

**EVALUATION OF  
THE WOMEN'S REPRODUCTIVE  
HEALTH INITIATIVE IN UKRAINE**

POPTECH Assignment No. 97-118-060  
April 1998

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Prepared for

U.S. Agency for International Development

Bureau for Global Programs

Office of Population

Contract No. CCP-3024-Q-00-3012

Project No. 936-3024

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## LIST OF ABBREVIATIONS

AIHA	American International Hospital Alliance
ACNM	American College of Nurse-Midwives
AVSC	AVSC International
CA	Cooperating Agencies
CAR	Central Asian Republics
DMPA	Depo Medoxy Progesterone Acetate
FCMC	Family centered maternity care
FP	Family planning
FPA	Family Planning Association
IEC	Information, education, and communication
IRH	Institute for Reproductive Health
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/PCS	Johns Hopkins University/Population Communication Services
LAM	Lactational amenorrhea method
MCH	Maternal child health
MOA	Memorandum of Agreement
MOH	Ministry of Health
NFP	Natural family planning
NIS	New Independent States
OB/GYN	Obstetrician/Gynecologist
OC	Oral contraceptive
PID	Pelvic inflammatory disease
POLICY	Policy Analysis, Planning, and Action project
SOMARC	Social Marketing for Change project
SOW	Scope of Work
STI	Sexually transmitted infection
TOT	Training of trainers
USAID	United States Agency for International Development
WRHI	Women's Reproductive Health Initiative



## EXECUTIVE SUMMARY

USAID/Kiev contracted the Population Technical Assistance Project (POPTECH) to conduct this evaluation of the Women's Reproductive Health Initiative (WRHI). POPTECH, in turn, contracted a three-person team composed of a team leader and training specialist, a practicing obstetrician/gynecologist with extensive experience in international family planning, and a nurse-midwife/epidemiologist with extensive experience with USAID and international reproductive health. The scope of work for the evaluation focused on seven areas:

- Achievement of project goals and strategic objectives;
- Cooperating Agency (CA) activities;
- Family planning (FP) service delivery;
- Family planning training;
- Information, education, and communication (IEC) in support of family planning;
- Family planning commodities; and
- Family centered maternity care.

This evaluation took place between October 29 and November 21, 1997. The evaluation began in Washington, D.C., where the evaluation team met with representatives from USAID and most of the CAs involved in the WRHI. While in Washington, the team reviewed extensive documentation supplied by the CAs and USAID. The team then traveled to Ukraine for meetings with USAID/Kiev and Ukrainian Ministry of Health officials. The team visited the three oblasts (regions) in which the WRHI has been implemented and interviewed individuals at all levels of the health care system. The team then returned to Kiev to prepare the report and conduct additional interviews with CA representatives and Ministry of Health officials.

USAID's reproductive health strategy for Ukraine, as well as for Moldova, Belarus, and Georgia, was based on a strategy originally developed for the Central Asian Republics (CAR). USAID's work in the CAR was initiated by a seminar held in Almaty, Kazakhstan, in January 1993. USAID followed the CAR model to initiate its reproductive health work in the western New Independent States (NIS). In June 1994, a six-person team including representatives from USAID, MotherCare, and WellStart conducted a preliminary assessment of reproductive health problems and services in Ukraine and Moldova (Collins et al). This assessment focused on maternal and infant health and services, breastfeeding, abortion, contraception, and training of physicians and midwives, and made recommendations for USAID support to Ukraine regarding maternal and infant health; breastfeeding; family planning; IEC; and training. An "exit survey" of 300 women

who received care at 28 delivery houses in Kiev, Donetsk, and Lviv also provided information on mothers' opinions of maternity care in Ukraine.

The findings from this assessment were used to plan the Reproductive Health Seminar held in Kiev, October 24 to 28, 1994. The NIS participants included approximately 130 high-ranking Ministry of Health (MOH) officials and senior reproductive health professionals from the five countries that form the western region of the NIS: Armenia, Belarus, Georgia, Moldova, and Ukraine. The purpose of this seminar was to provide a group of influential policy and professional leaders from each of those countries with information and descriptions of successful programmatic approaches to improving reproductive health. Such approaches included health care provided to pregnant women and newborns, breastfeeding, modern contraceptive methods, safe abortions, and improved information, education, and communication. USAID staff and representatives of some USAID CAs remained in Kiev after the seminar to plan USAID's strategy for assistance to improve reproductive health in Ukraine, Moldova, and Belarus.

The Ukraine Reproductive Health Project strategy was based on conclusions derived from information obtained during the June 1994 needs assessment, the exit survey, and the October 1994 seminar. These conclusions included the following:

- Very low fertility—less than replacement level—in the country is caused mainly by repeated induced abortions and use of traditional contraceptive methods, especially withdrawal, that were assumed to be very ineffective.
- Modern contraceptive methods are not widely used because of the lack of access to the necessary commodities, physician and public misconceptions regarding the health risks associated with hormonal contraception, and poor-quality family planning services due to inadequately trained physicians.
- Heavy reliance on abortion as the main method of fertility control contributes to maternal mortality. Abortions were said to be directly responsible for 23 percent of maternal deaths.
- High infant mortality rates are related to the high rate of induced abortion. Frequent abortions were also thought to contribute to some portion of obstetric complications resulting in neonatal mortality.

The strategy developed to improve this situation was based on these conclusions and assumptions and the resources available to USAID through its CAs. Financial support for this project has come from a Congressional earmark to the NIS region (Congressional Earmark Number 4.1).

The scope of work for this evaluation called for a review of the WRHI's accomplishment of its overall goals and strategic objectives. The WRHI's goals and objectives are as follows:

**Overall Goals:**

- To improve the quality of reproductive health services, and
- To improve access to reproductive health services.

#### **Interim Goals:**

- To increase the use of modern contraceptives, and
- To reduce abortion rates in service sites.

#### **Strategic Objectives:**

- Establishment of demonstration sites for training and delivery of family planning services;
- Institutionalization of reproductive health training;
- Increased public information, education, and communication about family planning;
- Improved family planning policy environment;
- Increased supply and distribution of contraceptive methods; and
- Improved methods of child delivery and maternal care (this item was not included in the Scope of Work (SOW) list of strategy objectives but is a funded part of the WRHI project).

Regarding the project's goals and strategic objectives, this evaluation team concluded that the project has achieved most of its strategic objectives. However, it is not clear that there has been an impact on project goals, such as a decrease in number of abortions or an increase in the use of modern contraceptives. In part, this may be because the project has only been operational for three years and it is too early to find such impacts.

The evaluators also found that the assumptions that link strategic objectives with project goals may not be valid. For example, there may have been a fairly high level of contraceptive use when the project began. With this existing level of contraceptive use and the WRHI's emphasis on oral contraceptive use, the project may not have brought about cost savings. Furthermore, with very low fertility, virtually no use of sterilization, the lack of acceptance of unintended pregnancies, and ready availability of abortion, Ukraine will likely continue to have a relatively high abortion rate.

#### **Cooperating Agency Activities**

Seven Cooperating Agencies were assigned a specific role in achieving the project's strategic objectives. All CAs have performed their roles effectively; however, the large

number of CAs working in each oblast has created some confusion and extra work for staff of the in-country counterparts. Coordination among the CAs has focused primarily on logistics and scheduling. Significant conflicts between some CAs on strategic plans and other substantive matters were never resolved. USAID gave AVSC the responsibility for CA coordination; however, AVSC is also an implementing agency and does not have the authority or objectivity to resolve CA conflicts.

CAs reported that they have been given an unusual amount of autonomy in planning and implementing their activities in Ukraine. Some reported that USAID has not adequately provided project leadership, strategic planning, monitoring, and resolution of conflicts between CAs.

### **Family Planning Service Delivery**

Family planning services are provided mainly in clinics run by specialists, not by “regular” doctors or nurses. These services are not a routine part of primary, postpartum, or gynecology care. Family planning services are also being provided in separate family planning rooms (encouraged by WRHI) and are only provided at special times by special doctors.

Family planning counseling and services are now being provided in most of the government “Ladies Consultation Centers.” These centers offer many opportunities for expansion, integration, and improvement.

Ukraine does not have a seamless system for proactively providing family planning services throughout the health system. The emphasis in Ukraine is clearly on the use of hospitals and hospitalization as a means to centralize health care and to allow the specialist a way to focus care. Such a system seems to decrease the overall integration of preventive care.

Because the focus of this project has been on training the obstetrician-gynecologist specialists and providing services to women, there has not been an adequate focus on services for men. Men are generally “put down” in this process. Not only are men not informed or educated, but their important role in family planning is not recognized. Men are valuable partners in family planning and probably account for over 50 percent of contraceptive protection, given the wide use of withdrawal and the substantial use of condoms.

Clinical observation of sterilization services, Intrauterine device (IUD) services, and counseling services were all given high marks in the 1996 assessment. The current evaluation team encountered nothing that would provide any reason to change that assessment. Contraceptive commodities, particularly low-cost or free condoms, were not available in sufficient numbers. Infection prevention practices appeared to be satisfactory. The demonstration sites in urban areas have been established, but family planning services are not available to many rural residents.

## **Training**

Previous evaluations and feedback from this team’s interviews with trainers and officials suggest that the quality of training delivered by the CAs was high and was well received by participants. Important innovations in both content and training methodology have been institutionalized. However, some information presented in refresher training, especially regarding oral contraceptives (OC), is not consistent with international guidelines. No national family planning guidelines for reproductive health have been developed to guide training content.

Second generation training conducted by Ukrainian trainers is proceeding well and on schedule. At least 1,000 service providers have received family planning training through the WRHI.

Trainers in the three oblasts are now ready to train trainers in the “expansion” oblasts, perhaps with some support and supervision at the outset. These trainers are being asked by the CAs to conduct this expansion training.

Training materials have been translated and adapted for use in Ukraine for refresher courses and national family planning training. These materials have been judged to be effective by the trainers, but funds are not available to produce them for all trainees.

## **Information, Education, and Communication**

A great deal has been accomplished through the IEC efforts of obstetricians/gynecologists (OB/GYN) associated with the regional maternal child health (MCH) centers that have been the primary partners in this project. The IEC materials and training provided through the project have helped to stimulate and support these efforts. However, the project cannot take full credit for these activities; some had been initiated before the project began. Some OB/GYNs were working with schoolteachers and the media before this project began and continue to do so, often as volunteers and community members.

In addition, the project provided important support for the First National Family Planning Week. This was a national effort, as compared with the other aspects of the project’s IEC efforts. The regional MCH centers in Odessa, Donetsk, and Lviv are actively involved in IEC outreach to schools, radio, TV, and press. Although the involvement of local physicians in local IEC is extremely important, all of these relationships also need to be addressed at the national level.

Although the IEC inputs have had many good effects, the overall emphasis on IEC has been too small a part of the project, and the focus—on OB/GYNs based in tertiary training institutions in three oblasts—is too narrow. The project has not even initiated contact with some major participants in reproductive IEC in Ukraine. Most health care providers and officials interviewed agree that IEC should be a priority. Ukraine’s family planning effort would benefit from immense supplies of IEC materials.

The focus group methodology used in the WRHI is very useful but is not widely known in Ukraine.

### **Family Centered Maternity Care, Breastfeeding, and Rooming-In**

Family centered maternity care (FCMC) is low technology, which goes against the Ukrainian belief that the most technically sophisticated care is best. It is therefore difficult to introduce changes. Nevertheless, FCMC is popular with women, and doctors and midwives are beginning to see the advantages. The FCMC component of the project has had remarkable success with very limited funding. This project component helps to balance the project, which otherwise would focus almost exclusively on contraception, in a country with a very low birth rate. This project element also verifies USAID's interest in maternal and infant health.

**Every component of the family centered maternity care approach is supported by conclusive medical evidence of substantial health benefits. All components of the WRHI should reinforce the concept of basing health care on such evidence. Recommendations based on these conclusions can be found in the List of Recommendations.**

## **LIST OF RECOMMENDATIONS**

### **Project Goals and Strategic Objectives**

1. USAID should review the assumptions on which the WRHI strategy is based. In USAID's documents that assessed the reproductive health needs in Ukraine and established the WRHI strategy, the team found many statements and assumptions that may be unsound. Although after a two-week visit the team does not presume to know all of the answers, it is concerned that some of the assumptions may not be valid. If these assumptions are not valid, the WRHI's basic strategy may be unsound. The Policy Project's proposal may offer an opportunity to examine and verify these assumptions.
2. The WRHI should recognize and stress the male role in contraception, especially in use of withdrawal and condoms. IEC activities and materials should be developed to support the male role and responsibility in contraception.
3. The WRHI should not denigrate the importance of access to legal abortion as a method of family planning in Ukraine. The project should promote the concept of women having complete and accurate information, access to a variety of methods, and the right to make informed decisions regarding contraception and abortion.

### **Cooperating Agency Activities**

4. USAID/Kiev should develop and articulate a clear strategy for the WRHI and communicate it clearly to the CAs.
5. USAID should provide stronger leadership to the CAs, including coordinating and assigning tasks and activities, monitoring performance, and managing conflicts.
6. USAID should consider reducing the number of CAs that work with each demonstration site.

### **Family Planning Service Delivery**

- The WRHI should take steps to help integrate reproductive health services into the health system. This would include establishing a closer working relationship between those dealing with family planning and those working with reproductive tract infections, including the municipal health systems, and rural health programs.
7. The WRHI should provide low-cost or free condoms as part of its humanitarian assistance.

8. The WRHI should begin a program of social marketing of contraceptives.
9. The WRHI should train administrators of reproductive health systems in management skills, including the development of management-oriented reporting systems.
10. The WRHI should increase the focus on male and adolescent services and should include withdrawal as part of the contraceptive mix in IEC and training programs.

### **Training**

12. The WRHI CAs should transfer much of the training activities in “expansion” oblasts to experienced trainers from the first three demonstration sites.
13. National reproductive health guidelines should be developed with participation from all training sites and other Ukrainian experts. When adopted, national guidelines can be used as the standard for training content.
14. Funding should be provided to locally produce written training materials for all trainees who receive refresher training.
15. The training curricula for refresher training should be revised to include stronger modules on the male role in family planning and male-oriented contraception.
16. The CAs should study the feasibility of training midwives and family practice physicians in in-service and pre-service settings.

### **Information, Education, and Communication**

17. USAID/Kiev should continually assess the reproductive health situation in Ukraine. Reproductive health activities are complex and changing rapidly. USAID should determine an IEC strategy that takes other donors’ efforts into consideration and capitalizes on the strengths and experience of USAID CAs, perhaps including some not previously involved in this project.
18. The WRHI should follow up the National Family Planning Week activities to identify opportunities for effective IEC programs and consider making the National Family Planning Week an annual event.
19. The IEC effort should be national, not limited to local demonstration projects. A broader, national-level IEC strategy should be developed and should emphasize males, adolescents, and people in rural areas.
20. The WRHI should develop IEC materials aimed at boys and men. Care should be taken to not undermine use of withdrawal. It is less effective than some modern

- methods but is still relatively effective, and it is free, widely available, and culturally acceptable.
21. The WRHI should support IEC to educate the public regarding effective use of withdrawal, natural family planning (NFP), lactational amenorrhea method (LAM), condoms, and basic reproductive information to assist women in understanding their bodies. This would include information on the menstrual cycle and its relationship to fertility, and effective ways to use withdrawal, NFP, LAM, and condoms. Such IEC should be targeted to those groups who are least likely to use medical methods.
  22. The WRHI should concentrate on developing the capacity of its institutional partners to create and reproduce large volumes of written IEC materials.
  23. The WRHI should use findings from the Johns Hopkins University/Population Communication Services (JHU/PCS) focus groups to produce IEC materials that appeal to women. The WRHI should conduct focus groups with women who have had abortions to better understand barriers to effective contraceptive use.
  24. The project should consider teaching more effective training methods and counseling methods to village health workers and midwives.
  25. The project should provide IEC to support early identification of pregnancies, to encourage women to obtain emergency contraception, and to obtain abortions at the earliest possible stage in the pregnancy.
  26. A video or a slide/tape program should be developed to show family centered maternity care practices. The project should develop information on the value of prenatal care and IEC materials to support breastfeeding.

### **Family Centered Maternity Care, Breastfeeding, and Rooming-In**

27. Ukrainian physicians should be encouraged and supported to write and publish papers that provide evidence for each element of modern maternity care that deviates from standard Ukrainian practices.
28. This project should strive to institutionalize FCMC changes and integrate these practices into regular maternal care, rather than viewing them as something special requiring a special unit.
29. FCMC practices should be separated from midwifery care. Maternity care practices can be changed without transferring authority from obstetricians to midwives, although both groups need training.
30. A controlled study should be conducted to measure costs (use of personnel time and material resources) and maternal and newborn morbidity associated with FCMC. These findings should be compared with costs and morbidity associated

with standard maternity care for women with similar risk status at the onset of labor.

31. Information should be introduced about the biological basis for the advantages of early and on-demand breastfeeding, immediate skin-to-skin contact between newborn and mother, and rooming-in into the pre-service medical school curriculum, the pre-service midwifery curriculum, and OB/GYN internship training.
32. The MotherCare project should collaborate with WHO/Europe in the WHO Baby Friendly Hospital Initiative. WHO's criteria for a baby friendly hospital should be promoted (acknowledging WHO's role, rather than USAID's) and hospitals should be encouraged to seek WHO Baby Friendly Hospital status.
33. JHU/PCS should produce a video of normal births in the United States (probably not possible in Ukraine), a slide and tape program showing family centered maternity care practices.

# **1. INTRODUCTION**

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## **1.1 Evaluation Methodology**

USAID/Kiev contracted the Population Technical Assistance Project (POPTECH) to conduct this evaluation of the Women's Reproductive Health Initiative (WRHI). POPTECH, in turn, contracted a three-person team composed of a team leader and training specialist, a practicing obstetrician/gynecologist (OB/GYN) with extensive experience in international family planning, and a nurse-midwife/epidemiologist with extensive USAID and international reproductive health experience. The Scope of Work (SOW) for this evaluation focused on the following seven areas:

- Achievement of project goals and strategic objectives;
- Cooperating Agency (CA) activities;
- Family planning (FP) service delivery;
- Family planning training;
- Information, education, and communication (IEC) in support of family planning;
- Family planning commodities; and
- Family centered maternity care.

This evaluation took place between October 29 and November 21, 1997. The evaluation began in Washington, DC, where the evaluation team met with representatives from most of the CAs involved in the WRHI. While in Washington, the team reviewed extensive documentation supplied by the CAs and USAID. They then traveled to Ukraine for meetings with USAID/Kiev and Ukrainian Ministry of Health officials. While in Ukraine, the team visited the three oblasts in which the WRHI has been implemented and interviewed individuals at all levels of the health care system. The team then returned to Kiev to prepare the report and conduct additional interviews with CA representatives and Ministry of Health officials (see Appendix C: List of Contacts).

## **1.2 Origin of the USAID Reproductive Health Strategy for Ukraine**

USAID's reproductive health strategy for Ukraine, as well as for Moldova, Belarus, and Georgia, was based on a strategy that was originally developed for the Central Asian Republics (CAR). USAID's work in the CAR was initiated by a seminar held in Almaty, Kazakhstan, in January 1993. Reproductive health leaders from all of the Central Asian Republics were invited to participate in the seminar, which featured presentations on modern contraceptive methods, including natural family planning (NFP) and the lactational amenorrhea method (LAM). Other seminar themes included family centered maternity care, breastfeeding, and genital infections. Presentations providing the American perspective were made by staff and consultants from selected USAID Office of Population and Office of Health CAs including the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), AVSC International, the Georgetown University Institute for Reproductive Health (IRH), the Johns Hopkins University/Population Communication Services (JHU/PCS) MotherCare, and WellStart. The seminar served as the basis for the development of activities supported by USAID Office of Population CAs in the Central Asian Republics (CAR). Of particular note was a coordinated set of inputs provided by JHPIEGO and AVSC.

USAID followed the CAR model to initiate its reproductive health work in the western New Independent States (NIS). In June 1994, a six-person team including representatives of USAID, MotherCare, and WellStart conducted a preliminary assessment of reproductive health problems and services in Ukraine and Moldova (Collins et al). The assessment focused on maternal and infant health and services, breastfeeding, abortion, contraception, and training of physicians and midwives, and made recommendations for USAID support to Ukraine regarding maternal and infant health, breastfeeding, family planning, IEC, and training. An "exit survey" of 300 women who received care at 28 delivery houses in Kiev, Donetsk, and Lviv also provided information on mothers' opinions of maternity care in Ukraine.

The findings from this preliminary assessment were used to plan the Reproductive Health Seminar that was held in Kiev, October 24 to 28, 1994. This seminar was organized by WellStart International on behalf of USAID/Washington's Bureau for Europe and the New Independent States. NIS participants included approximately 130 high-ranking Ministry of Health (MOH) officials and senior reproductive health professionals from the five countries that form the western region of the NIS: Armenia, Belarus, Georgia, Moldova, and Ukraine. The purpose of this seminar was to provide a group of influential policy and professional leaders from each of those countries with information and descriptions of successful programmatic approaches to improving reproductive health. Approaches included health care provided to pregnant women and newborns, breastfeeding, modern contraceptive methods, safe abortions, and improved IEC. USAID staff and representatives of some CAs remained in Kiev after the seminar to plan the USAID strategy for assistance to improve reproductive health in Ukraine, Moldova, and Belarus.

The Ukraine Reproductive Health Project strategy was based on conclusions derived from information obtained during the June 1994 needs assessment, the exit survey, and the October 1994 seminar. These conclusions included the following:

- Very low fertility—less than replacement level—in Ukraine is due mainly to repeated induced abortions and use of traditional contraceptive methods, especially withdrawal, which were assumed to be very ineffective.
- Modern contraceptive methods are not widely used because of lack of access to the necessary commodities, physician and public misconceptions regarding the health risks associated with hormonal contraception, and poor-quality family planning services due to inadequate training of physicians.
- Heavy reliance on abortion as the main method of fertility control contributes to maternal mortality. Abortions were said to be directly responsible for 23 percent of maternal deaths.
- High infant mortality rates are related to the high rate of induced abortion. Frequent abortions were also thought to contribute to some portion of obstetric complications resulting in neonatal mortality.

The project strategy was based on this information and the resources available to USAID through its CAs. The Office of Population and its CAs took the lead in developing the strategy, which focused primarily on inputs intended to increase the safe and effective use of modern female methods of contraception, especially hormonal methods. A secondary element of the strategy was to improve care during childbirth and the postpartum period, and to support breastfeeding for its benefits to infant health and its contribution to contraception. The particular resources available through USAID’s working relationships with CAs also influenced the strategy.

Financial support for this project has come from a Congressional earmark to the NIS region (Congressional Earmark Number 4.1). The primary purpose of this earmark is to reduce the number of abortions by encouraging the use of modern contraception, although the focus has been expanded to include improving maternity care and preventing sexually transmitted diseases (STD). The earmark funds work in both Ukraine and Moldova. Funding for Ukraine totaled \$3 million in FY 1995, was increased to \$3.8 million in FY 1996, and increased to \$3.7 million for FY 1997. The money has come on a year-by-year basis, with no commitment for further funding. This funding method has discouraged the development of long-term planning. However, all of the funding is “two-year money”—money obligated for a particular fiscal year that can be used during a two-year period.

Reproductive health (or any aspect of health) is not a priority of USAID/Kiev outside of the mandate of the Congressional earmark. The Mission’s other focus on health is health care reform.

### **1.3 The Situation in Ukraine**

Ukraine's population is estimated at about 51 million. With a crude birth rate of about 10 per 1,000 population and a crude death rate of about 15 per 1,000, Ukraine's population is declining by nearly 0.6 percent per year, an annual reduction of about 300,000 people. The total fertility rate is about 1.4 births per woman (Clyde, Bickert and Kocher). Two-thirds of the population live in urban areas.

Concern about female infertility was not a major issue during the 1994 seminar but has since arisen as a frequently mentioned reason to improve reproductive health. There is concern that tubal problems related to STDs and Intrauterine devices (IUD) contribute to female infertility and that women who have many abortions may experience pathology during a later pregnancy that they try to carry to term. Also of concern is the incomplete return to fertility following prolonged use of hormonal contraception. There is growing concern among many government leaders that family planning programs will lead to further reduction in births, thus exacerbating the country's "demographic crisis" ("Policy Project Revised Proposed Workplan for Ukraine," November 1997).

In 1995, the Cabinet of Ministers adopted a National Family Planning Program for 1995 to 2000 that calls for widespread provision and promotion of modern contraception and reduction in the number of abortions. The four primary components of the program are (1) preventing unwanted pregnancies, (2) providing medical-genetic counseling, (3) treating infertility, and (4) educating the public. No funds have been made available to implement this program due to an extreme shortfall in the MOH budget (Clyde, Bickert and Kocher, 1996).

In Ukraine, the quality of health service facilities and care is highly variable. Hospitals and other facilities visited were extremely clean and some were well equipped. However, the team read first-hand accounts of recent visits to hospitals that were not clean. Dr. William Swartz, an American obstetrician-gynecologist who worked in Donetsk and Odessa for the MotherCare project, found that the young OB/GYNs he was working with relied primarily on obstetric textbooks that had been published in Russia during the 1960s and relied on advice from senior physicians in the institutions where they work (Glatleider, Swartz and Paluzzi). Soviet organization, procedures, and science still dominate health care in Ukraine. Health care personnel work under centrally generated regulations that give explicit directions on what must be done.

Maternal health care is focused primarily on diagnosing and treating pathology, which is thought to be highly prevalent among pregnant women in part because of the environmental consequences of Chernobyl's nuclear disaster. Dr. Swartz observed many instances of diagnosis and treatment of conditions that are not considered pathologic in the United States, including several cases in which unnecessary medical interventions led to maternal and newborn complications (Glatleider, Swartz and Paluzzi). Both maternal and infant mortality rates are high relative to other European countries with low fertility.

The public health orientation in Ukraine appears to be weak. Most health service administrators focus entirely on the patients who use their services and assume that, because services are available in the health care system, everyone who needs these services will come to the service delivery sites. However, there are new barriers to health

care in Ukraine. Patients are now expected to pay (“contribute”) for services that were free, and patients need to either purchase or bring drugs and other necessary supplies when they seek some services through the government health system. Thus, universal access to care—long the strong point of the Soviet health care system—may be faltering. For example, although medical authorities insist that virtually no home births occur, in 1997 (January to October) 2 of 57 maternal deaths in Donetsk were caused by hemorrhage following out-of-hospital births. Women who do not get prenatal care were also said to account for maternal deaths, although the team was told that virtually all women get prenatal care and only those with “social pathology” do not. Women with “social pathology” (who do not seek medical care) are an important group and are missed in information gathering efforts that include only people who use government services. For example, the Donetsk Regional Maternal Child Health (MCH) Center conducts surveys to assess general health problems, including health habits and life style issues among the population in the catchment area served by the hospital. These surveys are based on information from about 3,000 women, including (1) women who are admitted to the hospital for treatment of pathology and (2) women who come to the hospital for their annual examination. Surveys are based only on the patients who use the services, not on the entire population.

Low and declining fertility has resulted in a surplus of obstetricians and neonatologists. Most physicians in Ukraine are specialists, although the MOH is trying to develop family medicine as a specialty. There are three to five midwives per obstetrician in city clinics and hospitals, and the ratio increases the further one goes from the cities. Midwives actually catch most babies but are limited to prenatal care and assisting during labor in city facilities. In rural areas, however, midwives carry significant responsibility for maternity care.

In Ukraine, the training of doctors and midwives is completed in a shorter period of time than in the United States. Medical school takes 5 years after 10 years of basic education. Specialty training in obstetrics and gynecology has recently been reduced from 3 years to 18 months.

Doctors and midwives are supposed to participate in refresher training programs every five years. However, since there is less money available to pay for travel expenses and per diem, it is unclear to what extent this directive is followed. Some training of rural practitioners is being done, including training of rural midwives at the Regional MCH Center in Odessa. Following are the MOH’s three current priorities: (1) adolescents, (2) the rural population, and (3) the victims of the Chernobyl nuclear disaster.

## **2. ACHIEVEMENT OF PROJECT GOALS AND STRATEGIC OBJECTIVES**

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The scope of work for this evaluation called for a review of the WRHI's accomplishment of its overall goals and strategic objectives. The WRHI's goals and objectives are as follows:

### **Overall Goals:**

- To improve the quality of reproductive health services, and
- To improve access to reproductive health services.

### **Interim Goals:**

- To increase the use of modern contraceptives, and
- To reduce abortion rates in service sites.

Documents describing the WRHI differ slightly but agree on the main emphases regarding the project's goals and objectives. AVSC's October 1996 document, "Evaluation of AVSC Supported Activities in Ukraine," states that USAID's objectives are "to reduce reliance on abortion by shifting fertility control to the use of contraceptives." JHPIEGO's statement of objectives also stresses abortion reduction as the primary objective. An August 1995 report, "Developing Family Planning Training Capacity in Ukraine" states that JHPIEGO's objective is "to reduce women's reliance on repeated abortions and the subsequent consequences of repeated abortions, by developing a system to train service providers to deliver safe contraceptive services." "Assistance of Reproductive Health Care for Ukraine, Moldova, and Belarus," the December 1994 USAID planning document that initially outlined the project strategy states:

The primary outcomes expected in the short term are an increase in contraceptive use and concomitant reduction in abortion rates at the demonstration service sites and, later, in their surrounding oblasts. The strategy is also expected to have a long-term impact on national policies regarding reproductive health and thus on overall maternal and child health.

The strategic approach described in these initial papers included four strategic objectives, which were subsequently expanded to six:

- Establishment of demonstration sites for training and delivery of family planning services;
- Institutionalization of reproductive health training;
- Increased public information, education, and communication on family planning;

- Improved family planning policy environment;
- Increased supply and distribution of contraceptive methods; and
- Improved methods of child delivery and maternal care (this item was not included in the SOW list of strategy objectives but is a funded part of the WRHI project).

## **2.1 Accomplishment of Strategic Objectives**

WRHI's strategic objectives are the programmatic objectives that, when attained, are intended to achieve the project's overall and interim goals. This section addresses each of the strategic objectives and summarizes the accomplishments of each.

### **2.1.1 Establishment of Demonstration Sites**

Demonstration sites were successfully established at the regional MCH centers located in Donetsk, Odessa, and Lviv. Each of these sites is providing family planning training and services (see Chapter 6). Signed memorandums of agreement (MOA) between each site and JHPIEGO and AVSC describe the responsibilities of each site to provide family planning training and services.

### **2.1.2 Institutionalization of Reproductive Health Training**

In each demonstration site, reproductive health training has been incorporated into an existing program of refresher training, a one-month course required of all physicians every five years. A minimum of three days of family planning training based on a standardized curriculum is included in the one-month refresher training program. Each site is using the educational methodologies, equipment, and materials as planned. Written training materials on natural family planning and clinical family planning, written in Ukrainian for trainers, were developed jointly by the training sites and CAs for use in the refresher training. The training approach used in these courses has changed from primarily lecture to an approach that uses highly participative teaching methods, such as role playing, discussion, and skill practice on anatomical models. Written materials supplied by the project for trainees are in short supply and are given to all trainees.

The total number of providers trained as of November 1997 is difficult to determine because each CA does its own reporting and many providers received multiple training courses from different CAs. In addition, most trainees had already received some family planning training before being trained through the WRHI. Data is available, however, on the total number of attendees for all training conducted directly by CAs and by second generation training programs. As of June 1997, AVSC reports a total of 598 attendees: 431 in four-day reproductive health seminars held in each project site, 157 in one-week training courses on integrating counseling and clinical skills, and 5 OB/GYNs in one-

week training in laparoscopic sterilization. AVSC also conducted one-week minilaparotomy training in the three sites for 5 gynecologists. JHPIEGO has conducted three training skills courses, two course design workshops, and one infection prevention course for a total of about 60 attendees. PCS, IRH, and MotherCare have also presented workshops, both in Ukraine and for Ukrainian participants in the United States.

Since no reporting is done on the numbers of persons trained in second generation training, the number of persons who have received training influenced by WRHI's activities cannot be determined. The training officials in Donetsk reported that 644 people have received reproductive health training since the project began; officials in Lviv reported about 160 trained. Data from Odessa is not available, but large numbers have been trained there as well. In three years, over 1,000 people have attended courses in reproductive health in the three oblasts. However, because some individuals attended several courses it is not possible to estimate the actual number of service providers trained.

#### 2.1.3 Increased Public Information, Education, and Communication on Family Planning

The project has increased public information, education, and communication about family planning, mainly in the three oblasts involved in the WRHI. Four family planning IEC products were designed by Ukrainian gynecologists and produced for use in the Ukraine. These products were two videos, one for adolescents and one for women over the age of 17, and two pamphlets that provide information about all eight methods of contraception available in Ukraine, one for adolescents and one for women over the age of 17. Although relatively large numbers of each product were produced and distributed, most of these products have been distributed to sites associated with the three regional MCH centers that are the primary Ukrainian partners in this project. Unfortunately, the actual need far exceeds the supply. The WRHI project played a critical role in stimulating and supporting the first Ukrainian National Family Planning Week in May 1997, which had an important IEC impact.

#### 2.1.4 Policy Environment

The project has not yet made any significant improvements to the family planning policy environment. The Policy Analysis, Planning, and Action project's (POLICY) work was delayed at the request of USAID/Kiev. POLICY hopes to begin its work in Ukraine in December 1997 and to complete it by the end of 1999. Although this component of the project has not yet started, other components have contributed to improving the environment in which national family planning policies are made. For example, the success of the first Ukrainian National Family Planning Week had a positive impact on policymakers at various government levels.

POLICY conducted needs assessments in Ukraine in May 1996 and June 1997 and sent a proposed SOW to USAID/Kiev in November 1997, during the WRHI evaluation. The

first phase of the proposed SOW calls for gathering and analyzing data about abortion, contraception, and practices related to the prevention of sexually transmitted infections (STI), including HIV/AIDS, and using modeling methods to estimate the health and cost effects of making specific changes in these practices. Proposed questions and issues to be addressed include (1) the amount of contraceptive use required to avert pregnancies that are currently being terminated by induced abortion, (2) the impact of reduced use of abortion and/or improved treatment of abortion complications on maternal morbidity, (3) the impact of reproductive health services on the transmission of STIs and HIV/AIDS, and (4) the impact of reduced abortion, abortion complications, and STIs on the incidence of secondary infertility. The study would include secondary analysis of findings from the reproductive health survey conducted by the Centers for Disease Control and Prevention (CDC) in Russia, as well as relevant quantitative and qualitative studies conducted in Ukraine.

The second phase of the proposed SOW calls for using information generated during the first phase to determine the financial costs of relying on abortion as a major means of fertility regulation (costs of providing the abortion services or treating abortion complications, and costs resulting from lost productivity, etc.) and to estimate the costs of providing the contraception necessary to avert the pregnancies currently being terminated by abortion. Findings from these analyses would then be used to compare the cost-effectiveness of relying primarily on contraception as compared to abortions as the country's major means of preventing unwanted births.

#### 2.1.5 Increased Supply and Distribution of Contraceptive Methods

Commodities such as contraceptive pills, IUDs, and limited Depo Medoxy Progesterone Acetate (DMPA) has been brought to selected Ukrainian sites. These supplies have been distributed and continue to be distributed in these selected areas. DMPA is not available at any site other than the tertiary hospitals in Odessa and Donetsk. Condoms are not available from this program and were apparently not part of USAID's commitment. The progestin-only pill was not seen in any pharmacy. Lo Feminal pills were seen in some pharmacies in Odessa, Donetsk, and Lviv. The private sector pharmaceutical industry has started to make inroads and has raised questions regarding the "free" oral contraceptives (OC) and their quality. There is a rumor that these OCs are old and obsolete, and that the newer OCs are advantageous because they have newer and better hormones. Marketing surveys apparently show that the public believes Marvelon is a superior OC. Condoms are in short supply or unavailable in some areas, but there are abundant supplies in private pharmacies in Odessa. However, these condoms are too expensive for many adolescents and others who need to purchase them. The MOH does not provide any free condoms, even to indigent men who have AIDS.

In Odessa, there appears to have been a small increase in the use of both oral contraceptives and IUDs from 1992 through 1996. Most of the shift has been an increase in new OC use and a decrease in new IUD acceptors. Although this is occurring, the majority of clients using "modern" contraceptives choose the IUD.

### 2.1.6 Family Centered Maternity Care, Breastfeeding, and Rooming-In

A “family centered maternity care” unit (FCMC) has been established in each demonstration site. FCMC is low technology, which goes against the Ukrainian belief that the most technically sophisticated care is best. Nevertheless, FCMCs are very popular with women, and doctors and midwives are coming to see the advantages. This project component has had remarkable success with very limited funding.

A national MOH order issued in 1996 directs all delivery units to implement postpartum rooming-in. The MotherCare project was instrumental in the MOH decision to make this significant nationwide policy change.

## 2.2 Accomplishment of Overall and Interim Goals

The Ukraine Women’s Reproductive Health Initiative was developed in December 1994 and has been operational for three years. It is, therefore, too early to fully assess the project’s impact on improving quality and access to family planning services and reducing abortion rates. In addition, reliable data that would indicate changes in these goals are not available. It is possible, however, to report perceived changes in quality and accessibility of services and changes in individual service sites.

### 2.2.1 Impact on Maternal Mortality

There is sufficient data to precisely assess the WRHI’s impact on maternal mortality. This is, however, anecdotal and partial evidence from which inferences can be drawn. Maternal mortality is affected by many factors other than the WRHI’s efforts. Ukraine has changed rapidly and a reduced standard of living, nutritional problems, increased stress, and changing access to medical services have probably contributed to maternal mortality. The following findings indicate important trends:

- Deaths related to induced abortions have declined by 13 percent (information provided by Dr. Irkina).
- Maternal mortality has increased in Donetsk during this project. According to local health officials, there were 25 maternal deaths in 1995, 57 in 1996, and 57 during the first 10 months of 1997. These increases occurred despite an overall reduction in pregnancies—reduced births and fewer induced abortions. Thus, the ratio of maternal deaths to births has increased even more than these numbers indicate.
- Of 57 maternal deaths in Donetsk Oblast in 1996, only one was abortion related. This was an illegal abortion induced by an untrained person to terminate the pregnancy of a young, unmarried girl whose mother did not want anyone to know that her daughter was pregnant.

- Many maternal deaths are attributed to planned pregnancies of women with serious, chronic medical conditions (“extragenital pathology”). Family planning can make an important contribution by preventing unwanted pregnancies among women with such conditions. Long-term methods such as female sterilization and Depo-Provera play important roles in this regard.

The gestational age limit for legal abortions is 12 weeks. Pregnancies terminated beyond this time limit are more likely to be terminated by an untrained person. Advanced gestational age is associated with an increased incidence of morbidity and mortality even under ideal circumstances.

### 2.2.2 Impact on Neonatal and Maternal Morbidity

Leaders of the regional MCH centers in both Odessa and Donetsk reported reductions in newborn infections when rooming-in was instituted. These leaders are collecting data to document changes and plan to have a conference on this topic next year.

Leaders of the MCH center in Odessa also reported significant reductions in breast abscesses as a result of rooming-in. Approximately 25 cases required surgical treatment each year before rooming-in was instituted. None have required surgical treatment since rooming-in was instituted.

The gynecology service of the Odessa Regional Hospital has a unit for infectious patients. Most of these patients have postoperative infections, but some have pelvic inflammatory disease (PID). During 1997, 20 percent of the women hospitalized in this unit developed PID with an IUD in place. This 20 percent represents approximately 20 patients per year. The number of IUD users in the district is about 120,000. Dividing this number by the number of gynecology beds, about 40,000, means that less than 1 per 1,000 IUD users per year are being hospitalized for a pelvic infection. This is well within a normal expected range based on international data. (Since this is the tertiary hospital for the Odessa Oblast, we assume that most serious PID cases would be referred to this hospital.)

Several project components are intended to reduce morbidity caused by infections:

- Breastfeeding and rooming-in as major means to prevent infections in newborns,
- The “no-touch” IUD insertion technique to prevent infections from IUD insertions,
- Training to improve general hospital infection control practices, and
- Training to improve services and IEC related to preventing STIs and HIV/AIDS.

### 2.2.3 Impact on Number of Abortions, Abortion Rates, and Abortion Ratios

MOH data show a definite, steady decline in the number of reported abortions, from more than 1 million performed in 1991 to 663,000 in 1996. The ratio of abortions fell from 79 per 1,000 women of reproductive age in 1994 to 51 per 1,000 in 1996. Following are the team's observations on this issue:

- The data from the sites visited did not show any reduction in abortion rates in the three years of the project, 1994 to 1996.
- Health authorities believe that about 10 percent of abortions occur outside of government health care facilities; most occur in authorized private facilities. The health care authorities interviewed reported few “criminal abortions.”
- Officials in Odessa believe that the abortion rate has declined in rural areas, where the regional MCH center has influence, and that this decline has occurred in areas served by specific doctors with WRHI training. These officials also said that the overall abortion rate has not declined as much in the city, which is not influenced by the regional MCH center.

### 2.2.4 Impact on Cost

When officials in the regional health administrations were asked about cost savings associated with the WRHI, none could provide an answer. However, based on observations from this evaluation, the evaluation team would not expect to see savings. The withdrawal method costs nothing and international research (Hatcher et. al., 1994) shows that this method is nearly as effective as the condom. The cost of oral contraceptives, \$2 to \$5 per cycle, is at least \$30 to \$60 per year, with no exam or laboratory costs, and since many doctors insist on laboratory tests—one Donetsk doctor gives her pill patients blood clotting tests—the cost is probably higher. An abortion costs a women up to \$15, although some reports indicate an occasional higher cost. This, of course, does not include health system costs. If the WRHI promotes OCs and reduces the use of withdrawal and natural family planning methods, the costs to the ordinary Ukrainian will increase.

Abortions are very safe and very cheap in settings where there is an overabundance of doctors and hospitals. In “Life Risks Associated with Reversible Methods of Fertility Regulation,” Christopher Tietze, a Population Council expert on family planning and abortion, describes his economic model that shows that use of one of the barrier methods or withdrawal backed up by abortion is the safest method of contraception (Tietze and Lewit, 1979). As indicated in “The Economic Value of Contraception: A Comparison of 15 Methods,” James Trussel’s cost model shows that the OC is an expensive contraceptive method, but supports the use of the IUD as a cost-saving method (Trussel,

Leveque, Koenig, et. al., 1995). Because abortions are cheap in Ukraine, the argument that oral contraception is both cheaper and safer for women is not valid.

There are potential cost savings associated with more complete and prolonged breastfeeding, rooming-in, and other elements of the family centered maternity care, such as avoiding unnecessary shaving and enemas, and using surgical attire during births.

### 2.3 Conclusions

1. The project has achieved most of its strategic objectives: establishing three demonstration sites, institutionalizing refresher training in family planning for OB/GYNs, establishing new training approaches and providing some training materials, providing limited supplies of some methods of contraception, providing limited IEC materials, and demonstrating family centered maternity care.
2. It is not clear that there has been an impact on the number of abortions or on public health parameters.
3. Some of the assumptions on which the program was designed appear to be faulty. For example, there may have been a fairly high level of contraception when the project began. With this extant level of contraception and the WRHI's emphasis on OC use, the project may not have brought about cost savings. With very low fertility, virtually no use of sterilization, the lack of acceptance of unintended pregnancies, and ready availability of abortion, Ukraine will probably continue to have a relatively high abortion rate.

The following assumptions appear in the documents on which the project's strategy was designed:

**Assumption # 1.** There are too many abortions performed in Ukraine. Excessive use of abortion causes a great deal of morbidity and mortality. The basic cause of this problem is the lack of contraceptive use, which is principally due to inadequate or inaccurate contraceptive information among obstetricians and gynecologists.

High abortion rates would be expected in a country with the low fertility rate found in Ukraine. Internationally, the mortality rate associated with legal abortions is about .5 per 100,000. The team did not find evidence that legal abortions are a major cause of maternal mortality and morbidity or that abortions are a significant cause of infertility. First trimester abortions performed under medical conditions in this system seem to be safe. Complication rates are under or around 1 percent. In the hospitals visited, there are few hospitalizations due to complications from abortions. In the United States, abortions performed during the first 12 weeks (first trimester), as they are in Ukraine, are not a cause of infertility. The evidence in the Ukraine is unclear, but interviews indicate a distribution of infertility not unlike that of the United States and other parts of Europe,

with male infertility and female infertility at about the same level. Also, lack of access to legal, medically induced abortions is itself a major cause of maternal morbidity and mortality. Abortion motivates women to use contraception. Throughout the world, abortion services have been found to be a focus for initiating contraception.

**Assumption # 2.** Reduced abortions will result from the use of modern female contraceptive methods.

Per “Aggregate and Lifetime Contraceptive Failure in the United States,” models of unintended pregnancy rates in countries that use reversible contraceptives and have low sterilization levels show that women will have two to four unintended pregnancies in their lifetime (Trussel and Vaughn, 1989). This paradigm applies in the United States among women who do not use sterilization as a contraceptive method, and is even more applicable in countries with low fertility. In Ukraine, women do not tolerate unintended pregnancies; they choose to have abortions. Thus, Ukraine has few unwanted births, unlike the United States, where half of all births are unintended.

**Assumption # 3.** At current levels, abortions represent an excessively expensive way to reduce unwanted births in Ukraine.

Abortion is relatively inexpensive in Ukraine, and women are more able to afford occasional abortions than oral contraception. The findings from several USAID documents that abortion is an expensive procedure in Ukraine were not supported in the team’s discussions in the field. In most places, abortions were free to the client, and the total cost in Odessa was at most \$15. On the other hand, the most widely sold OCs in Odessa were about \$5 per cycle.

**Assumption #4.** In Ukraine, contraceptive use is very low. Contraceptives being used are often unreliable and ineffective. This is particularly true of withdrawal and condom use.

Withdrawal is often not mentioned as a family planning method in WRHI materials and courses and is not included in WRHI contraceptive training. It is, however, mentioned in the JHU/PCS brochures and is clearly a commonly used method in Ukraine. International evidence shows that withdrawal has the same level of effectiveness as barrier methods (including spermicides). Condoms are also used extensively in Ukraine.

Assuming that the Ukrainian people are similar in culture, education, and background to people in Russia, Poland, and other Eastern European countries that surround Ukraine, we would expect a contraceptive prevalence rate approaching 70 percent. The CDC studies showing these levels in nearby countries also show a distribution of contraceptive use not significantly different from that in Ukraine. That is, 20 to 30 percent use no method, less than 20 percent use traditional methods such as withdrawal and periodic abstinence, and 50 to 60 percent use modern methods: 30 percent IUD, 12 percent condom, and 5 to 10 percent OCs. This distribution is similar to the data from Odessa, Donetsk, and Lviv and is consistent with the contraceptive preferences found in the recent UNICEF survey in Ukraine (see details in the section on commodities).

**Assumption #5.** Better modern female contraceptives provided by OB/GYNs are the way to increase contraceptive prevalence.

Experience around the world, particularly in USAID's family planning programs, suggests that the best approach to promoting wide-spread contraceptive use is to move beyond the specialist OB/GYN to primary care providers and commercial distribution. The lessons learned regarding medical barriers to contraception are clear: specialists tend to medicalize family planning in counterproductive ways. OB/GYNs play a vital role in sterilization and IUDs, but the distribution of contraception should not be restricted to OB/GYNs.

## **2.4 Recommendations**

1. USAID should review the assumptions on which the WRHI is based. POLICY's proposed SOW should be revised to gather the data and conduct the analyses needed to test the assumptions that support the current WRHI strategy. This evaluation has recommended that these assumptions be examined and verified before additional resources are expended in further implementing the current strategy. POLICY's proposal may offer a convenient, already budgeted means to conduct that work.
2. The WRHI should recognize and stress the male role in contraception, especially in use of withdrawal and condoms. IEC activities and materials should be developed to support the male role and responsibility in contraception.
3. The WRHI should not denigrate the importance of access to legal abortion as a method of family planning in Ukraine. The project should promote the concept of women having complete and accurate information, access to a variety of methods, and the right to make informed decisions regarding contraception and abortion.



### **3. COOPERATING AGENCY ACTIVITIES**

Seven Cooperating Agencies have been involved in implementing the WRHI. Each CA was assigned a specific role by USAID, as follows:

- **AVSC International:** Establish demonstration sites providing a range of reproductive health services in three oblasts.
- **Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO):** Strengthen and institutionalize training through training of trainer (TOT) activities.
- **Johns Hopkins University/Population Communications Services (PCS):** Produce and distribute educational materials for the public and for health professionals.
- **Institute for Reproductive Health/Georgetown University:** Incorporate LAM, breastfeeding, and natural family planning at demonstration sites.
- **The Futures Group International (POLICY and Social Marketing for Change project (SOMARC)):** Develop policy through providing technical assistance for strategic planning and study the feasibility of social marketing of contraceptives.
- **John Snow Incorporated/MotherCare:** Introduce family centered maternity care at three sites.
- **Centers for Disease Control and Prevention (CDC):** Manage shipping and monitoring of commodities and conduct a contraceptive prevalence survey.

#### **3.1 Findings**

All CAs carried out activities in a timely manner according to the annual plans prepared by each CA under the coordination of USAID and AVSC, the designated coordinating agency. According to officials in each demonstration site, the activities have been effectively carried out. Training courses were fully attended and participant evaluations showed that trainees were highly satisfied with the quality of their training.

Some of the trainees and officials at the demonstration sites reported that the content of some of the training and technical assistance was superficial and rudimentary and did not take into account the level of training and experience of the Ukrainian trainers and service providers. As one trainer put it, “They thought we were third world people.”

The CA's activities were appropriate to accomplishing the project's strategic objectives. Each CA had a specific role in the strategy that had been designed to accomplish the project's goals. For example, AVSC conducted the original training of service providers and selected trainees who exhibited an interest in and the capability to become trainers. JHPIEGO then trained and certified this group as clinical trainers. Georgetown University/IRH trained these trainers to train service providers in NFP. AVSC also provided advanced training in counseling skills to the trainers.

USAID delegated overall coordination of the CAs to AVSC. Cooperation and coordination among the CAs was carried out informally by telephone, through biannual coordinating meetings in the United States, and through sharing of all trip reports and other documentation. All CAs reported that interagency cooperation and coordination was very good in terms of logistics and information sharing.

However, coordination was not effective in terms of strategic planning. Most of the CAs mentioned difficulties in developing coordinated workplans and strategies. One problem of programmatic coordination has existed throughout the project and has continued into the plans for expansion. USAID originally designated AVSC to conduct the first training program in each region. This training was a one-week reproductive health seminar that was to be a model for seminars that would be included in refresher training in each training site. JHPIEGO was designated to follow up these seminars with a clinical training skills course to enable selected participants in the AVSC course to become certified trainers of the basic reproductive health seminar. A conflict developed between AVSC and JHPIEGO because the AVSC seminar used different training materials and differed somewhat in content and methodology from the JHPIEGO model for a reproductive health seminar. AVSC and JHPIEGO were never able to agree on the proper model for the refresher training curriculum.

This disagreement about the curriculum for the basic reproductive health training persists into the plans for expanding of the project into new regions. Plans presented by AVSC and JHPIEGO show both CAs presenting their versions of the reproductive health seminar in each new region. AVSC's course will be presented to primary care providers; JHPIEGO's course will be presented to service providers in the perinatal centers. JHPIEGO will then present its clinical training skills course to prepare the perinatal center physicians to teach the JHPIEGO version of the reproductive health seminar in refresher training courses.

Another coordination problem was in the reporting of results and accomplishments. Although a committee had been established to create an evaluation and monitoring framework, the plan was never implemented. AVSC conducted an evaluation of its own activities, but the coordinated data collection was not done. As a result, each CA reports results and accomplishments for its own areas of responsibility. Because of the overlap in reporting, it is impossible to determine how many providers have been trained or how many received duplicate or multiple training.

The CAs feel that they have been given unusual autonomy to carry out their work, because the USAID Mission in Ukraine was low on staff and unable to provide strong coordination and leadership. Although CAs have appreciated this relative autonomy, they

also report that the project has suffered from the lack of USAID leadership in providing strategic direction. The CAs have often created their individual plans in coordination with each other but with little input or feedback from USAID. Another complaint was that documents needing USAID authorization are often slow in being approved; therefore, the CAs must begin their activities prior to receiving formal approval.

Coordination between the WRHI and the other USAID health initiatives, such as the American International Hospital Alliance (AIHA) and the Breast Cancer Initiative, appears to be very weak. In locations such as Odessa, where two USAID-sponsored projects are working in the same facility, there is little contact between the projects. In Lviv, also, the members of the AIHA project at the pediatric hospital have little knowledge of the WRHI or contact with its participants. This lack of coordination is unfortunate, because obvious opportunities to share resources and expertise have been lost. For example, some of the AIHA projects have access to computers that could be shared for record keeping, statistical analysis, and e-mail communications. The WRHI project has developed expertise in modern training skills, which could help to strengthen AIHA's work.

### **3.2 Conclusions**

1. Seven CAs were assigned specific roles in achieving the project's strategic objectives. All CAs performed their assigned role effectively.
2. The large number of CAs working in each oblast has created some confusion and work overload for the Ukrainian counterpart personnel.
3. Coordination among the CAs has focused primarily on logistics and scheduling. Significant conflicts between some CAs on substantive matters have not been resolved.
4. USAID delegated to AVSC the responsibility for CA coordination. AVSC is also an implementing agency and does not have the authority or objectivity to resolve conflicts among CAs.
5. CAs report that they have been given an unusual amount of autonomy in planning and implementing their activities in Ukraine. Some reported that USAID has not adequately performed its role in project leadership, strategic planning, monitoring, and resolution of conflicts between CAs.

### **3.3 Recommendations**

4. USAID/Kiev should develop and articulate a clear strategy for the WRHI and communicate it clearly to the CAs.

5. USAID should provide stronger leadership to the CAs, including coordinating and assigning tasks and activities, monitoring performance, and managing conflicts.
6. USAID should consider reducing the number of CAs that work in each demonstration site.

## **4. FAMILY PLANNING SERVICE DELIVERY**

The evaluation team looked at the overall picture of service delivery, but had little opportunity to directly observe how the services are delivered. Most of the questions in the SOW for this assessment that dealt with quality of clinical care were satisfactorily answered in the “Evaluation of AVSC Supported Activities in Ukraine” conducted in September and October 1996.

### **4.1 Findings**

Women’s reproductive health services are not now integrated with other services. In some areas, however, attempts are being made to create more integration, for example, in the Women’s Health Center in Odessa. Service providers trained under the WRHI, who recognize that the needs of the client should guide the planning of health services, have initiated changes to increase integration and prevention.

The team did not evaluate the quality of administrative activities but the few clients and numerous staff in the oblast family planning clinics probably indicate that the services are very inefficient. Few of the administrators interviewed seemed informed or concerned about cost-effectiveness.

A reporting system at each oblast collects a variety of service delivery statistics. At least three different types of information are provided on a monthly basis. These include perinatal and obstetrics data, abortion-related data, and family planning information. Monitoring of the districts within the oblasts is based on these regular reports, combined with visits from the central site to the districts. It is not clear, however, whether the data system is used effectively in making management decisions.

One service delivery issue is the lack of availability of some methods of contraception. The limited financial resources to purchase contraceptive commodities and materials is a problem mentioned by almost all evaluation respondents.

Client follow-up procedures are adequate in the family planning and reproductive health services.

Ukraine’s current family planning activity is organized around a centralized structure that existed prior to USAID involvement. After the WRHI began and following two years of discussion, the government adopted a policy to establish a family planning program coordinated by a family planning center in each oblast. These FP centers were located in tertiary-care hospitals to gain the support of the specialists at the tertiary centers before family planning training and services were initiated on a larger scale. The WRHI training has been carried out in these tertiary care centers in each of three oblasts. The training sites were often not placed at locations where family planning services are actually delivered, such as preventive health and primary care centers, but rather at the specialist centers where the emphasis is on treating pathology rather than prevention.

One purpose for setting up a family planning center in each oblast was to identify patients who were planning to have abortions and ensure that they had adequate counseling prior to the procedure. A significant number of staff has been assigned and a specific line item created in the central budget to ensure that this service is carried out. This counseling service was set up to increase the number of births. The theory is that if women have these births rather than aborting the pregnancy and then use family planning, the centers will prevent abortion, reduce morbidity, and generally forward the benefits of family planning.

There are many perspectives to the question of how well the family planning services have been integrated into the existing health system. This evaluation team could only answer some of these questions. We observed women's services primarily within the oblast. Following are some of the team's observations:

#### **Oblast Facilities:**

- **Women's Consultation Clinic (care provided by OB/GYNs):** Family planning seems to be thought of as a disease requiring special doctors, rooms, records, and clinic hours. It is not a part of standard care. On the other hand, this is the center of women's health care and has some potential for further expansion and integration.
- **Polyclinic Services (Outpatient Services):** Women's consultations are included in urban polyclinics and probably can be expanded.
- **Services to Women in Rural Areas:** Family planning services to women in rural areas are extremely limited. Midwives and Feldsher points are yet to be fully trained and integrated into the family planning system. There is a great opportunity to improve services to the rural areas.
- **Adolescent Services:** Improving services for adolescents is an MOH priority. A considerable number of activities are being directed at adolescents. This is true in the three oblasts visited, as well as in Kiev. The following are representative observations:
  - Volunteers from the "Women's Health and Family Planning" NGO headed by Dr. Galina Mystrook visit schools in Kiev to work with teachers, give lectures, and arrange for students to come to the special NGO youth center to view films and receive information and services.
  - The Ministry of Family and Youth maintains 360 centers throughout Ukraine, all focusing on youth and providing counseling and social services.

- STD and HIV education programs in Odessa focus on youth, providing education, condoms, and social service outreach programs.
- The MOH wants to provide contraceptives to adolescents but is limited in its supply of condoms and educational materials.
- The Regional MCH Centers in Donetsk, Odessa, and Lviv have special OB/GYN units and organized activities to support the focus of adolescent health care. These include summer programs, phone lines for answering specific questions, and family planning services.
- **Perinatal and Postpartum Services:** Sterilization services are being performed in Odessa on a limited basis, including postpartum minilap procedures. These services are limited in Ukraine and represent an opportunity for potential expansion. Family planning information is not provided on a routine basis in antenatal care.
- **Gynecological Services:** See Women's Consultation Clinics.
- **Reproductive Tract Infections:** Treatment of STDs is provided as a separate part of the health service and is not well integrated into ongoing care. Separate STD clinics in urban areas emphasize tracking, labeling, and following these clients in ways that probably discourage reporting and treating those who may have early infections.
- **Abortion and Postabortion Services:** See previous description.

### **Municipal Facilities:**

These services have not been fully integrated with other services. The municipal facility in Odessa serves approximately half of the women of the region. Delivery house #5 in Odessa appears to be a high-quality unit. The regional chief of gynecology has his office there, not at the regional center. The staff has served longer and the physicians are apparently of a higher "status" than those at the regional center. Odessa has a very high-quality (Roche) lab that can do the newer lab tests at reasonable prices. They have integrated rooming-in and family centered delivery. The facility is modern and would equal most in the United States. There appears to be a competitive atmosphere between the municipal and regional centers.

- **Services for Men:** Virtually no reproductive health services or education are directed toward men.
  - Private sector pharmaceutical companies are marketing contraceptives aggressively in Ukraine. They have introduced oral contraceptives and have created the idea that their product is superior to any "donated" product. Oral contraceptives are

available in nearly all of the urban and many of the rural pharmacies. Their products are reasonably priced at \$3 to \$5 per cycle, while the “humanitarian” OC is sold at about \$2 per cycle.

- **Nonmedical Family Planning Services:**
  - Condoms are available in many of the pharmacy outlets and cost from \$.10 to \$.30 each. Few varieties were available in the outlets the team checked; some pharmacies did not have any available. Free condoms were not available at any of the sites visited. According to available data, condoms are a popular method of contraception.
  - Natural Family Planning is a popular FP method, especially in the western part of the country. NFP training has been included in refresher training but has not been integrated into the nonmedical entities, such as the church and women’s groups. In other parts of the country, there is interest in more training in this method.
  - Withdrawal is a nonmedical method and has not been integrated into the contraceptive teaching nor is it part of the information taught to the trainers and the practitioners. It is included in the PCS multiple method brochure.
  - LAM training has been provided at all three sites. Breastfeeding is widely used in the country, and physicians estimate 50 to 60 percent use at three months.

## 4.2 Conclusions

1. Family planning services are provided mainly in clinics run by specialists, not in those run by “regular” doctors or nurses. It is not a routine part of primary, postpartum, or gynecological care.
2. Family planning services are being provided in separate family planning rooms (encouraged by WRHI) and only at special times by special doctors.
3. Family planning counseling and services are now being provided in most of the government “Ladies Consultation Centers,” providing a base for expansion, integration, and improvement.
4. Many providers throughout the health system have been trained in counseling and family planning service delivery.
5. A seamless system to proactively provide family planning services throughout the health system does not exist.

6. The emphasis in Ukraine is clearly on the use of hospitals and hospitalization as a means to centralize health care and to allow the specialist a way to focus the care. Such a system seems to decrease the overall integration of preventive care.
7. Because this project has focused on training the OB/GYN specialists, there has not been a focus on men. Men are generally “put down” in this process. Men are not only not informed or educated, but their important role in family planning is not recognized. Men are valuable partners in family planning and may account for over 50 percent of contraceptive protection, given the wide use of withdrawal and substantial use of condoms.
8. Clinical observations of sterilization services, IUD services, and counseling services were all given high marks in the 1996 assessment. This evaluation team did not receive information to the contrary.
9. Contraceptive commodities, particularly low-cost or free condoms, were not available in adequate supply.
10. Infection prevention practices appear to be satisfactory according to our observation and previous assessments.
11. The demonstration sites have been established in urban areas, but family planning services are not available to many rural residents.

### **4.3 Recommendations**

7. The WRHI should take steps to help integrate reproductive health services into the health system. This would include establishing a closer working relationship between those dealing with family planning and those working with reproductive tract infections, including the municipal health systems, and expanding to rural areas.
8. The WRHI should increase the availability of low-cost or free condoms as part of its humanitarian assistance.
9. The WRHI should begin a program of social marketing of contraceptives.
10. The WRHI should train administrators of reproductive health systems in management skills, including the development of management-oriented reporting systems.
11. The WRHI should increase the focus on male and adolescent services and should include withdrawal as part of the contraceptive mix in IEC and training programs.



## **5. TRAINING**

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The WRHI's training strategy has been to focus on developing the knowledge and skills of the refresher course trainers at the perinatal care centers in each of the three oblasts included in the project. In turn, these trainers pass on this knowledge and skills to OB/GYNs who rotate through the refresher training courses every five years. In addition, trainers have trained some OB/GYN residents and a few midwives. The training provided to the trainers has included all of the topics needed to teach a modern contraceptive course, including natural family planning, counseling, and infection prevention.

### **5.1 Findings**

Team leader Gary Bergthold observed second generation training (i.e., training conducted by certified trainers) during his November 1996 visits to Donetsk and Lviv. In his trip report to JHPIEGO, he reported that the quality of the training conducted by the JHPIEGO-certified trainers was high. In Donetsk, the trainers were making good use of the training technologies and methodologies they had received and participants were acquiring the knowledge and skills. In addition, the trainees in the second generation courses reported satisfaction with their learning and all commented favorably on the trainers' participative methodology. In Lviv, second generation training had just begun in November 1996 and the quality of the training was also high for those trainers who had attended the TOT courses.

In Lviv, trainers gave out some misinformation about IUD and oral contraceptives. Dr. Bergthold pointed out these errors during his 1996 visit and also asked the trainers during the November 1997 visit what information they were presenting on the length of time that IUDs and oral contraceptives could be continuously used. The trainers were still giving some information that is faulty according to international standards and research but explained that they were using their own clinical experience as a basis for training rather than using "outside information." In Odessa, team member Gary Stewart also questioned trainers about issues of OC and IUD use. In general, trainers were more knowledgeable about IUD use than about oral contraceptives. Their knowledge was uncertain about "rest periods" for pill users, quality of Lo Feminal oral contraceptives, and management of bleeding and spotting. Team member Judith Rooks also found that trainers in Donetsk were adding some "faulty" information during their training, including advice that women on OCs should be tested for blood clotting.

A recent evaluation by Dr. Cecilia Pyper reported on her observations of second generation training on natural family planning. The NFP training was conducted by the same trainers of the Lviv perinatal center as observed by Dr. Bergthold. Dr. Pyper also reported that the quality of training was high. The trainers were well organized, presented their material clearly and in a participative manner, and imparted a high-level of knowledge to participants.

AVSC representative Nina Schwalbe reported that as a result of AVSC's review of training in the three regions, AVSC will make the following changes in its training plan:

- Reduce the number of trainees in each seminar so all can practice skills adequately,
- Provide more monitoring and follow-up to trainees after the seminars,
- Provide more opportunities to practice counseling skills, and
- Use experienced trainers from previous sites as trainers in the new sites.

Of course, refresher training in family planning was conducted prior to the WRHI project. The question is what innovations or improvements in this training can be attributed to the project. In previous evaluations and this team's interviews with trainers and trainees in the three oblasts, the following innovations were mentioned most frequently:

- An increase in training time devoted to family planning from a few hours to three to five days,
- The addition of clinical skills training and practice to former lecture-only courses,
- Discovery of scientific evidence for the relative safety of hormonal contraceptives,
- Use of no-touch technique of IUD insertion,
- Development of counseling skills and the introduction of the concept of informed consent, and
- Use of adult teaching methodologies.

The participative training methodologies used in most of the WRHI have been particularly well received, and evidence suggests that modern training techniques and approaches are now being used in a variety of courses beyond reproductive health. The evaluation SOW asks whether the training has affected service delivery, decreased abortion, and increased contraceptive use. Without controlled studies it is not possible to answer this question with certainty, but clearly the training has increased the awareness of modern contraceptive alternatives and given service providers improved skills in family planning service delivery.

The question is whether training is being given to appropriate trainees. Training in the WRHI has been given primarily to OB/GYN specialists, some midwives, and a few family practitioners. It is probably appropriate that OB/GYNs receive most of the training since these specialists provide most family planning services. However, the reliance on perinatal center trainers to conduct family planning training is a problem; since the perinatal centers are tertiary-care facilities, the trainers are not usually providing family

planning services themselves but are conducting research and providing curative services. Ideally, trainers should be experienced service providers of family planning. The dilemma is that typically only trainers from the perinatal centers conduct the refresher training courses.

## **5.2 Conclusions**

1. Previous evaluations and this team’s interviews with trainers and officials suggest that the quality of training delivered by the CAs is high and is well received by participants. Innovations in content and training methodology have been institutionalized.
2. Some information presented in refresher training, especially information regarding OCs, is not consistent with international guidelines. No national family planning guidelines for reproductive health have been developed to guide training content.
3. Second generation training conducted by Ukrainian trainers is proceeding well and on schedule. We estimate that at least 1,000 service providers have received family planning training through the WRHI (see Section 2.1.2 of the report).
4. Trainers in the three oblasts are now ready to train trainers in the “expansion” oblasts, perhaps with some support and supervision at the outset. Trainers are being asked by the CAs to conduct this expansion training.
5. Training materials have been adapted for use in Ukraine for refresher courses and NFP training. These materials have been judged to be effective by the trainers, but funds are not available to produce them in sufficient numbers for all trainees.

### **5.3 Recommendations**

12. The WRHI CAs should transfer many of the training activities in “expansion” oblasts to experienced trainers from the first three demonstration sites.
13. National reproductive health guidelines should be developed with participation from all training sites and other Ukrainian experts. When adopted, national guidelines can be used as a standard for developing training content.
14. Funding should be provided to locally produce written training materials for all trainees who receive refresher training.
15. The training curricula for refresher training should be revised to include stronger modules on the male role in family planning and male-oriented contraception.
16. CAs should study the feasibility of training midwives and family practice physicians in in-service and pre-service settings.

## **6. INFORMATION, EDUCATION, AND COMMUNICATION**

In Ukraine, there was a great deal of interest and activity related to family planning and reproductive health IEC before this project began. For instance, USAID's December 1994 report, "Assistance for Reproductive Health Care for Ukraine, Moldova, and Belarus" described plans to design a public information, education, and communication program on family planning. These plans included developing pamphlets and radio and TV advertisements as part of a program to be supported by a loan from the World Bank.

### **6.1 Findings**

#### 6.1.1 Focus on Adolescents

Adolescent health is one of three MOH priorities, along with preventing HIV/AIDS and preserving the fertility of young women. These priorities have given particular impetus to IEC efforts to reach adolescents with information about contraception, STDs, and other topics relevant to preventing disease and promoting health. The Ministry of Family and Youth was established in 1992 with a specific mandate to focus on youth. The MOH, the Ministry of Family and Youth, and the Ministry of Education are trying to collaborate in these efforts. The Ministry of Education's role includes the training and support of valeologists, secondary school biology teachers and psychologists who are specially trained to function as health educators as an additional, part-time responsibility. The extent to which these individuals are being trained and used, their backgrounds, the training, and the curricula all need further investigation. These individuals could be allies in this reproductive health and adolescent health effort.

The regional MCH centers in Odessa, Donetsk, and Lviv are actively involved in IEC outreach to schools, radio, TV, and the press. The MCH center in Donetsk is particularly strong in outreach to adolescents and has a special adolescent gynecology program that reaches out to youth organizations, operates a youth "hot line," and provides special "child/youth gynecologist" services through the regional MCH center and at polyclinics throughout Donetsk. WRHI activities have supported these efforts but cannot take credit for initiating these activities, which antedated the beginning of this project.

#### 6.1.2 IEC Products Produced and Distributed by the WRHI

Four IEC products were developed, produced, and distributed in Ukraine as a result of this project. All of these products were developed with input from Ukrainian health and information specialists, with technical and financial assistance from JHU/PCS. JHU/PCS also produced and/or translated several products to support the WRHI's training and service delivery objectives. The IEC products are as follows:

- Two 20-minute videos: "Night Saxophone," which is intended for adolescents, and "Life Story," which is intended for young women ages 18 or older. "Night Saxophone" depicts a radio advice call-in program that is

dealing with a call from a young girl who wonders whether she should give in to pressure from her boyfriend to have sex. The people who call to comment on her situation include other girls who are facing the same situation, outraged parents who complain that such matters should not be discussed in public, and a doctor who provides information about contraceptives and tries to correct common misunderstandings about the risks of using contraception.

- “Life Story” is about a young woman who is engaged to be married. While visiting her sister, she goes to a pharmacy and to a doctor to receive accurate information on safe, effective contraceptive methods and realizes that family planning can preserve her own health and that of her future children and will help her achieve her goal of combining a successful career with a happy marriage.
- Two “all-methods” family planning brochures produced in both Russian and Ukrainian. One brochure is aimed at adolescents, one is aimed at women ages 17 or older.

Most people report that both JHU/PCS videos are popular among teenagers, are shown frequently, and are effective in changing the knowledge and attitudes of girls. Copies are available in some video rental outlets due to their popularity. However, not all of the feedback was positive; the head of UNICEF’s office in Kiev (which is also focusing on adolescents and has established a “forum” consisting of representatives from all major youth organizations) said that many young people think that “Night Saxophone” is silly and laugh about it. In 1996, two focus group assessments of “Night Saxophone” were conducted with small groups of young people and instructors of valeology in Lviv. Results from that assessment suggest that the video is an effective tool for generating productive discussion. Plans are being made to use parts of both PCS videos in a cycle of broadcasts on sex education for young people, and “Night Saxophone” will be shown weekly in Lviv, as a kick-off for youth discussions.

JHU/PCS reports anecdotal evidence of the effectiveness of the videos: personnel from some clinics have said that the number of women seeking family planning services increased after one of the videos was shown locally. Most of the people the team interviewed knew about the video, had opinions about it, and agreed that more such information materials would be useful.

In addition to providing many of these products, the WRHI gave its institutional partners camera-ready art on computer diskettes for the brochure and duplicate master tapes of both videos. These materials will allow them to make additional copies quickly and relatively inexpensively with no loss of quality. Some oblasts have already duplicated and distributed additional copies of the two videos. JHU/PCS staff report that they wish they had produced more of these materials.

The project’s eight-method IEC pamphlets were displayed at virtually all sites visited, including the women’s consultation service at Municipal Polyclinic #3 in Donetsk and at

the district hospital at Belgorod-Dnetrovsky in Odessa Oblast. (Most other sites observed were directly related to the MCH centers developed as demonstration sites.) However, it did not appear that any site had enough pamphlets to give copies to individuals, and it was not clear how the pamphlets were being used since they were only in the FP “room” and seemed to be only given out on special occasions. On one occasion, one of the doctors copied the FP pamphlet and took the black and white copies with her to a school where she was giving a talk. Some posters were displayed at most sites. Sites had posters produced by the project, as well as posters and pamphlets produced by other international donors and family planning commodity drug companies. These materials seemed lacking in focus and were generally few in number. The project’s IEC materials were not displayed in the pharmacies visited. Very few IEC family planning materials were seen in the postpartum, antepartum, or hospital areas where pregnant women receive care.

### 6.1.3 Training in the Planning and Implementation of an IEC Strategy

PCS conducted two workshops—one in 1995 and one in 1996—to introduce oblast doctors, psychologists, and MOH leaders to the concepts and methodology of health communication, ways to design an IEC strategy, and ways to use videos as tools for group discussion. More than 400 individuals attended the workshops, during which participants worked in small groups to develop local IEC strategies. The groups were expected to focus on using the materials provided by JHU/PCS. In the period following these workshops, PCS received requests for 600 additional copies of the videos, 80,000 additional copies of the brochures, and additional copies of Russian language versions of certain issues of *Population Reports* (on IUDs, voluntary female sterilization, and injectables) and JHU/PCS-produced cue cards for use during family planning counseling. Most of the IEC training was directed at OB/GYNs.

According to Laurie Liskin of JHU/PCS, “Doctors are bright and underemployed. Once they got the idea, they ran with it.” With a good education base, the gynecologists get a spark from the training, which empowers them to use their own creativity. This is very rewarding to the gynecologists and reinforces their initiative and satisfaction. For example, OB/GYNs at the regional MCH center in Odessa have developed a short series of lectures on adolescent sexology for valeologists. They also give lectures directly to students and interviews on radio and television. Additionally, these OB/GYNs have created video cassettes and have organized a public education series about family planning through local women’s organizations. They gave a lecture to students at a teacher-training institute and have given lectures to both teachers and students during summer youth camps held in Odessa.

As of May 1997, the JHU/PCS videos had been shown at least 30 times on four different TV channels, representing at least 10 hours of free TV time. They had also been shown to more than 500 groups in schools, clinics, discos, maternity homes, museums, and local cinemas (about 13,000 people). In addition, these videos were shown to large numbers of adolescents who participated in summer youth camps in Odessa.

#### 6.1.4 A Focus Group Study of Knowledge and Attitudes About Family Planning

One of JHU/PCS's first activities was to commission a focus group study to explore the knowledge and attitudes of adolescents, young women, and gynecologists regarding the expression of sexuality by adolescents, knowledge of the consequences of sexual intercourse, knowledge of specific methods of contraception, attitudes about abortion, and sources of information on contraception. The study was conducted in 1995. Following are some of the findings from that study:

- Advertisements produced by the companies that sell contraceptives are a major source of pamphlets and posters about contraceptive methods. Some of these advertisements give the impression that primarily “immoral people,” such as sexually active, unmarried women, practice contraception. Many women do not trust advertisements that only mention the positive factors about a contraceptive method and do not mention any drawbacks.
- Most women of all ages do not understand the fertility implications of the normal menstrual cycle and thus cannot take advantage of the calendar method of contraception either as a primary or secondary contraceptive method.
- Most adolescent girls have a negative attitude toward doctors. These girls are afraid that doctors will not protect their privacy if they ask about contraception or that doctors will be rude or insulting. Doctors are an important source of information immediately following abortion, but most women do not trust the physicians who are available to them locally. Although many women do not have a favorable opinion of doctors, they rely on doctors to tell them what contraceptive method is safe and best for them.
- Many women are interested in NFP (the sympto-thermal method).
- Many women consider withdrawal to be quite effective.
- Exhibits of printed information have some effectiveness.
- Women want contraceptive information to be aimed at men, as well as at women.
- Students and doctors consider schoolteachers to be incompetent in teaching about sex and contraception.
- Women would like to have a special women's magazine.

- Among older women, those who use contraception know much about it; those who do not use contraception know nothing about it. There is high correlation between knowledge and use. Nonusers could name methods of contraception but did not have accurate information on their effectiveness and risks.

#### 6.1.5 National Family Planning Week

The first Ukrainian National Family Planning Week was held during the last week of May 1997 as part of the MOH Family Planning Initiative. The WRHI played a very positive support role in making this initiative a success. There were many special events, including talks, conferences, open houses at local family planning centers, exhibits of family planning materials at libraries, and wide-spread distribution of informational materials, and even distribution of contraceptives. There was extensive news coverage of family planning events, loudspeaker announcements in crowded streets, well-publicized openings of new family planning service delivery sites, press conferences, and family planning theme parties for adolescents. Questionnaires about sexual and contraceptive experience were distributed at high schools, and meetings brought adolescents and family planning specialists together for discussions. Lectures on sex and family planning were presented at high schools and universities and information about family planning and STD prevention was combined with entertainment for youth and presented in popular public places. Many TV broadcasts focused on family planning and there were daily radio briefings, special radio programs, and many newspaper articles. After National Family Planning Week the number of women going to the Donetsk and Odessa Regional MCH Centers for family planning increased noticeably.

#### 6.1.6 Information, Education, and Communication as a Priority

OB/GYN leaders of the Odessa Regional MCH Center believe that informing the public is the area in which they need the most help and support. In their opinion, receiving additional IEC support would be more productive than receiving more pills. The head of the MCH in Donetsk identified providing contraceptives and media support for family planning IEC as most important, more important than training, which they “can solve by themselves.”

#### 6.1.7 Other Findings

JHU/PCS staff report that there is still a wide-spread belief among the public that hormonal contraceptives are injurious to women’s health and future fertility. The staff add that they need to learn more effective ways to convince women that these methods are safe. (This concern is consistent with a wide cultural interest and concern about endocrinologic and immunologic imbalances and pathologies). Few people know how modern contraceptive methods work. This lack of knowledge supports fears about the possibility of harmful effects on the body. There is also concern that use of contraception

reduces sexual satisfaction. Many people are more concerned about reducing their partner's satisfaction than their own, or failing to satisfy their partner and thus disappointing and perhaps losing their partner.

We were told that women receiving “counseling” prior to an abortion are told about every possible abortion complication and some abortion facilities show the “Silent Scream” video (the point of this video is to make the viewer identify with the fetus and view an abortion as murder). The focus group research showed that adolescents, older women, and gynecologists share a negative view of abortion but do not consider aspiration evacuations of the uterus during the early weeks of pregnancy as real abortions (one-third of all abortions are early vacuum abortions based on data from Odessa and Lviv).

“Future Mother’s School,” a series of prenatal education classes, is offered to all women who obtain prenatal care at the regional MCH centers in both Odessa and Donetsk. About 70 percent of the women who obtain prenatal care at those facilities attend the classes. One class focuses on information relevant to the postpartum period, including information on breastfeeding, LAM, and postpartum contraception. Husbands are invited to attend that class and some do. Women are instructed in family planning during the long period of postpartum hospitalization. In Odessa, one person has been designated as head of family planning counseling for postpartum women. She provides information about all methods but stresses breastfeeding and LAM. There does not appear to be any family planning IEC provided in conjunction with well baby care, although women bring their babies for their first immunizations at a time that is ideal for the initiation of postpartum contraception.

Many of the physicians and leaders of this program think that midwives should be prepared to play a larger role in family planning IEC. Although midwives are not authorized to prescribe pills or insert IUDs, the regional MCH centers in both Odessa and Donetsk are expanding their family planning training of midwives to prepare them for family planning IEC and counseling. The Odessa Regional MCH Center is conducting a three-day course for groups of 40 midwives; they had repeated the course three times when the team visited in November. Most of the course is directed toward preparing the midwives to educate women about family planning; two hours are devoted to STDs and HIV/AIDS. The head of the family planning training program in Donetsk plans to organize a course for tutors from the local midwifery schools. Dr. Irkina also supports a larger role for midwives; she pointed out that midwives can provide condoms and could provide oral contraceptives to women who have initiated oral contraception based on a prescription provided by a physician.

SOMARC identified an organization (WINROCK) that represents 70 Ukrainian women’s organizations. The WRHI project has not made any efforts to involve women’s organizations in family planning IEC, although some of the OB/GYNs trained in IEC methods have reached out to women’s organizations.

The WRHI project does not appear to have made any effort to work with the Ministry of Family and Youth, a new ministry that did not exist when the WRHI began. None of the IEC efforts have focused on men or boys.

The director of the UNICEF program identified focus group methodology as a contribution that Americans (as opposed to people from any other nation) are particularly well prepared to make to family planning in Ukraine. An American working through PATH is teaching this method to teen volunteers involved in the UNICEF initiative that focuses on improving the health of adolescents. UNFPA and UNICEF have planned a major initiative with a significant IEC component to be carried out in conjunction with the Family Planning Association of Ukraine. The UNICEF director expressed a desire to work with USAID to develop coordinated strategies, research, IEC materials production, and program activities.

The head of the Family Planning Association (FPA) is a sexologist, one who practices a small specialty of medicine that focuses on the study of sexual behavior. This person also leads the Ukrainian sexology society and is the coordinator of the new UNFPA initiative. Physicians can obtain additional training in sexology after completing training in either gynecology, psychiatry, or andrology (urology). The FPA brings together and uses the skills and interests of a wide variety of professionals, including sexologists and psychologists.

## **6.2 Conclusions**

1. A great deal has been accomplished through the IEC efforts of OB/GYNs associated with the regional MCH centers, the primary partners in this project. The IEC materials and training provided through the WRHI project have helped to stimulate and support these efforts, although the project cannot take full credit for these activities, some of which had been initiated before the project started. Some OB/GYNs were working with schoolteachers and the media before this project began and continue to do so, often as volunteers and community members.
2. The project provided important support for the First National Family Planning Week. This was a national effort, unlike the project's other IEC efforts. The regional MCH centers in Odessa, Donetsk, and Lviv are actively involved in IEC outreach to schools, radio, TV, and press. Although the involvement of local physicians in local IEC is extremely important, these relationships also need to be addressed at the national level.
3. Although the IEC inputs have had many good effects, the overall emphasis on IEC has been too small a part of the project, and the focus—on OB/GYNs based in tertiary training institutions in three oblasts—is too narrow. The project has not even initiated contact with some major participants in reproductive health IEC in Ukraine.
4. There is widespread agreement that IEC should be a priority.

5. The country's family planning effort would benefit from immense supplies of IEC materials.
6. The focus group methodology is very useful but is not widely known in Ukraine.

### **6.3 Recommendations**

17. USAID/Kiev should continually assess the reproductive health situation in Ukraine. Reproductive health activities are complex and changing rapidly. USAID should determine an IEC strategy that takes the other donors' efforts into consideration and capitalizes on the strengths and experience of USAID CAs, perhaps including some not previously involved in this project. This assessment should also consider the priorities of the Government of Ukraine. Findings from the JHU/PCS focus group study should be published to share information with the wider community involved in family planning and reproductive health IEC. Other focus group research efforts should be coordinated, such as those of UNICEF, UNFPA, and SOMARC.
18. The WRHI should follow up the National Family Planning Week activities to identify opportunities for effective IEC programs and consider making National Family Planning Week an annual event.
19. The IEC effort should be national, not limited to local demonstration projects. A broader, national-level IEC strategy should be developed and should emphasize males, adolescents, and people in rural areas. The regional MCH centers, the primary partners in the WRHI, are well placed to increase their influence in rural areas.
20. The WRHI should consider developing IEC materials aimed at boys and men. A male focus integrated into the message seems important. Care should be taken not to undermine the use of withdrawal. It is less effective than some modern methods but is still relatively effective, and it is free, available, and culturally acceptable.
21. The WRHI should support IEC to educate the public regarding effective use of withdrawal, NFP, LAM, condoms, and basic reproductive health information to assist women in understanding their bodies. This would include information on the menstrual cycle and its relationship to fertility, and effective ways to use withdrawal, NFP, LAM, and condoms. Such IEC should be targeted to those groups who are least likely to use medical methods.
22. The WRHI should concentrate on developing the capacity of its institutional partners to create and reproduce large volumes of written IEC materials. Current project inputs are not sustainable.

23. The WRHI should use findings from the JHU/PCS focus groups to conduct additional studies, and work with women's organizations and women journalists to better understand the nature of women's concerns about hormonal contraception and to produce IEC materials that appeal to women. The WRHI should conduct focus groups with women who have had abortions to better understand barriers to effective contraceptive use. Focus groups should be used to test materials and other approaches before widespread production. The WRHI should not be one-sided; the program should discuss the contraindications and risks, as well as the benefits, but make the discussion true and proportional to actual risks. IEC (and training) should provide clear, easy to understand explanations of how each contraceptive method works. The project should support IEC to inform the public—not just doctors—that pills are safe for most women. Furthermore, the project should develop a cadre of reporters who have a special interest in women's health issues and educate these individuals.
24. The project should consider teaching more effective training methods and counseling methods to village health workers and midwives.
25. The project should provide IEC to support very early identification of pregnancies, to encourage women to obtain emergency contraception, and to obtain abortions at the earliest possible stage in the pregnancy.
26. A video or a slide/tape program should be developed to show family centered maternity care practices. The project should develop information on the value of prenatal care and IEC materials to support breastfeeding.



## **7. FAMILY CENTERED MATERNITY CARE, BREASTFEEDING, AND ROOMING-IN**

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### **7.1 Family Centered Maternity Care**

FCCM is being introduced as a way to improve the quality and outcome of care provided to pregnant women in two of the three demonstration sites, especially the care during labor, delivery, and routine postpartum hospitalization. FCCM is an attitude and approach to maternity care rather than a precise protocol: birth is supported as a meaningful life event, as opposed to a medical procedure, and the woman is respected and supported as the most important participant in that event. Physicians and midwives monitor the process; provide information, support, and assistance to the woman; and intervene when there are complications. However, they should not exert unnecessary control over either the woman or the process. Implementing this approach requires some substantial changes in the standards of maternity care in Ukraine. These changes include:

- Providing more information and allowing women to make some decisions regarding their care;
- Encouraging women to invite their husband or another significant person to be with them during labor and delivery;
- Avoiding shaving women's pubic hair or administering enemas routinely;
- Protecting the privacy of women whose bodies are exposed;
- Minimizing use of analgesic drugs but providing intensive support and nonpharmacologic comfort measures to women in labor;
- Allowing and helping women to sit, stand, and walk during labor, and to change positions frequently and assume a position of their choice for giving birth;
- Performing episiotomies only as needed (thus infrequently);
- Placing the baby on its mother's abdomen after its birth and providing time for the parents to be with their newborn in relative privacy;
- Keeping the infant in the same room with its mother during its postnatal hospitalization;
- Assisting the mother to breastfeed shortly after giving birth; and
- Providing skilled and knowledgeable assistance to overcome breastfeeding problems.

These innovations are designed to support the natural physiologic processes of labor, birth, and breastfeeding and to enhance the emotional and social aspects of the childbirth experience for the woman and her companion, usually her husband. As per *A Guide to Effective Care in Pregnancy and Childbirth, 2nd Ed.*, each of these changes is supported by research showing that the practice is not only safe but beneficial as compared with the practice it replaces (Enkin, Keirse, Renfrew and Neilson, 1995).

These innovations tend to demedicalize birth and de-emphasize pathology, medical technology, and the role of the physician—all tendencies that go against the Ukrainian belief that many if not most pregnancies are complicated by pathology and that technically sophisticated care is inherently superior. The needs assessments that preceded the 1994 USAID Reproductive Health Seminar in Kiev described childbirth practices in Ukraine as similar to those in the United States during the 1960s and 1970s. The changes involved in FCMC were introduced into American obstetrics primarily because of the demands of consumers, and initially most physicians resisted changes. These changes have come slowly and are not complete in the United States. Of all of the new ideas introduced during the 1994 seminar, the information about FCMC met with the greatest degree of skepticism. Yet in just three years and with expenditures of less than \$100,000, the MotherCare project has had remarkable success in the two demonstration sites (Odessa and Donetsk) in which FCMC has been implemented. The strategy of sending multidisciplinary teams from Donetsk and Odessa to observe care in U.S. birth centers was an essential component of the success the project has achieved. This success is not complete, but it is significant. Telling obstetricians about this approach to childbirth was not enough; seeing it in action in the United States made a powerful impression. In addition, the American College of Nurse-Midwives (ACNM) midwives and MotherCare obstetricians who have conducted the training in Ukraine have been extremely effective.

Both demonstration sites have established separate rooms in which a woman can go through labor and delivery with her husband in attendance. The concept has been implemented most fully in Odessa, where the obstetricians and midwives personally painted and renovated the room. The FCMC unit in Odessa opened in March 1997; there have been 40 births. Only 10 percent of women who deliver at that hospital are deemed to be of low enough risk to qualify for FCMC, and not all who qualify choose it. But those who have used it have liked it. Doctors associated with the FCMC discussed the program on at least one radio show; the public response was positive, and FCMC is becoming well known and popular. Although the hospital cannot charge for its services, women who want to use the FCMC unit are asked to make a contribution. Doctors reason that it is “special” care—nicer than what most women get—so the patient should be willing to pay. Doctors have dropped routine shaving and enemas, even without specific approval for this deviation from standard, centrally authorized procedure. These issues fall under the authority of the oblast epidemiologist, who participated in the U.S. training tour and became convinced of the safety of this approach. Furthermore, there is a strict MOH order to put ice on the woman’s abdomen immediately after the birth to stimulate the uterus to contract and thus prevent postpartum hemorrhage. Conversely, FCMC calls for the baby to be put on the woman’s abdomen instead. The baby’s presence, and the effect of its suckling on the mother’s nipples, are an even greater stimulus for uterine contraction.

Since no one wants to put ice next to a newborn, the doctors write in the record that they have applied the ice, but they apply the baby instead.

Although still relatively new, the FCMC concept is spreading. All physicians in obstetrics and gynecology “internships”<sup>\*</sup> at the Odessa Regional Hospital receive lectures on FCMC and have experience with it while they are on duty in the labor and delivery unit. The obstetrician who gives the lecture refers to FCMC as “rational delivery,” focusing on the scientific evidence that supports each element of this approach. He says that the young doctors laugh at these ideas at first, but they become more interested when they are shown American video tapes of this kind of birth, and begin to believe in it when they have experience with an actual patient in the FCMC unit. The Odessa demonstration site also conducts refresher training for midwives and has incorporated both didactic and clinical training in FCMC into the midwives’ course. Midwives enrolled in the refresher course take turns being on call during the evening and night shifts; if there is a birth in the FCMC unit, the on-call midwife trainee is always pulled in to provide some of the care or, at a minimum, to observe. Some obstetricians from other delivery houses in Odessa have also visited the FCMC unit. Obstetricians from an adjacent oblast have also visited and are in the process of developing a FCMC unit. In addition, consumer support for these changes may have an impact. Some women from the city of Odessa are coming to use the FCMC units at the Odessa Regional Hospital, even though they are supposed to obtain their care from the delivery houses operated by the municipal health care system.

There are two FCMC rooms at the Regional Hospital in Donetsk, both unnecessarily large and lacking in any kind of comfortable chair. The considerable extra space is used to accommodate a standard operating room delivery table, complete with stirrups. This table is considered necessary in case of an unanticipated complication. Stirrups also seem to be attachable to the normal delivery bed. The obstetrician in charge, who attended the training tour in California and is a proponent of FCMC in general, prefers to use stirrups because she has a method to avoid perineal tears that requires good access to the perineum during a delivery. She explained that she pushes and pulls some of the tissue from the anterior part of the vaginal opening toward the posterior part of the vaginal opening. This, she believes, provides additional tissue where it is needed at the time of maximum pressure.<sup>\*\*</sup> The pregnant woman’s husband must have an X-ray to rule out lung infection before he will be allowed to stay with his wife during labor. After a long period of resistance, the epidemiologist for Donetsk has studied the data that support the safety of not shaving or giving enemas to all women before delivery and has given permission for these practices to be omitted for women who use the FCMC unit. Five hospitals in the Donetsk Oblast are trying to implement FCMC. It is easier to do in new hospitals, where the space can be rearranged.

Obstacles to introducing FCMC include the physical limitations of the labor and delivery units of most Ukrainian hospitals and what doctors refer to as “psychological barriers.”

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\* They use the term “internship” in the same way that we refer to a medical-specialty “residency.”

\*\* This is an example of the kind of theories and treatments that are in use in Ukraine and need to be tested. See discussion under recommendations for a new strategy for this project. It should be noted, however, that studies conducted in the United States find an increased rate of perineal tears associated with use of stirrups.

For example, an obstetrician in Odessa explained that the chief of obstetrics in Lviv thinks that a man seeing his wife deliver will become impotent. Although the FCMC units in Donetsk and Odessa are successful, there is resistance to institutionalizing these changes, or making them part of regular maternity care, instead of using them as something special, unusual, and rare. Many doctors feel that this is just a fad and hope that it will go away.

## **7.2 Breastfeeding**

Breastfeeding is traditional in Ukrainian society, but mother/newborn rooming-in was not. Nevertheless, there are problems: women want more information about breastfeeding; many fear that they do not or will not produce enough milk or think that they may produce poor-quality milk.

## **7.3 Rooming-In**

In 1996, the MOH issued an order (order #4) that rooming-in be implemented throughout the country. Rooming-in is the standard practice in every hospital visited. The chief midwife for the delivery house associated with the Odessa Regional Hospital said that this order would not have been issued without the MotherCare project. However, some WellStart breastfeeding and rooming-in training preceded the start-up of the WRHI. Both organizations have received USAID support for work in the NIS. The World Health Organization and UNICEF are also active supporters of both breastfeeding and rooming-in. The influence of all of these international organizations has been mutually reinforcing, and most importantly, it has been effective. The change in policy has resulted in nearly universal rooming-in, with many health benefits for both mothers and babies. Furthermore, there is a much greater sense of happiness on the postpartum wards now than in the pre-rooming-in era.

Ukrainian physicians tend to talk about this care being more expensive because they have devoted unnecessarily large rooms as FCMC units. But, it requires less use of many materials (for perineal shaving, enemas, surgical attire for births, etc., and reduced infections). MotherCare's SOW for September 1997 through September 1998 includes plans for a study to determine the costs and potential cost savings of integrating the FCMC approach into the general maternal and newborn services.

## **7.4 Conclusions**

1. FCMC is low technology, which goes against the Ukrainian medical belief that the most technically sophisticated care is best. It is therefore difficult to make changes. Nevertheless, FCMC is popular with women, and doctors and midwives are coming to see the advantages. This project component has had remarkable success with very limited funding.

2. The FCMC component helps to balance the project, which would otherwise focus almost exclusively on contraception, in a country with a very low birth rate. This element of the project also verifies USAID's interest in maternal and infant health.
3. Every component of the family centered maternity care approach is supported by conclusive medical evidence of substantial health benefits. All components of the WRHI should reinforce the concept of basing health care on evidence.

## **7.5 Recommendations**

27. Ukrainian physicians should be encouraged and supported to write and publish papers that provide evidence for each element of modern maternity care that deviates from standard Ukrainian practices.
28. The project should strive to institutionalize FCMC changes and integrate these practices into regular maternal care, rather than viewing them as something special requiring a special unit.
29. FCMC practices should be separated from midwifery care. Maternity care practices can be changed without transferring authority from obstetricians to midwives, although both groups need training.
30. A controlled study should be conducted to measure costs (use of personnel time and material resources) and maternal and newborn morbidity associated with FCMC. These findings should be compared with costs and morbidity associated with standard maternity care for women with similar risk status at the onset of labor.
31. Information should be introduced about the biological basis for the advantages of early and on-demand breastfeeding, immediate skin-to-skin contact between newborn and mother, and rooming-in into the pre-service medical school curriculum, the pre-service midwifery curriculum, and OB/GYN internship training.
32. The MotherCare project should collaborate with WHO/Europe in the WHO Baby Friendly Hospital Initiative. WHO's criteria for a baby friendly hospital should be promoted (acknowledging WHO's role, rather than USAID's) and hospitals should be encouraged to seek WHO Baby Friendly Hospital status.
33. JHU/PCS should produce a video of normal births in the United States (probably not possible in Ukraine), a slide and tape program showing family centered maternity care practices.

## **APPENDICES**

# APPENDIX A

## Scope of Work

### Purpose

The purpose of this evaluation, conducted by Population Technical Assistance Project (POPTECH), is to review the of the Women's Reproductive Health Initiative (WRHI) in Ukraine with regard to overlap, sustainability, accomplishments, strength and weaknesses; to assess the impact of activities on present policy, individual/organizational change and cost effectiveness; to assess program effectiveness in responding to current needs in family planning and reproductive health; and to use the findings from this evaluation to recommend direction and focus for planning of future activities based on low, medium and high funding options.

### Objectives

The Scope of Work for the evaluation will address the following issues/questions:

- I. Overall Goals
  1. To what extent has the program accomplished the overall goals of the Ukraine Reproductive Health Initiative? How can the program be improved to reach to overall goals?
  
- II. Strategy Objectives
  1. To what extent has the program accomplished the objectives of the strategy?
  
  2. To what extent could the strategy be improved?

Listed below are some specific questions that will be helpful in addressing the goals and objectives:

#### A. Cooperative Agency Activities

1. How appropriate are the activities for accomplishing program strategies? Could other activities be more effective?
  
2. How effectively have these activities been carried out?
  
3. Is there overlap or duplication of efforts in the activities?
  
4. How effective is the overall coordination among the CAs, USAID, and other donors? Suggestions to strengthen program coordination?

5. How effective is the coordination of the WRHI and other health initiatives within USAID i.e. AIHA, and Breast Cancer Initiative?

B. Have family planning services been integrated successfully in the services of family planning sites?

#### Service Delivery

1. Are all areas of service delivery being adequately supported? How can service delivery be improved?
2. What is the quality of the service delivery? Clinical, including female sterilization? counseling, organizational. What areas of improvement are needed?
3. To what extent are the family planning services (clinical and counseling) integrated into pre-natal, postpartum and post-abortion care? Can these services be more integrated? How?
4. What is the quality of counseling offered? Can it be improved? How?
5. What is the quality of IUD insertion? Can it be improved?
6. What are the procedures to monitor quality care? Are they effective?
7. Are there adequate procedures for client follow-up? What are they? Can WRHI assist in developing them further.

#### Training

1. Is training adequate? Is there 2nd generation training? Is quality high? Can it be improved?
2. Is data available on how has the training impacted service delivery, decreased abortion, increased contraceptive use?
3. Is the training provided to appropriate trainees? How do the trainees feel about the effectiveness of the training?

## IEC

1. Have the IEC materials developed for the WRHI been effective? How can they be improved?
2. Do all sites have materials? What sites need additional material? How can distribution be improved?
3. What effect has WRHI had on public awareness of the safety and effectiveness of contraceptives?

## Commodities

1. Are the mix of commodities appropriate? Are supplies adequate?
2. Is there data on what areas have experienced increased contraceptive use? If so, what has influenced this increase? What are the areas of increase? Adolescents? Women postpartum? Men? What contraceptive methods have shown an increase?

## C. National Impact

1. What impact has the WRHI had nationally in Ukraine?
2. What has the impact been in local blasts?
3. Has there been an impact on service delivery?
4. What effect have Ukrainian medical/service delivery policies had on WRHI delivery services? Ministry of Health? Policy issues/barriers?

## D. Cost Savings

1. Do the demonstration sites report cost savings?

## E. Reduced Infection

1. Has there been a reduction in infection rates related to WRHI interventions, i.e. changes in procedures following JHPIEGO's infection control training course? If so has there been cost savings?

## Methodology

A three person team composed of POPTECH consultants will visit the Kiev site Nov 3-5 for USAID briefings and meetings with contacts. The team will split up Nov 6-13 to cover the other three sites and return to Kiev for debriefing and preliminary draft preparation, Nov 14-21.

**Gary Bergthold, Team Leader;** evaluation specialist with expertise in population and family planning - Lviv

**Gary Stewart,** physician/obstetrician -Odessa

**Judith Rooks,** evaluation specialist in reproductive health training - Donetsk

The team will visit demonstration sites to gather information and available data on the reproductive health environment in Ukraine. The team will visit facilities and meet with staff and other reproductive health experts to get their thoughts and ideas on the status of the reproductive health services in Ukraine, the effectiveness of WRHI interventions and how they feel we can better meet their needs. The focus will include technical, clinical, IEC and social marketing issues.

The team will present a workplan on Nov 3, and the agenda of the trip will be discussed. The team will prepare a draft of the evaluation by Nov. 19th. Final revision of the draft before departure Nov.21 Final formal evaluation is due 30 calendar days after the field work.

## **Support**

The USAID WRHI program provided background information and bibliographies of CAs; a list of interview contacts at each site; and arranged for interviews at the Kiev site. AVSC, the lead CA agency was recommended for logistical support.

Through Raissa Bogatyriova, Deputy Minister of Health, it was arranged for MOH representatives to meet and travel with the team at the three demonstration sites Nov 12 and 13th. The representatives are:

1. Dr. Nina Goida, Head, Maternal and Child Health-Lviv
2. Dr. Irina Vovk, Head, Family Planning Center, Institute of Pediatrics, Obstetrics and Gynecology and member of Coordinating Committee for Family Planning in Ukraine.- Donetsk.
3. Dr. Tamara Irkina, Deputy Director of Administration, Head of Obstetric-Gynecological Department-Odessa.

Teresa Ingham, Reproductive Health Advisor will assist and coordinate at one or more sites and be available for and debriefings and review of preliminary draft the week of the

17th. Alina Yurova, Health Coordinator will assist at the Donetsk site on the 12th and 13th.

**Other Issues**

The following Ukraine visitations coincide/overlap with the Poptech field work and will be utilized as resources for the team's research.

Infectious Disease Program: HIV/AIDS assessment

WRHI:	CDC-	Reproductive Health Survey Planning Visit
	AVSC-	New roll-out sites; Intro of new country rep.
	PCS-	IEC Seminar; Crimea assessment
	JHPIEGO-	New roll out sites
	SOMARC-	Social Marketing assessment

**Due to the above timetable and staff availability, USAID administrative support for the team was curtailed. JHPIEGO facilitated in this area.**



# **APPENDIX B**

## **Bibliography**