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**THE RUSSIA REPRODUCTIVE HEALTH  
PROGRAM STRATEGY  
AND  
ACTION PLAN**

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## ABBREVIATIONS

<b>AIDS</b>	<b>acquired immunodeficiency syndrome</b>
<b>AIHA</b>	<b>American International Health Alliance</b>
<b>AVSC</b>	<b>Association for Voluntary Surgical Contraception</b>
<b>CA</b>	<b>Cooperating Agency</b>
<b>CAR</b>	<b>Central Asian Republic</b>
<b>CDC</b>	<b>Centers for Disease Control and Prevention</b>
<b>CTO</b>	<b>Cognizant Technical Officer</b>
<b>DHS</b>	<b>Demographic and Health Survey</b>
<b>ENI</b>	<b>Bureau for Europe and the New Independent States (USAID)</b>
<b>ENI/HR/HP</b>	<b>Bureau for Europe and the New Independent States, Office of Human Resources, Health and Population Division (USAID)</b>
<b>FPIA</b>	<b>Family Planning International Assistance</b>
<b>FP</b>	<b>family planning</b>
<b>FPLM</b>	<b>Family Planning Logistics Management Project</b>
<b>FY</b>	<b>fiscal year</b>
<b>IEC</b>	<b>information, education, and communication</b>
<b>IPPF</b>	<b>International Planned Parenthood Federation</b>
<b>IUD</b>	<b>intrauterine device</b>
<b>JHPIEGO</b>	<b>Johns Hopkins Program for International Education in Reproductive Health</b>
<b>LAM</b>	<b>lactational amenorrhea method</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MOU</b>	<b>Memorandum of Understanding</b>
<b>NGO</b>	<b>nongovernmental organization</b>
<b>NIS</b>	<b>New Independent States</b>
<b>ob/gyn</b>	<b>obstetrics and gynecology practitioner</b>
<b>ODA</b>	<b>Overseas Development Administration (United Kingdom)</b>
<b>OECD</b>	<b>Organization for Economic Cooperation and Development</b>
<b>PCS</b>	<b>Population Communication Services</b>
<b>PHN</b>	<b>Population, Health, and Nutrition</b>
<b>PROFIT</b>	<b>The Promoting Financial Investments and Transfers Project</b>
<b>PVO</b>	<b>private voluntary organization</b>
<b>RFPA</b>	<b>Russian Family Planning Association</b>
<b>RLMS</b>	<b>Russian Longitudinal Monitoring Survey</b>
<b>RRHP</b>	<b>Russia Reproductive Health Program</b>
<b>STD</b>	<b>sexually transmitted disease</b>
<b>TA</b>	<b>technical assistance</b>
<b>TFR</b>	<b>total fertility rate</b>
<b>TOT</b>	<b>training of trainers</b>
<b>UNC</b>	<b>University of North Carolina</b>
<b>U.S.</b>	<b>United States</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>USSR</b>	<b>Union of Soviet Socialist Republics</b>

## EXECUTIVE SUMMARY

Maternal morbidity and mortality rates in Russia are five to ten times higher than comparable rates for other industrialized countries. As Russia has undergone the difficult transition to a democratic society and free market economy, these rates appear to have worsened. Economic dislocations have forced many women into unemployment. Simultaneously the state's ability to support a once extensive system of publicly-funded medical facilities has also been compromised. As a result, Russian women, particularly women in their childbearing years, have become increasingly vulnerable to the economic and social pressures resulting from the current transition.

One of the major strategic objectives of USAID's Russia program is to develop a network of social services that can operate in a fiscally sustainable manner in a market environment, effectively addressing the needs of vulnerable groups. The new initiative in women's reproductive health will directly support USAID/Russia's ability to achieve this objective by working directly with private and public sector health care providers to enhance the quality of, and increase the fiscal sustainability of, reproductive health services. In Russia, high rates of maternal mortality and morbidity are due—in large part—to Russian women's almost exclusive reliance on repeat abortion as a method of contraception. The most effective way of reducing these high rates of maternal morbidity and mortality is to change the reproductive health care system so that it emphasizes the use of modern contraceptives. USAID/Russia has concluded that improving the health status of Russian women in this manner is one of the most important strategic interventions that it can undertake related to the U.S. government objective of addressing the needs of vulnerable groups while refining public and private sector roles in the management of health services.

At present, only about 22% of Russian women of reproductive age use a modern family planning method (19% IUD, 3% oral contraceptives). This low level of contraceptive use is a result of several historical factors including the country's isolation from Western advances in contraceptive technology; negative experience with poor-quality contraceptives manufactured in the former Eastern Bloc; and a lack of information regarding the health benefits of modern contraceptive methods. It also stands in contrast to Russian women's very low desired family size; the current total fertility rate (TFR) of 1.3 is significantly below replacement level fertility.

Because both contraceptive use and desired family size are very low, Russian women experience a large number of unwanted pregnancies. These pregnancies carry significant health risks for women under 19 years of age and those over 35-40. Moreover, in the absence of contraceptive information and services, some 80% of Russian women of reproductive age rely on abortion as their primary means of fertility regulation. These women have an average of 3.5 abortions during their reproductive lives, with a range of up to 20 abortions for some women. Many of these abortions are poorly performed and/or performed in the environment of a deteriorated health care system, resulting in a high risk of infertility. They are the primary contributing factor behind 25% of maternal deaths. The high number of abortions also places a significant financial burden on a resource-poor medical infrastructure. It has been estimated, for example, that approximately 50% of the Health Ministry's reproductive health budget is spent on abortion and its related complications. In addition, the recuperation time needed by Russian women to recover from these complications diminishes their income and their opportunity to participate more fully in economic activity.

**The GOAL of USAID's program is to decrease Russia's current high rates of maternal mortality and morbidity.**

**The PURPOSE of this program is to effect these improvements by promoting widespread change in the current family planning information and service delivery systems, leading to much greater adoption of modern methods of contraception as an alternative to repeat abortion.**

**The USAID/Russia reproductive health strategy calls for the implementation of a four-year, US\$7.5 million program designed to improve women's health by effecting broad-based changes in Russia's reproductive health information and service delivery systems. This strategy will increase the adoption of modern family planning methods by:**

- 1. installing new reproductive health/family planning technologies into the health care systems of selected oblasts, which will themselves serve as dissemination centers for these new technologies to other regions of the country; and**
- 2. increasing public knowledge regarding the use, safety and health benefits of modern family planning methods.**

**The key program elements of this strategy include:**

- Demonstration and Training Centers:** Located in at least six oblasts, these Centers will serve as model reproductive health care facilities for clients and as regional training sites for health care providers from the host oblast and other parts of the country. Each Center will be a focal point for system-wide efforts to integrate additional services, IEC, training and strategic planning into the participating oblasts' approach to reproductive health care.
- Contraceptive Availability and Supply:** Contraceptive supplies will be provided for use at the demonstration and training centers, and to serve as initial supplies needed to launch family planning services in trainees' "home" oblasts. These contraceptive commodities will be provided in a manner that will stimulate a broader role for the commercial sector in meeting client demand for modern family planning methods.
- Information, Education and Communication:** IEC activities will directly support the development and operations of the demonstration and training centers; create a favorable attitude within the public and provider community regarding family planning; and help stimulate a commercial sector response to increasing client demand for modern contraceptive methods.
- Improving the Policy Environment** by strengthening the data collection, analysis, planning and management skills of decision-makers and program administrators.

**These specific activities were selected because they have high potential to produce broad-based, durable changes in the way the Russian health system delivers family planning and reproductive health services. These changes can be effected at relatively low cost to USAID and be institutionalized at a very modest recurrent cost to the Russian health care system, thus enhancing their likelihood for continuation and broad replication.**

**These changes in Russia's family planning and reproductive health services will increase Russian women's demand for and use of modern contraceptive methods. As a result of their increased use of such methods, women will be exposed to fewer of the life- and health-threatening risks associated with unwanted pregnancy and repeat abortion.**

# **PROGRAM STRATEGY FOR REPRODUCTIVE HEALTH**

## **I. BACKGROUND**

### **A. Russia: Demographic Profile**

The largest country to emerge from the former USSR, Russia today includes 16 autonomous republics and a total of 15 autonomous regions and districts. Ethnic Russians comprise over 81% of the country's population of approximately 148 million persons.

The level of urbanization is high, with approximately 75% of the population living in urban areas. In 1992 and 1993, the natural population growth rate of the Russian Federation was negative, as deaths exceeded births. This trend is the result of both increases in the death rate and decreases in the birth rate.

The total fertility rate had declined by 1992 to 1.55, which is substantially below replacement level fertility. Preliminary figures for 1993 indicate a further decline to about 1.3. The population under five years of age has declined from 12.0 million to 9.6 million between 1989 and 1993.

### **B. Reproductive Health Status of the Population**

The Soviet Union's impressive gains in health indicators in the 1960's and 1970's were followed by stagnation and decline in the 1980's and 1990's. In 1993 the government reported a 20% increase in the crude death rate over the previous year. During the same period, infant mortality rose from 17.4 in 1990 to 18.6 in 1993—a level which is two to three times that of the OECD countries. Maternal mortality is currently five to ten times higher than in other industrialized countries. The following table summarizes these trends.

**Trends in Maternal and Child Health in the Russian Federation, 1989 - 1992**

	<b>1989</b>	<b>1990</b>	<b>1991</b>	<b>1992</b>
<b>Maternal Mortality Ratio</b> (per 100,000 live births)	<b>49</b>	<b>47</b>	<b>52</b>	<b>51</b>
<b>Infant Mortality Rate</b> (per 1000 live births)	<b>17.8</b>	<b>17.4</b>	<b>17.8</b>	<b>18.0</b>
<b>Abortion Ratio</b> (per 100 live births)	<b>186.3</b>	<b>197.1</b>	<b>201.0</b>	<b>216.5</b>
<b>Contraceptive Prevalence Rate</b> (per 100 women age 15-49)	<b>16.5</b>	<b>18.9</b>	<b>20.2</b>	<b>22.4</b>
<b>Abortion Rate</b> (per 1000 women age 15-49)	<b>(-)</b>	<b>108.8</b>	<b>100.3</b>	<b>98.1</b>

**Footnote:** Extreme caution must be exercised in interpreting Russian statistics on health indicators, whether from official sources or otherwise, since these figures are often unreliable, and widely divergent estimates can be obtained from different sources for the same year with no guarantee that any of them are very close to the actual situation. While this caveat applies particularly to abortion and contraceptive prevalence rates, it applies also to a lesser extent to vital statistics. These figures do serve, however, to provide a reasonable magnitude of prevailing numbers and rates.

**Source:** "Maternal and Child Health in the Russian Federation: Priorities for Action", World Bank, 1994, citing statistics from the Russian Ministry of Health

In Russia, women marry young and generally complete their childbearing by their mid-twenties. Desired family size is low, as indicated by the current abortion rate of over two abortions for every live birth. Use of modern contraceptives, however, is also very low: about 22% of reproductive age women use a modern family planning method. This low level of contraceptive use is a result of several historical factors which have severely limited Russian women's access to or information about modern FP methods. These factors include:

- The isolation of the former Soviet Union from Western advances in contraceptive technology, and, in the absence of up-to-date information, medical practitioners overestimated the negative side effects of modern contraceptives.
- In the case of hormonal contraceptives, a medical bias which has contributed to a continuing, wide-scale wariness toward oral contraceptives throughout both provider and client populations.
- Negative experiences with poorly manufactured Russian or Eastern European IUDs and oral contraceptives which had high failure and complication rates.
- Lack of information about the potential harmful effects of repeated abortions on reproductive health.
- To Soviet planners, the utility of abortion as a low-cost alternative to research, development, importation and/or local production costs of contraceptive products.
- More recently, the de facto "privatization" of abortion services. The new private sector abortion service providers often offer better treatment and pain relievers but have little incentive to correct widespread public misperceptions about the relative safety of modern contraceptive methods.

The combination of small family size preference and—for the reasons noted above—low levels of contraceptive use leads inevitably to a relatively large number of unwanted pregnancies, and, in Russia's situation, to a heavy reliance on abortion as a primary means of fertility regulation. The 80% of Russian women who resort to repeat abortions face considerable risks associated with the procedure itself: as currently practiced in Russia, abortion is probably the primary contributing factor behind at least 25% of maternal deaths. In addition, the 4 to 5 million abortions performed annually place a major financial burden on Russia's resource-poor medical infrastructure. It has been estimated, for example, that approximately 50% of the Health Ministry's obstetrics and gynecology budget is spent on abortion and its related complications. Medical complications also severely limit the income-earning opportunities of women and their ability to participate fully in the country's economic activities.

Finally, it should be noted that sexually transmitted diseases (STDs) are a major neglected area of reproductive health in Russia. Reports from gynecological and family planning clinics in Moscow and Kaluga suggest that from 20% to 40% of women have untreated vaginal infections, such as chlamydia and trichomoniasis, and that STD rates are rising rapidly among adolescents. Russia's criminal code—which penalizes people transmitting STDs—hinders more accurate assessments of the extent of STDs in the country and also complicates treatment and prevention efforts.

### **C. The Post-Soviet Environment: Implications for an Effective Program Strategy**

The political and social transition currently under way in Russia provides both opportunities and obstacles to positive change in the reproductive health care system. The central government is continuing the Soviet government's 1990 policy supporting decentralization of budget authority (and responsibility) to the oblasts. In the health sector, this policy is enabling creative oblast-level administrators to adopt health care practices which are more responsive to local priorities than were allowed under the centrally established norms of a few years ago. To date, however, few of these administrators have attempted to effect significant changes in the basic structure of the Soviet-style health system. The system is extensive in its coverage, but poorly equipped and maintained. It is amply staffed, but the training of the staff does not always reflect current levels of medical technology. It is highly fragmented by an overemphasis on specialized, curative services, while preventive health care needs are not adequately addressed.

A major constraint to the introduction of broad-based changes in the health system is the lack of new financial resources during the current period of economic crisis. Thus, even though the oblasts are now responsible for the collection and disposition of approximately 80% of their own funds, total revenues available at the oblast level have not generally matched Soviet-era outlays. The implication for a successful short-term assistance strategy in this context is clear: changes introduced into the reproductive health care system must represent obvious improvements over current practices in terms of their responsiveness to client needs, and they must be at least as cost-effective as prior practices. Moreover, they must be sustainable without the need for significant additional resources.

A successful strategy in this environment must focus on the transfer of skills and information rather than resources. Specifically, such a strategy should call for the demonstration and teaching of new technologies that can be incorporated into the current health care structure in ways which will actually reduce costs to the health system and the education of the client population so they can become informed—and more frequent—users of these new technologies.

## **II. SUMMARY STRATEGY AND PROGRAM RESPONSES**

### **A. Goal and Purpose**

The Goal of the USAID/Russia Reproductive Health Program (RRHP) is to *decrease Russia's current high rates of maternal morbidity and mortality*. These high rates are the result of the large number of unwanted pregnancies experienced by Russian women, the risks associated with these pregnancies, and especially the risks associated with repeat abortion.

The Purpose of the program is to reduce unwanted pregnancies and women's reliance on abortion by *promoting widespread change in the current family planning information and service delivery system leading to much greater adoption of modern methods of contraception*.

## **B. Constraints to Achievement of Project Purpose**

There are several obstacles to the successful introduction and adoption of widespread changes in the Russian health/family planning system. A partial listing includes:

- **Real resource scarcities:** Innovations/new procedures must pass the test of practical value and cost-effectiveness.
- **Historical patterns of centralized direction** have not rewarded innovativeness. Change is still inhibited by inertia.
- **More recent moves to decentralize the health care system** have begun to stimulate creative approaches to health care organization and delivery; but as noted above, many changes may still be thwarted by a lack of resources. In addition, decentralization may limit the extent and speed with which new technologies are adopted outside their area(s) of origin.
- **The factors which have historically limited women's access to family planning information and services in Russia** (see section II.B) have not yet been replaced by new attitudes, training or practices. Health care providers, family planning clients and the general public are still wary of modern contraceptive methods and still rely heavily on abortion, even in areas where some modern contraceptive methods are available.
- **The training and information systems needed to respond to the lack of provider/client knowledge** are not in place. Public sector and private sector activities in this area are weak, isolated and sporadic in their execution.
- **A cautious commercial sector is poised to provide plentiful contraceptive products at reasonable prices** but is waiting for a demonstration of increased demand before committing major resources to meet a presumed unmet need for these products.

USAID, moreover, faces some important internal constraints to the development and implementation of a meaningful assistance strategy:

- **USAID resources available for the assistance program** are very limited and may not exceed US\$7.5 million over the four-year life of the program.
- **The life of program, at four years, is brief and creates special challenges to the objective of installing widespread and durable changes throughout the Russian health/family planning system.**
- **In view of the foregoing constraints, the USAID program must leverage extensive changes beyond the geographic areas in which it is implemented, and beyond its scheduled duration, if it is to produce a significant and lasting impact.**

### **C. Strategy**

**A successful strategy will reduce the large number of unwanted pregnancies experienced by Russian women and their subsequent reliance on repeat abortions by greatly expanding the use of modern family planning methods.**

**The strategy will produce changes which represent clear technical advantages over current practices, at virtually no incremental cost to the health system. It will provide new information which responds directly to deeply-ingrained biases—in the health provider community and in the general public—against modern contraceptive methods. It will offer new, professionally attractive skills to health care providers who will want to be trained in those skills. It will acquaint the public with hitherto absent services and give it the information it needs to ask for those services. And it will help policy-makers recognize and endorse these changes in ways that will ensure their long-term sustainability.**

**The program elements described below were selected for their technical, financial and operational feasibility in meeting these strategic objectives within the time and cost constraints of the USAID assistance program. With the exception of some limited amounts of donated contraceptives and other commodities, resource transfers under this strategy are very modest. The central theme of the strategy is the transfer of new skills to medical practitioners and new knowledge to clients, program managers and policy-makers.**

**These new skills will enable health care providers to deliver additional family planning (FP) services to clients while simultaneously reducing the burdens which unwanted pregnancies, repeat abortions and their attendant complications impose on the health system and on Russian women. Government and health program administrators will recognize the cost savings generated by the adoption of the new services and take steps to install them permanently in their health systems. The demonstration effect of these changes—broadcast by the participation of trainees from other oblasts—will promote the widespread replication of the improved information and service model to other parts of the country. Spurred by an informed clientele, the commercial sector will make modern contraceptive products regularly available to the public.**

**The specific program elements which will contribute to the attainment of these outcomes are as follows:**

- 1. Demonstration Service and Training Centers in at least six key oblasts will provide hands-on training in modern family planning technologies for health care personnel from the oblast, the region, and other parts of the country. These demonstration facilities will be affiliated with major maternity hospitals and postgraduate training institutions as well as medical and midwifery schools. Training will focus especially on ob/gyns and midwives and will emphasize the need for, and means by which, new FP service delivery norms can be institutionalized into the reproductive health care system. In addition to functioning as training centers, these facilities will provide previously unavailable, high-quality services to local communities. Participating oblasts/health facilities will be selected on the basis of several criteria including the size and regional importance of the site, the level of political/administrative support of the oblast government leadership, and the extent of collaboration with other government entities and private sector (NGO and commercial) parties. The role of these centers as training sites for health providers from other regions and as the**

source(s) of itinerant trainer-of-trainer teams will be a key factor toward ensuring a "roll out effect" of the overall program.

**2. A vigorous Information, Education and Communication campaign will, for the first time in Russia, provide accurate, comprehensive information on modern FP methods to potential FP clients, health professionals, and the general public. The IEC program will be structured to reinforce the activities of the demonstration and training centers by improving the knowledge of health care providers and counselors; improve client knowledge via print and electronic media; and, through improved patient counseling practices, stimulate commercial sector responsiveness to the public's contraceptive requirements by generating new demand for modern FP methods.**

**3. Sufficient Contraceptive Supplies will be provided on a donation basis to meet the needs of the demonstration and training centers for a period of one year, plus provision of supplies for trainees to take back with them to initiate training and supply activities in their "home" oblasts. Pharmaceutical manufacturers will be asked to donate initial stocks of some contraceptive supplies (i.e., pills, condoms and Depo-Provera) to stimulate client use of the commercial sector to meet their contraceptive resupply needs. Contraceptive supplies which cannot be obtained in this manner from commercial manufacturers will be provided on a donation basis by USAID.**

**4. The execution of a nationally representative Survey of the Population's Demographic and Health Characteristics will be considered if such a survey is found to be necessary to meet the strategic planning needs of policy-makers at the oblast and central government levels. No countrywide data on such characteristics currently exist in Russia in a form or content needed to develop a long-term assessment of changes in family planning practices and fertility in the country. A decision whether or not to carry out this survey will be made following close consultation with the University of North Carolina, which is conducting another long-term, longitudinal study which may provide some of the needed data.**

In addition to the possible survey, policy-makers will be supported by a) the preparation and dissemination of computer graphics presentations of the health and financial implications of unwanted pregnancies; and b) technical assistance useful to strengthen the planning, management and evaluation of family planning programs.

#### **D. Factors Supportive of Program Implementation**

Several factors in the current Russian environment are likely to promote the success of this program. They include:

- 1. A Russian health system which, while resource-poor and hindered by excessive specialization and emphasis on curative services, is intact, extensive in its population coverage, and in several oblasts directed by creative, change-oriented professionals.**
- 2. An emerging private sector, comprised of entrepreneurial and NGO institutions, which is evolving and prepared to play an important role in promoting/complementing public sector efforts in the field of reproductive health.**

3. A large number of health professionals (ob/gyns, other physicians, midwives, pharmacists) who are basically well trained but need more specific training in reproductive health.
4. A gradual waning of Russia's long-term scarcity of contraceptives.
5. A growing consumer demand for contraceptives.
6. Political and health professional interest in promoting positive change in
7. A perceived need among health professionals for vigorous efforts to inform women and health care providers regarding the benefits of modern contraceptive methods.

### **III. COORDINATION AND LINKAGE WITH OTHER PROGRAMS**

#### **A. Russian National Reproductive Health Programs**

In the summer of 1994 President Yeltsin issued a decree establishing a new "Children of Russia" program which, inter alia, represents a far more responsive and humane approach to women's rights in the area of reproductive health. The new law implicitly acknowledges the social and economic cost of abortion and assumes governmental responsibility to help ensure that Russian women (and men) have access to a broad choice of contraceptive methods. Reversing the practice of the past two years, during which time the central government purchased virtually no contraceptive products, the new decree directs the central government to purchase and provide such products for oblast-level programs which do not have local-level resources for contraceptive purchases. The law also calls for the creation of approximately 95 Family Planning Centers throughout the country.

This decree marks an important new development in the government's approach to family planning rights in Russia. However, the new law must be considered in the context of other concerns that it is also designed to address and that will bear on government policy and practice in the coming years. First, even with the central government's acceptance of responsibility for supporting family planning choice nationwide, the central government will probably be a relatively minor participant in actually determining or providing the financial resources needed to implement the policy. Oblast-level administrations now collect and allocate some 80% of their own revenues and are becoming increasingly autonomous in setting their own health care priorities. In this context, the central government's pledge to purchase contraceptive supplies for resource-poor oblasts is helpful, but may be largely symbolic. Second, while the new Family Planning Centers are intended to provide a wider choice of FP methods to clients, they are also designed—some might say primarily designed—to serve as diagnostic and treatment centers for infertility—a major concern to the leadership and citizens of a country that is experiencing negative population growth.

A more practical consideration for USAID's strategy, then, is the operational environment within which the program elements must function, i.e., whether these program activities can be implemented in a hospitable and receptive environment conducive to their success.

In the case of the demonstration and training centers, the selection criteria for potential sites include a requirement that the centers be located within a complex of service and training

facilitates including, but not limited to, a major maternity hospital, a medical and/or nursing school, a post-graduate training institution and a full complement of outpatient facilities. By placing the center within this training and service network, and by linking the center's activities closely with those of the other institutions, the changes installed in the demonstration and training facility can be quickly mainstreamed into the oblast's overall health care system. A participating oblast would also have to demonstrate the local government's commitment to the planning, training and operational objectives of the program. To the extent possible, these selection criteria will also consider the interest and cooperation of local NGOs such as the Russian Family Planning Association and local pharmacies, adolescent support groups and educational institutions. The intent in forging these many linkages will be to fully integrate the program interventions into the political and social fabric of the host community.

The program's IEC activities will be structured to reinforce this broad-based approach across several elements of the community. Mass media messages will be used to inform the public regarding the health benefits of modern FP methods; acquaint them with the new services available in the health system; and encourage them to utilize the system and the commercial (pharmacy) sector, when appropriate, to meet their contraceptive requirements. Health care providers will be able to distribute informative materials describing FP methods, their health benefits and their side effects—greatly enhancing the content and quality of the patient counseling process and improving the credibility/public acceptance of modern contraceptive products.

The IEC campaign's effort to improve public attitudes toward family planning will also create a positive environment for program activities intended to promote policy dialogue and improved strategic planning. Policy dialogue, using computer graphics presentations of oblast-level data, will engage service providers in discussions with their administrators and will include in these discussions persons who are not directly responsible for health services—such as leaders in government, the NGO community, finance and education personnel—but whose participation is crucial to the development of a broad consensus for sustained improvements in the delivery of improved family planning information and services.

## **B. Linkages with the USAID Assistance Strategy**

USAID has identified three strategic objectives for assistance activities in Russia:

1. Foster the emergence of a competitive, efficient, market-oriented economy.
2. Transparent and accountable governance, and the empowerment of citizens, and respect for human rights and fundamental freedoms.
3. Redefined public and private sector roles in the management of humanitarian, health and related social services.

The strategy described herein will further the attainment of these overall objectives in the following manner:

### **Objective 1.**

Unwanted pregnancies, abortion and its complications place a substantial financial burden on public sector health facilities and an emotional and financial burden on Russian women.

Reducing this burden will make scarce financial resources available for more rational allocation in conformance with market-driven requirements and will enable women to participate more fully in the economic life of the country. Moreover, the private sector has not previously responded to the potentially huge demand for contraceptive products in Russia, as women have depended so heavily on abortion to regulate their fertility. By promoting greater reliance on modern contraceptives, this strategy will contribute importantly to the emergence of a strong, private sector-based pharmaceutical industry which will be better prepared/capitalized to respond to Russia's needs across several aspects of medical care.

**Objective 2.**

Provision of family planning information and services will enable Russian women to more effectively and safely determine their own fertility. The introduction of contraceptive options at clinics, pharmacies and through private physicians/health practitioners will ensure that such options are available. Integrating accurate and comprehensive counseling into the doctor-patient relationship will put women in charge of their fertility management decisions. Reducing the negative consequences of unwanted pregnancy and repeated abortions will impact positively on women's ability to participate as active, healthy members of society. Family planning information, counseling and service activities specifically designed to meet the needs of adolescents will greatly reduce their exposure to the risks of unwanted pregnancy and clandestine abortion.

**Objective 3.**

The private sector is emerging as a constructive and essential partner to public sector health institutions in Russia. It is more efficient in its resource allocations and more quickly responsive to client needs for consumer medical supplies such as contraceptives. Donated contraceptive supplies will be provided sparingly, and with the intention of stimulating subsequent purchases from commercial vendors.

Women and children are especially vulnerable and suffer disproportionately during economic and political transitions. Helping women to avoid abortions as they are performed in Russia is crucial and humane in an environment where infections and complications from abortions are high and antibiotics are still scarce.

**C. Coordination with Other USAID-Funded Projects in the Health Sector**

Two buy-in agreements were executed with the Association for Voluntary Surgical Contraception (AVSC) and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) in FY 1994 to support reproductive health activities in Russia. The Scopes of Work of these agreements have been amended to bring them into accordance with the strategy described herein. Technical personnel involved in the development of those agreements will provide oversight and technical assistance for the programs of both organizations, i.e., in support of the demonstration and training activities described above.

Beginning in 1993, The PROFIT Project, managed by Deloitte and Touche, developed activities to increase the availability of reasonably priced contraceptives in the commercial market. However, a continuing role for PROFIT is not evident after that project terminates in the spring of 1995, as the commercial pharmaceutical sector in Russia has moved more quickly than was originally anticipated to meet retail demand for contraceptive products.

The NGO-PVO Support Project managed by World Learning has the potential to stimulate the emergence of a critically important sector in Russia, particularly as indigenous NGOs seek to define their unique roles in a still-ambiguous legal environment. USAID/Russia Health Office staff reviews and/or monitors the project's health-related activities and will be closely involved in the design of future programs.

The American International Health Alliance (AIHA) currently supports eight partnerships in Russia across a variety of health service, research and management areas. The Magee Woman's Hospital-Savior's Hospital for Peace and Charity partnership opened a family planning center in Savior's Moscow hospital in 1994. The center emphasizes individual care and patient education. With a grant from World Learning, the Magee-Savior partnership is planning to duplicate the family planning center in 24 other sites. The implementing agencies for this strategy will consult with AIHA to identify the potential for collaboration, particularly in instances where existing partners are in a position to help upgrade the reproductive health facilities of counterpart Russian facilities. Collaboration is also anticipated in developing and distributing print materials for health care providers, clients and adolescents.

The ZdravReform Project managed by Abt Associates is attempting to develop patterns of cooperation in the fields of cost recovery and management training. These outcomes will have special relevance to this strategy's objective to ensure financial sustainability of reproductive health services at the oblast, and eventually, national level. The project sites selected for participation in The ZdravReform Project will be considered for inclusion as project oblasts in the reproductive health program if it appears that such collaboration would be advantageous for both activities.

#### **D. Participation of the Private Sector**

Unlike the situation in some other former Soviet republics, a dynamic private sector—including commercial and NGO elements—is emerging in Russia.

Several NGOs have entered the field of family planning and reproductive health, building in several instances on their leaderships' prior service in government and the networks which those personal affiliations offer for public/private sector cooperation. The Russian Family Planning Association (RFPA) appears to be an especially vigorous participant in the field, and has already established an in-country network of some 30 regional affiliates. USAID maintains excellent ties with the RFPA and is considering the possibility of providing modest support to the organization. Under the strategy described herein, the RFPA will receive support to strengthen its IEC activities.

With regard to the commercial sector, all major multinational manufacturers of contraceptives maintain offices in Moscow and import their own products for distribution and sale in the country's principal cities. These manufacturers detail their products to physicians, clinics, hospitals, family planning associations and pharmacies (including the provision of free samples and promotional materials to some clinics and family planning associations). These firms also conduct seminars and workshops to acquaint the medical profession with their products. These manufacturers will be contacted to explore their interest in providing donated products to the demonstration and training sites in the selected oblasts, i.e., in keeping with the manufacturers' interest in expanding market penetration in these oblasts. This donation will

ensure that the same products used for training purposes will be available on a continuous, commercial basis after the demonstration project ends.

#### **E. Other Donor Programs in Family Planning/Reproductive Health**

Although several donor agencies are involved in development activities in Russia, very few are engaged in the health sector in a major way. Currently, only the World Bank has indicated readiness to provide significant assistance in this area.

Thus far, the World Bank has provided technical assistance to the development of new health insurance legislation and US\$118 million under Russia's first rehabilitation loan to purchase raw materials for manufacturing pharmaceuticals.

The US\$120 million Health Sector Reform Project currently being negotiated by the World Bank is the organization's first lending operation specifically directed to the health sector in Russia. The Health Sector Reform Project has two components: 1) health sector reform in two or three oblasts and 2) strengthening selected federal health sector institutions. The first component will address both health finance and service delivery issues and will finance pharmaceutical supplies (including contraceptives), medical supplies and equipment and physical plant costs. The second component will address health promotion, quality assurance through better medical education and health care management, and implementation of the health insurance legislation.

The Ministry of Finance has indicated that the government would be reluctant to borrow at standard Bank rates for the technical assistance required to implement the project. Technical assistance would be required primarily in two areas: health financing and health promotion. USAID and Bank personnel will consult closely on the selection of target oblasts for the USAID project to determine whether those sites could/should be located in the Bank's project area(s).

Health Canada is supporting a small program of health promotion. With a total cost of US\$600,000 and working through the National Research Center for Preventive Medicine (of the Ministry of Health [MOH]), the project supports the implementation of pilot programs in seven urban areas to demonstrate the potential impact of community-based programs for health promotion. The World Bank intends to seek Canadian cofinancing for the health promotion component of the Bank's project.

The Russian Family Planning Association receives relatively modest support from the European Union, British Overseas Development Administration (ODA) and the International Planned Parenthood Federation (IPPF)/London. Under USAID's strategy, the RFPA will receive technical assistance to improve its IEC capabilities and possibly to expand FP services.

Family Planning International Assistance (FPIA) is supporting a project of the Russian International Women's Center to establish and operate FP clinics in factories/industrial facilities. Thus far, clinics have been set up in 17 such locations. FPIA intends to solicit partial financial support for this program from USAID. This project could be a candidate for assistance under the NGO support project.

#### **IV. END OF PROJECT STATUS**

**The Women's Reproductive Health Project will significantly reduce the high rates of maternal morbidity and mortality which Russian women suffer due in large measure to their reliance on abortion as a method of contraception. Specifically, by the end of the project:**

- **Russian women will have greatly increased access to comprehensive family planning information and services.**
- **Many of these women will choose to utilize these methods as an alternative to abortion.**
- **This decreased reliance on abortion will decrease the high rates of maternal morbidity and mortality attributed to abortion as currently practiced in Russia.**
- **Birth outcomes will improve as a consequence of decreases in abortion-related complications.**
- **The Russian health care system will be "humanized"; health professionals' attitudes toward modern contraception will be transformed and their interaction with patients will reflect greater sensitivity to patient needs.**
- **Linkages will be created among Russian government/private/commercial/social institutions whose support is crucial to the continued pursuit of program objectives after USAID assistance ceases.**
- **The commercial supply and distribution systems will be reliable and efficient sources of modern contraceptive products.**

## **ACTION PLAN FOR REPRODUCTIVE HEALTH**

**The Action Plan for Reproductive Health outlines the implementation of the Russia Reproductive Health Strategy. This Action Plan will work toward the goal of reducing the high rates of maternal mortality and morbidity. It will take direct steps toward the program purpose of promoting widespread change in the current family planning information and service delivery systems, leading to much greater adoption of modern methods of contraception as an alternative to repeat abortion.**

**The major elements of the Action Plan include: 1) establishing Demonstration and Training Centers; 2) promoting Information, Education and Communication; 3) supporting Contraceptive Availability and Supply; and 4) improving the Policy Environment.**

**These four elements will work together to improve the reproductive health of women throughout Russia. The interventions will predominantly focus on family planning; however, STDs and other select maternal health interventions will be included. The demonstration sites will create models for replication of quality reproductive health services around the country. The existing health infrastructure will be strengthened through working with key training institutions where populations of a million or more will be affected by the interventions. Oblast medical and refresher training institutions will provide updated practicum training for physicians at the newly equipped sites (e.g., maternity hospitals and women's consultation centers). Existing curricula will be revised to institutionalize quality training for physicians. To disseminate knowledge and skills nationally, physicians will be trained from not only within but outside the demonstration site oblasts, and training of trainer programs will be developed.**

**The program will be reinforced by linking it to the fullest extent possible with other programs (e.g., World Bank, USAID, NGOs) planned or under way in the health sector. Oblast health committees and key policy-makers will be a focal point of advocacy work. Schools and other educational institutions will play a role in disseminating reproductive health information. To increase access to family planning information and services within the selected oblasts (and nationally), the Russian Family Planning Association and other NGOs will be provided with technical assistance. This will provide wider coverage and furnish adolescents, men or other underserved groups with alternative places to obtain reproductive health services.**

**Information, education and communication through mass media (radio, television, newspapers, magazines) and other educational materials (pamphlets, videos, posters) will provide the knowledge needed by clients and health providers to understand the benefits of modern family planning methods. This information campaign will create a positive environment in which physicians will be stimulated to provide high-quality family planning services and consumers will seek a range of modern family planning methods.**

**A limited amount of contraceptives will be supplied to the demonstration sites to support training activities and the initial needs of new clients. Commercial sector sales will be stimulated by the mass media campaigns that will provide information on family planning methods and their benefits directly to the population. To ensure product availability in program site oblasts, technical assistance will be provided to work with pharmaceutical companies.**

**The collection and analysis of nationally representative health and demographic statistics will provide a baseline for assessing future changes in women's health status and will provide to**

governmental and nongovernmental policy-makers and donor agencies the information they need to make informed decisions.

The program elements are outlined in detail in the following sections.

## **I. PROGRAM ELEMENTS**

### **A. Establish Demonstration and Training Centers**

#### **1. Background**

Due to the isolation of the Russian medical community from Western contraceptive research and practice, exposure to the use of modern contraceptive methods has been limited. For decades, Russian physicians have provided abortions as the primary family planning method. Due to this practice, with less than ideal equipment, the rates of maternal mortality and morbidity are high. Use of modern contraceptives (predominately the IUD) has been limited to approximately 22% of women. (In comparison, contraceptive use in Europe and the United States is 60% to 70%). Due to the lack of exposure within the Russian medical community (and within the public at large), misinformation about modern family planning methods is widespread and the reliance on abortion as a method of family planning remains almost universal.

Although pregnancy and abortion rates among adolescents are high, services are not oriented to serving youths. Typically adolescents avoid obtaining services from government facilities. STDs are diagnosed at many facilities, although they are only treated at specialized STD clinics where clients by law are officially registered. This provides a strong deterrent to obtaining proper medical care.

Reproductive health training is either non-existent or minimally incorporated into preservice, in-service or post-graduate training for health practitioners. The majority of current training is theoretical and/or observational, thus not allowing students an opportunity to obtain the necessary clinical skills to deliver quality services. Teaching materials are usually outdated, technically inaccurate or, most commonly, non-existent.

#### **2. Constraints to the Provision of Quality Reproductive Health Services**

- Reluctance (on the part of some physicians) to move away from the provision of abortion and the income gained in providing abortion services
- Prejudice concerning low-dose oral contraceptives based on experience with high-dose pills in the 1960's and 1970's
- Lack of knowledge about the effectiveness of injectables, such as Depo-Provera
- Lack of training in modern counseling skills or exposure to client-centered orientation practices

- **Lack of experience/information with the use of minilaparotomy and laparoscopy sterilization as a contraceptive method**
- **Lack of exposure to organizational structures that provide an integrated approach to reproductive health**
- **Lack of experience with teaching methodologies to train others to use interactive techniques**
- **A curative orientation of the medical community and consequent lack of interest in family planning as a preventive measure to avoid pregnancy**
- **A physician orientation to medical care which stresses physician control of clients' health care decisions**

### **3. Program Components**

#### **a. Establish Demonstration and Training Centers**

**The establishment of demonstration and training sites is the core element of USAID's strategy in Russia. These demonstration sites will link oblast-level medical training institutions with facilities responsible for delivery of reproductive health care services in the oblast. The reproductive health care curricula of the training institutions will be enhanced and strengthened. As service-level personnel will participate in these training innovations, improvements in health care will be immediately reflected in the quality of services provided at the health care facilities. This new training-cum-service approach will serve as a model for physicians and policy-makers—from within and outside the participating oblasts—as to how significant improvements in reproductive health care can be effected in a rapid, cost-effective manner.**

**Specifically, model service and training sites will be developed at existing facilities in six oblasts with populations of a million or more people. Ideally, each site will include a women's consultation clinic, maternity home and abortion facility. These sites will provide high-quality services to the local community while their staffs are trained in modern contraceptive technologies and counseling. With the support of the oblast and NGO officials, clinic staffs from outlying areas will also receive training, and training of trainers (TOT) programs will be developed. If not already in place, linkages will be developed with local health training institutions so that their students participate in demonstration site training. Existing medical school curricula will be revised to institutionalize quality training for health professionals.**

**The program will have an impact on the entire administrative, financial, educational and service delivery system in the region. A network of partners will be created involving oblast and city health officials, health service providers, contraceptive suppliers, educational institutions and NGOs. Specific plans will be developed to involve each participating institution in the program. A dissemination plan will also be developed to ensure that the demonstration sites impact other areas of the country.**

The project's IEC component, described below, will promote the use of modern family planning methods and will inform clients about the availability of services at the demonstration sites.

**b. Improve Training for Health Care Providers**

In addition to serving as models for high-quality reproductive health care, the demonstration sites will also play a key role in improving ongoing training for health care providers. Training institutions are typically attached to maternity hospitals and women's consultation centers where practicum training is provided to medical students or physicians receiving refresher training. The maternity hospitals and consultation centers linked to demonstration sites will be upgraded to high-quality training centers for training medical students and physicians. To institutionalize improved reproductive health training, technical assistance will be provided to revise the existing medical school and/or refresher training curricula at the oblast level and, to the extent possible, at the national level. If such changes in curricula are not possible, technical assistance will focus on the development of additional/parallel and elective training programs on family planning and reproductive health technologies. The institutionalization of reproductive health training will begin at these demonstration sites and expand nationally as national- and oblast-level medical guidelines/protocols for reproductive health are reviewed and revised with local counterparts.

High-quality training programs will require a sufficient supply of high-quality training materials and educational equipment. In addition, to ensure the sustainability of the training system, training of trainers courses in training methodology will be linked to preservice and post-graduate training for reproductive health.

Since doctors from throughout the country are free to choose the site of their post-graduate training, it is foreseen that many doctors will choose these sites and thus extend the impact of the demonstration services beyond the oblast in which training takes place. As part of the dissemination plan, training opportunities will be provided to many other health professionals within and outside the oblast, encouraging emulation in other parts of the country. (It must be stressed, however, that these dissemination efforts will be most successful if they take place after the demonstration/training initiative is fully operational within the reproductive health care system of the "home" oblast).

To reinforce a team approach to reproductive health, physicians and midwives will be trained as partners in a team. Special attention will be given to STD/AIDS and the contraceptive needs of adolescents. The training will emphasize a wide range of family planning methods (IUDs, pills, injectables, the lactational amenorrhea method [LAM] and sterilization) and selected maternal health interventions. Integral to all training will be the concept of client-centered quality care with its emphasis on information and counseling.

In the initial stage of the program in each participating oblast, a contraceptive technology update seminar will be held to inform policy-makers, physicians and other health providers of the benefits of modern family methods, STD management and other maternal health interventions. This will set the stage for development of the program in each oblast. The next steps will be to implement targeted interventions for physicians, policy-makers, medical students and the population at large. These will include clinical and counseling training for physicians, TOT, advocacy work with policy-makers, curriculum development with training institutions and communication interventions for the local population. (The outline of the training plan is detailed in Annex I).

If additional funding is made available, an accelerated "roll-out" of the current design will be effected by extending training opportunities to other oblasts. Under an expanded program, intensive training will be undertaken in the demonstration sites to ensure that training teams from numerous other oblasts are trained as trainers. Essential equipment and supplies will be provided to these teams to initiate training in their respective oblasts.

An expanded program would also intensify training in the areas of supervision and service delivery management. These components would help ensure the sustainability of the changes incorporated into the reproductive health training and service delivery system. Assistance will be provided to counterparts to develop the management training needed to produce high-quality managers and supervisors of the emerging reproductive health services.

## **B. Information, Education and Communication**

### **1. Background**

Educating clients and health care providers about family planning is a major component of program activities. For maximum impact and sustainability, the communication program will be designed in close collaboration with Russian counterpart organizations at the demonstration sites and in surrounding areas and will involve multiple channels of communication to influence policy-makers, health care providers and the public. To achieve the Russia Reproductive Health Program goal of improving women's reproductive health, all IEC activities and materials will stress the safety and health benefits of family planning methods and promote their use as alternatives to abortion.

Russian men and women prefer small families. Birth rates have declined in recent years, and the desired family size is fewer than two children (Bodrovna, 1994). Although modern methods are available, contraceptive prevalence is low. An estimated 19% of reproductive age women rely on IUDs and 3% use oral contraceptives. Recent surveys in St. Petersburg and Kaluga suggest that many couples also rely on condoms and traditional methods—withdrawal, rhythm, and douche—to prevent pregnancy. Contraceptive failures, even with modern methods, are reported to be high.

Almost all Russians have access to television and radio, providing ample opportunities for family planning promotion through the mass media. Literacy is almost universal, and newspapers and magazines are circulated widely. With the breakup of the former Soviet Union, many independent media channels have emerged. The capital cities of every oblast have one or more local television and radio stations and local programming, allowing for targeted regional mass media campaigns.

Current family planning IEC programs have not yet utilized these opportunities. Existing activities, most carried out by the Russian Family Planning Association and other small organizations, include limited mass media programs, training, distribution of print materials for clients and health professionals and pilot education and service delivery programs.

## **2. Constraints**

Despite the evident success of current IEC programs in improving quality of care in model clinics and educating providers about family planning, many constraints have limited more widespread national and regional efforts. Principal among these are lack of funding, particularly for mass media activities, the absence of a clearly defined national- or oblast-level IEC strategy, poor coordination of activities between organizations and the lack of training and experience in managing IEC programs, developing mass media and print materials and evaluating program effectiveness.

Major unmet needs in IEC activities are listed below:

### **a. Limited Use of Mass Media**

The influx of western advertising has inflated media broadcast costs, putting mass media programming beyond the means of most organizations. Current programs consist of talk shows and brief interviews with health professionals and demographers, often focusing on the falling birth rates rather than women's reproductive health. Lack of funding has limited more innovative and entertaining approaches. There is a reported lack of interest about women's health needs from media executives and an unwillingness to supply free or discounted broadcast time for public health programming.

### **b. Programs for Youth**

Unwanted pregnancy is increasing among adolescents. Age-specific fertility rates are rising among women ages 15-19, while falling in every other age group. Abortions and STD infections are reported to be common. There are no systematic, large-scale sex education programs in or out of school despite the perceived need. Trained teachers, appropriate training and educational materials and funding are in short supply.

### **c. Informational Materials for Clients**

Print materials are very limited. Notably lacking are materials developed and pretested in Russia, materials with an entertaining format, such as comic books or photonovellas, and client materials on oral contraceptives and injectables.

### **d. Provider-Client Interaction**

The concepts of counseling and informed choice are new to Russia. Lack of technical information about contraception, training in health education and time with clients are constraints for health professionals. On the clients' side, distrust of doctors and the health care system are major barriers. The poor counseling environment leads to many missed opportunities to educate clients and promote family planning.

## **3. Program Response**

The IEC component will be implemented in two phases. The first phase will focus on increasing knowledge and awareness of family planning. Primary interventions will be developing and distributing educational materials for clients and providers, increasing discussion of family planning in the mass media, and building local capability for IEC program management and client counseling. The second phase will focus on generating demand for family planning services at the demonstration sites through mass media campaigns and support for local activities.

To enhance regional and national activities, avoid duplication of effort and increase overall program effectiveness, the IEC component will be designed to support the other components of the strategy, collaborate to the greatest extent possible with other donor-funded activities and foster collaboration among Russian government and nongovernmental organizations working on IEC activities. Efforts will be made to share materials and research findings and promote coordination of IEC activities.

The program's IEC activities will be designed to reach health professionals and the public beyond the demonstration sites. Political leaders, NGOs, local social action groups, women's organizations and youth programs will be involved in program planning and information dissemination. Through the mass media, technical assistance to local- and regional-level family planning organizations, supplies of educational materials and dialogue with policy-makers, the IEC program will reach a large audience and contribute to the overall acceptance on family planning the regional level.

The institutional objectives of the IEC component of the RRHP are to:

- Upgrade the capability of family planning providers to give quality information and interpersonal counseling to new and continuing clients
- Increase technical knowledge of modern contraceptive methods among Russian physicians
- Increase the capability of Russian counterpart organizations to design and manage FP/IEC projects and produce and distribute high-quality IEC materials
- Increase collaboration and cooperation between Russian organizations—government and NGOs—providing family planning services and IEC materials
- Promote cost-sharing and other IEC cost recovery approaches, such as sponsorship of television and radio programs and free space and broadcasting time

The communication objectives of the IEC component are to:

- Increase knowledge of modern contraception as a viable alternative to induced abortion
- Increase positive attitudes toward oral contraceptives
- Increase knowledge about long-term methods—injectables and female sterilization
- Increase the percentage of women and men who approve of using modern contraceptives
- Increase the percentage of women and men who intend to use modern contraceptive methods in the next 12 months

- **Increase requests for family planning services and attendance at family planning clinics**
- **Increase the number of women who report having received information and/or referrals about family planning at government clinics**

**a. Mass Media Interventions**

To support and reinforce clinic- and community-level activities and motivate contraceptive use, the IEC component will produce 1) regional-level—and, depending on availability of funds, national-level—television and radio programming and 2) regional mass media and social mobilization campaigns at the demonstration sites.

For mass media interventions the extent and type of television and radio programs and the mix of national and regional channels will depend on production and broadcast costs at the time of RRHP start-up and results of market research in demonstration sites. A number of programming formats will be considered: advice segments, personal testimonials by new family planning users, celebrity endorsements, infomercials, round table discussions and mini-dramas. Print advertisements and stories in popular newspapers and magazines will use the same messages. Local advertising firms and production houses will be contracted to produce materials and place them in the media.

Regional campaigns will be carried out in the demonstration sites to bring women into clinics for counseling and information and into pharmacies to buy contraceptives. In addition to television, radio and print messages, campaigns will involve local activities such as press conferences, rallies, contests, speeches and other special events. Print materials and, if appropriate, hats, T-shirts, key chains and other materials with family planning messages will be produced.

Technical assistance will be provided to health authorities and RFPA affiliates managing the campaigns. A training workshop will be held in the first year of the project to outline the objectives, management and possible activities of regional campaigns. Regional personnel will be free to modify campaign activities as appropriate for local conditions.

The campaign will be designed in close collaboration with the training and logistics components of the RRHP to ensure that demonstration clinic and health centers will be prepared to serve new clients. Campaigns will not begin until personnel at demonstration sites have been trained and equipped with contraceptive supplies and are prepared to provide high-quality family planning services.

Working with Russian counterparts and other organizations, the IEC implementing agency will make every effort to secure free or discounted broadcast time. For example, InterNews, an NGO working with regional media in Russia, has agreed to broadcast free of charge RRHP public service announcements on its four television programs that are broadcast on national and regional media. Similar agreements will be sought with other organizations and networks to achieve maximum coverage and visibility at minimum cost.

Projected IEC activities will involve many outputs. A unifying and motivational slogan may appear on all IEC outputs to reinforce program impact.

**b. Technical and Counseling Materials for Health Professionals**

Materials distributed to health providers in the demonstration sites and to other Russian family planning organizations will provide technical information and counseling; support. These materials will include Russian translations of Population Reports on modern contraceptive methods and counseling; one-page review sheets on each method and on the lactation amenorrhea method for use in counseling; and a new contraceptive handbook, scheduled for publication in 1995, which will provide the latest recommended eligibility guidelines for using IUDs and hormonal contraceptives. Counseling review cards will be adapted from materials already prepared in the Central Asian Republics (CARs) to increase cost-effectiveness and rapid production for use in training.

To further increase counseling skills, a short video on counseling will be developed for use in training health professionals. This effort will be a joint collaboration between the organizations working in the IEC and training component of RRHP so the final product will be integrated into the training program. Additional copies will be duplicated for use in training by other organizations.

**c. IEC Materials for Clients**

Method-specific leaflets and motivational posters for clinic waiting rooms will be developed in Russian. Leaflets and other materials on oral contraceptives will emphasize the safety of low-dose formulations and tell women to ask their pharmacists or doctors for low-dose pills. A leaflet on LAM will also be produced for postpartum women. All print materials will be based on results of qualitative and quantitative research and will be designed in Russia and pretested with women in the demonstration areas. Materials will be produced in large print runs to reduce costs and meet client needs in the demonstration sites and neighboring clinics.

**d. IEC Materials for Young People**

To support the RFPA and other organizations working with young people, materials will be developed for sex education and outreach. One possible output is a short dramatic video about young people making choices about sexual activity and family planning. This will be used to promote discussion in group education. The video will be duplicated and distributed to many organizations along with a users' guide containing family planning information, sample discussion questions and other training tips. A comic book with the same characters as the video will be developed with messages about sexual responsibility and prevention of pregnancy and STDs. In addition, technical assistance will be provided to health educators in the demonstration sites who wish to work on in-school and/or out-of-school sex education activities to develop creative educational approaches and curricula for young people, including role plays, personal risk-assessment and skills building exercises.

**e. Training/Workshops**

Several workshops will be conducted in the first two years of the project to increase institutional capabilities and coordination among family planning organizations. The participants will include family planning managers, health professionals and social researchers. Training will include the steps of health communication and materials development and management of IEC programs. Strategies for conducting local campaigns will be discussed to ensure a similar level of effort in each of the demonstration sites.

Additional workshops will be conducted with journalists in Moscow and from the demonstration sites to increase coverage of family planning and related women's health issues in the national and local media.

**f. Formative Research**

Qualitative and quantitative research will be used to ensure the quality of IEC interventions and measure effectiveness. Focus group discussions and the preparation of a literature review of recent Russian family planning research will help develop messages and define target audiences. Focus group discussions will be conducted in various sites and populations in the demonstration sites to ensure geographic and ethnic coverage.

Market research will be conducted in the demonstration site regions to assess media use patterns among the population. Results will help plan cost-effective advertising and mass media programming and ensure maximum coverage of the population.

**C. Contraceptive Availability and Supply**

**1. Background**

**a. The Pre-1991 Situation**

Under the former USSR, procurement and distribution of contraceptives was effected through a highly centralized "top down" system with decisions on allocations among republics and, within Russia, among administrative divisions (republics and oblasts) emanating from Moscow. The Soviet procurement and distribution agency, Pharmacia, had access to a relatively well developed network of transport and distribution points nationally.

Allocation of contraceptive supplies among administrative units was based on centrally determined distribution formulas that were determined primarily by population size, other demographic variables and central availability of products.

The formula was used to calculate the "demand" for the family planning method. Little, if any, effort appears to have been made to validate these figures, which are reported to have been made at the highest policy-making levels through such means as examination of differences in local patterns of "dispensed to users" data. Thus, since "demand" was centrally determined, with no real feedback from local administrative units, resupply decisions were generally not responsive to local differences in real underlying demand. This system of allocation was thus a "push" system, from the center outward, conducted with very little feedback from the periphery regarding the appropriateness of the allocations.

**b. The Current Situation**

Since 1991, the system of contraceptive distribution has changed radically and continues to evolve into a market-oriented, decentralized, client demand-driven system. The centralized procurement and distribution of the old public sector Pharmacia system has given way to an active and competitive private sector. Russian entrepreneurs have already accomplished much of the transition to a system of client supply through widespread commercial outlets. These outlets in turn are supplied through a wide network of distributors and wholesalers who receive their products from an extensive network of pharmaceutical companies. These companies, along with the distributors and wholesalers are licensed by the Ministry of Health to import pharmaceutical products, including contraceptives, and serve as wholesalers and distributors of these products.

While this system remains imperfect, it appears to be evolving rapidly into a national distribution system for generally affordable contraceptives.

To illustrate the far-reaching changes from the monolithic central Pharmacia era, Moscow now is reported by different sources to have about 500 to 900 registered pharmaceutical companies, even though it is likely that only a fraction of these are currently active. The Organon pharmaceutical company, for example, estimates that 80-100 are "active" and 25 are "serious" distributors in Moscow. Ekaterinburg is reported to have about 180 registered companies for pharmaceutical wholesaling and distribution.

Major pharmaceutical multinationals now have offices in Moscow, including (among manufacturers of contraceptives) Organon, Schering, Upjohn, Johnson and Johnson, Searle and Syntex. Each of these uses substantial numbers of private sector distributors. Their networks in turn supply the four major provider categories consisting of the remaining public sector (MOH, oblast, municipal facilities, etc.), the NGO component (RFPAs, FPIA, etc.), the quasi-commercial sector (parastatals, private companies, factories, and also private health insurance schemes, etc.) and the fully commercial sector (drug stores, kiosks, hard currency stores, etc.).

## **2. Constraints to Contraceptive Availability**

Supplies of contraceptive commodities were not consistently available under the pre-1991 centralized quota-driven distribution system with its insensitivity to local demand factors combined with a generally negative attitude, particularly toward hormonal contraception. While the transition to a more demand-responsive supply situation is not yet complete, there is evidence of rapid change toward a competitive free-market supply system. However, the evolving system is subject to a number of constraints.

The main constraints to further expansion of this nascent free-market system appear to be two demand-related factors which this project will be addressing to varying extents.

The first is insufficient demand for specific products to justify pharmacies stocking the product. The second factor is that in the transition to privatization, many pharmacies have found themselves short of operating capital to purchase initial stocks of contraceptives from their wholesalers/distributors for subsequent resale to clients. Pharmacies are sometimes able to reduce the effect of this problem by arranging with distributors to receive commodities on consignment. However, these are typically very short consignments of 10 to 21 days, which does not fully meet the needs of small volume retailers.

Regarding prices, oral pills generally range from under 2000 to over 12,000 rubles per cycle, with the median around 5-6000 rubles. At current exchange rates (roughly 3000 rubles per US dollar) this is a range of about US\$0.70 to US\$4.00, centered typically just below US\$2.00, with a wide proliferation of brands. There appears to be general agreement among pharmacists, manufacturers and public and private sector service providers that these prices are affordable to the great majority of Russian women.

Condoms range from under 100 rubles for locally produced condoms, which are generally not well regarded, up to 500 or more rubles for imported brands. Available brands are more limited than pills. This price range of under US\$0.30 to over US\$0.17 per condom "piece" is also generally affordable to potential clients.

IUDs, both the Cu "T" 380A and other copper-bearing IUDs ("Multiload", "Utering 330") range in price from about 6000 to 15,000 rubles (exclusive of insertion costs at the clinic). And this too is considered "affordable". IUDs are generally available through pharmacies.

At present, the injectable Depo-Provera is not widely available through pharmacies, though its producer, Upjohn, reports very rapid growth in the past two years, mainly through hospitals and clinics. The retail price recommended by Upjohn is reported as US\$2.50 per 1 ml vial, or US\$3.50 for the "prepared" syringe/vial combination, which provides three months of contraceptive protection.

As noted, price does not appear to be a major constraint to consumers, but pharmacies are reluctant to lay out scarce operating capital when demand does not justify establishing an inventory of products which are selling only slowly. The corollary is that retailers are eager to stock and sell products for which an expressed demand exists and which are readily available from their wholesalers.

Use of hormonal contraceptive pills remains very low by comparison with most Western nations. As previously noted, this appears to be a legacy of the poor quality of the high-dosage pills available in earlier years. Physicians, including obstetricians and gynecologists, and also women who had first- or second-hand experience with these products retain a strong bias against these products. One of the goals of the present project is to replace outdated attitudes toward these and other modern methods through dissemination of updated information on current versions of these methods and convince practitioners and clients of the far greater efficacy and safety of these methods, particularly as an alternative to abortion.

Success in this demand-creation effort, resulting in increased requests from customers to retailers, will eventually translate into increased orders to distributors. This demand will in turn be passed back to manufacturers to import additional products to meet the needs of the retail outlets.

### **3. Program Response**

The existing and still developing system of contraceptive supply and distribution is moving toward a market-driven national supply system for all the major contraceptive methods. Consequently, no major action is called for on a national basis in this project on the supply side of the equation, though provision of limited supplies of IUDs and injectables (Depo-Provera) will be required for training sites.

While direct supply interventions will not be undertaken at a national level, project activities designed to stimulate and increase demand will in turn result in increased contraceptive supply. This can be expected to be far more cost effective than interventions to supply methods not currently/regularly available at affordable prices, either directly or through the introduction of social marketing programs.

Specific tasks to be undertaken include the following:

**a. Involve Private Sector Suppliers**

- In view of the existence of a rapidly expanding market-driven distribution system for contraceptive supply, this project should not support contraceptive procurement nor seek to develop parallel supply or distribution systems, except in those situations where demonstration training sites require specific methods to be directly available at the training sites for training purposes and for trainees to initiate further training at their own clinics.
- Based on current trends, questions of supply accessibility, availability and continuity of supplies for the foreseeable future seem to be addressed adequately by the evolving private sector market-oriented economy. If, at later phases of this project, it is determined that a "jump start" is justified, either for a specific method or product such as injectables or NORPLANT<sup>®</sup>, or if external technical assistance is required to establish the viability of local production of one or more products, those options can be assessed. However, at present it appears that the existing and expanding private sector system will in all probability not require such assistance, and importation, distribution and local production are not issues this project needs to address.
- Major criteria for establishing social marketing programs include lack of availability or prohibitively high costs of a range of modern contraceptive methods to serve urban populations. Since, in general, neither of these conditions applies in urban areas, program funding can better be utilized in creating demand through IEC activities and through provider training, while allowing commercial marketing forces to meet the increased demand that these activities generate.

**b. Provide Technical Assistance**

- Technical assistance will be provided during the initial planning phase for the selected demonstration training sites, to determine with greater precision than is now possible the quantities of IUDs and injectables to be consigned to each site and to assist with arrangements for shipment of these contraceptives in a timely fashion. In the initial assessment, the logistics management consultant will also conduct a retail audit of a selection of pharmacies to assess initial availability of contraceptives. Depending on findings, the consultant may then work with the pharmacies and their wholesalers/distributors to augment the flow of contraceptive supplies. If necessary, manufacturers may also be alerted directly with regard to the opportunities presented to them by demand creation activities in the areas selected for intensive efforts.
- In addition to the initial logistics assessment, using external consultants, arrangements will be made for periodic post-training visits to demonstration site areas by a local-hire consultant having prior experience working with pharmaceutical manufacturers, distributors and retail outlets. This individual will conduct contraceptive supply status reviews at pharmaceutical outlets. Based on findings of availability, the consultant may then contact distributors and

manufacturers in order to address directly problems identified in the supply system. The purpose of this exercise will be to ensure the availability within the catchment areas of these sites and through the general distribution system of the contraceptives required (at least IUDs, pill, condoms and injectables) in order for a full range of method choices to be available to women and couples.

- National trends in demand for and availability of supply-based contraceptives will also be addressed by the logistics management component of this program. Thus, the logistics technical assistance will also assess the availability of these contraceptives in non-project areas. Such spot checks would include additional isolated or rural oblasts or regions in which access and availability may have been identified from other sources as being potentially problematic.

#### **4. Contraceptive Commodity Requirements for Demonstration and Training Activities**

Preliminary estimates for six initial training sites have been prepared on the following basis. First, the only two methods to be supplied directly to the training sites would be IUDs and the injectable Depo-Provera, because these are the two main products for which direct technical training will be provided.

Second, while it is recognized that a determination of the actual number of trainees at each site cannot be made at present, and this number will vary among the six sites, a simplified assumption is made that 100 staff persons will receive this clinical training, and that, in addition to the initial training at the headquarters site, each of these staff persons will require a modest stock of contraceptives to take back to their home facility in order to provide training to colleagues. In addition, both to meet initial training needs and subsequent contingencies, a substantial stock of each method should be provided for the headquarters training site. However, this quantity should not be so large as to undermine the local development of a market-based system of supply along the lines of the system that is evolving nationally. These donated supplies are all intended to be provided free of charge to clients and are not intended for resale.

Details of the contraceptive commodity estimates are in Annex II.

#### **D. Improving Policy Implementation**

##### **1. Background**

The breakup of the Soviet Union has resulted in the decentralization of many government functions and the health sector has not been exempt from this trend. Whereas in the past resources and direction flowed from the center (Moscow) down through the system, each oblast is now responsible for developing its own budget and establishing and maintaining a local health care structure. The health system is characterized by fragmentation and overspecialization. Maternal and child health care are almost always joint but separate from other parts of the system.

The laws and regulations in the family planning arena are inconsistent. In some cases, they permit a wide range of choice (e.g., abortion is permitted up to 22 weeks) while in others they

are more restrictive (e.g., a woman must have two children and be over age 35 or meet certain medical criteria to have a sterilization). Medical care has always been available free of charge and a strong bias toward free care and care for all remains. Within the overall population, teens and youth have emerged as a priority subpopulation for maternal care. With the exception of a new requirement for girls under 14 to receive parental permission before getting an abortion, there do not appear to be legislative or regulatory barriers to the provision of family planning services to teens. On the other hand, there are clearly attitudinal barriers that interfere with a client's freedom to choose and right to quality care.

As noted earlier, the new family planning decree of 1994 provides for the establishment of Family Planning Centers in each oblast and independent region (a total of approximately 95 centers) but does not provide resources for these centers. The law reflects central political support for the expansion of family planning services but commitment to implementation, as measured by resource allocation to family planning, is less evident and seems to rest primarily at the local level.

Another factor complicating the policy environment is the lack of a clear distinction between the public and private sectors. For example, the Russian Family Planning Association and many of its regional branches are housed in government buildings and/or receive modest financial support from the government. Similarly, the Institute of Mother and Child, a government-supported hospital in Ivanovo, is a member of the International Federation for Mother and Child Health Care, a non-governmental foundation. While this close, but indistinct relationship between the government and nongovernmental institutions makes it difficult to segment the market and define clear roles for the public and private sectors, it also suggests that the various institutions share a common goal of expanding access to family planning.

## **2. Constraints in the Policy Environment**

A supportive policy environment is emerging, but it requires nurturing. There are a variety of constraints to expanding access to family planning:

### **a. Data Constraints**

Only limited demographic and health data are available at the national level. While some summary statistics do exist, there are no detailed data on reproductive behavior or contraceptive knowledge, attitudes and practice. The data that do exist are inconsistent, not nationally representative, and not comparable over time. Information about Russia is often incomplete in internationally recognized compendia of data, such as United Nations and World Bank publications, because reliable, detailed data are unavailable. Further, programmatic decisions are being made in the absence of good data.

### **b. Financial Constraints**

Russia is struggling with the transition from a centralized economy to a decentralized, free-market system. Previously secure markets and sources of supply have disappeared. Inflation and unemployment are high. Regional disparities are magnified. Local-level officials (oblast and city) suddenly find themselves responsible for generating revenues and allocating funds in order to provide social services in an environment of economic hardship and uncertainty. The health sector has been underfunded historically, and, with the bias toward curative care, family planning receives a relatively small share of an already limited budget.

**c. Skills Constraints**

With decentralization of the health sector, medical personnel have been thrust into the management and administration of local programs without necessarily having the skills or background to do so.

Out of necessity, programs are being run on a day-to-day basis. Yet the long-term viability of the health care system depends on effective planning and administration.

**3. Program Response**

The goal of policy interventions is to improve the policy environment for expansion of the provision of voluntary, high-quality family planning services. Given the current policy environment and USAID's comparative advantage, three priorities emerge in the policy area:

- Collection, analysis and dissemination of nationally representative demographic and health data
- Policy dialogue to raise awareness and build commitment among policy-makers about the value of family planning as, first, an effective reproductive health intervention to reduce reliance on abortion and improve maternal health and, second, as a sound economic investment
- Strategic planning to institutionalize data-based decision-making and expand the resources available for family planning

A priority in the management area is the development and improvement of management skills among program administrators.

Specific elements of the program include:

**a. Data Collection**

In order to overcome many of the current data constraints, a nationally representative survey of reproductive attitudes and behavior should be undertaken. The survey should be a DHS-type survey, adapted to the particular information needs of Russia and undertaken by the Centers for Disease Control and Prevention (CDC). The rationale for having the CDC as an implementing institution is cost and flexibility. Moreover, a CDC survey will be less costly and easier to modify to the Russian situation than a DHS would be.

Among other information, the team recommends that the survey include:

- Over-sampling of teens and a special module on the family planning knowledge, attitudes and behaviors of teens
- Questions on women's attitudes toward and experience with abortion

- A male questionnaire to be implemented among the male partners of female respondents
- Questions on sources of information about family planning and interpersonal communication

Such a survey could serve as a baseline against which progress in the family planning area could be measured, both to assist USAID in demonstrating the impact of its assistance and, more importantly, to enable the Russians to assess program progress and make program modifications. In addition, social scientists in Russia and worldwide would have a rich database of demographic information for analysis and research, greatly expanding the collective understanding of reproductive behavior in Russia.

Prior to this survey being undertaken, CDC will consult with the University of North Carolina (UNC) regarding the extent to which the Russian Longitudinal Monitoring Survey (RLMS) will be able to provide the types of information to be gathered in the proposed DHS-type survey. In the event that sufficient relevant information can be extracted on a nationally representative and timely basis, the proposed survey would not be undertaken or would be postponed until a later stage of the program.

It is noted that the RLMS was designed as a quarterly longitudinal study in which information of particular relevance to women's health and reproduction was largely an afterthought to the main focus on elements of the "social safety net," such as household income and nutritional status. This study may eventually provide information useful for certain social sector programs and policies. However, based on a review of available documentation on the study design, including the sampling design and the questionnaires used in recent rounds, along with the very scant tabulations available after the first four rounds, it appears highly improbable that this instrument will satisfy even minimal information needs of the national family planning and reproductive health community. It therefore appears that a DHS-type survey providing the information indicated above will be required.

USAID should also support smaller data collection efforts in the oblasts that are chosen as demonstration sites. These efforts should provide the quantitative and qualitative data specifically needed to serve as a baseline for measuring progress in those sites.

#### **b. Policy Dialogue**

Strong and consistent support by policy-makers for family planning is an important element of a favorable policy environment. The new decree described above explicitly and officially includes family planning as part of the federal government's health program. For the law to have real meaning, however, policy-makers, particularly at the local level, need a deeper understanding of the rationale for the program they are being directed to implement.

Policy activities will contribute to institutionalizing support for family planning through the preparation and dissemination of computer graphics presentations for policy-makers in the oblasts where demonstration sites are established. Presentations will be customized, as need be, for each demonstration site. Issues that might usefully be included are:

- The health benefits for mother and child of using family planning
- The health benefits of family planning as an alternative to abortion

- **The cost/benefits of providing family planning services in terms of savings to the public sector**
- **The importance of including family planning in reproductive health services for youth**

**Presentations should be developed collaboratively with local counterparts, with input from service providers and others, to identify the most important policy audiences. It may be important to include officials who are not directly responsible for health services—such as those in the areas of education, finance, and youth affairs—as part of the target audience in order to build broad-based political consensus for the expansion of family planning.**

**Policy-makers should be explicitly included in the public events that launch each demonstration site and in ongoing publicity. These events are important opportunities for policy-makers to articulate their support and demonstrate their commitment to making the demonstration sites successful.**

### **c. Strategic Planning**

**The uncertain economic conditions in Russia require local-level officials to make difficult budget decisions. At the same time, the changing socio-political environment demands that they take bold steps to commit resources to family planning. USAID-supported technical assistance will help oblast officials improve the planning and management of the family planning program, with a focus on strengthening institutional capacities to secure and allocate resources and plan for program expansion. Two kinds of activities should be implemented in each selected oblast or in groups of oblasts.**

**First, strategic planning exercises should be undertaken to strengthen the public sector's capacity to plan, manage and evaluate family planning programs. These exercises will help prioritize the issues facing the establishment and/or expansion of the oblast's program, identify strategies for implementing the program and assess the structural and personnel requirements in relation to available resources. An examination of program financing options will be integral to the discussion. Emphasis will be placed on making decisions based on data. The strategic planning component will include transfer of computer equipment and software packages and training of key personnel in basic demographic and program planning concepts.**

**Strategic planning should be an inclusive effort. This is particularly important in Russia where the government and nongovernmental sectors are closely intertwined. Mutual understanding and agreement about goals, objectives and relative responsibilities will facilitate the implementation of a coordinated and effective oblast-level family planning program.**

**Second, technical assistance should be provided to analyze public finance and resource allocation issues. These analyses will reinforce the policy dialogue efforts described above by demonstrating the policy implications of service expansion, broad method mix, program financing and savings gained by providing family planning services. The data will also provide health officials with a more accurate estimate of the cost of services and, therefore, a more defensible budget. Activities under this component should be coordinated with those of USAID's NIS Health Care Financing Project, where appropriate.**

## **II. PROGRAM MANAGEMENT AND IMPLEMENTATION**

### **A. USAID**

Overall responsibility for implementation of the reproductive health program will rest with USAID/Russia. The Mission's PHN Division will manage the reproductive health program directly. Fiscal responsibility will move to the Mission from the ENI Bureau. The Mission will manage and communicate directly with the Cooperating Agencies (CAs) with backstopping/coordination assistance from the Global Bureau Field and Program Support Office. The regional coordinator (in the Field and Program Support Office) will coordinate CA activities (on the Washington side) as needed by the Mission and provide any support necessary for the Mission to undertake the reproductive program.

The program will be implemented through "buy-ins" to the Global Bureau (G/PHN/POP), centrally managed cooperative agreements and contracts. Contraceptives will be purchased through the central procurement mechanism.

An initial joint assessment will be undertaken with the participation of the Mission and each major CA involved with program activity. This will assist in ensuring that the oblasts that are selected as program sites have been selected with input from the Mission and each CA involved in program activity. Training, IEC and the contraceptive commodity situation will be assessed in a number of oblasts during this assessment.

### **B. Participating Cooperating Agencies**

Each CA involved with the reproductive health program is required to undertake the following activities:

- **Integrated Implementation Plan.** An integrated implementation plan will be developed with the participation of all CAs. All reporting will be done with reference to this plan. Performance will be measured with reference to this integrated implementation plan and the evaluation plan (see below). With Mission and CA agreement, the implementation plan may be adjusted as the reproductive health program progresses.
- **Logistical Assistance.** Each CA will take responsibility for its own logistical support as needed. This would include hotel reservations, translators, transportation and any other administrative support necessary to carry out program activities. (One option would be for logistics assistance to be provided by Statistica via sub-agreements with each CA.)
- **Debriefings.** Each CA will debrief USAID/Russia staff after each trip or as requested by the Mission PHN chief or his/her designee. The technical advisor on site will be expected to keep the Mission continually informed of each technical assistance visit and of program activity generally. CAs will periodically debrief Global and ENI Bureau staff as requested.
- **Trip Reports.** Following each technical assistance visit, each CA will prepare a report documenting the accomplishments undertaken during the trip. Trip reports

should report on benchmarks met and progress achieved in relation to the Integrated Implementation Plan. Recommendations should be made for refining project and program activities. Copies of trip reports will be submitted to USAID/Russia and the Global and ENI Bureaus.

- **Quarterly Financial and Activity Reports.** Quarterly activity and financial reports will be submitted to USAID/Russia and the Global Bureau (G/PHN/POP Cognizant Technical Officer [CTO]) for each CA and regional coordinator. The CTO will provide copies of the activity reports and quarterly expenditure accrual reports to the ENI/HR/HP Office. The reports will be prepared in accordance with the U.S. government fiscal year, therefore, quarterly and cumulative financial reports will be due within 15 days of the end of each quarter (e.g., January 15, April 15, July 15, and October 15).
- **Evaluation.** Each CA will contribute to the development of an evaluation framework for the reproductive health program. This plan will outline how CA activities will be evaluated as the project progresses—midterm and at the end of the project. The evaluation plan will be referred to quarterly to identify progress to date in meeting the benchmarks originally outlined in the evaluation framework.
- **End-of-Project Report.** An end-of-project report will be prepared by each CA once activities are completed. A summary report will be prepared jointly by all CAs involved with program activity at the end of the program period.

### **III. EVALUATION**

The principal goal of the USAID reproductive health strategy is to decrease women's morbidity and mortality by reducing unwanted pregnancies and dependence on abortion. Improved access to family planning information and high-quality family planning services will decrease abortion rates. This objective will be accomplished by expanding information to the public and information and training to physicians on the effectiveness, safety and health benefits of modern family planning methods.

Monitoring and evaluation, using appropriate indicators, are key components of the reproductive health program strategy. An evaluation framework will be developed during the initial CA team trip to Russia. This framework will outline for each CA: 1) ongoing process indicators which will be used to measure project activity and 2) measurement tools and indicators which will be used to evaluate the outcome of each activity at project midterm and completion.

Major indicators will include:

1. Reduction of abortion use at demonstration service sites, verified by service statistics at the site (short-term) and oblast levels (long-term)
2. Increase in contraceptive use at demonstration service sites, verified by service statistics at the site (short-term) and oblast levels (long-term)

3. Increase in the range and supply of modern contraceptives in sentinel pharmacies and increase in the sales of modern contraceptives in sentinel pharmacies (long-term)
4. Increase in reproductive health curricula in preservice and post-graduate training courses, verified by medical school and post-graduate curricula (long-term)
5. Adoption of reproductive health service delivery guidelines by Ministries of Health, verified by official documents (long-term)
6. Increase in public awareness of the benefits of contraception, verified by survey (long-term)
7. Increase in availability of contraceptive methods, verified by sampling at selected service sites commercial shops and oblast storage (long-term)
8. Increase in requests for family planning information and methods at demonstration sites
9. Existence of a favorable policy environment for reproductive health services, verified by adoption of national- and oblast-level plans (short-term) and increases in budget allocations for family planning services (long-term)
10. Increase in services for adolescents, verified by numbers of IEC messages for youth and the variety of services provided to adolescents.

(See Annex V for other process indicators.)

#### **IV. REPRODUCTIVE HEALTH PROGRAM ACTIVITIES AND FUNDING LEVELS**

Table I outlines FY 1994 and FY 1995 funding levels by project. In FY 1994, US\$1.45 million was provided by the ENI Bureau for buy-ins to the Global Bureau for AVSC and JHPIEGO activities in Russia. As stated previously, the activities of these two projects will be part of the reproductive health program's activities. As can be seen in the table, these funds are separate and distinct from the US\$6 million which will be provided by the ENI Bureau for FY 1995 to meet the Congressional Earmark for family planning activities in Russia. Although the strategy is fully integrated and each element relies on or is strengthened by the other elements, each component was developed as a separate entity to which supplemental funds could be added to increase the impact of the whole program.

**TABLE I Budget Levels (US\$000)**

	<b>FY 94 \$1.5 M (ENI)</b>	<b>FY 95 \$6 M (ENI)</b>	<b>Total</b>
<b>AVSC</b>	<b>\$950</b>	<b>\$1,100</b>	<b>\$2,050</b>
<b>JHPIEGO</b>	<b>550</b>	<b>650</b>	<b>1,200</b>
<b>PCS</b>	<b>0</b>	<b>2,500</b>	<b>2,500</b>
<b>CDC</b>	<b>0</b>	<b>600</b>	<b>600</b>
<b>Policy</b>	<b>0</b>	<b>300</b>	<b>300</b>
<b>CDC/FPLM</b>	<b>0</b>	<b>150</b>	<b>150</b>
<b>Commodities</b>	<b>0</b>	<b>250</b>	<b>250</b>
<b>Georgetown</b>	<b>0</b>	<b>300</b>	<b>300</b>
<b>MotherCare</b>	<b>0</b>	<b>150</b>	<b>150</b>
<b>Totals</b>	<b>\$1,500</b>	<b>\$6,000</b>	<b>\$7,500</b>

**TABLE II Program Activities and Budget Levels**

The specific activities to be undertaken by each Cooperating Agency are shown below along with their levels of funding and planned outcomes. (The outcome and impact column will be refined during the initial visit of the CAs.)

<b>Reproductive Health Program Activities</b>	<b>Activities at US\$7.5 Million Budget Level</b>	<b>Outcome/Impact (examples)</b>	<b>Implementing Agency</b>
<b>Establishing demonstration service sites</b>	<b>Comprehensive Assessment</b>	A comprehensive implementation plan and timeline of activities	AVSC
	<b>Demonstration and training sites established/equipped at six sites.</b>	An evaluation plan MOUs developed with responsible institutions at each site  # of clients provided family planning services	AVSC
	<b>Oblast contraceptive updates</b>	# of methods offered # of persons attending	AVSC
	<b>Clinical Training</b>	# of persons trained	AVSC
	<b>Ongoing medical monitoring</b>	Quality of services provided	AVSC
<b>Subtotal</b>	<b>\$2.05 million</b>		<b>AVSC</b>
<b>Strengthening and institutionalizing training systems</b>	<b>Training trainers at six sites</b>	# of Trainers trained	JHPIEGO
	<b>Equipping trainers</b>	# of trainees trained by trainers	JHPIEGO
	<b>Developing/adapting medical guidelines/protocols</b>	# of medical schools and in-service training institutions adopting/developing protocols	JHPIEGO
	<b>Strengthening preservice/in-service training curricula</b>	# of preservice and in-service institutions adopting/developing curricula	JHPIEGO
<b>Subtotal</b>	<b>\$1.2 million</b>		<b>JHPIEGO</b>

**TABLE II Program Activities and Budget Levels (con't.)**

<b>Reproductive Health Program Activities</b>	<b>Activities at US\$7.5 Million Budget Level</b>	<b>Outcome/Impact (examples)</b>	<b>Implementing Agency</b>
<b>Promoting reproductive health through IEC</b>	Mass media campaigns undertaken in six project site oblasts	# of MOUs/contracts developed with responsible institutions  # of media campaigns undertaken # of radio and TV stations with messages # of media involved	PCS
	Develop and distribute IEC materials linked to six training sites and surrounding areas	# of materials printed/distributed	PCS
	National media coverage and promotion of family planning	# of persons hearing messages # of persons understanding the messages	PCS
<b>Subtotal</b>	<b>\$2.5 million</b>		<b>PCS</b>
<b>Improving supply and availability of contraceptive methods</b>	Agreement with American pharmaceutical companies to: a) market contraceptives to six project sites oblasts and b) donate contraceptives to project sites and trainees  (Mission supported)	# of MOUs developed with companies  # of companies that market contraceptives at project sites  # of companies who donate contraceptives # of contraceptives donated	Contractor
	Supplies of IUDs and Depo-Provera to six sites and trainees for a limited number of clients. (\$250,000)	Availability of IUDs and Depo-Provera ordered at project sites	USAID
	TA for: a) logistics work involved with distribution of USAID contraceptives and b) setting up reporting/tracking system for abortions and contraceptive use. (\$150,000)	a) # availability of contraceptives at the sites  b) # of period for which data are collected for abortions and contraceptive use	CDC
<b>Subtotal</b>	<b>\$400,000</b>		<b>Commodity Logistics</b>

**TABLE II Program Activities and Budget Levels (con't.)**

<b>Reproductive Health Program Activities</b>	<b>Activities at US\$7.5 Million Budget Level</b>	<b>Outcome/Impact (examples)</b>	<b>Implementing Agency</b>
<b>Improving policy Implementation</b>	Technical assistance for strategic planning in six project site oblasts; advocacy work at oblast level to increase budget share for reproductive health care. (\$300,000)	# of MOUs developed with policy-makers # of policy-makers involved with advocacy work # of workshops held # of observation tours undertaken % of budget share increased	Policy Project
	National level Reproductive health survey (\$600,000)	# of women interviewed # of oblasts involved Ability of survey institution to undertake further survey activity	Policy Project
<b>Subtotal</b>	<b>\$900,000</b>		<b>Policy Project</b>
<b>Maternal Health</b>	Breastfeeding Promotion (\$300,000)	# of MOUs developed with hospital administrators on rooming-in policies # of hospitals with rooming-in	Georgetown
	Select maternal health interventions (\$150,000)	# of MOUs developed with midwifery administrators to change hospital practices # of midwives trained in quality delivery practices	MotherCare
<b>Subtotal</b>	<b>\$450,000</b>		<b>Maternal Health</b>
<b>Funding Totals</b>	<b>\$7.5 million</b>		

## **ANNEX I TRAINING PLAN**

**The initial activity at a model clinic site will be the presentation of a three-day seminar on Modern Contraceptive Technology to 125-200 ob/gyn from the maternity houses in the city and its surrounding area in the oblast, representatives of the oblast and city health governments and practicing doctors in women's consultation clinics. AVSC faculty will be supplemented by Russian experts who are knowledgeable about Russian reliance on abortion and biases about hormonal methods.**

**A second step will be a two-week training course for 20 counselors (doctors, nurses and midwives) in modern interviewing techniques and client-centered approaches to encouraging choice. These health personnel will have attended the seminar on modern contraception. They will be recruited from the maternity house staff persons who will work in the model clinic, other family planning clinics working in the city (e.g., RFPA), staffs working in obstetrical inpatient units and separate abortion clinics, as well as from surrounding women's consultation clinics in the city. This course will be given by AVSC.**

**Immediately following the counseling training, these same trainees will receive advanced clinical training in the up-to-date use of IUDs, including insertion and removal of IUDs, the administration of Depo-Provera and the use of oral contraceptives for high-risk populations, such as teenagers. This one-week training is designed for service providers who will be model clinic staff members and representatives of other family planning and women's consultation clinics in the city and surrounding oblast areas. This training will be carried out by AVSC.**

**From this group, JHPIEGO will select eight individuals for a two-week training of trainers course based on their enthusiasm, knowledge and innate abilities. Care will be taken to include candidates from the medical or post-graduate institutes and have a geographic dispersion of candidates so that as many parts of the oblast as possible will have local access to a trainer who will iterate the training. These trainers will receive training manuals, slides, overhead transparencies and literature suitable for provider-level information. Included in this course will be principles of interactive teaching, training in basic clinic management and curriculum organization. After completion of the course each trainer will teach his/her first course under the observation of one of the course's faculty members.**

**Medical students and ob/gyns attending their five-year refresher will participate in model clinic activities and thus carry information and attitudes to many other hospitals and clinics beyond the city and the particular oblast.**

**These model clinics will strengthen and expand their family planning services and will become models for other regions to emulate. Integral to all training will be the concept of client-centered care with its emphasis on quality and access to services. Since ob/gyns throughout Russia may choose where to obtain their post-graduate refresher training, it is foreseen that these model clinics will attract applicants from many parts of the country, thus creating a wider impact for each model clinic site.**

**When the USAID-sponsored activities have been completed, women will have access to better treatment and a reliable source of a range of contraceptive services at a demonstration site which will be well equipped to support excellent services. Women and doctors will have a**

**more positive view of family planning choices. The most significant criterion of success will be the demonstrable increased reliance on contraception rather than abortion for birth prevention.**

**The model clinics will have a training program in minilaparotomy emphasizing the postpartum procedure. Special emphasis will be placed on the role of counseling during the antenatal course of patient care that is given to each Russian woman.**

**Depending on availability of resources, laparoscopy training may be given at selected sites. The daily care of its fragile lens system and light source require special training for doctors as well as operating room staff.**

**The ultimate place of male sterilization in Russia is an open question. No-scalpel vasectomy may be carried out at one or two model centers with care taken to identify ideal sites.**

## **ANNEX II CONTRACEPTIVE COMMODITY REQUIREMENTS**

**IUDs:** For budgetary and planning purposes, each demonstration and training center will be scheduled to receive 15,000 IUDs. Of these, 5000 will be designated for the training site. The remaining 10,000 will allow each of the anticipated 100 trainees to take 100 IUDs back to her/his clinic to conduct training of colleagues and provide clinic services. For six sites, the total number of IUDs will therefore be 90,000. (At US\$1.10 per IUD, the product cost will be US\$99,000. If shipment is by air, as proposed, the additional cost is estimated at US\$25,750, for a total of US\$23,750.)

For Depo-Provera, each site is scheduled to receive 16,000 doses. The central training site will be allotted 6000 doses for initial training, subsequent follow-up and contingencies. The remaining 10,000 will be comprised of 100 doses for each of the 100 trained staff persons to take back to their facilities for training of colleagues. For six sites, the total number of doses will be 96,000. (At the present cost of \$0.96 per dose, including the syringe, the total product cost is US\$92,160. Air shipment would add an estimated US\$23,040, for a total of US\$115,200).

Before the Depo-Provera orders are submitted, the Upjohn pharmaceutical company Moscow office should be approached for possible interest in supplying these quantities free of charge at the designated sites, since it will clearly be in its interest to see this commodity attain widespread popularity throughout the country. This program could serve as a catalyst for that purpose.

(The grand total estimated commodity cost for both IUDs and Depo-Provera is US\$238,950. Allowing for some minor changes in product and shipment costs, a budget allocation of US\$250,000 seems appropriate. If shipment were instead to be made by surface, costs could be reduced from the estimated US\$238,950 to US\$204,541. However, considering the multiple sites and the relatively small quantities involved, plus the need for timely arrival of the two products shortly before each training program commences, the team strongly suggests that these commodities be shipped by air freight.)

### **ANNEX III**

## **ABORTION IN RUSSIA: THE PRIMARY FAMILY PLANNING METHOD**

Abortion became legal in the Former Soviet Union in 1920 and has remained so until present, with the exception of the years 1938-1958, a pronatalist period encompassing the "Great Patriotic War" (World War II). In the absence of available modern contraception, abortion has remained the major method of birth prevention for Russian women for two generations. Currently the abortion rate (abortions per 1000 women ages 15-49) is 98, the highest in the world (c.f. 1993 data from Sverdlovsk Oblast 90, Ukraine 57, USA 30, Sweden 20, UK 14).

Hypothetically, a highly fecund couple using abortion as their only means of birth prevention for 10 years between ages 25 and 34 could conceive and abort three times per year. Over that decade, barring complications of abortion such as infection or injury to the uterus and excluding mental and physical exhaustion, a woman could have an astronomic 30 terminations of pregnancy. Although some Russian women have been reported to have had 20 or more abortions over a reproductive lifetime, the average number of abortions is believed to be five to six. Clearly many factors operate to minimize the theoretic possibility, especially the scrupulous use of various forms of the "rhythm system" augmented by condoms, withdrawal and abstinence or the use of an IUD.

Data for the past two years taken from the Sverdlovsk Oblast show that 88% of women having abortions were in their 20's and 30's while 12% were teenagers (c.f. US 25% under 20)—0.2% less than age 15. Only 5% of women seeking abortion were pregnant for the first time.

Abortion was considered to be one of Russia's five major health problems in 1989 based on a study by Rimashenskaya entitled "Family Welfare and Quality of Life in Urban Russia 1988-1989," The Tagenrod Study. It has been estimated that approximately 50% of the Ministry of Health's budget for obstetrics and gynecology is spent on abortion and its related complications (this includes staff time, hospitalizations, equipment and drugs). Half of Russia's 37,000 ob/gyn doctors spend a significant part of their official professional time in abortion care and some have also begun private practices.

In the last years of the USSR (1986-1990), the officially reported numbers of abortions were dropping. However, a large number of medical care sites were not included in the enumeration (e.g., the Ministry of Defense and the Armed Forces, Aeroflot and other large industries, the KGB and river and rail transport services all of which ran independent hospitals and clinics). These omissions and the fact that "mini-abortions" up to seven weeks of pregnancy were considered "menstrual regulation" and not counted as abortions may have amounted to 20-25% more procedures than reported in the official Soviet statistics. Moreover, other changes in definitions of abortions in 1988 and again in 1991 make comparisons with past data even more difficult.

In the first years of the Russian Federation, official abortion numbers have not increased; however, with "demonopolization" of medical care, abortions are widely performed in the private sector and are not reported. Therefore, it can be said that all figures are based on under-reporting of cases.

The death rate for abortions in Russia is generally cited as 25% of the maternal death rate which is 57/100,000 births (c.f. U.S. maternal death rate of 8, 1993 data from Sverdlovsk

Oblast 64). Deaths from abortion expressed per 100,000 abortion procedures is 17/100,000. This figure is an over-estimate because of the above-mentioned under-enumeration of procedures while the relatively small number of deaths are more likely to be officially reported. Even allowing for a 25% reduction based on under-reporting, a death rate of 10.5/100,000 compares unfavorably with U.S. figures of 0.7 deaths/100,000 for first trimester abortions done with vacuum procedures and approximately 6.5/100,000 for abortions after 13 weeks. Furthermore, no data are available for specific causes of death nor is there any information on the causes of morbidity from this widely practiced procedure.

There is no information on the role that repeat abortion may play in the relatively high (12%) prematurity rate in Russia (c.f. U.S. rate of 7-8%). Nor can the affect of abortion on infertility be assessed. It is reported that approximately 15-20% of couples are relatively infertile (i.e., not able to conceive after one year of coital activity), a rate similar to that found in the U.S. at the present time.

There are numerous anecdotal reports of the great distress caused by the callous treatment of women forced to have terminations of pregnancy by seemingly uncaring providers without analgesia or paracervical block in cold, impersonal surroundings. This situation leads women to search for better circumstances by finding a professional friend, paying for care within the system, going to a private clinic or in desperation seeking nonprofessional help—especially likely if the woman is young and unmarried. In none of these instances would abortion be likely to be reported unless it results in a serious complication.

Nevertheless, some older women are said to consider abortion a "cleansing" procedure. Doctors have said that some women over age 25 would prefer an occasional abortion to taking hormones with the reputed side effects that were common with high-dose oral contraceptives which were intermittently available in the past.

Disaffection is also prevalent among providers who feel overburdened, underpaid and forced to work in poor or overcrowded clinics with inadequate or poorly functioning equipment. Because abortion outside the system is a means of augmenting income, modern family planning is not enthusiastically welcomed by some practitioners.

Doctors are said to prefer curettage to vacuum procedures because of their ingrained habit. A recent observation suggests that this preference may be necessary and practical in many situations. Suction pumps are old. In one facility the pump was out of order. In another the pump created insufficient negative pressure to provide for rapid and complete evacuation with minimum blood loss. Thus the doctor was forced to fall back on sharp curettage.

There are no studies of the psycho-social effects of abortion on women and their partners. Anecdotally, decreased frequency of coitus and more general interpersonal problems in marriage are common when abortion is used as the only available contraceptive choice.

Opponents of abortion within Russia and foreign visitors who support Right to Life movements have been active in the country in the last several years. Any legally decreed decrease in access to abortion services, especially in the absence of full choice of modern contraception delivered with high-quality service, would force women to obtain unsafe abortions with even higher rates of death and disability—a catastrophe for them and their families.

## **ANNEX IV STERILIZATION IN RUSSIA: CURRENT STATUS**

In 1990 the Ministry of Health of the Russian Federation approved sterilization for limited social reasons in addition to medical indications for severe diseases that threatened a woman's life. A woman could be sterilized if she had three children or if she had two and was over age 30. Sterilization at the time of repeat cesarean section was considered medically indicated.

With order No. 303 on December 28, 1993, the Ministry of Health for the first time legally accepted sterilization as a method of family planning and included vasectomy for males.

In 1991 and 1992, respectively, 7255 and 9660 female sterilizations were reported in Russia, most of which were medically indicated for disease or prior cesarean section. Not enumerated were laparoscopic procedures in for-profit clinics which go unreported in official statistics.

Minilaparotomy, interval or postpartum, is essentially unknown and unpracticed. Laparoscopes are available at the Research Centre for Obstetrics, Gynecology and Perinatology of the Russian Academy of Medical Sciences and other widely scattered tertiary care units. They are used primarily for the diagnosis and treatment of infertility.

The maternity house affiliated with Hospital 40 visited in Yekaterinburg had a laparoscope and one trained gynecologist, but the instrument was malfunctioning for reasons that were not specified.

In Ivanovo at an ob/gyn and perinatology center, which the team also visited, there were two doctors trained in laparoscopy by Dr. John Fishburne under the auspices of AVSC with funds provided by the World Bank. In the last six months this team has done over 700 procedures, 150 of which were interval sterilizations. Attending four to nine cases per day, this group is highly trained and motivated and, with the right support, could train others.

The six model centers proposed for special family planning training by AVSC and JHPIEGO will have a program for minilaparotomy training, both postpartum and interval. The postpartum procedure is technically easier. It could be easily added to the already extensive prenatal and delivery services in Russia. Special emphasis will have to be placed on the counseling component in order to ensure voluntarism and completely informed consent.

The place of laparoscopy at the training centers should be left open and discretionary. A laparoscope is a highly valued instrument, and training in its use is much sought after by gynecologists who see it mainly as a tool to diagnose pelvic pain and infertility. Thus it could easily be diverted for uses other than sterilization. In addition, daily care of its lens system and light source requires special training for the operating room staff and the physicians who use the instrument. Finally, even with adequate preventive maintenance, repair and replacement of parts is frequently necessary. Thus the cost of a laparoscope unit far exceeds that required for minilaparotomy capability.

The ultimate place of sterilization of men in Russia is an open question. The doctors interviewed about this were quite conservative about its utility in the short term. No-scalpel vasectomy should be carried out at one or two training centers with care taken to identify ideal sites.

## **ANNEX V PROCESS INDICATORS**

### **A. ESTABLISHING DEMONSTRATION SERVICE SITES**

- 1 Number of reproductive health training courses implemented**
- 2 Number of minilaparotomy training courses implemented**
- 3 Number of breastfeeding seminars implemented**
- 4 Number of completed shipments of equipment, supplies, and materials to training sites**
- 5 Number of doctor/nurse-midwife participants attending the reproductive health training courses**
- 6 Number of doctors trained in minilaparotomy**
- 7 Number of doctor/nurse-midwife trainees who participated in counseling training and are now counseling clients about family planning methods**
- 8 Number of professionals trained in breastfeeding promotion**
- 9 Baseline abortion service statistics at the training site compared with end-of-project abortion service statistics**
- 10 Baseline contraceptive service statistics at the training site compared with end-of-project contraceptive service statistics**
- 11 Number of hospitals adopting the "10 Steps" of breastfeeding promotion**

### **B. STRENGTHENING TRAINING SYSTEMS**

- 1 Number of reproductive health modules developed for preservice training**
- 2 Number of TOT courses conducted in preservice settings**
- 3 Number of TOT courses in contraceptive sterilization**
- 4 Number of trainees who completed TOT courses, by category**
- 5 Completion of service delivery guidelines development**

### **C. PROMOTING INFORMATION, EDUCATION AND COMMUNICATION FOR REPRODUCTIVE HEALTH**

- 1 Completed report on results of formative research and market research**
- 2 Completed evaluation of IEC interventions**
- 3 Number of training workshops completed**
- 4 Number of mass media outputs produced and broadcast/printed**
- 5 Completed production of regional campaign materials and the number of regional campaigns carried out**
- 6 Number of provider materials distributed in demonstration sites and to other health professionals**
- 7 Number of leaflets for clients developed and distributed to clinics in demonstration sites.**
- 8 Number of posters provided to demonstration service sites and other health and community organizations**
- 9 Completion of a training video on counseling**
- 10 Completion and distribution of a set of materials for youth—video, users' guide and comic book**

#### **D. IMPROVING THE SUPPLY AND DISTRIBUTION OF CONTRACEPTIVES**

- 1 Number of completed shipments of contraceptive commodities in support of demonstration service sites;**
- 2 Number of clients receiving contraceptives, by method, by demonstration service site;**
- 3 Number of completed shipments of contraceptive commodities to demonstration service site oblasts;**
- 4 Completed evaluation of contraceptive logistics systems.**

#### **E. IMPROVING POLICY IMPLEMENTATION**

- 1 Number of technical assistance interventions in support of national strategic planning for reproductive health.**
- 2 Implementation of seminar to analyze the legal and regulatory environment and foster a favorable policy environment for contraceptive services.**