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*Applying Science to Strengthen  
and Improve Systems*

## USAID ASSIST Project

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# Ukraine Country Report FY15

**Cooperative Agreement Number:**

AID-OAA-A-12-00101

**Performance Period:**

October 1, 2014 – September 30, 2015

**DECEMBER 2015**

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#### DISCLAIMER

This country report was authored by University Research Co., LLC (URC). The views expressed do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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For more information on the work of the USAID ASSIST Project, please visit [www.usaidassist.org](http://www.usaidassist.org) or write [assist-info@urc-chs.com](mailto:assist-info@urc-chs.com).

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## Abbreviations

ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
BPI	Brief physician intervention
HCI	USAID Health Care Improvement Project
MOH	Ministry of Health
NMAPE	National Medical Academy of Postgraduate Education
PDSA	Plan-Do-Study-Act
QI	Quality improvement
URC	University Research Co., LLC
USAID	United States Agency for International Development

# 1 Introduction

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project began working in Ukraine in 2014 as a continuation of similar work conducted through the USAID Health Care Improvement Project (HCI), to implement a non-communicable disease pilot in Poltava Oblast, also known as “Improving Alcohol and Tobacco Control During Pregnancy in Ukraine.” The work was funded by the USAID Europe and Eurasia Bureau.

Alcohol and tobacco use in Ukraine are among the highest in the world. As a result, the overall goal of this intervention was to reduce alcohol and tobacco use among women during pregnancy, which has serious risks to the health and welfare of mothers and unborn babies. Preterm birth, developmental disabilities such as fetal alcohol syndrome, mental and growth retardation, low birth weight, asthma, and sudden infant death are some of the effects that drinking and smoking while pregnant have on babies. The intervention examined the feasibility of using an evidence-based structured counselling protocol known as the *brief physician intervention* (BPI) to assist pregnant women to quit smoking and stop drinking alcohol.

The project had the following two key objectives:

- Secure at minimum 80% reduction in tobacco and alcohol use by pregnant women in selected facilities
- Secure at minimum 80% coverage of women of reproductive age (ages 15-49) with BPI and family planning counselling

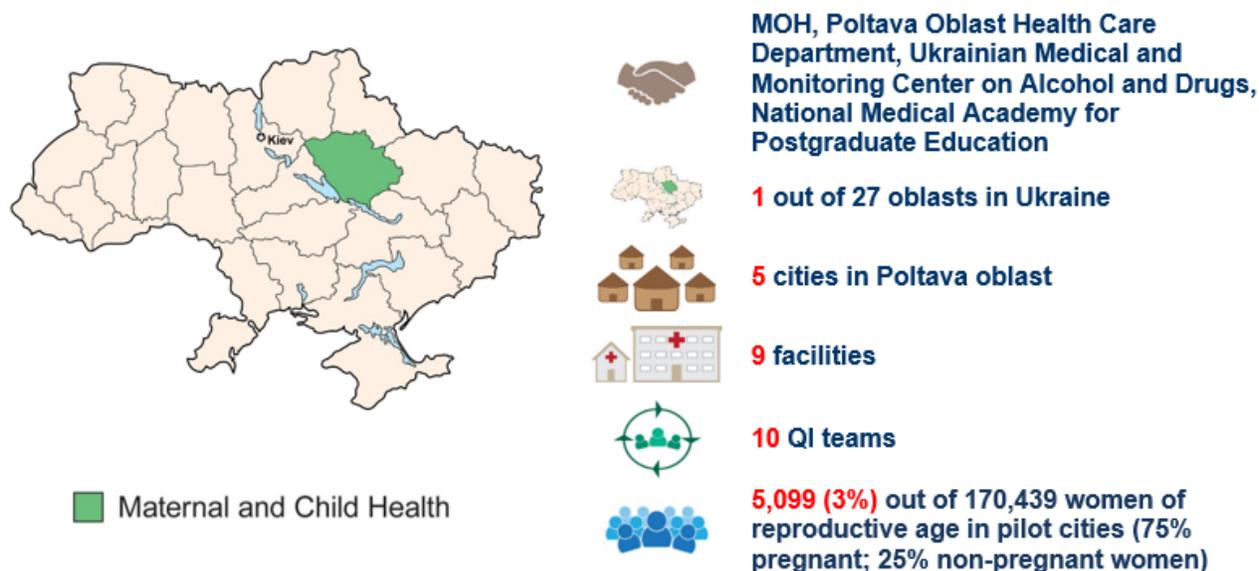
The intervention initially was to be implemented in the Luhansk and Poltava oblasts, however due to the political situation in Ukraine, the work was ultimately only implemented in Poltava Oblast. Nine facilities located in five cities in Poltava Oblast were included in the intervention. The project first conducted a “training-of-trainers” of national and local trainers on the use of BPI for tobacco and alcohol reduction. A baseline assessment was conducted in Poltava Oblast in July and August 2014 to establish patterns of alcohol and tobacco use among a cohort of pregnant women seen for initial evaluation in the facilities before BPI was introduced (Cohort 1). Health care providers from the nine facilities were trained on BPI in August 2014, in a two-day training conducted jointly with the Oblast Health Care Department.

From September 2014 to March 2015, ASSIST provided coaching support to each of the nine facilities for BPI implementation and convened one-day learning sessions in December 2014 and March 2015 to facilitate sharing of experiences and results among providers regarding BPI implementation. An end-line assessment was conducted among a different cohort of pregnant women (Cohort 2) seen for initial evaluation and followed up after the BPI intervention was introduced.

To achieve the goal of reducing alcohol and tobacco use among women during pregnancy, ASSIST supported the Ministry of Health (MOH) in Ukraine and partners in developing a national protocol for health facilities to incorporate BPI into the routine practice of health care providers in the country. The draft national protocol is being finalized for approval by the MOH and includes recommendations on BPI, the process of BPI delivery, recording and reporting tools, job aids, and referral mechanisms to specialty care.

The ASSIST activity in Ukraine closed out on June 30, 2015.

## Scale of USAID ASSIST's Work in Ukraine



## 2 Program Overview

What are we trying to accomplish?	At what scale?
<b>1. Improving alcohol and tobacco control during pregnancy</b>	
<ul style="list-style-type: none"> <li>Develop a national protocol and training curriculum for the brief physician intervention</li> <li>Ensure 80% of pregnant women do not use tobacco or alcohol during pregnancy in selected facilities of Poltava oblast</li> <li>Ensure 80% of women of reproductive age (15-49 years) are exposed to BPI and family planning counselling</li> </ul>	<p>Oblast: Poltava</p> <p>Cities in Poltava Oblast: 5 (Poltava, Kremenchuk, Komsomolsk, Mirhorod, Lubny)</p> <p>Facilities: women's consultations and family planning offices (total number 9), covering 80% of women population of pilot cities</p> <p>Health care providers: 80</p> <p>Target population: women of reproductive age, including pregnant women and adolescent girls</p> <p>Quality improvement (QI) teams: 10</p>

Improvement Activity

## 3 Key Activities, Accomplishments, and Results

### Activity 1. Improving alcohol and tobacco control during pregnancy

#### ACCOMPLISHMENTS AND RESULTS

- Development of a National Protocol for BPI and forming of working group.** Order #951 (December 11, 2014) was signed by the Minister of Health of Ukraine to set up a multidisciplinary working group at the national level to develop a National Clinical Protocol of BPI to decrease tobacco and alcohol using by pregnant women. ASSIST helped the State Expert Center to organize a first meeting in March 2015 of the working group to discuss a first draft of the BPI protocol and adapted evidence-based medicine guidelines for further development. The second meeting was organized in June 2015 to initiate the review process. The national protocol includes recommendations on BPI, the process of BPI delivery, recording and reporting tools, job aids, and referral mechanisms to specialty care. Approval of the protocol is expected early in 2016.

- **ASSIST conducted a pre-/post-intervention comparison in which behavioral changes in alcohol and tobacco use among a cohort of pregnant women seen for initial evaluation in the pre-intervention period (Cohort 1) (July – Aug 2014), were compared to changes among a different cohort of pregnant women who were seen for initial evaluation, provided the BPI, and then followed-up (Cohort 2) (Sept 2014 – Mar 2015).**
  - The **BPI implementation phase** occurred from September 15, 2014 until March 2015. Interventions during the implementation phase included: screening all pregnant women who came to the nine intervention facilities for the first prenatal (antenatal) visit; physicians completing patients' screening forms for the first and second visits; and patient's undergoing the urine diagnostic test for cotinine. If a patient was positive for tobacco use (cotinine test) or used alcohol, the physician provided immediate BPI consultation in accordance with the BPI protocol. A second visit was scheduled within three weeks for all cotinine-positive patients.
  - During the BPI implementation period, ASSIST organized and provided **coaching support** to health care providers. Coaches (monitors) were trainers and specialists in obstetrics and gynecology who had prior experience in conducting professional audits and working with other international projects.
  - Five **monitoring visits** were conducted to each of nine facilities (45 visits overall) from December 2014 to March 2015 to check the status of BPI implementation, the quality of screening, review how forms were being filled out, and discuss with teams any barriers to implementing the new protocol and how to overcome them. During the visits, teams reviewed the Plan-Do-Study-Act (PDSAs) cycles they were working on and tried to record them; reviewed their data and run charts; and planned the next steps of changes and action plans according to assessed barriers to change in each facilities. The intermediate results showed improvement in accessibility of BPI provided during prenatal visits in pilot facilities. In addition, ASSIST's work in Ukraine was also evaluated by a USAID monitoring team including a visit to the Poltava Health Care Administration and pilot facilities in Poltava and Komsomolsk (Oct/Nov 2014).
  - To facilitate **shared learning** between health care providers on the BPI implementation, the results of these visits were recorded and reported during two one-day **learning sessions** held in December 2014 and March 2015, respectively, and at the Oblast Health Care Department meeting in March 2015. The sessions were attended by 60 participants who represented the nine pilot facilities/polyclinics of Poltava city and oblast. During the learning sessions, participants discussed challenges with BPI implementation, presented data, reviewed results, and planned further steps toward BPI implementation. Evidence from the coaching visits showed improvement in access to screening and provision of brief counselling services for pregnant women in participating facilities.
- **Characteristics of pregnant women at their initial evaluation.** There were slight differences between the demographics of Cohorts 1 and 2. While women in both cohorts were of similar age, Cohort 2 on average came for their initial evaluations later in their pregnancy, were less likely to be single, and were better educated than women in Cohort 1 (**Table 1**) Pregnant women in Cohort 2 on average returned for their follow-up visit earlier than those in Cohort 1. These factors were controlled for in statistical analyses.
- **Pregnant women in Cohort 2 were more likely to agree to a cotinine test, more likely to test negative on the cotinine test, less likely to say they smoked, and more likely to be honest about whether or not they smoked.** When including pregnant women who either tested cotinine-positive or admitted smoking as women who smoke in Cohort 1, 19% of pregnant women were smokers at initial evaluation, while in Cohort 2 only 13% of pregnant women smoked (**Table 2**).

**Table 1: Demographic background of pregnant women in Cohorts 1 and 2 (July 2014 – March 2015)**

	<b>Cohort 1 (n = 652)</b>	<b>Cohort 2 (n = 3159)</b>	<b>p value</b>
<b>Age (years)</b>	26.9 n = 592	27.0 n = 3045	p=0.799
<b>Marital status</b>	Civil marriage 24% (154) Married 60% (388) Single 16% (105) Widow 0% n = 647	Civil marriage 28% (869) Married 59% (1841) Single 13% (420) Widow 0.1% (3) n = 3133	p=0.075
<b>Educational status among pregnant women</b>	Higher/master 41% (265) Incomplete higher/bachelor 10% (63) Secondary/incomplete secondary 27% (175) Special secondary 22% (141) n = 644	Higher/master 45% (1371) Incomplete higher/bachelor 10% (293) Secondary/incomplete secondary 22% (651) Special secondary 23% (708) n = 3023	p=0.017
<b>Gestation at first visit (weeks)</b>	12.0 n = 628	12.6 n = 3100	p=0.021
<b>Days between initial evaluation and follow-up visit</b>	Mean = 28.9 n = 543	Mean = 19.6 n = 538	p<0.001

**Table 2: Smoking-related behaviors of pregnant women in Cohorts 1 and 2 (July 2014 – March 2015)**

	<b>Cohort 1</b>	<b>Cohort 2</b>	<b>p value</b>
<b>Percentage of pregnant women who agreed to a cotinine at initial visit</b>	Yes = 93% (599) No/refusal = 7.0% (43) n = 642	Yes = 98% (3035) No/refusal = 2% (74) n = 3109	p<0.001
<b>Result of cotinine test</b>	Positive = 18.1% (113) Negative = 81.9% (511) n = 624	Positive = 12.3% (375) Negative = 87.7% (2679) n = 3054	p<0.001
<b>Are you a smoker?</b>	Yes = 10.2% (66) No = 89.8% (583) n = 649	Yes = 8.8% (277) No = 91.2% (2857) n = 3134	p=0.283
<b>Did pregnant women who tested cotinine-positive admit smoking?</b>	Yes = 49.6% (56) No = 50.4% (57) n = 113	Yes = 65.3% (245) No = 34.7% (130) n = 277	p=0.003
<b>Smokes at first visit (includes all pregnant women who test positive and those who say they are smokers)</b>	Yes = 19.0% (123) No = 81.0% (526) n = 649	Yes = 13.0% (407) No = 87.0% (2727) n = 3134	p<0.001

- Effects on smoking and drinking:**

**Smoking quit rate:** The primary outcome of interest was the BPI's effect on the smoking quit rate calculated using the formula:

$$\frac{(\# \text{ pregnant who test cotinine-negative at follow-up}) - (\# \text{ pregnant who admit smoking at follow-up})}{(\# \text{ pregnant who test cotinine-positive at first visit}) + (\# \text{ pregnant who admit smoking at first visit})}$$

- Pregnant women who admitted to smoking at the first visit were included in the denominator, even if they refused the cotinine test. Because these women were included in the denominator, they were excluded from the numerator. Using this formula, the immediate quit rate for Cohort 1 was 49%, and the immediate quit rate for Cohort 2 was 22% (**Table 3**). However, this difference may not accurately represent the true difference between cohorts because there was a large difference in the percentage of pregnant women for whom no follow-up data was collected (11% for Cohort 1 and 35% for Cohort 2). To account for this difference, we also calculated the immediate quit rate among pregnant women who did have a follow-up visit, disregarding pregnant women for whom we do not have follow-up data. Among this group, the immediate quit rate for Cohort 1 (55%) still significantly exceeds that of Cohort 2 (34%).

**Table 3: Smoking behaviors of Cohorts 1 and 2 (July 2014 – March 2015)**

	Cohort 1	Cohort 2	p value
<b>Women who tested positive or admitted smoking at initial evaluation</b>	123	407	
<b>Women confirmed to have stopped smoking at follow-up visit (tested cotinine-negative and denied smoking)</b>	60 (49%)	89 (22%)	p<0.001
<b>Immediate quit rate</b>	49% (60/123)	22% (89/407)	p<0.001
<b>Number of women with no follow-up visit or had no cotinine test at follow-up</b>	13 (11%) (No follow-up visit=10, no follow-up cotinine test=3)	142 (35%)	p<0.001
<b>Is a smoker at follow-up (tests positive or admits smoking)</b>	Stopped smoking = 55% (60) Still smokes = 45% (50) n = 110	Stopped smoking = 34% (89) Still smokes = 66% (176) n = 265	p<0.001

- **Alcohol use.** The second outcome of interest was reduction in alcohol use. As with the smoking data, it appears that pregnant women's drinking practices were different from Cohort 1 and 2: fewer pregnant women at their initial visit admitted to binge drinking (drinking six or more standard drinks in one day) in Cohort 2 (4%) compared to Cohort 1 (17%) (**Table 4**).

**Table 4: Responses about alcohol use among Cohorts 1 and 2 (July 2014 – March 2015)**

	Cohort 1	Cohort 2	p value
<b>1 month BEFORE you knew you were pregnant how many days did you drink 6 or more standard drinks in one day? (visit 1)</b>	Among women who drank 6 or more drinks at least once: Mean = 2.08 n = 102 17% of women said they drank 6 or more drinks at least once n = 613	Among women who drank 6 or more drinks at least once: Mean = 1.78 n = 108 4% of women said they drank 6 or more drinks at least once n = 2752	p=0.303  p<0.001
<b>On average, in the last 30 days, how many days per week did you drink?</b>	None = 80% mean = 0.31 n = 638 (Among drinkers, mean = 1.56, n = 126)	None = 75% Mean = 0.34 n = 3072 (Among drinkers, mean = 1.36, n = 777)	p=0.260  p=0.012
<b>When you did drink usually, how many standard drinks would you have in a day?</b>	Mean = 0.49 n = 628	Mean = 0.48 n = 2771	p=0.888

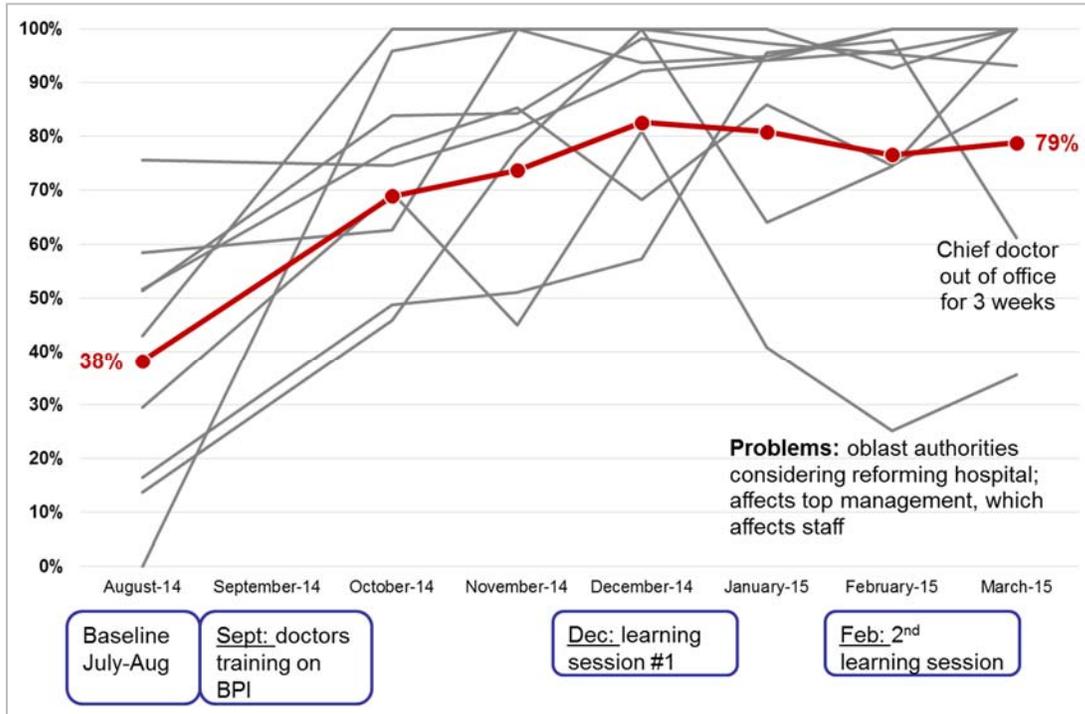
- In both Cohorts 1 and 2 pregnant women were more likely to say it was not good to drink when pregnant and that drinking may harm their baby at their follow-up visit, and reported drinking less at their follow-up visits in both cohorts. Overall, the pregnant women showed larger gains in their perceptions about the harm caused by alcohol, but the difference in gain between Cohorts 1 and 2 was not statistically significant. Likewise, while both groups reported drinking less, the difference in reduction between Cohorts 1 and 2 was not statistically significant (Table 5).

**Table 5: Changes in alcohol-related perceptions and behaviors from initial antenatal visit to follow-up visit (July 2014 – March 2015)**

	Cohort 1		Cohort 2		Difference made by intervention
	Initial evaluation	Follow-up	Initial evaluation	Follow-up	
<b>On a 1-10 scale, do you believe pregnant women may drink, but not abuse alcohol?</b>	Mean = 9.06 n = 583	Mean = 9.20 n = 583 Diff = +0.14 p=0.324	Mean = 8.84 n = 549	Mean = 9.05 n = 549 Diff = +0.21 p=0.162	+0.08 p=0.623
<b>Do you believe drinking beer or red wine during pregnancy may benefit or harm the baby? (10-point scale)</b>	Mean = 9.24 n = 586	Mean = 9.47 n = 586 Diff = +0.23 p=0.03	Mean = 9.17 n = 546	Mean = 9.60 n = 546 Diff = +0.43 p<0.001	+0.21 p=0.111
<b>On average in the last 30 days, how many days per week did you drink alcohol?</b>	Mean = 0.32 n = 563	Mean = 0.06 n = 563 Diff = -0.26 p<0.001	Mean = 0.68 n = 544	Mean = 0.39 n = 544 Diff = -0.29 p<0.001	-0.03 p=0.472
<b>When you drank, usually how many standard drinks would you have per day?</b>	Mean = 0.50 n = 534	Mean = 0.15 n = 534 Diff = -0.35 p<0.001	Mean = 0.79 n = 502	Mean = 0.48 n = 502 Diff = -0.31 p<0.001	+0.04 p=0.512

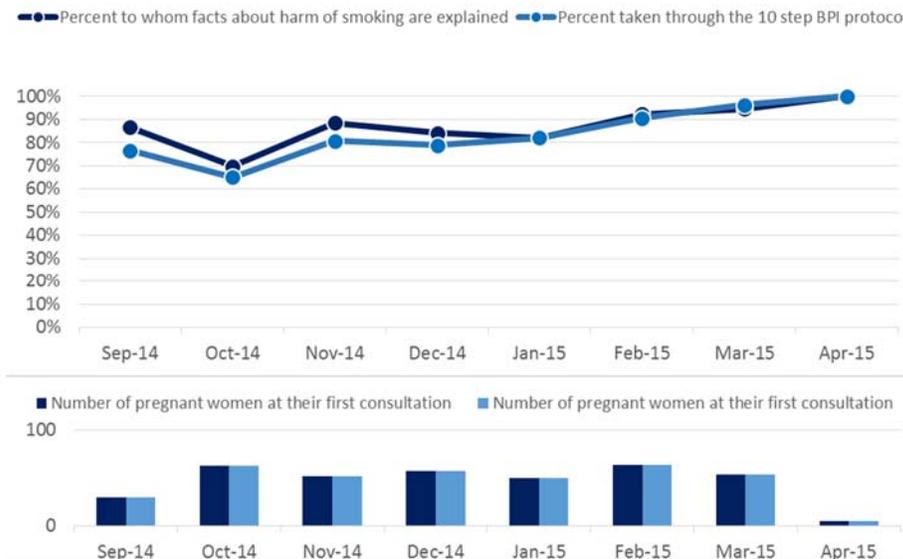
- **Counselling women on the effects of tobacco and smoking.** Timely assessment of pregnant women for tobacco use and counselling them about quitting smoking provides a higher chance that a mother will quit smoking during pregnancy, which in turn can improve her health and help prevent negative outcomes for her newborn. Data showed that the percentage of pregnant women screened for alcohol and tobacco increased from 38% in August 2014 to 79% in March 2015 (Figure 1).
- **The evaluation also measured the percentage of pregnant women who were assessed for tobacco use by the health care provider and who took an express urine cotinine test during their first prenatal visit.** Those women who tested positive for tobacco use received a brief physician intervention counselling for quitting smoking during their pregnancy.
- **According to patient records, during the implementation period, 90% of pregnant smokers and 74% of pregnant women who admitted to drinking any alcohol received the BPI intervention.** This was corroborated by the patient survey, in which 95% of smokers who came to the clinic because of expected pregnancy said that their doctor advised them to quit smoking, and 91% of drinkers who came to the clinic because of expected pregnancy said that their doctor advised them to quit drinking alcohol, both higher than the pre-intervention values of 83% (p=0.1) and 75% (p=0.008), respectively. Further, at end-line, 94% of smoking women who came to the clinic because of expected pregnancy said the doctor explained to them how to reach the goal and about possible difficulties the woman would face, up from 83% at baseline. Some 93% of women who came because of expected pregnancy and drank alcohol said the doctor explained how to reach the goal compared to 75% in the first cohort.

**Figure 1. Percentage of pregnant women who were screened for tobacco and alcohol use among those registered (Average of all facilities compared to individual facilities) (Aug 2014-March 2015)**



- **Likewise, 92% of pregnant women received information about family planning during the BPI implementation period.** This was corroborated by a patient survey, in which 92% of reproductive age women indicated that they discussed the use of contraceptives with their doctor, a statistically significant increase from the baseline period when 82% of women reported that they discussed family planning. **Figure 2** shows an increase in the percentage of pregnant women receiving the BPI intervention among those who were tested cotinine positive at their first visit. Definitions and values of indicators, numerators, and denominators for **Figure 2** are provided in **Table 6**.

**Figure 2. Percentage of pregnant women receiving BPI intervention among those who test cotinine positive at their first consultation (Sept 2014 – April 2015)**



**Table 6: Definitions of indicators, numerators, and denominators**

Definitions	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
Percent of pregnant women to whom facts about harm of smoking explained (indicator 1)	87	70	88	84	82	92	94	100
Number of women to whom facts about smoking explained	26	44	46	48	41	59	51	5
Number of pregnant women at their first consultation who test cotinine-positive	30	63	52	57	50	64	54	5
Percent of pregnant women who received BPI counselling (indicator 2)	77	65	81	79	82	91	96	100
Number of women who received BPI counselling	23	41	42	45	41	58	52	5
Number of pregnant women who test cotinine-positive at their first consultation	30	63	52	57	50	64	54	5

- **The final conference of the ASSIST project in Ukraine took place on June 12, 2015 in Kiev.** The event brought together principal stakeholders to present and discuss the key technical assistance activities of the project to improve alcohol and tobacco control among pregnant women and women of reproductive age in Ukraine, as well as the project's goal and objectives, and the results and evaluation of the implemented QI strategy.

#### SPREAD OF IMPROVEMENT

To scale up best practices among the professionals at the national level, the training curricular for BPI was developed and approved through the scientific council at National Medical Academy of Postgraduate Education (NMAPE).

To improve access to quality improvement countrywide, all quality tools developed by ASSIST were incorporated into the national BPI protocol for tobacco and alcohol decrease among pregnant women by the multidisciplinary working group. To strengthen national and regional reporting systems, the quality indicators used during pilot implementation were incorporated into the regional reporting system.

The national BPI protocol is pending approval by the MOH for implementation countrywide in 2016.

## 4 Sustainability and Institutionalization

ASSIST worked in close coordination with the MOH, oblast health care authorities, and the NMAPE to enhance the capacity of Ukrainian health care providers and institutions to effectively deliver quality care and respond to the needs of patients to decrease alcohol and tobacco usage among pregnant women. ASSIST-supported work in Ukraine has included orienting health care providers and key decision-makers both at the national and local level on a BPI tobacco and alcohol cessation protocol, as well as supporting a national multidisciplinary working group at the State Expert Center to prepare the national protocol and guideline for BPI. ASSIST also facilitated the institutionalization of the new BPI protocol through working with local and national health authorities to support its incorporation into the routine practice of health care providers in the country. In addition, the project worked with the NMAPE to incorporate the BPI curricula into post graduate medical education to further achieve sustainability objectives.

## 5 Knowledge Management Products and Activities

- **A technical report detailing the intervention's results** published by ASSIST in December 2015: Improving Alcohol and Tobacco Control during Pregnancy in Ukraine. Available at:

<https://www.usaidassist.org/resources/improving-alcohol-and-tobacco-control-during-pregnancy-ukraine-0>

- **A brief on the role of gender in alcohol and tobacco cessation among pregnant women and adolescents was developed** and then presented during learning session #1 in December 2014 for QI teams at the Poltava Health Care Department Administration. (See Appendix: Gender Integration Brief.)
- **Published the following job aids to support Ukrainian health providers to implement BPI:**
  - Doctor's Guide to the Brief Physician Intervention
  - Pocket card for doctor with short audit WHO test to assess alcohol use by patient
  - Pocket card for doctor with the BPI protocol
  - Workbook for pregnant women
  - Wall poster with recommendations to quit tobacco use during pregnancy
  - Wall poster with recommendations to quit alcohol use during pregnancy

The job aids were also incorporated into the BPI protocol presented to the Ministry of Health for approval.

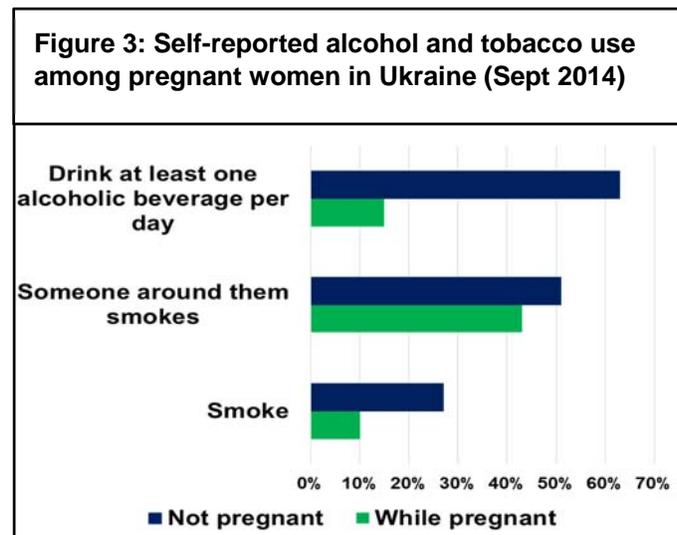
## 6 Gender Integration

In September 2014, ASSIST conducted research to better understand how gender impacts the project's target health issues (i.e., alcohol and tobacco use and violence during pregnancy). This quantitative survey was developed by the project QI team, with input from ASSIST partner WI-HER LLC. Data were collected from 617 women of reproductive age (including 209 pregnant women) that visited participating women's consultation clinics in Poltava Oblast. Results from a preliminary analysis were analyzed in October 2014 (**Figure 3**) and shared with participants at two gender integration trainings.

Survey findings revealed that 42.5% of pregnant woman reported being exposed to second-hand smoke, and 6.5% of women surveyed reported being subjected to physical violence.

Mrs. Megan Ivankovich of WI-HER LLC conducted two gender sensitization and integration workshops in October 2014; nine doctors in Poltava and seven advisors in Kiev participated. Sessions included defining gender and related concepts, identifying gender issues and gaps (gender analysis), addressing gender issues and gaps (designing changes to test), and analyzing and reporting results (sex-disaggregated data and gender-sensitive indicators). Based on these workshops and technical assistance on gender integration provided in October 2014, recommendations on how best to integrate gender into the project were proposed: 1) Integrate the family approach into informational materials; 2) make modifications in electronic form and hard copies; 3) develop a brief about role of gender for providers or patients; and 4) increase male participation during consultations.

As a response, the project developed a brief about role of gender in alcohol and tobacco cessation among pregnant women and adolescents and presented the brief during learning session #1 in December 2014.





## Appendix: Gender Integration Brief

### **How does gender relate to improvement work in Ukraine?**

Males and females face different levels of susceptibility to health concerns based on their genetic makeup as well as on prevailing gender norms that influence behaviors and quality of health services. For example, 46% of women in Ukraine reported alcohol use in the most recent months of pregnancy [17], yet counseling on the reduction of alcohol use during pregnancy is insufficient since health providers don't consider women at risk because these behaviors have been historically associated with men and boys. In addition, exposure to environmental pollutants such as second-hand smoke can negatively impact the health of pregnant women and their unborn children.

Women are also disproportionately affected by environmental pollutants: in Poltava, 49% of women reported that they live or spend time with someone with smoke around them. Globally, roughly 47% of deaths caused by second-hand smoke are in women, while just 26% are in men [14]. Power imbalances can cause women to be less able to negotiate smoke-free spaces in work places, social gatherings, and in their own home. Gender-related power inequalities also have implications for treatment, as women and girls may depend on their husbands or partners for health care decision-making, access, and expenditures. Lack of awareness among women and health care providers of the risk faced by women may negatively affect health-seeking behaviors, prevention, and early detection and treatment of this serious disease.

### **What is gender integration and why is it important?**

Addressing the different needs, behaviors, preferences, access to, and utilization of health services for men, women, girls, and boys is critical to any improvement effort. It is critical that improvement interventions consider gender issues and gender gaps to ensure they equitably reach half of the population and to avoid unintentionally exploiting or harming one sex. From an implementation perspective, addressing gender issues in improvement activities is an efficient use of resources; from a quality improvement standpoint, this encourages patient-centeredness, safety, and equality. Gender issues related to alcohol and tobacco use in pregnant women need to be taken into account when designing, implementing, and evaluating strategies and services.

Gender integration means identifying, and then addressing gender inequalities during strategy and project design, implementation, and monitoring and evaluation of a project. Through the USAID ASSIST Project, we use the science of improvement to identify and then address gender-related gaps to improve health outcomes. Our holistic approach promotes gender integration through contextualized and adaptable methods requiring little or no additional costs to the improvement effort while maximizing benefits. It results in locally-developed solutions, improved country leadership, an expanded partner base with links to other sectors, and institutionalization of gender integration in improvement at all levels of care.

### **Gender integration efforts in Ukraine**

In September 2014, the USAID ASSIST Project conducted research to better understand how gender impacts the project's target health issues (i.e., alcohol and tobacco use and violence during pregnancy). This quantitative survey was developed by Dr. Elena Novichkova, with input from WI-HER LLC. Data was collected from 617 women and girls of reproductive age that attended participating women's health centers in Poltava Oblast. Results from a preliminary analysis were shared with participants at two gender integration trainings and the survey results were utilized during training exercises.

In October 2014, the USAID ASSIST Project conducted two gender integration trainings; nine doctors in Poltava and seven advisors in Kiev were trained. Sessions included defining gender and gender-related concepts, identifying gender issues and gaps (gender analysis), addressing gender issues and gaps (designing changes to test), and analyzing and reporting results (sex-disaggregated data and gender-sensitive indicators).

### **Recommendations**

Based on these trainings and technical assistance on gender integration provided to the project in October 2014, a list of recommendations on how best to integrate gender into the project were proposed.

Acknowledging that the USAID ASSIST Project in Ukraine is expected to end in 2015, there are several potential short and long-term activities to integrate gender. Examples of recommendations are presented below.

### **Short-term**

- Sensitize health care providers to different cultural norms that affect health-seeking behaviors, care, and treatment through technical brief or learning sessions
- Raise awareness (e.g., integrate gender-sensitive language into patient materials, develop handouts and talking points for providers to use during counseling sessions) among female patients about the importance of male involvement to reduce drinking or smoking during pregnancy
- Strengthen the capacity of health care providers responsible for non-communicable disease care to identify and respond to gender-related issues in their programs through trainings, and by developing gender-sensitive guidelines and protocols
  - Integrate gender-sensitive language into the academic post-graduate education curriculum
  - Review treatment protocols and guidelines to ensure that gender-related issues are addressed and support their implementation
  - Integrate gender-sensitive language into national protocols and necessary materials
- Select one motivated provider to integrate gender during intervention, such as engaging male partners in ANC visits (outcomes could be measured for two months)
- Develop gender-sensitive indicators that measure male involvement in ANC appointments and track over time
- Express interest in continuing gender integration in reports so partners, including the Ministry of Health and USAID, understand the need and demand to continue this work
- Submit funding requests to USAID or other funders to pursue opportunities to address gender issues within this work.

### **Long-term**

- Conduct a gender analysis and develop comprehensive strategies that consider local barriers that impact alcohol and tobacco use by pregnant women in the community.
- Discuss opportunities to collaborate with local ministries, NGOs, or other partners working on gender to determine how the project can coordinate efforts to address gender disparities affecting relevant health outcomes
- Where possible, advocate for gender-sensitive policies with MOH related to project goals
- Strengthen the capacity of health care providers and systems to make services gender-inclusive and equitable (e.g., increase male participation)
  - Design strategies that encourage men and women to access available health care services (e.g., make women's clinics more male-friendly [for example, there is no men's bathroom in the clinic]; create incentives for males to attend clinic visits [for example, offer free WiFi])
  - Encourage the same level of responsibility to each parent
  - Integrate intensive gender integration course in academic post-graduate education curriculum
  - Provide incentives to doctors who counsel a certain number of couples
- Raise awareness among the public and educate males and females about risks of tobacco and alcohol use in families with pregnant women and their male partners and related healthy behaviors
- Address the specific disadvantages that women and girls tend to face which cause them to be less likely to access relevant services in certain communities, such as lack of decision-making power.



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University Research Co., LLC  
7200 Wisconsin Avenue, Suite 600  
Bethesda, MD 20814

Tel: (301) 654-8338

Fax: (301) 941-8427

[www.usaidassist.org](http://www.usaidassist.org)