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SCALING UP ACCESS TO REPRODUCTIVE HEALTH SERVICES IN ROMANIA

THE ROMANIAN FAMILY HEALTH INITIATIVE
2001 – 2007

JSI Research & Training Institute, Inc.

FINAL PROJECT REPORT
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The U.S. Agency for International Development funded the Romanian Family Health Initiative (RFHI) through Cooperative Agreement 186-A-00-01-00013-00. The RFHI (September 2001–December 2007) expanded access to reproductive and women's health services to all Romanians, with an emphasis on underserved populations.

JSI Research & Training Institute, Inc. implemented the RFHI with its partners the Society for Education on Contraception and Sexuality; Youth for Youth Foundation; the Romanian Association Against AIDS; the East European Institute for Reproductive Health; and Population Services International/Romania.

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The Romanian Family Health Initiative (RFHI), funded by the United States Agency for International Development (USAID) and managed by JSI Research & Training Institute, Inc. (JSI), worked to expand access to reproductive and women's health services to all Romanians, with an emphasis on underserved populations.

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ACRONYMS

AFER	Association of Roma Women's Emancipation
AIDS	acquired immunodeficiency syndrome
ARAS	Romanian Association Against AIDS
BCC	behavior change communication
DCWCFH	District Commission for Women's, Child, and Family Health
DPHA	District Public Health Authority
EU	European Union
FD	family doctor
FP	family planning
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOR	Government of Romania
GP	general practitioner
HIV	human immunodeficiency virus
IEC	information, education, and communication
IOCN	"I. Chiricuta" Institute of Oncology in Cluj-Napoca
IR	intermediate result
JSI	JSI Research & Training Institute, Inc.
LCG	local coordination group
LI	line item
LMIS	logistics management information system
M&E	monitoring and evaluation
MLSSF	Ministry of Labor, Social Solidarity, and Family
MOPH	Ministry of Public Health (previously Ministry of Health and Ministry of Health and Family)
MOU	memorandum of understanding
NAFP	National Agency for Family Protection
NFPP	National Family Planning Program
NHIH	National Health Insurance House
NIAC	National Intersectoral AIDS Commission
NGO	nongovernmental organization
ob/gyn	obstetrician/gynecologist
PAC-PP	postabortion/postpartum care
PHC	primary health care
PMU	Program Management Unit
PLWH	people living with HIV
PSI	Population Services International
RFHI	Romanian Family Health Initiative
RH	reproductive health
RHM	Roma health mediator
RHS	Reproductive Health Survey
SECS	Society for Education on Contraception and Sexuality
SRC	Romanian Cancer Society

STI	sexually transmitted infection
TASC	technical assistance and support contract
TB	tuberculosis
TOT	training of trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOPA	National Union of Organizations of People Living with HIV/AIDS
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization
YfY	Youth for Youth Foundation

ACKNOWLEDGMENTS

The JSI Romanian team would like to thank all those we have worked with in the country program over the past seven years. In particular, we would like to acknowledge the dedication and hard work of the staff of the government departments at national and local level. The support of the Government of Romania through the Ministry of Public Health (MOPH) and the District Health Authorities has been the determining factor in the implementation and success of the national family planning program. Their partnership has been invaluable.

We will like to thank our partners at the RFHI, the nongovernmental organizations with whom we have worked. There are too many names to acknowledge all those who have collaborated with us on the Romanian Family Health Initiative, but, we would particularly like to thank: the Society for Education on Contraception and Sexuality (SECS), Populations Services International (PSI), the East European Institute for Reproductive Health (EEIRH), the Romanian Association against AIDS (ARAS), and the Youth for Youth Foundation.

In addition, we wish to express our appreciation for the guidance provided by USAID/ Romania's Office, especially to Cate Johnson, Gabriela Paleru, and Alina Panait for their longtime support and enthusiastic encouragement to the RFHI. We thank, too, the thousands of Romanian professionals who offer their best capacities to serve their clients with high-quality services.

And finally, the team would like to thank both Diane Hedgecock, the Senior Advisor of the project and Rebecca Coughlin, our Program Coordinator, for their tireless support to the project from JSI headquarters.

Sincerely,
Dr. Merce Gasco
On behalf of the JSI Romania Team

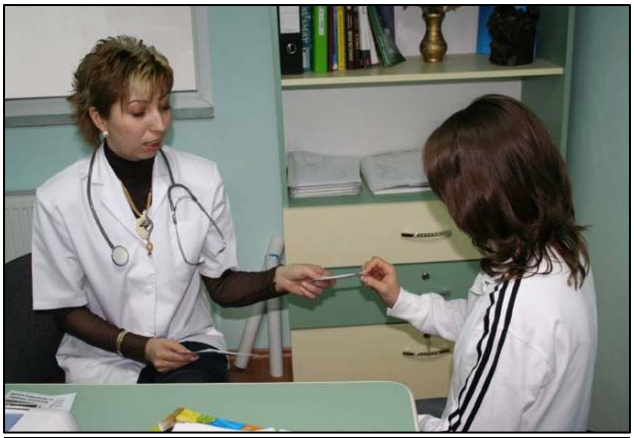
INTRODUCTION

In 2001, the U.S. Agency for International Development (USAID) signed a cooperative agreement with JSI Research & Training Institute, Inc. (JSI) for the purposes of: 1) enhancing primary care to include reproductive health; 2) developing an effective network of reproductive health services; and 3) promoting the use of services. The program, the Romanian Family Health Initiative (RFHI), was a partnership of USAID/Romania, the Romanian Ministry of Public Health (MOPH), and JSI. During the first year of the program, JSI subcontracted with key partners: the Society for Education on Contraception and Sexuality (SECS); Population Services International (PSI); the Romanian Association Against AIDS (ARAS); Youth for Youth Foundation (YfY); and the East European Institute for Reproductive Health.

USAID/Romania designed the RFHI to contribute to its Strategic Objective 3.4: "Improved effectiveness of selected social and primary health care (PHC) services for targeted vulnerable groups in Romania." Initially the RFHI was a five-year program, but in 2005 USAID extended and funded it through 2007 to address additional technical priorities.

The program worked toward achieving the following USAID/Romania intermediate results:

IR 1: Improved legal, regulatory, and policy framework.
IR 2: Improved mobilization, allocation, and use of social-sector resources.
IR 3: Increased access to quality integrated services.
IR 4: Citizens better informed about social services, rights, and responsibilities.



Family doctors trained by RFHI are now able to accurately counsel clients and dispense family planning methods.

RFHI addressed multiple reproductive health needs including family planning; antenatal and postpartum care; early detection of breast and cervical cancer; prevention, protocols, and referrals for sexually transmitted infections (STIs); prevention of HIV; and prevention of domestic violence. In order to increase access to reproductive health services, RFHI worked on cross-cutting issues such as national policy and resource allocation, public education and behavior change communication (BCC), training, quality of care, and sustainability.

RFHI originally intended to operate in ten districts but quickly expanded, with USAID and MOPH encouragement, to all 42 districts of Romania due to rapid achievements early in the program and the decision of the United Nations Population Fund (UNFPA) to support expansion in eight districts. The primary focus of the program until 2004 was to reach poor, rural women of reproductive age with information and services.

Although the program addressed multiple priority health issues, it quickly became clear that it had been particularly successful in increasing access to family planning services, with most annual outputs achieved or surpassed. Three other factors supported a decision to make family planning the main focus of the program: (1) USAID's priority intervention was family planning, (2) the national health system could not absorb multiple interventions within the program timeframe, and (3) RFHI did not have sufficient human and financial resources to address all program interventions simultaneously and with the same levels of quality and intensity. The program progressively focused on strengthening family planning and prenatal services at the PHC-level nationwide and refined its strategic approaches for the remaining technical areas. A joint USAID-JSI assessment team ratified this approach in 2004, recommending family planning as the program core, with a focus on increasing access to high-quality family planning services.

In 2004, RFHI received additional funds to increase access to family planning/reproductive health services for poor, urban populations as well as Roma communities. RFHI rolled out this new component promoting and strengthening local partnerships.

In 2005, RFHI again added a new component, this one to assure that postabortion and postpartum clients received adequate counseling and, if appropriate, contraceptives. The length of the program was extended until September 2007.

In 2006, USAID added two new components: "Emergency Assistance for Avian Influenza Pandemic Preparedness" and "Enhancing the Sustainability of Nongovernmental Organizations (NGOs) and Continuing Support to National AIDS Campaigns." The length of the program was again extended through December 2007.

Most program components added after 2004 aimed to extend or scale up original RFHI elements, such as assuring comprehensive, high-quality family planning services at different entry points to the health system; diminishing service access barriers for vulnerable populations; and strengthening health system capacity. Therefore, this report describes activities in each technical area, whether they were part of the original project or added later.

This report includes descriptions of the following program components:

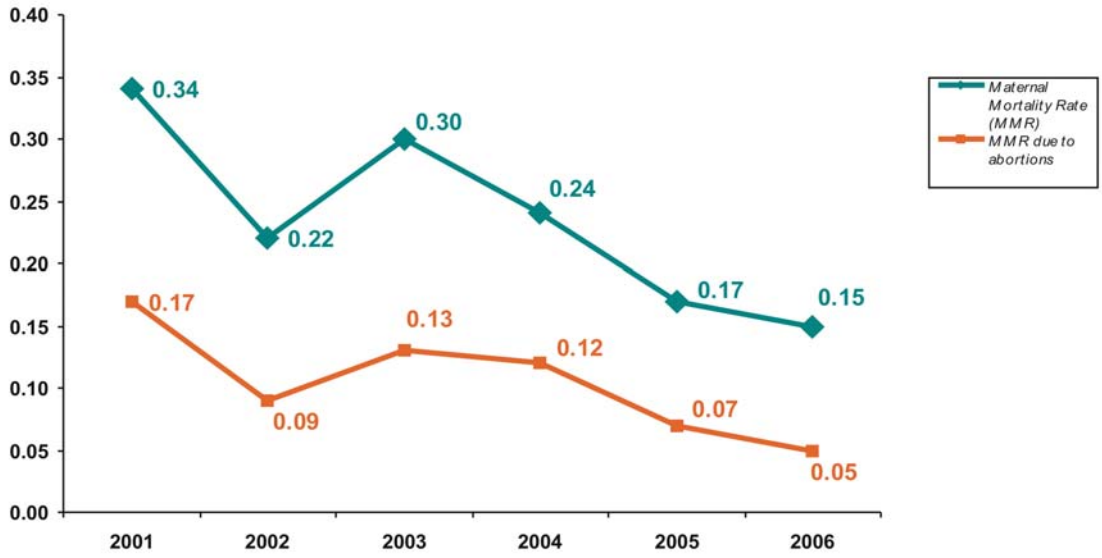
- Expanding family planning services in rural Romania;
- Increasing access of poor urban populations to family planning/reproductive health services;
- Assuring appropriate counseling and supplies for postabortion/postpartum care (PAC-PP);
- Enhancing access of Roma communities to family planning/reproductive health services;
- Modeling youth-friendly family planning/reproductive health information and services;
- Sustaining population awareness activities against stigma and discrimination toward; people living with HIV (PLWH);
- Developing a regional cervical cancer early detection program;
- Strengthening governmental and nongovernmental sectors to combat domestic violence;
- Enhancing the sustainability of NGOs; and
- Providing emergency assistance for public health emergencies: avian influenza and floods.

Key Achievements

RFHI contributed to improvements in the health status of Romanians. Some examples include:

- Decline of the abortion ratio from 1,156.5 abortions/1,000 live births in 2001 to 684.5 abortions/1,000 live births in 2006.
- Decline of the infant mortality rate from 18.4 deaths of infants one year of age or younger per 1,000 live births in 2001 to 13.9/1,000 live births in 2006.
- Decline of the maternal mortality ratio due to abortion from 0.17/1,000 live births in 2001 to 0.05/1,000 live births in 2006 (see Graph 1).

Graph 1: Maternal Mortality rate and Maternal Mortality due to Abortions



Source: National Statistics Institute

SCALING UP ACCESS AND SERVICES

Background

The health sector received immediate attention following the 1989 revolution, particularly the problems of maternal mortality and child abandonment. Both these problems were related to a legacy almost unique to Romania: the rigidly enforced pronatalist policy of the previous regime that, since 1966, had banned contraception and severely restricted abortion to women who had five children or more. The ban had resulted in high rates of unwanted pregnancies that ended in illegal and unsafe abortions—to which over 80 percent of maternal mortality was attributed—or in child abandonment. Romania had the highest maternal mortality ratio in Europe at the time, at 170 per 100,000 live births. By 1990, an estimated 150,000–200,000 abandoned children lived in

overcrowded, understaffed, and poorly equipped orphanages and hospitals. On December 28, 1989, one day after the violence of the revolution ended, the provisional government lifted the restrictions on abortion and the ban on contraceptives. As a result of the legalization of abortion, maternal mortality fell by half almost immediately. However, because Romanian women and couples wanted small families and contraceptives were still very rare, abortion became the leading method of fertility control. In 1990, there were more than three abortions for every live birth.

In 1992, the MOPH, with financing from the World Bank, established a network of urban family planning clinics and referral centers that raised the contraceptive prevalence rate to 29.5 in 1999 from 13.9 in 1993.[1] Nevertheless, the incidence of unintended pregnancy, the abortion rate, and maternal mortality due to abortion remained high compared to the rest of Europe outside the former Soviet Union. Access to modern contraceptives continued to be extremely limited in rural areas and among low-income urban populations, particularly as stocks of donor-supplied, free contraceptives dwindled. Contraceptives were not included under health insurance drug benefits and clients were left no option but to purchase them from pharmacies.

Initially, the Romanian Family Health Initiative was to focus on ten districts supported by USAID. However, within a year the MOPH determined that scale up should take place nationwide and cover all 42 districts. USAID supported RFHI's expansion to 34 districts and UNFPA covered the remaining eight. This meant that, for the first time, rural women would have easy access to family planning counseling and modern contraceptives.

Soon after the project convention was signed, the MOPH decreed that reproductive health be included permanently in the public health agenda and family planning/reproductive health services were included as a component of the Basic Health Package—an important contribution to the success of the national family planning program. In addition, authorities assured that both insured and uninsured populations would be covered.

Joint meeting of the Mehedinti and Dolj district commissions.

Within this increasingly favorable policy environment, other obstacles to the provision of high-quality services emerged. Thousands of doctors and nurses at the PHC level needed updates in modern contraceptive technologies and counseling; contraceptives needed to be available and affordable to clients; and populations needed information about where to go to receive family planning services. These three mutually reinforcing strategies became the Three Pillars of RFHI national programming.

[1] Bucharest, Romania, Institutl de Ocrotire a Mamei si Copilului, 1995 March. [20], 167, [34] p.

The challenge was to transform the culture of responding to unexpected or unwanted pregnancies with abortion or child abandonment into a culture of prevention, through family planning and contraceptive use.

The USAID Intermediate Results (IRs) provided a framework within which RFHI's Three Pillars Approach could be implemented.

IR 1: Improve the legal, regulatory, and policy framework for reproductive health service provision

RFHI's overall approach to policy activities was rooted in the idea that policies must, first and foremost, support practical efforts to strengthen service delivery and, therefore, be primarily informed by conditions in the field rather than academic studies and theoretical models.

To address the policy deficiencies in family planning/reproductive health, in 2001, the governments of Romania and the U.S signed a memorandum of understanding (MOU) that launched RFHI. The MOU included a partnership convention that specifically named the MOPH, USAID, and JSI (on behalf of RFHI) as partners and that outlined clear objectives and assigned the responsibilities of each organization. This partnership agreement was essential to success because it provided an overarching framework for collaboration. RFHI and its partners were able to prioritize legislation or policy elements that needed attention, such as legislation specifically allowing family health doctors to provide family planning services and contraceptives and specifying the eligibility criteria for free contraceptives. Although the consensual process took almost two years, in 2003, the Government of Romania (GOR) endorsed the new National Sexual and Reproductive Health strategy.

Other important policy achievements include:

- In January 2002, the MOPH established criteria for defining population groups eligible for complimentary contraceptives: the unemployed, high school and university students, social work cases, rural residents, and women who had had an abortion in a public hospital within the last three months. The big gain was the inclusion of persons living in rural areas among the eligible categories.
- New regulations addressed the role of trained family health doctors in providing family planning and prenatal care services; health system management; standards and protocols for family planning service

RFHI led the development of National Sexual and Reproductive Health Strategy (SRH) 2002-2006, which was approved by the Ministry of Health as well as the World Health Organization. This conference in Bucharest in May 2003, titled "Family Planning in Romania: from strategy to best practice," officially launched the strategy.

delivery in PHC, including contraceptive supply distribution and characteristics of the logistics management information system (LMIS) for free contraceptives. The authorization of family doctors to provide family planning services at PHC facilities allowed the creation and development of the rural family planning services network and was included in the technical norms for family planning services issued by the MOPH in 2002.

- The annual Framework Contract between the MOPH and the National Health Insurance House (NHIH), which regulates health services provision at all levels of the public system (including primary care), gives the entire population the right to access and use family planning services free of charge, regardless of insurance status. This inclusion diminishes inequalities in access to services for poor and vulnerable populations.
- Romanian norms for family planning service provision now include the World Health Organization (WHO) eligibility criteria for modern contraception, ensuring the use of evidence-based practices by the national family planning program and improving the quality of services provided at the PHC level.
- National Strategy for STI Prevention and Control: RFHI participated in developing this strategy in a collaborative process with the MOPH, UNFPA, and WHO that took over one year. The strategy followed the same decentralization process as the reproductive health strategy—moving away from a vertical system to incorporate STI prevention and control as part of PHC.
- National AIDS Strategy: The strategy includes a chapter on legislation supporting protection and social integration of PLWHA, prevention of mother-to-child transmission, prevention and services for vulnerable and disadvantaged groups, and access to treatment.
- National Plan for the Early Detection of Cervical Cancer: In May 2004, RFHI supported the MOPH to organize the national conference "Strategies for Early Detection of Cervical Cancer in Romania." Consensus was reached during the conference on the main recommendations for setting up the Romanian National Plan for Early Detection of Cervical Cancer.
- National Domestic Violence Strategy: RFHI supported the creation of the National Coalition against Domestic Violence in order to address this issue. This National Coalition was comprised of all 33 NGOs in the country involved in programs combating violence against women. As a result, the first law acknowledging and regulating domestic violence in Romania was endorsed in 2003.

IR 2: Improve mobilization, allocation, and use of social sector resources

While fostering policy and regulatory frameworks, RFHI simultaneously made substantial efforts to build institutional capacity within the national and District Public Health Authorities (DPHAs). RFHI strengthened central and district-level capacities in planning and managing health programs by providing technical assistance for mobilization, allocation, and use of resources. It continuously promoted effective partnerships and worked in collaboration with the MOPH and other donors to complement efforts and leverage resources.

In February 2002, the MOPH issued a Ministerial Order regulating the establishment and functioning of the Mother and Child Care National Program.[2] The provision was extremely important, as it created a new structure dealing exclusively with the management and technical quality of the family planning program. The Order initiated the Program Management Unit (PMU)[3] for the Mother and Child Care National Program at the central level, and called for District Commissions for Women's, Child, and Family Health (DCWCFH) in each of the 42 districts, following the model of the previous local task forces and coordination committees.

From the beginning, RFHI promoted effective partnerships and multisectoral approaches to pool resources from the public and private sectors and to achieve a functionally integrated network of family planning services. Romanian stakeholders recognized the need to coordinate their efforts through a stakeholders' working group. This coordination allowed the MOPH, donors, NGOs, and other implementing partners to identify key service availability gaps and issues and to improve coordination and collaboration.

The program invested in continuous technical assistance and "on-the-job" training provided to DPHA staff to improve their managerial capacities. Several interventions aimed to improve the decision-making process by involving more stakeholders, developing tools to expand the necessary information available to take appropriate decisions, assessing local needs and defining solutions to address them, improving communication among stakeholders, and increasing program management skills of DPHA staff. By strengthening and empowering district authorities to manage the family planning program, districts were able to tailor or add new services that met the specific needs of their communities, thus a better allocation and use of their scarce resources.

The DCWCFHs' experience in addressing family planning made other issues easier to address. For instance, districts more easily managed the MOPH intervention to address maternal mortality through the revision of prenatal care protocols. DCWCFHs quickly developed a strategy for implementation of the interventions targeting maternal care and district coverage was rapidly completed. The same happened for the national campaign promoting breastfeeding as well as other activities.

IR 3: Increased access to quality integrated services and **IR 4: Citizens better informed about social services, rights, and responsibilities**

Contributions to these IRs depended on the qualifications of health care providers, availability of contraceptives, and clients' awareness of available services and their right to use them—RFHI's Three Pillars Approach.

[2] The Mother and Child Care National Program, or National Program number 3 (NP3) is one of four national health programs in Romania. It currently comprises 17 main components, including reproductive health.
[3] MOPH order #109/27.02.2002 initiated the Program Management Unit (PMU) for NP3 at the central level and called for a local commission for women's, child, and family health (DCWCFH) in every district.

The Three Pillars Approach

The Three Pillars Approach was developed within the framework of USAID IRs 3 and 4 and formed the core of the RFHI. The Three Pillars are:

- Increase capacity of health providers
- Increase awareness of FP/RH issues and services
- Ensure contraceptive security and LMIS

First Pillar: Increase capacity of health care providers

Training in family planning and prenatal care

RFHI started with in-service training in family planning for PHC professionals (family doctors and nurses) in rural areas. Under USAID's Technical Assistance and Support Contract (TASC) project implemented by JSI from 1999-2001, the National Center for Postgraduate Training of Health Professionals[4] trained and accredited 50 family planning service providers as trainers in FP/RH. In addition, the project supported the development of a family planning training curriculum and training workshops for approximately 630 family doctors (FDs).

During its first year, RFHI implemented family planning training workshops in 18 of Romania's 42 districts, based on the existing curriculum and with the help of trainers trained from previous projects.

In the second year, partners agreed to the extension of family planning services throughout the country. The Training Consultative Group[5] and the MOPH established the strategy to expand basic RH service delivery capacity, especially family planning, nationwide. This consisted of: 1) updating the training skills of a limited number of master trainer physicians who had experience in both the delivery of family planning services and in training; 2) employing these master trainers to train a larger number of family planning district trainers in counseling and training skills; and 3) employing these district trainers to train FDs and nurses throughout the country in the provision of basic family planning services.

The training of trainers (TOT) for master trainers, the revision of the TOT curriculum for district trainers, the development of a counseling curriculum for training district trainers, and the implementation of counseling refresher training with district trainers were major components of RFHI support to the MOPH strategy to extend the delivery of basic reproductive health services at the PHC level to all districts in Romania. As a result of this effort, each district has at least two local trainers for family planning training

[4] National Center for Postgraduate Training of Health Professionals is the officially recognized Romanian institution in charge of postgraduate competency-based training, and is responsible for training of trainers in accordance with current legislation.

[5] The Training Consultative Group was established at the beginning of RFHI consisted of representatives from the MOPH, JSI/Romania, SECS, UNFPA, and delegates of the College of Physicians and Universities.

Training family doctors in family planning and HIV and STI prevention and treatment, as in this training in Sania in 2003, enabled RFHI to have a dramatic impact throughout Romania.

Special attention was given to planning the training activities during the scaling-up process. The RFHI team prepared an initial quarterly workplan for each District Public Health Authority, considering its specific training needs and priorities. These plans were shared with DPHA counterparts. The team discussed the training plan for each district with the DCWCFH to jointly plan the number of workshops, timing, and criteria for selection of participants, in order to reach RFHI program objectives.

At the end of the second program year, RFHI had already trained over 1,600 professionals from different rural communities and the need became obvious for a simple, visual tool to allow a quick evaluation of service coverage.

The training database was linked with the Digital System Register of the Administrative Units in Romania, an electronic standardized tool used in processing the geographic data and with the geographic information system software. Using these tools, it became easy to produce maps presenting the location of trained providers, which facilitated the DPHAs' decisionmaking and monitoring of the dynamic results of the program.

As a result of the development of local training resources, the program achieved an average of two training courses per district per year between 2003 and 2006; thus the national coverage of FP services in rural areas by the end of the project was over 80 percent (see map on next page).

In addition to training FDs and nurses on providing family planning services, RFHI supported other training activities for health and non-health professionals, including medical school doctors, family planning promoters, Roma health mediators, community nurses, and social assistants. Although these categories of personnel are not directly involved in contraceptive distribution, their interventions were very useful for increasing the awareness of the population regarding existing FP/RH services, and for building the safety net of family planning services.

Prenatal and postnatal care has been provided routinely for many years. The high maternal mortality ratio raised questions, however, about the effectiveness of these services. In general, the quality of prenatal care was weak in terms of the thoroughness of screening; accuracy and timeliness of client charting; adequacy of client education; and treatment and/or referral for identified problems. Among the reasons given for these weaknesses were a lack of standards and protocols, lack of necessary equipment, and a lack of provider skill. In addition, there was a lack of demand for prenatal consultations early enough in pregnancy—according to 2001 data, only 58 percent of pregnant women registered in the first trimester of pregnancy—as well as an

inadequate recommended schedule of consultations that would enable women to benefit maximally from the screening and preventive care provided. Similar descriptions were given for postnatal care.

In an attempt to meet these challenges and in parallel with the family planning program, RFHI addressed the improvement of prenatal care. In the second year of the program, the MOPH initiated the revision of prenatal and postnatal protocols for PHC, exclusively involving the leading obstetricians and gynecologists (ob/gyns). RFHI advocated and supported consultations with DPHAs, FDs, and other doctors active in PHC.

RFHI supported MOPH efforts by developing an implementation model applicable at the district level, a training curriculum, and a toolkit synthesizing the protocols and standardizing prenatal consultations.

Quality of services

In order to ensure the quality of family planning services provided at the PHC level and following the National Family Planning Program Guidelines, RFHI developed a methodology for organizing technical supervision visits. These supervision visits also aimed to improve program management at the district level and had the following objectives:

- Evaluate overall family planning service delivery and the implementation of guidelines/protocols following basic service provider training.
- Monitor the implementation of the logistics system for free contraceptives (appropriate method mix, stock levels, the inventory control system and reporting).
- Monitor and evaluate the implementation of the information, education, and communication (IEC) component (availability and distribution of materials to clients).

Because of the large number of trained providers, the supervision methodology included criteria to be used by the DPHA to select FDs for visits, such as incorrect or inconsistent reporting of contraceptive use; low level of contraceptives dispensed, compared to average monthly level/FD medical office; lack of balance in method mix; complaints from clients regarding medical practices; practices with registered cases of infant/maternal mortality or lack of monitoring of pregnant women.

RFHI and its partners produced and distributed the “Family Health” quarterly newsletter to provide updated information to trained health professionals and to share experiences, successes, and lessons learned between the international, national, and local levels.

Inclusion of family planning in pre-service training

RFHI designed this intervention to assure sustainability of the program. In-service training requires financial and managerial resources not always available in the public system and is, fundamentally, not sustainable over time. For this reason, and to give family planning its due importance, medical training should include the basics of modern contraceptive technology. At the 2006 dissemination conference at the completion of the program’s rural component,

"*Celebrating 15 Years of Family Planning in Romania,"* RFHI included a round table for Romanian medical school professors to discuss the importance of including family planning in the medical school curriculum with Dr. Robert Hatcher, one of the leading family planning experts in the world and author of *Contraceptive Technology*. As a result, several professors expressed their commitment to develop a new module on family planning. This represented a major achievement in the Romanian medical education system.

Second Pillar: Increase population awareness about family planning and reproductive health issues and services

The second pillar improved people's knowledge of FP/RH issues, and awareness of FP/RH services and people's rights regarding new services within ongoing health reform.

The program introduced the public information component after providers had been trained and family planning supplies were in place. RFHI invested strongly in improving staff knowledge and skills and generally strengthening the capabilities of the MOPH, the program's main IEC partner. JSI also funded NGOs in this area and spent considerable effort building local partnerships between them and the DPHAs. By the end of the program, IEC coordination teams had been built at the local level, both within the DPHAs themselves and between the public sector and civil society.

The program branded the increasingly available high-quality rural and urban services with a logo representing services that had a trained provider offering client-centered services and free contraceptives. All communications and informative campaigns promoting the clinics used the logo to signify the availability of quality services. Doctors and nurses were introduced to the logo in the packet of materials they received at training, which also included a first complement of contraceptives and educational materials.

Over the life of the program, RFHI partners JSI, PSI, and SECS all worked on information and education activities and interpersonal communications with various local partners, under the umbrella of the Partnership Convention.

The main IEC interventions included:

Campaigns promoting free contraceptives
These campaigns were the first for public institutions working jointly with NGOs and the partnership. The process included joint proposal design, implementation, and evaluation of planned activities in each district.

Local activities included use of media, group information and education sessions, and distribution of informational materials in supermarkets, discos, schools, and at cultural and artistic events. These district groups were the basis for the successful BCC coordination groups under RFHI's Urban Component.

Prenatal campaign

The prenatal campaign used the same strategy as the family planning one: a campaign that included radio spots and printed materials aimed at increasing women's awareness of the importance of early prenatal exams; informing them of available services at FD clinics and the right of all pregnant women to use them, regardless of insurance status.

Prenatal Campaign poster

Prenatal Campaign Leaflet

Among Us Women Project

In order to improve women's abilities to make informed contraceptive choices, RFHI negotiated with trade unions for permission to conduct interactive educational sessions in factories during breaks or after work. This intervention took place from 2002–2005, primarily in textile industry factories where many women—including rural women—work. In 2005, under RFHI's urban component, the project team transferred skills to provide these sessions to DPHAs and local NGOs, thus insuring sustainability of this approach.

A Daily Subject

RFHI implemented *A Daily Subject*, a media campaign and journalism contest for national (in 2003) and local media in three districts (in 2004). Journalists were invited to compete by writing factual articles about contraception, with a special focus on modern methods. Journalists who enrolled received a series of eight technical information sheets to inspire their writing, combat misconceptions, and update their understanding of facts about contraception.

Third Pillar: Contraceptive security and the logistics management information system (LMIS)

Providing of an uninterrupted supply of free contraceptives for eligible groups constituted the third critical pillar of the program. To ensure a favorable policy and legislative environment, RFHI provided technical assistance to the Romanian Government, not only in the formulation and implementation of improved public policies and strategies, but also in enforcing existing policies.

A series of policies adopted in 2002 offered a boost to the National Family Planning Program (NFPP) by: improving program management at the national level (through creation of a Prpgram Management Unit) and district level (through creation of DCWCFHs), spelling out government's commitment to family planning program objectives, and institutionalizing the MOPH Consultative Group for Mother and Child Health. The result of these policies was the focus on the provision of free contraceptives through general practitioners to well-defined target groups, mainly rural and economically disadvantaged populations. Development of a series of regulations helped ensure program implementation. The most important included the MOPH's decision to procure contraceptives and the reimbursement of PHC providers for services provided to insured (per capita) and uninsured beneficiaries (per service). The annual contract scheme between healthcare providers and the NHIH included this last regulation.

The training and logistics management pillars were intrinsic program components and both constituted eligibility criteria for being sanctioned by the MOPH to provide family planning services, including the distribution of free contraceptives. Meanwhile, training of rural doctors and nurses providing PHC services was mandated to include a module on the LMIS recording/reporting requirements for free contraceptives, to ensure its proper functioning.

Ensuring access to free modern contraceptives in rural areas required rolling out:

- Development and implementation of an LMIS to track commodities' flow within the supply chain and to ensure continuous availability of supplies based on sound forecasting;
- Procurement of contraceptives for free distribution to the program's eligible beneficiaries;
- Capacity building at national level through institutionalization of a PMU and at the DPHAs to adequately manage the improved supply chain.

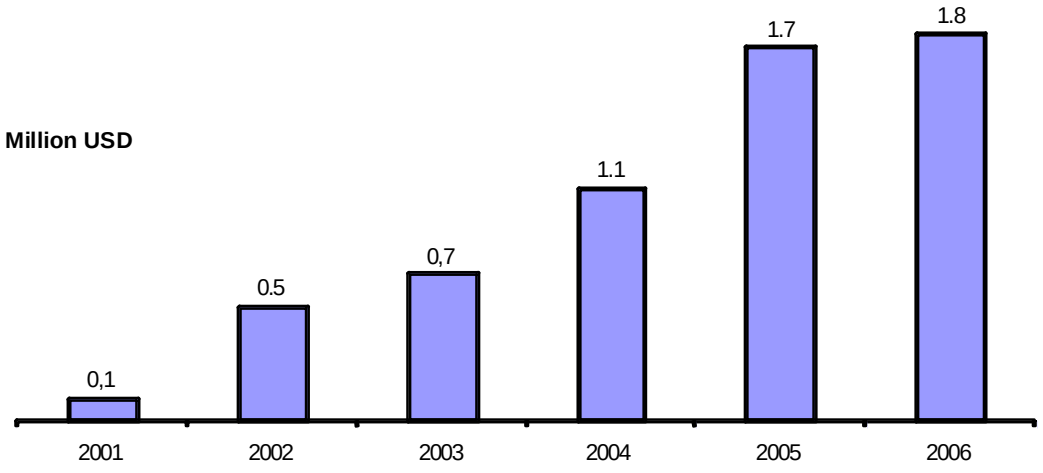
A participatory, consensus-building approach among all local stakeholders led to the design of the LMIS as did experience accumulated under the Women's Reproductive Health Initiative/TASC pilot project.

With the increase in availability and use of information technology at district and national levels, RFHI supported the transition towards electronic LMIS reporting. JSI and its main partner, SECS, provided specific training and technical assistance to all DPHA and central Inter*CON* software users and developed and distributed a user manual.

Since January 2007, Inter*CON* has been used by all DPHAs to record logistics data and report on program performance at the district level and by the MOPH to monitor overall program achievements and plan for budget allocations and procurement needs. USAID, which funded the Inter*CON* software, donated it and its Web domain and the supporting hardware to the MOPH before RFHI's closure to guarantee program sustainability.

From the beginning, RFHI intensively fostered coordination of donors, the MOPH, and other local actors to ensure continuous supply of free contraceptives. Products donated by USAID and UNFPA or procured by the MOPH were constantly matched with forecasted needs. The LMIS and supply chain's effectiveness is reflected in contraceptive forecasting, increased financial resources allocation from local public funds, as well as in product selection, and coordinated procurement and donations.

Graph 2: MOPH budget allocated for the procurement and management of contraceptive supplies



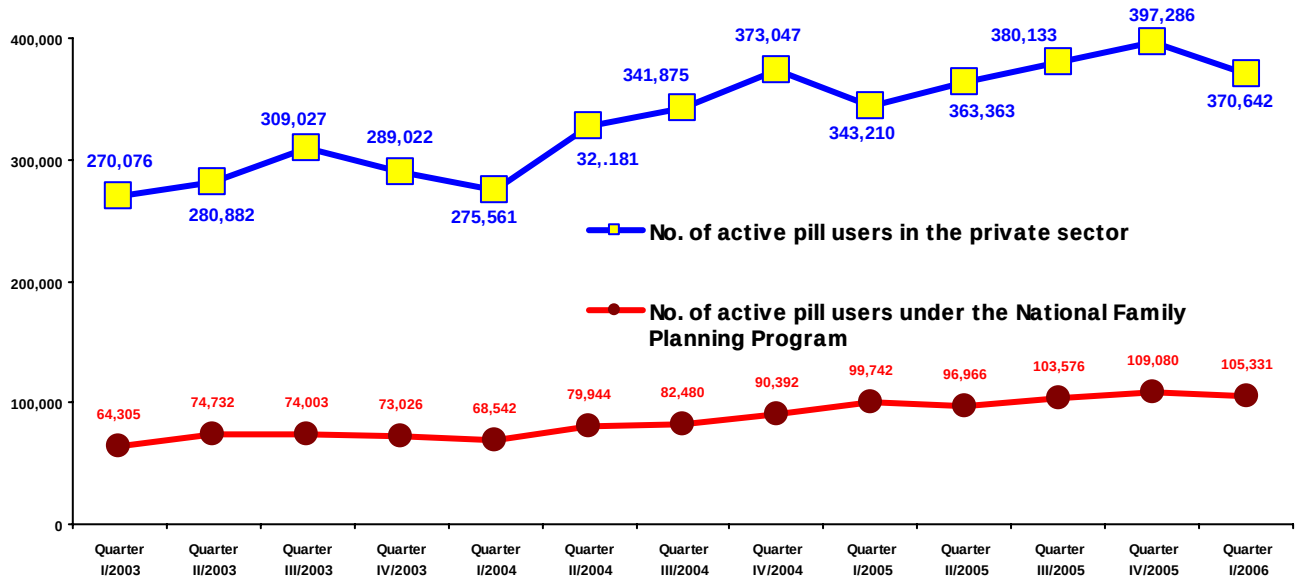
Data source: MOPH 2001-2006 and RFHI Data

Building the LMIS forged a successful partnership among government, civil society representatives, and international agencies and donors. In fact, it is one of the factors that contributed to an increasing prevalence rate of modern contraceptives (45%, Reproductive Health Survey [RHS] 2004) combined with decreasing abortion and maternal mortality ratios over the last years.

The transparent monitoring of commodity distribution through the LMIS allowed a gradual transition from almost exclusive reliance on donated contraceptives towards the NFPP purchasing a growing share of products with public funds. The MOPH budget for contraceptive procurement increased from $100,000 in 2001 to $1.1 million in 2004 and to $1.8 million in 2006 (see Graph 2).

RFHI also facilitated partnerships between governmental institutions and the private sector to ensure the availability of contraceptives in pharmacies. The number of beneficiaries of free contraceptives has risen significantly as has the number of users accessing contraceptives through the private sector. Private market data show that RFHI's activities may have stimulated contraceptive demand in the private sector, and thus brings some evidence that free contraceptive distribution does not replace consumption in the private sector (see Graph 3 on next page).

Graph 3: Trends in use of oral contraceptives provided freely by the NFPP or by the private sector, Romania, 2002-2006



Data source: MOPH, IMCH/PMU, Market research Company/Cegedim

Main accomplishments and results

IR 1. Reviewed and improved legal, regulatory, and policy framework to support provision of quality reproductive health services:

- RFHI supported the development of **five national health strategies**: National Reproductive Health Strategy, National STI Strategy, National HIV/AIDS Strategy, National Public Health Strategy, and National Domestic Violence Strategy.
- The **Framework Contract** regulating the provision of services within the social health insurance system was revised to **include complimentary family planning services for all Romanians**, including the uninsured.
- **Eligibility criteria** for free contraceptives were reviewed to include more disadvantaged groups, including rural populations.
- **Family planning regulations were revised** to allow FDs in rural areas to provide services, including free contraceptives.
- **Protocols for family planning, prenatal care, and STIs were developed**.
- **National LMIS** was put in place in all districts.

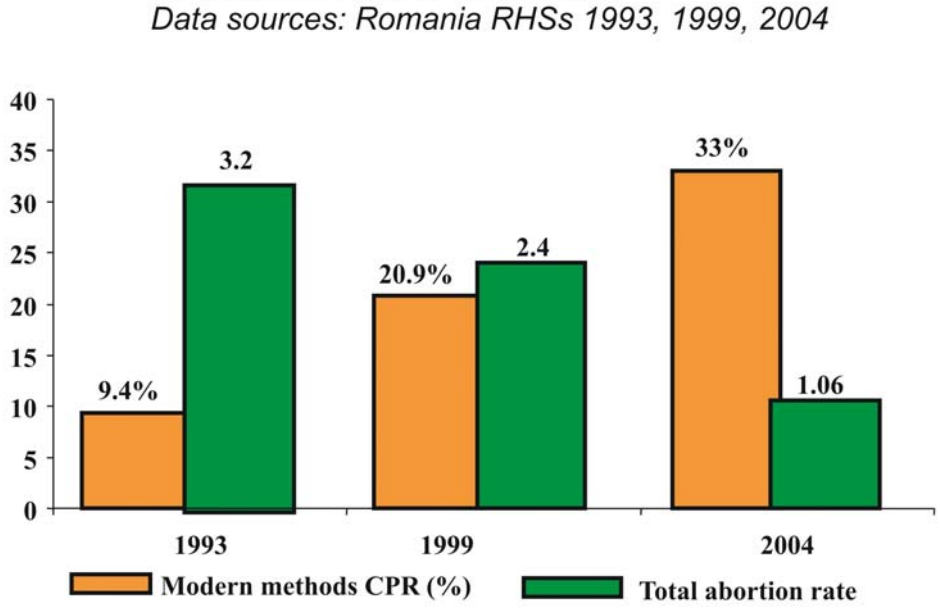
IR 2. Improved mobilization, allocation, and use of health sector resources to increase access to quality reproductive health services:

- The MOPH introduced a special **family planning budget line** and consistently increased the budget allocated for contraceptive procurement. Since 2001, when the budget was $101,000, it has continuously increased; in 2006, the budget allocated by the MOPH for contraceptives was almost $1.8 million, 18 times higher than in 2001.
- **DCWCFHs were created and supported** in every district.

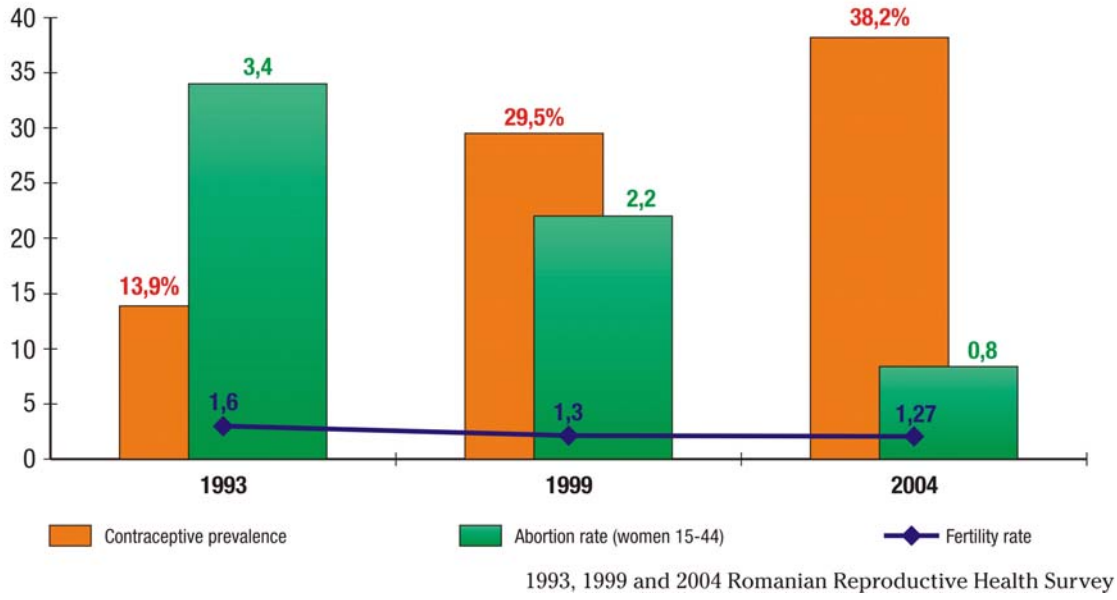
IR 3. Increased access to quality integrated reproductive health services:

- Modern contraceptive prevalence rate in rural areas increased from 20.9 percent in 1999 (RHS 1999) to 33 percent in 2004 (RHS 2004) (see Graph 4 below). The trends in abortion rates decreased as trends in contraceptive prevalence increased, keeping the fertility rate stable (see Graph 5 for national trends).

Graph 4: Trends in CPR among women in union, 15-44 years, and abortion rate in rural areas

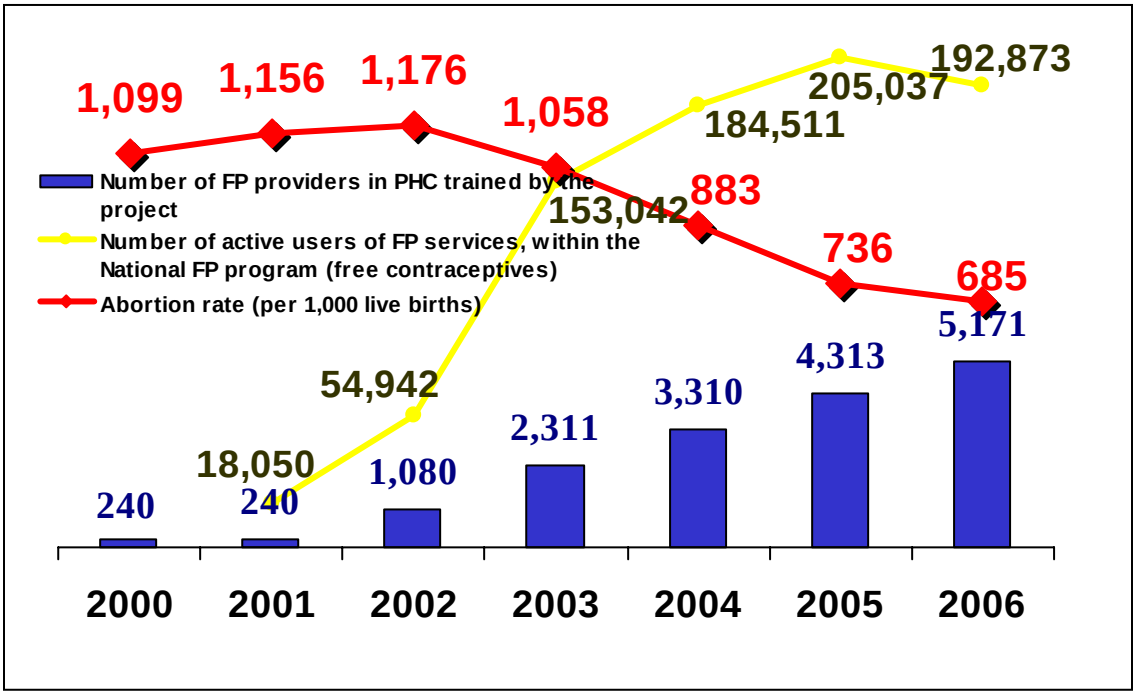


Graph 5: Trends in Contraceptive Prevalence, the abortion rate and the fertility rate. Romania 1993 – 2004



- By September 30, 2006, more than 5,100 FDs were trained in family planning, 75 percent of whom were rural. These doctors represent half the FDs under contract with the NHIH (see Graph 6 below).

Graph 6: The National Family Planning Program



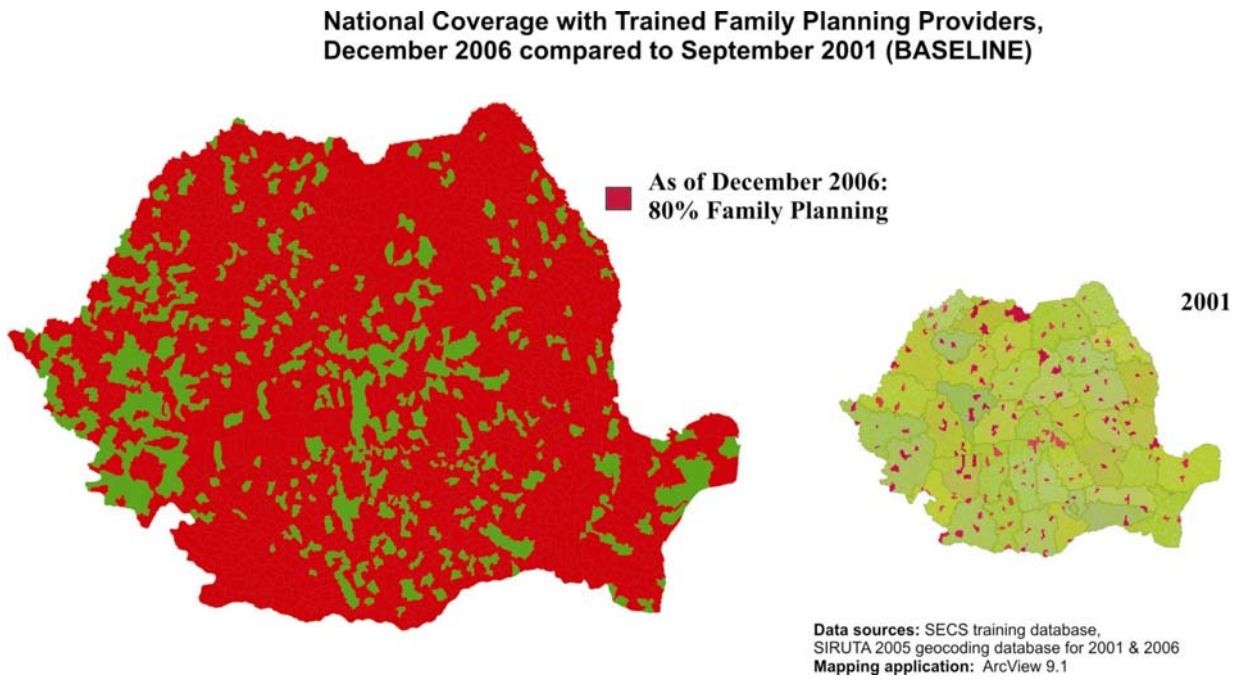
By the end of the project a broad array of job aids and toolkits were designed and used during in-service training for health care providers, with approximately 3,000 family doctors (almost one third of the total number of family doctors) trained to provide prenatal care and detect the early signs of obstetric risk.

- In total, between 2002 and 2007, RFHI trained 2,873 FDs in integrated reproductive health services[6] (5,302 in FP; 2,925 in prenatal care and 101 FDs in cervical cancer prevention). The project exceeded its target of 1,640 FDs trained in integrated reproductive health by 75 percent.
- FHI trained 3,647 nurses working in FDs' offices in FP.

[6] Since family planning, prenatal and postpartum care, STI screening, and early detection of breast/cervical cancer require different training objectives, professional standards, and infrastructures, these components were weighted as follows to calculate one FD trained in integrated basic RH care: FP = 40%; pre/postnatal care = 25%; STI screening = 15%; breast/cervical cancer early detection = 20%.

- RFHI developed, printed and distributed a comprehensive reproductive health training package covering the following topics:
  - Training of Trainers for FP/RH
  - Advanced Counseling for Family Planning Services
  - Family Planning for PHC Providers
  - LMIS
  - Antenatal and Postpartum Care and Counseling
  - Cervical Cancer Early Detection and Prevention
  - Postabortion and Postpartum Contraception
  - Training of Trainers for Roma Health Mediators (RHMs)
  - Training of RHMs in Reproductive Health, Pre- and Post-HIV Test Counseling.

By the end of the project, 80 percent of rural villages throughout the 42 districts in Romania had at least one provider trained in modern family planning.



IR 4. Romanians were better informed about health services, rights, and responsibilities:

- RFHI conducted 23 IEC/BCC campaigns addressing: availability of free contraceptives, prenatal care, safe sex for youth, discrimination against PLWH, domestic violence, and breast cancer.
- More than 155,000 women were exposed to FP/RH messages during approximately 10,000 factory meetings.
- An estimated 170,000 women were exposed to the series of articles developed under the "A Daily Subject" program.
- More than five million people were exposed to media events organized around December 1, 2006 World AIDS Day.

In conclusion, by focusing on prevention and centering on PHC in rural areas, RFHI helped strengthen the double role acquired by FDs following health reform. From an FP/RH perspective, the FD now serves the role of *gatekeeper,* by providing top-quality, efficient, frontline health services, but also that of *gate-opener,* by facilitating people's access to more complex, specialized medical services. Integrating FP/RH services in PHCs helped expand the FDs' portfolio of preventive services for beneficiaries.

Special Program Components to Increase Access and Expand Services

Youth

Background

As in many countries, Romanian adolescents and youth have difficulty accessing the health system, as neither pediatric nor adult services are appropriate for them, especially in the highly sensitive area of sexuality and reproductive health.

Youth (aged 15–24) represented 17 percent of the Romanian population in 2003 and some research indicated that youth lived in poorer conditions than the general adult population. Youth represent a vulnerable group from many perspectives, including their limited access to appropriate medical care and reproductive health services. The age at first sexual intercourse is decreasing and only 26 percent of Romanian youth used a modern contraceptive method (22% used condoms) at the time of their first intercourse, while 31 percent used a modern contraceptive method at the time of their last sexual contact (RHS 2004). Several factors contributed to this situation and most of them could be addressed through appropriate policies and interventions.

Specific needs of this group may be summarized as follows:

- Lack of information about contraception, services, and reproductive health in general.
- Lack of communication on these issues with informed and trusted sources (family, teachers, other relatives).
- Low awareness of the risks of unprotected sexual intercourse.
- Existing FP/RH services are not appropriately marketed to adolescents and youth.
- Preference for private family planning, ob/gyn, or general practitioner over the services of school physicians.

Interventions

Under RFHI, Youth for Youth Foundation (YfY) was the primary partner for youth-related activities, although other NGOs and public institutions were also involved. The main youth-related activity was the launching of a youth-friendly clinic. The overall goal of the YfY project was to ensure a continuum of services by linking family life education sessions in schools with services appropriate for young people and advocacy efforts to include youth needs in the public agenda.

The main youth interventions included:

- Conduct a quantitative and qualitative study to analyze youth opinions, attitudes, and behaviors related to RH services
- Design, set up, and run pilot clinic(s) for youth
- Promote youth-friendly services
- Introduce health education in schools
- Implement summer youth campaigns
- Assess the model(s).

Youth for Youth trainings trained and engaged youth as peer educators, as with this training for the “It’s Not Forbideen to Ask” summer campaign.

Main accomplishments and results

While implementation remains a challenge even today, the model clinic was quite successful, having an increasing number of client visits and continuing users. However, the MOPH decision to locate family planning centers in hospitals hindered the development of youth-friendly services, as hospitals are not particularly welcoming environments to youth seeking preventive services. Reshaping the strategic approach toward one model clinic at YfY premises ensured success of the model but was not sustainable. There was a steady increase in the number of clients, clearly linked with a promotional media campaign and interpersonal activities.

RFHI partner Youth for Youth Foundation served as the technical secretariat for the consultative committee that designed the strategy to introduce health education in Romanian schools.

In 2002 and 2003, summer campaigns combined peer education with local media support. The first was a six-week coordinated campaign using one slogan in eight cities along the Black Sea coast, managed by one NGO, and involving three other partners. Forty previously trained volunteers aged 17–25 provided safer sex and dual protection messages to more than 40,000 young adults, using many innovative approaches, e.g., on the beach, at discos. A peer drama was presented in the evening. Local radio stations very actively promoted similar messages and also announced campaign events or shared feedback from beneficiaries. The campaign's immediate impact was evaluated both quantitatively and qualitatively, demonstrating a considerable success.

During the summer, the resort towns on the Romanian Black Sea coast are engulfed by youth. In 2002, RFHI partners launch the health education campaign, "Take Care Not To Get Burned", a six-week campaign to raise awareness among youth (ages 15-25) of the risks of unprotected sex.

Each week, groups of youth volunteers, outfitted in bright orange uniforms displaying the campaign logo, walked the beaches handing out informational brochures and condoms, having interpersonal discussions, and leading interactive contests on the beach related to reproductive health the risks of unprotected sex. They ended each day in the disco, where they distributed condoms and danced.

The second campaign was a compilation of individual NGO activities in various locations on the Black Sea coast and other locations where youth gathered during the summer (e.g., rural camps), each having an individual slogan. This approach ensured a larger geographical coverage, by implementing activities both at the Black Sea coast resorts and in summer camps in seven other districts.

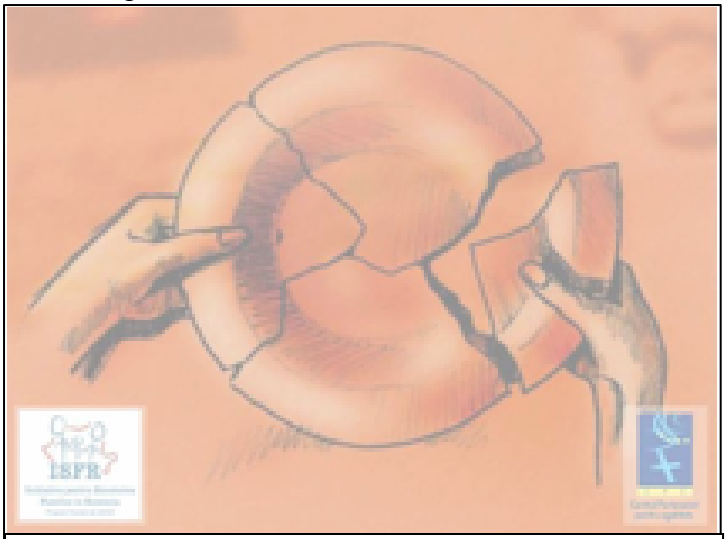
Sustainability

Activities and projects in the youth area are always a sustainability challenge—youth constitute a beneficiary group that is typically poorer than adults, does not access preventive health services, and for whom health is often not perceived as a priority. The main lesson is that unless political will exists and youth are a policy priority, no other efforts will substitute. It is clear that the state has to put higher priority on youth and then partnerships with NGOs can ensure good quality, client-oriented, appropriate services for young people.

Domestic Violence

Background

Among other negative effects, gender-based violence has a profound impact on women's reproductive and sexual autonomy and health. For this reason, the development of a national system for domestic violence prevention became part of the RFHI reproductive health strategy in 2002. Culturally, domestic violence has often been tacitly permitted—even by police and prosecutors—as it is considered a private issue in which others should not interfere. Not until 1995 did civil society begin to respond to the phenomenon of violence against women in Romania by starting support services for victims and setting up temporary shelters. NGOs have played an important role in providing a safety net of services that fall outside the purview of governmental agencies supporting violence victims. In 1996 and 1997, Romanian NGOs started to develop the first campaigns to combat domestic violence, although such initiatives remained small scale and had a limited impact on national policies due to limited resources, collaboration, and mutual support. In this context, advocates decided that the formation of a coalition of NGOs to improve communication and build partnerships would be an appropriate way to address domestic violence in Romania



Poster prepared for consultative meeting about Domestic Violence (Sinaia, March 2004).

RFHI developed and worked through partnerships to achieve results at the national level. USAID contracted JSI through RFHI to play an active role in identifying partners to work on domestic violence issues in Romania and to coordinate the participation and collaboration of stakeholders. These included local and national NGOs, the designated Romanian authorities (MOPH; Ministry of Labor, Social Solidarity, and Family [MLSSF]; National Agency for Family Protection [NAFP]), key funding agencies (USAID, UNFPA, the United Nations Children's Fund [UNICEF], the World Bank, and the European Union [EU]), and other key international partners, such as the American Bar Association/Central European and

Eurasian Law Initiative.

Interventions

In addition to providing mechanisms to these stakeholders for cooperation and partnerships, RFHI provided technical and logistical support to the GOR in the formulation of new legislation and policy to address domestic violence. Main activities included:

Conducting a baseline/situational analysis
RFHI conducted a baseline assessment of the existing regulatory framework, key NGO actors, and their ongoing interventions and programs. The situational analysis conducted in 2002 was the first source of consistent data and information at the national level to document domestic violence activities implemented at the grassroots level by civil society organizations. The database was subsequently updated annually and disseminated on CD-Rom to all local stakeholders.

Improving stakeholder coordination
Based on the NGOs identified in the situational analysis, RFHI and the Partnership for Equality Center jointly promoted the creation of the National Coalition Against Domestic Violence in 2003. The coalition's purpose was to strengthen civil society initiatives and create strong collaborative partnerships among all key stakeholders (government, NGOs, church, professionals working in the field, and other international organizations). The coalition encouraged the involvement of DPHAs in activities addressing domestic violence in many cities. The RFHI assisted the consultative committee established by the MOPH to develop coordination and communication mechanisms that improved the effectiveness of policy, service, and awareness interventions.

Providing technical assistance for formation of domestic violence policies
The national situational analysis also examined current regulations and policy in the field of domestic violence, including a comprehensive analysis of general inequalities in accessing information and services, and the availability and fragmentation of programs. It also recommended ways to improve the situation. Based on this analysis and existing knowledge and expertise, RFHI provided technical support to the Inter-Ministerial Working Group composed of most of the governmental and nongovernmental institutions active in the field of domestic violence to design the National Strategy on Domestic Violence (2002–2003). RFHI also worked through the coalition to ensure civil society involvement in the development and implementation of the legislation.

> "It is one thing to have a law in place but what is truly important is to change behavior."
>
> Deputy Director of the Ministry of Labor, Social Solidarity, and Family
>
> Consultative Meeting on Domestic Violence in Sinaia, March 2004

Main accomplishments and results

One of RFHI's major achievements in the domestic violence arena was the establishment of a continuous dialogue between state and civil society representatives. The Consultative Meeting on Domestic Violence, held in Sinaia March 18–21, 2004 was the first meeting that brought together all the major stakeholders in Romania to

collaboratively address the issue.

By providing technical and financial support to the National Domestic Violence Coalition Secretariat, RFHI strengthened the role of civil society in domestic violence policy. The NAFP and the coalition created a protocol of collaboration to jointly serve as key partners in the design and implementation of the National Domestic Violence Strategy.

A collaborative negotiation process among all key stakeholders in the field of domestic violence, including JSI technical assistance to the Inter-ministerial Working Group, resulted in the National Strategy on Domestic Violence (2002–2003). This included improved measures regarding victims' rights, such as restraining orders, protecting victims from perpetrators.

Partnerships developed through the National Coalition, in collaboration with the NAFP and with JSI technical and financial support, also led to the implementation of the awareness-raising campaign "16 International Days of Activism Combating Violence against Women." One intervention during the campaign showed black silhouettes of women and children, while a case history of how these persons were killed from acts of domestic violence was read aloud to the audience. This was a particularly effective way to educate the public and decision-makers about the implications of domestic violence and the need to produce more effective legislation to combat it. **The coalition was registered in 2006 and included a majority of Romanian organizations that address domestic violence.**

Sustainability

In order to sustain the Domestic Violence Coalition over time, JSI addressed the financial sustainability of the NGOs involved by increasing capacity in accessing alternative sources of financing. The program conducted a workshop on identifying EU funding opportunities and on developing NGO business plans.

The national strategy was also launched as a Program of National Importance, thereby placing it firmly on the national agenda and allowing it to qualify for increased public funding. In addition, the sustainability of the Coalition itself is enhanced by its legal status as a Romanian NGO, granted in the fall of 2006. This status gives the Coalition access to funding and consolidates its public image as an important actor in civil society.

HIV and AIDS

Background

Romania has a very specific HIV epidemiological profile. The country became well known in the 1980s for the relatively high number of iatrogenic infections among children transmitted through infected blood, blood products, and unsterile syringes. By December 31, 2006, children accounted for 4,488 of 6,613 HIV cases and 3,526 of 11,906 AIDS cases registered in Romania.

A systemic Romanian response to the HIV epidemic was slow in the 1990s and focused largely on prevention. For instance, HIV testing was performed only in cases already showing signs and symptoms of advanced illness. Moreover, hard-to-reach groups and vulnerable populations, such as people with disabilities and special needs, were underserved. In response, PLWHs, doctors, and private organizations—mostly sustained by international funding—initiated a number of independent projects aimed at combating stigma and discrimination, notably within health care settings, and promoting HIV/AIDS care and treatment, psychosocial support, and/or prevention. Gradually, nongovernmental efforts became more visible and coherent, despite the absence of any significant financial contribution from the government. Although the MLSSF allocated small grants for NGOs to address HIV and AIDS, this body lacked the technical expertise to prioritize programs or interventions.

Poster with red ribbon pledge.

Beginning in 2001, RFHI embraced a holistic and collaborative approach to the amelioration of Romania's family health problems, including reducing HIV and STIs. Efforts focused on incorporating equality, anti-stigmatization, and the right to services and information into policies regarding HIV & AIDS and STI services and campaigns at both national and local levels. Outreach activities focused on behavioral change and use of preventive and treatment services, including voluntary counseling and testing (VCT). These campaigns resulted in a reduction of HIV & AIDS-related stigma and discrimination. RFHI priorities included providing information to the general public to prevent HIV transmission and to promote support to PLWH.

Interventions

Policy and advocacy

Advocacy efforts by local NGOs supported by RFHI—such as the Romanian Association Against AIDS (ARAS) and National Union of Organizations of People Living with HIV/AIDS (UNOPA)—government ministries, USAID, UNAIDS, and UNICEF led to government recognition of the AIDS epidemic as a public health priority. As a result, the National Intersectoral AIDS Commission (NIAC), created at the end of 2001, provided an institutional framework for collaboration in analysis and coordination of the Romanian response to HIV and AIDS.

RFHI advocacy efforts highlighted the involvement of people living with HIV (PLWH) in various innovative activities. Under a subcontract with the UNOPA Federation, PLWH organizations monitored and reported on PLWH rights on a quarterly basis. This initiative

contributed significantly to a more favorable regulatory framework for ensuring the socio-medical rights of PLWH.

The NIAC contributed significantly to the development of the first National HIV/AIDS Strategy, adopted in 2002 by the GOR. RFHI partner, ARAS, provided technical assistance and support for the implementation of the strategy, including producing its subsequent revision. This framework directly supported Romania's ability to access financial support from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). As an active member of the Romanian National Country Coordination Mechanism, JSI contributed substantially to the successful application of Romania to the GFATM, which funds, strengthens, and supports the national HIV/AIDS and TB programs. JSI provided technical assistance to the Romanian Global Fund Principal Recipient in all critical areas, including the development of procurement and financial guidelines, elaboration of overall performance and subcontractors' monitoring plans, and monitoring and evaluation (M&E) training for GFATM national partners. JSI also assisted sub-recipients in the development of strategic workplans and assessed sub-recipient capacity to carry out their respective scopes of work. JSI worked closely with the national principal recipient and the MOPH, providing training to improve the program management capacity of the Project Implementation Units for HIV/AIDS and TB. In addition, JSI played a substantial role in the preparation of the successful GFATM Round 6 proposal and was a key institutional member of the local proposal evaluation committees for both the TB and HIV/AIDS components.

A human ribbon in the center of Bucharest garnered significant media attention on World AIDS Day, December 1, 2002.

Information, education, and communication/behavior change communication (IEC/BCC)

Although, beginning in the early 1990s, national HIV activities focused primarily on preventive messages, only in 2002 did key stakeholders nationwide begin coordinating their efforts through an IEC working group fostered by RFHI. This working group contributed to strategizing and organizing IEC/BCC activities and campaigns by establishing partnerships and optimizing resources at the national and local levels. Strategic planning of public campaigns built on survey results, prioritizing the following areas: a) providing correct information about HIV transmission and b) combating stigma and discrimination.

The goal of the IEC/BCC activities was to decrease the number of persons—mainly vulnerable people (such as street children, Roma, commercial sex workers, teenagers, and prisoners)—who

display high-risk behaviors. Specifically, the aim was to educate individuals regarding high-risk behaviors, personal risk evaluation, risk-reduction strategies, anti-stigmatization principles, condom use, and available services. An AIDS helpline service was also implemented that ensures constant access to information and counseling supplemented outreach activities.

Each year, RFHI contributed to events organized by NGOs for World AIDS Day, in support of the annual UNAIDS theme. In 2002, the IEC working group produced a unique logo and slogan to be used in all activities: *"Deschide Ochii! Deschide Inima!"* (*Open your eyes! Open your heart!*) The international symbol—the red ribbon—was adapted in the shape of a heart as a logo unique to Romania.

To specifically fight discrimination against PLWH, RFHI relied on teamwork and peer educators recruited from the target population and trained by NGOs and volunteers. Condoms, informational materials, and hygiene products complemented outreach activities. In addition to information campaigns, volunteers conducted sessions that focused on increasing knowledge and developing communication and negotiation skills at institutions for young people.

ARAS, in partnership with the Medical Directorate of the Ministry of Justice, trained inmates in prisons to provide peer education. The project also trained teachers, educators, and doctors in penitentiaries to act as resource persons in their sites.

Reaching out to street youth with information about HIV and STI prevention and giving them hygiene kits was part of RFHI's peer education program conducted by RFHI partner, ARAS.

Of prime concern, HIV-positive youth lacked sufficient knowledge and skills to avoid high-risk behaviors. In particular, young HIV-positive women needed information on how to protect themselves from unwanted pregnancies and—for young HIV-positive pregnant women and mothers—how to protect themselves and their babies. RFHI supported UNOPA's efforts to promote the right to a healthy sexual and reproductive life for PLWHs diagnosed during childhood and currently of reproductive age, by facilitating their access to quality, client-centered sexual and reproductive health information. A pilot project used a specially designed curriculum to train PLWHA as peer educators. This initiative continues independent of RFHI, with GFATM funding.

Although other NGOs and ministries actively participated in RFHI's youth-related activities, Youth for Youth Foundation linked family life education sessions in schools, including HIV and AIDS, with appropriate youth-friendly services. Youth for Youth and partners also advocated for placing the needs of this age group firmly on the policy agenda.

Human resources development

ARAS conducted training for health professionals and social workers to:

- Provide updated information about STIs, including HIV;
- Contribute to early detection of HIV infection among those vulnerable and at-risk;
- Promote positive attitudes toward condom use;
- Promote safe sexual behavior through pre- and posttest HIV counseling;
- Contribute to the improvement of life skills (communication, negotiation, evaluation); and
- Promote positive attitudes towards PLWH.

The program also provided training on HIV prevention education to an additional 593 persons, including volunteers, counselors, health professionals, and peer educators.

> "At the beginning, I didn't want to go there because I don't like to go to the doctor. But the boys in the street—I think they were ARAS outreach workers—used to tell me to go. I went and found out about this disease. Somehow, I expected to have this [positive test]result. But I liked the girls working there. They spoke to me kindly, and I understood that it was good for me that I went there. I also brought other friends of mine. You know, I would not come if I didn't like the center, and if I did not find any help here."
>
> ARAS beneficiary

Voluntary counseling and testing (VCT) services

RFHI promoted client-centered VCT services, through ARAS' support to government efforts in public drop-in centers and linking HIV prevention interventions with care and support for HIV-positive individuals.

In the cities of Iasi, Constanta, and Bucharest, ARAS established the first VCT centers in Romania through a partnership with the DPHA. ARAS promoted the centers and provided pre/posttest HIV counseling, while the DPHA provided medical servces, such as drawing and analyzing blood samples. These VCT centers promote and sustain behavioral change, and provide a link to other interventions aimed at preventing the spread of STIs and HIV. Specific services offered include HIV pre and posttest counseling, risk self-assessment, HIV testing for HIV and other STIs, individual risk-reduction strategy development, distribution of IEC materials and condoms, and referral to other medical and social services, if required.

Based on the experience with developing the drop-in VCT centers, ARAS developed working standards and protocols that are included in a health worker training manual for pre and posttest counseling, printed in 2006. They also developed a curriculum for HIV counseling and testing, and established working standards for HIV counseling.

Main accomplishments and results

RFHI partners **trained 729 professionals in HIV VCT**; **conducted 21,765 pretest counseling sessions in three VCT centers**, for high-risk populations including commercial sex workers, street children, Roma individuals, and other vulnerable groups. Ninety-six percent of the beneficiaries returned for posttest counseling. The VCT center in Iasi has been particularly successful in preventing mother-to-child transmission of HIV by promoting voluntary counseling and testing services to a high proportion of pregnant women in the district.

RFHI contributed to the strong, vibrant, and mature partnership that now exists in Romania among the various actors involved in the HIV and AIDS field. These partnerships significantly improved coordination, as evidenced during activities funded by the GFATM, in which RFHI partners played an important role. This represents perhaps one of the best examples in Romania where public authorities and NGOs have worked together in efficiently and with concrete results.

The following quantitative IEC/BCC results are illustrative of the successful partnerships under the *Deschide Ochii! Deschide Inima!* campaign:

- In 2002, program activities reached over 92,000 youth. It is estimated that 8 million viewers saw the talk shows, music videos, and testimonials broadcast on four national television stations. Nine artists from popular music bands *Hi-Q, Impact,* and *Class* produced both the *Deschide Ochii! Deschide Inima!* tour song and testimonials.
- In 2003–2004, the first recall survey done in Romania after a public campaign showed that, although the sentimental message was highly appreciated, the transmission of two linked messages (prevention and combating discrimination) was quite confusing. Nevertheless, the number of calls to the HIV telephone helpline doubled during the campaign period.
- In 2005–2006, more than 115 youth participated in a campaign photo contest.
- In 2006–2007, the mass media alone exposed almost five million Romanians to World AIDS Day-related events.

Cervical cancer early detection and prevention

Background

For the last twenty years, Romania has had the highest cervical cancer incidence and mortality rates in Europe. In 2006, 1,839 women died and more than 3,000 new cases were diagnosed, making cervical cancer second to breast cancer among the female neoplasia.

Cervical cancer particularly affects young, active women, representing the primary cause of death for the Romanian female population aged 20–44. This pattern is primarily due to changes in sexual behavior and leads to dramatic consequences: over 30,000 life years are lost annually in Romania due to premature deaths caused by cervical cancer.

This situation reflects both changes in risk behaviors and the inefficiency of cancer prevention measures adopted in the past. In spite of the well-known benefits of the Pap smear test, a very small number of women in Romania are tested annually, largely through opportunistic screening during a regular gynecologic examination.

The population's low levels of knowledge and awareness regarding cervical cancer also contribute to current incidence and mortality. The situation is particularly difficult in rural areas, where "nine out of every ten women have either never heard of the Pap test or have heard of, but never had the test."[7] The situation in Romania requires interventions designed specifically to reach the most vulnerable women. The 2004 RHS reports that 89 percent of rural women, 91 percent of women who completed only elementary or lower secondary school, and 93 percent of women in the lowest socio-economic category had never been tested.

In support of its mission to improve the reproductive health of vulnerable groups, in 2003, RFHI included the early cervical cancer detection and prevention program in its portfolio. The program extended an ongoing collaboration of the Romanian Cancer Society (SRC) and "I. Chiricuta" Institute of Oncology in Cluj-Napoca (IOCN), with funds up to that time provided by the MOPH and various donors.

RFHI supported the program between 2003 and 2006, gradually expanding from Cluj district to include the neighboring districts of Salaj, Satu-Mare, and Bistrita-Nasaud. SRC and IOCN implemented the program, building on their previous work to develop a model public-private partnership.

RFHI used a mobile van to bring cervical cancer tests to women.

Interventions

The program focused on women living in geographically isolated rural communities with little access to information and health services, as well as underprivileged urban women.

According to Romanian law, all women enrolled in the social health insurance system can receive a free Pap test every five years. However, as the 2004 RHS showed, access to screening services is very limited, especially for rural women. This is due both to lack of physical access to and specific information about services. Therefore, the team adopted a program strategy of bringing services to the population in need. This meant designing an outreach intervention model implemented by program professionals, but strongly supported by local stakeholders and benefiting from the involvement of community FDs. The program took care to clearly define each partner's roles and responsibilities. The contribution of the local community also added tremendous value.

[7] 2004 Reproductive Health Survey Romania, Summary Report, May 2005, p. 57. ftp://ftp.unfpa.ro/unfpa/RHSE2004.pdf

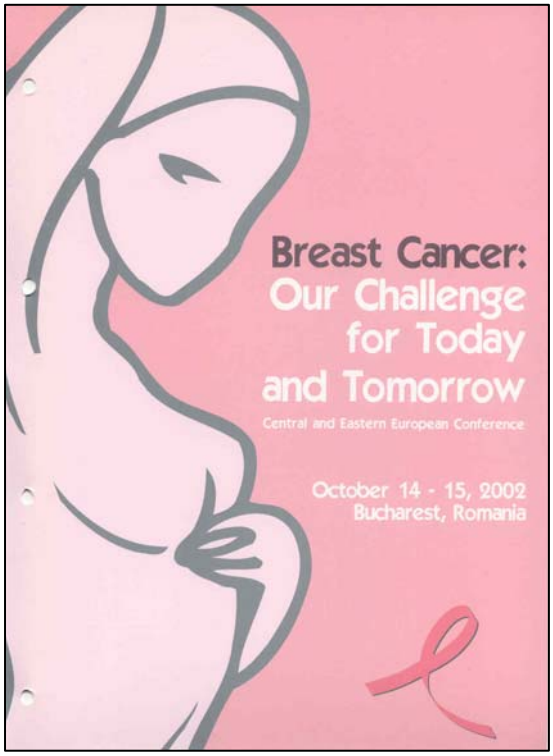
Information, education, and mobilization of the target population

In order to raise women's awareness about the importance of breast and cervical cancer prevention and to inform them about Pap tests and breast self-examination, the project team organized information-education meetings with groups of women between 20 and 65 years of age. Local FDs promoted the messages. Innovative local initiative groups were created to mobilize women to go to screening. The initiative groups included the mayor, the FD, the school principal, and the priest: people who are influential with the target group. Their participation facilitated contact with the population.

In addition to community-based activities, the team also organized information-education sessions in schools. This was an efficient way to improve the knowledge of young people about breast and cervical cancer prevention, with the objective of changing attitudes about personal health, focusing on preventive behavior.

Provision of free Pap tests and mammograms

Once informed, women were encouraged to visit a participating FD or medical service for a Pap test. If conditions at the facility did not allow for a test, a mobile and well-equipped project van could provide one. IOCN gynecologists or trained FDs performed the testing after individual counseling. Doctors also did breast examinations and, when appropriate, referred the women for mammograms—the costs of which were covered by the program. Doctors followed up with any patient suspected of having malignant tumors and, if this diagnosis was confirmed, the woman had free access to treatment.



Training family doctors

The RFHI implemented a well-structured theoretical and practical training course. The Romanian College of Physicians accredited the eight-hour theoretical course "Early Detection of Breast and Cervical Cancer: Clinical Interventions for Female Oncological Pathology within Primary Health Care" which was attended by 101 general practitioners (GPs), working in both rural and urban areas in Cluj and Satu Mare districts. Based on this training activity, RFHI developed a curriculum that can be used for future trainings in other programs.

Consensus building, experience sharing, and disseminating results

In 2002 the RFHI held a conference to facilitate consensus building among key stakeholders, including over 90 gynecologists, oncologists, cytologists, and FDs involved in the national prevention program. Key conference outputs included the development of a guide to help the GPs in their outreach activities and the adoption of guidelines for cervical cancer early diagnosis and treatment that comply with European standards.

At the end of the program, staff organized a dissemination conference in Cluj-Napoca for national stakeholders and colleagues from all over the country. This was an opportunity for professionals involved in cervical cancer prevention, early detection, and/or treatment to learn more about the innovative approaches and elements used by a successful screening program, especially to reach disadvantaged groups.

Main accomplishments and results

Outreach activities covered 116 villages and nine cities in the four project districts in northwestern Romania. The program conducted 209 group information-education sessions, **reaching 9,015 beneficiaries**. Health workers provided information and counseling to all clients, both at the time of testing and when communicating the results.

13,402 women had Pap tests, 91 percent of whom received the test for the first time. In 5.2 percent of the tests, results indicated dysplasia and patients entered the next phase of the screening program.

Providers performed breast examinations for 83 percent of the women receiving Pap tests and 260 mammograms for cases that needed further investigation.

The program developed a curriculum that became part of the RFHI comprehensive reproductive health curricula. **Training in prevention and early detection of cervical cancer reached 101 FDs** and the program demonstrated that, to fully benefit the population, the role of the FDs should be redefined to include additional prevention interventions, such as this, that can be implemented at local level.

Another important result was improved **local stakeholder awareness of their communities' needs**, specifically related to the cervical cancer problem, and the creation and functioning of the local initiative groups. In terms of sustainability, this may be one of the most important achievements of the program.

At the policy level, the program disseminated and shared the model with national and local decisionmakers who recognized it as a best practice in the field of cervical cancer prevention in Romania. This created not only a framework for policy discussions, but also the premise for replication in other parts of the country. One of the most important policy and advocacy results of the program was the fact that the **MOPH increased the budget allocated for cervical cancer screening** to the IOCN, thereby acknowledging its efforts. This will allow the Institute to continue its important work and also encourage others to become involved.

Postabortion and postpartum care

Background

In May 2005, RFHI received supplementary funds to implement postabortion and postpartum counseling in selected public hospital facilities. This new component aimed to support completion of a family planning "safety net" at the main entry points to the health care system by complementing the ongoing RFHI components targeting rural underserved populations, poor urban populations, and the Roma ethnic minority.

The integration of family planning counseling and contraceptive provision into the routine practices of abortion clinics was expected to develop a new layer of services—hospital-based—to function parallel to family planning services already in place at the start of the postabortion-postpartum care (PAC-PP) component.

RFHI support to the National Family Planning Program had already succeeded in shifting the fertility control behaviors of Romanian couples from abortion to effective contraception. However, comprehensive scaling up of modern family planning services in both rural and urban communities can not by itself ensure reaching all high-risk groups, such as those seeking repeat abortions.[8]

In addition, new mothers have a special need for family planning services and other health information, such as optimal birth spacing, childcare, breastfeeding, and STI and HIV prevention. The brief stay in the maternity after delivery is an opportune time for informed referral to postnatal care services in the community. This is a particularly good way to reach the most vulnerable groups with special health needs and/or difficulty in accessing available family planning services to avoid unwanted pregnancies and repeat abortions.

A study conducted by RFHI[9] indicated that Romanian women were more likely to resort to abortion—and repeat abortions—when they had had at least one previous abortion, approached the upper age limit of fertility, and had achieved their desired family size. Women with a less favorable economic, educational, or socio-cultural profile depended more on abortion for fertility regulation. Some Romanian women seeking abortion had not used modern or traditional contraception, and research showed that method failure or inconsistency in method use also was responsible for a percentage of unwanted pregnancies.
Almost all abortions and deliveries in Romania take place in primarily urban hospitals, and women have direct access to abortion services without referral from their primary care physician. However, traditionally, only ob/gyn specialists received training in contraceptive technology and counseling. Therefore, it became obvious that a crucial part of RFHI's PAC-PP program needed to be in-service training of a range of health care providers.

To best address the needs of all groups concerned, RFHI assessed both current efforts in Romania and available research to support technical approaches to any proposed interventions. Building on the experience of RFHI and other local initiatives such as USAID's Catalyst

[8] RFHI's definition of repeat abortion refers to women who have had more than one abortion.
[9] The eight-month study, carried out in 2006-2007, involved 773 Romanian women attending abortion clinics.

Project,[10] RFHI's PAC-PP program proposed to integrate a comprehensive package of family planning and reproductive health services consisting of counseling (including family planning, postnatal care, breastfeeding, and HIV prevention, as needed) and free contraceptive supplies for all women in immediate postabortion or postpartum service settings.

Interventions

The two objectives of the PAC-PP Program in Romania were to implement postabortion and postpartum family planning counseling and contraceptive provision in out-patient and hospital settings and to empower the community to demand quality postabortion and postpartum services.

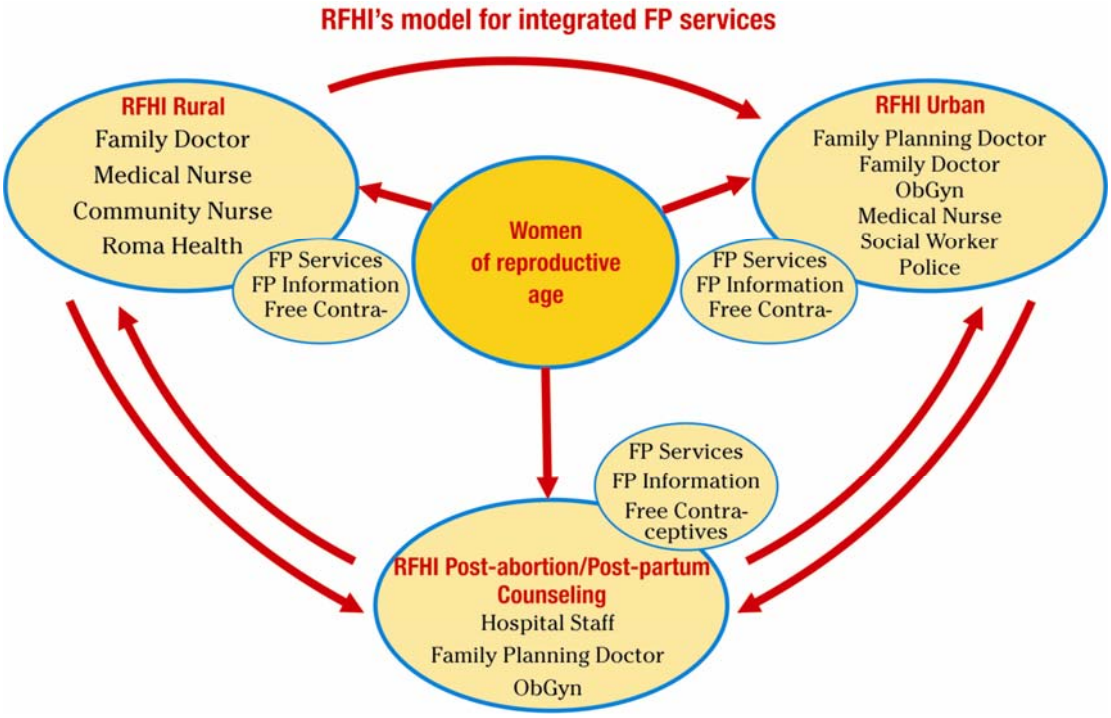
A PAC-PP pilot project that began in 2002 demonstrated the acceptability and feasibility of integrating family planning services in Romanian public-sector abortion clinics. It showed that: Both providers and clients were very satisfied with the introduction of quality family planning services, particularly the mandated access to free contraception in public abortion wards.

- In-service training is critical for increasing abortion providers' knowledge and skills and in creating a medical environment favorable for quality family planning service provision, including distribution of free contraceptives.
- Introducing postabortion family planning services increased the level of modern contraceptive use among abortion clients immediately and at six and 12 months postabortion.
- With sufficient commitment and professionals' involvement in tailoring planned interventions to the realities of a specific health facility, the PAC model can be easily replicated.
- Despite initial intentions, the short study period did not allow a cost-efficient impact evaluation of the potential reduced risk of subsequent unwanted pregnancies.

The RFHI PAC-PP program delivered family planning services in abortion and obstetric departments in 52 hospitals and out-patient care facilities in 11 districts and Bucharest.[1] These facilities cover 44 percent of abortion events and 40 percent of deliveries reported[1] nationwide.

RFHI staff worked to improve the referral system between primary health and community care providers and secondary and tertiary care providers, with a special emphasis on awareness-raising and preventive services at the community level. As a result, women have improved access and new system entry points for a continuum of FP/RH care including information, counseling, care, and contraceptive provision.

[10] USAID's Catalyst Project aimed to dispel myths and misconceptions regarding contraception by updating clinic- and community-based providers' knowledge about FP and their counseling skills. Trained providers have counseled PAC clients on the dangers of repeat abortions and where to obtain family planning methods.



RFHI first developed a logical framework defining provider responsibilities, referrals, and training in order to integrate family planning practices and other reproductive health issues into antenatal, postpartum, and postabortion services at all levels of the health care system.

Activities included:

- Selection of project facilities
- PAC-PP program introduction at the national and local levels
- Design and implementation of situation analyses
- Development and implementation of facility-level action plans
- Development and implementation of training package
- Availability of contraceptives
- Public information

Main accomplishments and results

Between 2005 and 2007, **over 123,000 women received information about the rapid return of fertility after an abortion** and the ready availability of family planning methods to to avoid future unwanted pregnancies or for birth spacing.

Forty-eight family planning doctors became project trainers and trained:

- 2,672 nurses and 343 auxiliary staff in "Contraception for All";
- 830 nurses in family planning counseling for postabortion and postpartum women; and
- 183 family doctors and 220 nurses in residential training on counseling and contraceptive technology.

This project poster had a strong impact on abortion clients.

Translation:
"You can get pregnant again as soon as 7 days after an abortion. If you want to have a child after having an abortion, it is best to wait for 6 months.
For more information on this and on family planning methods, ask the ob/gyn, the FP doctor, the nurse, the family doctor, the community nurse, or go directly to a clinic showing this sign.
(the NFPP logo is posted in all FP clinics around the country that offer FP services and free contraceptives under the national program)

To assure seamless functioning of the referral system and good links with community care, RFHI convened and updated 850 primary health care providers about PAC-PP.
Research conducted under the PAC-PP initiative revealed potential areas for focused intervention, including increased attention to young cohorts just entering reproductive age, the importance of improving public-sector reporting, and the importance of assessing the burden of abortion complications originating in both public and private settings.

Several contextual factors positively influenced the expansion of the family planning "safety net" to include hospital-based, PAC-PP service delivery points. These include the existence of a favorable policy framework and the dynamic experience accumulated over the previous five years in implementing the NFPP (including the provision of free contraceptives for eligible groups). Gaining political support from district health authorities and involvement of all local stakeholders created the basis for program ownership at the community level.

Health professionals' exposure to leading international specialists in the field, state-of-the-art training materials, and training tailored to their needs fostered evidence-based practice in ob/gyn wards and the creation of best-practice models in specialized hospital care. The PAC-PP program demonstrated and institutionalized the role of ob/gyn nurses in providing effective counseling to their beneficiaries.

The program also promoted an articulated and seamless services and referral network, in which DPHAs coordinated links between FDs and nurses from PHC and family planning services and facility-based ob/gyns. This created a comprehensive community approach for family planning service provision.

Given interest shown to date in the PAC-PP program, an evolution is anticipated similar to that observed during the RFHI rural component, when districts competitively created the basis for "horizontal contamination."

Sustainability

A major RFHI sustainability achievement is the introduction of the modern contraception training curricula in selected Romanian medical faculties, helping assure the continuity of human resources capable of providing high-quality family planning services.

Roma communities

Background

The inequality of ethnic minorities in accessing healthcare is an issue that arises in many countries. This is the case for the Roma ethnic group, which constitutes a substantial minority population in many Eastern European countries and has not enjoyed the health improvements seen in the general population during the political and economic transition period. Reproductive health program experts have recognized the need to design interventions that meet the specific needs of particular sub-populations, including ethnic minorities, and the importance of mitigating the profound and lasting effects of social and economic marginalization on health outcomes.

Roma families are often not able to access health care because they do not have identity cards, issued at birth. RFHI worked to create flexibility so the Roma would not be turned away from services for lack of an ID card.

The current situation in Romania and other former communist countries provides insight into the effect of ethnic disparities between population groups. Historically, the forced assimilation of Roma into Romanian society under communism prevented overt recognition of these inequalities, which have since resurfaced. While living standards in Romania have declined in general during the transition to a market economy, the conditions for Roma have deteriorated much more severely.

Roma life expectancy is on average ten years lower than the majority of the population in Central and Eastern Europe.[11] Poverty among Roma is related to a range of factors such as poor health and educational status, limited employment options, as well as discrimination. In Romania, it is estimated that the Roma minority constitute 1–2 millon persons or 4–10 percent of the overall population, although the official census states that there are 535,250 Roma. The lack of definitive numbers stems from two main issues. Many Roma do not have basic identification papers, such as birth and marriage certificates, and are therefore not recorded in the census or

[11] Ringold, D. 2000. *Roma and the Transition in Central and Eastern Europe: Trends and Challenges.* Washington, D.C.: The World Bank.

other population surveys. The second reason is that many do not officially declare themselves as Roma to avoid both overt and subtle discrimination.

Reproductive Health Indicators

The marginalization of the Roma can be seen in the reproductive health sector. In Romania, legal access to contraception since 1989 has coincided with a decrease in the abortion-related maternal mortality ratio. It is not yet apparent if the Roma will follow this pattern, as their reproductive health indicators are considerably worse than national rates. The 2004 RHS illustrates a pattern of negative health status for Roma in relation to national figures. When indicators are broken down by ethnicity, Roma consistently have the poorest outcomes of any group in Romania. For instance, Roma women have the lowest rates of early prenatal care.

NGOs, donors, and governments have become increasingly active in supporting programs that address Roma health, in an effort to improve their overall standard of living. The RFHI, launched in 2001, included the objective to reach underserved populations, such as Roma. But it was not until 2004 that the RFHI allocated considerable technical and financial resources to a national program to diminish health inequalities among Roma communities by reducing access barriers to FP/RH services.

Roma Health Mediator training, 2004

Since 2001, the Romanian MOPH has implemented the Roma Health Mediator (RHM) Program, which employs Roma women with at least an eighth-grade education to serve as links between the Roma community and health clinics. Recognizing the value of these Roma community health promoters in improving the health of their communities, RFHI designed a project to improve the capacity of RHMs to provide RH information and education based on its "three pillar" approach (training, product/service supply, and behavior change communication) and continuous support for favorable policy development. The policy component began with a series of working group meetings that included the MOPH, NGOs, and donors.

To learn more about Roma reproductive health behaviors and attitudes, RFHI conducted focus group discussions in seven communities. Participants showed a high level of willingness to speak about reproductive health issues, including abortion. In response to a general question about their experience learning about issues such as pregnancy, sexuality, and contraception, women from more urban and less traditional communities felt that they had at least a basic knowledge about these topics. Women from smaller and more traditional Roma communities more often stated that they had not learned about these topics when they were younger. Women from both traditional and less traditional communities believed that there is a need for more information and mentioned the RHM as a primary resource. Many participants cited embarrassment and a

cultural tradition of not speaking about reproductive health as the main reason for their communities' lack of knowledge.

The 2004 RHS revealed that Roma women access prenatal care services later in pregnancy than women in the general population. Few Roma women use modern contraceptives, and most choose abortion as their primary birth control method.

The proportion of women reporting sexual debut before the age of 15 was larger among Roma women compared with women in the general population. Roma men also reported earlier sexual debut.

Interventions

RFHI aimed to increase access to and use of FP/RH services by Roma communities with a focus on RHMs, who are trained to promote good health and cultivate reciprocal trust between community members and medical and social service providers.

The program developed:

1. RHMs' capacity to provide FP/RH information and to refer the Roma population to specialized services through:

- Training package (trainer's manual and participant's guide), based on the nature of the RHM's work and the characteristics of Roma culture, focusing on interactive methods and simple messages;
- Five-day training of trainers;
- Training of RHMs with a minimum of six months of work experience; each training was developed by two RHM trainers and supervised by a master trainer; and
- Follow-up meetings to strengthen the knowledge and abilities gained during the education/training sessions, evaluate community sessions, and exchange information among RHMs to stimulate professional motivation.

Roma women of two generations in the community thank Dr. Andor for his kindness and assistance. Dr. Andor says he was better able to meet the needs of his clients after attending an RFHI training in FP and RH.

2. Simple and interactive IEC tools, adapted to the cultural characteristics of Roma communities.

3. Monitoring of outreach activities to support the work of the RHMs.

4. Enhanced professional status of RHMs through provision of badges marked "Health Mediator," identifying RHMs as a distinct professional group, facilitating access to public institutions, and supporting the RHMs' outreach work.

5. Roma people's access to PHC by organizing six one-day workshops for FDs. The objective of the workshops was to increase FDs' understanding of cultural diversity and communication to subsequently facilitate the client-provider encounter. The project developed a guide to cultural diversity for FDs for these workshops.

6. Support for medical and social interventions in Roma communities by organizing technical meetings between governmental and nongovernmental organizations involved with Roma health programs.

7. An evaluation of the RHM Program implemented by the MOPH in order to extend the program and the medical/social services provided in Roma communities. The most important results of the evaluation showed that:

- RHM training needs are recognized, important, and declared; RHMs participate in training courses organized by DPHAs or other institutions/organizations;
- The following materials were identified as requirements for adequate working conditions for RHMs: an office for developing daily activities, communication tools (e.g., mobile phones, phone cards), transportation, work equipment (e.g., badges, rain coats, umbrellas, rain boots);
- RHMs need acknowledgment of their social and professional status; and
- RHMs represent important "vectors" in the community for disseminating information and providing education to the Roma population.

> As a result of the training in family planning I have initiated a campaign in the community. I started with the young daughters-in-law, those who were most interested in this topic. I began to inform women about the family planning cabinet in Fetesti, which offers free services and counseling. Shortly after that I presented the advantages and disadvantages of birth control methods. I continued to meet women, sometimes at their request, in order to offer more information about family planning and reproductive health…
> Whereas, at the beginning, many women didn't know about using condoms; now most of them know about almost all contraceptive methods.
>
> Jenica Ganea
> Roma health mediator
> Ialomita District

Due to the initial absence of RHMs in Cluj and Salaj districts, RFHI partner, the Association of Roma Women's Emancipation (AFER), undertook a different approach. The first steps were to select 26 Roma communities from Cluj and Salaj districts, train 29 Roma women to become health mediators and in FP/RH, and organize IEC sessions in all selected communities. Another

particularity of this pilot project was the partnership among local authorities, FDs, and AFER in order to support the RHMs in their work. By the end of this one year-project, the two DPHAs hired seven RHMs each.

When the PAC-PP component started in 2005, a specific set of activities addressed the particular needs of Roma women and families. Main activities included:

- Training the RHMs in birth spacing and postpartum and postabortion care.
- Developing IEC materials promoting breastfeeding and child care.
- Organizing workshops about Roma culture for nurses in several maternities.

Main accomplishments and results

- Developed **training pack for trainers** and participants;
- **Ten RHMs trained as trainers** in FP/RH;
- **177 RHMs from 20 counties trained in FP/RH** and covering over 200 communities. (This number represents practically all RHMs active under a contract with the MOPH.);

Steluta Batar, Roma health mediator from Gircini A, was trained by RFHI and now assists the local family doctor to provide appropriate counseling for on FP and RH for Roma women, in particular adolescent girls.

- Educational tools and informational materials developed specifically for Roma communities;
- **Health mediators received equipment**, including professional identification badges;
- **6,800 information sessions carried out in 200 communities;**
- 111 FDs from Roma communities participated in **cultural diversity workshops;**
- **More than 30,000 Roma people were reached within the almost 7,000 IPC activities** carried out by the RHM trained by the project;
- Active working group for Roma health established
- Evaluation of the RHM Program served as basis for future MOPH interventions; and
- Seven new RHMs hired by two DPHAs as a result of the project support and others using RFHI curricula to train new RHMs to be hired in their districts.

As a result of the above achievements, the activity of RHMs has visibly increased the access of the Roma population to health services, including reproductive health.

Sustainability

The project will be sustainable as long as the MOPH continues to support the RHMs' activities and their functional integration within the health system is assured by an effective management unit. Provided that these conditions are met, this intervention represents a long-term investment expected to result in a significant improvement in the health status of Roma communities in Romania.

LOCAL PARTNERSHIPS FOR FAMILY PLANNING/ REPRODUCTIVE HEALTH

Background

Initially, RFHI focused activities in rural areas having the poorest reproductive health outcomes. However, urban areas, even the most prosperous cities, have pockets of health inequalities, for either cultural or financial reasons. RFHI found that most family planning services in urban areas are not used by those most in need due to cultural or geographical barriers. Family planning centers housed inside hospitals or with private practitioners can also prove a barrier to access, and many cultural barriers exist for groups such as the Roma to accessing services.

In 2005, RFHI launched a strategy to strengthen health care services for the poor in 11 cities. The crux of RFHI's strategy was partnerships across all levels of the health care system and among different sectors and civil society. RFHI brought together groups that had never worked together before—such as the police, educators, and civil society members.

This collaboration was enacted through formal agreements among local partners—including mayors' offices, DPHAs, insurance houses, directorates of child protection and social assistance, labor and social solidarity offices, education inspectorates, police departments, and NGOs representing civil society.

Interventions

By involving local officials, professionals, and civil society in the problem-solving process, RFHI built local capacity using a learning-by-doing process and, at the same time, built the commitment of key local actors to jointly address access issues and other problems encountered by the urban poor.

Constituting the local partnerships: steps in creating local coordination groups (LCGs)

Step 1. Introducing the program to stakeholders

After consultation with relevant central authorities for alignment with national policy trends, RFHI presented the program either within the DCWCFH or individually to each potential partner. In all cities, the Mayor received a personalized presentation.

Step 2. Signing collaboration agreements

Once communities were committed to the initiative, RFHI brought key stakeholders together in partnerships. The Romanian NGO and RFHI partner, SECS, was instrumental in identifying and convening stakeholders and providing them with background information for sound decision making.

Partners signed formal agreements in all 11 cities to strengthen collaboration. LCGs planned and implemented FP/RH activities and became, over time, FP/RH advocacy groups within their locality. Each agreement framed specific plans to reflect local priorities and the partners' involvement.

Step 3. Analyzing the situation

Each LCG conducted a situation analysis at the start of the urban initiative that included community mapping, interviews, secondary data research, and focus group discussions. These gave a complete picture of the health of target urban populations as well as environmental conditions, services, government structures and stakeholders, and available facilities and professionals. These analyses helped ensure that all stakeholders had a complete and consistent picture of their area.

Step 4. Developing implementation plans

After data analysis, in order to better match existing resources to the needs of the population, each LCG developed a specific implementation plan that included detailed strategies for the following program actions:

Expanding service availability

The LCGs assessed services to best adapt the existing program to better meet clients' needs (e.g., set hours acceptable to working women, improve the referral system). The groups identified client-perceived barriers in order to address the problem through re-organizing existing facilities, programs, and schemes.

Each LCG designed its own referral network to ensure access to appropriate services. It also reviewed and refined roles and job descriptions for health/social professionals involved in program service provision. This effective staff utilization helped maximize operational efficiency.

Training
The assessments highlighted the need to strengthen the technical capacity and interpersonal skills of service providers. Practically all plans included basic family planning training for FDs in order to expand services.

Outreach
The outreach component was extremely important in reaching the target populations—especially the uninsured—with appropriate information regarding clients' rights, basic family planning, and available services. The objective was to inform and motivate target groups to actively participate in their own health care, and to seek and utilize appropriate services. The informational activities played a central role in increasing the use of health services in general, and family planning services in particular. Nevertheless, IEC targeting specific FP/RH issues needs to be placed within a larger framework of activities aimed at increasing the target population's awareness of their right to access free public/private health services.

Main Accomplishments and Results

- **LCGs or local partnerships are in place in the 11 major cities in Romania** and have increased capacity to sustain family planning services for the urban poor.

- **Improved cross-sector communication, with pooled resources across health and social sectors, resulted in more cost-effective use of available services**. The LCGs built on mutual trust among partner institutions to plan service and community-related events together. They built strong relationships not only in FP/RH but across other social sectors as well. For example, the steep costs associated with providing family planning services at new clinics were avoided through the provision of integrated social and health services, including family planning, for parents at children's centers, particularly those parents considering abandoning their children. The LCGs also promoted sharing of human resources, using social services personnel to connect their beneficiaries with health services, for example through significantly expanded family planning information dissemination. In the long run, addressing unwanted pregnancies, prenatal care, STIs, and other reproductive health issues at the community level will reduce costs for the secondary and tertiary care system.

- **Increased awareness** of local stakeholders and partners **about health inequalities** and population needs facilitated a more coherent strategy to tackle local priorities for vulnerable populations.

- New entities (NGOs, police, social services) were **exposed for the first time to RH issues and began allocating resources** and providing integrated information and/or services. As a result of the ongoing partnership, some of the local Child Protection Departments developed family planning services in their medical offices, and FDs provided counseling to youth institutionalized in children's centers. Two foundations that had not provided reproductive health services opened family planning clinics targeting the urban poor. Police officers edited and distributed family planning informational materials.

- **LCG local action plans** are in place and will be sustained after the RFHI ends.

- The project **trained over 500 doctors and nurses** in family planning counseling and **1,100 social workers** attended sessions on providing information about the benefits of family planning.

- **More than 110,000 beneficiaries attended information sessions and almost half a million women were exposed to the "True Women" mini-series** on family planning and women's health broadcast on local television.

Sustainability

- As RFHI draws to a close, it is clear that the LCG partnerships will remain in place and be sustainable in the 11 project municipalities. In January 2007, RFHI organized a national conference for local and national partners to share implementation experiences and reassert ownership among partners. Potential donors were invited in order to attract further support for scaling up the urban FP/RH program.

- Strengthening the will and ability of central and local governments to better target health resources and to develop a clear legislative framework of required competencies is key to the success and sustainability of urban health programs for the poor.

- A two-year project implementation period is a short term to guarantee sustainability. While some aspects of the program are likely to remain in place, a longer period is needed to truly assess whether policy changes and consensus building across partners are sustainable.

- Introducing health inequalities into local public policy discussions should develop in parallel with the consolidation of local partnerships. RFHI found that the most successful local partnerships were those with the highest level of commitment from the local governments—and the partnerships helped the government express its commitment to reduce such inequities.

EMERGENCY ASSISTANCE

JSI was asked to add two emergency assistance activities to the RFHI portfolio: Avian Influenza and Flood Assistance.

Avian Influenza

Background

In 2005 and 2006, Romania faced two outbreaks of avian flu among birds in both the wild bird population and in some domestic poultry flocks. Although no human cases were identified, current worldwide vigilance and the fact that the Danube Delta represents a major natural migratory bird reservoir dictated the need for strong preparedness and intervention strategies at all levels.

At the beginning of 2006, Romania lacked any comprehensive preparedness strategy to respond to a potential avian influenza outbreak. Therefore, in May 2006, USAID provided a grant entitled ***"Romanian Avian Influenza Pandemic Emergency Preparedness"*** to JSI under the RFHI partnership to assist the GOR in preparing for a possible human pandemic of avian influenza.

Interventions

In all activities, JSI built on past successes in working in partnership with GOR institutions, Romanian NGOs, and international agencies and donors. Throughout implementation, staff followed values such as partnership and consensus building, leveraging of existing human and financial resources, and the use of the "three pillars approach" (trained providers, consumables, and informed public). JSI provided technical assistance in developing a National Plan of Action, training key professionals across the relevant sectors, and increasing public awareness by providing correct information and education. The duration of the grant was May 2006–June 2007.

Main accomplishments and results

One of the key implementation challenges was the short timeframe to carry out interventions. As an immediate avian influenza pandemic already threatened, it was important to provide a rapid response in preparing the GOR, key professionals, and the public for such an outbreak. Despite this restriction, the team achieved significant progress in each of the following areas.

> *"This was the first time that my role as a family doctor in the surveillance system was clearly explained and I understood that all reports I sent are indeed used. This was the first time trainings were done as peer meetings, rather than a teacher-student approach."*
>
> A family doctor from Ceamurlia, Tulcea

The program convened representatives of institutions in Romania with roles in a disaster situation—particularly an influenza pandemic—to facilitate consensus building at the policy and strategic level. Staff carried out an initial assessment and shared conclusions with key stakeholders, focusing mainly on the need for intersectoral cooperation for a comprehensive, sensitive, and rapid response. The team organized three working meetings of key stakeholders to discuss the current legal framework; assess the stage of preparedness; and discuss future priorities, gaps, and practical steps to design a comprehensive national plan, under MOPH coordination. The institutions involved in this process were: MOPH in the coordination role, Ministry of Administration and Interior, General Inspectorate of Emergency Situations, National Agency for Sanitary-Veterinary and Food Safety, Ministry of National Defense, Ministry of Education and Research, Ministry of Justice, Ministry of Transport, Construction, and Telecommunications, Ministry of Public Finance, Government Special Situations Center, State Official Office for Special Problems, Romanian Red Cross, the Romania liaison office of WHO, and the United Nations Development Programme.

As avian influenza represented a relatively new area in Romania, the group identified **strengthening the capacity of health and veterinary professionals** as a priority. As the influenza surveillance system is sentinel-based, training efforts focused mainly in sentinel districts. Professionals from key medical disciplines attended interactive seminars and workshops aimed at increasing knowledge about avian flu, improving understanding of their roles and responsibilities in the national influenza surveillance system, and preparing them for an adequate response in the case of a pandemic. To create effective partnerships at the local level, epidemiologists and specialists in veterinary medicine trained together. The program procured 60,000 masks and 10,000 latex gloves, which it distributed to trained personnel. The U.S. also donated personal protective equipment and the project distributed 2,250 brochures on how to use it.

For other specialties, the group recommended a national approach, especially for the media, due to its ability to convey timely information to the population. However, it lacked accurate communicable disease information in general, and avian influenza facts, in particular. Therefore, the program and health communication leaders held interactive briefings with national and local media. A total of 760 staff from various health specialties and non-health domains benefited from these briefings.

Children at a puppet show that helps them understand how to prevent avian flu.

When avian influenza outbreaks occurred, public information represented a challenging domain, as it was crucial to disseminate correct information to the population in a timely and nonthreatening manner. JSI designed, produced and distributed an impressive amount of printed materials (140,000 posters, 90,000 stickers, 90,000 brochures for teachers, 940,000 flyers and an additional 15,000 flyers in Hungarian) for use in small group sessions in schools, mayors' offices, airports, buses, and other public places. During summer 2006, a caravan with a puppet show offered an entertaining and interactive approach to providing correct information to 3,500 children and 551 adults from 80 villages in eight districts.

In addition, the program conducted a knowledge, attitudes, and practices study of the general population aged 15–60 in rural areas in summer 2007, as well as a qualitative study of those who had participated in IEC activities. These studies showed the following:

- Conditions and behaviors related to the care of backyard poultry were not appropriate for preventing avian flu transmission. Almost all people living in rural areas (92%) let their poultry feed out of the courtyard.
- One-third of the rural population received IEC materials, 20 percent knew that meetings with local authorities had taken place, and 10 percent had attended an information session or event in their community.
- A higher percentage (26%) of those exposed to campaign messages than in the general population (11%) reported using four or more key behaviors aimed at decreasing H5N1 infection risk in their own backyard.

After concluding that the population generally lacked basic information on preventing respiratory infectious diseases, the program designed an information campaign for the 2007–2008 flu season. FDs, DPHAs, hospitals, mayors' offices, and MOPH personnel distributed 27,500 stickers, 80,000 brochures, and 35,000 fever cards and independently conducted information sessions with the population.

Key Results of the Avian Influenza Emergency Preparedness Intervention

- **MOPH led the process to design a national preparedness plan**
- **760 professionals in health and non-health domains trained in rapid response**
- **3,500 children and 551 adults educated through innovative puppet show**
- **MOPH personnel committed to conducting information sessions using JSI-produced IEC materials**

Lessons learned

Developing the multisectoral approach required for this intervention within such a short timeframe represented a challenge. Building partnerships requires time, particularly when tackling a new field such as avian influenza. In the area of IEC, where collaboration had already existed for some time, partners designed and implemented activities in a smooth manner. However, identifying key actors to address avian influenza and facilitating a climate of trust in the area of policy design proved to be more difficult. At the local level, partnership entailed collaboration of various health professionals who had not necessarily worked together before. The team approached the challenge of developing partnerships through training various professionals across different sectors together, which produced multidisciplinary teams at the local level that can ensure an appropriate and rapid response. It became clear by the end of the project that one of the best ways to develop functional partnerships is to take this type of multisectoral training approach.

Flood Emergency Assistance

Timis Floods, 2005

Background

In spring 2005, Romania suffered severely from flooding, with approximately 3,000 people dislocated in one district alone and three villages almost completely destroyed. By the end of the summer, multiple waves of flooding had affected 32 of Romania's 41 districts. The MOPH requested emergency assistance from USAID, which contracted JSI/Romania to design a health education campaign.

The objectives of the campaign were to:

- Encourage simple behaviors in the population regarding personal hygiene and disease prevention;
- Motivate the population in affected areas to identify first disease warning signs and seek medical advice when needed;
- Increase awareness among threatened districts regarding basic disease prevention measures to be adopted, if affected.

Interventions

JSI/Romania designed a health education campaign related to behavior during and after flooding. The main messages of these campaigns were: take care of your personal hygiene, protect water and food safety, and go to the doctor/seek medical advice if any disease warning signs occur. The campaign used an interpersonal approach, with DPHA health promotion staff volunteers, mainly from the Romanian Red Cross, implementing educational sessions. Educators made a special effort to reach pregnant women and children.

Main accomplishments and results

The team developed user-friendly and very sturdy materials to resist the severe weather conditions. These included 20,000 posters, 16,000 stickers, and 100,000 flyers. An additional 3,500 posters, 3,500 stickers, and 8,500 flyers were produced in Hungarian, as Hungarian-speaking districts were also affected by the flooding. JSI/Romania translated the WHO guidelines on disaster and epidemiological risk management and distributed them to all DPHAs in electronic format to use as a reference guide. In addition, the program procured and distributed water purification supplies in the 20 districts most affected by the floods.

SUSTAINABILITY

Background

Sustainability of the national family planning program has been the main concern of the RFHI since the program started in 2001. After the first year, the MOPH progressively increased already substantial budgets to assure contraceptive availability; thus, financial sustainability was not considered as an important challenge. Nevertheless, other critical elements for program continuity were a considerable challenge. These included political will to keep family planning visible in the public agenda—especially in a region with low fertility—and the limited institutional capacity of private, mostly nonprofit, organizations.

During the years preceding Romania's accession to the European Union, the NGO community hoped that the government would provide an increasing number of grants and contracts to private organizations in order to implement critical social and public health programs. This would be similar to the United States and many European countries, where government departments often provide policy guidance, regulatory oversight, and financing to implementing organizations to ensure that public needs are met. However, most national and local civil society organizations in Romania, both within and outside the health sector, had difficulty accessing public funding due both to their own limited capacity and the lack of resources and interest offered by government, specifically the MOPH, in partnering and supporting NGOs.

Interventions

RFHI planned all activities considering their sustainability and all programs were functionally integrated with national health programs and included in a co-financing scheme. The program institutionalized the training of health professionals through officially accredited courses in colleges training different types of professionals. RFHI provided technical assistance to national and local public institutions to strengthen their structures and increase capacity to better manage available resources.

RFHI conducted an initial sustainability workshop for its key NGO partners in May 2003. The workshop provided an overview of sustainability and included a self-assessment of organizational, programmatic, and financial sustainability. A second workshop in December 2003 focused on financial sustainability, with topics including revenue generation, domestic fundraising, and donor cultivation, with a focus on accessing EU funding.

However, it was only in May 2006 that RFHI started to implement a comprehensive sustainability strategy after USAID funded the project's "Enhancing the Sustainability of NGOs" component.

Main strategies in this component were:

1. Increase NGOs' capacity to understand the funding environment, legal and regulatory opportunities, and barriers to accessing public-sector financing and EU structural funds.

RFHI organized a three-day workshop for members of the German Foundation for World Population, using updated information and tools.

2. Build a secure financial base to ensure financial sustainability of SECS.

This strategy focused on generating income through fees and building domestic fundraising capacity. The goal was not only to generate income to undertake key activities, but also to establish reserves to cover unfunded mandates, invest in program development, and provide funds for financial match requirements. Unlike international grants and government-funded activities, surplus from income-generating activities or funds raised from corporations and individuals tend to be unrestricted and can therefore be used more flexibly.

In its sustainability plan, SECS identified potential income-generating activities, including revitalizing its network of clinics, providing training to FDs and private health organizations, etc. RFHI supported SECS in assessing the viability of those income-generating options, preparing business plans for viable options, and undertaking the required investments and implementation.

Key areas of support provided to SECS are described below.

Restore the clinic network to financial health

At the beginning of the project SECS was operating seven clinics. Based on the initial assessment and the recommendations of international experts, SECS took the decision to re-configure its clinic network and invest in its further development. The approach was to remodel the four clinics remaining in the network, develop staff's knowledge and skills through training, and increase volume through expansion and marketing of services.

Provide start-up capital for viable income-generating activities

During this process, RFHI covered the clinics' operating costs to keep them open while SECS implemented its strategy. Any income generated by the clinics during this period was invested in an interest-bearing account and not accessed until the end of the project. This provided SECS with some reserves to support their operations after USAID funding ended.

Improve governance

RFHI supported SECS to build more effective governance and business structures and systems. International and local technical assistance helped SECS establish a flexible structure supporting headquarters, regional, clinic, and volunteer operations; improve financial, human resource, and program management systems; and link strategic planning to operational planning.

In addition to assistance to SECS, RFHI also assisted the Domestic Violence Coalition to establish a formal structure and register as a legal entity, facilitating development of bylaws and all other legal steps.

Build business skills

RFHI and SECS identified international and Romanian experts and private firms to help SECS evaluate new business opportunities, adapt its technical expertise to match market needs, and raise its visibility among clients, constituents and donors.

Institutionalize the introduction of family planning and new contraceptive technology in Romanian medical schools

RFHI invested considerable human and financial resources in training doctors in family planning service delivery, including counseling. The in-service training effectively trained thousands of doctors who had received no family planning training during their academic years. However, including family planning in medical school curricula is both less expense and more sustainable than in-service training. In 2006–2007, the project enlisted prestigious international professors to provide credible technical assistance to professors of different medical schools.

Develop and disseminate "lessons learned" and "best practices" that feature RFHI activities in the fields of family planning and HIV/AIDS

RFHI produced a wide range of materials: curricula, educational and informational tools, program assessments, etc. Most documents are available on the JSI/Romania website (www.romania.jsi.com).

The program disseminated information about the Web site and its contents to key stakeholders in both Romania and the regional and international public health communities that might replicate or expand core project elements.

Main accomplishments and results

- RFHI conducted a workshop, "Strengthening the Capacity of Romanian NGOs Working in the RH Field to Access EU Funds" for all partner NGOs.
- SECS initiated organizational restructuring measures supporting a new development strategy, prepared a transition to EU funds, and elected a new Board, which is operational.
- RFHI supported a SECS assessment of its clinic network. Four of seven clinics will remain in the SECS network. SECS developed and implemented a strategy for marketing and re-branding the remaining clinics.
- SECS set up a unit to develop new business opportunities; sent staff for training to prepare them for new roles and responsibilities; became accredited as a training company and, with assistance from an international consulting company, started developing proposals to be submitted for EU funding.
- The Domestic Violence Coalition was registered as a legal entity.
- Three medical schools introduced or updated their family planning curriculum.
- The MOPH managed a national contraceptive LMIS, which is operational nationwide.

MONITORING AND EVALUATION

In order to support evidence-based decisionmaking and ensure timely achievement of project objectives, RFHI designed and implemented a project monitoring system. It included tracking progress using the main RFHI performance monitoring tools: the annual workplan and the monitoring and evaluation (M&E) plans.

RFHI developed an annual workplan in accordance with the USAID-approved strategic project framework, the available budget, and the performance milestones. The team designed M&E plans for each RFHI component during its strategic planning phase and reviewed them to reflect any changes in the strategy and implementation plan.

Following gradual program expansion, RFHI developed five complementary M&E plans corresponding to each of the project components (Line Items – LIs): Rural (LI1), Urban and Roma (LI2), PAC-PP (LI3), Avian Influenza (LI5) and NGO Sustainability and AIDS (LI6). The M&E team designed all plans in consultation with program partners and obtained approval from USAID.

In addition to routine monitoring activities, the program conducted all evaluation interventions, as outlined in the program's M&E plans. An illustrative example of RFHI evaluation efforts was the Romania RHS conducted in 2004 as a national collaborative effort that included the MOPH, USAID, JSI, UNFPA, and the World Bank. RFHI used a comparison of the 2004 and 1999 RHS results as its primary evaluation, documenting overall progress made in reproductive health and, particularly, family planning. Significantly, the surveys documented particular progress in rural areas, the focus of RFHI. Also in 2004, USAID and JSI carried out a mid-term assessment assessing project achievements

To complete the program monitoring system and ensure the necessary link between the workplan and M&E plans, the team created a new, innovative tool: the Project Operations Matrix. It represented a unified project database that included information on: activities (timeframe, progress, expected results) and responsible staff/subcontractors and budgets (projections, monthly/quarterly expenditures, expenditure rate). More information on RFHI operations management can be found on the JSI Web site (romania.jsi.com).

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ANNEX A: FAMILY PLANNING ACTIVITIES COMPLIANCE

Three months before the end of the project the CTO met with the Chief of Party of the Romanian Family Health Initiative (RFHI) and discussed the project's family planning activities compliance.

RFHI started in September 2001 and ended in December 2007. The primary purpose of RFHI was to promote education and training about, and the wider availability and use of a wide range of modern contraceptive methods to prevent abortion.

Activities were implemented through a cooperative agreement with JSI Research & Training Institute, Inc. and included several subagreements with Romanian NGOs. RFHI activities covered three components: 1) training for general and family practitioners at rural health centers, community nurses, and health educators to provide quality family planning services; 2) contraceptive security work with the MOH to assure the supply of commodities across the country; and 3) awareness building to let the public know that services are available and affordable, as the government provides contraceptives without charge to the poorest populations.

Abortion is legal and readily available in Romania, but general practitioners (with whom the project primarily worked) are not permitted to perform abortions. Abortions are performed at maternities, and people know where to go and do not need referrals.

Project documents over the six-year life of the project clearly demonstrate that JSI has fully and completely understood, agreed upon, and implemented all Standard Provision requirements.

JSI carefully monitored and analyzed how the program applied family planning legislative and policy requirements during the six years of technical assistance provided. Monitoring compliance is imbedded into the strategic framework, annual workplans, and M&E plans of the project. These were routinely updated by the CTO and the COP.

JSI submitted to the CTO a Memo documenting the project activities in compliance with family planning legislation and policies.

The main program activities are listed below, as described in the memo submitted by JSI:
RFHI developed different information and education materials to assure the accuracy of the information provided about patient/client rights and the effectiveness and side effects of contraceptives. Posters and leaflets including this information are posted in all public health clinics (note: the project operated only within the public sector clinics).

During JSI'S visits to RFHI partner clinics under the national family planning program, regular checkups were conducted to verify that these materials were available at the clinics.
Voluntary use of family planning was at the core of the training process for counseling. All certified doctors and nurses (the only people allowed to provide free of charge contraceptives) benefited from a comprehensive curriculum on counseling services, highlighting the need to respect the client's decision.

No Monitoring & Evaluation plans from either the project or from the health system in Romania has any indicator, quota or target for new users of family planning.

During the length of the project no scientific study was conducted.

The project was not involved in any activity related to Voluntary Sterilization. Sterilization is uncommon in Romania and no incentives/reimbursements are ever provided.

The project did not procure any medical equipment.

RFHI was never involved in any public discussion in favor of or against abortion.

Neither voluntary sterilization studies nor biomedical research were a part of the Project.

All JSI sub-grantees were carefully selected through a thorough assessment in order to ensure that they were fully eligible and complied with all USAID family planning legislative and policy regulations. Prior to the signing of any subagreement, all NGOs partnering with JSI received a full orientation concerning the necessities and consequences of USAID's required family planning policy compliance. NGO compliance was monitored by field site and supervisory visits. Copies with signatures documenting the NGOs' agreement with family planning policy compliance were kept on file in the JSI/Romania office and moved to the JSI/Boston office upon completion of the project.