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**PRELIMINARY REPRODUCTIVE HEALTH ASSESSMENT
OF UKRAINE AND MOLDOVA**

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	iv
I. INTRODUCTION	1
Methodology	1
Site Visits	2
II. COUNTRY PROFILES	2
Ukraine	2
Moldova	5
III. REPRODUCTIVE HEALTH CARE PRACTICES	7
Maternal and Infant Health and Services	7
Breastfeeding	10
Abortion	10
Family Planning	11
IV. PROFILE OF HEALTH CARE SERVICES	12
Policies and Institutions	13
Commodities and Logistics	14
Information, Education and Communication (IEC)	14
Government and Donor Support	14
V. TRAINING	15
Physicians	15
Midwives	15
Feldshers	17
Resource and Training Needs	17
VI. FINAL RECOMMENDATIONS	17
Maternal and Infant Health and Services	17
Breastfeeding	18
Family Planning	18
Information, Education, and Communication (IEC)	18
Training	18
REFERENCES	20
ANNEX #1	21
Country Profile: Belarus	
ANNEX #2	23
Institutions Active in the Reproductive Health Sector	
ANNEX #3	25
Contact List	
ANNEX #4	37
Draft Reproductive Health Seminar Agenda	

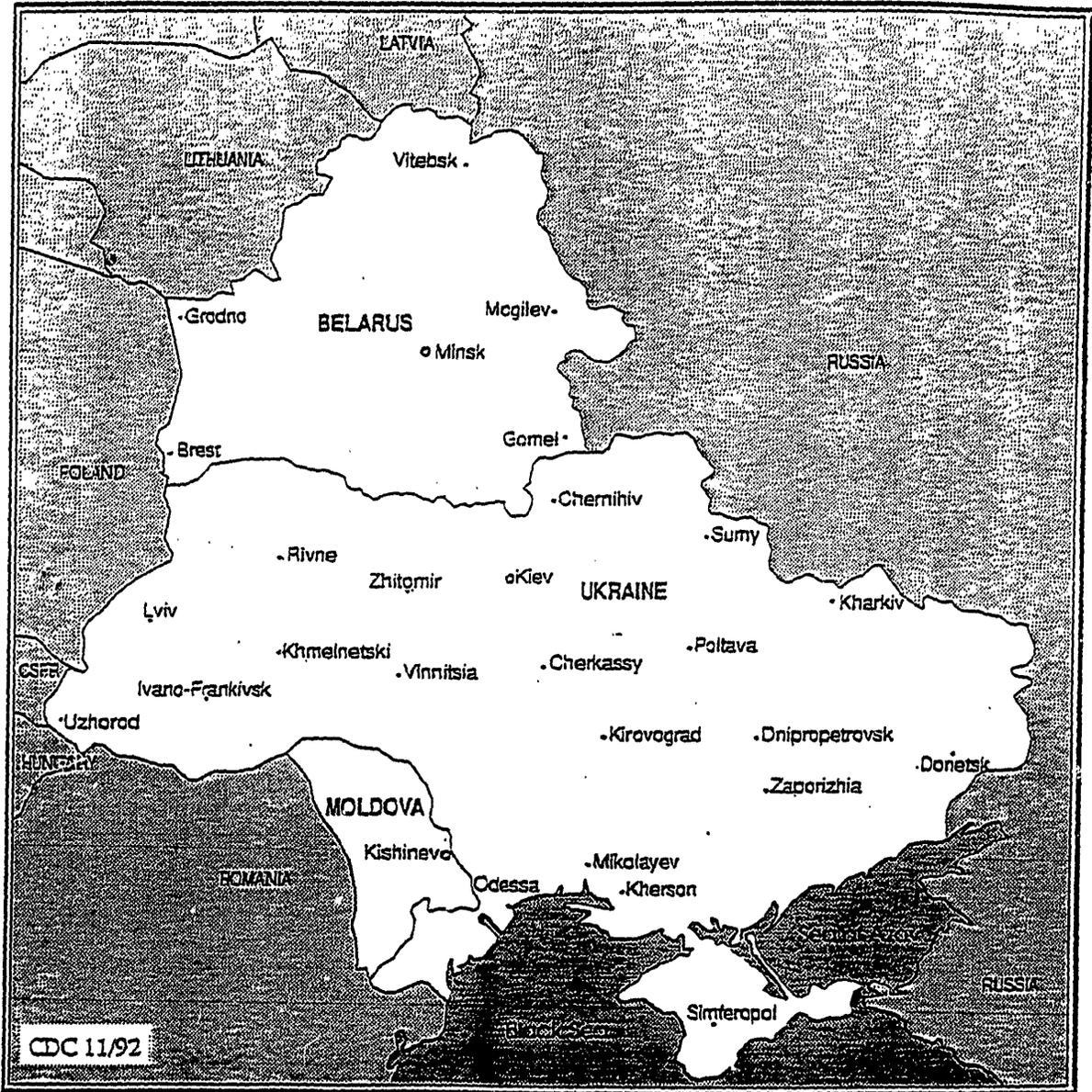


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WESTERN STATES OF THE CIS





EXECUTIVE SUMMARY

Ukraine and Moldova are in a process of transition from the Soviet system to a new, more western style of health care. Soviet organization, procedures and science still characterize health policy and health services in these two countries, although there is significant innovation and experimentation occurring at the service delivery level, and progressive policies are increasingly the focus of attention and support at central levels. Health care staff are highly committed even within a transitioning system in a precarious financial condition. Nonetheless, much of the system still runs on rigid adherence to the norms and regulations of the Soviet system; knowledge and application of western research, techniques, and program strategies is uneven.

Rates of maternal and infant mortality are significantly higher in the Newly Independent States (NIS) of Ukraine and Moldova than in Western Europe. Approximately 45 percent of maternal mortality seems to be caused by obstetrical conditions and abortion. Abortion is the principal form of contraception due to lack of information and access to modern methods of contraception. High rates of infertility, hemorrhage, infections, and other gynecological problems are attributed to the multiple abortions women have during their reproductive years.

These medical systems provide primarily expensive curative care. The weak public health orientation and the financial status of the health system calls for a shift to preventive care with a public health education approach.

A team of five (working with USAID/Kiev) visited medical institutions in Ukraine and Moldova to assess maternal health practices, breastfeeding and family planning. This document provides information obtained during a reproductive health assessment undertaken in Ukraine and Moldova from June 13 - 24, 1994. This assessment has provided the background necessary to plan a maternal and child health (MCH) seminar and make initial recommendations to USAID/Kiev (and other donors) concerning reproductive health needs of the two countries.

Maternal and Infant Care

All pregnant women have easy access to health services, and most women use them at maximal levels. There are currently no user fees for these services. In spite of easy access and availability of maternal and infant care, the maternal mortality ratio in Ukraine was 32 deaths per 100,000 live births in 1990. In Moldova, the ratio was 44.1 deaths per 100,000 live births. These rates are well above the WHO/EURO target of 10 per 100,000. The infant mortality rates have also recently increased in Ukraine and Moldova. Maternal and infant mortality are higher than would be expected given the low fertility rates.

Breastfeeding

The frequency and duration of breastfeeding are declining. The recommended practice that infants be put to the breast immediately after birth is rarely followed. Generally, mothers and infants are separated for one to two days after birth. Women are instructed to feed on a schedule rather than on demand. Other factors that contribute to the decline in breastfeeding are the common misconceptions about its safety due to widespread reports of hypogalactia attributed to maternal stress, malnutrition or pesticide contamination of breast milk.



Abortion

High rates of maternal mortality and morbidity in Ukraine and Moldova may be related primarily to the high rates of legal and illegal abortions. Throughout the former Soviet Union, the widespread use of dilation and curettage for abortion procedures (instead of vacuum aspiration) has led to many abortion-related complications. Women have no choice but to endure multiple abortions because access to family planning information and services is limited. High rates of infertility, hemorrhage, infection complications of pregnancy, and increased risk of preterm delivery and low birth weight infants are attributed to the multiple abortions women have during their reproductive years.

Family Planning

The use of abortion as fertility control appear to have created severe health risks for women. Although there is interest in modern family planning programs, medical personnel and the public share strong misconceptions about current low-dose oral contraceptives. Russian made IUDs are used, but knowledge of alternative methods of contraception is limited. Except for IUDs, contraceptives are typically not available through health services. Up-to-date family planning information and educational materials are lacking. Abortion is used as a primary family planning method with 108 abortions to 100 live births in Ukraine and 105 abortions to 100 live births in Moldova.

Communication

Communication and implementation of policies is uneven despite the existence of a very centralized system. Typically, decisions that deviate from the routines and procedures of the former Soviet Union are made by the director of each institution. Knowledge and application of western research, techniques and program strategies vary. Communication approaches to public education are lacking, but policy makers and service providers are interested in learning more about mass media, design of educational materials, and interpersonal communication and counseling techniques. Services are generally provided by more than one person, but providers do not appear to work as a team.

RECOMMENDATIONS

Maternal and Infant Health and Services

- Provide assistance for the procurement of essential drugs and supplies and aid in the establishment of a system to assure a continuous supply.
- Assist the MOH to refine physician and midwifery training curricula in the area of maternal and infant care.
- Provide assistance for the study and expansion of the role of the midwife in maternal and infant care.
- Assist the MOH in the development of standard protocols and guidelines for the delivery of safe maternal and infant services for the various levels of providers. Guidelines should help to maximize the efficient use of health personnel and promote quality of care in service delivery.
- Provide technical assistance and funds for research on the causes of anemia during pregnancy.
- Explore the feasibility of establishing "nutrition houses" for pregnant women where nutrition counseling, routine iron and folate supplementation and iron and folate rich foods would be provided at a subsidized cost. Nutrition intervention programs may be integrated into the existing



"milk kitchens" which provide foods and supplements to mothers at low cost. The team was not able to visit a milk kitchen on this visit.

Breastfeeding

- Support suitable institutions as demonstration sites for rooming-in and Baby Friendly Hospital Initiative procedures.
- Explore the potential for funding applied research on breastfeeding issues such as hypogalactia and its links to stress and environmental contamination, Rh incompatibility, "hemolytic disease," breastfeeding/LAM for child spacing, and cost effectiveness of breastfeeding promotion.
- Address women's empowerment and critical importance of sustaining rights to leave from work for child bearing and child rearing.
- Identify teams for training at Wellstart's Lactation Management Education program in San Diego.

Family Planning

- Institutionalize family planning training into the existing training infrastructure. Family planning training should be integrated into the curriculum of the medical and research institutes that train physicians, midwives and paraprofessionals throughout the country.
- Assist in the dissemination of existing family planning materials (translated into Russian) such as Contraceptive Technologies.
- Establish AIHA partnerships between MCH service and training facilities in the region and reproductive health service facilities in the United States.
- Provide assistance for contraceptive commodities (pills, IUDs, and injectables) and technical support for public and private sectors to establish a logistics system to recover costs.
- The team recommends a significant family planning effort with a broad reproductive health focus, that includes breastfeeding.

Information, Education, and Communication (IEC)

- Provide technical assistance to train health education professionals in the development of public information, education and communication programs on reproductive health and family planning.
- Provide funds for the translation of training materials.
- Incorporate interpersonal communication and counseling skills into curricula at all levels. A key component in the training of providers should be an emphasis on client and family centered care.

Training

- Provide technical assistance and material support to physician and midwifery schools to review and refine curricula, design comprehensive curricula that uses competency-based training approaches, and reorient training to emphasize a public health focus in the training of providers. Encourage physicians to involve superior level midwives in the development of a midwifery curriculum.

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- Organize study tours to the United States for personnel from the MOH to view different approaches to family-centered care.
 - Send selected neonatologists to the United States for a short training course in the resuscitation and management of high risk newborns. Visits to perinatal centers could be included as part of the training activity.
 - Sponsor graduate study for OB/GYNs involved in the management of services and training of providers. Send selected midwives for advanced training in midwifery.
 - Consider the following topics for presentation and discussion at the October 1994 Reproductive Health Seminar:

prenatal care and the use of a simplified risk assessment approach
use of the partograph in the management of labor
anemia and pregnancy
resuscitation and care of the newborn
breastfeeding
family-centered maternity care
management of hemorrhage and sepsis
management of perinatal infections
abortion techniques and abortion counseling
family planning technology and family planning counseling
infection prevention methods in maternal and infant services



I. INTRODUCTION

Ukraine and Moldova are in a process of transition from the Soviet system of health care to a new more Western style of care. USAID/ENI provided funds to Wellstart International to carry out a preliminary assessment of the Reproductive Health situation and for a seminar that would focus on sharing of technical information and exchanges in the area of reproductive health care. An informal assessment was conducted in June 1994 to determine whether a seminar would be an appropriate mechanism as a follow-up activity to the assessment exercise.

Methodology

USAID Team Program in Ukraine and Moldova June 13 - 24, 1994

The following individuals served on the team:

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Victor Boguslavski, Regional USAID/Kiev

The team's objective was to assess the health care sector in Ukraine and Moldova in order to prepare for the Reproductive Health Seminar in October 1994. The Kiev Seminar will emphasize maternal and infant health, breastfeeding, and family planning and will prepare a provisional program of collaboration in this field for the next 2-3 years. Important outcomes of the seminar will be the formulation of recommendations, the next steps by country delegations, and the presentation of a provisional program of collaboration in these areas for the next 2-3 years.

Further objectives of the assessment were:

- to conduct site visits in order to obtain a comprehensive picture of the reproductive health care system in Ukraine and Moldova;
- to establish priorities and a subsequent program of assistance;
- to identify institutions and health care contacts; and
- to prepare the preliminary program for the October Seminar.
- to identify key health care professionals and focal institutions and
- to establish priorities and propose a program of assistance.



Site Visits

Key Reproductive Health institutions visited during the assessment include:

Kiev Research Institute on Pediatrics, Obstetrics and Gynecology (KRIPOG)
Kiev Center for Health Protection of Maternity and Childhood, "Levoberehzie"
Maternity Hospital #1
Kiev Institute of Advanced Medical Training of Physicians (KIAMTP)
Ukrainian Health Education Center (UHEC)
Women's Hromada of Ukraine (WHU)
Women's Antenatal Clinic (Women's Consultation Clinic)
Odessa City Clinical Hospital, Maternity Department
Maternity Hospital #4
Odessa Medical University
Children's Hospital #3
District Hospital, Orhgey

II. COUNTRY PROFILES

Ukraine

Population Characteristics

Ukraine is the second most highly populated republic of the Newly Independent States (NIS) with a population of approximately 51.7 million. It is third in land size after Russia and Kazakhstan. Approximately 79 percent of the inhabitants are ethnic Ukrainians, 21 percent are Russian, and 0.6 percent are Belorussian. Two-thirds of the population live in urban areas. Although the total fertility rate is low (2.0 births per woman), the maternal and infant mortality rates are higher than those found in Western European countries with similar fertility rates. This mortality is thought to be related to the frequent use of abortion for fertility control, other obstetrical conditions, and environmental factors such as those associated with the 1986 Chernobyl nuclear accident, heavy pesticide use and air pollution.

Economic Summary

The government can no longer afford to support the system developed under Soviet rule. However, broadening the private sector, the transition from a command to a market economy appears to be moving more slowly in Ukraine than in some other areas of the NIS. Although Ukraine has a strong agricultural base, mineral deposits and an industrial sector, the country is dependent on gas and oil from Russia. The need to import fuel and other necessities has resulted in explosive inflation rates. Family incomes have fallen sharply due to the effect of inflation on salaries. There is a growing dependence on government allowances such as pensions and family payments.

Health Care System

The poor economic situation has particularly affected the health sector. Ukraine has an existing national network of well-staffed health institutions and facilities; however, the health service delivery system is suffering from a lack of pharmaceuticals, vaccines, equipment and supplies. Emergency supplies from donors have been covering basic requirements for immunization and curative services, but the future of continuing donor support is uncertain. Health officials are particularly concerned about equipment repair and replacement, especially in tertiary facilities that depend on high-tech equipment. Health services are essentially free; however, clients frequently must purchase drugs from pharmacies and are expected to

tip health providers for services. Under the former Soviet system, the government provided generous social protection programs for citizens including long-term maternity leaves and allowances. Ukraine is struggling to maintain these programs to provide maternal-child protection while political reforms and economic privatization proceed.

**HEALTH INDICATORS - UKRAINE***

Total Population	51.8 million (67% - urban)	1990
Crude birth rate	12.7 / 1,000	1990
Crude death rate	12.1 / 1,000	1990
Infant mortality	14.5 / 1,000	1987
Maternal mortality	32.7 / 100,000	1989
Fertility rate (TFR)	2.0 / woman	1990

**CAUSES OF INFANT DEATHS IN 1986
per 1,000**

Respiratory diseases	2.23
Perinatal conditions	5.27
Congenital anomalies	4.10
Trauma and poisoning	0.63
Infectious diseases	1.34

**VACCINATION OF CHILDREN
DURING THE FIRST YEAR**

Diphtheria	79.2%	1989
Pertussis	74.5%	1989
Polio	80.5%	1989
Measles	88.4%	1989 (by 24 mos.)

*Reproductive Health Indicators compiled from Ukraine: USAID Health Profile (Arlington: Center for International Health Information/International Science and Technology Institute, 1992) 5-11.



Moldova

Population Characteristics

The Republic of Moldova, the second smallest republic in the NIS after Armenia, has a population of 4.4 million. The majority of the population is ethnic Moldovan, with Russians and Ukrainians forming the most significant minority groups. Moldovan (Rumanian) is the official language and is widely used, but Russian remains a major language. Moldova is densely populated with approximately 55 percent of the population living in rural areas. Moldova fertility rates are the highest in the Western NIS region with the overall rate of 2.5 births per woman.

Economic Summary

Agriculture accounts for more than a third of employment. A major source of revenue or barter comes from wine exports to Russia. Much of the agricultural production is devoted to grapes rather than basic food crops that could improve the nutritional status of the population. Moldova, like Ukraine, is dependent on Russia for oil and needs wine for trade. They have been unsuccessful in gaining access to international markets for their agricultural products, particularly wine. Moldova has also suffered severe inflation as a result of the fuel shortages.

Health Care System

Moldova has an extensive, well-staffed urban and rural health care system based on the former Soviet system found throughout the NIS. Facilities are adequate but deteriorating. There are no resources for the repair or replacement of equipment. Since independence, the health care system has been dependent upon donated shipments of pharmaceuticals, vaccines, and supplies. Reportedly, vaccine coverage for young children has dropped from approximately 88 percent in 1989 to 65 percent in mid 1994, with most of the decrease in rural areas. The Ministry of Health (MOH) is progressive and is urgently seeking ways to increase funding for services. The MOH recently permitted physicians to open private practices with set fees developed by the MOH and has expressed interest in learning about other health financing schemes.

Women in Moldova receive the same maternity leaves and allowances as in Ukraine. Family planning services consist largely of abortion services since contraceptives are expensive and not widely available. Maternal and infant mortality are high and the causes are not well-defined, although about 20 percent of maternal mortality is directly attributed to abortions. The Moldovan Government Parliament Committee on Health, Ecology, Motherhood and Childhood considers maternal and child care one of the most important issues for the Republic of Moldova. They seem dedicated to maintaining the positive social system, including maternity leaves and allowances for mothers and infants. Moldova, like the other NIS countries, is attempting to maintain the positive, but costly social policies developed under the former USSR.

**HEALTH INDICATORS - MOLDOVA***

Total Population	4.4 million (46.8% - urban)	1990
Crude birth rate	17.6 / 1,000	1990
Crude death rate	9.7 / 1,000	1990
Infant mortality	25.9 / 1,000	1987
Maternal mortality	34.1 / 100,000	1989
Fertility rate (TFR)	2.5 / woman	1990

**CAUSES OF INFANT DEATHS IN 1986
per 1,000**

Respiratory diseases	8.13
Perinatal conditions	7.46
Congenital anomalies	4.69
Trauma and poisoning	1.52
Infectious diseases	3.81

**VACCINATION OF CHILDREN
DURING THE FIRST YEAR**

Diphtheria	87.8%	1989
Pertussis	84.3%	1989
Polio	91.6%	1989
Measles	94.7%	1989 (by 24 mos.)

*Reproductive Health Indicators compiled from Moldova: USAID Health Profile (Arlington: Center for International Health Information/International Science and Technology Institute, 1992) 5-11.



III. REPRODUCTIVE HEALTH STATUS AND PRACTICES

Maternal and Infant Health and Services

Maternal and Infant Morbidity and Mortality

Maternal mortality remains a serious problem. The maternal mortality ratio in Ukraine and Moldova, respectively, was 32 and 44.1 deaths per 100,000 live births. Approximately 45 percent of maternal mortality are attributed to obstetrical conditions and abortions. The most frequent obstetrical conditions were stated to be hemorrhage, sepsis, dystocia, extragenital diseases (heart, lung, kidney, and liver disease and diabetes), toxemia and anemia.

Although 1994 rates are not available, the infant mortality rate is reported to be increasing in Ukraine and Moldova. The leading causes of infant mortality (1987 figures: 15 per thousand live births in Ukraine, 25.9 in Moldova) were attributed to congenital malformations (mainly due to environmental factors), birth trauma, perinatal asphyxia, perinatal infections, acute respiratory diseases, low birth weight and premature births.

Care During Pregnancy

More than 95 percent of women receive prenatal care. Women are encouraged to attend antenatal clinics early in pregnancy and are given a bonus of four months' salary after delivery if they attended all of their visits. Prenatal visits are numerous with 12-15 or more visits per woman. During these visits, excessive screening and diagnostic testing are undertaken and several examinations by specialists are performed. Each client may receive up to 3 sonograms, an EKG, pap smear, vaginal smears, and urine and stool analysis, repeated screening for blood type, CBC, gonorrhea, syphilis, HIV and AFP. Fetal well-being is monitored jointly by the obstetrician and pediatrician.

All facilities visited by the team were using a risk assessment tool which categorizes level of risk in accordance with the score obtained. This risk assessment approach makes screening for diseases so sensitive that in some areas more than 80 percent of women are placed in the risk category. A 30 year-old primigravida with no problems other than her age is considered high risk. She was scheduled for additional prenatal visits and screening tests and is admitted to the hospital at 38 weeks to wait for labor to begin. A revision of the risk factors for pregnancy and birth that more closely follow international standards for "Safe Motherhood" and limiting the number of exams and tests could go a long way in saving resources.

Client records are color-tagged according to degree of risk (mild, moderate, severe). Clients are referred regularly to more advanced centers in accordance with the protocols for diagnosis and management. Recent research indicates that risk screening is useful only when based on demonstrated risk factors. The current risk assessment approach used in Ukraine and Moldova needs to be evaluated.

Team discussions with physicians indicated that anemia is a major problem in pregnancy and that from 25 to 59 percent or more of pregnant women are anemic. There does not appear to be a standard measurement to define anemia, although Moldova reported that 59 percent of pregnant women have less than 11 gms hemoglobin per deciliter. The cause of anemia is unknown, but it is postulated that poor nutrition combined with environmental factors are major contributors to its prevalence. Anemia is said to be a major health concern for both pregnant and non-pregnant women. Anemia contributes to poor pregnancy outcomes by increasing the risk of infection, hemorrhage and low birth weight infants. Iron and folate supplementation is provided as treatment only for severe cases when supplies are available.



There is exaggerated concern about health problems that may have been caused by environmental radiation and the extensive use of pesticides.

Labor and Delivery Practices

By law, all deliveries must occur in hospitals and attended by physicians, although it appears that most normal deliveries are performed by midwives in hospitals under the direct supervision of a physician. At admission, all women bathe, are shaved and receive an enema. A client goes to another room during active labor for pelvic examinations and then returns to the labor ward. Observation visits revealed that during labor, women receive little support from labor room staff. Husbands or other support persons are not permitted into the labor and delivery areas. There is no privacy (there are no screens in rooms with four or more laboring beds), and the atmosphere appears cold and sterile.

There is minimal variation in the positions that women may maintain during the laboring process. In most cases, they lay flat on their backs during labor. This position impedes the progress of labor, contributes to poor oxygenation of the fetus and may also contribute to the sensation of more pain. Occasionally, women walk or stand during labor. One woman in Moldova was observed laboring in the squatting position immediately prior to delivery.

Due to the shortage of drugs, most women do not receive narcotics or other pain medication. Techniques to reduce the pain of labor, such as maternal movement, counterpressure, stroking, massage and the presence of a support person do not appear to be routinely practiced. Although prenatal classes are offered, most women do not report attending and safe birth and management are not emphasized. In most cases, delivery room staff assist the clients with breathing techniques during delivery.

In the institutions visited by the team, the partograph is used inconsistently as a tool to monitor and manage the progress of labor and to assist in the early identification and prompt management of abnormal labor. It appears that the partograph is used in accordance with the wishes of the physician-in-charge. The only fetal monitors that were seen were those at the central level high risk facilities. One institution had six monitors, but only two were in working order.

The rate of episiotomies appears to be very low. Episiotomies are not routinely performed on primigravidas. Midwives observed were very skilled, without training, at massage and managing deliveries of large babies. There is an extremely limited supply of local anesthesia for use in repairing episiotomies and lacerations.

It appears that the use of forceps is favored over the use of vacuum extraction to facilitate delivery. Equipment for vacuum extraction is scarce, and at one institution it was explained that physicians did not have much success with the use of vacuum extraction. The rate of cesarean section is low at 6-10 percent.

Management of the third stage of labor needs to be strengthened. Oxytocin is not routinely used to prevent hemorrhage. Due to severe shortages, oxytocin is only used for those who are at risk of hemorrhage. One mother was observed stimulating her nipples during third stage to encourage the release of oxytocin as the placenta was being delivered. Delivery of the placenta would be aided by early initiation of breastfeeding which is not common.

Moderate delay in the clamping of the cord was observed. The use of controlled cord traction to deliver the placenta does not appear to be routinely practiced. Although all delivery equipment and supplies are steam autoclaved, there is a need to update staff on the importance of a clean and safe delivery. Caps, gowns, masks and boots are routinely worn by hospital staff, reportedly to prevent the spread of infection, but areas that need to be emphasized in infection prevention practices are: hand washing and

decontamination; care of reusable gloves, syringes and needles; and disposal of materials contaminated with blood and blood products. This is of particular urgency as the team was informed that approximately 15-18 percent of the population is estimated to carry the Hepatitis B virus. Five to ten percent of newborns are said to be infected with the virus. The prevalence of HIV infection is unknown, but it is reported that in Moldova there has been a 150 percent increase in the incidence of Sexually Transmitted Diseases (STDs). Disinfectants and other solutions and supplies required for effective infection control are lacking.

Care of the Newborn Infant

The Apgar Score is routinely used to assess the condition of the newborn, but of the deliveries observed by the team, the immediate care of the infant and the methods of resuscitation need to be improved. Routine and aggressive nasal and oral/pharyngeal suctioning was performed, but the use of a bulb syringe was minimal. Newborns were not immediately dried off and placed under the warmer. Moreover, the radiant warmers were not in the delivery room, but in an adjacent room. Antibiotic eye drops are routinely administered in the eyes and around the genital area of the females to prevent gonococcal ophthalmia and chlamydia.

Immediate maternal-infant bonding and breastfeeding is restricted. An infant is generally not provided the opportunity for immediate skin-to-skin contact with the mother. The following conditions are inappropriately regarded as contraindications to breastfeeding: hemolytic diseases, asphyxia, intrauterine infections, low birth weight and pre-term babies.

Most infants in the newborn nurseries are of substantial weight and are, in fact, much bigger than newborns in the United States. Physicians attribute this to the fact that most women gain 12-15 kgs. during pregnancy, with most weight gain going to the baby and to relief from work during the last months of pregnancy because of the liberal maternity leave policies. There does not appear to be a consistently used standard definition for defining pre-term or categories of low birth weight infants nor routine gestational age assessments of newborns. Approximately 22 percent of infants are low birth weight (less than 3000 to 2500 gms), and pre-term deliveries occur in about 6 percent of births.

Sixty percent of the babies in the neonatal intensive care unit visited by the team were pre-term or low birth weight, and 40 percent had a history of infection, birth trauma, and congenital anomalies. Recently, there has been a delay in transporting babies to the intensive care units due to lack of fuel and reliable transport. Rather than arriving at the intensive care units within 24 hours of delivery, most high risk newborns arrive 3 to 4 days later.

Postpartum Care

Several hospitals have instituted a modified rooming-in program, but in most cases infants are still separated from their mothers from two hours to up to three days after delivery. Infants are swaddled immediately after birth and remain swaddled throughout the hospital period, even during breastfeeding. Infants are not bathed in the hospital. Rather than use one midwife, there are different staff to care for mothers and babies.

Most postpartum women are crowded four to six to a room with no provisions for privacy. Despite this crowding, some hospitals have vacant rooms on the wards. Women remain in the hospital for approximately eight days and may not be discharged until the infant's cord has dried and fallen off. Fathers are not allowed in the hospital and see their family only after they are discharged from hospital.

After the mother is discharged, she is visited by the midwife for three days in the rural areas. The pediatrician or obstetrician will also make a home visit if indicated. Some institutions have classes for

mothers on feeding, care of the baby and health and hygiene. It does not appear that routine or detailed information or counseling on family planning or the consequences of abortion is provided to the postpartum mothers.

Breastfeeding

Current policies are not very effective in promoting longer duration of breastfeeding. The promotion of breastfeeding would not only save the cost of infant formula but could be effective in spacing births. Most women breastfeed initially but do not continue for more than three or four months. Various birth procedures and infant care practices decrease the breastmilk supply and discourage breastfeeding.

The timing of maternal-infant contact and initiation of breastfeeding is directly related to whether the hospital is associated with a western hospital partnership program, or whether the director of obstetric services had traveled to a western country or attended a technical seminar on the advantages of family-centered care, rooming-in and breastfeeding. Managers of care who had been exposed to other models of delivery aggressively promote change within their obstetrical services.

Most hospitals keep infants in separate nurseries and are taken to their mothers for feeding at rigidly scheduled three hour intervals. Some institutions keep breastfed babies in the nursery overnight to enable the mothers to rest. Routine glucose feedings are also given to the infants.

The team was informed that mothers are allowed into the intensive care nursery to touch and feed their babies, but no mothers were observed to be in or around the neonatal unit. The team was advised that breastmilk is used to feed the infants and a special room has been allocated for the collection of breastmilk. However, no milk was seen in the breastmilk room.

Abortion

Abortions outnumber births 108 to 100; 800,000 abortions are officially reported annually. The World Bank reports that approximately 23% of maternal deaths are directly related to illegal abortions (World Bank, Country Report, 1994). Abortion is the major method of fertility control in the NIS due to a lack of safe, effective contraceptives. Women are usually hospitalized for abortions and receive paid sick leave for the procedure. As some of the most commonly used methods of contraception are traditional methods such as withdrawal and douches, many abortions could be prevented if modern, effective contraceptives were available.

Health Costs

Many health problems are directly associated with the multiple abortions women have during their lifetimes. Health personnel report high rates of infertility, infections, hemorrhage, and other gynecological problems related to abortions. According to the 1994 Ukraine World Bank Country Study, high levels of pelvic inflammatory disease, pregnancy complications and miscarriages are directly associated with abortions.

The widespread use of dilation and curettage for abortion procedures has led to many abortion-related complications. Even early term "mini-abortions" undertaken with a vacuum aspirator are performed with a metal canula (instead of the flexible plastic canula used in the United States) making uterine perforation much more likely.



Human Costs

Because drug supplies are limited or absent, most women are forced to suffer painful abortion procedures with no anesthesia. The large numbers of abortions undertaken are particularly dangerous due to the limited supply of antibiotics. Women do not easily discuss the number of abortions they have had. These experiences are seen as painful and embarrassing.

Economic Costs

Enormous resources are consumed performing the hundreds of thousands of abortions each year. The World Bank has estimated that the cost of abortions and the treatment for complications of abortions is at least four times the cost of providing contraceptives. Complications from abortions cost the health system substantial amounts of resources in staff time, gynecological beds and drugs. In Ukraine, hospital costs to treat complications from abortions were estimated at 3-4 billion rubles in 1991 (World Bank, 1994). Four to five days of sick leave are officially allotted to obtain an abortion and additional work days can be lost due to the sick leave taken for abortion-related complications.

Family Planning

Medical personnel recognize the detrimental effect of abortion on women's health and support the use of family planning. However, due to the absence of accurate information, many misconceptions exist about specific family planning methods. The countries of the former Soviet Union have been isolated for decades. During this time, access to information related to modern western medical practice was very restricted. During the 1960s and 70s, high-dose oral contraceptives (produced in Hungary) were used throughout the NIS. These contraceptives resulted in many serious side effects. Physicians and the public continue to have fears about modern low-dose oral contraceptives.

Training in modern family planning service delivery is minimal for physicians, midwives and paramedical personnel. Due to the lack of training and supplies, family planning service delivery is weak. Approximately 17 percent of sexually active women use contraceptives (UNICEF/WHO, 1992). Although IUDs are the primary method used, supplies are either dwindling or absent. Russian produced IUDs are the only IUDs available. These IUDs, no longer in production, are considered of very poor quality and are associated with low effectiveness and high infection rates. IUDs from the United States and Europe are preferred by physicians and clients. However, except for periodic charitable donations, supplies are unavailable or unaffordable.

Sterilization, the primary family planning method used in the United States, is considered unacceptable unless a woman has serious medical problems that could be life-threatening during pregnancy. Medical personnel's knowledge of other methods of contraception, including depo-provera (injectables) and Norplant, is limited. The use of condoms is recommended to women in some health facilities.

According to the UNICEF/WHO mission report, a survey in Ukraine revealed that most women obtain contraceptive information from their friends or popular publications rather than from a health professional. Only 18 percent stated that they received information from health personnel. Although health educators are interested in creating sex education programs for the general public, existing programs in both Ukraine and Moldova are weak.

Mothers are counseled at four weeks postpartum about family planning and the hazards of abortion. It is not clear, however, how much information is given to the mothers. The team observed that the health providers themselves have insufficient knowledge and many biases and misconceptions about various family planning methods.



IV. PROFILE OF HEALTH CARE SERVICES

The existing health infrastructure is designed to provide services during pregnancy, labor and delivery, the postpartum period and infancy. The infrastructure is highly developed with a well-functioning referral and follow-up system from the feldsher and community rural health post level to the district, regional, and central level referral hospitals. The major challenge for the health sector in Ukraine and Moldova is maximizing efficient use of resources to provide quality care. Much of the current maternal and infant health care system still operates with rigid adherence to the traditions, laws and regulations of the old Soviet system. The system lacks public health approaches in promoting and improving maternal and infant health. Some senior officials clearly see that a new problem solving approach that examines costs and weighs alternatives will be required if the current level of care is to be improved. Despite the troubled economy, most policy makers are still looking for improved technology and better quality medicines, reagents, contraceptives and infant formula. Some services, however, have already been cut back. In Chisinau, Moldova, only 65 percent of eligible children will be immunized this year due to vaccine shortages.

Although providers are dedicated and committed to their work, their attitudes and focus of care are not on client or family-oriented service delivery, but on rigid compliance to outdated procedures and protocols. Providers follow procedures that rely upon extensive testing, physician specialists and interventions in order to rule out disease in what often appear to be healthy women with normal pregnancies. There is an overwhelming concern that service activities must always be carried out in accordance with regulations rather than in accordance with the needs of each individual client. Routines are not easily changed for the benefit of the client.

Because policy and program development, management of services, and provision of maternal and infant care services are heavily physician driven, care is focused on the identification and management of disease rather than health promotion, health maintenance, health education, counseling and disease prevention.

There are constraints to health personnel working together as a team due to physicians' perceptions that nurses and midwives are very low-level providers and that their role is to act as assistants to the physicians. This is further exacerbated by physicians' beliefs that midwives and physicians should not participate together in conferences, seminars or educational sessions. Opportunities for sharing and learning from each other and reducing costs through the more effective utilization of mid-level providers are minimized. Moreover, this limited role of the mid-level providers, and particularly the midwife, impacts on the quality of care provided to women during pregnancy.

Informal discussions with women reveal that the attitudes of health care providers need to be improved. There is insufficient information and emotional support given to women. Procedures and routines are not explained beforehand. There is little sympathy provided during labor and delivery (women are told not to cry or make noise). Clients participate only minimally in decision making.

The physician is responsible for educating and counseling women during clinic visits and Mothers Classes. This area needs further study as one of the directors of services indicated that it does not appear that physicians are adequately focusing their efforts on educating women on preparation for pregnancy, labor and delivery, nutrition, healthy life-styles, breastfeeding, abortion and family planning. It is difficult for obstetricians, neonatologists and pediatricians to spend adequate time fulfilling these obligations in addition to performing abortions, managing complicated labors, monitoring newborns, performing surgery, training, research, follow-up with postpartum clients, and if indicated, home visits.

Midwives and nurses appear to devote their time to acting as assistants to the physicians--obtaining supplies and completing records--and appear to be minimally involved in counseling and health education activities.



Policies and Institutions

There is immense interest in the western style of health care, and there is significant innovation, experimentation and health care reform occurring at the service delivery levels. Hospital partnerships with organizations from the United States, Canada, Germany and France have been established.

The institutions visited by the team keep impressive demographic and service statistics data on maternal and infant care which they use to design interventions for the improvement of maternal and infant outcomes. However, these were high level institutions, some with U.S. Hospital partnerships and it is not clear if data is used as effectively in the health system in general.

To encourage prenatal care, women who register and attend prenatal clinics are regularly provided with allowances. Additional allowances are provided after delivery for mothers and infants. Pregnant women may take up to 56 days of leave prior to delivery. Most women take at least a month of leave before delivery and three months of additional paid maternity leave. Women are also permitted up to five years of unpaid leave after pregnancy and are guaranteed their previous employment in the same position upon their return. Discussions with the Ministries of Health in Ukraine and Moldova indicate that the health leadership continues to support the maternal leave policies. In fact, Ukraine is extending the period of prenatal leave to 70 days. Moldovan officials were also planning on extending leave. The maintenance of liberal maternity leaves and allowances will depend upon the governments' ability to continue to provide funding for these policies during economic restructuring.

The primary service providers of maternal and infant care are physicians (obstetricians, gynecologists, neonatologists and pediatricians) and mid-level providers such as midwives and nurses. As stated previously, the scope of activities of the midwife appears to be limited in comparison to the functions of a midwife in other developed and developing countries. There appears to be an abundance of specialist physicians and reproductive health care staff within the institutions, with an approximate ratio of one physician to three or four mid-level providers. In the past two years, births have declined by 20 percent in some areas due to deteriorating social conditions and this has contributed to the surplus of staff.

Physicians hold key positions in the Ministry of Health, and in addition to managing and providing services, are the key health care policy decision makers in Ukraine and Moldova. Although the MOH in both countries are making serious efforts to make health reforms, develop policies and create an environment that promotes reproductive health, the process is slow, hampered by: a) lack of knowledge and expertise in state-of-the-art maternal and infant care practices and b) inadequate resources to develop and implement policies.

The extent to which the concepts of informed choice and voluntarism exist in a system that has been traditionally dominated by physicians is questionable. Considerable interest and scarce resources appear to be invested in research examining highly technical areas such as chromosomal disorders, genetic diseases and the effects of radiation and environmental pollution on pregnancy. This is in an environment where many lives could be saved by shifting resources to health education to the public, or in the provision of preventive health care services like family planning.

At the institutional level, directors of hospitals appear to have sufficient authority to institute new maternal and infant care policies and programs. Consequently, variations in types of maternal and infant care programs and services may be found within districts and regions. This was particularly noted in Moldova which has moved ahead quickly to develop national plans and is making serious efforts to implement breastfeeding, rooming-in, family planning and modified forms of client-oriented services. In Ukraine it was notable that the training institutions visited felt at liberty to establish their own curricula priorities, not staying within previously established standards.



Commodities and Logistics

All of the republics are lacking in drugs and other supplies. The previous system of drug and commodity distribution was totally centralized from Moscow. Until 1991, drugs produced from various parts of the former Soviet Union were distributed to all countries through Pharmasia, the commodities distribution arm of the MOH. The system of forecasting supply needs was calculated on a population-based formula (not service statistics or health needs) of the districts or areas served. This system left some pharmacies with unmet needs and others with a surplus.

In some countries of the former Soviet Union, Pharmasia has separated from the MOH and is privatizing. In Ukraine and Moldova, the majority of pharmacies continue to be part of Pharmasia, although some pharmacies have begun to privatize. These private pharmacies procure drugs and supplies directly from their own sources.

Now that the Soviet system has broken down, republics must obtain drugs and equipment on their own. However, there is little or no foreign currency to purchase commodities. The countries are now dependent on periodic donations. There is an urgent need for essential drugs and supplies. Priority drugs that were identified are oxytocin, narcotics and sedatives, anesthetics, iron and folate tablets, intravenous infusions, and blood products. Antiseptics, disinfectants, gloves, syringes and needles, and laboratory reagents are also needed. A mechanism needs to be established to assure the continuous supply of essential drugs and supplies. The distribution system within both republics continues to be based on population-based statistics and not the specific needs of each facility. Most equipment is old and/or in need of repair. Many obstetric facilities are inadequate and require upgrading. Ukraine and Moldova are relying on humanitarian aid to assist them in coping with these shortages and deficiencies.

Information, Education and Communication (IEC)

Health education is undertaken in each republic through Health Education Centers at the national level. Within these centers, print materials are developed with some quantitative research guiding the design; however, little qualitative research is undertaken. Due to scarce resources, little evaluation of IEC activities is undertaken. Radio and TV productions are typically lecture-style with limited variety. Innovative AIDS prevention TV spots have been produced in Ukraine with the assistance of UNICEF.

Although the work of these health educators was not evaluated, knowledgeable sources state that due to limited resources, activities at the district level are weak. Each district has one health educator (physician) who has been trained within the Faculty of Sanitation and Hygiene.

In 1989, the Health Education Centers began promoting the theme "Healthy Lifestyles" based on the WHO's strategy of "Health for All." Sex education in the schools is included in the plan to promote "Healthy Lifestyles." Although health educators expressed interest in promoting a national program for health lifestyles, both countries are severely limited by lack of funds. National programs to promote "Healthy Lifestyles" in both countries have been severely limited by the lack of funds.

Government and Donor Support

The Ministries of Health in Ukraine and Moldova have voiced strong support for improving the health of women by reducing the high rates of abortion and introducing broader choices of family planning methods. In Ukraine, the World Bank has agreed to provide focused support for five city programs, a national information center and substantial contraceptive commodities. Oreganon (producer of an oral contraceptive) assists an information center at the Kiev Research Institute for Pediatrics and Gynecology. In October 1994, the Institute will hold a training seminar on oral contraceptives.



In Moldova, The International Planned Parenthood Federation (IPPF) undertook an assessment in May 1994 and is planning to provide the Ministry of Health with technical support and emergency contraceptive commodities. A family planning conference will be held in October with IPPF support.

The MOH/Moldova plans to train 65 family planning specialists (with IPPF assistance). These specialists will be identified from each district and major city. USAID has agreed to provide 500 copies of the Russian version of Contraceptive Technologies to Moldova for the upcoming family planning conference.

With strong support from the governments of Ukraine, Moldova and Belarus, USAID will hold a Reproductive Health Seminar in Kiev in October 1994. This Seminar will bring policy makers, physicians and midwives together to exchange ideas with international experts in the area of safe maternity practices, breastfeeding, and family planning. The conference will expose participants to the most current information on maternal and infant care and on the delivery of family planning services and modern family planning methods.

V. TRAINING

Physicians

The duration of training for physicians is five years following completion of ten years of general education. An additional three years is required to complete the chosen specialty area. The medical training system for physicians appears to be highly specialized, with 120 specialties as compared to approximately 45 specialties in the United States. The chronology for general course work for physician training is as follows:

year 1 and 2	theory
year 3	practical
year 4	obstetrics
year 5	gynecology
year 6 - 9	internship to complete specialization

Similar to the nursing and midwifery curricula, the curriculum for physicians is now developed through the Ministry of Health. Each training school may make curriculum course content adjustments up to 20 percent. Typically, each trainer in charge of a subject area makes the content adjustments, obtaining approval for the modifications from the faculty and department chair. The team was informed that an increased focus on training in public health, with content areas to include communal hygiene, sanitation and healthy lifestyle behaviors, is being introduced into the curriculum.

Physicians are required to attend a 1-2 month refresher training course and pass the state board examinations every five years in order to be recertified. A curriculum has been developed for refresher training in reproductive health.

Midwives

Midwives are recognized worldwide for their ability to provide safe, cost-effective and satisfying women's health care in a variety of settings. Effective and efficient use of midwives has contributed to the increase in maternal and infant survival. In the Ukraine and Moldova, current restrictions on the functions of midwives severely limit their role as service providers and affect the quality of care in reproductive health. At the present time, midwives have not organized themselves to form a society or professional organization that responds to their own professional needs.



In Ukraine and Moldova, nursing and midwifery training are separate entities. Students are eligible to enter the training programs after completing ten years of general education. Nurses training is of three years duration in Ukraine and Moldova. In Ukraine, the length of midwifery training is three years, and in Moldova it is two-and-a-half years. There is a special three-year midwifery course in Moldova designed for girls 15 years of age who have not completed the ten years of general education.

The midwifery program encompasses training in general nursing and midwifery skills training. Midwives are trained to provide care for clients in the antenatal, intrapartum and postpartum periods, including normal neonatal and infant care. They are not trained to provide care as independent practitioners managing normal clients throughout the reproductive cycle since all care must occur under the immediate supervision of a physician. However, midwives work alone in the feldsher/rural posts where pregnant clients make their first contact with the health system. In the feldsher posts, midwives refer clients on a regular basis to the district hospital for examination and monitoring by physicians. After an examination, clients return to the feldsher post for care by the midwife.

Theoretical and practical examinations are conducted during and at the end of the midwifery training. Students are expected to pass the state examinations (theoretical and practical) in obstetrics and gynecology, surgery and medicine. Specific criteria have been established for poor performance, and students may be dismissed during the training program. It appears that some form of clinical performance assessment tools/checklists are used to assess skill competency, but these tools were not available for review.

All midwifery training schools are expected to follow the state curriculum. However, adaptations in the total curriculum content may be adjusted up to 20 percent to allow for the training needs of each institution. Allowing 20 percent flexibility in adjusting the curriculum components may affect the outcome behaviors of the graduates. It is possible that some programs may prepare graduates with insufficient skills in key behaviors and competencies.

The recently revised curriculum appears to be incomplete as it only includes the major subject areas, a listing of content topics for each subject, and hours allocated (theoretical and practical) for each subject and content area. Curricular philosophy, objectives, learning activities and experiences, evaluation methods and performance assessment methodologies to achieve the objectives were not identified. The curriculum does not have a competency-based approach to learning.

It is difficult to ascertain the breadth and depth of training allocated to safe prenatal and delivery care, family planning technology and counseling, abortion counseling, breastfeeding, prevention and control of STDs, family-centered maternity care, infection prevention and public health approaches to reproductive health. Although the trainers indicate that these topics are included in the curriculum, it appears that they are fragmented. Insufficient time is allocated to both theory and practice. Students are not taught these subjects in a systematic and coordinated manner that builds skills.

Physicians conduct all classroom training and supervise most of the clinical component of training. Senior midwives may assist the physicians during the clinical component. This is an area of concern as the traditional training of midwives by midwives focuses on the development of support, counseling and clinical skills with an emphasis on health promotion and health education. Further study is required to ascertain the focus of the training of midwives by physicians.

Midwives must take compulsory refresher courses every five years. The training varies from 1-3 months' duration. It appears that the refresher training is designed in accordance with the category of provider attending the training. Midwives are categorized as midwife, second midwife or superior midwife based on their experience and level of proficiency. At the end of the refresher training, students must pass the state examinations. Post basic training programs are residential, and costs are incurred by the state.



Feldshers

The team was not able to visit a feldsher training school but was informed that feldsher training is of two years' duration. Students enter the program after completing ten years of general education. Their training is limited in the area of obstetrics and infant care, and their status is regarded as equivalent to the status of a midwife. The feldsher's role in reproductive health care needs to be explored further.

Resource and Training Needs

Resources needed for physician and midwifery training are current training materials, supplies, audiovisual equipment, reference texts, journals, computers, improved training facilities for the classroom and upgraded clinical training sites. Funds for translation of training materials are urgently needed.

There is immense interest in learning about physician and midwifery training programs in western countries. There is a desire to promote cooperation and collaboration between training institutions such as universities and hospitals.

Physicians have requested update training in the management of perinatal infections, neonatal resuscitation (particularly for low birth weight, pre-term and high risk neonates) and safe labor and delivery practices to reduce birth trauma. Further technical assistance and resources are needed to study the causes of maternal and infant mortality and morbidity. Technical assistance and training are needed in the management of toxemia, anemia, difficult labor, management of instrumental deliveries, organization and management of family planning programs and techniques and management of abortion.

VI. FINAL RECOMMENDATIONS

Maternal and Infant Health and Services

- Provide assistance for the procurement of essential drugs and supplies and aid in the establishment of a system to assure a continuous supply.
- Assist the MOH to refine physician and midwifery training curricula in the area of maternal and infant care.
- Provide assistance for the study and expansion of the role of the midwife in maternal and infant care.
- Assist the MOH in the development of standard protocols and guidelines for the delivery of safe maternal and infant services for the various levels of providers. Guidelines should help to maximize the efficient use of health personnel and promote quality of care in service delivery.
- Provide technical assistance and funds for research on the causes of anemia during pregnancy.
- Explore the feasibility of establishing "nutrition houses" for pregnant women where nutrition counseling, routine iron and folate supplementation and iron and folate rich foods would be provided at a subsidized cost. Nutrition intervention programs may be integrated into the existing "milk kitchens" which provide foods and supplements to mothers at low cost. The team was not able to visit a milk kitchen on this visit.



Breastfeeding

- Support suitable institutions as demonstration sites for rooming-in and Baby Friendly Hospital Initiative procedures.
- Explore the potential for funding applied research on breastfeeding issues such as hypogalactia and its links to stress and environmental contamination, Rh incompatibility, "hemolytic disease," breastfeeding/LAM for child spacing, and cost effectiveness of breastfeeding promotion.
- Address women's empowerment and critical importance of sustaining rights to leave from work for child bearing and child rearing.
- Identify teams for training at Wellstart's Lactation Management Education program in San Diego.

Family Planning

- Institutionalize family planning training into the existing training infrastructure. Family planning training should be integrated into the curriculum of the medical and research institutes that train physicians, midwives and paraprofessionals throughout the country.
- Assist in the dissemination of existing family planning materials (translated into Russian) such as Contraceptive Technologies.
- Establish AIHA partnerships between MCH service and training facilities in the region and reproductive health service facilities in the United States.
- Provide assistance for contraceptive commodities (pills, IUDs and injectables) and technical support for public and private sectors to establish a logistics system to recover costs.

Information, Education, and Communication (IEC)

- Provide technical assistance to train health education professionals in the development of public information, education and communication programs on reproductive health and family planning.
- Provide funds for the translation of training materials.
- Incorporate interpersonal communication and counseling skills into curricula at all levels. A key component in the training of providers should be an emphasis on client and family centered care.

Training

- Provide technical assistance and material support to physician and midwifery schools to review and refine curricula, design comprehensive curricula that uses competency-based training approaches, and reorient training to emphasize a public health focus in the training of providers. Encourage physicians to involve superior level midwives in the development of a midwifery curriculum.
- Organize study tours to the United States for personnel from the MOH to view different approaches to family-centered care.



- Send selected neonatologists to the United States for a short training course in the resuscitation and management of high risk newborns. Visits to perinatal centers could be included as part of the training activity.
- Sponsor graduate study for OB/GYNs involved in the management of services and training of providers. Send selected midwives for advanced training in midwifery.
- Consider the following topics for presentation and discussion at the October 1994 Reproductive Health Seminar:

- prenatal care and the use of a simplified risk assessment approach
- use of the partograph in the management of labor
- anemia and pregnancy
- resuscitation and care of the newborn
- breastfeeding
- family-centered maternity care
- management of hemorrhage and sepsis
- management of perinatal infections
- abortion techniques and abortion counseling
- family planning technology and family planning counseling
- infection prevention methods in maternal and infant services



ANNEX #1

COUNTRY PROFILE: BELARUS

Population Characteristics

Belarus has a population of approximately 10.3 million, with 65.5 percent of Byelorussians living in urban areas. Ethnic Belorussians comprise 77 percent of the population. Thirteen percent are Russian and approximately three percent are Ukrainian. The majority of the population (83 percent) speaks fluent Russian, with 78 percent speaking Byelorussian.

Economic Summary

Belarus has a broad agricultural base focusing on the cultivation of potatoes and grain and dairy products. The broad industrial base has traditionally focused on high-tech production, including weapons production, for the former Soviet Union. The break-up of the Soviet Union has disrupted normal trade for Belarus, resulting in increased economic hardship.

Health Care System

According to the USAID Health Profile of Belarus, as a former republic of the Soviet Union, the Byelorussian health system suffers from "years of neglect, sub-standard technology and poorly trained staff." Basic medical services, such as prenatal care, diagnostic capabilities and childbirth assistance are lacking. The Ministry of Health reports a sharp increase in infant and child morbidity since 1986.

Belarus is experiencing a near-zero population growth due to both the fear of birth defects resulting from environmental contamination and infertility. The fallout from Chernobyl in Belarus was 90 percent and was worse than Ukraine. Anemia among pregnant women has tripled in the past ten years.

**HEALTH INDICATORS - BELARUS***

Total Population	10, 300,000	1990
Crude birth rate	13.9/1,000	1990
Crude death rate	10.7/1,000	1990
Infant mortality	13.4/1,000	1987
Maternal mortality	24.8/100,000	1989
Fertility rate (TFR)	2.1/woman	1989
		1990

**CAUSES OF INFANT DEATHS IN 1986
per 1,000**

Respiratory diseases	2.4
Perinatal conditions	4.9
Congenital anomalies	4.0
Trauma and poisoning	1.9
Infectious diseases	1.1

**VACCINATION OF CHILDREN
DURING THE FIRST YEAR**

Diphtheria	90.0%	1989
Pertussis	86.6%	1989
Polio	90.4%	1989
Measles	97.0%	1989 by 24 months

* Reproductive Health Indicators compiled from Belarus: USAID Health Profiles (Arlington: Center for International Health Information/International Science and Technology Institute, 1992) 5-11.

ANNEX #2**INSTITUTIONS ACTIVE IN THE REPRODUCTIVE HEALTH SECTOR****Kiev Research Institute on Pediatrics, Obstetrics and Gynecology (KRIPOG)**

KRIPOG, with a staff of 1,500, was organized in 1929. It is now in the process of creating the Ukrainian Center on Family Planning, with branches in all regions of Ukraine. KRIPOG and its Family Planning Center is under the influence of Organon which is renting offices there. The Institute is not aware of Norplant or female surgical sterilization. KRIPOG has traditionally been responsible for creating and producing breastmilk substitutes. Massive production of breastmilk substitutes began in Ukraine in the '70s with two giant enterprises. All institutions visited by the team in Kiev and Ukraine referred to KRIPOG as a scientific leader.

Kiev Center for Health Protection of Maternity and Childhood, Center "Levoberezhie"

Center Levoberezhie is similar to KRIPOG except for a more modern technical vocabulary resulting from a one year cooperation with the University of Pennsylvania Medical School under the Hospital Partnership Program. The center has been serving the 1,000,000 Kiev population. It appears to be a teaching center for the nurses and midwives of this territory.

Kiev Institute of Advanced Medical Training of Physicians (KIAMTP)

KIAMTP, founded in 1918, now has 75 departments performing the post-graduate training of 11,000 - 12,000 physicians annually. All physicians must pass the Advanced Medical Training Course every five years. KIAMTP has 530 scientific and teaching staff members, and a total staff of 1,300. KIAMTP is designing academic programs for all of Ukraine.

Ukrainian Health Education Center (UHEC)

UHEC has printing and publishing facilities that may be of use for educational purposes; however, some UHEC programs exist only on paper.

Women's Hromada of Ukraine (WHU)

Women's Hromada of Ukraine is a non-profit charitable, educational organization with approximately 10,000 members throughout Ukraine. WHU is dedicated to the promotion of social welfare and the building of civil society in a newly independent Ukraine. WHU is particularly dedicated to promoting health education for women and children but does not actively promote contraception. WHU has good printing facilities and media contacts all over Ukraine. The organization is potentially a very good source of public information and education.

Women's Antenatal Clinic (Women's Consultation Clinic)

If interventions are to be done in Odessa, the Women's Antenatal Clinic can be recommended as a part of the chain of "antenatal care - maternity hospital - children's hospital." Local officers are Dr. V. Lebedbko - Regional Chief Obstetrician-Gynecologist and Professor N. Aryaev - Chief of the Pediatric Chair, Odessa Medical University.

Odessa City Clinical Hospital, Maternity Department

The Odessa City Clinical Hospital serves as the teaching Medical University Hospital. It does not want to introduce rooming-in, because the staff believes that it will increase the number of infections in infants, that infants will disturb the mothers and other common misconceptions. Professor Nagornaya is preparing a new manual for students.

District Hospital, Orhgey [Orgeevsky], in Moldova

The hospital administration receives great support from local authorities and the community. The hospital is in great need of equipment and instruments. Rooming-in was introduced last year, but babies are in cribs across the room from their mothers. We obtained permission to move the cribs closer to the mothers' beds. The hospital staff appears to be very receptive to innovations.

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ANNEX #4**DEPART AGENDA FOR THE OCTOBER 1994
MATERNAL AND CHILD HEALTH CONFERENCE****SEMINAR OBJECTIVES:**

- Information dissemination
- Recommendations to each MOH of guidelines for service delivery

SEMINAR TOPICS:**Family Planning:**

Benefits of family planning
Technology updates (OCs, IUDs, Depo, Norplant, barrier methods, sterilization, LAM)

Breastfeeding:

Benefits: economic, birth spacing, maternal and infant health, nutrition
Baby Friendly Hospital Initiative (UNICEF/WHO); Risk management;
Rh incompatibility; infant feeding in the community; hypogalactia; stress; contaminants; water;
supplements

Safe Motherhood/perinatal care:

STDs and HIV
Different approaches to family centered maternity care
Abortion; consequences
Prenatal care; optimal # visits (WHO)
Postpartum care; swaddling (WHO)

Major themes:

Programming for cost effectiveness
Quality of Care
Women

Evening sessions:

Communications strategies (mass media and counseling)
Policy development
Team approaches

FORMAT:

Morning and afternoon plenaries

Morning and afternoon working groups (by topic)

Night plenaries on cross cutting issues

Issues: Media mix? Site visits? Any hands-on or skill building? Any follow-on training or institution based work?

2nd week: small working groups (4-6 people) from each country (identified by MOH) to make recommendations for action on each topic.