



**ASSESSMENT
OF
REPRODUCTIVE AND MATERNAL HEALTH IN UKRAINE**

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December 2003

**Submitted by:
LTG Associates, Inc.
TvT Global Health and Development Strategies™
a division of Social & Scientific Systems, Inc.**

**Submitted to:
The United States Agency for International Development/Ukraine
Under USAID Contract No. HRN-C-00-00-00007-00**

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Assessment of Reproductive and Maternal Health in Ukraine was made possible through support provided by the United States Agency for International Development (USAID)/Ukraine under the terms of Contract Number HRN–C–00–00–00007–00, POPTECH Assignment Number 2003–139. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

ACKNOWLEDGMENTS

The team would like to acknowledge the support it received from the staff at USAID/Ukraine in conducting this assessment. The team expresses special appreciation to Mary Jo Lazear, USAID/Washington, who was working at the Mission during this assignment and provided useful information and insights as the team progressed from culling through findings to drawing conclusions and making recommendations to the Mission. The many officials from the Ministry of Health that allowed the team to tour their facilities and ask many questions about the current family planning and reproductive health services are also acknowledged. The time and assistance provided by staff of the USAID-supported projects in Ukraine is greatly appreciated, including the American International Health Alliance, the Maternal and Infant Health Project of John Snow, Inc., and the POLICY Project of the Futures Group. The team is much indebted to the translators, Irina Reshevskaya and Maria Chitashvili, and to Irina for all the logistical support she provided.

ACRONYMS

ABC	Abstinence, be faithful, and/or use a condom correctly and consistently
AIHA	American International Health Alliance
CDC	Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
EU	European Union
FP	Family planning
FY	Fiscal year
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IEC	Information, education, and communication
IR	Intermediate Result
IUD	Intrauterine device
JSI	John Snow, Inc.
MEDMA	Medical Management Consulting and Auditing, Ltd.
MIHP	Maternal and Infant Health Project
MOH	Ministry of Health
NGO	Nongovernmental organization
NRHP	National Reproductive Health Program
PDG	Policy Development Group
POPTECH	Population Technical Assistance Project
RFA	Request for Application
RH	Reproductive health
SDC	Swiss Agency for Development and Cooperation
SO	Strategic Objective
STI	Sexually transmitted infection
UAH	Ukrainian hryvnia
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URHN	Ukraine Reproductive Health Network
URHS	Ukraine Reproductive Health Survey
USAID	United States Agency for International Development
WfW	Women for Women crisis centers, operated by Winrock International
WHO	World Health Organization
WRHI	Women's Reproductive Health Initiative
WWC	Women's Wellness Center

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EXECUTIVE SUMMARY

In the fall of 2003, the United States Agency for International Development (USAID)/Ukraine contracted with the Population Technical Assistance Project (POPTECH) to conduct an assessment of reproductive health (RH) in Ukraine and to recommend directions for future assistance. A four-person team carried out the assessment in Ukraine from October 20 to November 7, 2003. The team interviewed key informants, including staff from USAID/Ukraine, the Ministry of Health (MOH), USAID-supported projects, and other donors. The team visited more than 25 health facilities in different regions of the country.

In the assessment, particular attention was given to the current state of family planning (FP) services and the use of contraception because family planning is seen by USAID as the core intervention in reproductive health. The team was apprised of past efforts under the Women's Reproductive Health Initiative (WRHI) in Ukraine (1995–2000) to improve family planning and reproductive health and related assessments.

KEY FINDINGS

The level of maternal mortality declined substantially in the past decade, although maternal mortality remains high compared with Western European and some other Eastern European countries. The level of unintended pregnancies continues to be high, with more than half of pregnancies unintended (as of 1999), and with the majority of those ending in abortion. While the MOH reports significant declines in abortion, the official abortion rate is still high relative to Western European and some other Eastern European countries. Disparities between official figures and the 1999 Ukraine Reproductive Health Survey (URHS) findings suggest that the number of abortions was 30 percent higher than reported; it is likely that abortion continues to be underreported. Avoidance of unintended pregnancies and reducing abortion are among the highest reproductive health priorities cited by many MOH officials, in part because they could contribute to further reducing maternal mortality.

Based on the 1999 URHS, use of contraception increased during the 1990s. The overall level of contraceptive prevalence reached 68 percent of married women of reproductive age, but only 38 percent of couples used a modern method. When compared with more developed countries as well as other countries in the region, Ukraine has not been as successful. For example, modern contraceptive prevalence is significantly higher in Kazakhstan (55 percent) and Russia (53 percent). Traditional methods of contraception, used by 30 percent of couples, have higher failure rates; their use contributes to the continuing problem of abortion.

A one-child family is rapidly becoming the norm in Ukraine. The majority of women do not want additional children, and yet most women do not use the most effective long-term methods. Therefore, there is a significant gap between women's stated fertility intentions and contraceptive method choice. This gap also helps explain why abortion levels continue to be high despite the increasing use of contraception. Furthermore, a large proportion of couples lack adequate knowledge about the effectiveness and safety

of modern contraception, resulting in inappropriate method choice given fertility intentions or ineffective or no use of methods.

National Reproductive Health Program

The government of Ukraine adopted a National Reproductive Health Program (NRHP) in 2001. It builds on the former Family Planning National Program (begun in 1995) but is much broader in scope. Various ministries and officials at oblast and city levels are expected to implement the program, but the national budget is very limited and insufficient for the breadth of the program. One aspect of implementing the NRHP has been the development of outpatient and inpatient policies (pricazs) that may help to improve the organization of health services. Other efforts are underway to develop guidelines and clinical protocols for maternal and infant care. Recent research on the barriers to improving reproductive health has highlighted inefficiencies in the current health care system that, if addressed, might allow for a more effective allocation of resources and improved health services.

Gaps in Public Sector Service Delivery

The broad scope of the NRHP is a positive development. However, many health providers interviewed by the team were not particularly concerned about providing family planning services. While the 1999 URHS showed that many users of intrauterine devices (IUDs) and oral contraceptives received their methods from an MOH facility, virtually all the facilities visited offered a limited range of methods and had limited or no supplies of contraceptives (IUDs, condoms, and oral contraceptives). Given the shortage of supplies, family planning services are often limited to counseling, with a bias that appears to have developed toward recommending oral contraceptives for most clients. In addition, the provision of family planning services is fragmented among the multiple MOH facilities (e.g., maternity centers, outpatient clinics, and women's consultation centers). Since there are no functional referral systems in place (for postpartum and postabortion patients), many clients do not receive the services they need. In short, evidence of the lessened attention to family planning in the public sector includes

- a limited range of methods,
- failure to address contraceptive commodity needs,
- inadequate counseling, and
- limited postpartum and postabortion family planning.

Given the shortcomings identified in current MOH family planning programs, it is unlikely that modern method prevalence has improved since the 1999 URHS was conducted.

Private Pharmaceutical Sector

Private pharmacies and drug kiosks are an important source of some contraceptives, such as condoms and oral contraceptives. With public sector commodities in short supply, it appears that many couples simply bypass the MOH system and purchase contraceptives at pharmacies or drug kiosks, as evidenced by a doubling of the oral contraceptive market in the last few years. The potential for the private sector to have an increasing

role in the provision of methods is considerable, although there are two caveats. The government is required to provide free family planning services to the most vulnerable groups but is unable to fill this role at present; low-income groups may find private sector commodities too costly at current prices. Furthermore, pharmacies do not provide counseling in method use, and this may contribute to method failure and discontinuation of use, both of which are problems in Ukraine.

Youth

The NRHP includes a component to promote healthy lifestyles among youth. A number of international organizations are supporting educational and health projects for youth, although such projects include little or no family planning information and services. Adolescents are a vulnerable group, and they are at increasingly high risk of unintended pregnancies and sexually transmitted infections (STIs)/HIV/AIDS, in part because of a declining age of first sexual activity. At the same time, adolescents want more information about reproductive health.

Maternal Health Services

Virtually all women deliver in MOH hospitals; 90 percent receive antenatal care, and the majority receive such care in the first trimester. Pregnancy is viewed as a disease, and an excessive number of pregnant women are hospitalized before delivery. Observations by the team found that clinical management, including antenatal, intrapartum, and postpartum care, does not meet international standards. At the same time, the MOH is engaged in a pilot effort to standardize and update a number of clinical practices. One additional finding is that although maternal mortality has declined, efforts to identify systematic shortcomings of maternal care may be frustrated given that the process of maternal mortality investigation is not anonymous.

RECOMMENDATIONS

The recommendations are presented in four broad areas: policy, integration and linkages, youth, and maternal health.

Policy

- USAID should continue support for implementation and monitoring to increase the MOH's ability to develop the written policy and programs. Assistance should be provided to the MOH to establish priorities aligned with public health concerns and financial resources and to develop action plans, including monitoring systems, to implement its national RH program.
- Additional studies/surveys are needed to monitor and follow up on the implementation of RH policies.
- There should be continued support for advocacy on family planning/reproductive health (FP/RH) to increase public awareness and to ensure that this area remains a priority for the MOH.

- Assistance to the MOH should be provided to improve its contraceptive management capacity to ensure the development of plans for sustainability and self-reliance. Such plans will also enable the MOH to ensure that its limited supplies are available to the most vulnerable groups in the population.
- USAID should support increased involvement of the commercial sector in the provision of contraception to improve method mix and pricing of contraceptives through a social marketing effort and by exploring corporate social responsibility partnerships with pharmaceutical companies.

Integration and Linkages

- Additional effort is needed to integrate organized family planning counseling and services into both postpartum services and postabortion care in order to increase the use of modern family planning methods among postpartum and postabortion clients.
- Family planning counseling and services should be integrated into trafficking initiatives to ensure that this vulnerable population is not put at additional risk of unwanted pregnancy by promoting collaboration between nongovernmental organizations (NGOs) that address trafficking and reproductive health providers.

Youth

- Support should be provided to ensure that FP/RH counseling and services are fully integrated into a number of programs directed toward youth, including the MOH's youth activities, programs supported by other international agencies through the Ministry of Education, youth organizations and networks, and university health centers.

Maternal Health

- While USAID should continue to support the improvement of clinical practices for maternal and newborn care, additional support should be provided to ensure that there is careful monitoring of the process of development of the new clinical standards. If warranted, implementation of the new standards should be extended beyond pilot sites to include obstetric/gynecology training sites.
- Support should be given to modify the process of death investigation so that it is anonymous.

I. INTRODUCTION

PURPOSE

The United States Agency for International Development (USAID)/Ukraine contracted with the Population Technical Assistance Project (POPTECH) to conduct an assessment of reproductive health in Ukraine and to recommend directions for future assistance.

METHODOLOGY

A team of four persons was engaged by POPTECH to conduct the assessment. All team members had extensive experience in family planning and reproductive health and with USAID programs. Two members were medical doctors (one is a practicing obstetrician/gynecologist). The scope of work is included in appendix A.

The assessment was conducted from October 20 through November 7, 2003. The team reviewed existing documents on previous and ongoing work in family planning/reproductive health (FP/RH). A number of key informants were interviewed, including USAID staff, staff of USAID-supported projects (the POLICY Project of the Futures Group, the Women's Wellness Centers of the American International Health Alliance, and the Maternal and Infant Health Project of John Snow, Inc.), Ministry of Health (MOH) officials, and other donors. The team divided into two groups; each group visited a number of sites in different regions of the country. These sites were in or near the following cities: Donetsk, Lviv, Lutsk, and Simpheropol. The persons who were contacted are shown in appendix B.

II. BACKGROUND

EVOLUTION OF USAID/UKRAINE SUPPORT FOR REPRODUCTIVE HEALTH

From 1995 to 2000, USAID/Ukraine supported a women's reproductive health initiative (WRHI) to improve the use of modern contraception and to reduce abortion. The initiative helped develop model family planning and maternity care services in seven sites (Odessa, Donetsk, Lviv, Crimea, Kharkiv, Ivano-Frankivsk, and Zaporizhyya). It supported training projects; worked to improve the policy environment; developed information, education, and communication (IEC) materials; procured contraceptive commodities; and promoted family-centered maternity care and early breastfeeding. A midterm evaluation of the WRHI found that specific project objectives had been met (such as establishing demonstration sites for training) but there was little evidence that overall goals had been achieved (Bergthold, Rooks, and Stewart, 1998).

Subsequent to the evaluation, USAID continued to support a number of FP/RH activities through the WRHI, including policy work with the MOH to develop a reproductive health strategy, additional training of service providers, and an IEC effort directed to postpartum and postabortion clients. In addition, the Ukraine Reproductive Health Survey (URHS) was conducted with assistance from the Centers for Disease Control and Prevention (CDC) in 1999 with results published in 2001.

To complement the efforts in FP/RH, USAID/Ukraine also provided some assistance for health reform efforts between 1994 and 1999. Due in part to the weak economy, the reform process apparently stalled. However, one specific result of the reform effort was the MOH's official designation of the position of family doctor in 1997 (see discussion of family doctors in section IV, Family Planning Services and Counseling).

By mid-2002, USAID/Ukraine's focus on reproductive health was expanded to maternal and infant care. More attention was given to national-level policy change and less focus was placed on the implementation of family planning programs. Currently, two projects are being supported:

- policy work with governmental and nongovernmental organizations (NGOs) to promote reproductive health and to reform MOH norms on patient care through the POLICY Project, and
- continuing support to a number of Women's Wellness Centers (WWCs) in the MOH and with the Ukrainian Railways medical system, support for equipment for breast cancer screening and resuscitation of infants, and support for the MOH's effort to train family doctors through the American International Health Alliance (AIHA).

Also during 2002, the Maternal and Infant Health Project (MIHP), implemented by John Snow, Inc. (JSI), began to focus principally on maternal deliveries and perinatal services.

Two other areas that USAID/Ukraine is supporting or plans to support have relevance for future work in FP/RH. Since the 1990s, AIHA has been carrying out a pilot anti-trafficking initiative designed to facilitate referrals of trafficking victims to women's health services. In 2003, the Mission developed a strategy for dealing with the growing problem of HIV/AIDS (USAID/Ukraine HIV/AIDS Strategy, 2003–2008). The major focus of the strategy is on strengthening the delivery of HIV/AIDS information and services. Prevention is a priority area for information and services and includes preventing sexual transmission, preventing mother-to-child transmission, and targeting at-risk youth.

USAID/UKRAINE STRATEGIC PLAN FOR FISCAL YEAR (FY) 2003–2007

In the USAID/Ukraine Country Strategic Plan for FY 2003–2007, Strategic Objective (SO) 5 is “improved social conditions and health status.” The Mission's work in reproductive health falls under this objective as does its work in preventing the spread of HIV/AIDS and dealing with problems of human trafficking. There are two Intermediate Results (IRs) under this SO:

- IR 5.1: Changed behaviors and systems to improve health, and
- IR 5.2: Conditions for targeted vulnerable groups are improved.

Most of the activities being carried out in reproductive health are within IR 5.1.

CURRENT DEMOGRAPHIC AND HEALTH SITUATION

Although the economic situation in Ukraine has improved in the last few years, the population continues to decline, with the annual number of deaths in excess of the annual number of births. The total population was estimated at 48.4 million in the census of 2001, a decline of more than 2 million people since independence in 1991 (Ukrainian Reproductive Health Network, 2003). There are approximately 13 million women of reproductive age (15–49) in Ukraine (CDC, 2003). The majority of the population lives in urban areas.

The average number of children born to a woman during her childbearing years had dropped to 1.4 in 1997–98 from 1.7 in 1991 (Kyiv International Institute of Sociology, CDC, and USAID, 2001). There is some indication that the number of births may be increasing due to the improved economic situation (registered births increased by 3 percent in 2002 compared with 2001) (“The Day,” 2003a), but this is not enough of an increase to halt the population decline.

The rate of infant mortality has improved in recent years. In 2001, it was 11.9 per 1,000 live births, a decrease from almost 15 in 1993 (MOH, no date, and Steshenko and Irkina, 1999). According to MOH statistics, maternal mortality has declined about 30 percent in the past decade and reached 21.8 deaths per 100,000 live births in 2002 (MOH Press Service, 2003). While both of these rates show improvements, the levels are still considered high compared with many other European countries. For example, maternal mortality in Western European countries ranges from 4 to 17. In several Eastern European countries (Slovakia, the Czech Republic, Poland, and Hungary), maternal mortality ranges from 3 to 16 (the World Health Organization [WHO], the United

Nations Children's Fund (UNICEF), and the United Nations Population Fund [UNFPA], 2003). This source also estimates maternal mortality in Ukraine to be 35 and additionally provides a range of estimates between 23 and 47.

Reproductive health problems in Ukraine continue to center around unintended pregnancies, high abortion, and the increasing spread of sexually transmitted infections (STIs) and HIV/AIDS. According to the 1999 URHS, more than half the pregnancies (54 percent) were unintended: 38 percent were unwanted (a woman wanted no more children at the time she became pregnant) and 17 percent were mistimed. Almost all unwanted pregnancies (92 percent) were ended by abortion, and the majority of mistimed pregnancies (60 percent) resulted in abortion. Despite these levels of unintended pregnancy, the number of abortions reported by the MOH has declined to about 324,000 in 2002—a rate of 25.8 per 1,000 women of reproductive age (“The Day,” 2003b; MOH, 2003). While abortion levels are reduced, they are still high relative to other European countries. In addition, there is some question about the actual number of abortions. Based on a comparison of MOH statistics from 1999 and data from the 1999 URHS, there was a substantial discrepancy between the two sets of information, suggesting underreporting by about 30 percent in the MOH statistics (Kyiv International Institute of Sociology, CDC, and USAID, 2001). Furthermore, key informants for this assessment indicated that many abortions are not being reported by providers, suggesting that the reliability of MOH data on abortion may be an issue.

The spread of STIs and HIV/AIDS is also a growing health problem. For example, the rate of syphilis increased sharply in the early to mid-1990s and may have foreshadowed the spread of HIV infections (USAID/Ukraine, 2003a). Levels of HIV and AIDS infection have risen dramatically, and the MOH reported almost 44,000 HIV cases and 3,000 with AIDS by the end of 2001. Both MOH and international experts estimate that by the end of 2002, more than 500,000 people in Ukraine may have been infected, representing slightly more than 1 percent of the total population. In addition, the number of HIV cases due to heterosexual transmission increased from 300 cases per year in 1995 to almost 1,900 cases per year in 2001. The number of cases of HIV due to vertical transmission from mothers to their newborn children also increased exponentially during this period, reaching over 900 (USAID, Request for Application [RFA], 2003b).

The delivery of health care services in Ukraine is characterized by an overemphasis on curative care, too little attention to primary and preventive health care, and an excess of specialized doctors. While there are large numbers of facilities, including oblast, rayon, and city hospitals and maternity centers as well as outpatient polyclinics, there is much inefficiency in these facilities, especially in the use of financial, human, and material resources. This inefficiency also reflects the structure of the current system, and causes health resources to be directed away from preventive care and basic supplies and equipment. It also serves as a disincentive for improving the quality of care. A reform effort to introduce the concept of family doctors and place more emphasis on primary health care is unlikely to succeed in the near future, given the current health services delivery environment. A recent study conducted by the POLICY Project revealed that with a substantial deficit in the health care budget, underlying inefficiencies need to be addressed so that available resources can be put to better use (POLICY Project/Ukraine, 2003).

OTHER DONOR ACTIVITIES

The **United Nations Population Fund (UNFPA)** has been supporting family planning and reproductive health in Ukraine for a number of years and has recently developed its new assistance plan for 2003–07. As in the past, donor contributions will be sought to support the plan but to date no funds have been committed. UNFPA plans to support a special integrated approach to reach youth through the MOH. This would involve working with providers at six types of facilities: family planning and reproductive health clinics, STI clinics, health education centers, HIV/AIDS centers, drug abuse centers, and social services for youth centers. UNFPA has also been the major source of contraceptive supplies for the MOH, along with USAID, since 1994. However, UNFPA's contraceptive donations ceased two years ago and currently it does not have funds to continue donations.

The **European Union (EU)** is working with the oblast departments of education to add to schools' life skills curricula education that would address the topics of drug and alcohol abuse, HIV/AIDS, STIs, and communication and negotiation skills. The EU plans to expand its interventions from 5 to 10 oblasts. At present, the EU-supported program does not include any FP/RH, but the EU representative thought it would be a useful addition.

The **Canadian International Development Agency (CIDA)**, through the Canadian Partnerships for Health, is supporting an effort in two oblasts to develop a curriculum for children and youth in grades 1–11 on healthy lifestyles for schools in Kyiv. It hopes to expand to two more oblasts.

The **United Nations Children's Fund (UNICEF)** supports two clinics specifically serving youth in Kyiv and one in Odessa.

Other organizations conducting activities indirectly related to reproductive health include the following:

- The **International Red Cross** is supporting visiting nurses services to socially vulnerable groups as well as youth activities for the prevention of STIs, HIV/AIDS, and tuberculosis.
- **Project Hope** is working on the development of a curriculum for children, teachers, and parents in two oblasts.
- **La Strada** is lobbying to increase awareness and gain support for victims of trafficking and is also providing assistance to victims.
- **Winrock International** supports seven Women for Women (WfW) crisis centers that offer job skills training for women. The centers also conduct seminars and other meetings on women's health with the participation of doctors and other representatives of health care institutions. The purpose of these sessions is to encourage referrals of battered women to specialists who can provide medical assistance, to provide information on the WfW centers'

services (including hotline services) to medical institutions, and to organize training and requalification programs for health care providers to promote greater understanding of the problem of human trafficking.

III. POLICY ENVIRONMENT AND ISSUES FOR REPRODUCTIVE HEALTH

STATUS OF THE NATIONAL PROGRAM: REPRODUCTIVE HEALTH 2001–2005

The national reproductive health policy, issued as an Order of the President of Ukraine in March 2001, approves the National Program: Reproductive Health for 2001–2005. Having the status of presidential decree grants a large measure of political support to this program, referred to as the National Reproductive Health Program (NRHP). Furthermore, the program document serves as an administrative order, outlining the specific roles and responsibilities of the ministries and other executive institutions, including oblast and city administrations. It orders the Cabinet of Ministers to demarcate funds for the program on an annual basis.

EVOLUTION OF THE NATIONAL REPRODUCTIVE HEALTH PROGRAM

In 1995, a family planning national program was implemented. It resulted in a reinvigorated focus on family planning for several years. Senior, influential officials of the MOH and universities were greatly influenced by study tours about the importance of family planning and their observations of family planning services in the United States and other countries. The intensity of donor assistance from 1995–2000 under the WRHI for inservice and postgraduate FP/RH training, IEC, social marketing, policy, and other areas resulted in increased appreciation of the importance of family planning among health professionals.

With support from USAID, beginning in 1998, the POLICY Project's collaboration with the MOH was instrumental in raising the level of awareness of reproductive health issues across many sectors of the government. This collaboration resulted in the development of two groups: the Policy Development Group (PDG) and the Ukraine Reproductive Health Network (URHN). Ukraine's PDG is an intergovernmental, multisectoral working group dedicated to improving the quality of and access to reproductive health in Ukraine. Its work with the MOH resulted in the development of the current NRHP. The PDG has also sponsored a study of operational policy barriers in reproductive health that may serve as a catalyst for policy and program improvements.

The URHN has been a useful mechanism for stimulating public awareness of reproductive health issues, engaging civil society in the advocacy process, and bringing the influence of a multiorganizational force to advocate for policy reforms. For example, in Lviv, the URHN lobbied successfully for public hearings on the NRHP. These hearings afforded an opportunity for senior health officials and administrative leaders to give attention to reproductive health. The hearings received media coverage, thereby reaching the public. The network also conducts workshops, training, and seminars for health professionals and has developed a database of its members to facilitate collaboration. Given the limited government resources allocated for reproductive health as well as limited donor interest, any network activities (whether national or local) that continue to increase the visibility of RH issues and press the MOH to match its policy with resources would be important.

PROGRAM IMPLEMENTATION

The NRHP is broad and encompassing and will be a significant challenge to implement, not least because of the financial requirements of the program. The national budget to implement the program is highly limited and insufficient for the breadth of the program outlined. Nevertheless, various ministries and officials at oblast levels, city-state administrations (Kyiv and Sevastopol), and the Autonomous Republic of Crimea are expected to implement the program.

The implementation process inherited from the Soviet system, from the highest levels of government to the lowest, remains strong. Changes in policies and practices are implemented by a *priczaz*, which could be described as a directive or an administrative order. This system has the potential to be an asset to positive changes in reproductive health care, since most *priczazs* concerning health care policies and medical practice are effective immediately and permanently, and the MOH has the authority to ensure compliance. In some locations visited by the team, oblast officials have had meetings with managerial and senior officials at given health facilities, and they plan to hold follow-up meetings to monitor progress in implementing changes. However, even though the MOH has the authority to ensure compliance with policies and regulations, it is more limited in its ability to monitor compliance with actual clinical practices or to introduce effectively significant changes in clinical practices.

A key aspect of implementing the 2001–2005 NRHP has been the development of outpatient and inpatient *priczazs* (MOH, 2002a). The development of the *priczazs* through the PDG was critical in engaging influential and respected members of the medical community in the process of reevaluating and revising practice norms inherited from the Soviet system and creating new openness toward international practices in reproductive health. *Priczazs* alone are not sufficient to significantly change and improve the quality of clinical services because they are concerned primarily with the organization of services. The follow-up process for the development of guidelines and clinical protocols is underway. These guidelines will direct specific clinical management, and their development and implementation will be vital in changing clinical practices. Compared with the inpatient and outpatient *priczazs*, these will require additional orientation and training of medical staff.

OPERATIONAL POLICY BARRIERS

The Policy Development Group has produced a report, *Overcoming Operational Policy Barriers to Reproductive Health in Ukraine*, that is based on a study of the efficiency of resource use in reproductive health conducted by Medical Management Consulting and Auditing, Ltd. (MEDMA) during 2001–02 (POLICY Project/Ukraine, 2003). This study is considerably informative on how national operational policies and budgeting processes, based on per capita financing and a per capita formula for obstetric/gynecologic beds, set the stage for filling beds, rather than keeping reproductive clients out of the hospital.

The current system is labor intensive and requires huge facilities demanding excess equipment. Facility managers lack the authority to make resource allocations to optimize services. During the site visits, officials repeatedly reported that deficiencies of

equipment (its absence or unavailability, antiquated state, or state of disrepair) are an impediment to offering a higher standard of care. For example, one hospital had 13 incubators in need of repair and was told that there were no funds to repair them. In many facilities, it was reported to the team that ultrasound equipment was outdated or insufficient in relation to the needs of the clients. In some cases, concerns about deficiencies in equipment were legitimate, and difficult choices must be made when need exceeds resources. In other cases, there was a desire to have the newest equipment, without much regard for actual need and potential benefit. The POLICY study points out that limited funds are budgeted for equipment maintenance. However, funds allocated for equipment purchase cannot be used for equipment maintenance and vice versa without explicit approval from a local health council.

Considerations of equipment in relation to reproductive health care are critical for several reasons. First, there are legitimate needs for new equipment to improve the level of care. Second, many donors, including USAID, have already made substantial investments in equipment, but with little regard for the associated costs for supplies and maintenance beyond the life of the project. For example, there is no budget for x-ray film for the mammography equipment supplied to WWCs, and staff that use the computers supplied to the WWC learning resource centers report that there are no financial resources for repairing their computers should they malfunction. Clients have to purchase x-ray film for mammography at a cost that may not be affordable to many. In addition, there are reports that donated equipment is unused because donors have provided little or no training in its use.

As a matter of policy, there is a constitutional right to free services in public facilities, and the team was repeatedly told that services are free. However, the POLICY study found that in many instances, clients are required to pay for drugs, supplies, and services at prices that prohibit some people from seeking care. Moreover, while some payments are official, many are not. The URHS findings also confirm that a significant proportion of clients pay for contraceptive supplies.

Key recommendations of the POLICY study include the need to

- decentralize financial decision-making to local and facility levels;
- optimize the number of staff, beds, and facilities to adequately meet local needs and use staff time efficiently;
- improve referral systems and coordination between facilities and departments; and
- develop alternative payment and targeting mechanisms.

This study shows conclusively that reforms in reproductive health care and medical practice in general, however positive, will have limited impact without broader reforms in the underlying national health care system and its financing. Some informants have noted that at the time the health reform project was introduced, people were not ready for it. Some suggested that there might be greater receptivity now to health reform given the overall improved economic situation in Ukraine. As evidence, the vast majority of people

are, in all likelihood, paying some fees for services. Thus, consumers would undoubtedly welcome a system that provides for greater efficiency and quality of care with greater transparency, equity, and accountability in cost. Health care providers, now reliant on low official remuneration supplemented by unreliable, unofficial payments, could benefit if a payment-based system were accompanied by efficiency improvements that could raise the salary base for providers.

The working processes of the PDG, in addressing reproductive health policy and program issues, are demonstrating how well-designed research with quantifiable findings can assist in articulating a problem and identifying potential solutions. The progress being made by the PDG in this regard may have the potential to impel broad health system reforms beyond reproductive health.

FAMILY PLANNING

The government of Ukraine is deeply concerned about the country's decline in population size and the reasons for the decline, particularly low fertility. Such concerns are explicitly stated in its reproductive health policy, as is the interest in further reducing high abortion rates (government of Ukraine, 2001). Reducing abortion and avoidance of unintended pregnancy are among the highest reproductive health priorities cited by many MOH officials. The broad scope of the current reproductive health program is a positive development. However, the team observed that health providers were not especially concerned about providing family planning services, perhaps given past achievements, declining fertility, and some reduction in the incidence of abortion. Evidence of the diminished attention to the family planning component of reproductive health includes

- the failure to address contraceptive commodity availability;
- a generic approach to counseling, in which oral contraceptives are recommended for nearly everyone; and
- extremely limited postpartum and postabortion family planning.

It is critical for officials at all levels of the MOH to recognize that family planning program performance needs to be improved to achieve reductions in unintended pregnancies and abortion rates.

DATA COLLECTION AND USE

There are two concerns about data. Reliability is a concern because some statistics reported by the central MOH are not supported by service statistics. In addition to this discrepancy, reliability also depends on the completeness of reported data. In general, service statistics from routine health reporting systems for many countries are not complete since they rely on information collected at service facilities and on staff willingness and ability to provide the information. Thus, it is not surprising that there are inconsistencies in MOH data and some key findings of the 1999 URHS. (See section IV, Induced Abortion and Postabortion Family Planning, for abortion data.)

The second area of concern is the type of data collected and its use. A significant amount of data is being collected, and the efficiency study cited above noted that clinicians spend a large percentage of their time complying with reporting requirements. However, there remains a need to collect data that are more meaningful and to put systems in place to analyze the data so that they can be used to improve the quality of care.

Many officials with planning and administrative responsibilities were not familiar with the 1999 URHS. Those familiar with the survey reported that the two-year delay in its publication diminished its usefulness. Nevertheless, given the absence of more recent national survey data, some findings remain relevant. For example, the survey found that respondents had low levels of knowledge about the relative effectiveness of various contraceptive methods. Given that there has been little to no provider training or IEC about method effectiveness since the time of the survey, the survey findings would likely be relatively unchanged if the same questions were asked today. Thus, this particular URHS survey data could still be used to develop appropriate training materials for providers and advertising or IEC strategies for the public. Information about sources of method is likely to have changed dramatically given the depleted stocks in MOH facilities so that new survey data would be extremely useful.

IV. REPRODUCTIVE HEALTH SERVICES

Family planning is the core reproductive health intervention of USAID's FP/RH program. As such, much of the information and many of the findings presented in this section are concerned with the use of contraception and the status of family planning information and services, including the availability of contraceptive commodities. Other components of RH that are reviewed in this section include the status of induced abortion and postabortion family planning and youth.

CONTRACEPTIVE USE

The data collected through the URHS in 1999 is the most recent reliable source for analyzing contraceptive use and trends in Ukraine. According to the survey, overall contraceptive use is relatively high. About two thirds (68 percent) of married women of fertile age use some kind of contraception. However, only 38 percent of couples use a modern method. (It should be noted that URHS data are based on responses from married women between the ages of 15–44, while most international surveys include all women in this age group. When adjusted using the latter definition, these rates would be 54 and 31 percent, respectively). Intrauterine devices (IUDs) (19 percent) and condoms (14 percent) account for the vast majority of modern contraceptive use, while oral contraceptive prevalence is only 3 percent, and only 1 percent of the women had been sterilized. Withdrawal is the most widely practiced traditional family planning method (20 percent), followed by periodic abstinence (11 percent).

URHS data (1999) reveal that contraceptive prevalence had been increasing steadily from 1994 to 1999. During this period, prevalence rose by about 7 percent, with greater increases in the use of modern contraception than in the use of traditional methods. Interviews with key informants and field observations indicate that contraceptive use may have been increasing since 1999, but it is difficult to make a valid assessment of the trends due to the lack of reliable data. A second national survey would be useful to assess recent trends in contraceptive use. (Issues regarding the lack of reliable national-level data are discussed in section III, Data Collection and Use.)

Despite these positive trends in the 1990s, modern contraceptive prevalence in Ukraine remains low in comparison with more developed countries and also with other countries in the region with similar social and economic structures. For example, modern contraceptive prevalence is significantly higher in Kazakhstan (55 percent), Russia (53 percent), and Moldova (50 percent), compared with 38 percent in Ukraine.

In addition to the low modern contraceptive prevalence, a closer look into contraceptive practices reveals other disturbing characteristics. The contraceptive failure and discontinuation rates for most methods are higher than found in some other countries. The failure rate in Ukraine for all methods after one year of use is 8.6 percent compared with 2.8 percent for Indonesia and 7.1 percent for Egypt (Curtis and Blanc, 1997). When looking at specific methods used in Ukraine, the failure rate is 6 percent for oral contraceptives and 7 percent for condoms. Not surprisingly, the highest failure rates are found for widely used traditional methods. For periodic abstinence, 16 percent of users become pregnant in the first year; for withdrawal, the failure rate is 11 percent. Data also

suggest that there is a considerable amount of method switching and contraceptive discontinuation. Discontinuation rates are extremely high across all methods, except for IUDs. For example, 54 percent of oral contraceptive users discontinue the method within one year. Another disturbing finding in URHS data is about the opinions and knowledge about family planning methods. Over one half of the women believed injectable contraceptives and female sterilization to be unsafe, while these methods are among the safest contraceptive options.

High rates of method failure and discontinuation and negative opinions regarding contraceptive methods apparently result from a lack of method-specific information. These findings indicate that there are significant gaps in the provision of family planning counseling. Couples are not provided with correct information on the use of contraceptive methods. In addition, they do not have adequate knowledge about the effectiveness, safety, and possible side effects of contraceptive methods.

URHS data also indicate a significant gap in Ukraine between fertility intentions and contraceptive method choice. The majority of women (66 percent) do not want any more children. As expected, the proportion of women who want no more children increases sharply with the number of living children. However, even among women with only one child, about one half do not want more children. These data indicate that a one-child family is rapidly becoming the norm in Ukrainian society. However, IUDs are the only widely used long-term method, and there is little demand for sterilization. Apparently, there is a disparity between desired small family size and method choice.

FAMILY PLANNING SERVICES AND COUNSELING

Family planning services and counseling are available through multiple facilities under the vast MOH service delivery network. These facilities include maternity centers, outpatient clinics, women's consultation centers, centers for reproductive health, centers for family planning, and family medicine centers. Quasi-governmental enterprises, such as the Railways Organization, also provide FP services. Based on the 1999 URHS, women's consultation centers provide the highest volume of FP services. At the time of the survey, 66 percent of IUD users and 39 percent of oral contraceptive users obtained their methods from women's health centers. Other public sources of contraception are hospitals (20 percent for IUDs and 7 percent for oral contraceptives) and maternity centers (5 percent for IUDs and 2 percent for oral contraceptives). It should be noted that all of these facilities are located at the oblast or rayon levels. (The team did not have an opportunity to observe FP services in rural areas.)

Based on the team's site visits, the level of integration of FP into the services of these facilities remains uncertain. While all facilities provide some type of FP services, it is not a priority area. This is so despite substantial efforts to train family planning service providers during the course of the WRHI (1995–2000). High numbers of service providers throughout the health system were trained in counseling and family planning service delivery, and the team was able to observe results of these efforts during site visits. However, these efforts were not sufficient (likely due to the limited timeframe and available resources) to standardize family planning training and maximize the MOH's training capacity. Providers' family planning knowledge and skills vary greatly.

The team met with providers who were equipped with up-to-date clinical and counseling skills as well as others who lacked appropriate knowledge and skills.

The WRHI also developed various information, education, and communication (IEC) materials and helped to improve the nature of client-provider interaction. The team observed IEC materials for clients and providers in most of the sites visited. However, as with training, the benefits of these past activities were not sufficient to ensure that the general population becomes better informed about contraceptive methods, their possible side effects, and reliability. Counseling of family planning clients remains a critical issue. Reportedly, counseling is universally provided to all family planning clients. However, available data suggest gaps in coverage and/or quality of family planning counseling. According to URHS, just over half of the women who had recently started a method were able to recall that the provider discussed the various family planning options available to her. In addition, about two thirds of modern contraceptive users recalled their provider giving information on potential side effects and what to do about them.

Despite extensive efforts to improve the efficiency of FP services since the mid-1990s, duplications and gaps remain, and provision of FP services seems to be fragmented. For example, few facilities provide all family planning methods. In most cases, clients are referred to other facilities to obtain the method they want. Since there are no functional referral systems in place, it is likely that many clients do not receive the services they need.

Services are underused and inefficiencies are obvious, given the abundance of providers and few clients. Gynecologists are the main providers of family planning services. The newly created cadre of family doctors also can provide FP services, depending on their qualifications. However, the number of family doctors is still small (estimated at about 1,100 for all of Ukraine). Most of the existing family doctors were previously general practitioners. In order to serve as family doctors, practicing physicians attend a 6-month course, including a few weeks on the care of pregnant women and family planning. Family doctors are authorized to provide a range of RH services, such as provision of contraception, screening and treatment of patients for STIs, and attending deliveries. Based on the team's interviews, family doctors are not comfortable in providing family planning, most likely due to their limited training. In addition, clients prefer to use specialist services. Thus, it is unlikely that family doctors will become an important provider of FP services in the future.

Key issues in FP service delivery are limited method choice and inadequate supply/provision of methods (described in the following section). While the 1999 URHS showed that many IUD and oral contraceptive users received their methods from an MOH facility, onsite method provision now seems increasingly uncommon. Few of the facilities visited during field trips had IUDs. Some facilities had limited quantities of condoms and/or oral contraceptives, and many did not have any method. Thus, family planning services of the public sector at oblast and rayon sites are often limited to counseling.¹

¹ In the absence of public sector supplies, clients are often given a "prescription" for oral contraceptives. The prescription is more of a recommendation, as prescriptions are not required by pharmacies for the sale of oral contraceptives or IUDs. Even if a provider makes a written recommendation for a particular oral

Although contraceptives in MOH facilities are theoretically free, this is not always the case. Due to supply shortages, family planning facilities generally provide contraceptives to only the most vulnerable groups. There is a government policy in place that mandates the provision of free contraceptives to women with extragenital pathologies, clients from the Chernobyl area, the socially underprotected, and adolescents under age 18. Given the extreme shortage of supplies, it is unlikely that even these groups have access to free contraceptives. Service providers refer clients to private pharmacies but admit that affordability is an issue for low-income groups.

Inadequate contraceptive supplies at MOH facilities lead to ineffective use of RH services provided by the government. Many couples seem to bypass MOH RH services, knowing that much needed contraceptives are not available at these sites. Clients that can afford commercial prices bypass government facilities and purchase contraceptives at pharmacies. This might be a feasible option for middle to high-income groups. However, family planning counseling is not available at the pharmacies. Thus, even those clients who can afford commercial contraceptives do not receive adequate counseling. There also seems to be a large proportion of the population that cannot afford to pay for commercial contraceptives.

In addition to inadequate contraceptive supplies, availability of clinical family planning methods varies across the facilities and is mostly limited. Tubal ligation is mostly performed during Caesarean sections. Interval female sterilization is reportedly available in a few inpatient facilities. Most facilities insert IUDs on an outpatient basis; however, in other places, IUD insertions are categorized under minor surgery and are available only in inpatient departments.

Based on the team's observations, the inconsistent quality of counseling and services offered to family planning clients is a critical issue. Many providers cited that clients are shifting away from IUDs in favor of oral contraceptives because they believe that IUDs increase the risk of infections. Other providers stated that they do not promote IUDs since they thought it is not a good choice for a population with increasing levels of STIs. These providers do not differentiate between women with high and low risk for STIs and are not aware of the relative risks associated with unintended pregnancies. There seems to be an unwarranted shift away from IUDs in favor of oral contraceptives. Such a change will only worsen the current method mix, which is not meeting women's needs and fertility intentions.

There is ample room to improve postpartum FP services and counseling in Ukraine. Given the fact that 99 percent of the deliveries take place in health facilities, the postpartum period is an excellent time to provide FP methods and information. Unfortunately, this seems to be a missed opportunity. The team observed little evidence on the provision of FP information to prenatal women as well as FP information and methods to postpartum women. URHS data support the observation on the lack of organized postpartum FP services: only one fourth of postpartum women were offered

contraceptive brand, the client is under no obligation to purchase that type. She could self-select another formulation or brand based on cost or other factors, such as personal preference or the recommendation of a friend, family member, or the pharmacist. In short, anyone can go directly to a pharmacy to purchase oral contraceptives.

contraceptive advice subsequent to their delivery. The proportion of women referred for counseling and services was as low as 5 percent.

As a final note on family planning services and counseling, there is a lesson to be learned from the previous WRHL. Despite substantial efforts to train service providers in family planning and the development of IEC materials between 1995 and 2000, providers' knowledge and skills in family planning vary greatly and many users of contraception apparently do not receive adequate counseling about methods. It may be that past training and IEC efforts were not sustained over a sufficient period to have had lasting and effective benefits.

AVAILABILITY OF CONTRACEPTIVE COMMODITIES

Public Sector: Past and Current Availability

According to the 1995–2000 Family Planning National Program, one stated objective was “to satisfy a demand of the population for means and methods of contraception.” Several ministries (public health, finance, and economics) were charged with purchasing hormonal contraceptives and “setting up the domestic production of contraceptives.” There is no domestic production, but some MOH officials continue to suggest that domestic production is the solution to shortages. These officials are probably not thinking of the cost implications of production or subsidization and are probably unaware that domestic contraceptive needs are far too low to justify domestic production.

The team was unable to verify whether any contraceptives had been procured in recent years with funds from the national budget. The MOH has relied completely on donated contraceptives to meet the supply needs in MOH facilities. In sites visited by the team, staff reported that more donated commodities were available in the past, but supplies have been depleted for some time. They reported that there have been few, if any, donations in the past two to three years. Past sources for donated contraceptive commodities included the International Planned Parenthood Federation and USAID, which supplied commodities in 1995 and 1996 in support of the training programs that were conducted in the Odessa, Donetsk, and Lviv oblasts (Perry, 1999). UNFPA has provided contraceptives to the MOH but future UNFPA assistance is uncertain. The American International Health Alliance, which receives funding from USAID, supplied the WWCs with contraceptives several years ago, but those supplies are now depleted.

Method Mix and Sources of Supply

The range of public sector commodities has generally been limited to three methods—IUDs, condoms, and oral contraceptives—although there have been limited donations of Depo Provera in the past. The overall limited method mix, in which the use of injectable contraceptives, implants, and sterilization is negligible, may have resulted from the absence of a specific policy regarding method provision and the ad hoc nature of donations. Although UNFPA allowed the MOH to request specific methods by brand and quantity, the basis of MOH method choices and need estimates is unknown.

In light of the current dearth of MOH contraceptive supplies, there may have been a shift to other sources of supply with cost implications for users. At the time of the 1999

URHS, the vast majority of IUD users had received their method through an MOH facility. Sixty-four percent of condom users reported that pharmacies and drug kiosks were the source of their method; only 13 percent identified MOH facilities as their supply source. The survey also showed that among oral contraceptive users, 82 percent of respondents reported that they paid cash for their oral contraceptives. More than 48 percent of oral contraceptive users received their supplies from MOH facilities; 35 percent purchased them from pharmacies or drug kiosks. These data suggest that in MOH facilities, women may have paid for donated commodities that were not intended for sale. This is consistent with the findings of the 2001–02 POLICY study that reported that patients are making unofficial payments for supplies and services at inpatient and outpatient facilities.

Public Sector Capacity to Manage Contraceptive Commodities

Although a 1999 contraceptive audit for USAID/Ukraine concluded that stocks of USAID–donated commodities could be accounted for in a pipeline analysis, the audit report noted several management concerns. It found that stocks could be accounted for at the facility level, but there was no aggregate reporting at the oblast level. Additionally, there was no information on the characteristics of the clients who received contraceptives. Further, there was inadequate reporting on quantities dispensed to individual clients.

In summary, at the time of the 1999 contraceptive audit, there was no system in place to collect data that could be used to manage contraceptive commodities and estimate future requirements at the local, oblast, and national levels. There is no reason to believe that any improvements have been made in this regard, given the status of current supplies. Indeed, the broader issue of financing contraceptive commodities needs to be addressed by the MOH, along with development of the capacity to forecast needs and budget for and procure contraceptive commodities. Without ensuring that a range of contraceptives is available in MOH facilities or is otherwise affordable and easily accessible, family planning program performance is completely undermined.

Private Pharmaceutical Sector

It is likely that the lack of public sector supplies of contraceptives is resulting in an even greater percentage of purchases being made from pharmacies and other private sector sources than in the past. Moreover, because there are costs associated with receiving services in MOH facilities, consumers may be bypassing the MOH system in favor of direct access to pharmacies. The 1999 URHS indicated that affordability of contraceptives was not an obstacle to their use, but at the time of the survey, many contraceptives were free or presumably sold at very low prices in MOH facilities. If a survey were conducted today, one might find that affordability is now a much greater concern for those with limited incomes.

The number of pharmacies in Ukraine is estimated to be about 10,000. The oral contraceptive market is currently worth US \$5 million and is double the 2002 market of \$2.5 million. Three pharmaceutical companies—Organon, Schering, and Gideon Richter—dominate the oral contraceptive market (Harrison, 2003). If consumers are in

fact bypassing the MOH and going directly to pharmacies, then the absence of point-of-sale information about contraceptive use and contraindications needs to be remedied.

A wide range of oral contraceptives is available in the urban pharmacies visited by the team. It was not possible to visit rural pharmacies so it cannot be assumed that product availability is the same in more remote areas. Oral contraceptive prices in a small sampling of pharmacies visited in October 2003 ranged from UAH 5.90 to 33.90 (approximately US \$1.10–6.35) per cycle. Pharmacy prices for the same products surveyed four years ago in October 1999 (Perry, 1999) have changed little. However, oral contraceptives at the above price points may not be affordable to low-income populations.

A wide range of condoms is available in pharmacies where prices range from UAH 4 to 11 (approximately US \$0.75–2) for three condoms. Condoms are also accessible in supermarkets and small shops and are widely available in kiosks. Kiosks are open late and sell some condom brands that are less expensive than those carried by pharmacies. Again, affordability may be a serious obstacle to some populations.

Women can purchase an IUD in a pharmacy and then take it to certain MOH facilities to have it inserted. Only one type of IUD (Multiload) was found in the pharmacies visited by the team, and its price varied from approximately UAH 20 to 67 (approximately US \$4–13). Some pharmacies had no IUDs in stock, but stated that they could be ordered upon request. Since many providers seem to charge for services despite the official policy of free services at MOH facilities, the addition of the provider's fee for insertion on top of the product price may make this method unaffordable for some potential clients.

The team did not identify any constraints to mass media advertising of contraceptives, and condom advertisements may be seen on television. The majority of advertising seems to be in print media, such as women's magazines. If there are, in fact, any legal constraints or other media censorship practices impeding contraceptive promotion, they could be addressed in the context of the implementation of the National Reproductive Health Program. The full extent of current private sector contraceptive product promotion needs to be analyzed in order to identify audience reach, successful strategies, and possible weaknesses in reaching high-risk groups. Small-scale surveys and focus group research may be needed to assess consumer information needs, attitudes, and financial constraints in order to develop educational and promotional strategies to reach subpopulations (e.g., adolescents; women and couples who have completed childbearing) at high risk for unwanted pregnancy and/or STD/HIV/AIDS. Some pharmaceutical companies with a presence in Ukraine and the broader Eastern European region have undoubtedly conducted such research; the rapidly growing sales of select oral contraceptives is evidence of effective marketing. Given the growing HIV/AIDS epidemic, some private pharmaceutical companies (pharmacies and pharmaceutical product manufacturers and distributors) with a sense of corporate social responsibility might be willing to tailor their contraceptive advertising in a way that addresses STD/HIV/AIDS prevention as a public service. A more comprehensive review of private sector activity in relation to contraceptive commodity availability and advertising is necessary in order to identify constraints to meeting the needs of high-risk groups and opportunities for intervention.

A full analysis of the public and private sector contraceptive commodity situation was beyond the scope of work of this assessment. Nevertheless, sufficient information was gathered to conclude that addressing the issues of MOH policies and commodity availability and affordability as well as provider and client knowledge and attitudes is fundamental to the success of any reproductive health interventions, including those projects currently being supported by USAID.

INDUCED ABORTION AND POSTABORTION FAMILY PLANNING

Low use of effective contraception coupled with a desire for small families results in high rates of induced abortion. Abortion has been a common procedure in Ukraine, and as in most of the former Soviet republics, abortion rates have been very high in recent decades. According to the official statistics, rates have been steadily declining over the last decade. Between 1990 and 2002, the official rate of abortion fell from 70 to 22 abortions per 1,000 women of childbearing age.

According to the URHS, the abortion rate, determined by self-reporting of abortions in 1999, was 54. This rate is about 30 percent higher than the official rate published for the same year by the MOH. This is an indication that official statistics miss a significant proportion of abortions that are occurring, possibly because many providers are not reporting them, for any number of reasons. The team's discussions with key informants suggest that rates may be higher because substantial numbers of abortions are being provided outside public facilities and are not being reported to the MOH. This is also an indication that reporting of abortion by URHS respondents may be relatively incomplete.

Overall, the high level of abortions remains an important public health issue in Ukraine. Data from a 1996 survey suggest that one fourth of all maternal deaths were caused by induced abortions (Cabinet of Ministers et al., 1997). The MOH officials state that one fourth of maternal deaths were due to complications of abortions up until recent years, but as of 2002, the ratio has declined to one seventh.

Induced abortion is legal in Ukraine up to the 12th week of pregnancy. Abortions are performed at outpatient clinics up to the 7th week of pregnancy, where the menstrual regulation technique is used. Termination of pregnancies beyond the 7th week takes place in inpatient clinics. The team observed only a few abortion clients during field trips.

Contrary to the widely held view that women in this region tend to prefer abortion to contraception, negative attitudes regarding abortion are nearly universal among the providers, women, and the public. The URHS indicates that 95 percent of women had negative overall opinions regarding abortion, showing a considerable gap between attitudes and practices. In addition, the team observed a high level of concern among providers and health care managers about the negative effects of abortions on women's health. It seems as if many women opt for abortion because contraceptive choices are not available or accessible. In many ways, abortion is used to regulate fertility although neither the providers nor the women approve of it as a contraceptive method. According to URHS data, an overwhelming majority of women opt for abortion because they do not

want any more children (60 percent) or because they cannot afford to have a child (25 percent).

The linkages for providing FP counseling and services to women who have undergone abortion are weak. Only a small proportion of women who have abortions receive FP information and methods. The URHS shows that 16 percent of women receive a contraceptive method or a prescription after an abortion. Another 7 percent are referred to other facilities for contraceptive services and counseling. These figures, supported by the team's field observations, indicate a great need to improve and expand the availability of postabortion counseling, referrals, and the provision of contraceptives.

YOUTH

In a recent report about the status of the NRHP (MOH, 2002b), it was reported that the State Committee for Family and Youth Affairs has initiated a comprehensive program for youth to promote healthy lifestyles. Outreach activities are directed towards youth in homes for minors, village culture homes, military units, family-type children's homes, houses of correction, and women's gymnasiums. These activities include seminars, group consultations, and lectures. Premarriage counseling about psychological, sociomedical, and legal services is offered in 17 oblasts. Social centers for youth also provide services. Pocket booklets, reference books, and brochures have been developed as have television and radio programs. A number of international organizations, including the EU, the United Nations Development Programme (UNDP), and UNFPA are working with the ministries of education and health with a focus on youth. (See section II, Other Donor Activities.) These projects address life skills education, including components on communication and negotiation skills, alcohol and drug abuse, and HIV/AIDS. However, the projects include little or no family planning information or services, and a negative perception of condoms among youth is reported to persist.

Despite the above efforts, adolescents remain a vulnerable group and there is evidence that they are at increasingly high risk. Key informants reported that results from an MOH study showed that the average age of first sexual intercourse has decreased to 14. This means that adolescents are at risk of pregnancy and STIs at younger ages. The legal age of marriage in Ukraine (16 for girls) is lower than many countries. Pregnancies are purported to be increasing among both married and unmarried adolescents (Cromer and Seltzer, 1999), and there were anecdotal reports during team visits in Donetsk and Simferopol that suggest that this is currently the case.

From 1990 through 1998, MOH data indicate that among girls ages 15–17, the incidence of pelvic inflammatory diseases increased fourfold and had not reached a plateau. During this same timeframe, syphilis increased over 25-fold, but the rate in 1998 had decreased from the high levels in 1996 (Steshenko and Irkina, 1999). A booklet prepared for journalists presents data showing that the decline from 1996 has continued (Vornik et al., 2003). Nevertheless, key informants reported that the incidence of other STIs is continuing to increase among adolescents.

In spite of increasing efforts to reach youth, key informants reported that adolescents continue to express a desire for additional information about reproductive health and that they want the information starting at relatively early ages. While they trust doctors, they

do not necessarily receive sufficient counseling from them. It is possible that adolescents, who see doctors as authority figures, may be afraid to ask questions. Results have been best in schools, where adolescents received information both through the curriculum and a peer-to-peer program.

V. MATERNAL AND INFANT SERVICES

The MOH reports a decreasing maternal mortality rate. The maternal mortality rates reported by the MOH are 31.3 per 100,000 live births in 1992; 26.2 per 100,000 live births in 2000; and 21.8 per 100,000 live births in 2002. However, considerably higher figures are cited by other sources. For example, the Population Reference Bureau (2003) cites a maternal mortality rate for Ukraine of 45 per 100,000 live births, and an International Planned Parenthood Federation source cites a rate of 50 per 100,000 live births. Nevertheless, even the 2002 rate cited by the MOH exceeds European indicators 2–2.5 times. The ministry ascribes the reduction in maternal mortality to the prevention of unintended pregnancies, the decreased contribution of abortion, and earlier registration for antenatal care. The ministry reports that the main immediate causes of maternal death are uterine bleeding (24.5 percent), abortion (14 percent), septic complications (12.2 percent), and pathology unrelated to the pregnancy (11.1 percent). An important factor contributing negatively to maternal mortality and morbidity is anemia. In hospitals visited, up to one third of pregnant women were anemic, and up to 16 percent of pregnant women were hospitalized for anemia.

According to the MOH, the role of abortion has significantly decreased and contributes to one in seven maternal deaths (as of 2002), a decrease from 25 percent of the maternal deaths a few years ago. As mentioned previously (section IV, Induced Abortion and Postabortion Family Planning), there is some suggestion, based on the interviews conducted, that women may be seeking abortions from private providers who do not report the procedure. Thus, an unknown number of abortions are not counted in MOH statistics.

There are about 564 hospitals in the country where women deliver, and approximately 99 percent of women deliver in hospitals. Approximately 12,000 obstetrician/gynecologists are trained in 14 centers in the country. Obstetrician/gynecologists directly provide antenatal care or supervise midwives in its provision. It is obstetrician/gynecologists who primarily attend deliveries. The 1999 URHS reported that 90 percent of delivering women had received antenatal care, with 65 percent initiating that care during the first trimester. Although exact statistics were not provided, the MOH reports that an increasing percentage of pregnant women are being seen in the first trimester.

Until the new outpatient *pricz* was issued, the number of antenatal visits prescribed considerably exceeded those recommended by the World Health Organization. Because the *pricz* addresses norms rather than clinical management, it does not direct how abnormal findings and conditions should be managed. Clearly, quantity of antenatal services is distinct from quality of services, and the latter is only addressed at the normative level by the outpatient *pricz*.

Another avenue for improving maternal and infant care has been the promotion of breastfeeding. As of 2002, 10 hospitals had achieved the status of meeting World Health Organization criteria for designation as a baby friendly hospital. In addition to the efforts to change clinical practices per se, the MOH has procured new equipment for maternal and neonatal services. For 2002, cited total outlays from budgeted and extra-budgetary funds of more than UAH 1.5 million are reported for acquisition of such equipment as

pulsoximeters, ultrasound machines, and respirators. Additional equipment valued at UAH 500,000 was donated, although technical assistance on using the equipment has been limited, or in some cases, entirely lacking. In spite of these financial outlays for equipment, much equipment remains broken, and hospital personnel continue to cite equipment shortfalls as a significant problem in the provision of high-quality services.

Clinical management, including antenatal, intrapartum, and postpartum care, does not meet international, evidence-based standards. Furthermore, pregnancy is viewed as a disease. It is considered the providers' responsibility to uncover pathology. This requires screening by several specialists and the overuse of some testing. Physicians are afraid of not doing everything they could do and then being blamed for a poor outcome. Up to two thirds of women are hospitalized before delivery, which is extraordinarily high by international standards. Many patients that would be treated on an outpatient basis in other countries are managed as inpatients in Ukraine.

Of note is the fact that within the outpatient приказ, it is mandated that family planning be included in the obstetric history. It is also obligatory that family planning be one of the topics for antenatal classes and be addressed during the postpartum nursing that should occur during the first 7 days after discharge. However, no quality assurance system is in place to monitor compliance with this order or the quality of these efforts. Because the inpatient приказ has not been issued, the extent to which it will address family planning is not known.

The MOH has been very receptive to the idea of standardizing and updating clinical practices. The MIHP reports that 31 clinical practice guidelines/protocols have been identified for development, and the process has been initiated. This represents major practice changes, although simply distributing documents to facilities cannot ensure compliance. According to MIHP project indicators, the MIHP project will only focus on compliance to the new guidelines/protocols at its own few project sites.

One area of possible assistance that has not been addressed is the process of maternal mortality investigation. Unlike some other countries, the maternal mortality investigation in Ukraine is not anonymous. The death investigation team may comprise up to 50 people, and the meeting in which results are presented may be attended by 200 guests. There is every incentive for the providers and administrators involved in the case to cover up mistakes. The investigation process is heavily oriented toward identifying individual practice mistakes. Even at the national level, the focus is more on the peculiarities of each case than on the common denominators among cases in clinical practices and organization of services. Therefore, opportunities are missed to systematically identify and improve critical factors directly contributing to maternal death. This is particularly unfortunate, given that in Ukraine, unlike in many countries, most women deliver in hospitals. A focus on correcting in-hospital deficiencies in quality of care might be especially effective in reducing mortality. A model for an anonymous, systematic approach to maternal death investigation can be found in the United Kingdom (see Department of Health, *Why Mothers Die*, Report on Confidential Enquiries into Maternal Deaths in the United Kingdom, 1994–1996, The Stationery Office).

A pilot project to improve maternal care is showing interesting early results. An eight-member, World Health Organization–sponsored team conducted a 2–week, whole-site

training in a maternity hospital in Ukraine. Emphasis was on family and partner involvement, antenatal education, intrapartum and postpartum care, clinical management of common problems, keeping babies warm, breastfeeding, and neonatal resuscitation. At this hospital, Caesarean section rates have decreased from 18 to 11 percent, episiotomy rates have declined from 39 to 8 percent, and asphyxiated babies (Apgar scores ≤ 6) have decreased from 30 to 17 percent. However, the focus is narrow and there is little attention to antenatal care or family planning (not even lactational amenorrhea). There is no budget for replication beyond the limited number of pilot project sites.

The MOH reports the following perinatal mortality rates: in 1993, it was 12.6 per 1,000 live births and stillborns; in 2001, it was 8.7; and in 2002, it was 10.3. It is not clear why the rate declined and then increased in 2002. Respiratory deficiency syndrome constitutes the biggest part of all factors of early neonatal mortality. Low birth weight, due to poor maternal nutrition, maternal smoking, and alcohol consumption are contributing underlying factors to poor neonatal outcomes. Neonatal resuscitation is an identified weakness; few staff members are adequately trained in this area. Some organizations, including the Swiss Agency for Development and Cooperation (SDC) and AIHA, have provided equipment, but there has not been a comprehensive approach to upgrading skills.

As previously discussed (section IV, Family Planning Services and Counseling), an MOH priority is to expand the role of family doctors in primary health care. Given the short training on women's health provided to physicians to enable them, in theory, to serve as family doctors, it is not surprising that they are reportedly reluctant to provide prenatal care. Their concerns include perceived liability risk, lack of knowledge and experience, pressures from other clinical demands, and the presence of midwives and obstetrician/gynecologists to provide the care. In addition, the patients themselves reportedly prefer seeing specialists. The implications of this are that family doctors are unlikely to have a significant role in women's health in the near future.

VI. INTEGRATION AND LINKAGES ACROSS SERVICES

INTEGRATION WITHIN REPRODUCTIVE HEALTH SERVICES, INCLUDING FAMILY PLANNING

Based on interviews with providers, it was determined that providers have a perception that reproductive services are already integrated under the following conditions:

- a number of services are provided at one facility, as is the case with the WWCs, and some referral between discrete services takes place; and
- facilities within close proximity offer multiple reproductive health services, and some referrals take place (e.g., referral of a postabortion client to family planning services).

However, in the absence of explicit management systems, referrals tend to be ad hoc and at the discretion of individual clinicians. This conclusion is supported by evidence in the 1999 URHS, which found that only 40 percent of postabortion patients had someone talk to them about contraception, and less than 16 percent left with a method or prescription. The survey's postdelivery findings were similar: only 25 percent reported that someone discussed contraception, and less than 4 percent left with a method. There is no reason to believe that the situation of postabortion and postpartum counseling has improved; indeed, it may have deteriorated given the lack of contraceptive commodities in all facilities.

Within the RH service context, assistance is needed to strengthen management capacity, including the development of formal rather than informal referral systems. The appropriate collection of data will be critical to assessing management effectiveness (e.g., more clients are being referred in a systematic way) and health impact (e.g., behavior change and outcome measures are increased contraceptive use and lower abortion rates) and ultimately improve the quality of services.

Information about STIs and HIV/AIDS prevention should be integral to counseling concerning contraceptive options. Since the risk of transmitting STIs and HIV/AIDS is higher among persons with multiple sex partners, family planning clients need to be apprised of such risks so that they can consider that information when choosing a method. Clients should be advised to use condoms if they are in a high-risk category. If clients, particularly adolescents, are simply given oral contraceptives or an IUD without adequate attention to their information needs, lifestyle issues, and relative susceptibility to STI transmission, then health care providers are not providing adequate quality of care.

LINKAGES

The ability to link family planning/reproductive health with other health programs is in part dependent upon improvements in the management of referral systems within RH services. There are immediate opportunities to link reproductive health services—family

planning programs in particular—with programs addressing trafficking victims, youth, and HIV/AIDS.

Trafficking and Reproductive Health

Governments, multilateral institutions, private organizations, and the media are increasingly acknowledging the problem of human trafficking. Awareness levels among the general public and health care providers about the nature and extent of the problem and its impact on the victims are likely to be low. Clearly, nongovernmental organizations (NGOs) are at the forefront in addressing trafficking and are probably the best group to educate health care providers about the situation of trafficking.

NGOs working on trafficking have tried to coordinate with reproductive health NGOs, which is an excellent first step. However, reproductive health NGOs are prohibited from providing services per se, but they could provide counseling and perhaps work with trafficking NGOs on facilitating the interface with health care services. Many members of the Ukraine Reproductive Health Network are also employees of the MOH, and therefore are in an excellent position to begin educating their colleagues about the trafficking problem through formal training and seminars as well as through informal mechanisms.

Victims of trafficking are generally unable to access reproductive health services. They may encounter negative attitudes among health care providers who may lack understanding of the circumstances of trafficking victims. There are also cost barriers. While NGOs have initiated lobbying efforts to have victims of trafficking officially designated as a vulnerable group, that is a long-term effort. In the interim, providers need to be educated and urged to develop policies that will enable victims to receive free health care, without any charges being demanded. Such efforts should be supported.

To date, limited public sector involvement in assisting victims of trafficking is occurring through a WWC in Lviv. Some WWCs, such as the one located in Kramatorsk, have a psychologist on staff who already provides social service support and mental health counseling. Staff with similar social support responsibilities in the MOH system may be among the best prepared to assist trafficking victims in their interface with reproductive health care. In addition, Winrock International, through its WfW centers, has begun to raise awareness among health providers of the health problems of women associated with trafficking.

Training for MOH staff might be developed by a program that draws upon the joint resources of a trafficking NGO staff and MOH staff that are already working effectively with victims of trafficking. Such efforts should be targeted institutionally and geographically to areas where the need is greatest. For example, if Odessa, Kyiv, or other cities are known to be prime destinations for returning victims of trafficking, then it makes sense to concentrate program efforts where they are most likely to be needed. Similarly, if adolescents who are soon to be released from orphanages are more likely than other adolescents to become victims of trafficking because of limited skills and their lack of a family support system, then preventive educational and vocational activities need to be targeted to such institutions.

Youth Initiatives and Reproductive Health

Health Facilities

Given the particularly high risks faced by youth who become sexually active at increasingly younger ages, there is a need to link reproductive health and family planning programs with the youth programs in MOH facilities. Adolescents have a high level of unmet need for reproductive health services; there is a lack of specific health care services for them. They see pediatricians until they reach age 19, but pediatricians may not be prepared to address their reproductive health concerns and services. One respondent suggested that adolescents might prefer to go to a pediatric facility because of their familiarity with providers who have treated them over many years and their willingness to treat everything. Adolescents may also prefer a pediatric facility because they perceive that it will preserve anonymity that may be compromised if they are seen in a facility specifically for STIs, for example. Some pediatric facilities are located in polyclinic facilities; whether adolescents are comfortable negotiating their way in such settings is unknown. Probably there is a need for some research to assess the health care needs of adolescents who are rapidly evolving into a more sexually active group than earlier cohorts. Research findings could be used to develop services that are more friendly and accommodating to youth needs.

An entire cadre of gynecologists for adolescents exists, and it is a well-developed specialty. However, these gynecologists are located in clinics that serve adults, making them less acceptable to youth. Many of the facilities visited had at least one gynecologist for adolescents, but there is some role ambiguity regarding sexually active adolescents. Most of the clients of gynecologists for adolescents are seeking care for non-family planning issues. In some centers, it was suggested that the adult obstetrician/gynecologist rather than the gynecologist for adolescents should see a sexually active adolescent.

There is an extremely limited number of reproductive health services that are friendly and accommodating to youth needs in the MOH system; in general, family planning services seem to lack an orientation to the special needs of adolescents. For example, the concept of dual protection—to prevent STIs and HIV transmission as well as to prevent pregnancy—does not seem to be adequately understood or perceived as a need by family planning service providers who advise sexually active adolescents.

UNICEF supports two clinics specifically designed for youth in Kyiv and one in Odessa; however, the MOH does not support them because of their syndromic management of STIs. Even if the number of clinics were expanded, the model would not work in many areas. For example, in rural areas, the lack of anonymity makes the concept of this type of clinic problematic. However, no alternative model exists.

Commercial Sources of Contraception

The public services that do exist for adolescents are no doubt often unused. Because public clinics do not have reliable supplies of oral contraceptives or condoms and the services may not be appealing to youth, there is little incentive to use them. Alternatives exist in the commercial sector. The primary source of condoms and oral contraceptives

is pharmacies; condoms are also available at kiosks. It is noteworthy that pharmacists mostly recommend oral contraceptives (rather than condoms) for youth. No prescription is necessary to purchase oral contraceptives; adolescents can go directly to pharmacies without seeing a provider to purchase them. When this occurs, they receive no counseling regarding such issues as mode of action, safety, correct use, or side effects. This situation emphasizes the need for additional sources of information at pharmacies or via other channels to compensate for the lack of interface with the health system.

Schools

Many schools have a life-skills curriculum, which may include prevention of drug abuse, STIs, and HIV/AIDS; healthy lifestyle issues, such as smoking and alcohol; and communication/negotiation skills. There are some donor-funded projects addressing youth; however, none of the projects has plans to incorporate an FP/RH component. Two projects are briefly described below.

- There is a large EU adolescent program operating in 10 oblasts, but it lacks an FP/RH component. The EU representative stated that family planning is an area that could benefit from additional support, and quoting MOH data, reported that sexual debut at age 14 demonstrates the need for this program.
- A UNDP project that combined peer-to-peer counseling with traditional in-school health education and life-skills education was considered highly effective, according to a UNDP self-assessment—more effective than programs without peer-to-peer counseling.

In addition, in many cases, staff members of WWCs and other MOH facilities already have been participants in programs to educate adolescents about reproductive health and family planning. Some educational programs take place in schools. In other cases, students (girls, in particular) are brought to MOH centers for both educational programs and physical examinations. The impact of such educational programs has not been assessed formally, but WWC staff in Donetsk noted anecdotally that the participants in such programs are likely to become sufficiently comfortable with center staff that some do return on their own to seek advice and/or family planning counseling. Some staff members have become highly committed to working with adolescents based on personal experience.

HIV/AIDS Programs and Reproductive Health

USAID has recently issued new technical guidance on FP/HIV integration (USAID, September 2003). The guidance points out that FP/HIV integration approaches need to be “tailored to the specific country context.” Further, FP/HIV approaches differ depending upon whether the HIV epidemic is concentrated in specific populations or generalized.

While the epidemic in Ukraine has been concentrated among intravenous drug users, there are some indications that heterosexual transmission in the general population is beginning to occur. It has been noted that there is some intravenous drug use among university populations, although its extent is unknown (USAID, Request for Application

[RFA], 2003). Adolescents, including university students, have a high risk of unintended pregnancies because their use of contraceptives is sporadic; thus, adolescents face a dual risk of unintended pregnancy and HIV infection.

Under the circumstances described above, programs for youth that stress behavior change, such as the ABC (abstinence, be faithful, and/or use a condom correctly and consistently) approach might delay the age of sexual debut and/or increase condom use to prevent pregnancy and HIV infection. The ABC approach targeting adolescents could be incorporated into schools' life-skills curricula or developed through youth organizations, sports programs, and adolescent church groups.

For several reasons, social marketing of condoms in Ukraine could be one of the most efficient and effective ways to address simultaneously preventing pregnancy and reducing the risk of HIV infection in high-risk populations:

- Because MOH facilities generally lack contraceptive commodities, many potential users of contraception are bypassing MOH facilities. They are purchasing contraceptives in a kiosk or pharmacy where they will not have an opportunity to discuss their needs, receive product information, or learn about STDS and HIV/AIDS.
- It appears that many clients who do receive family planning counseling and/or contraceptives in MOH facilities are not being adequately counseled about reducing their risk of HIV infection.
- The oral contraceptive seems to be the most widely recommended contraceptive for pregnancy prevention among MOH providers. However, the potential need for dual protection, especially among sexually active adolescents or adults who might have multiple partners, is not emphasized.
- Many people are uninformed or misinformed about their potential risk of STD or HIV infection and methods of pregnancy prevention; as a result, they may have unprotected sex.
- Contraceptives may not be affordable even to those who wish to use contraception and/or decrease their risk of STD and HIV infection.

All of these factors suggest an urgent need that more information about STDs/HIV/AIDS and pregnancy prevention be made available through multiple channels (mass media and point of sale, in particular). These factors also indicate a need for affordable and widely available protection against pregnancy and STD and HIV infection.

A social marketing program could engage condom manufacturers/distributors in developing an affordable pricing structure that would be profitable because of increased sales and ensure that messages developed for adolescents address both pregnancy prevention and reducing their risk of STD and HIV/AIDS infection. A mass media campaign coordinated with point-of-sale information could ensure that correct information is widely available and also counter misinformation or myths. Similarly, the

information needs of other high-risk groups in Ukraine could be assessed through small surveys and focus groups to design appropriate marketing campaigns.

Since USAID/Ukraine has just issued an RFA for an HIV/AIDS project, it may be premature and/or procurement sensitive to recommend specific linkages and integration strategies in this document.

VII. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The conclusions drawn from the findings presented in the report are presented as broad summary points.

Policy

- In theory, reproductive health is a priority for the MOH. Central policy and program emphasis is not reflected in field implementation and is further hampered by inefficiencies in the current health care system.
- Reproductive health—particularly family planning—is not a service priority among MOH sites at the oblast, rayon, and city health facilities, and by extension is not a priority among rural facilities.
- There is abundant evidence of a significant level of unmet need for family planning. The evidence includes a high level of unintended pregnancies from the use of ineffective methods, incorrect use of methods, and no method use.
 - Unintended pregnancies result in continued high rates of abortion, despite lower numbers of abortion officially reported.
 - Unintended pregnancies result in high numbers of abandoned infants.
 - Research shows a decline in the average age of first sexual activity among adolescents.
 - Childbearing occurs very early in marriage, and women have many years during which they need effective contraception.
 - There is a serious disparity between women’s stated desire for a small number of children and their use of effective methods.
- There are several impediments to widespread use of contraceptives in Ukraine.
 - Information and knowledge gaps exist.
 - ▶ Many people are not aware that modern methods of contraception are more effective in preventing pregnancy than traditional methods.
 - ▶ Ukraine has an unusually high rate of oral contraceptive discontinuation; this may be due to a lack of information about proper use, side effects, and contraindications.
 - ▶ Many people are not aware of the dual role of condoms to prevent both pregnancy and STIs.

- ▶ Many people are not aware of the risk of HIV infection and therefore do not take steps to protect themselves, such as condom use, abstinence, or limiting the number of partners.
- Too few methods are available.
- Cost may be an obstacle for those who are already motivated to use contraceptives.
- There are concerns about the reliability of service statistics (e.g., on contraceptive use), which may limit usefulness to inform decision-making on reproductive health services.
- Insufficient attention is given to the quality of services. Minimal data are being collected to improve quality, and systems for quality management are not in place.
- Significant gaps in reproductive health services persist. For example, method mix is very limited in both the public and private sectors (e.g., providers appear to have developed a bias against IUDs). Contraceptive availability in the public sector is limited to donor contributions, and there is no apparent strategy to address contraceptive needs for the long term. There is growing but still minimal involvement of the private sector and thus little market segmentation that would free limited MOH resources to meet the need of the most vulnerable population groups.
- The private sector has the potential to have an expanded role in increasing access to and use of contraception. There are many companies distributing condoms via pharmacies, kiosks, and other outlets. Three pharmaceutical companies (Organon, Schering, and Gideon-Richter) dominate the rapidly growing oral contraceptive market (there are other companies, but with far more limited market share). The involvement of the private sector could improve method mix (e.g., by increasing the availability of injectable contraceptives [such as Depo Provera], IUDs, and Norplant). Companies that distribute condoms and oral contraceptives could improve their market segmentation and add products at lower price points. This would reduce the burden on the MOH to provide contraceptives. Distributors of condoms, oral contraceptives, and other products could provide point-of-sales information to increase the level of knowledge about modern method effectiveness as well as product use and/or contraindications.

Integration and Linkages

- There are missed opportunities to address reproductive health, particularly family planning, in the context of other health and program areas. These areas include postpartum services, postabortion care, trafficking, and prevention of STIs and HIV/AIDS.

Youth

- Youth have unique problems. They are at particular risk for unplanned pregnancies, abortion, STIs, HIV/AIDS, drug use, and trafficking. This is partly due to their lack of awareness and knowledge of risky behaviors. In general, health services are not geared to the needs of youth so they may bypass clinical services in favor of accessing products (such as contraceptives) from commercial pharmacies. At the same time, youth represent an opportunity since they are interested in receiving additional information and even want the information provided at relatively early ages.

Maternal Health

- Maternal care is not consistent with international, evidenced-based practices. However, current USAID-supported projects have the potential to improve service quality and bring it more in keeping with international practices.
- The process of investigating maternal deaths is not anonymous and therefore not optimal for systematically identifying preventable, underlying factors that contribute to maternal mortality.

RECOMMENDATIONS

The recommendations are made in four broad areas: policy, integration and linkages, youth, and maternal health. They are based on the findings and conclusions made in this assessment, address crucial needs aimed at improving reproductive health in Ukraine, and represent targets of opportunities. Not all conclusions are addressed in these recommendations due to limited resources.

Policy

- While the overall policy environment for reproductive health has improved somewhat in recent years, four key areas require attention.
 - Continued support should be provided for implementation and monitoring to increase the MOH's ability to develop the written policy and programs. Assistance should be provided to the MOH to establish priorities aligned with public health concerns and financial resources and to develop action plans, including monitoring systems, to implement its national RH program. The MOH has developed a broad RH strategy but it lacks implementation plans and systems to monitor its implementation.
 - Additional studies/surveys are needed to monitor and follow up on the implementation of RH policies.
 - ▶ There should be a follow up to the Study on Overcoming Operational Policy Barriers to Reproductive Health in Ukraine, carried out under the auspices of the PDG. The PDG process was critical in identifying problems and possible solutions.

- ▶ It is advisable to conduct a second national survey on reproductive health. This survey would provide the MOH and the international donor community, including USAID, with reliable data to understand recent trends and to identify gaps and needs in order to program limited resources most effectively. USAID should consider approaching other donors, such as UNFPA and UNICEF (both have helped to fund national surveys in other countries in past years) to share the cost.
- Continued advocacy is needed on FP/RH to increase public awareness and to ensure that this area remains a priority for the MOH. Advocacy work should also address the great disparity between women's low desired family size and their use of less effective or no methods to prevent pregnancies during the many years in which women are at risk. NGO advocacy should also raise awareness among the public and among government officials about the need for public sector contraceptive supplies.
- Assistance to the MOH should be provided to improve its contraceptive management capacity to ensure the development of plans for sustainability and self-reliance. Such plans will also enable the MOH to ensure that its limited supplies are available to the most vulnerable groups in the population. The areas that will be addressed in this effort include
 - ▶ forecasting commodity needs,
 - ▶ financing,
 - ▶ procurement, and
 - ▶ logistics management.
- Two avenues are proposed to increase the involvement of the commercial sector: a social marketing effort for condoms and perhaps oral contraceptives and an initiative on corporate social responsibility partnerships with pharmaceutical companies.
 - The advantages of a condom marketing program are that men will be reached, synergy can be achieved through promoting dual use to prevent pregnancies and STIs, and youth is a potential target group.
 - Corporate social responsibility partnerships can involve sharing of information (e.g., the URHS) and discussion to engage pharmaceutical companies in providing a wider range of methods and additional information needed by consumers to facilitate their informed choice and proper use of contraceptives. Companies could also be asked to improve point of sales information for pharmacists and consumers and to modify advertising in a way that would enhance the acceptability of their products (e.g., eliminate negative attitudes about condom use).

Integration and Linkages

- Two major areas to improve the integration and linkages among RH and related programs have been identified. Strengthening these linkages is crucial for extending the reach of RH information and services.

- Additional effort is needed to integrate organized family planning services and counseling into both postpartum services and postabortion care in order to increase the use of modern family planning methods among postpartum and postabortion clients. These efforts should be focused on
 - ▶ setting up structural links between delivery and abortion services and family planning,
 - ▶ training providers in postpartum and postabortion family planning services and counseling needs as well as improving their attitudes regarding these services, and
 - ▶ informing postpartum and postabortion clients and their spouses/partners about their contraceptive choices.
- Family planning counseling and services should be integrated into trafficking initiatives to ensure that this vulnerable population is not put at additional risk of unwanted pregnancy and HIV infection. By working in collaboration, NGOs that address trafficking and reproductive health providers can establish both referral systems to
 - ▶ train providers to deal with victims of trafficking and
 - ▶ refer trafficking victims to centers where they have easy access to RH services.

Youth

- Youth in Ukraine is an increasingly important group. There are a number of good opportunities to address the needs of youth. Various existing and planned programs for youth are being undertaken but essentially ignore FP/RH. Counseling and services in FP/RH should be linked to programs, including
 - MOH's youth activities;
 - programs supported by other international agencies (EU, CIDA) through the Ministry of Education;
 - youth organizations and networks (e.g., church groups, Rotary International); and
 - university health centers.
- Initial peer-to-peer efforts should be explored and increased attention to this area should be considered.

Maternal Health

- Family planning alone cannot achieve USAID’s larger goal of reducing maternal mortality—additional direct interventions are also needed.
 - Support should include improvement of clinical practices for maternal and newborn care. First, it will be important to carefully monitor the process of development of the new clinical standards. Second, it is advisable to extend the monitoring of implementation beyond the few pilot sites now identified for monitoring. Ideally, monitoring should occur at facilities in each oblast, but at a minimum, it should occur at the 14 sites where obstetrician/gynecologists are trained. Third, if results warrant extension, the whole-site training should be expanded from the pilot sites to the 14 sites where obstetrician/gynecologists are trained.
 - Support should be given to modify the process of death investigation so that it is anonymous and to help the MOH strengthen its ability to identify systematic problems in the way services are delivered as well as to identify pervasive knowledge/practice gaps that could be addressed by additional training.

PROPOSED STRATEGIC FRAMEWORK

The team has proposed a strategic framework for the USAID/Ukraine RH Program (see next page), which both encapsulates the recommendations and presents a hierarchy of the key areas being emphasized. The framework addresses the Mission’s SO 5, “improved social conditions and health status,” by focusing on strategies that will lead to improved FP/RH services and education.

The first of two broad strategies is support for the implementation of the national FP/RH program by assisting the MOH to develop action plans, including monitoring systems. Three substrategies are recommended to improve program implementation:

- monitoring/advocacy for policy implementation, which includes support for additional studies/surveys and also continued support for advocacy on FP/RH;
- assistance to the MOH for improving the capacity for contraceptive management; and
- greater involvement of the private sector in providing FP/RH.

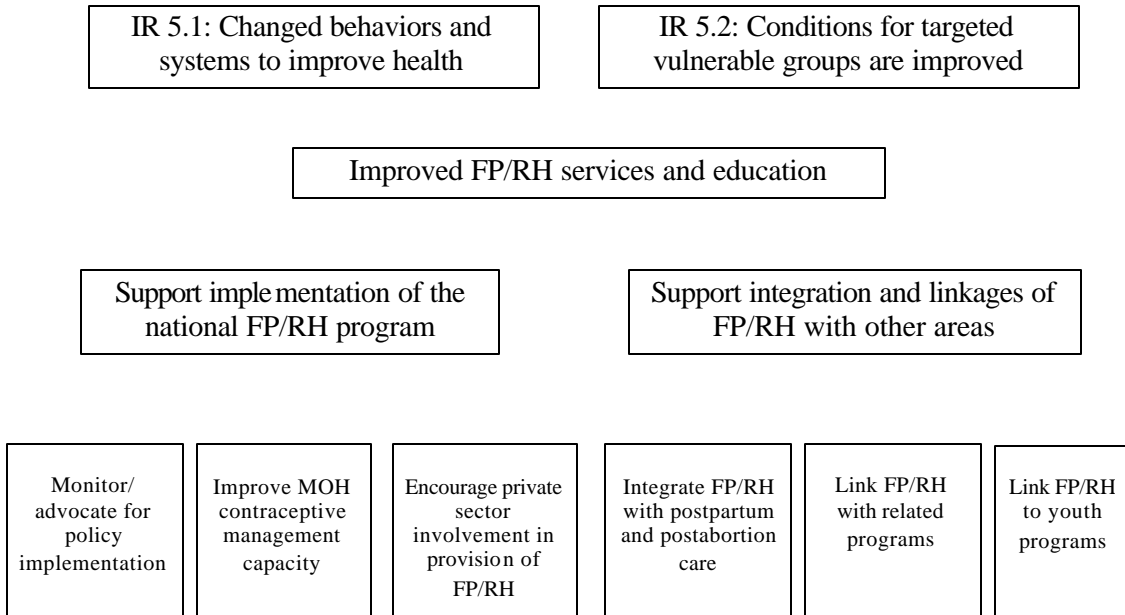
The second broad strategy is support for linkages and integration of FP/RH with other areas. Three substrategies are identified:

- greater effort to integrate FP/RH into postpartum services and postabortion care;
- linking FP/RH with other areas, specifically trafficking initiatives; and

- linking FP/RH to youth programs.

The recommendations in maternal health are not captured in the framework through a specific substrategy but are subsumed in the broad strategy of support for implementing the national program.

Proposed Strategic Framework for the USAID/Ukraine RH Program



APPENDICES

A. SCOPE OF WORK

B. PERSONS CONTACTED

C. REFERENCES

APPENDIX A

**SCOPE OF WORK
(from USAID)**

**USAID/Ukraine
Final Statement of Work
Health Assessment and Design Team**

Summary

This Statement of Work sets forth guidelines for an assessment of USAID/Ukraine's family planning/reproductive/maternal and infant health activities and serves as the basis from which the Mission will build upon past efforts while creating new avenues and directions for support. It is proposed that this assessment take place no later than November 2003.

Since 1992, USAID/Ukraine has supported numerous initiatives and programs that aimed to improve reproductive and women's health and subsequently infant health. Nonetheless, even though over the past ten years (and especially in the most recent five years) maternal mortality, infant mortality and abortion rates all have decreased, indicators still reveal that substantial work remains to be done. Therefore USAID/Ukraine seeks POPTECH support to coordinate a health assessment and design team to review the achievements of investments to date and to identify opportunities for future intervention.

Background

USAID/Ukraine has provided assistance in reproductive health since 1995 in response to Congressional earmarks and directives to reduce high rates of abortion and increase the use of modern contraception. The Women's Reproductive Health Initiative (WRHI), which was instituted in 1995, addressed issues of reducing abortion and increasing access to modern family planning. The program developed model family planning and maternity care services in Odessa, Donetsk, Lviv, Crimea, Kharkiv, Ivano-Frankivsk, and Zaporizhya through 1998.

Sustainable strategies to improve reproductive health services were implemented through the development of family planning centers, updating provider clinical and counseling skills and improving availability of high-quality contraceptives to consumers. The specific objectives of the WRHI were: establishment of demonstration sites for training and delivery of family planning services; institutionalization of reproductive health training; increased public awareness of family planning; improved policy environment for family planning and reproductive health; increased availability of contraceptives; and promotion of family-centered maternity care and early breastfeeding.

From 1995-2000, the WRHI was implemented through six cooperating agencies (CAs) and contractors including: AVSC; SOMARC and POLICY, two projects of the FUTURES Group International; JHPIEGO and Population Communication Services (PCS), two projects associated with Johns Hopkins University; the MotherCare Project of John Snow International (JSI); Centers for Disease Control and Prevention (CDC); and Georgetown University's Institute for Reproductive Health.

An Evaluation of the Women's Reproductive Health Initiative in Ukraine was conducted in October and November of 1997, and a report produced in April 1998. Three consultants under a USAID contract with the Population Technical Assistance

(POPTECH) project including, an OB/GYN, a nurse-midwife epidemiologist and a training specialist looked at achievement of project goals and strategic objectives; cooperating agency (CA) activities; family planning services delivery; family planning training; IEC in support of family planning, family planning commodities and family centered maternity care.

The recommendations contained in the report were numerous (33) and suggested that USAID/Ukraine, through the WRHI, should:

- recognize and stress the male role in contraception;
- begin a program of social marketing;
- increase the focus on male and adolescent services;
- determine an IEC strategy that takes other donors' efforts into consideration and capitalizes on the strengths and experience of USAID, perhaps including some that were not included in the WRHI project;
- strive to institutionalize family centered maternity care (FCMC) changes and integrate these practices into regular maternal care, rather than viewing them as something special requiring a special unit; and collaborate (through the MotherCare project) with WHO Europe in the WHO Baby Friendly Hospital Initiative.”

Building on some of the recommendations of this evaluation, USAID/Ukraine funded the following organizations for the following projects: JHPIEGO for training of service providers; Johns Hopkins University/Population Communication Services (JHU/PCS) for a post-partum/post-abortion initiative; AIHA for an anti-trafficking initiative; CDC for a Reproductive Health Survey (RHS); AED for study tours, training and conferences; Counterpart International to provide mini-grants to NGOs; and The FUTURES GROUP INTERNATIONAL's POLICY Project for assistance to the Ministry of Health and the Government of Ukraine (GOU) in forming a reproductive health strategy.

Several extensive analyses were conducted. In 1999 the Centers for Disease Control and Prevention (CDC) conducted a *Reproductive Health Survey* (RHS). That same year, the UN produced the *Aspects of the Demographic Situation in Ukraine: Reproductive Health and Family Planning*. Subsequently, the Government of Ukraine (GOU) issued its new *National Program Reproductive Health 2001-2005, Ukraine*. These analyses found that critical health indicators for children and women of reproductive age, such as infant and maternal mortality and abortion ratios were still high. According to the RHS, there was a sixty-seven per cent unmet need for family planning which was very high by the standards of developed countries, ranging from 14 percent for those who were not using a contraceptive method to 35 percent for those who used traditional methods. Although abortion ratios declined somewhat, they still remained high, with a total induced abortion ratio (the ratio of induced abortions to live births) of 1.01, indicating an equal number of abortions to live births (GOU stats). Abortion and related complications continued to take the greatest number of women's lives, and almost every fourth woman who died during pregnancy or because of related complications died because of an abortion or complications arising from it (U.N.). Maternal mortality rates had stagnated at twice the average for Europe as whole, with maternal mortality in 1999 at 26.5 per 100,000 live births (MOH stats). Infant mortality rates had also declined slightly, but remain at 12.8 per 1,000 live births.

Recent Activities

By June 2002, the goal of the USAID programs was to improve maternal and infant health in Ukraine through a number of activities that would result in:

- improved quality of reproductive health services;
- increased promotion of good maternal health care;
- supportive legislative/regulatory and analytical environment for provision of quality and efficient reproductive health services;
- strengthened public participation in policy and decision-making in reproductive health.

At that time, USAID was supporting:

- a New Policy Results project to facilitate policy dialogue among governmental and non-governmental entities thus bolstering the participation of well-informed Ukrainian citizens in health policy and decision making, and promoting the Ministry of Health's strategic approach to women's reproductive health issues;
- the American International Health Alliance that included reproductive health as an essential component in strengthening primary health/family medicine, and in supporting Women's Wellness Centers;
- the Birth Defects Surveillance and Prevention Program that provided for modern pregnancy outcome data processing and analysis, and characterize the situation in reproductive health and maternal health care.

In September 2002, USAID/Ukraine agreed to fund implementation of a new Maternal and Infant Health project that specifically aimed to improve reproductive and infant health by fostering quality perinatal services. Its goal were: to complement the ongoing Policy in Reproductive Health Program which assists the Government of Ukraine and NGO task force on Reproductive Health Policy Development in preparing a legislative and regulatory (care standards) framework for reproductive health care reforms; to test activities with this task force and test the feasibility and effectiveness of established standards of care, develop/adapt and institutionalize appropriate clinical protocols, and address barriers to effective reproductive health service delivery. This project also was designed to demonstrate how implementation of effective maternal and infant health services can improve the outcomes of pregnancies for women, and improve health of the neonates.

Proposed Scope of Work

Drawing on international literature and experience, the assessment team will review existing documentation on USAID support for women's health services in Ukraine and meet with a variety of implementers and governmental officials, both at the national and local levels. Building on previous evaluations and strategies, and based on consultations with USAID, the Ministry of Health, the Ukrainian RH NGO Network, and other concerned international organizations, the team will review USAID efforts to date with a view to documenting successes and lessons learned. In addition, the team will provide recommendations on remaining gaps and needs for consideration in future programming. This would include conceptualizing the overall USAID/Kiev framework for addressing reproductive health issues in Ukraine and the principal programmatic and management

structure to achieve impact. The team will consider the environment in which USAID support is given, with a special focus on contributions to national program achievements. This review will would emphasize, but not necessarily be limited to, key issues such as:

- Status of modern contraception – its availability, acceptability and use
- Availability, quality and use of maternal and infant health services
- Abortion rates and post-abortion care
- Status of the Women’s Wellness Centers
- Effective ways to integrate family planning and reproductive health into primary health care
- Effective ways to link family planning/reproductive and maternal and child health efforts to related programs such as HIV/AIDS, TB, trafficking, etc.
- Outstanding issues in the policy arena related to family planning/reproductive and maternal and child health, including but not limited to condom availability, quality, production and distribution systems
- Important gaps that are not being addressed by either USAID, MOH, or other donors

Team Composition

The Team shall consist of four international health experts. There will also be a USAID/Washington representative to provide background information and history on the Ukraine program, as well as limited USAID/Kiev participation, and in-country counterpart participation.

Level of Effort

It is estimated that the Level of Effort (LOE) for this assessment will roughly be as follows:

Background Reading	2 days
Travel Days	4 days
Field Work and Report Writing	17 days
Editing	4 days for Team Leader 1 day for Team Members
TOTAL LOE:	
Team Leader	27 person days
Other two Team Members	24 person days

Timeline

USAID/Ukraine anticipates that the entire review would be completed within a six week period. This would include preparation days, in-country work in Kyiv and the regions, and report writing and finalization. The assessment will begin October 20, 2003 in Kyiv and involve three weeks in Ukraine.

Logistics

USAID/Ukraine shall arrange for a logistician/interpreter to work with POPTECH and the team in arranging all in-country travel and transportation (including airport pickup), lodging, assistance with providing key documents, scheduling meetings and appointments, and hiring additional interpreters when needed. Once in country, the team shall schedule additional meetings as appropriate. USAID/Ukraine shall be available to the team for consultations regarding sources and technical issues, before and during the assessment process.

Preparatory Materials

USAID/Ukraine will provide to POPTECH a list of background and other relevant materials to be duplicated and distributed to team members. The team members will be expected to review the materials prior to arrival in Ukraine and will be given two (2) days of preparation time prior to departure from the United States. The materials will include, but not be limited to:

- The USAID/Ukraine Mission's current strategies
- The CDC *Reproductive Health Survey* (RHS) conducted by CDC in 1999.
- *Aspects of the Demographic Situation in Ukraine: Reproductive Health and Family Planning* conducted by the UN in 1999
- The GOU's *National Program in Reproductive Health 2001-2005*

Meetings and Briefings

Orientation Meeting with Mission Staff: The entire first day of the team's visit will be devoted to meetings with Mission staff and other relevant personnel. Among other matters, the Statement of Work will be explained, discussed and amended as appropriate.

Debriefing to Mission staff An Out-brief, including presentation of main findings and recommendations, will be presented both orally and in writing (preferably power-point) in bullet-text format.

Deliverables

The First Draft of the final report will be due at end of the team's visit. The length should not exceed 30 pages (not including appendices, lists of contacts, etc.). This draft will include findings and recommendations for Mission review.

Final Report: based on input and sections drafted by other team members, the team leader will prepare the final draft of the report for submission and processing to POPTECH who will, in turn, solicit further input from the Mission before issuing the final edited report. The mission would like 25 hard copies and an electronic version of the final report.

Estimated Budget

USAID/Ukraine estimates a total cost of not more than \$120,000.

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

UNITED STATES

U.S. Agency for International Development (USAID)/Washington

Mary Jo Lazear, Health and Population Officer, Office of Regional and Country Support,
Bureau for Global Health

UKRAINE

Kyiv

USAID/Ukraine

Nancy Godfrey, Director, Office of Health and Social Transition
Tim Clary, Senior Technical and Policy Advisor for HIV/AIDS and RH
Olena Radziyevska, Project Manager, Office of Democracy and Social Transition
Irina Gladun, Program Management Assistant

Ministry of Health

Raisa Moiseenko, Head, Department of Mothers and Children
Madezhola Zhilka, Chief Specialist, Department of Mothers and Children

American International Health Alliance (AIHA)

Alyona Gerasimova, Regional Director, West NIS
Elena Voskresenskaya, Senior Program Coordinator
Ella Kocharyan, Program Coordinator
Oksana Ivanyuk, Program Coordinator

POLICY Project, The Futures Group

Andrij Huk, Program Operations Manager
Oleg Semeryk, Technical Advisor for RH/HIV
Viktor Galayda, Consultant
Olena Truhan, Advocacy Coordinator

Maternal and Infant Health Project (MIHP), John Snow, Inc.

Helene Lefevre-Cholay, Chief of Party/Project Director
Alexander Golulov
Stanislav Pupyshev
Olga Dudina, Standards Development Specialist
Tamara Irkina, Clinical Specialist

Women's Wellness Center, Kyiv Maternity

Lesya Yakovenko, Center Director

Kyiv Family Planning Center

Yuri Smischuck, Director
Stepan Mailo, Medical Director

European Union

Anja Nitzsche-Bell, Project Manager, Health and Social Sector

United Nations Population Fund

Borys Vornyk, Program Coordinator

Winrock International

Amy Heyden, Director of Trafficking Prevention Programs

La Strada

Kateryna Levchenko, Ukraine National Director

Lviv and Environs

Galina Misyura, Local Coordinator, MIHP, and Deputy Head, Lviv Oblast Clinical Hospital

Kam'yanka-Buzka Central Rayon Hospital

Alexander Koval'chuk, Head Physician

Belous Zinoviy, Head, Maternity Department

Novicka Luba, Neonatologist

Lviv Oblast Health Administration

Nadiya Melnik, Deputy Head

Irina Mykychak, Head, Maternal and Infant Healthcare Department

Women's Consultation Center No. 2 at Lviv City Hospital No. 1

Olga Kareva, Head

Oleg Bizyakin, Physician

Lviv Oblast Clinical Hospital

Sereda Orest, Head Physician

Alexander Payenok, Physician

Stakh Zenovij, Physician

Mysjuza Halina, Physician

Soloscheuzko Ladi, Physician

Ukrainian Railways, Railway Clinic No. 3

Stanislav Kravets, Chief Medical Director

Lviv Women's Wellness Center at Railway Clinic No. 3

Lyudmila Gutsal, Director

Zibolki Family Practice Center

Yaroslav Paramud, Director

Lviv Family Practice Center

Yaroslav Nazar, Director

Yuriy Filts, Physician

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Irina Keslynka, Family Doctor

Center for Reproductive Health

Juri Ivanochko, Director

Lenia Ivasivka, Obstetrics/Gynecology Regional Coordinator

Adolescent Gynecology Center

Dr. Chaikivska, Physician

Lviv Regional Perinatal Center

Larysa Janiv, Head Doctor

Member of Ukrainian Reproductive Health Network

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Members of Policy Development Group

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Lutsk City Maternity Hospital

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Lutsk Perinatal Center

Geogory Vashchilin, Physician

Kovel Maternity and Women's Center

Mikola Legeza, Head Doctor

Donetsk and Environs

Slabokij Genadij, Local Coordinator, MIHP

Oblast Administration

Anischenko Alexandr Vladimirovich, Chief of Oblast Administration

Zelinskaya Elena, Chief Neonatologist

Shpatusko Nikolay, Chief Obstetrician/Gynecologist

Podolyaka Valentina, Chief Doctor, Hospital #3

Kirovskii District Health Administration

Valentina Obezinska, Head, Women's Council
Anatoly Gerasimenko, Head Doctor, Polyclinic # 25
Tatyana Plotnikov, Head, Women, Children, Adolescents and Youth Council
Larisa Lipskaya, Head, Family Practice Center
Angela Gotsalyuk, Head, Women's Wellness Center
Marta Gebedeva, Family Planning Doctor

Kramatorsk District Health Administration

Ludmila Komovalova, Head, City Health Administration
Elina Ovcharenko, Director, Women's Wellness Center

Women's Consultation Clinic in Polyclinic #3

Elena Metalica, Chief, Women's Clinic

Torez Central City Hospital

Yeremeyev Hennadiv, Chief Doctor
Lyudmila Kucherova, Deputy Chief Doctor
Ludmial Dzuba, Chief, Maternity Department

Oblast Hospital

Hennadiy Sidorenko, Deputy Chief Doctor
Valentina Sveridone, Director, Oblast Obstetrics and Gynecology Center
Irina Anpelogova, Neonatologist

Hospital #3

Tatyana Vakarchuk, Chief, Obstetrics and Gynecology Department

Simpheropol and Environs**Crimea Ministry of Health**

Ellia Glazkov, Chief Obstetrician/Gynecologist
Galina Michaelovena, Deputy of the Minister of Health
Tatyana Tekuchenko, Maternal and Child Health

Simpheropol City Maternity

Illya Glasoav, Head Doctor and Chief, Obstetrics and Gynecology, Republic of Crimea
Galina Zhiravlera, Head, Obstetrics and Gynecology Information and Statistics

City Family Planning and Reproductive Health Center

Igor Livshyts, Head, Department of Human Reproduction

Crimean Association of Family Planning

Elena Shevchenko, Coordinator

Saki Maternity

Gerasimenko Vasiliy, Chief Doctor, Saki

APPENDIX C

REFERENCES

REFERENCES

American International Health Alliance. "Women's Health Programs." (undated)

Bergthold, Gary, Judith Rooks and Gary Stewart. *Evaluation of the Women's Reproductive Health Initiative in Ukraine*. Arlington, VA: POPTECH Report No. 97-118-060, April 1998.

Cabinet of Ministers of Ukraine and Ministry of Health in cooperation with State Statistics Committee and National Academy of Sciences. *The Health of Women and Children in Ukraine*. Kyiv: United Nations Development Programme Office, Ukraine, 1997.

Centers for Disease Control and Prevention and ORC Macro. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*. Atlanta, GA and Calverton, MD, 2003.

Cromer, Charlotte and Judith Seltzer. *Reproductive Health Strategy for the Ukraine 1999-2002*. Takoma Park, MD: Monitoring, Evaluation and Design Support (MEDS) Project, June 1999.

Curtis, Sian L. and Ann K. Blanc. "Determinants of Contraceptive Failure, Switching, and Discontinuation: An Analysis of DHS Contraceptive Histories." *Demographic and Health Surveys, Analytical Reports No. 6*. Calverton, MD: Macro International Inc., October 1997.

"The Day," in *Weekly Digest*. October 28, 2003a.

"The Day," in *Weekly Digest*. November 4, 2003b.

The Futures Group International. "Social Marketing for Change III Project Final Report Under the Ukrainian Women's Reproductive Health Project." Ukraine, February 26, 1999.

_____. "The POLICY Project Strategy and Workplan: Ukraine, September 2002-July 2003." August 2002.

Government of Ukraine. Order of the President of Ukraine on the National Program "Reproductive Health 2001-2005." March 26, 2001.

Harrison, Denise. E-mail communication. October 30, 2003.

John Snow, Inc. *Ukraine JSI Strategic Framework 2002-2006: A Management Tool for Guiding Maternal and Infant Health Project (MIHP)/JSI Project Activities*. May 2003 and August 2003.

JSI/TASC Ukraine. *Maternal and Infant Health Project Site Needs Assessments Summary Report, February–March 2003*. JSI/TASC Ukraine Maternal and Infant Health Project, April 2003.

_____. *Maternal and Infant Health Project Quarterly Technical Report, 30 September 2002–31 December 2002*. JSI/TASC Ukraine Maternal and Infant Health Project, USAID Contract No. HRN-I-00-98-00032-00, January 31, 2003.

Kiev International Institute of Sociology, Centers for Disease Control and Prevention (CDC), and U.S. Agency for International Development (USAID). *1999 Ukraine Reproductive Health Survey*. Atlanta, GA, September 2001.

Kohut, Myroslaw B. and Natalya Lakiza-Sachuk. *Key Informant Study: Policymaker's Knowledge of and Attitudes Toward Reproductive Health in Ukraine*. A report to the POLICY Project, July 1999.

_____. *National Level Decision Making on Reproductive Health Policy in Ukraine*. A report to the POLICY Project, July 1999.

Ministry of Health (MOH), Ukraine, Family Planning National Programme. "Explanatory Note to National Programme on Family Planning." (undated)

_____. "Public Health in Ukraine, Overview." 2000.

_____. "On Improvement of Outpatient Obstetric-Gynecologic Care in Ukraine." Order #503, 2002a.

_____. "Information About the Implementation Status of the National Reproductive Health Program 2001–2005, According to 2002 Summary Data." 2002b.

_____. "Information" (table of indicators). April 2003.

Ministry of Health Press Service. "Information on the Status of Reproductive Health in Ukraine" (from a press conference held on October 29, 2003). 2003.

Perry, Steven. *Contraceptive Audit for USAID/Kiev*. Report for the Monitoring, Evaluation, and Design Support (MEDS) Project. Takoma Park, MD: October 1999.

POLICY Project/Ukraine. "Overcoming Operational Barriers to Reproductive Health in Ukraine." Policy Brief (based on the Reproductive Health Resource Efficiency Study in Ukraine [2001–2002]). October 2003.

Ravenholt, Betty Butler. *Implications of the Legal and Regulatory Environment for Family Planning and Reproductive Health Services Delivery in Ukraine*. A report to the POLICY Project. (undated)

Rudiy, Volodymyr. *Legal and Regulatory Framework for Family Planning and Reproductive Health in Ukraine*. A report to the POLICY Project, June 1999.

Steshenko, Valentina and Tamara Irkina. "Some Aspects of the Demographic Situation in Ukraine: Reproductive Health and Family Planning." United Nations Population Fund (UNFPA), 1999.

Ukrainian Reproductive Health Network (URHN). *Reproductive Health Newsletter*. Issue 1, 2003.

U.S. Agency for International Development. "Guidance on the Definition and Use of the Child Survival and Health Programs Fund: FY 2003 Update." May 23, 2003.

_____. *Family Planning/HIV Integration, Technical Guidance for USAID-Supported Field Programs*. September 2003.

_____. *Adding Family Planning to PMTCT Sites Increases the Benefits of PMTCT*. Issue Brief, HIV/AIDS. October 2003.

USAID/Ukraine. *Country Strategic Plan for 2003–2007*. Approved September 2002.

_____. *HIV/AIDS Strategy, 2003–2008*. October 3, 2003a.

_____. "Strengthened Delivery of HIV/AIDS Information and Services in Ukraine." RFA No. 121-04-001. Issue date: October 10, 2003b.

Vornik, Boris, N. Zhilka, V. Kolomietz, and K. Talalaev. *For Journalists about Reproductive and Sexual Health* (published in Ukrainian). UNFPA, 2003.

WHO, UNICEF, and UNFPA. *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, and UNFPA*, Final 18 July 2003. Geneva, Switzerland: Family and Community Health, WHO, 2003.

Winrock International. *Trafficking Prevention Project, Thematic Quarterly Report, January–March 2003: The Impact of Human Trafficking on Women's Health*. 2003.



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