>57%</td>
<td>17%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>25 - 29</td>
<td>15%</td>
<td>67%</td>
<td>13%</td>
<td>5%</td>
<td>5%</td>
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<tr>
<td>30 - 39</td>
<td>11%</td>
<td>67%</td>
<td>12%</td>
<td>15%</td>
<td>5%</td>
</tr>
<tr>
<td>40 - 49</td>
<td>7%</td>
<td>65%</td>
<td>23%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Figure 1.10 How often have you had sex in the course of last 12 months? Answers of respondents, who in the course of last 12 months had had one sexual partner, %, women, n = 867, men, n = 753
should be virgins before marriage. A higher proportion of respondents supporting this opinion is found only in the group of 15–19 years old women (23%) and in an older age group – 40–49 years (23.6% of women and 29.6% of men).

1.4 Sexual Relations

1.4.1 Satisfaction with Sex Life

Compared to previous studies, the satisfaction with one's sex life has increased among both female and male respondents, the number of satisfied respondents reaching 66% among women and 69% among men. The differences in the percentage of answers provided by women and men have also levelled out.

Similarly to the previous study, satisfaction with sex life differs in different age groups. In general satisfaction with sex life is lower in the age group of 40–49 years, in which 19.7% women and 15.7% men are dissatisfied and rather dissatisfied with their sex life. The type of partnership – marriage or unregistered partnership – does not have a significant impact upon the assessment of satisfaction.

1.4.2 Frequency of Sexual Relations

Similarly to the previous studies, the majority of Latvian inhabitants of reproductive age maintain sexual relations once per week or more frequently – these are 61.7% of female and 66.9% of male respondents. In general young people of the age group 15–19 engage in sex less frequently, which can be explained by this age group, when stable partnerships are not being established. However, in the survey young women indicate more intense sexual life compared to young men, which contradicts the perception expressed in interviews and focus group discussions about typical adolescent sexual behaviour.

Ethnicity, religious affiliation and income had no significant impact upon the intensity of sexual life. Women from small towns and rural areas admit more intense sexual life slightly more frequently compared to Riga and Latvian cities. This trend is not found in answers provided by men.

1.4.3 Age of Starting Sexual Relations

The comparison of the data from previous studies with the data of 2011 pertaining to young people in age group 20–24 shows that on average the time of first sexual experience is slightly earlier, however, this difference cannot be assessed as statistically significant (see Figure 1.11). The material obtained during interviews and focus group discussions shows that adolescents have formed an impression of starting sexual relations early, sometimes even mentioning the age of 13–14. The desirable age, in the understanding of adolescents themselves, is approximately 16–17 years, however, part of the survey participants assess themselves, their classmates, sisters, brothers and friends in this age as infantile and in practice link the start of sexual relations with reaching the age of 19–20. A discrepancy between the desirable age for starting sexual relations and their own readiness to start these relations can be identified in several interviews. A young woman pointed out in an interview that engaging in sexual relations allows getting rid of stress and starting to “live”:

“In fact I was rather glad, happy, it was all over, I could finally start living, well, that sex life, having calmed down, peacefully. Not like before it – what’s it gonna be like, what’s it gonna be like. Well, about getting pregnant, that was the main thing for me, I even, it seems to me, bought a pregnancy test. Of course, I was not pregnant. That’s logical. But there was some kind of fear about it, very intimidated girls.”

(Interview, 22 years old woman)

The analysis of the survey data on the motivation of young people for starting sexual relationships shows that in the age group of 15–19 years mutual desire dominates among 68% of girls and 57% of boys, 53% of girls and 44% of boys had felt ready for it. 31% of girls considered that they had met the right person, but only 23% of boys were of the same opinion. An important factor was their curiosity to find out what it meant. 35% of boys and 29% of girls...
Figure 1.12 How many sex partners have you had in the course of last 12 months? Answers of respondents, who have had sex, arithmetical average, in 2003 (women, n = 998, men, n = 960), in 2011 (women, n = 1128, men, n = 1105)

Figure 1.13 Victims of domestic violence, breakdown according to gender and years, Trauma Register, 2006–2010, all victims, in absolute numbers.

mentioned this factor. Compared to responses provided in the study of 2003, the proportion of respondents, who started relationship under the influence of alcohol, has slightly decreased, – these are 10% of girls and 15% of boys. At the same time, comparison with a study conducted in the same year, the group of young people aged 15–19 point out to relationships started while being under the influence of alcohol more frequently, which proves that the situation, most probably, has not improved.

1.4.4 Characterisation of Sex Partners

9.9% of women and 17% of men among the surveyed sexually active respondents admit that in the course of last 12 months they have had more than one sex partner. 34% of men and 58% of women had no chance sexual encounters. In general the survey shows a trend of decreasing average number of sex partners during the last year, compared to the previous reporting period (see Figure 1.12). The survey shows that emigration abroad influenced the frequency of casual sexual encounters and, thus, also the risk of STI and unplanned pregnancy. Women, who have a permanent partner, who in the course of last 12 months has lived abroad for at least 3 months, are at a greater risk of casual sexual encounters – 18.3% had had several sex partners concurrently. Among women,
whose partners had not stayed abroad for a prolonged period of time, the percentage of several sex partners concurrently was 7.7% of women. A similar situation can be observed among male respondents. 27.3% of men, whose permanent partners had lived abroad for at least three months in the course of last 12 months, had had several sex partners concurrently. Among men, whose partners were not staying abroad for a prolonged period of time, the percentage of several sex partners concurrently was 11.5.

The survey data on young people show that in the age group of 15–19 years young women had had on average 2.95 partners in the course of their lifetime, but men – 4.56. In the successive age group (20–24 years) the number of sex partners in their lifetime is 3.72 and 6.33, respectively. The average number of sex partners in the course of last 12 months shows that among young people aged 15–24 the number of partners on average was higher than in other age groups – 1.48–1.43 for women and 1.74–1.75 for men.

1.4.5 Homosexual relations
3.5% of surveyed men and 7.1% of surveyed women have indicated that they had had relations with a same sex partner in their lifetime. Most frequently it is pointed out that such encounter had happened only once or on isolated occasions. These data do not differ significantly from the data of 2003 and show that the discussions about homosexual relations, which have taken place in society following the previous survey, increase in information and access to support for different sexual identity have not influenced the respondents’ answers.

1.5 Violence
Since the previous reporting period the issue of violence has been systematically examined in Latvia, from the health perspective. A survey on violence and health in Latvia (Putnina, 2007) was conducted in cooperation with the World Health Organisation, and guidelines for identifying violence were drafted (World Health Organisation, Regional Office for Europe, Ministry of Health of the Republic of Latvia, Latvian Association and Gynaecologists and Obstetricians, 2009). From 2006 to 2008 in-patient and out-patient medical facilities submitted information on cases of violence to Register of Patients with Particular Diseases, Who Have Had Traumas and Injuries, (hereinafter – the Trauma Register). Since 2008 the registration rules have been amended, and only information on hospitalised patients from inpatient medical facilities reaches the Register. In view of the fact that obtaining information on violence and especially domestic violence on national scale is still problematic and absence of uniform definition and register of domestic violence, the more comprehensive Trauma Register, which functioned till 2008, could register various types of violence, the link between the victim and the perpetrator, providing credible and comparable information on the scale of violence in the country. The Trauma Register data reveal rapid increase of the number of victims of violence (see Figure 1.13). It must be taken into account that since 2008 data from outpatient medical facilities are no longer collected. The largest percentage of victims is of reproductive age, belonging to the age group of 25–49 years, and the perpetrators of violence typically have been spouses or partners.

The analysis of the survey data shows that the percentage of respondents, who have suffered from physical violence in the course of last five years, has almost remained unchanged since the survey of 2003 and has remained as 29.6% among women and 32.6% among men. 52% of women and 35.2% of men have suffered from emotional violence. The percentage of men has slightly decreased since 2003. 9.9% of women and 2.5% of men have suffered from sexual violence.

The survey shows that 22.6% of women and 24.5% of men sought help after an incident of violence, which does not differ significantly from the data of the previous survey. 49.7% of women and 52.1% of men answer that they knew where to look for help, but did not do it. Only 11.8% of women and 14.6% of men did not know, where to look for help. The percentage of people looking for help is lower in the group of people

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1 LGBT (lesbian, gay, bisexual and transsexual persons) NGO “Mozaīka” was established in 2006, it organised more extensive “Friendship Days” events in 2006, 2007 and 2008, informing about LGBT persons, discrimination and rights, organising support activities for its members, education on health and other issues. This NGO has a youth group, its most recent project “Closet” educates young people, families, teachers and social workers on issues of lesbian, gay, bisexual people and transpersons (www.skapis.eu, accessed on 14 November 2011).
Figure 1.14 Have you suffered from physical violence? Answers from all respondents, %, in 1997 (women, n = 2990, men, n = 1578), in 2003 (women, n = 1251, men, n = 1201), in 2011 (women, n = 1313, men, n = 1304)

<table>
<thead>
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</tr>
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<td>Men</td>
<td>24%</td>
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</tr>
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<td>2003</td>
<td>34%</td>
<td>55%</td>
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</tr>
<tr>
<td>2011</td>
<td>33%</td>
<td>54%</td>
<td>13%</td>
</tr>
<tr>
<td>Women</td>
<td>9%</td>
<td>89%</td>
<td>2%</td>
</tr>
<tr>
<td>2003</td>
<td>29%</td>
<td>52%</td>
<td>12%</td>
</tr>
<tr>
<td>2011</td>
<td>30%</td>
<td>48%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Figure 1.15 Have you suffered from emotional violence? Answers from all respondents, %, in 1997 (women, n = 2990, men, n = 1578), in 2003 (women, n = 1251, men, n = 1201), in 2011 (women, n = 1313, men, n = 1304)

<table>
<thead>
<tr>
<th>Year</th>
<th>Suffered violence</th>
<th>Have not suffered violence</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
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<td></td>
</tr>
<tr>
<td>Men</td>
<td>15%</td>
<td>71%</td>
<td>14%</td>
</tr>
<tr>
<td>2003</td>
<td>40%</td>
<td>49%</td>
<td>11%</td>
</tr>
<tr>
<td>2011</td>
<td>35%</td>
<td>53%</td>
<td>12%</td>
</tr>
<tr>
<td>Women</td>
<td>19%</td>
<td>78%</td>
<td>3%</td>
</tr>
<tr>
<td>2003</td>
<td>52%</td>
<td>36%</td>
<td>12%</td>
</tr>
<tr>
<td>2011</td>
<td>52%</td>
<td>38%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Figure 1.16 Have you suffered from sexual violence? Answers from all respondents, %, in 1997 (women, n = 2990, men, n = 1578), in 2003 (women, n = 1251, men, n = 1201), in 2011 (women, n = 1313, men, n = 1304)

<table>
<thead>
<tr>
<th>Year</th>
<th>Suffered violence</th>
<th>Have not suffered violence</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>3%</td>
<td>90%</td>
<td>9%</td>
</tr>
<tr>
<td>2003</td>
<td>3%</td>
<td>75%</td>
<td>22%</td>
</tr>
<tr>
<td>2011</td>
<td>3%</td>
<td>71%</td>
<td>27%</td>
</tr>
<tr>
<td>Women</td>
<td>7%</td>
<td>91%</td>
<td>2%</td>
</tr>
<tr>
<td>2003</td>
<td>17%</td>
<td>57%</td>
<td>26%</td>
</tr>
<tr>
<td>2011</td>
<td>10%</td>
<td>56%</td>
<td>34%</td>
</tr>
</tbody>
</table>
in their twenties (20–29 years). In the group of 15–19 years old women the number of respondents not knowing where to look for help is lower. This does not apply to young men of this age, where all age groups have a similar percentage of uninformed men. Young men aged 15–19 have looked for this kind of help more frequently than other age groups (36.1% compared to average 25.1% among all men).

Family members and relatives (51%), as well as friends (46%) are the ones most frequently helping women. 26% of female respondents have turned to law enforcement institutions. Additional 21% have sought a psychologist’s or psychotherapeutist’s advice. Men most often have turned to law enforcement institutions (47%), friends (42%). Only 29% have sought help from their family members, one fourth of men have sought doctor’s assistance. The differences in answers provided by men and women follows from the type of violence – with regard to men it is predominately physical violence, its consequences requiring intervention of health care professionals and law enforcement institutions.

Summary

1. The status of birth rate and nuptiality in the reporting period from 2003 to 2011 is characterised by both growth and decline, conforming to the changes in the economic situation of the state. On the basis of the analysis of reasons on the level of individual choice, the following should be mentioned as the main factors affecting decisions on birth:

1.1. Economic situation. The sense of insecurity regarding income and job stability in the future has increased. For women the factor of life conditions has slightly lost its significance. The national social policy has not been flexible vis-à-vis economic changes. Latvia lacks support measures targeting families having children over the age of one and/ or allowing to solve economic issues in the family. The active employment measures provided by the State Employment Agency do not include families with one or both unemployed parents.

1.2. Change of family model. The study data show that the family model and values connected to it continue to undergo change in Latvia. In the survey, compared to the previous study, more respondents have indicated that they do not live in registered partnership.

1.2.1. Partners’ change is linked with economic and social instability. Respondents living in unregistered partnership more frequently do not want children. At the same time it must be noted that Estonian experience shows that this factor is an obstacle only in case the state has not introduced effective support measures for parents in diverse family models.

1.2.2. The time of having children postponed for later age. The delayed child bearing and the low desirable number of children will leave a negative impact upon the birth rate indicators in the coming decades, until the gap caused by this delay levels out. As the EU demographic reports show (European Commission, 2011: 27–28), Scandinavian countries have overcome the demographic changes linked with postponed child-bearing and the postponed age of having children has not decreased the female fertility over their lifetime.

1.2.3. The period of the risk of sexually transmitted infections (STI) and unwanted pregnancies increases in human reproductive life. Young people plan family and children at a later stage, but start sexual relations at a younger age, thus extending the period of pre-marital experiments, during which the respondents do not aim at developing stable partnerships, change partners more frequently. The availability of contraception and STI prevention for a broader circle of population becomes more relevant.

1.2.4. Young people have lived in environment, in which their own or their friends’ parents have formed new relationships or the so-called “recombinant” families. During discussions and interviews young people note their lack of skills for developing permanent relationships, absence of discussions on these issues at school and in public space.

1.2.5. Migration affects partnerships. The survey shows that the absence of sex partner causes the risk of chance sexual encounters. The study on violence and health (Putnina, 2007) revealed that children suffer from their parents’ job searches. The lack of adult support during teenage years, when partnerships and sexual life develop, causes special problems.

1.2.6. No increase in violence indicators has been observed, however, its scope in general has not decreased, pointing to the low effectiveness of the implemented measures. The data of the Centre of Health Economics (CHE) from the Trauma Register data show that the consequences of domestic violence are registered at the institutions of health care more frequently, which shows that violence is better identified.
Chapter 2
Health Care

Various factors determine the status of health – heredity, habits, social conditions, as well as the quality and accessibility of the health care system. Improvements in a couple of reproductive health aspects are observed since the last reporting period – the number of abortions continues to decrease, man’s role in the reproductive health sector increases. A growing number of fathers get involved in various processes linked to child birth. Organised cervical cancer and breast cancer screening has been introduced, which in the future could decrease the mortality from these malignancies, which remains high in Latvia. The current trends show no evidence of improvements in the situation, and the screening coverage is lower than planned. Since 2010 the vaccination calendar includes vaccination of 12 years old girls against human papillomavirus, which is the main factor causing cervical cancer.

The survey conducted as part of the study shows that the indicators on visits to health care specialists have not improved since the previous reporting period in 2003. Men continue to visit out-patient medical facilities less frequently than women. The number of respondents with health insurance has decreased. Poor inhabitants constitute a special problematic group, limited means restrict health care and also purchasing safe means of contraception.

2.1 Self-assessment of Health
2.1.1 Overall Health

Comparison of the data from 2011 with the data from 1997 and 2003 shows continuous improvement in the self-assessment of health both among men and women – 58% of women and 65% of men assess their health as good (see Figure 2.1).

Similarly to the previous years, the self-assessment of health is influenced by respondents’ material status – the higher the income per one family member in the household, the more positive is the respondent’s health self-assessment. Thus, 51% of women and 58.8% of men with monthly income per member of household above 100 LVL assess their health as good and very good, but in the income bracket of 200 LVL and more this percentage is, respectively, 62.9% and 68.4%. However, the difference in self-assessment in groups with lower and higher income is smaller compared to the previous study in 2003. The respondents of both genders with secondary vocational education in general have lower assessment of their own health than those with higher or comprehensive secondary education.

Health assessment worsens with each successive age group. With increasing age the respondents more frequently assess their health as average: in the age group of 14–19 years 16.8% of men and 23% of women as-
sessed their own health as average, but in the age group of 40–49 such assessment is given by 44.2% of men and 48.3% of women. People with higher self-assessment of their overall health have a higher assessment of their own emotional and mental state.

The self-assessment of health measured in the survey is compatible with the data obtained in other studies. According to the data of the study on the health affecting habits among Latvian inhabitants aged 15–64 (Pudule et al., 2011) in 2010 28.3% of population assessed their own health as good and 27.3% – as rather good. 5.7% assessed their own health as poor and 2% – as rather poor. Women more frequently have poor health self-assessment compared to men. But 66% of respondents with higher education have higher assessment of their health – they assess it as good or rather good.

In difference to the data of the study on health affecting habits, the survey conducted as part of this study proves a correlation between good health conditions and respondent’s income, but not with a higher level of education.

2.1.2 Sexual and Reproductive Health

Similarly to the survey of 2003, men have a higher assessment of their own sexual and reproductive health status during the previous year. The trend that respondents with higher income have a better assessment of their sexual and reproductive health continues. Respondents with secondary vocational education have a lower assessment of their sexual and reproductive health than respondents with comprehensive secondary and higher education. In the age group of 40–49 years only 39.9% of women and 58.3% of men assessed their sexual and reproductive health as good and very good, but 40.3% of women and 30.8% of men in this age groups assess their own sexual and reproductive health as average.

Among those respondents, who live together with a married spouse, 59.4% of women and 72.5% of men have indicated that they assess their sexual and reproductive health as good and very good. Among those respondents, who have indicated that they live in unregistered partnership, the general assessment is higher – 71.6% of women and 80% of men. The respondents’ age could be a partial explanation to this, since unregistered partnership is more frequently chosen by younger respondents. Simultaneously it should be noted that stable partnership does improve the assessment – the lowest assessment of sexual and reproductive health is found among respondents outside stable partnerships.

2.2 Morbidity with STI, Risks and Recognition

The earliest possible diagnosing and treatment of sexually transmitted infections is an important factor for safeguarding good sexual and reproductive health, it is ensured by regular health care and awareness of the possibilities to become infected with STI.

2.2.1 STI Prevalence Trends

Globally more than 30 various sexually transmitted infections are known. In Latvia only four STI are subject to mandatory registration: syphilis, gonorrhoea and chlamydia (Chlamydia trachomatis) infections, including Lymphogranuloma venereum, and anal-genital herpes simplex virus (HSV) infection.

The analysis of morbidity should take into account that the STI registration in Latvia does not mirror the real morbidity level because of two reasons. First, asymptomatic forms are typical of STI, and infected persons do not seek medical assistance. Secondly, STI patients do not always visit a doctor and the doctors do not always report disease cases timely. The European Centre for Disease Prevention and Control has come to this conclusion regarding the chlamydia infection in all EU states (ECDC, 2011: 4, 31). Since 2008 the registration of infectious diseases, including STI, has improved, because laboratory reporting was introduced, allowing entering the morbidity data directly into the database from labs. The data of “Infectology Centre of Latvia” (ICL) for the period from 2003 to 2010 show that 14292 cases of STI were registered in Latvia; of these 6163 were chlamydia infection (43%), 4404 cases of gonorrhoea (31%), 3136 cases of syphilis (22%), 589 cases of anal-genital HSV infection (4%).
The ICL data on epidemiological monitoring show that in 2003 – 2010 STI cases among men were registered 1.6 times more frequently than among women: 8859 (62%) cases among men and 5433 (38%) among women.

During the period under study, from 2003 to 2010 the registered morbidity with syphilis among men has decreased 4 times, with gonorrhoea – 1.3 times, with anal-genital HSV infection – 1.5 times, but the morbidity with chlamydia has increased 1.1 times. Among women morbidity with gonorrhoea has decreased 1.3 times, but the morbidity with chlamydia has increased significantly (4.6 times), and this indicator is much higher than among men. In 2003 the morbidity with syphilis was the highest among men and women (38.0 cases per 100 000 men and 29.9 cases per 100 000 women), but in 2010 – with chlamydia (36.1 cases per 100 000 men and 55.1 per 100 000 women). The registration of morbidity with anal-genital HSV infection remained on the previous level.

According to ICL data during the reporting period the greatest morbidity with gonorrhoea among men was registered in 2006 in the age group of 15–24 (121.3 cases per 100 000 men and 29.9 cases per 100 000 women), but in 2010 – with chlamydia (36.1 cases per 100 000 men and 55.1 per 100 000 women). The registration of morbidity with anal-genital HSV infection remained on the previous level.

According to ICL data during the reporting period the greatest morbidity with gonorrhoea among men was registered in 2006 in the age group of 15–24 (121.3 cases per 100 000 men and 29.9 cases per 100 000 women) (see Figure 2.5) The highest morbidity with syphilis and anal-genital HSV infection among men is in the age group of 25–49, but with gonorrhoea and Chlamydia – in the age group of 15–24, and this trend has remained unchanged during the reporting period.

According to ICL data the highest morbidity with Chlamydia among women was registered in the age group of 15–24 (239.2 cases per 100 000 women in 2010), this indicator is 3.5 times higher compared to the average in the age group 25–49. A similar trend is observed in the indicators on morbidity with gonorrhoea, where 3.3 times higher morbidity indicators are observed in the age group of 15 –24 yrs olds (26.2 cases per 100 000 women of relevant age) compared to 7.9 cases per 100 000 women of the relevant age on average in the age group of 25–49.

2.2.1.1 Chlamydia Infections

The data of epidemiological monitoring show an increase in the cases of chlamydia infections per 100 000 inhabitants. The highest level of morbidity is observed in the age group of young people (15–24 years). The trend of increased morbidity is especially fast among young women. The number of diagnosed cases among men is considerably lower. As the EU Annual Epidemiological Report on Communicable Diseases for 2010 (ECDC, 2010) and the information provided by European Centre for Disease Prevention and Control (ECDC, 2011) point out, the differences in the data of EU member states and the growing prevalence shows that the spread of this infection is not sufficiently identified in all EU member states. Incomplete registration and also asymptomatic course of the disease, because of which infected persons do not seek medical assistance, are mentioned as the causes for this. Latvia’s data reveal a significantly small number of recorded chlamydia cases compared to Estonia or Scandinavian countries (ECDC, 2010: 32). The report shows (ECDC, 2010: 6., 31) that the vulnerable group, most frequently affected by chlamydia, are young people aged 15–24. The information of the European Centre for Disease Prevention and Control shows that the persons infected with chlamydia do not belong to the traditional STI risk groups, and that for this STI the main risk factors are young age and a new (recent) sexual partner (ibid.).

It is scientifically proven that untreated chlamydia infections can cause serious consequences for female reproductive health, cause pelvic inflammation diseases and lead to fallopian tube obstruction, leading to the risk of extra-uterine pregnancy or infertility. Chlamydia infection often progresses asymptomatically, therefore timely diagnostics and treatment is essential, including cases when the person has no complaints.

In Latvia chlamydia screening program applies only...
to pregnant women. The analysis of morbidity trends among pregnant women reveals almost threefold increase in the number of chlamydia cases within a year.

2.2.1.2 Syphilis

A decreasing trend in morbidity with syphilis was observed during the reporting period. Since 1999 the morbidity with syphilis has decreased almost 6.2 times, and yet it is still the second highest among the EU countries after Romania. Lithuania also has a similar number of cases (ECDC, 2010: 48–49). According to the report of the European Centre for Disease Prevention and Control (ibid, 2010: 48) the main risk group is men aged 25–44 (23 cases per 100,000 men of the relevant age) and women aged 15–24 (14 cases per 100,000 women of the relevant age). Almost every year cases of hereditary syphilis are registered in Latvia. In 2009 2 cases of hereditary syphilis were registered in Latvia or 0.09 cases per 1000 of live births.

2.2.1.3 Gonorrhoea

In accordance with the report of the European Centre for Disease Prevention and Control (ECDC, 2010: 36) in 2008 Latvia as to morbidity with gonorrhoea ranked second among the EU member states, after the United Kingdom
(21 cases per 100 000 of population; in the U.K. 27 cases per 100 000 of population). In the EU a specific proportion of morbidity is observed among young people aged 15–24. In Latvia this indicator among 15–24 years old men and women was, respectively, 74 and 73 cases per 100 000 inhabitants of relevant age and gender (ibid.: 35). In the case of gonococcal infection untreated infection or uncontrolled use of antibacterial medicines can cause a significant problem, which may lead to irreversible health consequences (for example, infertility) and have a negative impact upon future sexual and reproductive health.

### 2.2.2 Identifying STI Risks

The survey data show that the majority of respondents are aware of casual relationships as STI risks and would be able to choose appropriate means of protection. Among women, who have had STI, 64% had had casual relationships. Among men of the respective group this percentage is 89.2%. Among respondents, who have never had STI, 39.4% of women and 63% of men had had casual relationships.

### 2.2.3 Action in Case of Disease

The model of action in case of reproductive organ disease has not changed significantly compared to the previous survey in 2003. If suspecting inflammation of sexual organs, 90% of female respondents would visit a gynaecologist and 64% of men would visit an urologist or another specialist. Men would seek the advice of a general practitioner more often than women, 40% of men (in 2003 – 33%) and 25% of women (in 2003 – 19%) would...
do that.

Gynaecologist is the most popular advisor among women, and this doctor plays the most significant role in the formation of clients' behaviour in cases of reproductive organ disease. Gynaecologist becomes increasingly popular among women over 20, and also in the youngest age group is a more popular advisor than general practitioner. Among men urologist is more important advisor than the general practitioner in cases of sexual organ inflammation, and this popularity grows with each successive age group. At the age of 15–19, a half of respondents would seek the advice of an urologist, but in the age group 40–49 already 71.9% of respondents would choose to do that.

The survey reveals the trend, which began already in 2003, – younger female respondents, suspecting inflammation, would more often seek the advice of a general practitioner – 44.7% in the age group 15–19 years; 29.8% – in age group 20–24 years. In the older age group, 40–49 years, only 14.7% of women, suspecting inflammation, would consult a general practitioner. Likewise, the respondents in the groups of younger men would consult a general practitioner more frequently – 48.1% in the age group 15–19 years, 35.1% in the age group 40–49 years. It shows that the general practitioner is very significant, especially in the formation of the future model of action among adolescents.

Significant percentage of respondents would not consult a doctor at all. 12% of women and 21% of men would wait to see if the inflammation resolves itself. 9% and 12% of women and men would attempt to cure themselves. Younger female respondents would wait more often compared to older respondents for the inflammation to resolve itself – 16.2% in the age group 15–19 and 14.3% in the age group 20–24 years. In the age groups 25–29 and 30–39 years the share of male respondents is, respectively, 8.9% and 7.1%. Among male respondents waiting is equally accepted in all age groups. In the youngest group, 15–19 years, it constitutes 24.4%.

Only 5.42% of men admit having problems in sex life – problems of premature ejaculation and erection. In general, the older the respondent, the more frequently problems in sex life are admitted. However, only one fifth of these men have sought specialists' advice, and more often this was done by respondents with higher income.

2.2.4 Informing Partners about STI

To treat STI successfully, simultaneous treatment of both sex partners is essential. Section 6 in the law On Reproductive and Sexual Health (2002) provides that the infected person must inform his/her sex partner about the possible disease. The survey data show that 13.1% of women and 14.2% of men have failed to inform their partners about STI. The proportion of those not informing the partner has slightly decreased since 2003, however, it still remains high. In 2003 18% of men and 11% of women did not inform their sex partner about it while being ill.

2.3 Morbidity with HIV/AIDS

The prevalence of HIV (human immunodeficiency virus) in Latvia has stabilised (see Figure 2.9), the specialists at the Infectology Centre of Latvia (ICL) explain this by the fact that the spread of the disease has been curbed among injecting drug users, achieved through preventive work (informing, training, providing advice and testing), as well as concrete harm reduction measures (syringe exchange, distributing condoms and disinfectants) targeting the aforementioned risk group simultaneously in several cities (the number has increased from 10 cities in 2003 to 16 cities in 2011), decreasing the users' behavioural risks. The decreasing number of population, including those of the reproductive age, linked with immigration, decreasing number of HIV/AIDS testing (ECDC, WHO Regional Office for Europe, 2010), replacement of injectable drugs with oral substances (Trapencieris, Snikere, Kaupe, 2011) can be mentioned as possible concurrent causes.

The WHO survey is more critical and underline that Latvia is still experiencing a serious HIV epidemics (Laukamm-Josten et al., 2011:5–6). The main risk group is intravenous drug users and their sex partners, as well as men who have sex with men and providers of sexual services. Even though prevention programs have been created (syringe exchange and methadone therapy), the amount of provided services is insufficient to curb the epidemics. The number of HIV lab tests has decreased during the last two years, and a policy making diagnostics accessible to the risk groups – intravenous drug users and prison inmates – needs to be created (ibid.: 6).

An increasing trend of newly diagnosed AIDS cases is observed, which is linked to a certain period (10 years) since the maximum number of new cases of infection was registered in 2001, the prevalence of tuberculosis as AIDS indicator disease (when the infected person becomes ill with tuberculosis, the AIDS diagnosis remains also after TB has been cured), as well the centralisation of services and their geographical inaccessibility to patients, lack of compliance among patients and avoiding regular health examinations by infectologist.
No significant changes have been observed in the dynamics of newly diagnosed HIV cases over the last 6 years (on average 317 new cases annually; in 2010 – 274). The greatest proportion of new HIV cases among women is found in the age group 20–29 years. This potentially can increase the number of HIV-positive pregnant women, as well as the number of newborns, who have become infected by the mother during pregnancy, labour or breastfeeding.

The trend of increasing number of persons, who have become infected with HIV through heterosexual sex relations is observed (see Figure 2.10). Since 2008 heterosexual sexual contacts have become the main HIV transmission path in Latvia. The increase of the number of newly diagnosed HIV cases, acquired via sexual contacts, is especially rapid among women (UNDOC, WHO 2011:10). Thus, informing and motivating population, especially young people, about safe sex becomes especially significant and topical.

2.3.1 Morbidity Among Pregnant Women

HIV positive women during pregnancy receive preventive HIV anti-viral therapy (antiretroviral therapy), which decreases the risk that the child could become infected from the mother. It must be noted that the pregnant women, who were diagnosed both with syphilis and HIV, in 40% of the cases did not receive antenatal care, thus the prevention of vertical HIV transmission and treatment of syphilis did not occur during the antenatal period. According to the data from the Newborns Register the number of HIV positive women giving birth had increased in 2010, reaching 72 cases. During the previous years this number was fluctuating: 59 cases in 2005, 69 – in 2008, 57 – in 2009. The number of HIV positive newborns, born to HIV positive mothers, who became infected through vertical transmission (child getting infected with HIV from the mother during pregnancy, labour or breastfeeding) fluctuates: 2 cases in 2005, 8 – in 2007, 2 – in 2009, 4 – in 2010.

The Political Declaration of the UN General Assembly of June 2011 on HIV/AIDS underlines that by 2015 the new cases of HIV infection acquired though the vertical transmission path should be fully eradicated, which applies equally to all European countries. This aim can be reached only if all pregnant women receive comprehensive prenatal care and if HIV is diagnosed and treatment started timely.

2.3.2 Knowledge about HIV/AIDS

Respondents of both genders perceive the risk of getting infected with HIV as low. 47% of female and 46% of male respondents believe that the possibility of getting infected is “very low”. Additional 25.7% of women and 23.7% of men believe that the possibility of getting infected is “rather low”. Almost one fourth of respondents are unable to assess this possibility. Rural inhabitants more often refrain from assessing the possibility of becoming infected – they constitute one third of rural inhabitants, but in Riga – 17.4–17.7% among respondents of both genders.

Compared to the previous study, knowledge about the risks of getting infected with HIV has not changed significantly. The awareness has slightly increased among young people; the number of respondents unable to answer the question has decreased.

36.6% percent of surveyed women and 24.8% of surveyed men have taken HIV diagnostics test. The greatest share of respondents, who have taken HIV test, among both women and men is in the age group of 30–39 years – 54.5% of women and 38.3% of men. Rural respondents...
have taken HIV test less frequently – 27.4% of women and 18.2% of men, in Riga – 45.8% of women and 31.5% of men. Since the previous survey of 2003 the proportion of respondents, who have taken HIV test, has not changed significantly.

2.4 Infertility and Dealing with Infertility Issues

The legal acts regarding medical fertilisation that are in force to a large extent ensure the safety of patients, children and sex cell donors and their rights protection, however, a number of significant shortcomings are still identifiable in this field. The lack of a uniform register of sex cell donors is one of the issues causing serious risk. Latvian law stipulates that the number of children born from one sex cell donor may not exceed three5. The ground for such legal provisions is the need to decrease the risk of incidental incest, which could occur, if people born from the same sex cell donor met. Interviews with experts, conducted in the framework of a project implemented by the University of Latvia, Faculty of Biology “Capacity building for interdisciplinary biosafety research”, reveal that information about sex cell donors is collected only by individual clinics and that clinics do not share this information among themselves. In practice this system does not allow controlling the total number of children born to the same donor, if the person donates sex cells in several clinics. Representatives of clinics providing medical fertilisation consider that it is the obligation of the state to establish such a uniform register of donors; currently sharing of information among clinics is restricted only by the provisions on personal data protection.

The lack of a uniform register of infertile families and artificial fertilisation is also a significant problem. Currently each clinic of medical fertilisation maintains its own register, thus total statistical data on infertility and medical fertilisation are currently unavailable in Latvia. Such statistical data would be important both for scientific research and for elaborating state policy and a system for funding medical fertilisation.

A number of unresolved problems are linked with the practice of surrogation (a woman carries another couple’s child) in Latvia. The results of the aforementioned study show that there are at least a couple of surrogation cases annually in Latvia, however, legal regulation of the practice and assessment of its ethical aspects is lacking. This causes serious risks to all parties involved in surrogation. Likewise, Latvia lacks legal and ethical regulation of issues linked to utilising the fertilised egg after the couple has ceased co-habiting, in case of divorce or the death of one partner, serious discussion about the ethical aspects of pre-implantation diagnostics is lacking. In many European countries6 these issues are regulated by guidelines developed by national level ethics committees, however, in Latvia currently no guidelines on bioethics are being drafted, even though provision of recommendations and advice on the ethics of biomedical progress is included as one of the functions in the Regulation of the Central Committee of Medical Ethics7.

The state also lacks a program for overcoming infertility; these issues are left for the patients themselves to solve. The Guidelines on State Family Policy for 2011–20178 deal with this problem in demographic context, setting the objective – to assess the possibility of introducing state support measures for infertility treatment, as well as to inform society about threats and risks to reproductive

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5 Law on Sexual and Reproductive Health, Section 19.
7 Para 4.1. of the Cabinet of Ministers Regulation of 13 January, 1998 “Regulation of the Central Committee of Medical Ethics”.
8 Approved with the Cabinet of Ministers Order No. 65 of 18 February 2011.
health, which may cause infertility. To assess the possibility of introducing state support measures, the prevalence of infertility problem in Latvia should be identified.

In the study infertility was defined as a situation, when, having regular sex and not using any method of contraception, pregnancy has not occurred within two years. 6.5% of men and 2.2% of women have admitted that they suspect infertility. The majority of these women have sought doctor’s advice about it and one third have had infertility treatment. Slightly more than a half of these male respondents indicate that they have undergone tests and consulted a doctor, but only one fourth of them indicate, whether they themselves or their partner has received treatment.

2.5 Usage of Sexual Potency Stimulating Medicines

A question about using sexual potency stimulating drugs (like Viagra, Cialis, Levitra, and the like) was for the first time included in the survey. 7% of the surveyed men, who have had sexual relations, indicate that they have used such drugs, but 3% of women indicate that her partner has used them. The majority of men admitted that this usage was experimental, not regular. As indicated above, only 5.2% of all surveyed men indicated having problems in sex life.

2.6 Malignant Tumours

Female mortality from malignant breast and cervical cancer in Latvia, like in Estonia and Lithuania, is above the European average.

2.6.1 Breast Cancer

For women malignant breast tumour ranks first in the structure of malignancies related morbidity and mortality. The high morbidity from malignant breast tumour is determined by the belated detection of the malignancy – 25% of the tumours are detected only in the last (III–IV) stages.

Since the previous reporting period in 2003 the situation in morbidity and mortality from malignant breast tumour has not improved (see Figure 2.11). According to the study conducted in 2008 about the health forming habits of Latvian inhabitants aged 15–64 (Pudule et al., 2010) only 38.5% of the surveyed women had undergone breast mammography or ultrasonographic breast examination at least once in their lifetime. The proportion of examined women is higher in the age group 45–54 – 58% and the age group 55–64 – 55.4%, when such examinations are recommended. The data of this study show that the proportion of women, who have undergone examination, is higher among women with higher level of education.

2.6.2 Cervical Cancer

The cervical cancer prevention (screening coverage) remains insufficient in the Baltic States, the pre-cancerous diseases are not timely detected and treated, and the cervical cancer is diagnosed belatedly (see Figure 2.12). Late detection of malignancy (in III or IV stage) furthers high mortality.

As to morbidity and mortality this is one of the most widespread tumours in Latvia. The analysis of the morbidity data in Latvia on malignant cervical tumour among women in the age group 0–64 years shows an increase during the last two years, which, perhaps, can be explained by the increase in the number of diagnosed cases, through launching cervical cancer screening in 2009. An increase in the mortality from malignant cervical tumour was observed in 2010.

The data of 2008 population survey show (Pudule et al., 2010) that, even though the state pays for this service, only 35.8% of women indicate that they have never had an oncocytologic smear test done by a gynaecologist. For 2/3 of the women, who had undergone the examination, the test was done during the last 1–2 years.

To promote timely diagnosing of cervical tumour the
Figure 2.12 Standardised female mortality from cervical malignancy in Latvia, Lithuania, Estonia and the European Union, age group 0–64 years, per 100 000 of population

![Graph showing mortality rates over years](image)

**Source:** Data from WHO, European Health for All database.

Figure 2.13 Female morbidity and mortality from malignant cervical tumour in the age group 0–64 years (per 100 000 of population)

![Graph showing morbidity and mortality rates over years](image)

**Source:** Data of the National Health Service

Figure 2.14 Have you visited an out-patient medical facility (for example, out-patient clinics, doctors’ practices, medical practices, etc.) during the last 12 months? Answers from all respondents, %, in 2003 (women, n = 1251, men, n = 1201), in 2011 (women, n = 1313, men, n = 1304)

<table>
<thead>
<tr>
<th>Year</th>
<th>I have visited</th>
<th>I have not visited</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>68%</td>
<td></td>
<td>31%</td>
</tr>
<tr>
<td>2011</td>
<td>60%</td>
<td></td>
<td>40%</td>
</tr>
<tr>
<td>2003</td>
<td>84%</td>
<td></td>
<td>16%</td>
</tr>
<tr>
<td>2011</td>
<td>82%</td>
<td></td>
<td>18%</td>
</tr>
</tbody>
</table>
The state launched an organised screening program in 2009. The data of the Health Payment Centre show that during the preventive examinations conducted within the framework of this program from January 2009 to March 2011 in 2.3% or 1715 of the tested women (75524 samples were analysed) cytological pathology of the cervix was detected.

2.7 Visiting Doctors and Disease Prevention

The survey data show that during the last year women have visited out-patient medical facilities more frequently than men. Since 2003 both men and women in total have visited health care facilities less frequently, however, the decrease in visits is more significant among men – less than 8% of men have used the assistance of health care specialists (see Figure 2.14). The self-assessment of health, as described in the beginning of the Chapter, however, generally has improved. The frequency of visits to out-patient facilities was influenced by respondents’ material status, but the place of residence was not decisive in this.

During the last year women most frequently visited a general practitioner because of some general illness (56%). Only 24% of the surveyed women have undergone preventive medical examination during the last year. Significant cause for the visit was the need to receive a prescription, a referral or a certificate on the health status.

General practitioners have not been important advisors on sexual and reproductive health issues. 11% of women have indicated that they underwent preventive gynaecological examination with their general practitioner, but 6% – sought advice related to a gynaecological disease. Only 1% of female respondents indicated that they had sought the advice of a general practitioner on choosing a means of contraception, but 3% received from the general practitioner a prescription for contraceptive means. An additional one percent sought advice on STI issues.

The popularity of state funded services of gynaecologists has not increased since 2003. During the last year 48% of women, who had visited a gynaecologist, used state funded services. In 2003 this indicator was 55%. In this group of women 44% paid themselves for the gynaecologist’s services, which conforms to the 45% of the previous survey. 13% of women could not answer who had paid for the doctor. In assessing the data it must be taken into account that during this period the respondents might have used both types of services. The choice of the type of doctor’s services is linked to the respondent’s income – 54% of women with the monthly income above 200 LVL have paid for the services themselves. In the lower income group (up to 100 LVL) this proportion has been only 33.6%. 59% and 38.2% of women in the lower and higher income group have, respectively, chosen a doctor paid for by the state.

Men visit the general practitioner less often than women – 43% of respondents have consulted a doctor because of a general disease. 27% had to visit the general practitioner to receive a referral; 26% needed a certificate on their health status; 24% had needed a prescription for purchasing medicines. During the last year men have not sought the advice of a general practitioner on means of contraception.

2.7.1 Preventive Gynaecological Examinations for Women

In general with each successive year the survey indicates less frequent preventive examinations (see Figure 2.15). The survey data show that 59% of female respondents have visited a gynaecologist during the previous year. The women, who have not undergone preventive examination during the last two years, like in the previous survey, most frequently mention the lack of complaints as the cause (see Table 2.1). The number of those respondents, who mention the dislike for gynaecological examinations as the reason, has decreased by 6%.

2.7.2 Cervical and Breast Cancer Screening

Organised cervical cancer screening was introduced in Latvia in 2009. Since the program for timely cancer detec-
tion was launched 76,667 women have undergone the preventive cervical cancer examination, which constitutes 16.2% of the number of invited women, and 71,960 women have undergone mammography examinations, which constitutes 21.4% of the number of invited women. Considering the disturbing situation as regards late detection and high morbidity from both tumours, it was expected that the organised screening would allow improving the situation. The comparatively low response from women was unexpected. Questions to reveal the causes of this low response were included in the survey. The screening was launched relatively recently, and yet 32% of female respondents have indicated that they had received the invitation to screening, allowing analysing the respondents’ attitude towards screening.

The analyses of the causes for not attending the screening revealed that the main reasons mentioned in the survey were lack of time (32%) or that the respondents had taken the tests independently from the state program (28%). Additional 17% of women indicated that an obstacle to undergoing the examination had been additional payments for the visit and additional tests, linked with the state paid tests, but 12% of respondents considered such examinations unnecessary. The survey also identified problems in the screening-linked communication – 8% of respondents indicated that the text of the invitation did not make it clear, what was expected of them, and 2% indicated that the text of the invitation itself had been incomprehensible. Travel costs were not a significant factor hindering going for screening – it was mentioned only by 3% of the respondents.

### 2.7.3 Vaccination against HPV Virus

On 1 September 2010 vaccination of 12 years old girls against human papillomavirus stems, causing cervical cancer, was started in the framework of vaccination cal-

<table>
<thead>
<tr>
<th>Reason</th>
<th>2003</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not have any gynaecological complaints</td>
<td>61%</td>
<td>65%</td>
</tr>
<tr>
<td>I dislike gynaecological examination</td>
<td>36%</td>
<td>30%</td>
</tr>
<tr>
<td>Doctor’s services cost too much</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>I do not have time</td>
<td>17%</td>
<td>14%</td>
</tr>
<tr>
<td>No one has actively invited me to come for examination</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>I do not know how often I should visit a gynaecologist</td>
<td>-</td>
<td>6%</td>
</tr>
<tr>
<td>A visit to the doctor (travel expenses, etc.) costs too much</td>
<td>6%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Table 2.1 Women who undergo preventive gynaecological examination less frequently than once in two years, in 2003 n = 276; in 2011 n = 353**

<table>
<thead>
<tr>
<th>Territorial departments of the Health Payment Centre</th>
<th>Cervical cancer preventive examination</th>
<th>Breast cancer preventive examination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Invitations sent</td>
<td>Examined persons, % of the invited persons</td>
</tr>
<tr>
<td>Kurzeme Department</td>
<td>71 169</td>
<td>17.3%</td>
</tr>
<tr>
<td>Latgale Department</td>
<td>61 711</td>
<td>17.0%</td>
</tr>
<tr>
<td>Riga Department</td>
<td>215 844</td>
<td>14.6%</td>
</tr>
<tr>
<td>Vidzeme Department</td>
<td>53 861</td>
<td>21.4%</td>
</tr>
<tr>
<td>Zemgale Department</td>
<td>70 444</td>
<td>15.4%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>473 029</strong></td>
<td><strong>16.2%</strong></td>
</tr>
</tbody>
</table>

Source: Data of the Health Payment Centre

<table>
<thead>
<tr>
<th>Territorial departments of the Health Payment Centre</th>
<th>Cervical cancer preventive examination</th>
<th>Breast cancer preventive examination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Invitations sent</td>
<td>Examined persons, % of the invited persons</td>
</tr>
<tr>
<td>Kurzeme Department</td>
<td>71 169</td>
<td>17.3%</td>
</tr>
<tr>
<td>Latgale Department</td>
<td>61 711</td>
<td>17.0%</td>
</tr>
<tr>
<td>Riga Department</td>
<td>215 844</td>
<td>14.6%</td>
</tr>
<tr>
<td>Vidzeme Department</td>
<td>53 861</td>
<td>21.4%</td>
</tr>
<tr>
<td>Zemgale Department</td>
<td>70 444</td>
<td>15.4%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>473 029</strong></td>
<td><strong>16.2%</strong></td>
</tr>
</tbody>
</table>

Table 2.2 Number of invitation letters sent and the percentage of examined persons in preventive breast and cervical cancer examinations from January 2009 to March 2011
The vaccination course includes three doses of CPV vaccine. The data of the state agency “Infectology Centre of Latvia” show that the average vaccination coverage with the first dose of vaccine from 1 September 2010 to 30 September 2011 was 48.8%. The lowest response was observed in Riga and Riga region, where only 35.1% of the girls in the appropriate age group were vaccinated. In other regions of Latvia the vaccination level with the first vaccine was significantly higher and fluctuated from 57.7 to 59.4%. Among the girls, who received the first vaccine, 2.7 had not yet received the second vaccine, and 21.6% – the third vaccine.

2.7.4 Promoting Male Health

The survey data show that not only visits to doctors, but also genital self-examination habits have become slightly less frequent compared to 2003, decreasing by 6%. A half of respondents have performed self-examination. The habits have not changed significantly among those men, who performed self-examination. The majority of men belonging to this group (67%) admit that they perform self-examination at least once per month.

2.8 Accessibility of Health Care

The survey shows that 23.5% of female and 18.8% of male respondents admit that they often and sometimes have faced the situation of not being able to visit a general practitioner because of insufficient means. The lack of resources for visiting a doctor has not affected only 57.8% of women and 64.2% of men. The situation has not changed significantly since 2003. In the lower income group 32.7% of women and 27.5% of men often and sometimes have not been able to afford a visit to the doctor. People in their forties (40–49 years) have been unable to visit a doctor more frequently than other age groups – 38.4% of women and 25.5% of men.

29.4% of women (24% in 2003) frequently and sometimes have been unable to see a gynaecologist because of material conditions. Among men 11.9% (12% in 2003) had been unable to visit an urologist or a venerologist.

22.7% of women frequently and sometimes have been unable to afford purchasing means of contraception. Similarly to the previous survey, the material accessibility is determined by the priority of the means or services. Among people in their forties 31.3% of women and 14.1% and men frequently and sometimes have been unable to afford purchasing means of contraception, while in the group of 15–19 years old women this proportion is 11.8%, but in the age group 20–24 – 19.7%. This age group difference is not so obvious among male respondents. 15% of women and 9.8% of men had not been able to purchase condoms for STI prevention. Also with regard to this issue the priority of prevention is higher among younger women. In general the correlation between the respondents’ income and accessibility of means of contraception is identified in the group of older respondents, but not among young people, which means that the accessibility is determined not only by the amount of available financial means, but also the priority of this purchase in the structure of expenditure.

Only 12.9% of female and 16.2% of male survey respondents indicate that they have health insurance policies. Significant decrease in the proportion of insured respondents is observed compared to the study of 2003: in the survey of 2003 21% of women and 23% of men had indicated that they had health insurance. In 2011 most often the more prosperous respondents have health insurance. Only 6.5% of women and 11.8% of men in the income group up to 100LVL per household member have insured their health, in the income group above 200 LVL 28.1% of women and 26.3% of men respectively. Most often the insured respondents are in Riga (18.4% of women and 21.2% of men), but the least frequently – in rural regions (8.9% of women and 12.2% of men). The frequency of insurance increases with the increasing age of respondents. Most often the insurance premium has been paid by the employer (54% of women and 64% of men). While 46% of women and 33% of men indicate that they have purchased the policy themselves or it was purchased by a family member. Only 2% had policies provided by social services.
Figure 2.17 Which of these methods of contraception are you currently using? Women, who have had sexual relations, %, (1997, n = 2990, 2003, n = 1112, 2011, n = 1151)

- None: 24% (1997), 27% (2003), 24% (2011)
- Male condoms: 49% (1997), 41% (2003), 44% (2011)
- Interrupted intercourse: 18% (1997), 16% (2003), 14% (2011)
- Hormonal pill, patches and rings: 6% (1997), 8% (2003), 10% (2011)
- Hormonal pill: 10% (1997), 12% (2003), 16% (2011)
- Intra-uterine device (hormonal): 10% (1997), 11% (2003), 14% (2011)
- Calendar method: 2% (1997), 4% (2003), 7% (2011)
- Emergency contraception: 1% (1997), 2% (2003), 3% (2011)
- Vaginal rinsing: 1% (1997), 2% (2003), 3% (2011)

Figure 2.18 Which of these means of contraception are you currently using? Men who have had sexual relations, %, (1997, n = 2990, 2003, n = 1077, 2011, n = 1139)

- None: 24% (1997), 27% (2003), 24% (2011)
- Male condoms: 49% (1997), 41% (2003), 44% (2011)
- Interrupted intercourse: 18% (1997), 16% (2003), 14% (2011)
- Hormonal pill, patches and rings: 6% (1997), 8% (2003), 10% (2011)
- Hormonal pill: 10% (1997), 12% (2003), 16% (2011)
- Intra-uterine device (hormonal): 10% (1997), 11% (2003), 14% (2011)
- Calendar method: 2% (1997), 4% (2003), 7% (2011)
- Emergency contraception: 1% (1997), 2% (2003), 3% (2011)
- Vaginal rinsing: 1% (1997), 2% (2003), 3% (2011)
- Female surgical contraception (sterilisation): 1% (1997), 2% (2003), 4% (2011)

Figure 2.19 Which contraceptive means do you currently use? Sexually active women, who are not planning pregnancy, responses according to age groups (n = 1002)

- 40 - 49: None 10%, Emergency contraception 1%, Interrupted intercourse 4%, Calendar method 20%, Male condoms 30%, Male intra-uterine device 20%, Intra-uterine device (non-hormonal) 10%, Hormonal pill, patches and rings 10%
- 30 - 39: None 10%, Emergency contraception 1%, Interrupted intercourse 4%, Calendar method 20%, Male condoms 30%, Male intra-uterine device 20%, Intra-uterine device (non-hormonal) 10%, Hormonal pill, patches and rings 10%
- 25 - 29: None 10%, Emergency contraception 1%, Interrupted intercourse 4%, Calendar method 20%, Male condoms 30%, Male intra-uterine device 20%, Intra-uterine device (non-hormonal) 10%, Hormonal pill, patches and rings 10%
- 20 - 24: None 10%, Emergency contraception 1%, Interrupted intercourse 4%, Calendar method 20%, Male condoms 30%, Male intra-uterine device 20%, Intra-uterine device (non-hormonal) 10%, Hormonal pill, patches and rings 10%
- 15 - 19: None 10%, Emergency contraception 1%, Interrupted intercourse 4%, Calendar method 20%, Male condoms 30%, Male intra-uterine device 20%, Intra-uterine device (non-hormonal) 10%, Hormonal pill, patches and rings 10%
2.9 Contraception

Similarly to the status identified in the last report, population in general, especially young people, are well-informed about contraception use. At the same time the survey reveals that safe methods and means of contraception are not chosen or are used incorrectly, which shows that the respondents are unable to apply their knowledge in practice. Less than a half of sexually active respondents always use contraception in casual sexual relations; the risk of getting infected with STI is assessed as being low. The survey data show that population migration due to economic considerations influences the stability of partnerships and increases the presence of casual relationships.

The choice and use of contraception is significant both for family planning and STI prevention.

The survey conducted for this report reveals that the male condom is the most popular means of contraception among men. 41% of sexually active women and 51% of men use the male condom. Approximately one fifth of respondents use interrupted intercourse as a means of contraception, and it is the second most popular method of contraception. 13% of surveyed women and 17% of the surveyed men’s partners use hormonal contraception. The proportion of the users of this contraceptive method has not changed significantly since the previous study. The proportion of the users of non-hormonal intrauterine device and calendar method has decreased.

33% of the surveyed sexually active women and 25% of men use unsafe means of contraception – 20% of women and 18% of men – interrupted intercourse, 10% of women and 6% of men – calendar method, and 3% of women and 1% of men – vaginal rinsing.

Hormonal contraceptive means are more frequently used by respondents with high income. In the income group with up to 100 LVL per household member hormonal contraceptive means are used only by 6.6% of female respondents (men indicate the use of 8.9% by their partners), but in the income group above 200 LVL the proportion reaches 17.2% of female respondents (men indicate 11%).

Women with lower income more frequently use the calendar method (men’s responses do not confirm this trend), however, the frequency of use of the unsafe method interrupted intercourse is equal among the respondents of all income groups. Compared to the previous reporting periods – 1997 and 2003 – the use of interrupted intercourse has not decreased, this unsafe method is used by one fifth of sexually active Latvian inhabitants of reproductive age. Most frequently the use of interrupted intercourse as a means of contraception is indicated by women in the age groups of 20–24 and 25–29 (30.5% un 25.7%) and slightly more often by men in the age groups 25–29, 30–39, 40–49 (ranging from 20.1% –22.6%).

2.9.1 Use of Contraception Among Youth

2.9.1.1 Condoms

Condom use is the most popular means of contraception in the youth age groups (see Figure 2.21). Thus, 67% of women and 73% of men in the age group 15–19 and 50% of women and 61% of men in the age group 20–24 during the last year have always or often used male condom. In general a trend of more frequent condom use is observed among young people compared to period of previous study.

The data of WHO study (Currie et al, 2008) also prove that condoms are the most frequently used means of contraception among youth: 86% of boys and 77% of girls (at the age of 15) have indicated that during the last sexual relations have used a condom for prevention, but
hormonal contraception – 7% of sexually active boys and 11% of sexually active girls.

During interviews and discussions young people mention male condom as the first known means of contraception. To young people it seems attractive because of accessibility, safety, convenience in purchasing and price. «Shops are filled with condoms, and also at pharmacies no one is asked to leave. And everybody can visit a doctor, which, of course, is slightly more expensive. But that’s not a problem in the least, it’s only a question of money, but, on the other hand, if you want to start having sexual relations, then you must be aware of the consequences, and if you can’t afford contraception, then perhaps you cannot afford thinking about such relations at all.» (Interview, 21 years old woman)

At the same time young people point out that access to free-of-charge condoms, ensured by non-governmental organisations and health centres, allows using contraception also by those young people, who otherwise would not purchase condoms. Young people believe that condoms allow both partners to take responsibility for contraception and their health. «[I use condom] because it is simpler. For example, you want to get at it, but you don’t know, if your partner has some STD or what. If you have the condom – go ahead and romp, but if she [the partner] is swallowing contraceptive pill, you don’t know, whether you haven’t caught something, there’s no children, but you have the disease.» (Interview, 20 years old man)

2.9.1.2 Hormonal Contraception

The survey reveals prevailing prejudice against hor-
monal contraception, which impacts the frequency of its use. 67.2% of women and 41% of men agree and rather agree that the contraceptive pill causes the risk of weight increase. Additional 26% of women believe that the use of hormonal contraception increases the risk of oncologic diseases. Women’s habits influence the choice of hormonal contraception – 59.8% of women agree and rather agree that it is difficult to remember to take the pill regularly. However, approximately a half of the surveyed women admit that the use of hormonal contraception alleviates period pain. It is noteworthy that the answers provided by different age groups show that the prevalence of prejudices does not differ significantly in them. 15–19 years old young women significantly more frequently than women of other age groups are unable to assess statements about hormonal contraception.

Discussions show that young people hold an ambiguous opinion on hormonal contraception. On the one hand, they link the use of hormonal contraception with changes in weight and even infertility, but on the other hand – with balancing of hormonal fluctuations and even improved appearance. An important reason for not using hormonal contraception is that it is comparatively difficult to obtain it – to get a prescription one must visit a doctor, which, to young people’s mind, makes it more expensive and requires additional time.

2.9.1.3 Emergency Contraception

The survey shows that 26.8% of female and 19.9% of male respondents consider or rather consider the use of emergency contraception as an action comparable to an abortion. More than half of men aged 15–19 and one third of women of this age are unable to answer this question. Both the discussions and interviews show that young people aged 15–24 are well-informed about the use of emergency contraception and have often used it – almost in all discussion groups young people could name the price and knew the price difference in the neighbouring pharmacies.

“Yes, the condom broke, I had to go out at two o’clock in the morning and buy it. They are expensive, but in emergency, you have no choice. But it is good that you can buy them even at night, otherwise – I had my pants full.”

(Interview, 20 years old woman)

Emergency contraception allows young people to “correct mistakes” in their choice of contraceptive means, however, if using it, young people remain alone in situations of crisis and do not receive support and advice on correct use of contraception and the mechanism of action of emergency contraception.

“Of course, it is possible to take that fast response pill after that, or whatever it is called, which one can take and prevent everything. I myself haven’t had the experience, but I know girls, who have taken this pill. But, well, if they miss a period and are afraid that they might be pregnant.”

(Interview, 20 years old woman)

This method of contraception is expensive, so its choice is determined by the availability of financial means, which is a problem for young people. During discussions young people admitted that in such situations they borrow money from friends, elder brothers, sisters and sometimes from their parents.

2.9.14 Contraception in Casual Relationships

In casual relationships, which create additional unwanted pregnancy and STI risks, less than a half of respondents always use a condom – 44.9% of the surveyed women and 48.4% of men. Additional 29.1% of women and 26.8% of men admit that in such cases they use condom “more often than not”. 13.6% of women and 11.1% of men never use condom in casual relationships.

2.9.2 Awareness of Means and Methods of Contraception

The survey shows that respondents are best of all informed about the use of male condom (indicated by 84% of women and 88% of men). The next means as to the level of awareness are hormonal means of contraception, women are well-informed about them (66%), but men are less informed (only 40% admit being well-informed). In general the assessment of the information people have about hormonal means of contraception has decreased by 7% among women and 10% among men. The comparatively high level of awareness and the low proportion of use point to the controversial assessment of hormonal contraception described above.

The awareness of intra-uterine device has decreased even more significantly compared to 2003 – by 13% among women and by 10% among men. The awareness of emergency contraception has increased – from 33% in 2003 to 51% in 2011 among women and 17% and 28%, respectively, among men, 57% of women and 45% of men are well-informed about interrupted intercourse. 24% of men and 44% of women have good knowledge of the calendar method.

An important criterion in selecting means of contra-
**Figure 2.22** What is your general assessment of the impact of these means and methods of contraception upon women's health? Responses from all respondents, %, (women, n = 1313, men, n = 1304)

<table>
<thead>
<tr>
<th>Method</th>
<th>Not hazardous</th>
<th>Hazardous</th>
<th>Hard to say, doesn't know this method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male condom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>27%</td>
<td>4%</td>
<td>19%</td>
</tr>
<tr>
<td>Men</td>
<td>34%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Hormonal pills, patches and rings</td>
<td>24%</td>
<td>48%</td>
<td>57%</td>
</tr>
<tr>
<td>Men</td>
<td>24%</td>
<td>57%</td>
<td>19%</td>
</tr>
<tr>
<td>Intra-uterine device (non-hormonal)</td>
<td>33%</td>
<td>25%</td>
<td>42%</td>
</tr>
<tr>
<td>Women</td>
<td>14%</td>
<td>38%</td>
<td>48%</td>
</tr>
<tr>
<td>Men</td>
<td>26%</td>
<td>37%</td>
<td>42%</td>
</tr>
<tr>
<td>Women’s surgical contraception (sterilisation)</td>
<td>38%</td>
<td>22%</td>
<td>40%</td>
</tr>
<tr>
<td>Men</td>
<td>25%</td>
<td>39%</td>
<td>45%</td>
</tr>
<tr>
<td>Men’s surgical contraception (sterilisation)</td>
<td>26%</td>
<td>39%</td>
<td>45%</td>
</tr>
<tr>
<td>Women</td>
<td>38%</td>
<td>22%</td>
<td>40%</td>
</tr>
<tr>
<td>Men</td>
<td>31%</td>
<td>39%</td>
<td>45%</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>12%</td>
<td>43%</td>
<td>44%</td>
</tr>
<tr>
<td>Men</td>
<td>13%</td>
<td>39%</td>
<td>40%</td>
</tr>
<tr>
<td>Interrupted intercourse</td>
<td>46%</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>Men</td>
<td>54%</td>
<td>25%</td>
<td>21%</td>
</tr>
<tr>
<td>Calendar method</td>
<td>51%</td>
<td>8%</td>
<td>23%</td>
</tr>
</tbody>
</table>

**Figure 2.23** What is your general assessment of the impact these methods and means of contraception upon woman's health? Men's responses, %, (n = 1304)
2

Table 2.3 Criteria for selecting contraception. Responses “very important”, %

<table>
<thead>
<tr>
<th>Criteria</th>
<th>women</th>
<th>men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency against pregnancy</td>
<td>73.8%</td>
<td>63.5%</td>
</tr>
<tr>
<td>Efficiency against HIV/AIDS</td>
<td>71.9%</td>
<td>73.4%</td>
</tr>
<tr>
<td>Efficiency against STI</td>
<td>68.3%</td>
<td>69.0%</td>
</tr>
<tr>
<td>No prescription needed</td>
<td>26%</td>
<td>35%</td>
</tr>
<tr>
<td>Price</td>
<td>31.8%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Conforms with partner’s wishes</td>
<td>27.9%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Does not affect weight</td>
<td>51.8%</td>
<td></td>
</tr>
<tr>
<td>No need to harmonize with partner</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>I can regulate menstrual cycle</td>
<td>33.9%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2.24 Number of induced abortions per 1000 live births

Source: Data of the National Health Service.

2.9.3. Accessibility of Contraceptive Means

The survey shows that for one third of respondents price is a very important criterion of choice (Table 2.3.) and rather important for additional 32% of women and 27.7% of men. The higher respondents’ income, the less important the price becomes, which shows that the respondent’s material status has a significant, but not decisive role in the choice of contraceptive means. Also respondents living in rural areas more often mention price as an important factor in choosing contraceptive means compared to urban inhabitants and inhabitants of Riga. The respondent’s age and gender is the second important factor. The older the respondent, the more important the price becomes in choosing the contraceptive means. Among male respondents price has no significant impact upon the choice of contraceptive means.

For 26.1% of women and 34% of men the accessibility of contraceptive means without doctor’s prescription is very important (for additional 29.5% of women and 25.9% of men it is rather important). Relatively more often the availability of contraceptive means without a doctor’s prescription seen as important in rural regions – it is very important for 34.1% of women and 40.4% of men and rather important for 24.9% of women and 23.9% of men.

Since the survey of 2003 the percentage of those re-
spondents, who do not spend any resources at all for purchasing means of contraception, has increased (see Figure 2.27). Simultaneously an increase in expenditure is observed. On average men spend more for purchasing contraceptive means than women.

The structure of expenditure according to age groups reveals that young people spend on contraceptive means proportionally more than each successive age group. Large asymmetry of male and female spending is observed in the surveyed groups of young people (15–24 years), men assuming the greatest share of expenditure (see Figure 2.26).

Even under the conditions of economic recession the financial accessibility of contraceptive means has not significantly changed in the reporting period. 10% of men and 15% of women frequently and sometimes have not been able to afford STI and HIV/AIDS prevention. 14% of men and 23% of women have been unable to afford prevention of unplanned pregnancy.

2.10 Unplanned Pregnancy and Abortion

The analysis of statistical data related to birth planning shows the positive fact of decreasing trends of the number of both general and induced abortions. In general during the reporting period since 2003 the number of abortions per 1000 live births has continued to decrease, the rates of decrease slowing down after 2006. However, compared to the average EU member states’ indicator, the number of abortions remains high in Latvia.

The number of induced abortions per 1000 women of reproductive age (15–49 years) in 2008 was 18, in 2009 –15.6, in 2010 –13.3. In 2010 the highest proportion of induced abortions was in the age group of 20–34 (Figure 2.25).

As to the frequency of choosing abortion according to the age groups, the survey data show that in the age group 15–19 years, for 80% of respondents the outcome of pregnancy was abortion. It decreases to 22.5% in the age group 20–29 years; 16.1% in the age group 30–39 years and 6.7% in the age group 40–49 years.
Figure 2.27 How much money do you personally spend on purchasing means of contraception (monthly average)? Responses of respondents, who have had sexual relationship, %. In 2003 (women, n = 1112, men, n = 1077), in 2011 (women, n = 1152, men, n = 1141)

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2011</th>
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<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
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</tr>
<tr>
<td>34%</td>
<td>46%</td>
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<td>12%</td>
<td>5%</td>
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<td>10%</td>
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<td>19%</td>
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<td>9%</td>
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<thead>
<tr>
<th></th>
<th>2003</th>
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<tbody>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48%</td>
<td>57%</td>
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<td>9%</td>
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<td>11%</td>
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<td>8%</td>
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Figure 2.28 How much money do you personally spend on purchasing means of contraception (monthly average)? Responses of respondents, who have had sexual relationship, %. In 2003 (women, n = 1112, men, n = 1077), in 2011 (women, n = 1152, men, n = 1141)

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<tr>
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<th>2003</th>
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<tr>
<td><strong>40 - 49 years</strong></td>
<td>62%</td>
<td>67%</td>
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<tr>
<td><strong>30 - 39 years</strong></td>
<td>54%</td>
<td>56%</td>
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<tr>
<td><strong>25 - 29 years</strong></td>
<td>38%</td>
<td>37%</td>
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<tr>
<td><strong>20 - 24 years</strong></td>
<td>37%</td>
<td>57%</td>
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<tr>
<td><strong>15 - 19 years</strong></td>
<td>32%</td>
<td>49%</td>
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<tr>
<th></th>
<th>2003</th>
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<tr>
<td><strong>Women</strong></td>
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<tr>
<td>40 - 49 years</td>
<td>67%</td>
<td>51%</td>
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<tr>
<td>30 - 39 years</td>
<td>56%</td>
<td>49%</td>
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<tr>
<td>25 - 29 years</td>
<td>57%</td>
<td>49%</td>
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<td>20 - 24 years</td>
<td>49%</td>
<td>49%</td>
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<tr>
<td>15 - 19 years</td>
<td>51%</td>
<td>51%</td>
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</table>
The survey data show that 59% of women, who have not planned pregnancy, have chosen abortion as the solution. Only one third of unplanned pregnancies ends in birth. The data provided by men differ – abortion as an outcome is mentioned in 47% of unwanted pregnancy cases, but birth as an outcome – in 45% of unwanted pregnancies.

Of the surveyed women, who have ever been pregnant, 55.7% of respondents have considered abortion as an option. Out of women, who considered it, 44.9% had an abortion. 38.8% of women have never had to terminate pregnancy artificially. 59.7% of men, whose partners have been pregnant, were unable to answer this question. Only 8.4% of respondents are convinced that the termination of pregnancy has never been considered.

It must be kept in mind, that these data reflect the high rate of abortions during the previous decades. In general 15.5% of women, who have ever been pregnant, have admitted that during the last 5 years have had at least one induced abortion. A similar trend is seen in male respondents about their partners – 13%. People living in the countryside have had abortions two times less frequently than in Riga (11.3% in rural regions versus 20.8% in Riga). This trend is not pronounced in men’s responses, even though, similarly to women, the partners of men living in rural areas have opted for abortion less often. The proportion of abortions was higher in the highest and lowest income groups compared to the average income group both among men and women, indicating that the amount of financial means is not decisive with regard to the choice of abortion. The insufficiency of means is not decisive with regard to the choice of abortion. The insufficiency of means is not determined by the amount of available resources, but the subjective assessment of their insufficiency.

Women living in unregistered partnerships have had abortion more often (responses of 20.4% of women and 17.8% of men versus 13% of married women and 11.9% of married men).

2.10.1 Causes of Unplanned pregnancies

Respondents indicate not using contraception as the main cause, even though they had been informed about it – 46% among women and 52% among men (43% in 2003). The proportion of incorrect use of contraception is still high (burst condom, forgetting to take the pill, etc.) – indicated by 27% of male and 33% of female respondents.

Condom use has failed the respondents most often – 34% (26% in 2003), followed by interrupted intercourse – its unreliability is admitted by 28% of female and 24% of male respondents (23% in 2003). The calendar method has also often failed women – 25% of cases, but men indicated it in 15% of cases (21% in 2003). The use of hormonal pill has been comparatively safer – 15% of women and 17% of men report on complications in case of using it (19% in 2003). Additional 13% of women and 11% of men reported that the inter-uterine device had failed them.

2.10.2 Motivation for Terminating Pregnancy

As regards the reasons, which made respondents opt for pregnancy termination, the main reason was unwillingness to continue pregnancy. It was noted by 50% of women. Another 46% of women indicated material reasons, because of which they could not afford bringing up a child. Analysing this according to the female respondent’s income, women in the lowest income group (up to 100 LVL per family member) indicate the material reason in 53.5% of cases; however, also in the highest income group 39% of women indicate material difficulties as the reason for terminating pregnancy.

No correlation is found between the material conditions as the reason for choice and the respondent’s income level in responses provided by men. This shows that the self-assessment of income is subjective. 22% indicate lack of psychological readiness, but 20% – that the period following the previous birth had been too short. Lack of psychological readiness and unwillingness to continue pregnancy dominate among younger respondents. For 11% of women having a child would have been an obstacle to their careers.

Partner’s wishes are decisive in deciding on terminating pregnancy. Thus, 10% of women indicate that this had been their partner’s wish, but additional 8% have noted that they opted for terminating pregnancy because the farther of the expected child had left them. According to responses provided by men, whose partners had terminated pregnancy, in 31% of cases this had been the man’s wish. The same proportion was attributed to their partner’s unwillingness and the material inability to bring up a child.

2.10.3 Taking the Decision

In general men are well-informed about their partner’s pregnancy and choice of induced abortion. 15–19 years old men are an exception, 40% of them could not answer, whether their partner had had at least one induced abortion during the last five years, which is a sign of lack of communication between partners. The average proportion of such men is 2.6%. Additional 71% of men indicate that they had discussed the issue of terminating preg-
nancy with their partner, and 18% indicate that this was discussed with a gynaecologist. In general, compared to the responses by women, men are less involved in taking the decision and less frequently seek other’s advice.

42% of women indicate that the partner had supported the choice of abortion, but in 17.9% of the cases entrusted the women herself with taking the decision. In 13.2% of cases the partner was not informed.

It can be observed that women living in unregistered partnerships had noted more often that they had not wanted pregnancy, would not have had the material means for bringing up the child or that the child would have been an obstacle for the career. Women living in unregistered partnerships sought the advice of their partners less frequently than married women (67.5% versus 80.8%). Men living in unregistered partnerships, in their turn, more frequently note the partner’s wish to terminate pregnancy. However, married men have indicated more frequently that they themselves had not wanted this pregnancy.

In 75% cases of pregnancy termination women have talked to their partners. Only 40% indicated that they discussed this decision with a gynaecologist. 17% discussed it with their mother and additional 12% – with a girl-friend. 11% took the decision themselves. Girl-friends, mothers and gynaecologists play a more important role in the lives of younger women; they have consulted with several advisors. 16.6% of women were not informed about using contraception following abortion, which is still a rather higher indicator.

2.10.4 Unplanned Teenage Pregnancy

This is one of the indicators, which characterises the awareness of reproductive health issues, as well as the skill of minors in applying this knowledge. The number of abortions in the age group 15–17 per 1000 girls of relevant age is decreasing – in 2010 it was 5.7 per 1000 girls, in 2009 – 6.1, in 2008 – 7.1, in 2010 the number of newborns of minor mothers (15–17 years) continues to decrease, constituting 1.4% of all newborns; in 2009 this indicator was 1.7%; in 2008 – 2.1% (Centre of Health Economy, 2011).

2.10.5 Adolescents’ Views on Terminating Pregnancy

During discussions the majority of adolescents acknowledge abortion as a preferable solution for unwanted early pregnancy.

«I believe that abortion is totally normal. I believe there is no need to ruin the lives of three people, that is, the mother, the unborn child and the young father. Even more so, if they are teens, if they are not well provided for. Not to speak about burdening the grandparents with all that! That’s unimaginable! I don’t understand those people who get all worked up, that life should be preserved and so on. I don’t believe in it, I don’t think so. I also totally agree. I think; if something like that happened to me, I could have an abortion at any time, whatever. Because I would not want to have that child. Doesn’t matter, whether I’d be well off or not, a teenager or not. If I don’t want him, then I don’t want. I can do it.»

(Discussion among young women in Zemgale)

Adolescents link upbringing of a child with responsibility, which, mostly, they do not want to assume, even though in general they might have negative attitude towards termination of pregnancy.

«I think that one must opt for abortion, which sometimes is the best solution. But, if it is possible to avoid it, perhaps by carrying that cross [the child], live for five years, while [person himself/ herself] grows up and becomes materially independent, then all things will come to right.»

(Discussion among adolescents, a woman, Riga)

Adolescents perceive unwanted pregnancy as a tragedy and a most serious crisis, which an adolescent might encounter in the field of reproductive health.

«I have had a situation like that; that it almost turns out that there has been a child, and you feel awful. For four or five days I was thinking only about children, it was very hard. I did not want, well, I do not want [it] to happen. O, my God, it happens, it can happen to anybody, it happened to my parents, they have told me that I was an accident.»

(Discussion of adolescents, Kurzeme, a man)

Unplanned pregnancy makes some of them feel ashamed about the outcome of sexual relations becoming public, and about their inability to prevent it. Part of adolescents would use abortion as a possibility to keep this mistake secret even from close people, thus going without any support whatsoever.

«Perhaps I would not inform about it, I would keep silent, would go to a medical facility and say that I need an abortion. The financial aspect, that’s another matter. But, perhaps, if it could be arranged in a way that you don’t have to tell anybody.»

(Interview, 21 years old woman)
Adolescents’ anxiety about the negative consequences of abortion, about which they have been informed at school, creates stress. Adolescents believe that abortion causes risks of infertility and infection.

2.11 Pregnancy and Labour

To a large extent a child's development and health is influenced by mother’s health, pregnancy planning, parents’ attitude towards their own and the expected child's health and care for the child, as well as the accessibility and quality of perinatal care. The survey shows that among women, who have given birth, 27.2% of women had not planned pregnancy. Among fathers this proportion is 20.8%. The younger the respondent, the more frequently it is indicated that pregnancy was not planned. Respondents living in unregistered partnerships admit that pregnancy was not planned more often than those living in marriage (32.1% of men and 27.2% of women living in partnerships versus 17.4% of married men and 22.5% of married women).

2.11.1 Care for Pregnant Women

To ensure successful course of pregnancy, it is important to monitor it, by pregnant woman registering. Early registration decreases the risk that a child might be born with health problems, since possible risk factors to the child’s and mother’s health are identified and prevented timely. Statistical data show (see Figure 2.29) that during the last two years (2009–2010) the number of pregnant women, who have started receiving care prior to the 12th week of pregnancy, continues decreasing.

The pre-natal care indicator was growing till 2003, when timely registration was stimulated by a larger child-birth benefit. Starting with 2004, when amendments were introduced to the respective Cabinet of Ministers Regulations, there are no more material incentives for timely registration of pregnancy.

Since 2007 the trend of increasing proportion of women giving birth without pre-natal care is observed. It could have been fostered by economic recession. In 2010 the number of women who had not received ante-natal care remained on the level of 2009 – 2.7% (see Figure 2.31).

Female respondents, answering questions about their latest pregnancy, which ended in birth, reveal the trend to register pregnancy early (19.3% of respondents registered their pregnancy prior to the 5th week of pregnancy). Already 93% of women had registered their pregnancy prior to the 10th week. In general the survey shows that 97.4% of women had registered pregnancy during their last pregnancy, this indicator is higher than 91% recorded in the survey of 2003. The place of residence and geographical accessibility of a doctor was not decisive. The obtained statistical data on the proportion of pregnant women, who had not received antenatal care, are too small to be analysed with the help of a survey.

On average 9.2% of men cannot answer, whether their partner had registered her pregnancy, thus the proportion of pregnancy monitoring indicated by men is lower. It is interesting to note that with changes in the practice of giving birth and growing popularity of family birth, men’s awareness of pregnancy monitoring has changed. Among men, whose partner had given birth prior to 1994, 9.4%–12.2% of respondents did not know, whether their partner had had pregnancy monitoring. During the last three years the proportion of such partners was only 5.5%.

During the last pregnancy, which resulted in birth, 93.3% of respondents entrusted their care to a gynaecologist. Only 2.5% of women underwent pregnancy monitoring with a midwife, and additional 1.7% with a general practitioner. The total of 46.8% women, who gave birth, and 41.4% of men, whose partner gave birth, visited the

Figure 2.29 Pregnancy care started prior the 12th week of pregnancy, %

Source: Centre of Health Economy, 2011: 174

9 The Regulation of the Cabinet of Ministers of 14 September 2004 No. 791 “Amendments to the Cabinet of Ministers Regulation of 8 July 2003 No. 381 “Regulation on the Amount of Child Birth Benefit, the Procedure for Reviewing it and the Procedure for Granting and Payment of it”.

2
doctor or the midwife together with the partner. This was more often done in Riga (48% of cases among men and 62% of women) than elsewhere in Latvia. Men with a higher level of education were monitoring pregnancy together with their partner more often – this proportion among men with higher education is 56.3%. The woman’s level of education is not decisive in this matter.

The man’s age is also important – in other age groups approximately a half of men visited the doctor together with their partner, but in the age group 40–49 the proportion of such men is only 28%. Similarly, women in their twenties visited the doctor together with their partner more often than older women. The tradition to monitor pregnancy together with the partner has developed rapidly over the last 20 years: at around 1990 the partner joined for the visit to the doctor in one fifth of the cases, but during the recent years this proportion has reached 55.9%. Women living in marriage monitored pregnancy together with the partner more often (58.3%) than women living in unregistered partnership (31%). In men’s responses this difference is not significant.

2.11.2 Training During Pregnancy

The survey data show that in general 26.1% of those female respondents, who have ever given birth, attended “parents’ school”. Among expectant fathers this proportion is 19.5%. Territorial accessibility had been significant – in rural areas only 13.5% of women have had the training, but in Riga – 35.7% of women. Also among expectant fathers those in Riga have attended the training more often – 29.1% compared to 15.2%–15.8% of men living in other cities and rural areas.

The attendance of “parents’ school” among female respondents has increased from 12.5%–14.5% at the beginning of 1990s to 35.7% during the last three years. Fast increase of attendance by expectant fathers started in 1994, reaching almost one third of expectant fathers during the last 7 years. Quite often maternity medical facilities set the attendance of “parents’ school” as a precondition of participation for those fathers, who wish to take part in family birth. The family has to cover the costs of “parents’ school” itself; this conflicts with the declared state-paid family birth services, setting additional obstacles to family births. Latvian legal acts do not define, which persons are entitled to participate in family birth. Not only the father of the expected child, but also some other trusted person could be the support person to the woman giving birth.

2.11.3 Satisfaction with the Pregnancy Care Services

The survey shows that 80% of women and 76.3 of men were satisfied with the doctor’s or midwife’s attitude during pregnancy monitoring. 68.9% of women and 53% of men were satisfied with the preparation for birth. The satisfaction with preparation for birth has grown during the last 20 years (see Figure 2.31).

The time that the obstetrician allocated for conversation is assessed as insufficient in 15.3% of cases. Additional 12.5% could not assess, whether the obstetrician allocated sufficient time for discussions. In general the number of those satisfied with the time allocated by obstetricians has increased over the period of 20 years. In female responses decreased satisfaction with pregnancy care can be observed during the last three years.

2.11.4 Partner’s Support

42.8% of women have received emotional support from the partner during pregnancy, and additional 34.1% of women, who have given birth, have rather received support. 54.2% of men have definitely supported women, and 32% of men have rather supported them. In general women living in marriage report a higher level of emotional support compared to women living in unregistered partnerships. Responses from men confirm these data. Men with higher level of education, in their turn, more often admit having provided support to their partners.

63% of women have asked for their partner’s support during pregnancy. Only 23.2% of men admit the need of emotional and psychological support during the partner’s
pregnancy, but 32.1% have received it. The trend of increasing proportion of men who receive their partner’s support can be observed over the last 20 years.

2.12. Labour

During the last years the reform of the health care outpatient and in-patient services system has decreased the number of those in-patient medical facilities, which provide delivery assistance paid for by the state. In accordance with the data from the register of medical treatment institutions in 2009 31 institutions were providing delivery services, in 2010 – 23 institutions. In 2011 labour paid for by the state was ensured in 18 hospitals – Liepāja, Ziemeļkurzeme, Kuldīga, Dobele, Tukums, Jūrmala, Jelgava, Ogre, Cēsis, Valmiera, Madona, Jēkabpils, Daugavpils, Preiļi, Rēzekne and Gulbene–Balvi hospitals, as well as Pauls Stradiņš Clinical University Hospital and Riga Maternity Hospital, as well as since 2011 state paid physiological deliveries are ensured also at Riga regional hospital in Sigulda.

To improve the quality of deliveries paid for by the state, in June 2011 the Cabinet of Ministers adopted amendments to the Regulation No. 1046 “The Procedure for Organising and Financing Health Care”. The Regulation stipulates that obstetric assistance in local hospitals will be provided and paid for according to the principle “money follows the patient” on the condition – if the hospital is able to ensure 24 hour accessibility of a midwife, a paediatrician or neonatologist and a gynaecologist-obstetrician, and if in the previous year it had at least 200 deliveries. The concentration of obstetrician assistance in a smaller number of centres in general improves the quality of obstetric assistance; it influences accessibility, looking at it from the point of view of service recipient. The survey does not allow assessing the impact of reform-linked changes upon patients’ awareness, satisfaction and territorial accessibility of services to whole family yet.

The survey data show that in the recent years the proportion of those respondents, who chose to have obstetric services for a charge, has decreased. In total 20% of women and 15.8% of men indicate that they had concluded an agreement with an obstetrics specialist. Foreign women and respondents with higher income of both genders, as well as city dwellers have concluded such agreements more often.

The survey shows that from 1995 to 2007 approximately one fourth of the surveyed women giving birth had concluded an agreement with an obstetrics specialist. Male responses in general point to an increase in the number of deliveries with concluded agreements from 2000 to 2008. During the last three years the proportion of such agreement-based deliveries has decreased to 19.8% among female and 18.9% of male respondents.

2.12.1 Family Birth

The survey data show that 15.2% of men took part in family birth. This was more frequent among men with higher income. A significant factor in favour of family birth is education – men with higher education have indicated three times more often that they participated in family birth compared to men with comprehensive secondary or vocational education.

When asked about the wish to participate in family birth, 32.1% of all respondents tend to definitely and rather agree. It is most frequently supported by Latvian men (34.4%), rather then men of other ethnicity (28.5%); men from Riga (38.6%), not from rural regions (29.1%), men with higher education (43.3%) rather than men with comprehensive secondary or vocational education (28.8%) and

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The highest proportion of such men is found in the age group 20–24 years – 39.8%. The support diminishes with men's age. Among young men aged 15–19 the proportion of men, who have no opinion on this issue yet, is twice higher (40%).

### 2.12.2 Home Birth

Since the previous survey of reproductive health, home births have become legalised in 2006. The proportion of home births is not sufficient to use the survey for analysing statistical data, therefore the respondent's opinion was measured. 34.4% of women and 27.3% of men agree to the opinion that a midwife is able to provide sufficiently safe care to the woman and the newborn during home birth. At the same time 77.8% of women and 67.5% of men believe that a woman, giving birth at home, takes on additional risk. 66.6% of women and 61.8% of men believe such risk to be unnecessary. 15.2% of men and 20.6% of women support the opinion that the man has no rights to interfere with the woman's choice to have or not to have home birth. 22.8% of men and 16.4% of women have no opinion on this issue. The survey data show that the attitude towards home birth has not changed compared to the previous reporting period.

7.4% of women would like to give birth at home, but 11% of men would agree to the choice made by the woman, this proportion is slightly lower compared to the previous survey. Men with higher education agree to that more often (18.7%). Women's level of education does not play a significant role, when deciding on home birth, however, women with general secondary or incomplete higher education have a more positive attitude towards all issues of home birth.

### 2.12.3. Intervention into the Delivery Process with a Caesarean Section

The data of the Centre of Health Economy show that in 2010 237 Caesarean sections were performed per 1000 live birth, which is approximately 24% of all deliver-
ies. According to the data of WHO European Health for All database, in 2009 there were 233 Caesarean sections per 1000 live births in Latvia. The average EU indicator is 260. A slowly increasing trend in the number of Caesarean sections per 1000 live births is observed in the EU states. Since 2007 this growth has stopped in Latvia.

The main reasons for increase in the proportion of Caesarean sections are chronic diseases of pregnant women, including extragenital diseases, late first pregnancy, multi-embryo pregnancy, and also the fact that indications for performing Caesarean section have changed – till mid-1990s part of extragenital diseases were not considered to be a sufficient indication. Likewise, often doctors of other specialties approve the need of this operation, when gynaecologists do not consider it to be a medical indication.

2.12.4. Breastfeeding

WHO recommends mother’s milk as the most suitable food for the newborn, which ensures the nutrients needed for baby’s growth and development (WHO, 2003; VVVA, 2005). It is recommended to feed infants only with mother’s milk up to the age of 6 months (exclusive breastfeeding).

Statistical data show that breastfeeding indicators are improving in Latvia, especially the proportion of children who have been breastfed till the age of 6 months (exclusive breastfeeding).

Statistical data show that breastfeeding indicators are improving in Latvia, especially the proportion of children who have been breastfed till the age of 6 months (exclusive breastfeeding).

The survey data show that during last 20 years the proportion of women, who have received partner’s support, had gradually increased, reaching 55% of those women, who have given birth during the last three years. Men's responses do not exhibit such a rapid increase.

59.8% of male respondents confirm that women have asked the partner’s support during the postpartum period. Only 25.1% of men have admitted the need for emotional and psychological support during partner’s postpartum period. But 32.9% received it.

2.13. Pregnancy and Birth Complications

The child’s health is influenced not only by the accessibility and quality of care, but also by mother’s health and health affecting habits during pregnancy. Smoking, consumption of alcohol, drugs and other addiction causing substances leave a negative impact upon the pregnant woman’s health and foetal development. These adverse habits sometimes cause miscarriage, development disorders in the newborn, pre-term delivery, birth of premature babies, still born babies and infant mortality during the first week of life (Skrule, Ståle, Upmale, 2009).

According to the data of Newborn Register, approximately 10% of women giving birth have smoked during pregnancy, 0.5% – have used alcohol, 0.1% – have
used drugs. The survey conducted for the report reveals a slight increase in the proportion of respondents, who have smoked during pregnancy, compared to the survey of 2003.

A trend of younger women having smoked more often is observed – the proportion is 21% among women in their twenties and approximately 11% of women in their thirties and forties. On average 6.8% of pregnant women have consumed alcohol.

Genital tract infections have a significant role in causing pregnancy complications, causing pre-term delivery and hereditary infections. The risk of getting infected is increased by frequent change of sex partners, insufficient knowledge about STI prevention.

According to the survey 17.3% of pregnant women during their last pregnancy experienced complications of high blood pressure, 2% – anaemia, 8% – infections of urinary tract, 3.6% – genital infections, 31.7% – colds. 13% of women were at pregnancy termination risk, this proportion is lower compared to the previous survey of 2003. 25.7% of pregnant women took medications because of disease during their last pregnancy, but 56% took iron supplements, additional 84% took vitamins.

2.13.1 Maternal Mortality

The maternal mortality indicator, following a decrease in the period from 2002 to 2004, in general exhibits a trend of increase and remains high. In 2009 10 women giving birth died in Latvia, thus the highest point in the last decade was reached.

Expressing this number per 100 000 of live births, in 2010 maternal mortality was 26 (in 2009 – 46 per 100 000 live births). This indicator is usually used for international comparisons, in which Latvia’s indicator is disturbingly high, as the average EU indicator, according to European Health for All database, is 6 per 100 000 live births.

2.13.2 Perinatal Mortality

Since 2003 a trend of slow decrease in perinatal mortality indicators has been observed. A similar trend is observed in the indicators on still born children (see Figure 2.38). At the same time, according to the data from WHO
European Health for All database, the perinatal mortality indicators in Latvia are still higher than the EU average. In 2009 in Latvia this indicator was 7.04, but in the EU – 5.58 per 1000 live births. In 2009 this indicator in Latvia was considerably higher than in Lithuania (4.4) and Estonia (4.51). The proportion of still-born children in Latvia is higher than the EU average. In 2009 this indicator was 5.87 per 1000 live births, while the EU average – 4.06. In Lithuania and Estonia this indicator was, respectively, 4.1 and 4.99.
Summary

1. Assessment of health status correlates with income – accessibility of services has become poorer for people with low income, this group has lower health self-assessment, visit to the doctor is often delayed and contraceptive means are not purchased due to lack of money. One fourth of female and one fifth of male respondents note that because of limited means access to general practitioner had been restricted. Poverty affects harder women’s access to health care and health promotion. Social guarantees provided by employer have decreased – the number of insured persons has decreased.

2. The quality of partnership is essential in the assessment of sexual and reproductive health. Stable partnerships improve the assessment of sexual and reproductive health.

3. No improvements are observed as regards male reproductive health. The proportion of visits to out-patient facilities had significantly decreased among men. In case of reproductive organ inflammation men would consult a doctor less often than women. A positive trend is observed in the attitude taken by young men – young men would seek the advice of a doctor more frequently than older respondents. For young men general practitioner has a decisive role in forming their behavioural model, for young women – gynaecologist. At the same time the survey data show that men are more actively involved in reproductive health issues have greater trust in a gynaecologist than a general practitioner or midwife, it increases the cost of the service and accessibility of reproductive health services to socially vulnerable strata.

4. The proportion of visits for preventive health examinations has decreased, even though in the recent years focus has been upon disease prevention. Unless they have complaints, women do not visit gynaecologist. The surveyed women do not understand the payment terms of organised cervical and breast cancer screening – patients do not undergo the examinations because they are afraid of additional payments and also do not understand the text of the invitation letter. Additional 18% of women have taken the cervical oncocytological test outside the screening. The analysis of the reasons for seeing a doctor shows that concrete needs dominate and that only an insignificant proportion of respondents want to gain information about issues of sexual and reproductive health behaviour – choice of contraception and STI. 14% of women note that the doctor has not actively invited them for preventive examination.

Traditionally women with regard to sexual and reproductive health issues have greater trust in a gynaecologist than a general practitioner or midwife, it increases the cost of the service and accessibility of reproductive health services to socially vulnerable strata.

5. The survey data indirectly show that the number of inhabitants undergoing STI tests is decreasing; the testing has been regular only in some population groups (pregnant women – syphilis, chlamydia, HIV). Young people, who do not take precautions against STI during sexual relations, are a special risk group. Statistical data reveal a high proportion of chlamydia infection among young women, but not among men. Young people do not assess the risk of getting infected with STI and do not attribute the risk factors to themselves. Young people living in rural areas have less knowledge of and greater caution against STI.

The proportion of respondents, who have taken HIV/AIDS test, has remained on the level of 2003. Respondents living in rural regions assess the infection risk as being lower and have taken the tests less often. Knowledge about HIV infection is improving among young people, but the personal risk awareness is insufficient. The majority of respondents assess their own risk of getting infected as low.

6. The habits of using means of contraception have not changed significantly. Male condom is the most popular means of contraception, hormonal contraception is used less frequently and opinion about its hazardousness is expressed more frequently – more than a half of women consider it being hazardous to female health. Two diametrically opposite views on beneficial or hazardous health impact of hormonal contraception are observed among young people. At the same time the survey data show that hormonal contraception has been the safest means of contraception. Other means of contraception have been less effective. 33% of surveyed sexually active women and 25% of men use unsafe methods of contraception – interrupted intercourse, calendar method, vaginal rinsing.

In general only a half of the surveyed sexually active respondents use condoms in case of casual relationships. Compared to the previous survey of 2003, the use of condoms have become more frequent among young people. One fifth of women have frequently and sometimes experienced financial difficulties in purchasing means of contraception. The amount of resources needed for purchasing means of contraception has increased, however, the proportion of respondents, who do not buy means of contraception, has also increased. Purchase of contracep-
tion is not directly linked with the respondent’s income, but with the priority of this need in the total structure of expenditure. The survey shows that additional costs linked with the visit to the doctor to receive the prescription, as well as the distance to be covered to reach the doctor is an additional obstacle to obtaining hormonal means of contraception. Obtaining of prescription means of contraception creates more problems to rural inhabitants than to city dwellers.

7. The statistical data collected by the state show that the number of induced abortions continues to decrease in Latvia. Unplanned pregnancy more often ends in abortion than a planned one. The main cause of unplanned pregnancy, in its turn, is not using contraception or using unsafe methods. 80% of pregnancies among women aged 15–19 end in abortion. Incorrect use of condoms and, following it, interrupted intercourse, remain the most significant cause of unplanned pregnancy. In the majority of cases material conditions has been the cause for terminating pregnancy, as well as a too short period after the previous birth.

8. The proportion of pregnant women with hazardous habits has increased – 14% of women have smoked during pregnancy. Since the material incentives for timely pregnancy registration have been abolished, the proportion of pregnant women, who have received this service, has decreased.
Chapter 3

Reproductive Health and Education of Young People

Since the previous reporting period in 2003 significant changes in the field of sexual and reproductive health education have occurred. The instruments of this report do not allow assessing the outcomes of changes directly, however, indirect methods – interviews and discussions with young people – show that schools differ as to the contents, mode and scope of learning. Discussions with young people show that the role of media in the information flow had increased.

When answering the question about the most convenient way of receiving information on contraception, 15–19 years old young people most frequently indicate impersonal channels of information – the Internet (57% of girls and 65.9% of boys) and special booklets (41.2% of girls and 29% of boys). The role of the Internet has significantly increased since the last survey – in 2003 11.35 of girls and 25.9% of boys mentioned it as a preferable source. 43% of young women indicated gynaecologist as a preferable source, however, young men have lower trust in health care specialists – 12.2 % (17.2% in 2003) of young men would seek the advice of a general practitioner. Pharmacists as providers of information are as popular as general practitioners, but nurses and midwives are not considered to be health care specialists to be approached regarding issues of contraception.

15–19 years old young people have comparatively high trust in formal education – 30.5% of boys and 28.2% of girls would like to acquire information about means and methods of contraception exactly at school. The popularity of school as the potential provider of information has increased since 2003, when this answer was given by 23.1% of young women and 23.3% of young men.

3.1 Education at School

Systematic education on reproductive health issues has been implemented in schools since 1995, choosing the model of a separate study subject Health Education. Since 2005 the issues of reproductive health in basic schools have been integrated into Social Studies subject. The Studies on Reproductive Health of 1997 and 2003 recommended keeping health education as a separate study subject. At the time of elaborating this Report, in November 2011 the renewal of Health Education subject was included in the Government’s declaration.

Boxed Information 3.1 Learning about sexual and reproductive health at basic schools

From 1995 to 2006 the study subject Health Education for Grade 5 was included into educational curricula, but from 2001 to 2006 – the subject Health Education for Grade 8. The content of this study subject covered also issues of sexual and reproductive health. The study subject Social Studies was introduced gradually – during three school years. It means that in the school year 2005/2006 subject Social Studies was introduced only in Grades 1, 4 and 7. But in the school year 2006/2007 – in Grades 1 and 2, 4 and 5, 7 and 8. Thus, only in the school year 2007/2008 subject Social Studies was introduced into Grades 1–9. The model basic education programs envisage one class per week for mastering the contents of Social Studies, except Grades 4, 5, and 6, when two classes per week are allocated for it.

Its content comprises ethical, civic, economic and health education as equally important components. According to the Cabinet Regulation of 19 December 2006 No. 1027 “Regulation on the National Standard in Basic Education and on Standards of Basic Education Study Subjects” and Cabinet Regulation of 2 September 2008 No. 715 “Regulation on the National Standard in Comprehensive Secondary Education and on Standards of Comprehensive Secondary Education Study Subjects” issues of health education are included in various general study subjects, for example, Social Studies, Natural Sciences, Biology, Chemistry, Housekeeping and Technologies, Sports, Health Education, as well as in the contents of the Class Master’s lessons for Grades 1–12, elaborated by State Youth Initiative Centre.

Source: Information of the National Centre for Education
Boxed Information 3.2 Excerpt from the sample program of study subject Social Studies (the study program is recommended)
The sample program of the subject Social Studies offered by the National Centre for Education in 2007 includes, for example, the following topics: “Everything Grows and Develops”: Life cycle. Growth and development, relationships, interests and obligation in teenage period (Grade 5, up to 14 lessons are allocated for mastering it); “Sexual and Reproductive Health”: Body, physiological changes in the teenage period and adolescence. Sexuality, its manifestations, gender equality (Grade 7, up to 3 lessons envisaged for mastering it); “I Want to be Healthy”: Infectious diseases, their spreading. Immunity. The importance of sexually transmitted diseases, HIV/AIDS prevention (Grade 9, up to 7 hours envisaged for mastering it).


In comprehensive secondary education Health Education is an optional subject. The standard curriculum of Health Education includes also issues of sexual and reproductive health. The basic requirements set for Health Education provide that upon graduating from Grade 12 the student should be able to take decisions that help prevent sexually transmitted infections, including HIV; expresses his or her opinion on measures for curbing the spread of HIV infections, on the causes and consequences of sex industry; offer substantiated options for dealing with youth addiction problems. Since 2008 sample subject program for the year allocated 20% of the total 35 lessons for the section “Sexual and reproductive health”.

According to the data provided by the Ministry of Education and Science, in the school year 2010/2011 18.4% of educatees were studying Health Education at an institution of secondary education (see Figure 3.1). This proportion has decreased compared to school year 2008/2009, when 26.2% of educatees were studying Health Education. Especially low proportion of youth, who had studied Health Education in the study year 2010/2011, was in Jelgava (5.5%), Jūrmala (11.4%), Liepāja (14.5%), Riga (15.3%). During discussions young people admit that usually at schools information is taught at the age, when adolescents have not started sexual relations and, thus, are unable put questions and understand the situation. In secondary school, when a larger proportion of young people have become sexually active, there are no more classes and students lack an authoritative advisor.

Boxed Information 3.3 Extract from sample study program Health Education (the study program is recommended only). Learning outcomes.

Grade 10 –12


Source: Health Education. Sample study program of comprehensive secondary education. The National Centre for Education, 2008, p. 19

“...I think it is too soon, because I know, when I had health education in Grade 8, when we were talking about those things, and those classes, it was just laughing all the time, no one was serious, of, course, everybody understood what was what, understood, what was taught, but, if done seriously, it should come later, in the secondary school, when it goes on, and when you can understand that seriously, and, yes, that would be better.”

(A young man, focus group discussion, Vidzeme)
WHO standards recommend to start studying sexuality related issues already from pre-school age, however, as young people point out in the discussions, secondary school is the age, when adolescents develop deeper interest and feel the need to talk about issues of sexual and reproductive health.

Topics of sexual and reproductive health are not included in the study programs of institutions of secondary vocational education. Youth focus group discussions conducted for the purpose of this study show that students of vocational educational institutions lack systematic education and support in these issues.

The topics of sexual health issues included in the content of standards of comprehensive education Social Studies and Health Education comply with the WHO standards of sexual education in Europe (WHO Regional Office for Europe, BzgA 2010), as well as with UNESCO recommendations on teaching about sexuality to children and adolescents (UNESCO, 2007, 2009, 2010), however, a part of reproductive health specialists and young people themselves are critical about its implementation. The survey shows that in the age group 15–19 66.3% of girls and 48.3% of boys received complete and rather complete information during "health education" classes, but 19.2 and 26.2 % of young women and men, respectively, in this age group assess it as incomplete or totally incomplete. Another 5.4% of girls and 6.8% of boys have not had health education.

The number of classes dedicated to health education is set by the teacher, and their quality is influenced by the teacher’s skill to discuss sexuality linked topics. Since health issues have become integrated into the content of the study subject Social Studies, an evidence-based assessment of students’ knowledge and skills has been lacking. On the one hand, by skilfully integrating issues of health and human relationships, a better link between health education issues and the young student’s life-experience in various fields can be achieved, but, on the other hand, lack of methodological materials and teacher’s skills allows avoiding and evading discussions on sexual and reproductive health. Discussions and interviews with adolescents point to unevenness of sexual and reproductive health education – in some cases the basics are acquired during biology classes, in others this has been provided by the school nurse, by a person unknown to adolescents or by peer educators.

The qualitative study conducted for the purpose of this report shows that young people have high regard for discussions, participation and practical training in the process of education.

"I would have liked it, if my class also had had the chance to go to a youth health centre, in the context of all that sexual and reproductive health, and if were had been told and given a chance to try it out in practice, to put on a condom (...). It seems to me that a more practical [aspect] was lacking."

(Interview, 21 years old woman)

Adolescents have high regard for the opportunities provided by informal education. During discussions young people emphasized that they would listen to and perceive as important information on reproductive health, if the person imparting it could create interest in adolescents and children.

Part of adolescents mention as a drawback lack of the emotional side of relationships and values in the process of formal education. Equalling reproductive health with physiological information, on the one hand, sets certain standards in forming relationships and creates additional
stress, when young people apply this information in real life. On the other hand, part of the adolescents, participants of the study, perceive focusing upon physiological information as a negative phenomenon, believing that such view promotes juxtaposing the sexual and the emotional aspect and normalizes frequent and impersonal sexual contacts. Thus, for example, a young woman in an interview places special importance upon emotional closeness in sexual relations, contrasting it with sex without it.

3.2 Education within Family

The survey data show that with each successive generation parents have more significant role in education their children on reproductive health issues. At the same time only 52% of women and 34% of men aged 15–19 have discussed these issues with their parents (see Figure 3.2.) Even less of adolescents aged 15–19 have asked their parents questions about reproductive health and sexual relations – 41.5% of girls and 21.4% of boys.

In the survey 15–19 years old girls named parents as the preferable providers of information on contraception issues as often as school (28.6% and 28.2%). Young men of this age prefer school (30.5% versus 21.7%). The statements made by young people during discussions confirm that in those cases, when parents are able to explain and show with their own example that reproductive health and sexual relations is a natural part of every person’s life, which people should be interested in and assume responsibility for, young people admit that they can discuss it with their parents and take much better decisions on relationships and their sexual health. For majority of young people, who were interviewed and heard during discussions, the relationships with their parents had not been open enough to discuss sexuality linked issues with them.

«Should come from parents [information about sexuality]. If they are able to develop normal, viable relations, then the child should also be able to do that. On the other hand, it should be discussed also at school Because many have complete confusion in their families, one cannot count on it.»

(Interview, 19 years old woman)

Education within family covers many aspects of reproductive health. Mostly young people expect emotional support from their parents. Thus, a 19 years old woman admitted during a discussion, that she had discussed with her mother starting sexual relations, and had been encouraged to be open and to rely upon their parents: «Said that I should not hide it and should not be afraid, that everything can be dealt with.»

The experience of many adolescents shows that a typical parents’ response, after they have started sexual relations, is an offer to buy condoms or placing a package of condoms in adolescents’ reach at home, without discussing these issues.

«With us it was like that, Dad gave them as a present to my older brother, she [girl-friend] was my brother’s classmate (laughs). Dad gave him the big package on a birthday, as a joke, and that was fun for the whole family – we all laughed. Well, yes, I had a case in a shop, when my mum asked, if I needed. (...) That was awkward, well, if I’d have a need, I would buy myself. Then I go home, [and] she [mum] says: “You know, where we keep them!” Well, then I say: “O.K.”»

(Focus group discussion, Riga)

If such talks lack the background of emotional relations, adolescents link such parents’ encouraging discussions with a sense of awkwardness and mainly assess it as parents’ wish to rid themselves of the responsibility for the child’s unwanted pregnancy.

The sense of awkwardness influences also the formation of future partnership, because experience in discussing sexual issues is lacking. Thus, the experience gained within family is very important in the formation of adolescents’ behaviour, not only the scope of information or payment for contraceptives, but also regarding development of relationships. 19 years old woman admitted in an interview:

«And then, definitely, [are important] talks with the other partner, the opposite gender. What he knows about it, what I know, and then we put it all together, [decide] how it should be, should not be done. It is very important to talk it all through with the other person.»

Parents’ schools and specialised portals (for example, www.maminuklubs.lv, www.mammamuntetiem.lv, www.calis.lv), which have developed rapidly since the previous reporting period, do not deal with sexual and reproductive health issues for adolescents and are not mobilising parents to set up special interest groups, as it has happened with regard to discussions on pregnancy, delivery, infant care and child nutrition, or school experience. Thus, adolescents’ parents are one of the most difficult target groups to reach, compared with school or health care facility.
3.3 Education at Health Care Institutions

Health care institutions play a comparatively small role in educating adolescents on sexual and reproductive health issues. In the survey when responding about the preferable educator on issues of contraception, women aged 20–24 and older rank gynaecologist as the first (70.5%–77.1%). General practitioner is the most popular advisor among men, 20.5% of 20–24 old men would opt for this. The survey shows that adolescents of both genders aged 15–19 and men in general do not regard health care specialists as potential advisors.

The qualitative part of the study reveals a similar situation, except one group of adolescents in a local government with available youth health centre services, which was very significant in both educating young people (education was provided also to the students of the local vocational education institution) and ensuring accessibility of contraceptives.

3.4 Media and Education

Compared to the results of the qualitative study of 2003, in which adolescents did not note particular media influence in the formation of opinions on sexuality, during the group discussions and interviews included in this study, young people were more critical of the information on sexuality distributed by mass media.

«It seems to me that everything is so much about the [sex] act, made into pleasure, the feeling, the sense of love is disappearing. Those physical processes – the position, the rhythm, I don't know, the size, the length...»

(Focus group discussion, Riga)

Both the quantitative and qualitative part of the study confirms the great influence of informative materials upon knowledge formation. The special booklets that adolescents receive at school and from their parents play a significant role in their education. At the same time oversaturation with information makes adolescents feel confused.

«There is no lack of information, especially nowadays, when it seems that you have only relationships around you, they way you should develop them, etc. The question is, how to get out of all this amount of information things that are really sensible and useful...»

(Interview, 21 years old woman)

«It seems to me that all my sexual education has been gradually collected information from different sources and awareness about what is what, where, how. I, definitely, do not feel like saying – well, I am educated, there's nothing new I can find out and learn.»

(Interview, 21 years old woman).

Young people stress the difference between knowledge and information, pointing to the contradiction between the easily accessible information and inability to select it and apply in practice. On the list of preferable providers of information in the survey outcomes, school is the most frequently noted advisor by both genders, as the potential place, where information could be transformed into knowledge.

Adolescents were unable to name one or several trusted sources of information; predominantly they search information according to its content, not the source. Perhaps the lack of trusted source of information on various issues of sexual and reproductive health can explain the great diversity in young people's opinions on the hazardousness or harmlessness of hormonal contraception for health.

3.5 Awareness of Sexual and Reproductive Health

The interviews and focus groups show that the information provided by school has the leading role in developing knowledge on sexual and reproductive health. Adolescents take a rather distanced view on sexual and reproductive health – as maintenance of certain physiological functions in the context of medicine and hygiene, less as a personal responsibility, choice and a concrete model of actions.

«Avoid injuries to genitals, advisable not to catch sexually transmitted diseases in one's lifetime, and then everything will be fine.»

(Interview, 21 years old man)

For young people sexual and reproductive health is a concept, which is comparatively hard to perceive and visualise – something that could be linked with their daily health maintenance practice.

«Well, it seems to me that my overall health is important. But, talking about reproductive, it is not as “tangible”, I am not thinking about it on daily basis, for example, when getting into a tram or washing hands before lunch, not to get a virus. But I take care of it, (...) well, I know that one should take care of it, I visit a gynaecologist at least once per year, for those regular check-ups, for tests, and so, I don't take any special measures, but compared to other girls of my age, that's a lot.»

(Interview, 21 years old woman)

Young people link reproductive health with concrete
moments in life – sexual contacts and having children, not with long-term behavioural models and knowledge – developing relationships and family planning in the future. The list of measures for maintaining sexual health is shorter for young men than for women, and is less often linked with having children.

One can observe during interviews and discussions that for the majority of adolescents it is difficult to talk about this topic. Young people use medical terms, euphemisms and Anglicisms to describe reproductive organs. Deeper probing often reveals that young people have no grasp of the terms used or are not sure of their understanding. It can be explained by the fact that information on sexual and reproductive health is mainly obtained at school, when it is discussed in the context of a study subject, by learning information and correct answers, but not through discussions and by applying it directly to their own health and actions.

3.6 Assessing Risks to Reproductive Health

The qualitative part of the survey shows that adolescents are well-informed about the risks to sexual and reproductive health and are able to enumerate them: indifference towards one’s body, lack of hygiene, care and physical activities, use of intoxicating substances, recklessness and irresponsibility in sexual relations, failure to use means of contraception, irregular visits to gynaecologist or urologist; however, they are not linking them with their own experience and behaviour.

“Good reproductive health can be maintained by observing safe sex, thus avoiding various sexually transmitted diseases, also by visiting a doctor at least once in six months, taking tests and examinations, to be sure about one’s health (not only in connection with STI and STD).”

(Interview, 20 years old woman)

“With reproductive [health] it is so, that all pre-conditions should be facilitated, to maintain health. So that the woman would be healthy and groomed, so that she could have children and bring them up. Or also [it] applies to a man. He must be healthy, should wash himself, take care of himself. In general, I don’t know.”

(Interview, 19 years old woman)

Such understanding of sexual health, which is based upon lots of information, but remains formal, creates additional risks to adolescents’ health. Following this logic, adolescents mainly link the risk of sexually transmitted infections with the assessment of the potential partner’s social status and appearance – grooming and hygiene habits, believing that it is possible to reduce the risks of sexually transmitted infection by the choice of partner, not by prevention. Young people have a misleading perception of the possibility to identify a disease by appearance.

“If you do not sleep, go to bed with every other, then you won’t get them [STD]. It is for me more like a hygiene thing. That’s why people say, see, a vagrant, he has syphilis.”

(During a focus group discussion in Latgale, a man)

During adolescents’ discussions and interviews carrying a child is predominantly seen as an additional female reproductive health risk, not as a natural physiological condition.

Summary

1. The assessment of situation since the previous reporting period shows that growing flow of information on sexual and reproductive health reaches young people. Sources of information are numerous and easily accessible. At the same time young people lack authoritative, qualified advisor, who would help to evaluate this information.

2. Parents are still recognised as the best advisors; however, data show that parents do not fulfil this role.

3. Adolescents obtain information on sexual and reproductive health at school. Most often the teacher is not considered to be an authority or a trusted person, and young people prefer other providers of information, for example, the school nurse, who is not involved with students on daily basis.

4. Adolescents have high regard of the opportunities provided by informal education.

5. Adolescents are well-informed about sexual and reproductive health issues, know, where to look for information, but do not apply the obtained knowledge in practice. The lack of practical knowledge may be linked with the authority of information provider, the content, as well as with the choice of wrong age group for training. At the age, when the majority of adolescents start sexual relations, formal education does not envisage systematic provision of knowledge and skills, development of attitudes in the field of sexual and reproductive health.

6. Attempts to increase the general practitioner’s role in transmitting knowledge on sexual and reproductive health to adolescents have failed. Adolescents underestimate the role of a nurse and midwife as potential advisors on issues of sexual and reproductive health.
Chapter 4

Reproductive and Sexual Health Policy

Sexual and reproductive health issues pertain to a number of policy sectors, including health, welfare and education, on the state and local government level, and intersectoral cooperation is needed to define and implement them. Reproductive health has special relevance in the context of demographic policy. Aspects of sexual and reproductive health, for example, sexual behaviour, family planning habits, partnerships, health maintenance habits, accessibility of health care and family planning have significant impact upon demographic situation. In Latvia reproductive health comes into the focus of health policy mainly in the context of demographic situation, subordinate to issues of natural movement of inhabitants and reproductive health issues. Demographic situation should be viewed in its interconnections. The aspect of sexual and reproductive health allows examining the natural movement of inhabitants on the level of an individual, as the outcome of relationships developed over the course of each person’s health and life.

4.1 Demographic Policy

Strategy Europe 2020 admits that demographic policy is a challenge for states not only on Latvian but also on the EU scale, because population is aging rapidly, but the average life expectancy is increasing, with the birth rate remaining low. A closer look reveals that not only the European population structure, but also the size and structure of households and employment structure is changing. In other words, the way Europeans form their relationships within family is changing. The European Commission in its report of 2010 on the demographic situation in Europe (European Commission, 2011: 66) indicates that several EU states officially recognise other forms of family and relationships outside marriage, for example, heterosexual and same-gender partnerships, children are born outside marriage more often or grow up in a single-parent family. States are adjusting their policy to these changes. Thus, for example, France, the United Kingdom and the Netherlands are developing policy of support aimed at single parents bringing up children.

The Report indicates that in all European countries higher birth rate correlates with the accessibility of child care. Countries with high quality and accessible care have higher birth rate. The Report points out that high indicators of women’s employment and high proportion of children born outside marriage in the country do not have clearly negative impact upon birth rate, as previously considered. Postponing having children for later creates a shift in birth rate indicators; however, it does not mean that the respective generation would create fewer children. In general, those countries, where having children is delayed, the birth rate is higher (European Commission, 2011: 67, 70). Statistical data show that birth rate is higher in countries with higher degree of gender equality, higher female employment and less traditional forms of family (ibid: 68).

The recommendation following from the report (European Commission, 2011) – better support for families, increasing employment and work efficiency, sustainable public finances, promoting immigration and integration of immigrants are the solutions of the EU states for preventing demographic crisis. With regard to family main attention is paid to the long-term stability of family – combining work and family life, more comprehensive application of acquired knowledge and skills, with regard to which women thus far have been in a more disadvantageous situation compared to men.

In demographic policy of the EU member states focusing upon specific target groups and empirically verifiable policy dominate. The United Kingdom program for reforming labour market New Deal11, aimed at the inclusion of such social groups as youth and single parents, transiting from benefits to work is an example. According to the information prepared by the Department of Child and Family of the Estonian Ministry of Social Affairs, Estonian family policy is aimed at diversity of family forms, respecting the choice of couples and individuals, assessing separately the effectiveness of each political activity.

In Latvia, considering the seriousness of demographic problems, the Council of Demographic Affairs was estab-

lished in 2011, it has been entrusted with coordinating the development and implementation of uniform state demographic policy. Currently the objectives defined by the Council do not include sexual and reproductive health issues, no experts from this field serve on the Council. However, the Council has the right to invite them.

In Latvia family policy has the closest connection with demographic policy, it sees the solution to decreasing birth rate predominantly in strengthening the traditional family, not in policy aimed at empirically identifiable forms of family among population. Health policy is predominantly developed in the direction of improving health indicators, identifying problems on the level of health statistics. Gender equality policy has been aimed at more precisely defined target groups, its sub-branches include also health and sexual health issues. Measures in the field of education are mainly aimed at education standards and are described in Chapter 3. This Chapter provides a brief overview on the development of health and welfare sector policy during the reporting period.

4.2. Public Health Policy

Comprehensive analysis of policy documents in the field of health care is not the basic aim set for the study, however, considering the low integration of recommendations provided by the previous studies into the content of policy documents and thinking about more effective integration of recommendations into policy documents, the action parts in the field of sexual and reproductive health in the basic policy documents since the previous reporting period have been analysed. This analysis is founded upon the basic documents, which have shaped the national level policy during the reporting period (2003–2011). Strategy for Maternal and Infant Health Care for 2004–2007 and Action Plan for the Implementation of Strategy for Maternal and Infant Health Care for 2004–2007, Public Health Strategy for 2011 –2017.

Public Health Strategy was adopted in 2011; Action Program for Implementation of Public Health Strategy for 2004–2010 was developed on the basis of it. Reproductive health program was not set as a separate objective, its issues were dealt with in the chapter Health of Infants and Pre-school Children, more narrowly as “The quality of work provided by reproductive health services and antenatal, perinatal and child health care services.” The assessment of the program is mainly analysis of statistical data, but the effectiveness of applied policy instruments is not evaluated.

The Strategy for Maternal and Infant Health Care for 2004–2007 was drafted simultaneously with the Public Health Strategy, and in 2004 Action Plan for the Implementation of Strategy for Maternal and Infant Health Care for 2004–2007 was adopted, it defines as problems to be solved the consistently high maternal mortality, the consistently high rate of abortions, increasing morbidity with sexually transmitted diseases among children and teenagers. The document envisages several lines of activities:

1. Improving prevention, diagnosing and treatment in the following fields: STI, diseases of reproductive organs, perinatal care.

2. Improving documentation and recording in the following fields: united register of reproductive organ diseases, infertility and medical fertilisation, improving the system of methodological management of perinatal care (defining medical indications for hospitalising pregnant women and women giving birth, using uniform terminology, based upon WHO recommendations), methodological guidelines for assessing health and functional abilities in victims of sexual violence.

3. Improving material and technical facilities in perinatal care.

4. Educational activities in the following fields: in the field of perinatal care prepared materials on sexual and reproductive health, family planning, pregnancy, birth and caring for newborns, educational seminars for health care workers on maternal and infant care, breastfeeding and teenage health issues.

The minutes of the working group for Action Plan for the Implementation of Strategy for Maternal and Infant Health Care for 2004–2007 meeting on 4 December 2007, indicate that, while assessing the implementation of the Strategy, several members of the working group criticise lack of assessment of causes and the fragmentedness of the Strategy. The analysis of the Actions Plan reveals lack of comprehensive view on maternal and infant health and problems in this field that should be dealt with as priorities. The main instruments for implementing the policy are drafting of documents and educational measures, however, these are not included into a uniform system of assessment criteria and do not give an idea of, for example, objective indicators for improving prevention, diagnosing and treatment. The implementation of the plan is evaluated with enumeration of the instruments themselves (documents, educational materials, events), but not with the effectiveness of applied instruments. At the same time 15 studies and 7 activities of international cooperation are envisaged in the Plan, which do not improve the
implementation of other measures included in the Plan and do not facilitate more effective assessment of them.

In the implementation of Plan the capacity of the Ministry of Health was most comprehensively used in drafting documents. Non-governmental organisations and WHO have had the leading role in organising educational activities, also by using resources attracted from various sources of funding, which was neither local government, nor state funding. Material and technical facilities have been improved through donation campaigns, and, even though the activity is evaluated as implemented, the evaluation document points out that further improvements in the assessment of material and technical facilities needed.

The envisaged measures for dealing with infertility and medical fertilisation issues have not been implemented, a uniform system for data registrations has not been creat-

<table>
<thead>
<tr>
<th>Identified problem/aim</th>
<th>Performance indicator</th>
<th>Performance indicator</th>
<th>Actions</th>
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<tbody>
<tr>
<td>Insufficient knowledge among population, including adolescents and teenagers, on issues of sexual and reproductive health, STI prevention.</td>
<td>Topical information on preventive measures against disease</td>
<td>Number of informative materials</td>
<td>1. Ensure educating teenagers on sexual and reproductive health issues; implemented by Latvian Association for family planning and sexual health “Papardes Zieds”</td>
</tr>
<tr>
<td>Aim: morbidity with infectious diseases has decreased</td>
<td></td>
<td></td>
<td>Measures for improving awareness and statistics, all infectious diseases</td>
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<tr>
<td>Insufficient knowledge about the negative impact of using addiction causing substances upon the health of the pregnant woman and the foetus, breastfeeding, starting the care timely and trauma prevention among children</td>
<td>Informing parents about the impact of addiction causing substances upon the health of the pregnant woman and foetus and the importance of mother’s milk ensured.</td>
<td></td>
<td>1. To implement educational activities for parents on the impact of addiction causing substances upon the health of the pregnant woman and foetus.</td>
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<td>2. To inform health care staff, parents and mass media about the significance of mother’s milk.</td>
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<tr>
<td>Lack of data on infertility treatment and medical fertilisation procedures performed</td>
<td></td>
<td></td>
<td>To prepare an informative report on infertility problem in Latvia, identifying the situation and providing recommendations.</td>
</tr>
<tr>
<td>Lack of information about accessibility of contraceptive means in various target groups.</td>
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<tr>
<td>Aim: improve maternal and infant health, decrease infant mortality</td>
<td>Improvement of the infant mortality indicators.</td>
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</table>
ed, the uniform STI register has not been established. The envisaged measures for decreasing maternal and perinatal mortality have not been implemented. The activity is evaluated as implemented, however, the evaluation document includes remarks that materials on sexual and reproductive health, family planning, pregnancy, birth and care for newborns are lacking, and that in the future policy planning should focus upon decreasing hereditary anomalies in Latvia by improving genetic diagnostics. The working group decides to continue policy planning with Program of Maternal and Infant Health for 2008–2010, but the decision is not implemented, as the work on drafting Public Health Strategy ensures the political succession.

Public Health Strategy for 2011 –2017 contains a chapter “The Health of Mother, Father and Child”, which recognises the significance of parents’ health and knowledge for child’s health and development. The problems in adolescents’ education, identified in the previous reproductive health study, is recognised as the main problem – too little attention paid to problems in sexual experience, habits for preventing unwanted pregnancy, STI, HIV/AIDS; accessibility of contraceptive means and awareness of their use among all population of reproductive age.

The facts that men care for their health insufficiently, the impact of STI, causing complications in pregnancy, smoking and using other addiction causing substances during pregnancy, decreasing number of women, who have timely registered pregnancy, are mentioned as problems.

Compared to the Strategy for the Maternal and Infant Health Care for 2004–2007, the quality of the policy document has significantly improved. Effectiveness criteria are used to measure policy outcomes, however, part of indicators is still defined in the terms of quantity of the activity itself. Thus, for example, preparing educational materials on the prevention on infectious diseases or activities for parents is a tool for informing groups of population about how to decrease morbidity, but their effectiveness should be measured not by their number, but by measurements of the target group awareness. Criteria for measuring effectiveness of the activities envisaged in the Strategy are not offered, which is admissible, if a further action plan for the implementation of the Strategy is drafted, which would include such indicators.

The Strategy does not evaluate the previously developed policy and the positive and negative examples from its implementation. Lack of assessment prevents improving the quality of policy tools and adjusting the chosen tools for reaching the aim more effectively. At the same time a trend of focusing problems and actions upon smaller, but in terms of effectiveness of action, more significant and potentially measurable measures. However, part of the problems identified in the analytical part of the Strategy are not dealt with in the planning part (see Table 4.1.) The recommendations of this report (see : Conclusion) are aimed at developing effective tools for implementing lines of actions proclaimed in the Strategy, by using evidence obtained in the study and covering the missing links and tools.

A number of additional policy documents and initiatives, which are important in the development of reproductive health policy, should be mentioned. In 2009 Program for Controlling Oncologic Diseases for 2009–2015 was adopted, and in accordance with this Program state organised and paid for program for timely detection (screening) of malignant tumours was launched. To diagnose the disease in early stage and start appropriate treatment timely, to retain the quality of life, implementation of cancer screening program has been started in Latvia, which includes:

1. Breast cancer screening, performed with mammography method once in two years for women aged from 50 to 69.
2. Oncocytologic screening test of cervical cancer, performed once in three years for women aged from 25 to 70.

Starting the vaccination of 12 year old girls against human papillomavirus on 1 September 2010 was an important initiative of the state in the field of sexual and reproductive health, including this vaccine in the calendar of vaccines paid for by state 12.

Assessing processes in health policy since the previous reporting period, the Agreement of Cooperation between the Ministry of Health and the World Health Organisation Regional Office for Europe for 2010–2011 should be noted, knowledge of reproductive health specialists and general practitioners on domestic violence were improved in the framework of this agreement. Guidelines (Pasaules Veselības organizācijas Eiropas Reģionālais birojs, LR Veselības ministrija, Latvijas Ginekoloģu un dzemdību speciālistu asociācija, 2009) and trainer’s handbook “Teachers of Social and Health Care against Violence” (Allen, Perttu, 2010) were elaborated on the basis of WHO materials, international practice and experience. In-depth training courses were organised and recommendations

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for reproductive health specialists (gynaecologists, obstetricians, midwives and general practitioners) on examining a patient and providing assistance.

Several working groups and committees are working under the auspices of the Ministry of Health, preparing proposals for dealing with public health and health care related issues, including issues affecting sexual and reproductive health of population:

1. The aim of Commission for Coordinating the Curbing of the Spread of HIV, Tuberculosis and Sexually Transmitted Infections is to ensure the support of professional specialists from the field for the implementation of national policy for limiting the spread of HIV infection, tuberculosis and sexually transmitted infections and to promote intersectoral cooperation, and to ensure the involvement of civil society in preparing the decisions.

2. The Advisory Council on Maternal and Infant Health is an advisory and coordination body, its aim is to involve associations in the elaboration and implementation of health policy on issues of maternal and infant health care, which includes health care of pregnant women, women giving birth and newborns, child health, as well as abortions and contraception.

3. A working group for drafting proposals on strengthening the role of local governments in primary health care and health promotion, which has to prepare proposals by 1 November 2011 on the necessary measures for promoting the accessibility of primary health care and improving health promotion work in local governments.

Parallel to that the Ministry of Health plans to elaborate and approve by the end of 2011 the Health Promotion Guidelines for Local Governments, which would include a chapter on family health, covering also sexual and reproductive health. These Guidelines will envisage measures and activities that the local government should carry out throughout their territories, aimed at four main groups of population – children of school and pre-school age, adults, pregnant women, young mothers and young families, as well as elderly people (over 65).

Measures, which affect also health care sector, included in the Cabinet of Ministers Order No. 490 of 18 August 2010 “On Social Security Network Strategy”, deal with the health care accessibility for patients with low income. Alleviations for receiving health care are envisaged for poor patients, whose income per each family member during last three months has been below 120 LVL, as well as for patients with monthly income in the range of 120 to 150 LVL, who have to pay 50% of the patient’s fee and no more than 15 LVL as a co-payment for an operation. Data of the survey conducted for the purpose of this report shows that no changes are observed in the subjective assessment of the accessibility of services compared to the previous reporting period, when such support measures were nonexistent.

Since 2008 gynaecologist and dermato-venerologist is a direct access specialist, patients do not need a referral from a general practitioner to see them (CM Regulation No. 1046). Thus the problem of expenses, connected to the need to obtain a GP’s referral, is dealt with, and also the health care service can be received sooner.

To improve the accessibility of general practitioners and their work with patients, a voluntary program for assessing the quality of general practitioners’ performance was introduced in 2011. The program aims to provide financial support to doctors, who are doing a good and high quality job, popularize them among patients and encourage other doctors to join the program. Some of the program criteria apply also to promotion and improvement of sexual and reproductive health, for example, monitoring the data of organised cancer screening. The general practitioner’s practice can receive additional payment in the framework of this program, if the organised cancer screening coverage in the doctor’s practice is by 15% higher than the average response indicators in the respective territory. Another criterion, which is assessed for granting additional payment, is the scope of additional manipulations and services provided, and additional payment is granted if the doctor provides pregnancy monitoring and care and gynaecological examinations at the practice.

The European Social Fund, is preparing a training program for nurses, doctor’s assistants. The training program will be free of charge, and it is planned to train 500 second nurses, who will be engaged in health promotion and prevention work in the general practitioner’s practices.

4.3 Gender Equality Policy

Program for Implementing Gender Equality for 2007–2010 included also health issues. While implementing the program, the Ministry of Health has conducted public awareness raising campaigns “Don’t Forget the Technical Maintenance of Your Health”, women’s health campaign “Afford to be Healthy”, a campaign for promoting male reproductive health “Real Men are not Afraid of an Urologist”. At the same time the program evaluation document (Labklajibas ministrija, 2011) notes that “in several studies conducted by the MH [Ministry of Health] the gender aspect, nevertheless, is not taken into consideration, and they are not targeting female or male (boy’s or girl’s) audience, for example, – Activity 6.3. on issues of healthy nutrition and lifestyle, etc.”, emphasizing the need of greater precision in selecting target audiences and appropriate focus of chosen activities.

The Ministry of Welfare is drafting a plan for implementing gender policy for 2012–2014, which includes promotion of healthy and environmentally friendly life-style among women and men as one of its lines of activities.

4.4. Family Policy


The Guidelines of State Family Policy for 2011–2017 were adopted in 2011, and a section on family reproductive health and infertility problems is integrated into it. Reproductive health is mainly examined in the context of demographic policy and increasing the birth rate, for the first time emphasizing on the political level the family aspect, nevertheless, is not taken into consideration, and they are not targeting female or male (boy’s or girl’s) audience, for example, – Activity 6.3. on issues of healthy nutrition and lifestyle, etc.”, emphasizing the need of greater precision in selecting target audiences and appropriate focus of chosen activities.

The Ministry of Welfare is drafting a plan for implementing gender policy for 2012–2014, which includes promotion of healthy and environmentally friendly life-style among women and men as one of its lines of activities.

4.5 Public Opinion on Family Policy

The survey conducted for the purposes of this report included questions about the assessment of the national demographic and family policy, which were not covered before. The analysis of the survey data shows that respondents do not have a favourable assessment of the national demographic and family policy. Thus, 81% of women and 76% of men fully or rather disagree that the state of Latvia supports families (see Figure 4.1). The majority of respondents believe that the state should support families and that bringing up children is not a private matter of families. The majority of respondents – 86% of women and 81% of men do not agree that Latvian families can feel safe in situations of crisis. As was mentioned in Chapter 1 of this report, lack of long-term economic stability, not only the current assessment of situation, is increasingly seen as an obstacle to having more children in the family, compared to the previous period.

On the one hand, the survey shows that Latvia’s inhabitants are conservative. The majority of respondents – 90% of women and 80% of men – believe that during the first year in the child’s life one of the parents should be engaged only in child-care. On the other hand, slightly more than a half of respondents support various measures for combining family and working life during the first year of child’s life. 61% of women and 58% of men support solutions, in which both parents during the first year of childcare simultaneously take care of the child and combine it with paid employment.

The current model of parent benefit allows only one of the parents to use the leave in a concrete period. The views on the impact of exclusive (not combined with paid employment) child-care upon career is almost equally split. At the same time 12% of those women and 6% of

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14 Ibid., p. 38 – a natural fertility method is emphasised, in the document it is called “NaPro technology, patented in America, with very high results in treating infertility”, without providing scientific evidence to this statement.
Families with children in Latvia can feel secure about state support in situations of crisis.

The state takes care of parents' rights to combine work with caring for children.

The state of Latvia supports families with children.

The state guarantees to parents kindergarten services.

Bringing up children is a private matter of parents, and the state should not take care of that.

Child-care leave has a negative impact upon career at work.

During the first year in child's life parents should be given the possibility to combine paid employment with caring for the child.

Both parents should be given the possibility to work part-time and care for the child, receiving compensation for lost income.

During the first year in child's life one of the parents should be exclusively engaged in raising the child.

Figure 4.1 To what extent do you agree to these statements? All women, n = 1313, %

Figure 4.2 To what extent do you agree to these statements? All men, n = 1304, %
men, who are bringing up children below the age of five, admit that having a child had a negative impact upon their careers (see Figure 4.3). The survey shows that in this group of respondents 93% of female and 31% of male respondents have used the child-care leave. However, in the interpretation of data it must be taken into consideration that male respondents, without knowledge of social policy terminology, might consider 10 calendar day long paternity leave as a child-care leave.

When assessing their possibilities for combining work with family life, 64% of female and 47% of male respondents, who work and bring up children below the age of 5, admitted that the employer is giving or has given them the opportunity to combine work with child-care. At the same time it must be noted that one third of men and one fifth of women have not been given such an opportunity (Figure 4.4).

In general, the opinion expressed by inhabitants reveals a contradiction between the uniform moral support for traditional families and practices aimed at greater involvement of both parents. The demographic situation and diversity of family models outlined in Chapter 1 marks the need to offer more flexible family models to population, allowing to choose the division of parents’ roles during the early stage in the child’s life, forms for combining work and family life. The survey shows that population would be ready for such choice.
Summary

1. Considering the topicality of demographic policy in the EU and Latvian context, the choice of effective and focused policy instruments for increasing the birth rate is essential. While effective family policy in the EU countries aims to increase the birth rate via social inclusion of parents, making it easier to combine work, family and personal life, family policy in Latvia is aimed at strengthening the traditional family values. The data of the survey conducted for the purposes of this report show that the respondents assess the state support policy as insufficient. The employers’ support for combining work and family life is assessed higher. At the same time the survey data reveal a certain contradiction in the inhabitants’ responses, greater emphasis is placed upon supporting traditional family values, but assess their own long-term possibilities of raising children on the individual level cautiously. Basic state support measures are aimed at support during the first years in the life of a child, but support measures to ensure the economic stability needed for bringing up a child in case of losing a job or family disintegration are lacking.

2. Sexual and reproductive health in Latvian politics is mainly examined in the contexts of separate policy sectors – health, education, welfare and gender equality, emphasizing separate reproductive health aspects. Policy documents have poor intersectoral cooperation outcomes (for example, the Ministry of Health is responsible for educational measures for teenagers in the field of reproductive health). At the same time active intersectoral cooperation is observed on working group level, which does not follow through to the level of policy documents on all occasions. The drafting of health promotion guidelines for local governments is a positive initiative for intersectoral perspective.

3. Improvements are observed as to the quality of policy documents in health sector, both in consolidating aims and defining problems and actions. At the same time a better research component should be integrated into defining policy instruments (actions), in monitoring and evaluation. The field of sexual and reproductive health policy has not been evaluated during the reporting period. Evaluation has been done in a working group, without setting evaluation criteria.
Conclusions and Recommendations

Chapter 1

Conclusions
1. The status of birth rate and nuptiality in the reporting period from 2003 to 2011 is characterised by both growth and decline, conforming to the changes in the economic situation of the state. Main factors affecting the birth rate:
   • economic situation and the increased state of insecurity about income and keeping one’s job in the future;
   • change of family model, proportion of unregistered partnerships is increasing, economic and social instability connected with the change of partners;
   • postponing having children for a later stage in life;
   • lack of skills for developing stable relationships among young people, absence of discussions on these issues at school and in public space.

2. Migration affects partnerships. Absence of sex partner creates the risk of casual relationships. Lack of support to children and teenagers, whose parents are absent for long periods, is increasing.

3. Violence remains widespread in families. There are problems in identifying violence and obtaining data on cases of violence in families and partnerships.

Recommendations
1. The state and local government should ensure geographically and financially accessible support measures for child-care. To review and draft labour legislation that would be young parent friendly, taking into consideration the best practice examples from European states.

2. Developing policy, which would ensure equal opportunities to children, who are born in both registered and unregistered partnerships.

3. Elaborate definition, legal regulation, monitoring and identification system of domestic violence.

4. To develop support measures for young people, whose parents are absent for long periods of time, in the framework of youth policy.

Chapter 2

Conclusions
1. Inequality between individuals belonging to different social groups increases in the field of health.

2. No improvements are observed in the field of male reproductive health. Men consult the general practitioner on reproductive health issues. The number of men, who are informed about and are involved in their partner’s pregnancy process and obstetric care, increases.

3. Organised, state funded breast and cervical cancer screening programs have been introduced during the reporting period since 2003, however, women’s participation in the program is relatively low.

4. Vaccination of 12 years old girls against human papillomavirus causing cervical cancer has been launched. Since the beginning of vaccination in 2010 the proportion of vaccinated girls in the group of 12 years old girls has been rather high.

5. Critical increase in maternal mortality indicators has been observed during the reporting period of the study.

6. Morbidity with ST remains high. The number of inhabitants, who have been tested for STI, decreases. Pregnant women, who receive prenatal care, undergo regular STI tests.

7. Young people, who do not use condoms during sex, is a special STI risk group. Young people do not assess the risk of getting infected with STI and do not attribute risk factors to themselves.

8. Morbidity with HIV/AIDS has remained on the level of 2003. The awareness of personal risk for getting in-
fected with HIV/AIDS among young people is insufficient.

9. The use of condoms among young people has become more frequent since the previous survey, yet it is not sufficient.

10. Habits of contraceptives use have not changed significantly. Male condom is the most popular, hormonal contraception is used less often. More than a half of women consider hormonal contraception hazardous to their health.

11. Interrupted intercourse still remains the most popular method of contraception. It is used by 20% of respondents. One-fifth of women often and sometimes have experienced financial difficulties in purchasing means of contraception.

12. The statistical data collected by the state show that the number of induced abortions continues to decrease in Latvia. However, compared to the data of the EU member states, the number of induced abortions is still high. The number of unplanned pregnancies in the age group below 19 years also remains high.

13. The proportion of pregnant women with harmful habits has increased – 14% of women have smoked during pregnancy.

14. The number of women, who have registered for antenatal care timely, has decreased. It is linked with abolishing of material incentives for timely registering for antenatal care and also with social causes.

15. Comprehensive data on the prevalence of infertility and treatment results are unavailable.

**Recommendations**

1. To ensure accessibility of reproductive health care to people with low income, increasing the role of primary care in ensuring this service (general practitioners, midwives, second nurses of general practitioners).

2. To improve male awareness of STI and understanding of their sexual health, delegating this task to general practitioners and second nurses of general practitioners and by fostering the health care professionals’ skills in these issues.

3. To improve organised cancer screening coverage:
   - To improve the involvement of general practitioners and gynaecologists in educational work on oncocyto logical screening for cervical cancer – using access to existing databases, individually reminding women above the age of 25, irrespectively of the purpose of the visit, about the possibility of screening.
   - General practitioners and second nurses/ midwives should participate more actively in inviting women to come for screening and taking the cervical oncocyto logical test.

   The National Health Service and non-governmental organisations should conduct extensive information campaign in mass media on the essence and necessity of breast and cervical cancer screening.
   - To make the text of the invitation for state funded cervical and breast cancer screening easier to understand and simpler.
   - The National Health Service should establish a monitoring and supervisory committee of cervical and breast cancer screening.

4. To continue introducing vaccination of 12 years old girls against HPV and achieve maximum possible proportion of vaccinated girls. To educate school doctors, nurses, pedagogues and parents.

5. To introduce amendments to the legislation of the Republic of Latvia (Law on Medical Treatment), allowing the Council of Maternal and Infant Health of the Ministry of Health to use medical files to analyse maternal mortality and conduct perinatal audit. To introduce audit of cases of maternal mortality and life-threatening pregnancy-linked complications, using WHO methodology “Behind the Numbers.”

6. The National Health Service and non-governmental organisations should conduct extensive campaign in mass media on the harmfulness of smoking during pregnancy. To find possibility for providing support measures for pregnant women to quit smoking.

7. To introduce screening examinations for sexually active young people below the age of 25 for chlamydia infection, upon coming for health care services to general practitioner and/or gynaecologist.
8. To improve in a targeted way the knowledge of inhabitants, especially in rural regions and young people, about HIV and STI.

9. To increase awareness of the possibilities to undergo HIV test, to improve the accessibility of this service.

10. To include on the list of reimbursement medicines means of contraception for special groups: young people below the age of 24, social risk groups (HIV infected persons, drug users, people with low income).

11. To increase the role of general practitioner in advising healthy women on the choice of contraception, especially following birth or termination of pregnancy, involving also the second nurses of general practitioners and/or midwives.

12. To elaborate the legal and ethical regulation for setting up a database of infertility patients.

13. To create a database on infertility treatment and results.

14. To develop national guidelines for specialists to promote uniform approach to infertility treatment.

Chapter 3

Conclusions
1. The amount of information on sexual and reproductive health issues has increased since the previous reporting period. Sources of information are numerous and easily accessible. At the same time young people lack authoritative, qualified advisor, who would help to evaluate the information.

2. Young people admit that parents are the best advisors on sexual and reproductive health issues, however, parents lack the necessary knowledge and skills.

3. Young people gain knowledge about sexual and reproductive health at school. Often the teacher is not an authority and a trusted person. Young people prefer choosing another advisor, who is not connected with school on daily basis.

4. Young people have high regard for possibilities provided by informal education.

5. Young people are well-informed about sexual and reproductive health issues and know where to look for information. However, often the acquired knowledge is not applied in practice.

6. The planned measures for increasing the role of general practitioner in transmitting knowledge on sexual and reproductive health to young people have not met the expectations since the previous reporting period. Young people do not appreciate general practitioners and nurses as potential advisors on sexual and reproductive health issues.

Recommendations
1. Students’ knowledge, attitudes and skills in sexual and reproductive health issues should be regularly assessed. Regular diagnostic tests in social studies and health education should be conducted.

2. Contemporary study materials should be elaborated, supplemented with interactive study methods.

3. The study subject “Health Education” should be included in the study programs as a mandatory subject in comprehensive secondary and vocational education. The subject should be taught by competent, specially trained teachers.

4. Informal education should be developed and strengthened.

5. To involve nurses and midwives/ doctors’ assistants in health education, especially for people at social risk and young people.

6. Special attention should be paid to educating young people from risk groups and children, whose parents are absent for a long period of time, about sexual and reproductive health issues. To organise support structural units in local governments and social services.

7. Local governments, using the available resources, should enhance parents’ knowledge and skills in sexual and reproductive health issues, especially in socially vulnerable groups.
8. To enhance the professional responsibility of midwives, expand competencies in working with families and young people. To include midwives in the team of primary health care doctor, emphasising their skills in providing advice on sexual and reproductive health issues, as well as prescribing appropriate means of contraception.

9. To introduce into the basic and continuous education programs for assistants to general practitioners and second nurses a mandatory course on family planning, sexual and reproductive health of young people, which would include evidence-based guidelines, which are used in Latvia and recommended by the WHO.

10. Include advising on family planning as an assessment criteria in the evaluation program of general practitioners’ work.

Chapter 4

Conclusions

1. In Latvian politics sexual and reproductive health is mainly examined in the context of separate branches of politics – health, education, welfare and gender equality – emphasizing separate aspects of reproductive health.

2. Intersectoral cooperation in dealing with sexual and reproductive health issues is insufficient. Likewise, the involvement of local governments in the elaboration and implementation of sexual and reproductive health policy is insufficient.

3. The issues of social inclusion of families, as well as of balancing work, family and personal life do not find complex examination in Latvian policy.

4. Latvia’s family policy is not evidence based and does not target real family situations and problem situations in the state.

5. Sexual and reproductive health policy is aimed at society in general, not at solving concrete problems. To reach the set aims attention should be paid to more adequate implementation of objectives and measures, as well as to progress monitoring.

Recommendations

1. To create evidence based sexual and reproductive health policy and programs, improving the intersectoral state and local government cooperation.

2. To ensure the implementation of principle “health in all policies” and reducing inequality in the field of sexual and reproductive health.

3. Issues of sexual and reproductive health and their impact upon demography should be taken into consideration in the elaboration and implementation of demographic and family policy.

4. Existing models of partnerships and families should be taken into consideration in the elaboration and implementation of family policy in Latvia.

5. To target sexual and reproductive health policy at solving the problems of concrete target groups at risk. To integrate research in defining, monitoring and evaluation of sexual and reproductive health policy.

6. To identify the actual relevance of infertility in Latvia, to develop and implement evidence based strategy for dealing with infertility problems in the context of solving Latvia’s demographic problems.

7. To identify the causes of maternal and perinatal mortality in Latvia, to elaborate and implement long-term strategy for decreasing maternal and perinatal mortality in Latvia.
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Databases


Veselības norēķinu centra dati [Data of the Health Payment Centre], www.vnc.gov.lv


Legal Acts and Policy Documents


Ministru kabineta 2010. gada 7. decembra noteikumi


Working Groups


