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REPRODUCTIVE HEALTH MARKET ASSESSMENT IN RUSSIA

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Submitted to:

Marguerite Farrell, AOTR
Bureau of Global Health
Global Health/Population and Reproductive Health/Service Delivery Improvement
United States Agency for International Development

Sandhya Rao, Senior Private Sector Advisor
Bureau for Global Health
Office of Population & Reproductive Health
United States Agency for International Development



Abt Associates Inc. ■ 4550 Montgomery Ave, Suite 800 North
Bethesda, Maryland 20814 ■ Tel: 301-913-0500 ■ Fax: 301-652-3916
■ www.shopsproject.org ■ www.abtassoc.com

In collaboration with:

Banyan Global ■ Jhpiego ■ Marie Stopes International
■ The Monitor Group ■ O'Hanlon Health Consulting

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ACRONYMS

BSP	Bayer Schering Pharma
EC	Emergency Contraception
FGD	Focus Group Discussion
FP	Family Planning
GOR	Government of Russia
HDF	Health and Development Foundation
IUD	Intrauterine Device
MCH	Maternal and Child Health
MHSD	Ministry of Health and Social Development of Russian Federation
NGO	Nongovernmental Organization
OCs	Oral Contraceptives
PMS	Premenstrual Syndrome
RF	Russian Federation
RH	Reproductive Health
SHOPS	Strengthening Health Outcomes through the Private Sector Project (USAID- funded; 2009- 2014)
SMS	Short Message Service
STI	Sexually Transmitted Infection
U.N.	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

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I. BACKGROUND

In recent years, the Government of Russia (GOR) reactivated efforts to stimulate population growth in the Russian Federation (RF) through a series of strategic initiatives. Such initiatives include the “Maternal Capital” policy, which encourages birth or adoption of second and subsequent children among married couples, and the declaration of 2008 as the Year of the Family. Yet, according to the World Health Organization (WHO), the rate of nonchemical abortions in 2008 was 42.2 percent in Russia while the average global rate was 22 percent of all pregnancies (Sukhikh and Yarotzkaya 2010). Reproductive health (RH) experts indicate that 70 percent of women could use modern contraceptives to decrease the number of abortions (Sukhikh and Yarotzkaya 2010). However, a population-based survey conducted by the Independent Institute of Social Policies (2009), a Russian think tank, as part of the United Nations (U.N.)-led global *Generations and Gender* program, indicated that 51.8 percent of Russian women used modern methods in 2007.

Several government- and donor-funded programs have been working on maternal and child health (MCH) issues such as the protection of RH and the introduction of birth spacing concepts. USAID/Russia has implemented a successful MCH program in several cities that integrates RH clinical information and counseling through health provider training and in-service curricula development. Modern contraceptive methods are amply available in municipal and private pharmacies, and contraceptive products are regularly supplied through private distribution networks. Inspired by these achievements and the prior success of working with the private sector in other countries, USAID’s Office of Population, Health, and Nutrition requested an examination of opportunities for social marketing and public-private partnerships to support the GOR’s efforts to improve women’s health.

USAID selected the Strengthening Health Outcomes through the Private Sector (SHOPS) project, a USAID flagship program led by Abt Associates to increase the role of the private sector in the provision of family planning products and services around the world, to lead this effort. A longtime USAID partner, Bayer Schering Pharma (BSP), and its country affiliates, have a successful history of working with donor-funded programs to improve contraceptive security through combined supply and demand activities. The two counterparts, SHOPS/Abt and BSP, signed a letter of intent to conduct an assessment and design a viable partnership to support USAID efforts in achieving the following objectives:

- Increase access to and use of high-quality commercial contraceptives among nonusers, especially lower income nonusers, in Russia.

- Expand the private sector market of hormonal contraceptives, including oral contraceptives (OCs), intrauterine devices (IUDs), and other methods to lower income users in Russia.

1.1 ASSESSMENT METHODOLOGY

The SHOPS team, together with the BSP local office, approached this assessment as a multisector analysis and sought to identify key barriers, attitudes, and behavioral trends toward hormonal contraception among physicians and patients. In addition, the assessment team sought to find common ground between public health goals and private sector interests to design an “all-inclusive” partnership that would support increasing access and use of high-quality hormonal contraceptives. To gather comprehensive information, the team conducted a literature review prior to arriving in-country and analyzed 30 publications. While in Russia, the team met with more than 25 informants and conducted six group discussions with 48 female clients from December 7–17 in the cities of Moscow and Yekaterinburg. Persons interviewed included representatives of pharmaceutical companies, nonprofit Russian foundations, public and private ob/gyns and pharmacists, heads of women’s clinics, senior health officials, demographic researchers, and representatives of a company with a large female workforce.

The team also collected data on method mix, pricing, and product availability in a number of pharmacies of various sizes and types of ownership. Further, the team conducted Internet-based research to learn the current content of discussions in social networks, online chats, and blogs in regard to protection of women’s health and prevention of unwanted abortions.

2. OVERVIEW OF REPRODUCTIVE HEALTH ENVIRONMENT

2.1 REPRODUCTIVE HEALTH STATUS AND PROGRAMS

Fertility control programs have been functioning in Russia since the early 1920s, offering abortion as a main contraception method. From 1936 through 1955, however, abortion was banned until Russia’s fertility program restored legal abortions. The program, nevertheless, did not provide options for preventing unwanted pregnancies before conception. Family

planning (FP) counseling and modern contraceptive methods did not exist in Russia in this era. Traditionally, people used less reliable methods, including the calendar method, withdrawal, and locally manufactured low-quality condoms. OCs arrived in the Russian market in the late 1980s and early 1990s, significantly later than in Western countries, and even then, large cities experienced a severe shortage of pills, and remote and rural areas often lacked access altogether. The Ministry of Health was strictly opposed to these innovations and proclaimed OCs as harmful and the cause of severe side effects including cancer [Ministry of Health and Social Development (MHSD) and WHO 2009]. Lacking other sources of information, some women considered having an abortion to be safer than taking a pill. Aggravating the situation was the fact that women had no choice other than whatever pill was available on the very limited contraceptive market, and they often neglected to consult a doctor before making their decision. Consequences of such misuse fueled negative myths about oral and overall hormonal contraception in the minds of users and doctors for generations forward.

Today, Russia offers various abortion options. A woman can buy an abortifacient pill (also known as chemical abortion) in a pharmacy for an average of RUB 1,000 (US \$33). Government clinics provide abortion services for free. In the private sector, a woman can obtain an abortion for RUB 4,000–8,000 (US \$133–267). In locations further away from the capital, the price for abortions rises. For instance, in commercial clinics in Yekaterinburg, the price for an abortion may fluctuate from RUB 10,000–13,000 (US \$333–433). During the holiday season, the price can decrease as much as 50 percent, as evidenced by an advertisement in a local newspaper and reported by one of the focus group participants.

During the mid-90s, the GOR established a distinct, nationwide FP program with mandatory FP counseling services provided in all women's clinics. Since the GOR opened up the market in the 1990s, public and private pharmacies have offered a wide variety of modern methods and brands of contraceptives. As a result, use of modern contraceptives, including pills, increased, and abortions, as a percentage of total pregnancies, decreased from 70 percent in the early 1990s to 44.7 percent by 2008 (Johnston 2010)¹.

In 1998, the GOR cut funding for the national FP program, which resulted in the elimination of FP as a stand-alone program, followed by the closing of the majority of counseling rooms and the abolishment of sex and RH education programs in schools. Contraception procurement through subsidized channels such as the International Planned Parenthood Federation and the United Nations Family Planning Agency was minimized. Currently, the local governments are attempting to integrate FP and RH in MCH or health lifestyle programs and bring back RH education to the schools and FP counseling training to medical colleges and universities.

On average, sexual debut in Russia happens at the age of 15–16 among both boys and girls, although a number of pregnancies occur among 12–13 year olds. Sexually active youth

¹ Found at <http://www.johnstonsarchive.net/policy/abortion/ab-russia.html>

prefer the condom as a contraceptive method. According to the national survey *Parents and Children, Men and Women in Family and Society*, conducted in 2004 and 2007, condoms continue to be the preferred method of contraception among all age groups, with 30.3 percent use among women and 38 percent among men, and the number of users is steadily increasing. The second most popular method is the IUD (20.4 percent of women reported use and 18.9 percent of men reported partner's use), followed by the calendar method (14.5 percent of women reported use) and OCs (14.7 percent of men reported partner's use and 14.1 percent of women reported use).

Overall, the current modern contraception prevalence rate is 51.8 percent among women and 56.9 percent among men, according to the study. The proportion of women using OCs is about 15 percent (compared to 40–50 percent of users in Germany, Belgium, and France), and most OC users are not officially married and/or do not have children.

The same survey reported that unmet need² for contraceptives among couples who do not use any contraception is around 9–10 percent, which is not high by itself but is considerably higher when compared to some European countries (Hungary at 4 percent, and France at 3 percent). The study also calculated the percentage of unmet need for contraceptives among couples who use no contraception and those using traditional methods. In this case, the unmet need increases to 21–24 percent, which is significantly higher than the same indicator in France (5 percent) and Belgium (4 percent) (Independent Institute of Social Policy 2009).

2.2 MARKET ENVIRONMENT

The Russian market of contraceptive products is very viable and moderately diverse. Products, mainly imported from Europe, are disseminated through a wide network of local distributors to various-size private pharmacy chains as well as to municipal pharmacies, which are also available throughout the country. The most popular pharmacy is a high-end, private pharmacy chain called "36.6" with more than 1,000 outlets available nationwide and sub-chains represented in every mid to large city. Smaller, local chains, including "Doctor Stoletov," "Apteka-Klassika," and "Solnyshko," are competing with larger companies and tend to have lower prices for most contraceptives. Municipal pharmacies are perceived to have the cheapest products, but not all FP products are within the affordable range for mid-income customers.

Every pharmacy offers a range of OCs, including combined OCs and emergency contraception (EC) pills, IUDs, condoms, and, to a lesser extent, the vaginal ring (NuvaRing), vaginal suppositories, and the hormonal patch (Evra). The main suppliers of modern

² Currently married fecund women who either want no more children or want to wait at least two years before having another child, but who are not using contraception, are considered to have *unmet need for contraceptives* (or family planning)

contraception on the Russian market are three foreign manufacturers: BSP (OCs and Mirena IUD), Gedeon Richter (OCs and EC), and Organon (acquired by Schering-Plough, which has been recently acquired by Merck) (OCs, IUDs, and NuvaRing). Other manufacturers selling hormonal contraceptives are Janseen Cilag (now with Johnson and Johnson), which supplies the patch Evra and vaginal suppositories; Zentiva (Czech Republic), Berlin-Chemi (Germany), and Orion-Pharma (Finland), which provide OCs; and Innotech, Merz, and Pharmaceutical Industry Jakarta, which supply vaginal suppositories.

Consumer advertisements are legal for condoms only, and not for any hormonal methods. Condoms are sold in a variety of outlets outside of pharmacy chains, but hormonal contraceptives are not. To purchase a contraceptive pill, the client is required by law to have a written prescription from a doctor, but this method is easily available over the counter with verbal reference from the client to a prescribed brand.

RH services for women are provided through women's consultations, which are special clinics for women that survived from the Soviet health system. These clinics offer services such as gynecological exams and treatment for sexually transmitted infections (STIs), contraception counseling, and prenatal observation. Post-delivery services are given in maternal hospitals, which are separate from the women's clinics and do not provide FP counseling. Although these public sector facilities provide services free of charge through the national mandatory health insurance system, the widespread practice of out-of-pocket payments or in-kind gratifications for outpatient, and especially inpatient care, in government facilities remains a strong cultural norm in Russia. Alternatively, a woman can receive RH services in the growing private sector system of primary care clinics with ob/gyn specialists who also provide contraception counseling. Prices for such services vary and clinics mostly serve higher income women.

2.3 POLICY ENVIRONMENT

The main law in Russia that regulates contraception rights and access to FP is called *Legislation Bases of the Russian Federation about Health Protection of Citizens*. The law was enacted in 1993 and is in the process of significant revision. Currently, article 22 in Section V of the law states that every citizen has the right under medical indication to free consultation on FP, society-endangering diseases, marriage-related psychological issues, and other services. Since FP is not institutionalized in Russia, it is not included as a separate subject in medical school curricula, and FP services are not covered by the national mandatory health insurance. A short list of FP products is, however, included in the Essential Drug List as medications and not as contraceptive products.

After canceling the national FP program in 1998, the Duma (Russian Parliament) is now discussing a new bill on *Protection of Reproductive Health of the Population of Russian Federation* that would define a national vision and policies on RH. One of the bill's objectives

is to respond to country demographic needs based on internationally accepted standards. Among other actions, the new bill proposes bringing RH and FP topics back to school education, allowing public information dissemination and promotion of hormonal contraception, and defining RH rights of young patients.

Despite significant efforts to create a culture of FP during the late Soviet period and the 1990s, the concept of FP is still incorrectly understood by a large portion of society and perceived as a method to prevent population growth. As a result, under the current national demographic agenda with the goal to increase the population to 145 million by 2020³, RH has become a controversial political issue.

The Russian Orthodox Church, with its pro-life agenda, is lobbying the idea of birth as the only alternative to abortion and contraception. In the Church's view, abortion is considered a mortal sin equating to murder. Contraception is also viewed as a sin regardless of the fact that it precipitates abortion. National government agencies such as the MHSD and the Ministry of Education and Science have not yet devised consistent and unified messages regarding contraception, abortion, and FP. The country lacks a national RH and sexual educational program for teenagers and young adults. This has resulted in regional departments, local self-government institutions, and civic organizations taking the initiative to preserve the RH potential of women through local FP- and RH-related policies, programs, and activities that involve health provider education and skills building, outreach to youth and women, and provision of subsidized contraceptive products to marginalized population groups.

On the product supply side, the Federal Antimonopoly Service has recently worked with national agencies to develop regulatory documents and policies that limit marketing outreach and communication between pharmaceutical companies and doctors and pharmacists. This was triggered by the prime minister's critique of marketing approaches and methods used by some companies. Specifically, the MHSD drafted a new bill related to the law *On the Basis of Health Protection of Citizens of Russian Federation* in 2009. The bill regulates the relationships and level of communication between health providers and representatives of pharmaceutical companies by limiting direct, face-to-face communication and contacts between the parties during working hours. However, information sharing is allowed through public events such as conferences, workshops, and seminars supported by more than one drug company. The purpose of such revisions is to eliminate sources of potential favoritism of one company and brand (usually a more expensive one) over other options that might be more suitable for some clients.

³ GOR. The Concept of the Healthcare System Development in Russian Federation by 2020

3. ASSESSMENT FINDINGS

The SHOPS team travelled to Russia for two weeks in December 2010 to gather information about current attitudes, perceptions, knowledge, use, and availability of RH services and products. The collected data will serve as a basis for designing an integrated program in partnership with the private sector to increase use of hormonal contraceptives among Russian women.

The assessment consisted of four components:

1. Key informant interviews
2. In-depth doctor and pharmacist interviews
3. Focus group discussions (FGDs) with users and potential users of hormonal contraception
4. Examination of product availability and access

This chapter will present the most relevant and major themes that emerged from interviews, discussions, and observations. The assessment findings will provide an overview of the overall RH situation and stimulate ideas for developing guiding principles and concrete actions in designing the program.

3.1 KEY INFORMANT INTERVIEWS

Key informants were government officials, USAID-funded project managers, demographic researchers, and representatives of pharmaceutical companies, nonprofit Russian foundations, and the local manufacturing industry. Testimonials from these interviews were often iterative and are summarized below.

- At the federal level, contraception and abortion are not widely discussed and the influence of the Church is significant. Federal regulations prohibit mass media advertisement and promotion of hormonal methods. School education on RH and FP has not been addressed at the federal level since 1998; however, government at the regional level is open to identifying effective RH interventions. For instance, in the Ivanovo region, the local government issued a regulation that guarantees rights for RH and RH education among youth 14 years old and older. Each school in the region is to have a teacher trained in RH and FP counseling with students and parents. Other regions integrate RH/FP information into healthy lifestyle

modules or into the biology curriculum.

- The practice of counseling is not commonly accepted, especially in government facilities. This is partially due to national performance standards that allow a public sector doctor only 12 minutes per client visit with a daily norm of 20–22 patients. Women’s apathy and lack of interest in FP counseling can be partially explained by their limited knowledge of modern contraception, the historical acceptance of abortion as a contraception method, and the phobia that still exists toward hormonal products. In addition, physicians and midwives in maternity clinics do not counsel post-natal women on FP and contraceptives as it is not part of their responsibility. Nurses in women’s clinics are not perceived as qualified to counsel on contraception. The only doctors that are officially qualified to counsel are gynecologists and general practitioners (or family doctors), but Russia has no social norm for women who want to consult with their general practitioner about FP. Furthermore, public sector ob/gyns have low salaries and many of them leave the sector to work in private clinics, which are more expensive and not affordable for mid- to low-income women. Therefore, the majority of women do not have easy access to counseling on FP and methods of contraception.
- Physicians’ knowledge of modern methods of contraception varies and significant gaps exist. Pre- and in-service training programs do not comprehensively cover FP and RH topics and do not provide technology updates for abortion procedures. One of the interviewees shared that *some doctors have knowledge on contraception at the level of laymen, believing that hormonal methods are harmful, it’s not good to insert an IUD after abortion, and emergency contraception pills cause abortion.*
- Pharmaceutical companies are the only source of information about new methods, technologies, and products. Donor-driven programs are working hard to further introduce evidence-based medicine principles and revise clinical standards for RH services, but their efforts are not enough to maintain the level of knowledge required for quality service provision and cover the needs of the entire country. Currently, the USAID-funded project *Institutionalizing Best Practices in Maternal and Child Health* is working closely with the government to standardize MCH and RH service provision guidelines at regional and federal levels.
- Given the lack of FP information outside of health facilities, workplaces and prenatal classes may provide effective outlets for RH outreach. Print materials and trained counselors available for workers and class participants can partially replace the lack of school education and other public information on FP and RH that is not accessible on a regular basis.
- Representatives of pharmaceutical companies confided that the reasons for underutilization of hormonal methods are severe “hormonophobia” among the general population and low “replication” of information and misperception of OCs among doctors. The companies need help identifying “champions” in the provider community and among consumers that could help overcome resistance to hormonal contraception. A need exists for new, innovative channels to reach out to women (and men) with information on FP and RH. All traditional

communication channels have been regularly used, and some of them are not currently available due to policy restrictions (such as in mass media advertising of hormonal contraceptives). Social networks, customized websites, Short Message Service (SMS), or other mobile applications can be a way to repackage information and attract attention of potential users.

3.2 DOCTOR AND PHARMACIST INTERVIEWS

Respondents for this component were managers of public women's clinics, practicing gynecologists from public and private clinics, and pharmacists from the national pharmacy chain "36'6" and smaller drug stores. Key themes that emerged from these discussions were clients' FP preference and attitudes, FP counseling and service availability and accessibility, access to products, and access to information by providers.

- All interviewed doctors and pharmacists confirmed that they do not get counseling training through preservice curricula and not much in-service training exists. Most gynecologists get updates on RH by attending pharmaceutical company-sponsored events. Big pharmaceutical companies usually hold monthly lectures or half-day seminars and larger conferences every three to four months.
- Some doctors indicated they are witnessing an increase of STIs among youth and explained this trend is a result of increased sexual activity among youth who come to big cities to study and live away from their families. Many of these young women first present with STI symptoms and then seek information about contraception. At the same time, the doctors observed that the number of abortions have decreased in the last 4–5 years and women are less afraid of using OCs nowadays. The doctors reported, however, that many clients continue having a bias toward OCs and often inquire whether recommended pills cause weight gain and hirsutism. The head of one women's clinic shared that some women prefer abortion to OCs because they are afraid that OCs will cause cancer. Often only after experiencing their first abortion are women advised that this is not a contraceptive method.
- Despite bias against them, OCs are the most popular type of contraception prescribed in clinics, followed by IUDs, the vaginal ring, and patches. Injectable contraception is the least popular and available method among hormonals. This method was not found in any of the pharmacies visited during the assessment. The main disadvantages of injectables, according to the doctors interviewed, are the amount of time it takes to return to fertility after two rounds of injections, irregular and prolonged bleeding, and skin rash.
- Interviewed physicians stated that prior to prescribing a certain type of hormonal contraceptive (especially a pill), a patient undergoes a number of hormonal tests to determine OC acceptability and then the doctor develops a specific OC regimen. For many

women this procedure seems burdensome, and, therefore, they go directly to a pharmacy to buy the pills. Such behavior causes a large number of women to discontinue OC use because pharmacists do not have full information about the client and are not able to recommend the most appropriate brand.

- In general, pharmacists provide little counseling. They provide the contraceptive product requested, even if the client does not have a prescription. In pharmacies, no issue with lack of confidentiality and privacy was observed by the assessment team for women purchasing contraceptives, but these women do not have in-depth discussions with clerks about the methods they are purchasing. In big cities, many products, including contraceptives, can be purchased online.
- Public clinic doctors mentioned that all the educational and promotional materials posted on the walls in women's clinics are placed with the city or the local health authority's permission. In fact, they confided that all initiatives should be designed and implemented in close collaboration with and approval from local government. All service providers expressed a need for information and educational materials to hand out to their clients, especially young girls, to enable these clients to learn more about FP choices available. In addition, all respondents expressed that the state should be responsible for providing information on FP and RH issues through TV, radio, and other mass media sources.
- The Church often plays an active role in providing social support to women in difficult situations. When young women come for an abortion, some government clinics arrange meetings for them with a Church representative. Every clinic visited during the assessment had pro-life posters displayed and brochures sponsored by local religious institutions. The Church also provides housing and finances to lower income women, especially those women who keep their children despite having unwanted pregnancies. The duration of such social support has not been identified.
- All doctors expressed regrets about the elimination of the federal FP program, specifically mandatory FP rooms and FP days organized in women's clinics during the 1990s.

3.3 FOCUS GROUP DISCUSSIONS

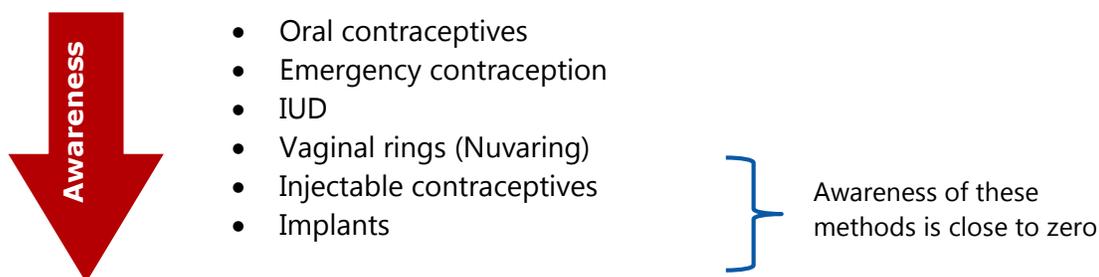
The assessment team conducted six FGDs in Moscow and Yekaterinburg among women of reproductive age from mid- to lower income groups. Two groups included users of hormonal contraception aged 18–24 and the other four groups were women aged 18–24 and 25–35 who were not hormonal contraceptives users.

- Among respondents, women had a high level of understanding of RH, the main risks to RH (abortion, STIs, infertility), and ways to maintain RH, however, few of these women reported

taking the necessary measures.

- Most respondents reported that a gynecological visit is not a routine procedure. Many women have negative attitudes toward doctors. Respondents perceived public sector physicians as unfriendly and unknowledgeable; they believe private sector doctors are expensive and try to sell them extra, unnecessary services. The FGD participants provided the following evidence to support these findings:
 - A gynecological examination is generally uncomfortable and the women are unwilling to discuss intimate issues with the doctor.
 - Free municipal clinics do not provide a sufficient level of service. Doctor qualifications, human qualities, and attitudes are inadequate and unfriendly.
 - The women reported not having enough time because of too much work, studies, or domestic chores.
 - The women reported a lack of money to go to private clinics.
- All respondents reported a high degree of awareness about modern and traditional methods. However, few realized that some modern methods include hormones. Figure 1 demonstrates the list of hormonal methods in order of respondents' decreasing awareness.

FIGURE 1. AWARENESS OF HORMONAL METHODS AMONG FGD RESPONDENTS



- Nonusers of hormonal contraception favor condoms and withdrawal. They believe that pills are unhealthy and cause side effects such as weight gain. If a physician advised, however, that the pill would be a suitable method for them, nonhormonal users said they would be willing to try the method.
- Hormonal users primarily prefer OCs, with a few using IUDs and EC.

- On average, respondents were willing to pay RUB 300–500 (US \$10–16) per month for contraceptives, and indicated that RUB 1,000–2,000 (US \$33–66) would be undesirable and the maximum amount they could agree on for a monthly supply of contraception.
- Respondents named the following strengths typical of hormonal contraception:
 - High reliability (mainly reported by OC users)
 - Convenience, ease of use (mainly reported by OC users)
 - “Nonintervention” in the process of sexual intercourse
 - An opportunity to reject condoms—one of the reasons men support this method
- Respondents indicated the following areas where hormonal contraception can bring health benefits:
 - Skin condition improvement (acne disappearance), hair and nails condition improvement
 - Regulation of an impaired endocrine profile, menstrual cycle normalization, treatment of certain endocrine-dependent diseases—cystic disease of the breast, ovarian cysts:
 - “A possibility to know that my period will start in two days just shocked me. It never started on time before. And the level of male hormones normalized.”
 - Reduction of premenstrual syndrome (PMS) symptoms and menstrual blood losses
 - Reduction of nervousness (since users do not fear unwanted pregnancy)
- Respondents named the following areas where, in their opinion, hormonal contraception can have a negative influence:
 - Planning pregnancy: reduction of the ability to conceive, problems with child-bearing and child development (nonusers more frequently mentioned this):
 - “It seems that the uterus gets used to such a situation. Pills do everything for it, and it stops producing oocytes... up to sterility.”
 - Negative changes in appearance: excessive weight, hirsutism, skin greasiness, acne.
 - Poor toleration of medications: weakness, nausea, headache, and hypertension appear. Some users have contraindications (varicosity).
 - Expense: Some Yekaterinburg respondents mentioned that hormonal contraceptives are expensive.
 - Failure of “the endocrine system in general”: thyroid and pancreatic glands, emergence of endocrine-dependent diseases (cystic disease of the breast).
 - Emergence of PMS, negative psychological changes, reduced libido, increased menstrual blood losses.
 - Negative attitude to pills in general (“its chemistry”).

- Ineffectiveness: Pills can be ineffective if a woman has diarrhea and increased temperature, or is taking other drugs.
 - Doctors' negative attitudes: Some gynecologists have a negative attitude toward hormonal methods and transfer this to their patients:
 - "My doctor says to me, "there are condoms, use them." "It's unclear what effect pills might have."
 - Prescribed without reason: Many respondents complained that doctors unreasonably prescribe pills (they do not examine an endocrine profile, recommend "the most expensive pills," leaving the choice to patients):
 - "They say: 'well, take something'... I'm 'so lucky' to have such doctors!"
 - Ineffective STI protection: Hormonal contraceptives (unlike condoms) do not protect against STIs.
 - A need to take breaks (and use other methods during this time):
 - "They say that it's necessary to take them for nine months— as long as a pregnancy period. Then you have to take a break, and you can easily get pregnant during this time."
- Respondents had similar opinions regarding OCs; however, they named a few additional strengths and weaknesses for OCs.

Strengths

- Provide comfort, ease of use.
- "They don't interfere with the process of sexual intercourse. No need to undergo injections, nothing is inserted into your uterus. You just take a pill, that's all."
- Offer user an opportunity to independently cancel contraception at any moment.

Weaknesses

- Have an influence "on the whole body."
 - Offer no protection during the first month of intake.
 - Cause forgetfulness, are difficult to take accurately every day, and cause nervousness in connection with their intake.
- Most women reported that abortion presents a greater health risk than using hormonal contraception. Although their attitude toward abortions is negative, most respondents do not reject it as a contraception option.
 - Women respondents reported they like to get information on reproductive health from the Internet, their friends, their mothers, and doctors. The most trusted sources of information are doctors, followed by the Internet and friends. Women are open to the idea of receiving SMS reminders about their method, and they also expressed interest in receiving

information from television programs such as serial dramas, if they are developed for women like them.

3.4 PRODUCT AVAILABILITY AND ACCESSIBILITY

The assessment team visited three pharmacies in Moscow and four in Yekaterinburg. All pharmacies visited had a wide array of modern contraceptive methods available. Many brands of OCs are available and prices in Yekaterinburg are generally 20 percent lower than those in Moscow. Table 1 provides information on prices and brands of modern methods sold in Russian pharmacies.

Interviews with pharmacists indicated that the fastest growing brands are third-generation pills such as Yaz, Yarina, and Diane 35, which are most expensive and actively marketed to doctors through pharma detailers. Mid-price products Marvelon, Regulon, Novynette, and Lindynette are market leaders among mid-income and younger women, though users are beginning to purchase newer formulations. Pills such as Microgynon and Rigevidon represent the lower end of the price spectrum.

TABLE I. BRANDS AND PRICES OF MODERN CONTRACEPTIVES IN RUSSIA

Brand	Manufacturer	Moscow Price range (USD)	Yekaterinburg Price range (USD)
Oral Contraceptives (price per cycle)		1 USD = 30 RUB	
Yaz	Bayer Schering Pharma	28-29	22-24
Diane 35	Bayer Schering Pharma	24-27	21-22
Jeanine	Bayer Schering Pharma	24-26/one cycle 58.5-64/ 3 cycles	18.5-21/one cycle 45-48.5/3 cycles
Logest	Bayer Schering Pharma	18-20	14-16
Yarina	Bayer Schering Pharma	22-30	21-22
Triquilar	Bayer Schering Pharma	11-13	9-12
Femoden	Bayer Schering Pharma	16.5-18	
Microgynon	Bayer Schering Pharma	6-9.5	4.6-5.6
Minisiston	Bayer Schering Pharma (Jenapharm)		5.8-6.6
Charozetta	Schering Plough (Organon)	27-29	21
Tri-Merci	Schering Plough (Organon)	17-22.5	14-15
Marvelon	Schering Plough (Organon)	16.5-19	13-14
Mercilon	Schering Plough (Organon)	16	14
Rigevidon	Gedeon Richter	6-14	3.5-4
Novynette	Gedeon Richter	10-12	8-9
Regulon	Gedeon Richter	7-10	6.6-8.6
Lindynette 20	Gedeon Richter		7.4-8
Chloe (generic Diane)	Zentiva, Czech Republic	13	12-14.5

Brand	Manufacturer	Moscow Price range (USD)	Yekaterinburg Price range (USD)
35)			
Belara	Berlin-Chemie	19	
Cilest	Johnson and Johnson (Janssen Cilag)	12.5	
Divina	Orion Pharma, Finland	12	
Emergency Contraceptives			
Postinor (2 tab)	Gedeon Richter	8.4-8.6	8
Eskapel (1 tab)	Gedeon Richter	10-10.5	8.5-10.5
Vaginal Ring			
NuvaRing	Schering Plough (Organon)	27-39	23-29
Intrauterine Devices			
Mirena	Bayer Schering Pharma	333	267-333
Nova T	Bayer Schering Pharma (Jenapharm)	58.5	
Multiload CU-375	Schering Plough (Organon)	90	
Hormonal Patches			
Evra	Johnson and Johnson (Janssen Cilag)	34.5-39	
Condoms			
Durex (3/pack)		4.2-4.6	3.1
Durex (12/pack)		14.5-15.6	10
Contex (3/pack)		2.6	2
Contex (12/pack)		8-9	6

4. PROPOSED STRATEGIES

Three potential scenarios were identified as ways of partnering to meet the RH needs of the Russian women:

- *Scenario 1.* Partnership between SHOPS/Abt Associates, BSP, and a local nongovernmental organization (NGO) such as the Health and Development Foundation (HDF) to promote hormonal contraception, particularly orals, in Yekaterinburg and Tver.

Note 1: The assessment team determined that Moscow is not a viable site for this activity given the already high penetration of modern methods and local sensitivities to the issue.

Note 2: BSP proposed Tver as a site for the program with the justification that (1) smaller cities usually have a lower rate of acceptance of OCs, and local administration might welcome such a program; (2) there is a higher chance of reaching lower income people; and (3) smaller settings are better for measuring the results.

Target audiences would include gynecologists and women of reproductive age (18–39).

- *Scenario 2.* Partnership between SHOPS/Abt Associates, BSP, and a local NGO such as HDF to promote hormonal contraception, primarily orals, in Yekaterinburg region only.

Target audiences would be the same as in scenario #1.

- *Scenario 3.* Partnership between SHOPS/Abt Associates, BSP, a local NGO such as HDF, and other pharmaceutical companies such as Gideon Richter, Organon, and Janssen-Cilag to promote hormonal contraception, with a focus on orals, in Yekaterinburg and Tver.

Target audiences would be the same as in scenario #1.

BSP and USAID/Russia prefer scenario 3. Preliminary discussions with Gideon Richter and Organon indicated that they are interested in participating in this initiative.

4.1 GENERAL GUIDING PRINCIPLES

The intervention strategy will address the program objectives from both the supply and demand sides by developing manifold partnerships with commercial, nonprofit, and governmental partners. This type of multilateral collaboration will provide a unique opportunity to create local ownership of the program, which is a cornerstone of USAID

assistance, and will serve as a framework for a multipartner public-private health intervention.

The overall approach to the program, regardless of the selected scenario, is to have a local NGO as an on-the-ground coordinator to manage relationships with partners, implement components such as provider training in Tver, manage an outreach campaign, and provide overall supervision of the intervention. Categories of partners will not be limited to pharmaceutical companies and donor projects. The program developers will also collaborate with local governments, research and communication organizations, and female-dominated workplaces.

To keep all stakeholders engaged and the program aligned with the objectives, a steering committee will be established. The committee, as a mechanism for collaboration, will be a venue in which all program partners are able to exchange ideas, share research findings, develop common strategies, identify mechanisms of resource leveraging and fund-raising, and contribute to and approve demand creation activities. Meeting every three to four months, the committee will also be in charge of accessing the scientific evidence on hormonal contraception and sales data and of identifying appropriate advocacy channels.

The program developers will leverage the technical capacity and expertise of existing donor projects. For instance, the program will maximize use of FP information and counseling manuals that have already been developed by the USAID and its partners in Russia.

5. SUGGESTED NEXT STEPS

5.1 ASSESSMENT IN TVER

Detailed design of the program requires comprehensive information about implementation sites. Because the suggestion to consider Tver as one of the program cities came in at the end of the in-country evaluation, a rapid assessment of the RH environment will be conducted in the city as a first next step. The evaluators will meet with senior regional and city-level health officials to learn about the current RH situation, including current plans and programs, as well as to examine potential support that local authorities might be willing to provide to the partnership. The evaluation team will also document attitudes and barriers

the physicians and pharmacists have toward OCs and overall hormonal contraception. The team will conduct an inventory of modern methods sold in Tver pharmacies and investigate opportunities to engage local small and medium-sized enterprises to develop a workplace FP education program.

5.2 WORK PLAN DEVELOPMENT

The SHOPS team will finalize the geographic scope and size of the program once the Tver assessment is completed, and will identify financial resources needed. Simultaneously, the team will initiate design of the implementation strategy and action plan. This will include developing the timeline, the description of roles and responsibilities of each contributing partner, and the budget plan. Based on that, a final decision will be made on the specific components and geographical scale of the program.

5.3 PARTNERSHIP AGREEMENTS

At the same time, the SHOPS team will draft partnership agreements, such as Memoranda of Understanding, to officially document partner intentions, objectives, and contributions to the program.

5.4 ADDITIONAL RESEARCH

During the program design, the team will determine if additional formative research is needed and what types of operational research and monitoring are needed for the intermediate and end-of-program evaluation. The assessment team is already suggesting in-depth interviews with doctors to understand origins of current attitudes and identify potential messages and materials to improve physician skills. During the assessment, respondents interviewed unanimously identified health providers as one of the most trusted sources of information considered by consumers when making decisions about FP and contraceptive use.

ANNEX A: LIST OF PERSONS INTERVIEWED

USAID and Partners:

Alyssa Leggoe, Deputy Director, Office of Health, USAID/Russia

Larissa Petrosian, Project Management Specialist, MCH Program, Office of Health, USAID/Russia

Victor Boguslavsky, Country Director, URC, Russia

Nicole Simmons, Project Director, Improving Care for Mothers and Babies, URC, Russia

Dr. Natalia Vartapetova, Director General, Institute for Family Health

Dr. Elena Dmitrieva, CEO, Health and Development Foundation

Pharmaceutical Companies:

Dr. Viktor Geisler, Country Division Head, Bayer Schering Pharma, Russia

Dr. Olga Glazkova, Head of Business Unit "Women's Health," Bayer Schering Pharma, Russia

Anna Usanova, Market Research Specialist, Bayer Schering Pharma, Russia

Veronika Lamberova, Yekaterinburg Regional Manager, Business Unit "Women's Health," Bayer Schering Pharma, Russia

Irina Khalemonenko, Moscow City District Medical Representative, Business Unit "Women's Health," Bayer Schering Pharma, Russia

Elena Parkhonina, Business Unit Manager (gynecology and urology), Gedeon Richter, Russia

Oksana Popova, Product Manager (gynecology), Gedeon Richter, Russia

Elena Bushberg, Business Unit Manager, Primary Care, Schering –Plough LLC, Russia

Health Sector Officials:

Dr. Lubov Posiseeva, Vice Chairman of the Board of Trustees, Health and Development Foundation, Member of the Scientific-Expert Board at the Chairman of the Federal Assembly of the RF

Dr. Natalia Davydenko, Sverdlovsk Oblast Chief Ob/gyn

Researchers:

Dr. Viktoria Sakevich, Senior Researcher, Institute of Demography, Higher School of Economics, Moscow

Sergey Tumanov, Director General, *Top of Mind* (marketing, research, and consultancy firm), Moscow

Olga Simonova, Moderator, *Top of Mind* (marketing, research, and consultancy firm), Moscow

Elena Zharkova, Director, *Marketing Bureau* (research firm), Yekaterinburg

Maria Zhdanova, Field Team Manager, *Marketing Bureau* (research firm), Yekaterinburg

Service Providers:

Natalia Yakunina, Head, Women's Clinic # 15, Moscow

Anna Protzenko, gynecologist-endocrinologist, Women's Clinic # 15, Moscow

Marina Petrova, Ob/gyn doctor, public clinic

Olga Kondratova, Ob/gyn doctor, private clinic *Doctor Plus*, Yekaterinburg

Svetlana Kondrashova, youth RH counselor, Women's Clinic # 1, Hospital # 6, Yekaterinburg

Lubov Gromova, Head, Women's Clinic # 1, Hospital # 7, Yekaterinburg

Representative of a local factory:

Ludmila Eduardova, HR Director, *Palmetta* (female underwear factory), Yekaterinburg

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