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РАЗОМ ДО ЗДОРОВ'Я TOGETHER FOR HEALTH
ПРОЕКТ ПОКРАЩЕННЯ ПЛАНУВАННЯ СІМ'Ї ТА РЕПРОДУКТИВНОГО ЗДОРОВ'Я В УКРАЇНІ
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TOGETHER FOR HEALTH

FINAL PROJECT REPORT

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JSI

РАЗОМ ДО ЗДОРОВ'Я ФІНАНСУЄТЬСЯ АГЕНСТВОМ США З МІЖНАРОДНОГО РОЗВИТКУ ТА ВПРОВАДЖУЄТЬСЯ ІНСТИТУТОМ ДОСЛІДЖЕНЬ ТА ТРЕНІНГІВ КОРПОРАЦІЇ ДЖОНА СНОУ У СПІВРОБІТНИЦТВІ З АКАДЕМІЄЮ СПРИЯННЯ ОСВІТІ ТА ШКОЛОЮ ГРОМАДСЬКОГО ЗДОРОВ'Я ГАРВАРДСЬКОГО УНІВЕРСИТЕТУ

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Acronyms & Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AR Crimea	Autonomous Republic of Crimea
BCC	Behavior change communications
CA	Cooperative Agreement
CabMin	Cabinet of Ministers of Ukraine
CAT	Critically Appraised Topic
CME	Continuing Medical Education
COC	Combined oral contraceptive
CYP	Couple-Year of Protection
DMIH	Department of Maternal and Infant Health (in the Ministry of Health)
DMPA	Depot medroxyprogesterone (injectable contraceptive)
EBM	Evidence-Based Medicine
EC	Emergency contraception
EGP	"Extragenital pathologies"
EU	European Union
FAP	*Feldsher-accousherski punkt* (feldsher-midwife points)
FP	Family planning
GOU	Government of Ukraine
HIS	Health information system
HIV	Human Immunodeficiency Virus
HIV+	HIV-positive
IEC	Information, education and communication
IUD	Intrauterine device
JSI	JSI Research & Training Institute, Inc.
LAM	Lactation Amenorrhea Method
LMIS	Logistics Management Information System
Low inc.	Low income
MCH	Maternal and Child Health
M&E	Monitoring and evaluation
MFYS	Ministry of Family, Youth and Sports
MIHP	Maternal and Infant Health Project
MOES	Ministry of Education and Science
MOH	Ministry of Health
N	Number (in a sample)
NGO	Nongovernmental organization
NMAPE	National Medical Academy for Postgraduate Education
Ob-gyn	Obstetrician-gynecologist *or* obstetrics and gynecology
OC	Oral contraceptives
PHC	Primary health care
POP	Progestin-only pills
PPP	Public-Private Partnership
PSP	Private sector partner
RCC	Regional coordinating committee (or oblast coordinating committee
RFPC	Regional Family Planning Center (or Oblast Family Planning Center)
RH	Reproductive health
RHC	Regional Health Department (or Oblast Health Department)
SPRHN	State Program *Reproductive Health of the Nation* up to 2015
SMD	Support for Market Development (pharmacy market research company)
STI	Sexually transmitted infection
TfH	Together for Health project
UDHS	*Ukraine Demographic and Health Survey* (2007)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
URHS	*Ukraine Reproductive Health Survey* (1999)
USAID	United States Agency for International Development
WAPS	*Survey on Willingness and Ability to Pay for Contraceptives in Ukraine* (2004)
WRA	Women of Reproductive Age
WHO	World Health Organization

I. Introduction and Background

Family planning (FP) was a largely unknown concept in Soviet times and Ukraine inherited this legacy. During the Soviet Union rule, women with a medical contraindication to pregnancy were given intrauterine devices (IUDs), but others who simply *wished* to plan pregnancy and childbirth relied either on abortion or IUDs. The oral contraceptives in use at the time contained high dosages of hormones, with their attendant side effects, and the Government recommended against their use in most situations.

Together for Health Project Website

http://tfh.jsi.com

Further information about the project and most project publications cited in this report are available on the site.

Together for Health (TfH) project began in late 2005. The situation at the start of the project is captured in Figures 1-3 on page 5, which show that Ukrainian women were far more likely to rely on abortion than their European counterparts, while their use of modern contraception--at 47% of married women--was low compared to Western Europe and even compared to the world as a whole. Use of traditional methods, meanwhile, was very high, at 22%. When looking at contraceptive use by method, IUDs and condoms dominated the method-mix and use of oral contraceptives was remarkably low, at 6%, compared with 70% in Western Europe. With a very low fertility rate, at 1.4 children per woman[i], it was clear that this was being achieved to a great extent due to abortion.

Previous to TfH, there was limited governmental or donor support for FP. USAID had supported the Women's Reproductive Health Initiative (1995-2000) to improve use of modern family planning and to reduce abortion as well as important policy work from 1996 onwards. The United Nations Population Fund (UNFPA) had also worked on FP/RH since mid-1990 establishing and supporting a network of FP clinics, but shifted their focus to other public health priorities in early 2000. All these international projects had helped the Ministry of Health (MOH) encourage a shift to modern FP and contraceptive methods, establish a network of "FP/RH centers" in regional (oblast) capitals[*] and some "FP/RH cabinets" in district (rayon) centers, train a number of obstetricians and gynecologists (ob-gyns), conduct public education on FR/RH and adopt two successive National RH Programs, among other interventions. However, given the overall struggles of Ukrainian health system and relatively limited donor support, little further progress was made. The FP centers and cabinets faced with increased policy challenges and funding shortages, shifted their focus to infertility care and, with frequent changes in leadership in the MOH, strong national leadership on the topic was lacking and the National RH Programs weren't being operationalized. Training of providers on FP/RH didn't advance, leaving most ob-gyns unfamiliar with modern international approaches to FP; medical education curricula remained out-of-date; FP remained the province of ob-gyns in women's health care facilities in towns and cities, with little or no involvement of family doctors, internists, midwives or other health professionals serving people in smaller communities. Adding to the complexity of the situation were the Government's high-profile pronatalist policies and the perception among policy-makers that more widespread use of contraception would accelerate population decline.

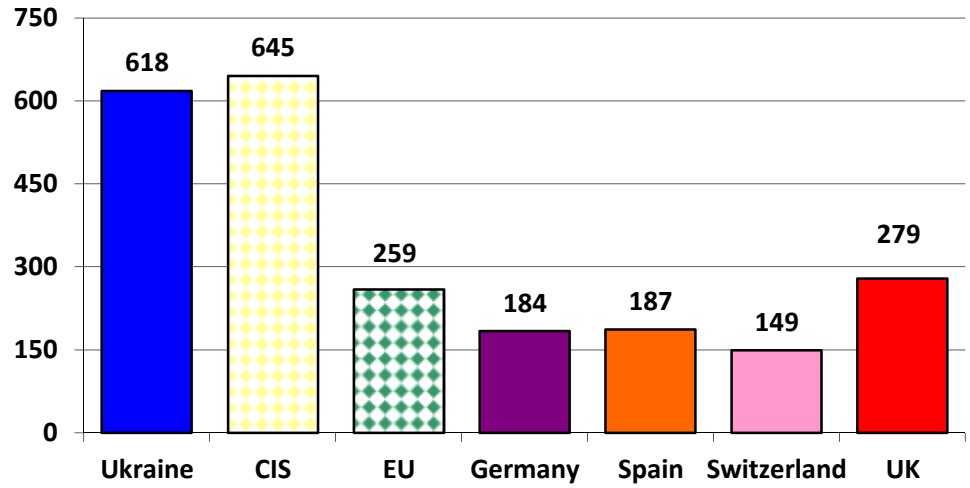
USAID/Ukraine designed the *Together for Health* project to support its Strategic Objective 5, Improved Social Conditions and Health Status, and its Intermediate Result 5.1, changed behaviors and systems to improve health. The TfH project goal was to "reduce the number of abortions and unintended pregnancies and the incidence of sexually transmitted infections (STIs) by improved provision of and access to quality reproductive health/family planning (RH/FP) services through the public and private sectors."

The expectation was that, by the end of the project, TfH would be working 13-15 regions, aiming to achieve its goal through four intermediate results:

1. *Improved service provider skills and behavior related to RH/FP (clinical component);*
2. *Improved client knowledge, attitudes, and use of appropriate RH/FP services and products (information, education, communication and behavior change component);*
3. *Increased availability, accessibility, and affordability of contraceptives (commodity security component); and*
4. *Increased capacity and commitment of the public and private sectors to support policies and systems for improved RH (policy component).*

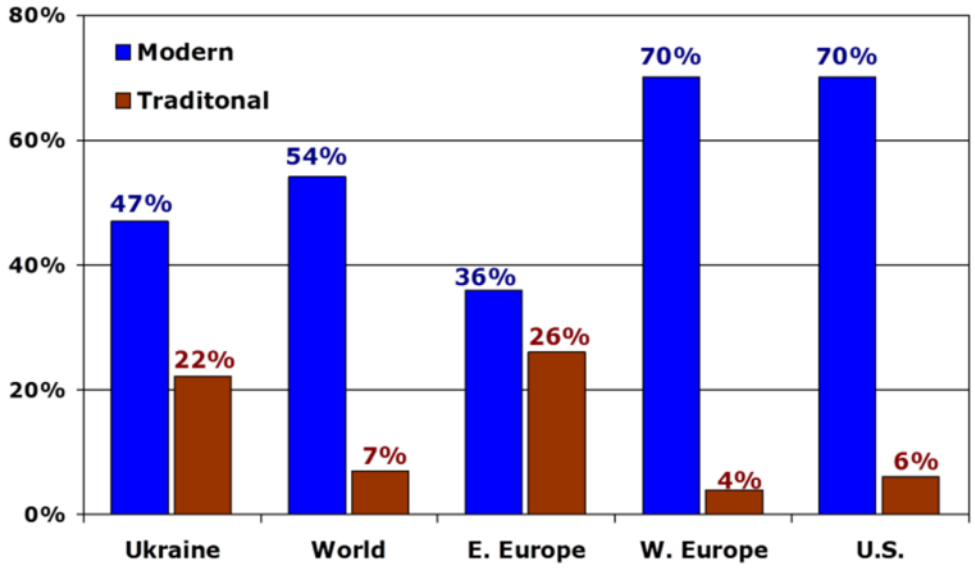
[*] The term "regions" (oblasts) is used in this report to include Autonomous Republic of Crimea and the City of Sevastopol.

Figure 1: Abortions per 1,000 Live Births, Ukraine and Selected Other Countries/Political Groupings, 2004



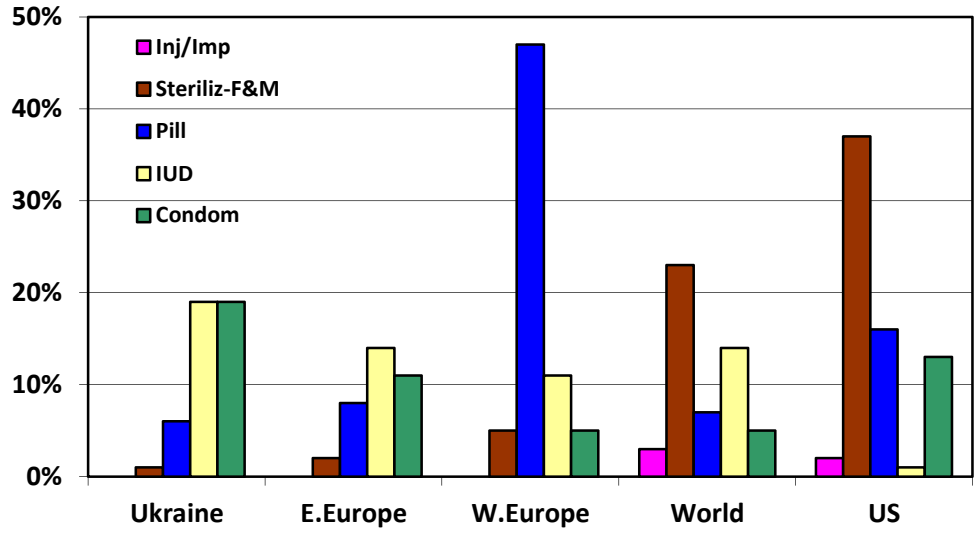
Source: WHO Health for All Database-data for 2004

Figure 2: Use of Modern & Traditional Contraceptive Methods, Ukraine, the World and Selected Other World Regions, 2004/2005 (percent of married women of reproductive age (WRA))



Source: UN World Contraceptive Use 2005; WAPS Ukraine 2004

Figure 3: Contraceptive Use by Method, Ukraine, the World and Selected Other World Regions, 2004/2005 (percent of married WRA)



Source: UN World Contraceptive Use 2005; WAPS Ukraine 2004

Originally envisioned as a five-year project, it ultimately ran for six years (2005 – 2012), with funding amounting to $12.3 million for technical assistance and $765,000 in from of a contraceptive donation consisting of combined oral contraceptive, IUDs, and injectable (see Annex 3). The project was awarded to JSI Research and Training Institute (JSI) for implementation together with its partners the Academy for Educational Development and Harvard School of Public Health.

This report outlines the main accomplishments and results of the TfH project, along with some key lessons learned and recommendation for the future.

II. Together for Health Project Impact

The project gave high priority to data-based decision-making and collected a variety of data to monitor its performance against plans (e.g. number of people trained, number of Behavior Change Communications (BCC) events conducted, etc.) as well as to measure the impact of its work on use of family planning and decreasing abortions and STIs. Annex 1 provides an overview of the data sources used to measure project impact and Annex 2 provides project results on the key indicators tracked by USAID. These data and others are used in this report to illustrate the results of the project's work.

> "The project really transformed the whole way that family planning is seen and provided in Ukraine. It created a more open climate for discussion on the topic. It transformed family planning from a strictly medical service to a service centered on counseling and client choice. It brought services closer to where people live and work. And it supported the Government in investing in family planning and managing the program in more modern and democratic ways."
>
> *Joel Lamstein, President, JSI*
> *At the end-of-project conference, September 2011*

The project gradually expanded its reach, starting with two regions and adding more each year until, by the fifth year, it was working with 15 partner regions that had 65% of Ukraine's population. It is impossible to isolate the impact of the project's work from other factors, such as promotional efforts by pharmaceutical companies, the work of other projects—although there were no other projects with a central focus on FP/RH—but the indications are that the project had a significant impact.

Access to family planning services and contraceptive supplies

The core of the project's work was to improve the provision of, and access to, quality FP/RH services, which was expected to result in increased contraceptive use and decreased number of abortions.

Figure 4: 568 Health Facilities Offering FP in 15 Partner Regions, 2005

Source: TfH project monitoring database linked with ArcGIS software.

When the project started, less than 600 specialized health facilities in large urban areas were offering FP services (see Figure 4 at page 6), and almost no free contraceptives were available. The Government of Ukraine (GOU) was already committed as a matter of policy to strengthen primary health care (PHC), opening the door to TfH to integrate FP/RH into services provided by family doctors and other PHC providers, such as internists, midwives, *feldshers* and nurses.

Another level of FP integration was into existing RH services such as prenatal, delivery and postnatal care, postabortion care, and STI and HIV/AIDS care. Such an expanded network of service providers resulted in improved access to care for the population, especially in rural areas. The dramatic effect of training new providers, combined with distribution of GOU procured or USAID donated contraceptives, can be seen in Figure 5 below. By the end of the project, the number of access points in the project's 15 partner regions had grown more than six-fold, from 568 to over 3,637 (Figure 5 below). The rayon colored in green have full coverage with at least one health professional trained in each PHC facility in that respective rayon.

Figure 5: Six-times Increase in the Number of Health Facilities Offering FP in 15 Partner Regions (from *568 health facilities in 2005 (figure 4), to 3,637 in the same regions in 2011.)*

2011

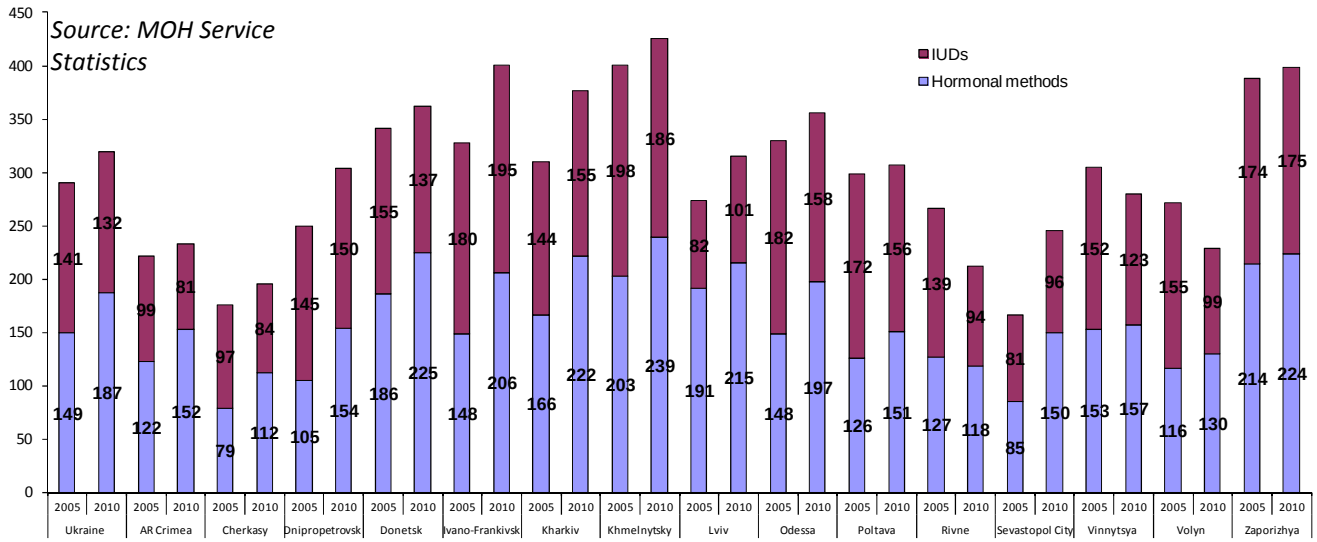
Source: TfH project monitoring database linked with ArcGIS software.

Use of modern contraceptives, including condoms

The project's work to improve the access to, and quality of FP/RH services, was expected to result in increased contraceptive use. MOH statistics show that there was, indeed, a 10.2% increase in contraceptive use nationwide between 2005 and 2010—as measured by the number of registered users of IUDs and hormonal methods/1,000 women aged 15-49—from 289.5 to 319.3 (see Figure 6 at page 8, and Figure 12 at page 11.)

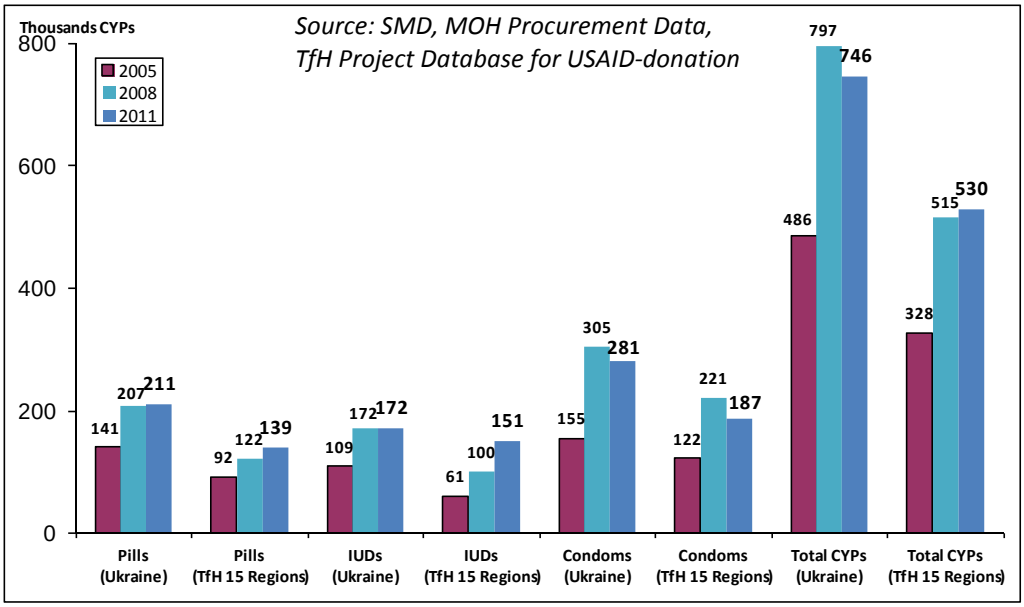
Although MOH service statistics indicate an overall increase of 10.2% percent in contraceptive use for Ukraine (from 2005 to 2010), the proportion increase is different for IUDs and hormonal methods. Between 2005 and 2010, use of hormonal methods went up by 25.6% (from 148.6 to 187.1/1,000 WRA), while use of IUDs decreased by 6.2% (from 140.9 to 132.3/1,000 WRA). Fourteen TfH regions saw increases in the rates of registered users of hormonals (except Rivne) and six TfH regions saw increases in the rates of registered IUDs. The largest increases of hormonal use were in Cherkassy (41.3%), Dnipropetrovsk (46.2%) and Sevastopol City (76.0%) (See Figure 6 at page 8.)

Figure 6: Registered IUD and Hormonal Contraception Use Rate, Ukraine and TfH Oblasts, 2005-2010



It should be noted that the MOH statistics presented on Figure 6 include only those people going to certain types of government health facilities—and not those going to smaller health facilities, pharmacies or private providers. Moreover, they include only IUDs and hormonal methods (mostly oral contraceptives) and do not include other methods, most significantly condoms. The figures also are only indicative (particularly for hormonals), since they reflect doctors' (formal or informal) prescriptions and, in most cases, not actual provision of a method. Thus the statistics do not constitute a contraceptive prevalence rate, but they are still valuable to assess trends in contraceptive use.

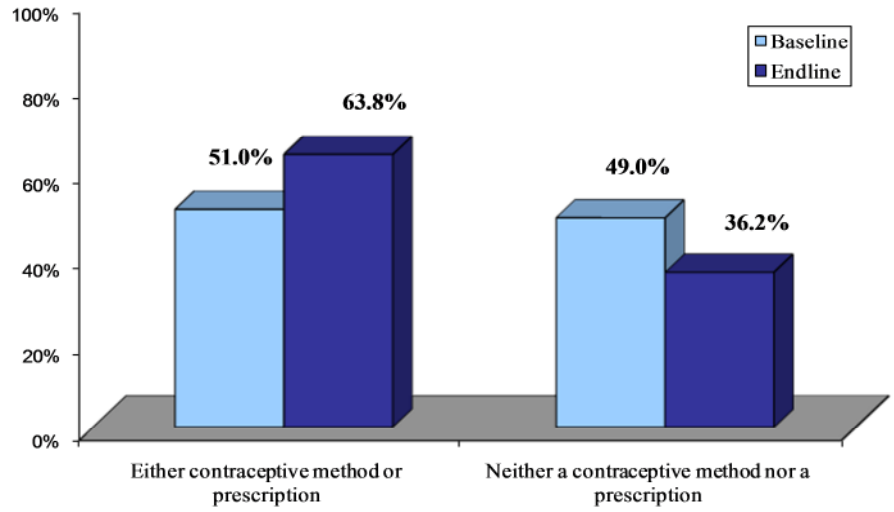
Figure 7: Couple Years of Protection, by Method and Total (in thousands), Ukraine and TfH priority regions, 2005-2011 (total public and private sectors)



Given the limitation of the MOH statistics, TfH also looked at the impact of its work on contraceptive use by using supplies and contraceptive logistics / distribution data from both public and private sectors. As most Ukrainians purchase contraceptives from pharmacies, the sales data were provided to TfH by Support for Market Development (SMD, a pharmaceutical market research company and TfH Private Sector Partner) at no cost ($15,000 annual value). Government-procured and USAID-donated contraceptives distribution data were gathered through the project supported electronic reporting system. All these data were summed-up (total of private sector sales, GOU procured, and USAID donations) and converted to Couple-Years of Protection (CYPs), which is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.[ii]

CYPs in the TfH 15 priority regions increased 61.6% from 328,065 in 2005 to 529,900 in 2011. Nationwide, the total increase was 53.6% from 485,655 in 2005 to 745,857 in 2011 (see Figure 7 above). The project used CYP data derived from condom sales and distribution to measure the impact of its STI-prevention activities. The number of CYPs from condom-use in Ukraine as a whole rose by 80.8% over the life of the project, from 2005 to 2011.

Figure 8: Contraceptive Prescription Practices of Health Care Providers Sampled, as Reported by Clients



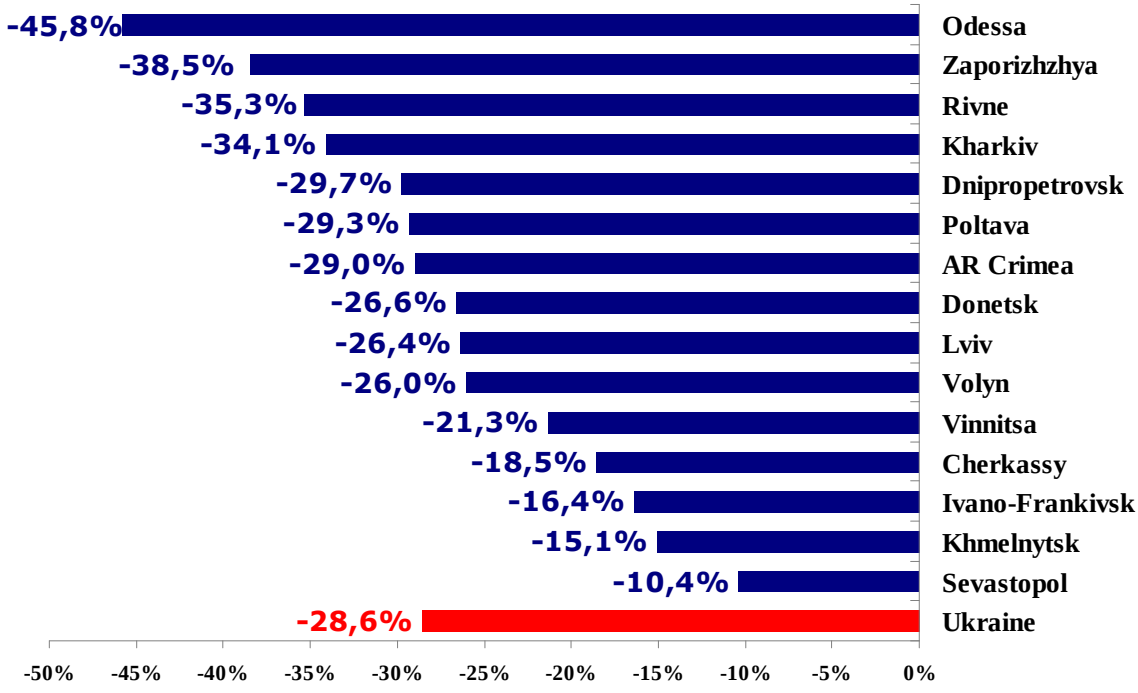
Source: TfH baseline and endline assessments

Finally, project surveys of women leaving project-assisted health facilities in seven partner regions indicate a remarkable 12.8% increase in contraceptive use over a period starting from before the project began working in these regions to about 24-28 months later. The proportion of women reporting that they either received a contraceptive method or a prescription during their visit rose from 51% before the project started work to 63.8% once some training and other activities had been conducted (see Figure 8 above.)[iii]

Decrease of the abortion rate and ratio[1]

The project sought to reduce the number of abortions. Nationwide the *abortion rate* fell by 28.6% from 19.5/1,000 WRA in 2005 to 13.9 in 2010. All TfH's 15 partner regions saw decrease of abortion rate ranging from 45.8% in Odessa to 10.4% in Sevastopol city (see Figure 9 below)[iv]. 7 TfH regions had a percentage reduction higher than Ukraine national level value: Autonomous Republic of Crimea (AR Crimea), Dnipropetrovsk, Kharkiv, Odessa, Poltava, Rivne, and Zaporizhya.

Figure 9: Percent Reduction of the Abortion Rate in TfH Partner Regions

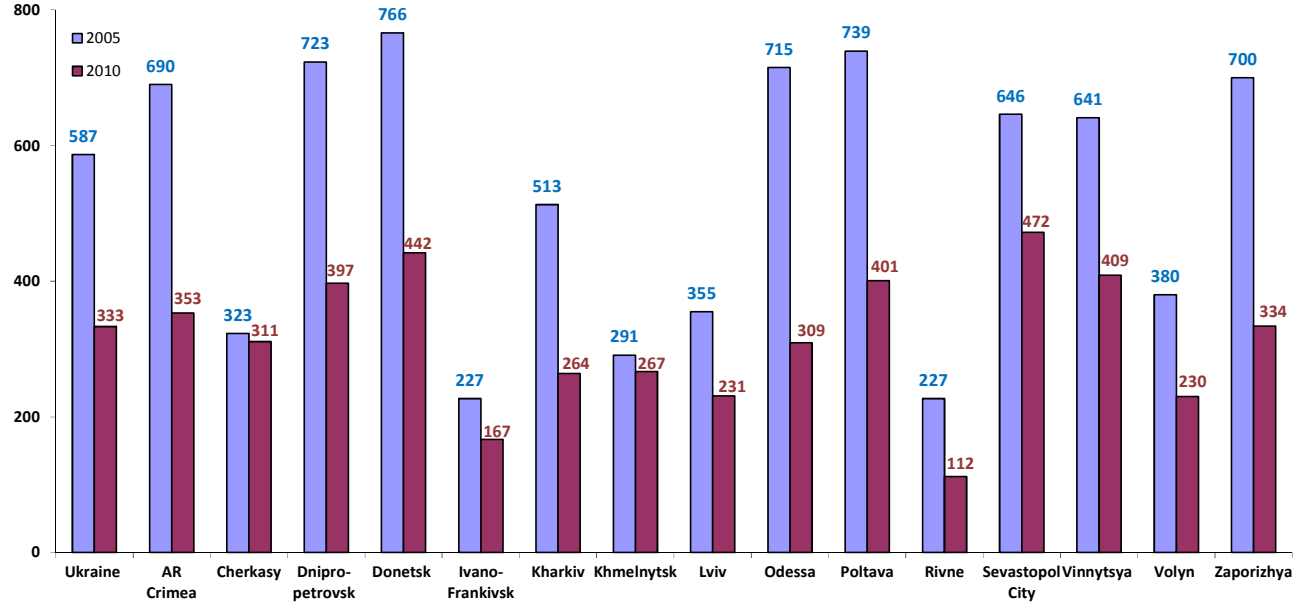


Source: MOH statistics data and TfH calculations

[1] Trends in the national abortion rate and ratio, as well at the MOH statistics on contraceptive use, cannot necessarily be fully attributed to TfH, since the project worked in 15 regions (out of 27). However, TfH's work on policy issues and its partnership with pharmaceutical companies should contribute to changes at the national level.

Both the abortion rate and the abortion ratio decreased in Ukraine as a whole and in most TfH partner oblasts, according to MOH statistics. The national *abortion ratio* (in MOH health facilities) for the country as a whole fell by 43.3% from 586.7 abortions per 1,000 live births in 2005 to 333.4 in 2010 (see Figure 10 below.) Not surprisingly, the steepest declines of abortion ratio (higher than Ukraine national level) was in the same 7 TfH regions that had the highest reduction of abortion rates: AR Crimea (48.8%), Dnipropetrovsk (45.1%), Kharkiv (48.5%), Odessa (56.8%), Poltava (45.7%), Rivne (50.7%), and Zaporizhya (52.3%.)

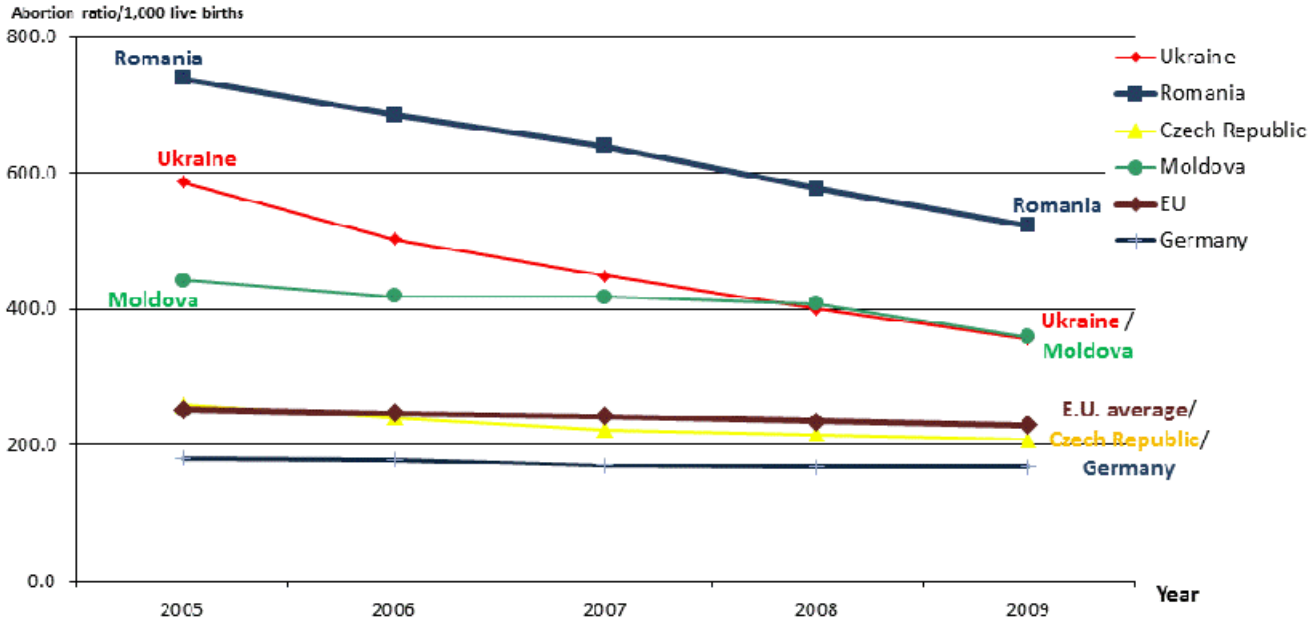
Figure 10: Evolution of the Abortion Ratio, Ukraine and TfH Partner Regions, 2005-2010



Source: MOH statistics data and TfH calculations

An analysis made using officially available WHO data for the period 2005-2009[v] reveals that the drop of the *abortion ratio/1,000 live births* in Ukraine was steeper than in the Czech Republic, Moldova, Romania, Russia or the European Union (EU)—see graph 11 below. If at the beginning of the project, in 2005, the Ukraine abortion ratio was more than two times higher than the EU average (586.7 vs. 251.6), towards the end of the project, in 2009, the abortion ratio declined significantly being about 1.5 times higher than the EU average (357.0 vs. 228.7).

Figure 11: Evolution of the Abortion Ratio, Ukraine, Selected Neighboring Countries and EU, 2005-2009

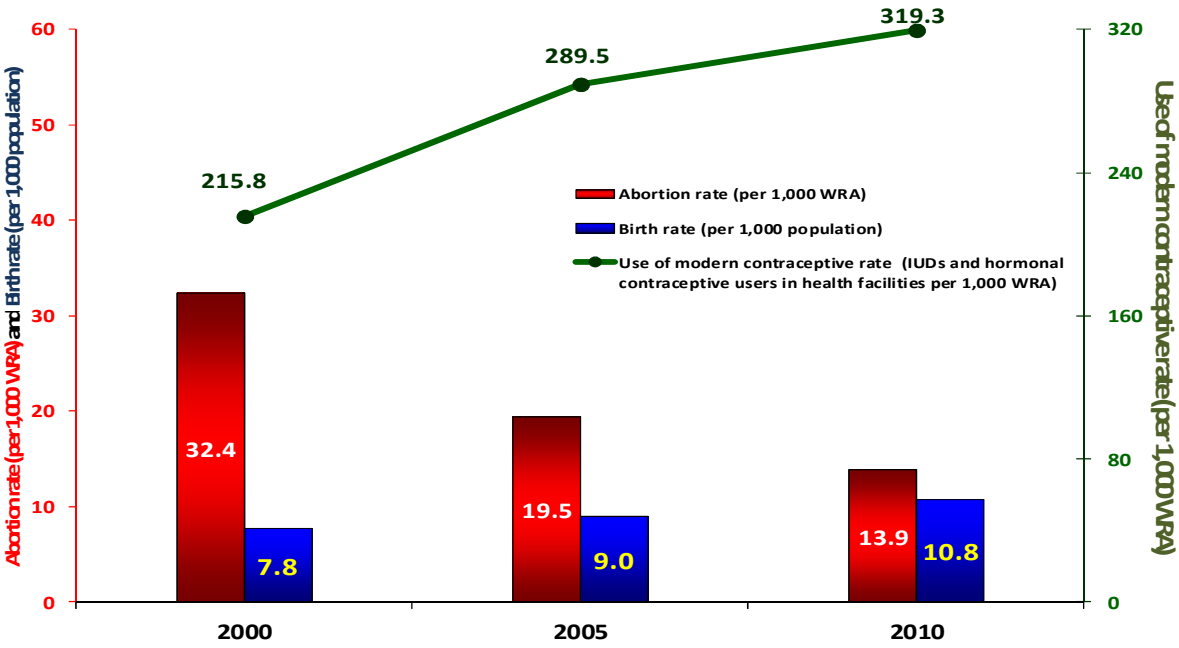


Source: Ukraine MOH and WHO, Health for All Database, for the other countries and regions

Evolution of birth rates and child abandonment at birth

In light of Government concern about the potential impact of increased contraceptive use on birth rates, it is noteworthy that all TfH regions showed increases in their birth rates. As can be seen in the graph 12 below, an increase of 10.2% in contraceptive use nationwide went hand in hand with a 28.6% decline in the abortion rate and a *20% increase in the birth rate from 9/1,000 population in 2005 to 10.8 in 2010* (data analysis for 2005 – 2010.)[vi] *The proportion increase of birth rates for each of the 5-years period was different. For the period 2000-2005 birth rate increased by 15%, and the increase was higher for 2005-2010—20%.* This evolution demonstrates that vigorous implementation of FP programs does not negatively influence the change of birth rates.

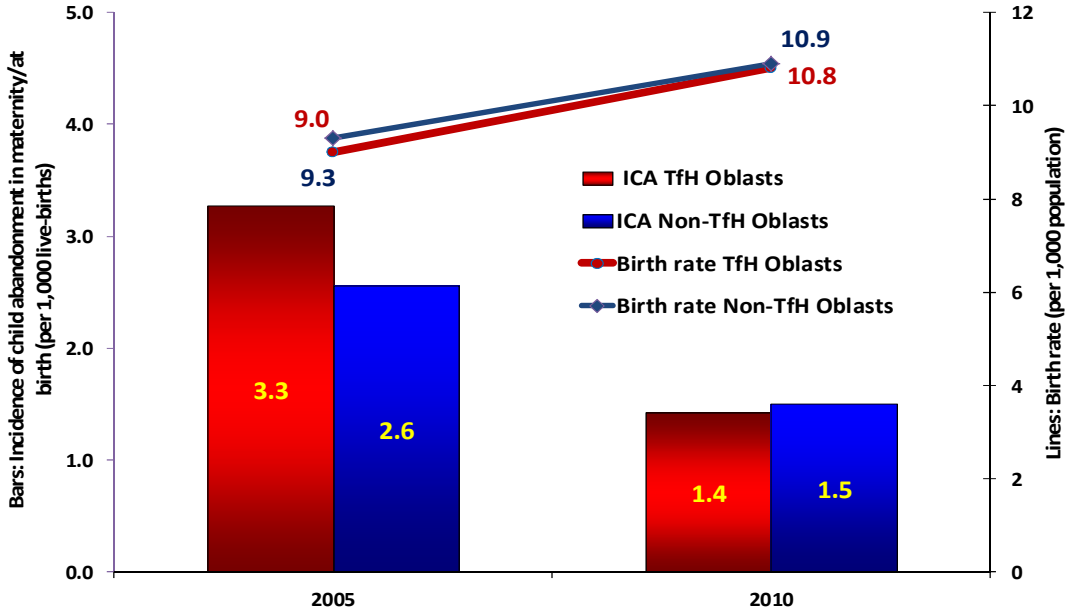
Figure 12: Increases in Contraceptive-Use Rates are Accompanied by Reduced Abortion Rates and Increased Birth Rates, Ukraine 2001-2010



Source: Ukraine MOH / GOU statistics data

Indicating a possible effect of fewer unintended pregnancies, incidence child abandonment (ICA) in maternity hospitals decreased more sharply in TfH regions than other regions between 2005 and 2010. It went from 3.3/1,000 live births in 2005 to 1.4 in 2010 in TfH regions, compared with 2.6 to 1.5 in non-TfH regions[vii].

Figure 13: Decline of Incidence of Child Abandonment, TfH and non-TfH Assisted Regions, 2005-2010



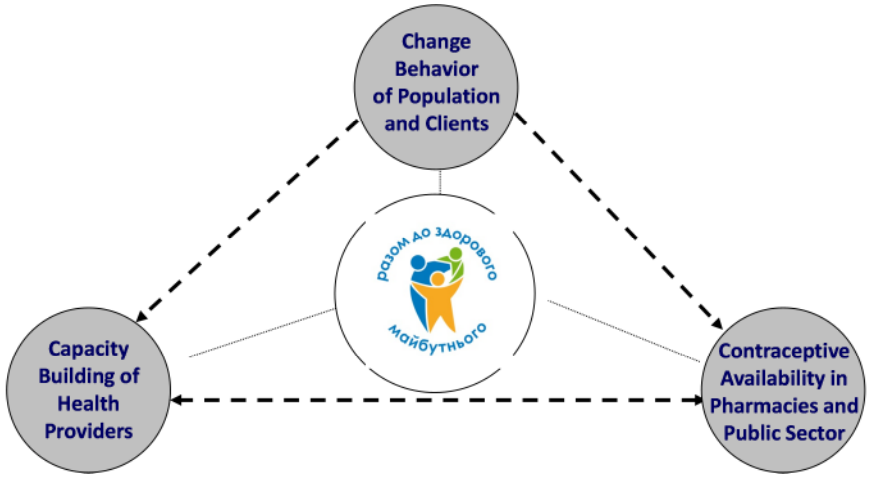
Source: MOH statistics data and TfH calculations

III. Key Methods of Technical Assistance Used

The main focus of this report is on the project's technical work to achieve the project goal. However, the *way* the project approached its work was also critical to building momentum, achieving results and promoting sustainability. TfH applied several key methods to its technical assistance:

- It adopted a "systems" approach to project implementation, recognizing that, in order to increase contraceptive use, changes needed to be made *concurrently and coherently* on three fronts:
    - Health workers needed better information and skills;
    - The population needed to be constantly informed in order change its behavior with respect to contraception; and
    - The population needed improved access to affordable contraceptives.

Figure 14: TfH's Systems Approach



This approach is represented in the triangle at left which shows how new, improved FP/RH services were "branded" with a "FP friendly" logo: together for a healthy future. Health facilities and pharmacies where health professionals had been trained and where free contraceptives were available received the logo; and BCC activities made the community aware of these services.

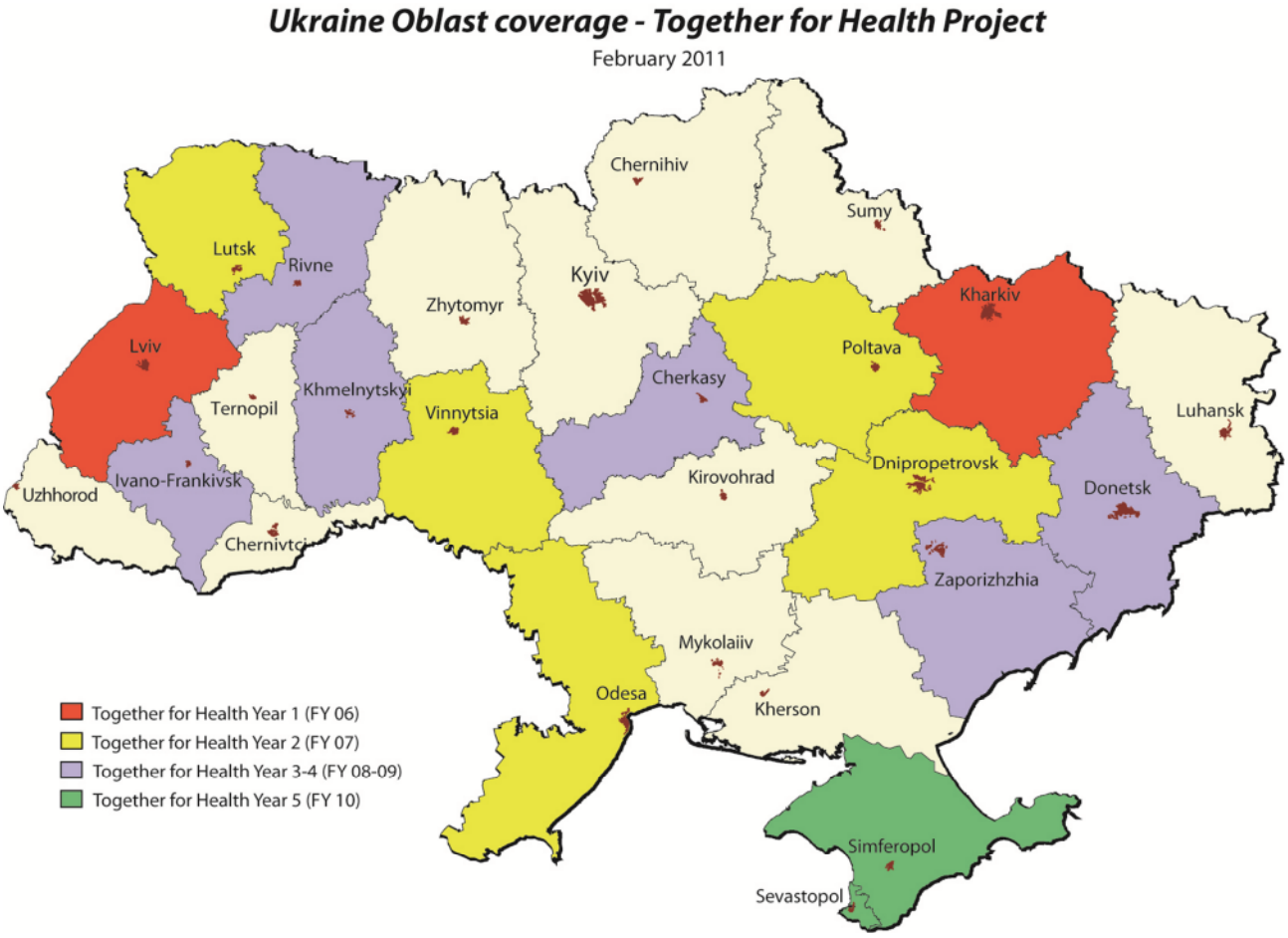
- The project took the opportunity presented by the expiration of the old National RH Program to adopt a new, stronger national Program and to use it as a platform to foster Government investment in FP/RH, to strengthen program management at all levels and to build sustainability. The vision was that TfH would work under the umbrella of the new Program, called State Program Reproductive Health of the Nation until 2015, synergizing the project and the Program resources to build a strong national Program while also leveraging Program funds for project-related activities.

- In an environment where FP was controversial, TfH chose an approach to rolling out the project that was designed to maximize the chances of success. Initially, it conducted a competition among the regions to identify those most likely to bring interest and commitment to their work—and thus to succeed. With the MOH encouraging regions to apply, 21 out of 27 regions did so. A distinguished review panel scored the proposals and recommended seven regions for participation. After discussion with these regions to confirm their commitment and make them aware of the project's expectations, they were announced as the winners, with the two highest-scoring regions starting first and the others joining a year later. The competition had an important collateral benefit as it gave the project a reputation for operating openly and transparently from the beginning on.

  Once there were seven regions in the project, TfH needed to expand in a more cost-effective way and it also wanted to solidify the commitment of its existing regional partners by drawing on their expertise. This led to a "twinning" approach where additional regions were selected to a great extent based on proximity to one of the initial seven regions and good neighborly relations—although other factors were also taken into account to ensure their commitment. This "twinning" process began with a key regional health department (RHD) official from the "old" region visiting its "twin" region to describe what they had done with project assistance and how. It continued with a study tour to the "old" region and sharing of their star trainers, BCC educators and other experts—but always under the oversight of national trainers or experts to ensure quality during roll-out.

- Building on the regional selection process just outlined, the first two regions served as pilots where the new approaches were tested and refined before being rolled out to five additional regions where a few further changes were made. After that, the basic approach to regional roll-out remained unchanged, although some fine points of implementation changed.

Figure 15: TfH Regional Coverage: 15 out of 27 regions with 65% of the population of Ukraine



- The project worked at the *central* level on policy and management issues, so its approaches would be institutionalized in national policy and supported by the MOH in its standard-setting and oversight role. This work went hand-in-hand with work at the *regional* level on FP/RH program management and implementation, consistent with the Government's commitment to decentralization of health services. This two-track approach supported the concept of a decentralized health system, where the MOH has a policy-making role and regions manage implementation of services delivered in the public sector.
- TfH's arrangements for project implementation sought to build capacity and commitment at the regional level by relying on a senior official in the RHD to manage project activities, with the assistance of a coordinator provided by the project to help with day-to-day implementation. This person was designated by the region and was generally the Maternal and Child Health (MCH) Director or Head Ob-Gyn, so that lessons learned in project implementation would be carried forward into the future and into other health programs. This individual worked in the framework of a partnership agreement signed by regional authorities and the project, which specified the project's goals and strategies, the nature of project inputs and expected contributions from the region as well as conditions of collaboration, such as compliance with the principles of voluntarism and informed choice.
- The project sought to build FP champions who would provide leadership for the field of FP/RH in their technical areas or in their regions and become a sustainable resource to keep the field moving forward in the future. When the project started, there were already a few individuals (mostly in the clinical arena) who had demonstrated strong commitment to the field for many years and they continued to provide invaluable leadership over the life of the project. Project staff sought to build the interest and commitment of other counterparts in the public and private sectors who showed the potential to make

outstanding contributions. They fostered these individuals' interest and expertise through mechanisms such as working groups, advanced training opportunities, recognition of their skills and commitment by sending them to other regions to provide training or technical assistance or featuring their work at national conferences. While it was difficult to develop a list of champions from the project's many outstanding counterparts, by the fifth year, a shortlist of 17 individuals[viii] had been identified as having gone well beyond the call of duty in helping and supporting the project's work and whose commitment to family planning was expected to continue far into the future—with or without the project. This group encompassed leaders and advocates on clinical issues, Evidence-Based Medicine (EBM), community education (including journalists), pharmacy and policy.

- The project sought to institutionalize all aspects of its work from the beginning on. This was done through support for the State Program *Reproductive Health of the Nation* up to 2015 (SPRHN); working groups to develop and advocate for progressive policies and their implementation; seeking to embody the project's innovations in national policy to give them nationwide application; ensuring that its training programs were formally adopted (by the MOH and Ministry of Education and Science (MOES)) as part of postgraduate education and that faculty were trained to teach the material and had the necessary teaching resources; and strengthening the management skills of MCH/FP/RH leaders in the regions.

- TfH adopted gender-sensitive approaches in its work, recognizing that its aim was to improve the health status of both men *and* women and emphasizing shared responsibility in decisions about FP/RH. It sought to involve both men and women in all aspects of its work, including men on the project staff, involving men in working groups in developing and implementing project interventions. One of the project's core activities—to expand FP/RH services beyond the traditional network of women's health care facilities into primary health care (PHC) facilities, which serve both men and women—made FP and STI services more accessible to men. And BCC activities made a special effort to reach out to men, involving them as community educators, reaching out to schools and workplaces where there were large numbers of men with BCC activities, and producing information, education and communications (IEC) materials specifically targeted to men. The project's wide dissemination of condoms through health facilities and a host of BCC activities was of disproportionate benefit to men. And a significant number of project indicators were broken down by gender, allowing the project to examine the extent to which it was able to reach men.

- It collaborated closely with many donors and projects so as to maximize the use of resources and build a unified Ukrainian FP/RH program well-integrated with related services and activities. Key partners were the USAID Maternal and Infant Health Project (MIHP), HIV-AIDS Alliance, Network of People Living with HIV, World Health Organization (WHO), UNFPA and the Swiss Development Cooperation.

  Some examples of this collaboration include joint sponsorship with the USAID Health Policy Initiative and MIHP of a national conference to launch the SPRHN planning tool; working with MIHP on integration of FP into prenatal, delivery and postpartum care (including production of a video) and coordination to reach the staff of health facilities where MIHP was already working; working with HIV-AIDS Alliance, WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) to review the major policies and protocols governing STI treatment and planning a coordinated strategy to move forward; working with HIV-AIDS Alliance to distribute USAID-donated condoms; organizing a working group including the MOH, HIV/AIDS Alliance, USAID HIV-AIDS Service Capacity Project, Network of People Living with HIV, WHO and UNICEF to develop a manual on family planning for People Living with HIV (the Network of People Living with HIV paid to print the manual, using Global Fund moneys but made copies available to TfH;) coordination with the network of HIV-AIDS service providers to include some of their cadres in TfH training courses, expanding the availability of FP counseling and commodities within HIV-AIDS services; working with the Health Policy Initiative to ensure that FP is included in the Government's policy on PMTCT; mobile STI testing and counseling in collaboration with nongovernmental organizations (NGOs) that had been given mobile labs by the HIV-AIDS Alliance, bought with Global Fund moneys; joint journalists' training in Kyiv with UNFPA; collaboration with the USAID-funded Center for Ukrainian Reform Education (CURE) on production of videos, journalists' workshops and TV programming; as well as participation on various committees and working groups convened by MIHP, the Health Policy Initiative, WHO, Swiss Development Cooperation and others.

IV. Technical Approach and Results

Intermediate Result 1: Improved service provider skills and behavior related to RH/FP

At the start of the project (2005), access to FP was quite limited, FP was provided almost entirely by ob-gyns working in women's health care facilities such as women's consultations, FP centers or cabinets and maternity hospitals, which were usually located in urban areas. Many women faced real access problems, particularly if they lived in rural areas, and men had almost nowhere to turn for specific prevention and care.

The quality of the FP/RH services provided also left much to be desired. Most ob-gyns had had little or no training on modern FP methods and approaches, there were no reference materials with updated information that they could draw on, and medical education curricula (both pre-service and postgraduate) were very old and not evidence-based. The main players in providing updated information to doctors were contraceptive manufacturers and distributors and, understandably, their focus tended to be on promoting the latest brands, often one manufacturer brands against the other. MOH clinical protocols were very outdated and not evidence-based. For example, they required unnecessary pelvic examinations, laboratory tests and specialist referrals before prescribing a method, rest-periods for oral contraceptives and other antiquated procedures that presented unnecessary barriers to care. It is hardly surprising in light of such precautions—and with a history of Soviet caution on contraception—that providers were skeptical of modern contraception, especially hormonal methods, and, as already noted, this was reflected in low use of modern methods and a method mix dominated by traditional methods, IUDs and condoms. Underlying this situation was the lack of familiarity with EBM, so that decisions about policy and practice were being made on the basis of opinion, rather than on the wealth of available international evidence.

In general, most providers saw contraception as something they had a responsibility to provide to women at medical or social risk should they become pregnant—and not as a choice allowing all couples to decide on the timing of pregnancy. The provider determined the appropriate contraceptive method—usually an IUD—and counseling was an almost unknown concept. In short, contraception was considered a medical decision that belonged in the hands of doctors. TfH sought to change this dynamic, so that FP would be seen as a matter of choice for all couples.

In light of this situation, the project sought to address three key challenges to improve FP/RH services:

- To update and improve care in line with international best practices;
- To recast FP from a strictly medical service to a matter of choice for the vast majority of clients, with a strong emphasis on counseling; and
- To broaden the cadre of providers beyond ob-gyns in order to make services more accessible.

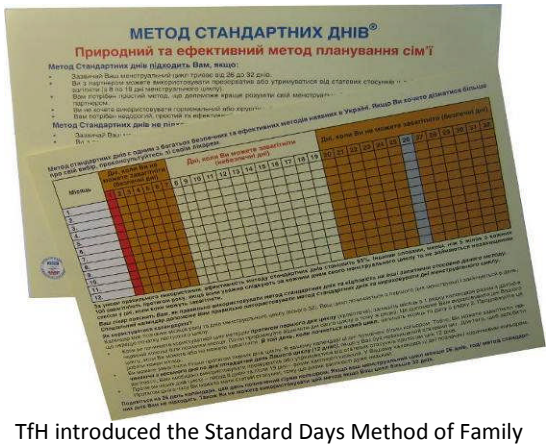
The quality of FP/RH services improved

TfH set out to improve clinical practices in project regions in line with modern international standards, drawing heavily on WHO's "FP cornerstones" documents.[2] This entailed updating the content of care and dispelling the myths about modern contraception, particularly hormonal methods, among health workers. The project also aimed to institutionalize these approaches through updated national policies, manuals and academic training curricula.

The starting point was a national seminar on international evidence-based standards and criteria for contraceptive provision for leaders in the FP/RH field, including pharmaceutical companies, to build momentum for change. Because of the high esteem in which WHO is held in Ukraine, the Reproductive Health and Research Advisor from WHO's Regional Office for Europe was invited to lead the workshop. The event was very well received and laid the foundation for updating the knowledge of opinion leaders in FP/RH, emphasized the importance of basing clinical policy and practice on solid evidence, and set the stage for updating national policies and materials.

[2] *Medical Eligibility Criteria for Contraceptive Use; Family Planning: a Global Handbook for Providers; Selected Practice Recommendations for Contraceptive Use;* and *Decision-Making Tool for Family Planning Clients and Providers,* http://www.who.int/reproductivehealth/publications/family_planning/9241562846index/en/index.html

The project asked the MOH to establish a working group to collaborate on development of an evidence-based reference manual and training program for health providers. In a marked break from the tradition of nominating only top officials to such panels, this group included top experts as well as front-line service providers and a midwife. The *Family Planning* reference manual that resulted from the group's work was solidly evidence-based and covered the contraceptive methods available in Ukraine, including fertility awareness-based methods, removing unnecessary medical barriers such as lab tests, specialist referrals and pelvic examinations and placed a strong emphasis on counseling skills to support clients' decision-making. It provided information about the safety and effectiveness of all methods available in Ukraine and promoted more holistic, integrated care, by linking FP with broader RH services, including prenatal, STI and HIV care. The training course that went hand-in-hand with the manual included a module on improving the availability of modern contraceptives, which addressed myths about mid- and low-priced brands and later, a booklet, *Contraceptives Available in Ukraine,* presented information about all available brands in Ukraine and addressed pricing issues.



TfH introduced the Standard Days Method of Family Planning, using a tool adapted specially for Ukraine. *Photo:Lidia Hryvg*

The MOH working group also developed an accompanying five-day training course, using adult learning techniques and integrating plenty of practicum to ensure that trainees emerged competent to provide services and counseling in line with international approaches. The course was certified by the MOH as a Continuing Medical Education (CME) workshop, giving participants CME credits toward the number required every five years, thus providing an incentive for them to participate. At first, these courses were conducted only by *national* trainers with a wealth of knowledge and experience in FP/RH, but from the beginning, the objective was to develop cadres of regional trainers. Initially, the regional trainers co-trained with national trainers, but once they were judged fully competent, they began training independently. TfH developed a system of short in-service trainings and a career-ladder for these new trainers. Those who conducted significant numbers of training courses, who went through in-service training, and who demonstrated a high level of skill, advanced to become regional trainers and ultimately a few even became national trainers.

CATs & Continuing Medical Education (CME)

One of TfH's innovative approaches to disseminating evidence-based information to health workers was to develop CATs—Critically Appraised Topics—and encourage their wide dissemination. CATs are one- or two-page fact sheets summarizing the evidence on a very specific clinical topic. TfH worked with project-trained EBM methodologists to develop a total of 59 CATs presenting the evidence to combat common myths about various contraceptive methods, for example:

- *There is no evidence supporting an association between combined oral contraceptives and weight gain;*
- *Progestin-only pills are safe for the infants of women who are breastfeeding;*
- *For long term users of Depo-Provera, there is no apparent association between use and failure to return to fertility, though return to fertility is often delayed.*

The CATs emerged from discussions with TfH's private sector partners who were seeking to market hormonal contraception and whose field forces often struggled to answer tough questions from doctors. Initially, the CATs were used by Bayer Health Care representatives when they visited doctors' offices or conducted seminars for doctors. The representatives found the CATs helpful, allowing them to cite concrete facts in their interactions with doctors, instead of just arguing with them. TfH also introduced the CATs to its partner RHDs, training their clinical trainers to conduct roundtable discussions with health workers on the topics addressed by the CATs as part of their CME efforts. The concept caught on and other PSPs followed suit. From TfH's point of view, the CATS were an invaluable tool to get value from CME events, whether conducted by PSPs or RHDs. They reinforced the information in clinical trainings, spread accurate information to the thousands of doctors nationwide reached by the PSPs' field forces—and at nominal cost to the project. Moreover, the CATs deepened the medical community's understanding of EBM.

Later, the project helped MOH working groups develop two additional reference manuals on neglected aspects of FP: *Postpartum and Postabortion Family Planning* and *Family Planning for People Living with HIV*. All three manuals were widely disseminated and formed the basis of training on these topics, although the project's main focus remained the basic five-day course. A total of over 10,600 health workers (about 86% women and 14% men) were trained in courses based on these manuals.

Recognizing that the training contained a lot of new information and sought to instill very new skills in participants, the project knew that it needed to reinforce the material after the training. Early in the life of the project, it instituted follow-up visits by trainers to participants at their work-sites about six months after training. While these visits proved very helpful and also produced information to improve the training course,

it became necessary to identify less costly mechanisms. So with an eye on sustainability, TfH built on the tradition of RHDs providing periodic updates to health workers through half-day and one-day meetings and conferences and worked with partner regions to integrate FP updates into these CME events. The regions drew on project-trained trainers in their own region to conduct these events, using the project's training materials in a modular format. The only cost to the project was for manuals and materials distributed. At first, the aim of this system was to reach health workers who had already participated in TfH training, but it soon came to be used to reach large numbers of health workers in districts not covered by the project's formal training. Almost 1,400 such CME events were conducted for many thousands of participants over the life of the project.

Various print materials also played an important role in reinforcing the messages of the training and promoting improved provider practices. In addition to the *Family Planning* reference manual itself which was given to all training and many CME participants, the use of Critically Appraised Topics or "CATs" in CME sessions proved a valuable strategy to address the most widespread myths among doctors (see text box on page 16.) In addition, the project's Private Sector Partners (PSPs), who were contraceptive manufacturers and distributors, used CATs when calling on doctors and conducting roundtables/seminars for the medical community. At first, posters and brochures designed for the public were the main job aids used by health workers, but later WHO's contraceptive "wheel" was translated into Ukrainian and distributed to doctors to use as a tool to remind them which clients were eligible/not eligible for the various contraceptive methods.

Lviv clinical training participants practice the "no-touch" technique for IUD insertion. *Photo: Iryna Dzioba*

All of these efforts brought some significant results in terms of the quality of care.

- Health providers who participated in clinical courses over the life of the project demonstrated substantial improvements in their knowledge, with average scores on pre-tests at the start of the training standing at 58%, but rising to 92% on post-tests at the end of the training.
- Follow-up visits showed that TfH-trained providers did better on many performance measures than others who hadn't received the training:
    - The most important change was seen on IUD insertion skills, with more than 75% of insertions by TfH-trained providers done using the "no touch" technique, compared with only 25% of non-TfH-trained providers. This technique greatly reduces the likelihood of infections by loading the IUD while it is still in its sterile package, instead of outside the package. With IUDs used by about 12% of Ukrainian women, according to the *Ukraine Demographic and Health Survey 2007* (UDHS)[ix], protecting these women from readily preventable—and potentially dangerous—infections is a critical improvement.
    - Another important improvement was in taking medical histories, with 65% of trained providers taking an appropriate history, compared with 36% of non-TfH-trained providers.[x]
- Women's satisfaction with the FP/RH services they received improved over time, according to project surveys of women leaving project-assisted health facilities in seven regions. After about 20-24 months of project interventions, 68.9% said the quality of services was good, compared with only 54.7% before the project came—an increase of about 14%.
- The project trained 51% or more of all ob-gyns and family doctors in nine of its 15 partner regions, creating a critical mass of providers that has the potential to bring about broad-based change among their peers in those regions.

The core of TfH's sustainability strategy in the clinical arena was to ensure that modern, evidence-based FP/RH practices were enshrined in national policy, since policy carries enormous weight in the countries of the former Soviet Union and is enforced through frequent inspections. The most important modern, evidence-based policies adopted were:

- *On Approving Clinical Protocols for Obstetrical and Gynecological Care, Family Planning*;
- *On the Organization of Ambulatory Obstetrical and Gynecological Care in Ukraine,* standards for FP services*;*
- *On the Organization of Family Planning Services and Reproductive Health in Ukraine* defining the functions of PHC in FP/RH service provision.[3]

Another facet of the project's sustainability strategy was to institutionalize an updated FP/RH program in medical education. Priority was given to postgraduate medical education, rather than pre-service education, because all practicing doctors in Ukraine are required to take postgraduate courses every five years, so this system opens the door to reaching large numbers of doctors already practicing all over the country. At the half-way point in the project, a working group from the MOH and leading medical schools adapted the project's manuals to suit the requirements of the postgraduate education curriculum. The group developed three instructional manuals[4] institutionalizing several new dimensions brought by the project to FP/RH in Ukraine, including involving family doctors in FP/RH, introducing evidence-based approaches, and putting clients in the center of FP services by emphasizing counseling. In addition, at the medical schools' request, it also developed a manual on modern teaching techniques, which are still relatively new in Ukraine *(Didactic Techniques for Teaching RH.)* These manuals were approved by the MOH and MOES as formal parts of postgraduate medical education and key faculty from all postgraduate medical schools in the country were trained.

The project also left behind the "infrastructure" to continue CME on FP/RH in partner regions, in the form of using the regions' established system of regular meetings with health workers to conduct one-day or half-day seminars on FP/RH topics at their own initiative and expense, using project training materials. A cadre of 292 experienced FP/RH trainers and specialists at the regional level remained behind in TfH's 15 partner regions to serve as resources for CME into the future.

A final aspect of the project's clinical work was to build understanding of EBM, so that eventually the medical leadership in Ukraine would be able to update its own policies and practices without the assistance of international projects. While the project promoted EBM widely in its work, it trained a small cadre of young ob-gyn leaders on EBM methodology and worked with the most talented of them to develop curriculum for medical schools and/or to apply their skills in developing CATs. To facilitate this, a small EBM Center was established in the ob-gyn department of the National Medical Academy for Postgraduate Education (NMAPE) to serve as a resource center for the methodologists to do their work as well as to enable teachers in postgraduate education for ob-gyns and family medicine to explain EBM to students. The center was formally integrated into NMAPE and has been fully financed by them since soon after its establishment.

FP began to be seen as a "choice," rather than as a purely medical matter

The foundation for making the transition from FP as a medical decision taken by health workers to FP as a matter of individual choice was to convince providers that contraception is safe and effective, enabling everybody to use it, if they wish. TfH showed providers how contraception, rather than abortion, is the main means of fertility control in most of the world and that most women of childbearing age—not only those at medical or social risk—use it. Indeed, it showed that modern pills and other hormonal methods, viewed with considerable skepticism by health workers in Ukraine, are the leading reversible methods worldwide and in Western Europe (see Figures 1-3 at page 5.) It also presented data on the safety and effectiveness of modern methods to allay fears about their widespread use. TfH's training, manuals and CME drew on a wealth of

[3] *On Approving Clinical Protocols for Obstetrical and Gynecological Care, Family Planning*, MOH Order # 905, 12/27/2006; On Organization of Outpatient Obstetric-Gynecological Care in Ukraine, MOH Decree # 417, 7/15/2011; *On the Organization of Family Planning Services and Reproductive Health in Ukraine*, MOH Decree # 539 8/4/2006 (especially Annex 4.)

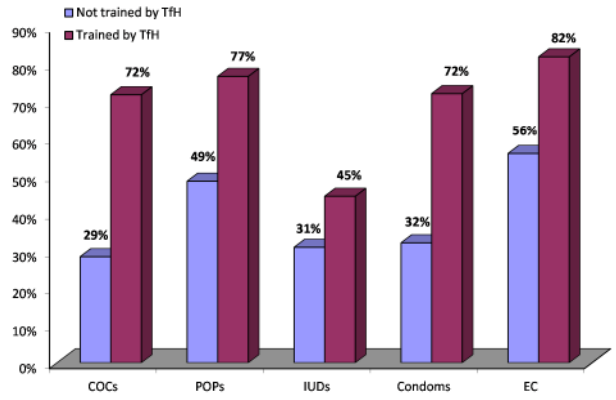
[4] *Modern Aspects of Teaching FP/RH*, a five-day training program for ob-gyn and family medicine teachers; *The Basics of FP/RH for Ob-Gyns and Family Doctors* is a five-day program for health workers going through postgraduate education; *Relevant FP/RH Issues*, is a 10-day program for ob-gyns that includes more in-depth information on modern contraception, including postpartum and postabortion contraception, contraception for People Living with HIV and prevention of STIs and HIV-AIDS.

evidence about the benefits and risks, indications and contraindications of each method, leading logically to the conclusion that the risk involved in using modern methods is minuscule.

The second step to making the transition to FP as a choice was to strengthen providers' interpersonal communication and counseling skills. The aim was to help them empower clients to make their own FP choices based on their lifestyles and preferences, rather than making choices on their behalf from a strictly medical perspective. To address the communications and counseling issues, 40% of TfH's basic five-day FP/RH course was devoted to counseling theory and hours of practice using role-plays. The project's clinical manuals also placed a strong emphasis on counseling skills and the concept of informed choice.

The results of these efforts were that more providers were, indeed, convinced about the safety and efficacy of modern contraception. Surveys of providers in seven regions before TfH began working found that only 59.7% had a positive attitude to the more effective contraceptive methods, while about 24 months later, after training had been conducted, this increased by 11%, so that 70.5% had positive attitudes.[xi]

Figure 16: TfH-trained Providers are More Likely to Counsel on a Range of FP Methods



Source: TfH baseline and endline assessments

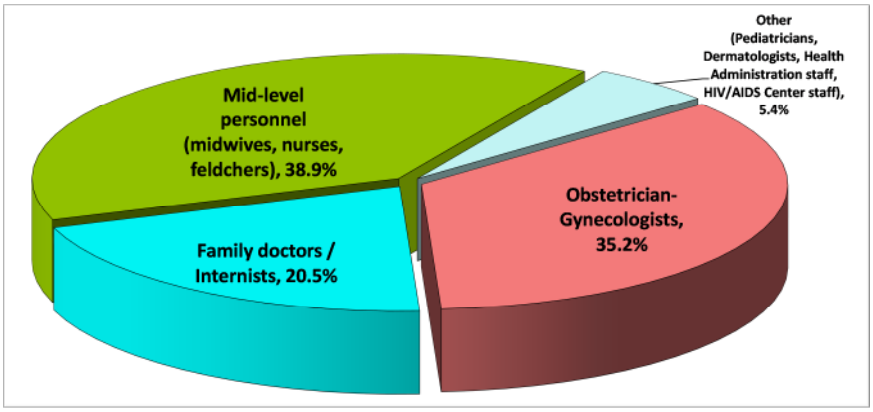
Trained providers were also more likely to counsel on a range of FP methods (combined oral contraceptives (COCs), progestin-only pills (POPs), IUDs, condoms and emergency contraception (EC))—***see figure 16 on left.*** They were also more likely to provide clients with key information needed to choose a contraceptive method appropriate to their needs. And the proportion of clients reporting in surveys in seven oblasts that the provider had discussed three out of five specific FP topics rose from 63% to 73%; while the proportion covering two out of three key STI topics rose from 61.7% to 78.6%.[xii]

FP services became more accessible

When the project started, the Government of Ukraine (GOU) was already committed as a matter of policy to strengthen PHC, with family doctors as the core of the system, opening the door to TfH to integrate FP/RH into services provided by family doctors and other PHC providers, such as internists, midwives, *feldshers* and nurses. This expanded network of service providers would result in improved access to care for the population, especially in rural areas.

Another level of integration was to integrate FP into existing RH services such as prenatal, delivery and postnatal care, postabortion care, and STI and HIV/AIDS care. The 1999 *Ukraine Reproductive Health Survey* (URHS) had indicated that this was very much needed, with only 26% of women counseled on contraception after delivery and less than 3% receiving a prescription or a method before leaving the hospital; and only 39% of women who had had an abortion receiving FP counseling and just 16% leaving with a method or a prescription.[xiii]

Figure 17: Types of Health Providers Trained (Total trained: 10, 623—86% women and 14% men)



The core strategy for integration was a team training approach, bringing together different types of staff from different types of health facilities into the same training course. As Figure 17 at left shows, almost two-thirds of the participants in TfH clinical training were non-ob-gyns and almost 40% were mid-level staff. Whenever possible, trainings were organized for networks of providers in a

district or town, e.g. ob-gyns would be in the same course as midwives from their health facility, an STI specialist from the local STI dispensary, one or more family doctors in the community and midlevel staff from a *Feldsher-accousherski punkt* (FAP or feldsher-midwife point.) This approach was important to build networks of service providers where family doctors and other non-ob-gyns who were new to FP/RH knew what they could do, but also felt supported. They knew where to refer clients for care that was outside their scope of work—most significantly IUD-related care or complicated cases--and knew where to turn for advice and support. The team-training approach was also important to convince ob-gyns that other types of health care providers could actually provide quality FP/RH services.

Many health administrators were initially concerned whether family doctors and midlevel staff could provide FP safely, but several TfH's pioneering regions (e.g. Kharkiv, Lviv, Poltava, etc.) had already taken steps to expand the scope of work of FDs and could attest to their capabilities. And evidence from elsewhere in the former Soviet Union showed that midwives were providing FP services, including IUD insertion and removal.[xiv]

Once administrators were on board, the process of building the confidence of family doctors and midlevel professionals themselves was not easy. The fact that national policy adopted in 2006 endorsed their new roles was critical. The training played a crucial role in building confidence because it placed so much emphasis on actually *using* the new information and *practicing* skills in the classroom. And the team training approach enhanced the comfort-level of non-ob-gyns. Continuing support through CME was valuable in reinforcing the messages of the training. But probably the most important factor was the availability of free contraceptives from USAID and the GOU, although unfortunately these were not yet available in the early years of the project.

Training Empowers Family Doctors

Sevilia Velilyaeva, a family doctor in Bakhchiseray in AR Crimea said after the TfH training, "I always thought that family planning and contraception were the prerogative of ob-gyns. But the training was easy to understand and encouraged me to apply my new knowledge in practice after returning to work. Now, when women and girls come to see me, I do my best to raise issues related to women's health and contraception, telling them about the progress made in modern medicine. My clients view my practice differently now."

In Ratne City in Volyn Region, a group of family doctors noted that "we're being greatly respected as specialists who can provide family planning counseling to patients and married couples; and we're no longer afraid of working together with ob-gyns."

Project monitoring determined that about nine out of 10 TfH-trained family doctors and midlevel professionals not only offered FP/RH counseling, but actually provided or prescribed oral contraceptives, condoms and/or the Lactation Amenorrhea Method (LAM.) They also provided IUD counseling, but referred to ob-gyns for IUD services, since that was outside their scope of work. Family doctors and midlevel staff, meanwhile, who had *not* been trained by TfH rarely provided FP/RH counseling or services.[xv]

The dramatic effect of training new providers can be seen in Figures 4 and 5 at pages 6-7. By the end of the project, the number of access points in the project's 15 partner regions had grown more than six-fold, from 568 to over 3,637. Taking services into primary health care (PHC) facilities also played an important role in giving men better access to information and services on both FP and STIs. Moreover, due to GOU efforts to allocate and fund contraceptive procurement within the SPRHN, and to USAID efforts to supply free contraceptives for most disadvantaged, the availability of free services and supplies in surveyed health facilities in seven oblasts increased from 27.5% at baseline to 59.8% at endline—Figure 19 at page 30.

Intermediate Result 2: Improved client knowledge, attitudes, and use of appropriate RH/FP services and products

There is an old dictum that there was "no sex in the Soviet Union," and consistent with that, at the start of the project there was a conspiracy of silence on FP/RH. A media analysis of FP/RH coverage showed that there were few mentions of these topics in mass media, while about half the articles addressed the country's low birth rate. Most mentions that did occur were about statistics, state policy and medical or social problems related to contraception, rather than being more consumer-oriented.[xvi] This conspiracy perpetuated the existing problems of high reliance on abortion, low contraceptive use and a limited method-mix.

The 1999 URHS showed that, while public awareness of the major modern methods of contraception was high, women had strong negative perceptions of these methods, especially hormonal methods: 57% had a negative opinion of oral contraceptives, 73% of injectables, 50% of IUDs and 40% of condoms. Concerns about safety were widespread, especially for hormonal methods and, despite their widespread use, 27% of women had

concerns about the safety of IUDs and 9% about condoms. In fact, concern about side effects was a major reason why women using contraception were not using their preferred method. It was clear that the public needed information about the safety and benefits of modern contraception.[xvii]

While the need for BCC was clear, there was very little understanding in the MOH and RHDs of the need to reach the population directly with health information. Public education on health topics had not been a priority in Soviet times and there was no real health education network in the health system, although health workers had long been required to conduct some interpersonal communications, which they generally did with reluctance—in the form of lectures. NGOs, that play a large role in BCC in many parts of the world, were (and remain) still relatively new in Ukraine and, thus, mostly young and weak; moreover, few of them had any experience in FP. In short, there was very limited BCC expertise in the health sector and even less on FP/RH—and a void of BCC activities on this topic throughout the country. Important concepts such as setting objectives for BCC activities, linking BCC to clinical or policy activities, developing effective messages, the principles of communication, etc. were all very new to Ukraine

The main challenges TfH took on to improve public knowledge, attitudes and behaviors on FP/RH were:

- Building a "system" to conduct BCC;
- Improving public attitudes toward modern contraception; and
- Improving public behavior with respect to abortion and contraception.

The basics of a "system" for BCC were put in place

The project's first task was to identify potential BCC activists and educators with whom to work. This was challenging and took time, until project staff determined which agencies were most likely to have interested people with relevant experience and skills:

- Some health workers had the interest and aptitude for BCC—but they were few and far between;
- The Ministry of Family, Youth and Sport (MFYS) network, especially social services for youth, was a much better skill-match and had the major advantage of already working with young, poor and vulnerable populations that were those most in need of FP/RH services;
- NGOs that worked with women, men youth or vulnerable populations or that were already active on health topics contributed considerable expertise; and
- Teachers in schools, colleges and universities were valuable resources with access to large numbers of young people.

In the interests of sustainability, the project made a special effort to identify people who could integrate BCC on FP/RH into their day-to-day work. It also tried, from the beginning, to involve men, knowing that male educators would be more effective than women in reaching male audiences. By the end of the project, 543 community educators had been trained, 114 (22.1%) of them men, and each partner region was left with a cadre of trained and experienced educators to carry them into the future.

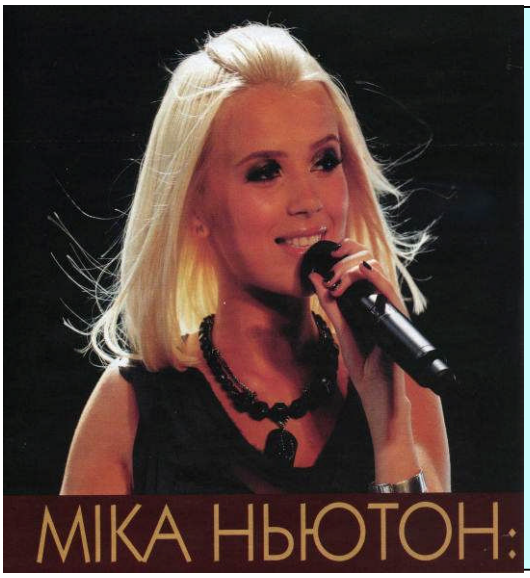
A Young Volunteer from a BCC Training in Odessa Speaks out

"I worked as volunteer for events on HIV/AIDS prevention before and I thought I knew a lot about prevention of STIs and reproductive health in general. But at the training I understood that there is much more information that young people should be aware of – information that will help them to change their behavior. I learnt this at the training and can now talk about these important topics to my peers."

The process of developing BCC activists focused on simple tasks at first and gradually became more sophisticated. It started with how and where to distribute IEC materials so they would reach the right audiences, and with participation in large public events organized on special occasions, like World Youth Day, World Health Day and Valentine's Day, which called for large numbers of volunteers. Public events proved to be valuable entry points into BCC because the planning process generated great enthusiasm and activists always felt rewarded by the positive public reaction to their work during the event. Only after participating in these "entry level" activities, and if they had the talent, were potential BCC educators trained to conduct interpersonal communication sessions. Initially, after being trained to conduct such sessions, they worked hand-in-hand with more experienced educators until they were capable of working alone or they conducted sessions consisting of showing a project video followed by a guided discussion. Only a few BCC activists around the country moved on to the most advanced tasks of planning BCC activities, working with mass media and developing print materials.

An additional challenge was to keep active BCC educators and activists involved and interested, particularly since TfH did not pay the educators for their work, and to foster their professional growth. The project sought to provide occasional opportunities for advanced training and for this growing network to share experiences and ideas at the regional and national level and these were important for advanced skill-building as well as keeping the level of enthusiasm high.

At the same time as developing this network of activists, TfH worked RHDs to help them recognize the value of BCC in shaping healthier lifestyles. An important factor in gaining their interest was the inclusion of BCC on FP/RH as part of the State Program *RH of the Nation* (SPRHN, see pages 34-37), which effectively gave the activity a Government imprimatur. In developing regional RH Programs, all TfH partner regions included BCC and their interest and commitment grew over time, as they participated in various public events, workshops for journalists, etc. and saw that health services can be more effective if the public is better informed. From the beginning, RHDs played an important role in working with mass media, many of which are government-owned, to publicize the project—an activity they were familiar with. Over time, they began to work with mass media to carry information useful to the public, such as information on contraception and the availability of services. As the project progressed, all TfH partner regions began conducting interpersonal communications sessions and public events at their own initiative and with their own resources, through SPRHN or otherwise. Some even invested in printing materials on FP/RH—a groundbreaking development.



Popular Singers Speak out on Family Planning, Contraception and Relationships
(Excerpts from *Tobi* Magazine)

Mika Newton: Talking about pregnancy—you should know about it when you are 13 or 14 years old. Tell teenagers about it! Tell them about the responsibility and about abortion and how difficult it is. A girl should think about having children only when she is ready for them, when she feels that things are harmonious in her life. It doesn't matter when that happens—when she's 19 or in her 30s.

***Arina Domski*:** Contraception is not only about protecting yourself from unintended pregnancy and STIs. Above all, it shows that you are responsible and care for your loved one. I think planning is the best way to start a family. And contraception is the foundation for such planning.

Vitaly Kozlovsky: *[Responding to a question about talking with a girlfriend about contraception:]* I think it's the right and correct thing to do. Modern youth are more open now than thirty years ago. That's why young people can talk easily about different topics. Talking about such things is an expression of care, respect and love for each other.

One of the events envisioned in the SPRHN was an annual celebration of FP Week and this proved to be a galvanizing event that involved not only BCC educators, but also RHD officials, health workers, MFYS, NGOs, educational institutions and small armies of volunteers. FP Week evolved over time to become a high-profile event that brought together all aspects of BCC: large public events, mass media, interpersonal communications sessions, distribution of IEC materials and innovative activities such as work with disc-jockeys to mix educational messages into their music and dance programs. In the latter years of the project, some regions became so enthusiastic that they began to conduct annual month-long FP campaigns, rather than the MOH-endorsed week-long campaigns, and ultimately, some regions' financial contributions for FP campaign activities exceeded those of the project.

To build capacity and promote buy-in, as regions gained experience, TfH gave them broad flexibility in developing their BCC programs, while working within set themes and around key messages. It then fostered exchanges between regions to share ideas and experiences. These exchanges were important opportunities for skill-building.

NGOs proved to be particularly dynamic, committed and innovative BCC partners and TfH worked closely with about 30 of them that were interested in working on FP/RH and whose mandates gave them the potential to serve as sustainable resources on FP/RH into the future. In the first half of the project, TfH conducted two rounds of competition for small grants to NGOs in partner oblasts to work hand-in-hand with RHDs on BCC and/or advocacy for FP/RH—the latter mostly in support of SPRHN. Forty-three applied and 15 were judged by a review committee and TfH staff as meriting funding. Their relationship with TfH was synergistic. TfH availed itself of the NGOs' networks, expertise and enthusiasm, while the NGOs learned about FP/RH, acquired new technical skills in BCC and advocacy and upgraded their financial and administrative capacities. They, along

with other NGO partners, played a large role in organizing public events and reaching TfH priority audiences. In fact, they conducted some of the project's most innovative BCC activities, such as theater productions on FP/RH themes, working with religious leaders, setting up an FP/RH hotline and working with RHD and local officials to advocate for funding for a youth-friendly clinic under one oblast's RH program. Many of them developed print materials that were later used in other oblasts and one NGO produced several educational videos. (See Annex 3 for a list of NGO partners.)

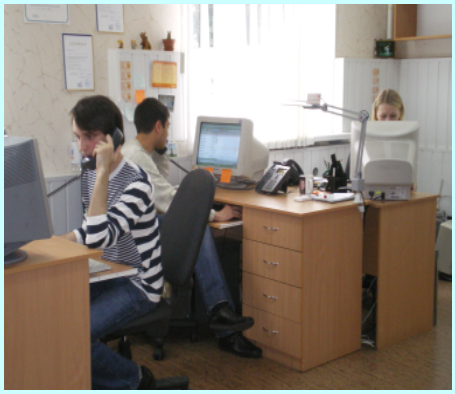
NGO volunteers join with volunteers for the British rock group, Queen*, to spread information about FP*

The legacy of TfH's efforts to build a system for BCC on FP/RH are:

- Improved understanding among regional counterparts of BCC activities and their importance, as evidenced by partner regions' investment of time and resources in BCC activities;
- A total of almost 550 trained and experienced BCC activists and educators in TfH partner regions;
- Over 30 NGOs in TfH partner regions involved in BCC and/or advocacy for FP/RH, almost all of them for the first time;
- More active, better-informed mass media in partner regions.

Public attitudes toward modern contraception improved

Telephone Hotline Reaches Pharmacists & their Clients



Apteka No. 1, a pharmacy chain based in Dnipropetrovsk and working in seven oblasts, started a hotline in 2005 when they recognized that clients and pharmacists need reliable information about health and medications. The hotline is operated by a team of seven trained telephone counselors and answers calls from both clients and pharmacists in the seven oblasts.

Apteka No. 1 took advantage of the opportunity to send its telephone operators to TfH's one-day FP/RH trainings for pharmacists.

Callers had often asked about the side effects of certain contraceptives or about newer hormonal methods, and after the training, telephone operator Yevgeny Chernev says he and his colleagues felt confident answering these questions with qualified, evidence-based information. He added that the telephone operators frequently used TfH reference materials to answer callers' questions. And the networking portion of the trainings—sharing names of TfH-trained doctors and pharmacists—was helpful for *Apteka No.1* because it helped them expand their network of consulting doctors, so pharmacists could use the hotline to get answers to questions from medical professionals on-the-spot.

From the project's perspective, the investment in training the hotline operators was a wise one, since *Apteka No. 1* already had a "constituency" that could be reached with FP/RH information at no additional cost to the project. And the investment paid off. Julia Garonenko, director of *Apteka No. 1,* reported that since the trainings, the telephone center received more calls about FP, and contraceptive sales rose accordingly—especially sales of hormonal contraceptives, which aren't yet popular in Ukraine.

To supplement the basic information on Ukrainians' FP/RH knowledge, attitudes and practices from the 1999 URHS and 2004 *Survey on Willingness and Ability to Pay for Contraceptives in Ukraine* (WAPS), TfH conducted a series of focus group discussions at the start of the project to get more in-depth information about various segments of the population, as well as health workers and pharmacists, on FP, abortion and STIs.[xviii] The results helped shape all aspects of the project's work and were particularly critical for development of the BCC strategy. Key focus group findings included that women knew about many methods of contraception, but thought of them as being risky for health—generally more risky than abortion. Moreover, for many people, the relationship between the quality of contraceptives and price was a major concern, with high priced brands seen as better quality and less harmful to health. The focus groups also identified specific myths about the different contraceptive methods that would need to be combatted. And they found that health workers and pharmacists had much the same views as the rest of the population. Interestingly, doctors said they considered FP counseling to be part of their job and they said they provided it—but women thought otherwise, reporting that they hardly ever got such information or counseling from doctors. However, both men and women said that health providers would be their first choice as sources of information about contraception, followed by family members and friends.

Based on the findings of the focus groups, the 1999 URHS and 2004 WAPS, it was clear that the project needed to give high priority to improving public *attitudes* toward contraception, since people would not actually *use* modern contraception until they began to see them as a healthy, safe choice and a social norm. The project's strategy emphasized reaching young people—particularly men and women aged 20-30, the group most at risk of abortions and STIs, and older teens—who were already more likely to use contraception than the older generation and who were open to new ideas. With a large majority of young people living in urban areas, urban youth became a priority audience. However, with a significant part of the project's work being to expand access to FP/RH services in rural areas, the priority there was to disseminate information and messages to as many women and men as possible, through IEC materials, BCC events and work with local mass media, particularly district-level newspapers that are enormously popular in these areas. The main media chosen to support the strategy of changing public attitudes were mass media, IEC materials and large public events which could create a climate of acceptability surrounding contraception and disseminate accurate information to broad audiences.

TfH BCC outreach activity in Simferopol during World AIDS Day. (Photo: Dmitry Dedenov)

To shape more positive images of contraception in the public mind, two types of key messages were developed. Some sought to cast FP in a *positive* light by positioning it as modern, safe and healthy. Other types of messages addressed specific widespread *misinformation* in order to dispel myths. Key messages were repeated in different media used by the project—IEC materials, mass media, public events, interpersonal communications sessions—and also reinforced during clinical trainings for health workers. Some of the most successful messages were, "Wanted children when they are wanted" and "Contraception is a better alternative to abortion" for broad audiences; and for youth, "Get older. Think about protection during sex" and "Love is important. Protect it."

The very first activity was to prepare the most essential IEC materials, in the form of a brochure and poster with accurate, unbiased information about the different contraceptive methods available in Ukraine, so people would have access to basic facts. Such materials had been produced several years earlier by the Ukrainian Family Planning Association and UNFPA and were still available in a few facilities, but by the start of the TfH project, they were out of stock and out-of-date. Materials produced by pharmaceutical companies were widely available, but generally promoted specific brands. In addition to these basic materials, the project went on to produce materials for various specific audiences, like young people, men and expectant or new parents. Partner regions were blanketed with brochures (over 1.8 million over the life of the project) made available through health facilities, public events, various BCC activities and disseminated by BCC partners, such as MFYS, NGOs, pharmacies and educational institutions. The project was always struggling to keep up with the tremendous demand for these materials. A number of videos were also produced, containing important information, but also adding emotional appeal, making them more likely than the other materials to change attitudes and behavior. Ultimately, the project produced the following educational materials:

Brochures:

Planned Choice—contraceptive methods

Wanted Children When they are Wanted—for youth

Plan Your Life—contraception for youth

For Women who want to Protect their Health and Plan the Number of Children for the Future—postpartum contraception

Men's Health—STI information for men

Posters:

Methods of Contraception

For Women who want to Protect their Health and Plan the Number of Children for the Future—postpartum contraception

Posters on women's and men's reproductive systems for educational sessions

Videos:

Informed Choice—postpartum contraception

Plan your Future—for youth

Let's Plan our Family Together—helping couples make contraceptive choices

Informational material became much more available over the life of the project. Facility surveys in seven partner regions before starting activities found that about two-thirds had a FP poster on display—generally old and outdated—or FP brochures, mostly produced by pharmaceutical companies. By the end of the project, 92% of health facilities surveyed in these regions had a TfH poster on contraceptive methods on display and 72% had at least one TfH brochure on display.[xix] Clients were also more likely to report that they had received FP information. About two-thirds (66%) of surveyed women in seven regions said they had received a print material on FP/RH (that wasn't branded or promotional) during their visit to the health provider, compared with 57% before the project. And the proportion of clients reporting that they received material specifically on FP increased from 35% at baseline to 55% about 24 months later.[xix]

The project worked with partners to conduct over 2,700 special events over the life of the project on occasions such as Valentine's Day, World AIDS Day, World Health Day, Students' Day, World Contraception Day and so on. The largest, most high-profile event was the annual celebration of FP Week in May which was officially endorsed by the MOH and partner regions. In the last year of the project it reached as many as 13.2 million people and it brought together all TfH communications activities. FP Week featured a large number of innovative activities in each region, such as:

A billboard displayed in Lutsk during FP Week encourages viewers to seek quality FP/RH services from providers identified by the FP-friendly logo. (Photo: Svitlana Demchuck)

- Mass distribution by volunteers of print materials on FP/RH on city streets, at popular markets, at university campuses and elsewhere where large numbers of people could be reached;
- Interviews about FP/RH in popular youth magazines with pop singers and other "stars" as well as with FP/RH experts;
- Billboards and "city lights" (illuminated street advertisements) with the FP logo and a message;
- Showing of project videos or clips on large plasma screens in city squares, in buses and in movie theaters before the featured movie;
- Educational messages and games during breaks in the entertainment program at nightclubs, discos or youth festivals;
- Mobile STI testing and counseling conducted in collaboration with NGOs that had been given mobile labs by the HIV-AIDS Alliance (bought with Global Fund moneys) and using TfH brochures;
- Mobile counseling points in the form of tents set up on city streets or in parks during large public events and staffed by health workers;
- Distribution of free condoms on university campuses in conjunction with educational sessions or public events.

Work with mass media was a critical element of the effort to promote more positive public attitudes to contraception. An early activity in each region was a workshop for journalists to inform them about FP/RH issues and their importance, connect them with local experts on the topic and make them aware of some of the sensitivities surrounding these topics. One of the concerns in these workshops was to shift media coverage from a focus on announcing events related to FP/RH to *educational* coverage to improve public knowledge. The journalists' workshops yielded quick results in terms of coverage of FP topics and some of the journalists developed a strong interest and became closely involved in project activities such as developing materials and videos and message development. As the network of journalists grew, the project set up a list-serve to keep them informed of new information and resources and to share coverage from around the country in order to inspire ideas for stories. TfH also worked with FP and BCC experts to develop sample articles that journalists could use or adapt. Another valuable activity was press tours for journalists to see health facilities providing FP services and to have a chance to talk with providers. These tours led to excellent media coverage and raised public awareness of the availability of services and of the fact that these services were more client-friendly than in the past.

Late in the project, TfH began using social media to reach out to young people, creating a profile in the enormously popular *V Kontakte* social network (www.vkontakte.ru) and a blog, *Healthy Youth* (healthy-youth.blogspot.com). TfH worked with the NGO*, Zdorov'ya Zhinky* (Women's Health) to integrate information about FP/RH into the blog, making it into an educational tool, and to administer the resources beyond the end of the project.

By the end of the project, there was a steady stream of mass media coverage, including newspaper and internet articles about methods of contraception and how FP services are provided; radio and TV roundtable discussions about specific issues, such as the needs of youth or the importance of postabortion contraception; public service advertisements about the availability of services—and so on.

In all its BCC work, the project adhered to the "systems approach" presented in the diagram on page 12, seeking to coordinate BCC with other project activities. Thus, for example, BCC would follow clinical training in a district, so as to build demand for the new, improved services, and education about postpartum contraception would go hand in hand with clinical work on that topic.

In the final project year, an estimated 13.9 million people in 15 regions were reached with BCC information through mass media, print materials, IPC sessions and special events—about 30% of the total population in the country. More significantly, women's attitudes toward modern methods of contraception actually improved, as intended. Women leaving health facilities in seven partner regions were more likely to have positive attitudes toward various methods of contraception after about 20-24 months of project interventions than before. Before the project, only 27.7% had positive attitudes toward the more effective methods, while afterwards 37.6% did so—an impressive 10% point increase.[xix]

Public behavior with respect to contraception and abortion improved

To actually help Ukrainians change their behavior on FP/RH, more personal approaches were called for than the broad approaches used to improve public knowledge and attitudes. The core of these efforts was interpersonal communications sessions, where a community educator leads a small group discussion session. The project reached about 68,500 people through such sessions, about 30% of them men.

Work began early in the project to lay the groundwork for an interpersonal communications program, an approach that is known to be highly effective in changing attitudes and behavior. The starting point was to develop a manual for use by community educators to conduct these small-group sessions for various audiences on FP/RH topics. The *Manual for Trainers on Conducting Educational Sessions for the Population on FP/RH*, was designed to be flexible, allowing educators to conduct a whole series of sessions for a single group over several days or alternatively to use individual modules with specific audiences or to address specific topics. The manual evolved over time and addressed not only the methods of contraception, but also human sexuality, FP as a better alternative to abortion, STIs, HIV, responsible decision-making and other topics. It proved popular from the beginning, but after it was endorsed by the MFYS and recommended by the Ministry for use in FP/RH education activities for youth, it acquired enhanced status that made it even more useful and that served as a draw for potential educators as TfH reached out to new regions and districts. The manual relies on adult learning theory and uses highly interactive techniques.

Educational session at Vinnytsya College of the Ministry of Emergency Situations. (Photo: Natalia Antoniuk)

Objectives for these sessions varied widely, according to the audience—which ranged from pregnant women (with or without their partner) in "mothers' classes" to couples getting their marriage license, from groups of firefighters to church groups, from young people in college or university to youth living in orphanages (see text box at page 27)—and so on. Moreover, most groups had specific needs and priorities, such as how to communicate with a partner on sex-related topics, men's RH needs or helping young people make wise decisions about initiating sexual relationships. The sessions always made participants aware of modern contraception and where to go to get FP/RH information and services from project-trained providers. TfH IEC

materials were distributed at most interpersonal communications sessions and project videos were used from time to time. Over the life of the project, 543 BCC educators (78% women, 22% men) were trained to conduct interpersonal communications sessions and each of the project's partner regions was left with a cadre of educators who can continue interpersonal communications sessions into the future.

Sustainable Sexuality Education for Orphaned Youth

There are over 6,000 young people living in orphanages in Kharkiv Region and the NGO *Rainbow of Life* was dedicated to providing comprehensive, appropriate sexual health education for this group. When it won a grant from TfH, the NGO wrote a curriculum based on TfH's materials on teaching family planning, relationships, and decision-making and used their own experience working in orphanages to tailor the material to their audience. As Olexander Polyansky, one of the educators from *Rainbow of Life* explained, "Many young people living in orphanages have difficulty understanding decision-making in relationships and family planning because they have very different concepts of what a family is." So the group added special emphasis in its curriculum on communication skills, building successful relationships and accomplishing goals.

Rainbow of Life discussed issues of love, friendship, health, communication, sexuality, contraception, pregnancy and HIV/AIDS with their young audience, working with co-ed groups of varying ages and using interactive techniques such as role plays, drawing and games. They treated the young people as independent, responsible adults, and the youth responded readily, seizing the opportunity to express their own ideas about issues important to them.

As *Rainbow of Life* continued to work, they realized that they simply couldn't reach all the orphaned youth in need. So they set out to train teachers at orphanages, using a curriculum that drew on their own experience addressing the skills educators need to work in an environment requiring much more than just academic attention. And knowing that TfH support would be short-lived, the NGO also worked hard on fundraising, winning grants from the Kharkiv City Council and elsewhere.

There were a number of highly innovative interpersonal communications activities. For example, a partner NGO worked with men in the Ukrainian navy at the Sevastopol City base**;** NGOs in some regions developed short drama productions about FP/RH and then followed up with an audience discussion on the topic; the youth movement of the railroad trade union proved an interested and dynamic partner; there were sessions at cookie factories, teacher training schools, police academies, schools for fire-fighters—and many more.

The focus groups at the start of the project showed that many people didn't know where to get FP information or services. So TfH developed a logo (see at right) and accompanying slogan, *Together for a Healthy Future*, that was awarded to health workers who successfully completed TfH training and to health facilities with TfH-trained personnel and free contraceptives available. As cadres of TfH-trained health workers were developed in a community, the logo began to be promoted through public events, interpersonal communications sessions, flyers listing the health facilities with trained providers, announcements on radio and in the local press and other activities. As the project evolved, so the logo also evolved. In the second half of the project, the logo began to go hand-in-hand with messages designed to encourage people to feel more comfortable asking for contraception. One carried the message "Remember to ask your doctor about contraception" and was placed on the door to doctors' offices and another, with the message "Did you ask your doctor about contraception?" was for the inside of their office doors, so women would see it as they left (see on right). These proved highly effective.

"Ask the doctor about FP methods"

"Did you ask the doctor about FP methods"

The logo achieved remarkable success, as evidenced by results from a project survey in the Autonomous Republic of Crimea (AR Crimea) and Sevastopol City, where, only 11 months after the project began working, 55% of clients said that the logo reminded them of family planning, 29% said that it influenced them in deciding to ask about FP and 20% said it reminded them about free contraception.

The ultimate success of BCC activities is that people decide to use contraception rather than abortion and the project's surveys of clients leaving health facilities in seven partner regions showed that the percentage of women saying they received a contraceptive method or a prescription during their visit rose about 14%, from

51% before the project to 63.8% after the project had worked for about 20-24 months.[xix] The number of CYPs from condom-use rose by 80.8% in Ukraine between 2005 and 2011, indicating the impact of the project's STI prevention efforts. And, as discussed earlier, MOH statistics show clear declines in abortion.

Intermediate Result 3: Increased availability, accessibility, and affordability of contraceptives

At the start of the project, there was essentially no Government procurement of free contraceptives for poor or disadvantaged populations. From time to time, the MOH, some cities and health facilities procured a few contraceptives—mostly IUDs—for women at the highest risk of adverse pregnancy outcomes and some pharmaceutical companies donated small quantities of contraceptives to individual health facilities. While international donors had contributed limited quantities of contraceptives in the past, there were no longer any donations—but USAID had committed to a donation to be distributed with special priority to, and through, family doctors and other PHC providers in project regions. The project's baseline assessments in seven regions showed that only 27.5% of health facilities had any free contraceptives available, including condoms.[xix] TfH sought to work with Government partners to build their understanding that Government has a responsibility to help poor and vulnerable groups gain access to contraception to prevent unintended pregnancy and abortion.

With the vast majority of contraceptives purchased in the private sector, it was clear that the project needed to work there. Information about the affordability of contraceptives at the beginning of the project, however, painted a somewhat unclear picture:

- The 2004 WAPS survey showed that over 90% of *current users* of oral contraceptives considered them either inexpensive or affordable but that only about a third of *potential* users considered them affordable. A similar situation was observed among current and potential IUD users. Condoms, however, were almost universally viewed as inexpensive or affordable.[xx]
- Project calculations on the price of contraceptives relative to the minimum wage showed that in 2005 a four-week supply of the cheapest COC on the market in Ukraine (priced at around $0.9) amounted to 1.5% of the minimum monthly wage (set by the government at of $60/month). In other words, at the beginning of the project, the minimum wage could have bought 66 cycles of the lowest priced COC brand.[vii]
- Project's pharmacy surveys in the first two project regions revealed that mid- and low-priced brands were less available on their shelves—a finding that was hardly surprising, given public concerns about lower-priced brands and pharmaceutical companies' promotion of their newest products, which tend to be higher in price.
- Project focus groups, meanwhile, indicated that, for the public, fear of side effects was a more important consideration than price in deciding about contraceptive use. There was widespread concern that cheap contraceptives were probably more risky than higher-priced brands. Women and men in their twenties in focus groups, when talking about contraception often made statements such as, "We can judge by the price. More expensive ones are better" or "If it is cheap it is very suspicious."[xxi]

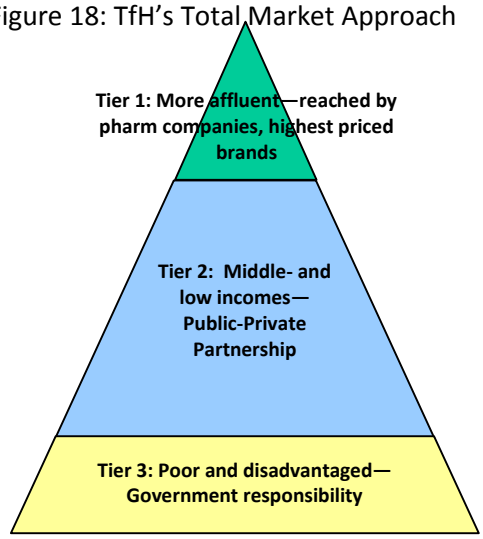
Therefore, the project's focus became to make affordable contraceptives more available in pharmacies and, to do this, it needed to work closely with contraceptive manufacturers and distributors as well as with pharmacies themselves.

Thus, the project worked in three main areas:

- Improving the availability of contraceptives;
- Improving the accessibility of contraceptives; and
- Improving the affordability of contraceptives.

The conceptual framework for TfH's work to increase the availability, accessibility and affordability of contraceptives was a Total Market Approach, as presented in the pyramid in Figure 18 at right. The project recognized that the *private sector* was—and would likely remain—the major supplier of contraceptives. With pharmaceutical companies targeting primarily the more affluent market segment (the "A tier" in the diagram), the project's focus was on improving access for the "B tier"—people with middle or low incomes—to low- and mid-priced brands through a Public-Private

Figure 18: TfH's Total Market Approach



Partnership with contraceptive manufacturers and distributors and for the "C tier"—people who cannot afford to pay for contraceptives or have limited access—by working with Government to improve the availability of free contraceptives and distributing USAID-donated contraceptives.

Free contraceptives became more available

When the project started, the MOH and the USAID-funded Policy Project were already working to develop a new National RH Program to build on the momentum of the National Program *Reproductive Health 2001-2005* which was set to expire (there is a fuller discussion of the project's technical assistance for the new Program on pages 34 to 37.) TfH gave the highest priority to including—for the first time—a line-item for contraceptive procurement in the new Program. This was a challenging undertaking in a strongly pronatalist environment and in the face of Government officials in the ministries of Finance and Economics who viewed contraception as something that allowed couples to avoid the consequences of sexual relations, rather than seeing it as a key strategy to improve maternal and child health. The project was able to arm advocates for the new Program with information to combat these perceptions. Key arguments were that most developed countries included FP in their health programs because of its contribution to reducing maternal and infant mortality; that it is cost-effective and that other countries of the former Soviet Union that had improved access to contraception saw a shift from abortion to contraception, while birth rates remained essentially unchanged. At the end of the process, when the new SPRHN was adopted, it included budget lines—in the central and local budgets—for contraceptive procurement amounting to the equivalent of $17 million in local currency over 10 years.

While the sum of money authorized was modest for a large country, it was an important breakthrough that contraceptives were included in the Program for the first time. Equally important was the philosophical shift underlying the population groups newly eligible for free contraceptives. In the past, health providers were authorized to provide free contraceptives to women with contraindications to pregnancy, victims of the Chernobyl nuclear disaster and adolescent girls, but the new Program extended eligibility to disadvantaged groups who *choose* to use contraception: those from low-income families, youth aged 18-20, and women living with HIV.

Formal adoption of the SPRHN was only the beginning of a long process to actually win funding for contraceptives. The next step was to work with partner regions to adopt regional RH Programs that also included funding for contraceptive procurement. The political hurdles in the regions were much the same as those at the national level, but eventually 13 of the project's 15 partner regions included these funds, authorizing a total of $12.8 million in local currency over the 10-year life of the Program. After that, there was an annual process, both at the central level and in each region, to ensure inclusion of funds in each year's budget and then to actually mobilize the money. TfH worked with its partner regions to craft persuasive arguments and to show the results of the Program in the previous year in order to help the regions win funding at each step in the process.

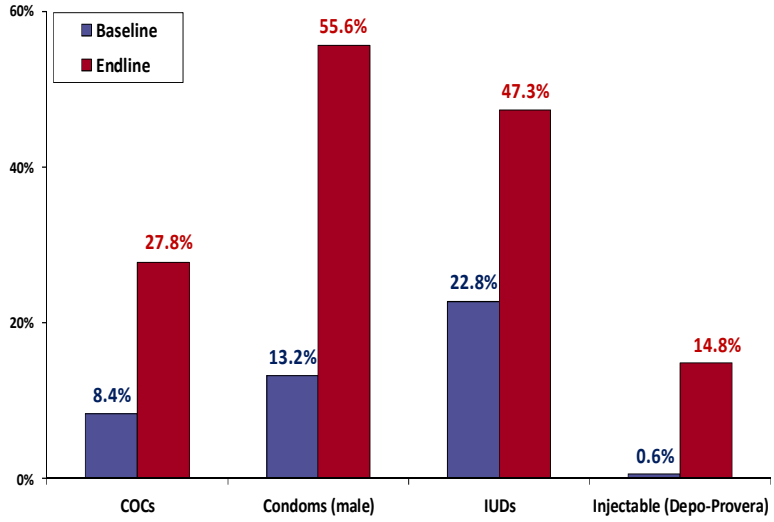
Centrally, the MOH managed to mobilize money for contraceptive procurement each year, although not always at the full funding level authorized. It spent the local currency equivalent of a little over $400,000 between 2008 and 2010, with the highest spending level in 2010, at somewhat more than $160,000 in local currency. At the regional level, it was challenging to win funding for the political reasons already outlined, but the level of planned spending increased each year, although actual expenditures never lived up the levels planned—often because funds were released so late in the year as to preclude procurement. However, 11 of the 15 TfH partner regions were successful in mobilizing funds and procuring contraceptives, spending over $400,000 in local currency between 2007 and 2010, with expenditures peaking in 2008 at almost $230,000. However, when the economic crisis hit Ukraine in 2008, Government at all levels had to make deep across-the-board budget cuts and contraceptive procurement often lost out. By 2010, only seven of the partner regions managed to mobilize money for contraceptive procurement and regional expenditures fell to a bit over $53,000 in local currency. Overall, the central and regional Governments spent the local currency equivalent of almost $900, 000 for contraceptives over the four years.

It is noteworthy that the MOH and regions that received technical assistance from the project managed to mobilize and spend more of the authorized funds for contraceptive procurement than other regions: the MOH spent 72.1% of its authorized funds and TfH partner regions spent 33.5%, versus only 29.8% in non-TfH regions.[vii]

Once funds were available for procuring contraceptives, the project set out to help Government counterparts use these funds as effectively as possible and to conduct fair and transparent procurements. There were several overriding challenges faced by the project in this respect. The first was to help partners estimate the number of people in need of free contraceptives based on the four eligible populations specified in the SPRHN, and then estimate the quantities of each method to be procured. The MOH and regions had to be convinced that meeting the contraceptive needs of the population involves making a *range* of methods available—and not just procuring IUDs because of the effective, long-term protection they provide or simply procuring the latest brand being promoted by one of the pharmaceutical companies. As a result of these efforts, some regions, most notably Lviv, Poltava, Vynnytsya, or Dnipropetrovsk*,* actually went ahead and procured a mix of different methods.

Another procurement challenge was to stretch the very limited funds available so that as many couples as possible would benefit. This meant procuring the cheapest product meeting specifications and quality standards, rather than the latest, most expensive brands and methods. TfH provided information about different brands of chemically identical contraceptives to partners, helping them to make informed decisions. And it encouraged them to open up the competitive bidding process by using specifications for the desired commodities, rather than brand names. Some regions went on to adopt this good practice.

Figure 19: Increased Availability of Free Contraceptives in Health Facilities



Source: TfH baseline and endline assessments

Toward the end of the project, more formal work on procurement was initiated, following an assessment of the current procurement system conducted by a USAID/DELIVER project consultant. TfH worked with two MOH departments to draft technical procurement guidelines for contraceptives, with an emphasis on gaps identified during the assessment. It also worked with the MOH and Kyiv National University, which is certified by the Ministry of the Economy to conduct procurement training, to draft a three-day training program for procurement of RH products. This work, however, remains to be completed.

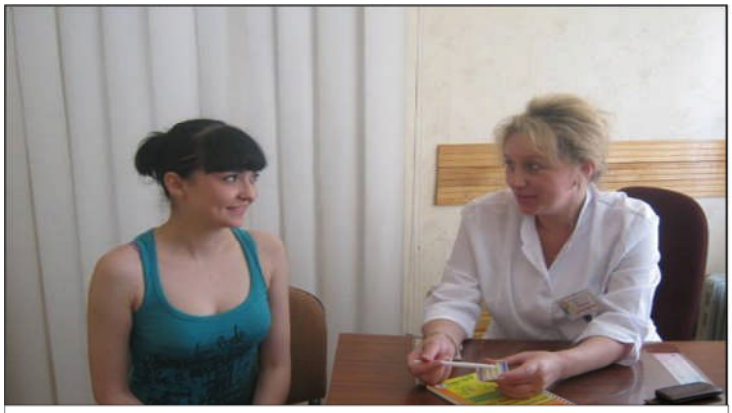
The result of all this work was that, at the end of the process, project assessments in seven regions found significantly increased availability of free contraceptives at health facilities, as can be seen in the Figure 19 above.[xix] It is believed that such an important increase in availability was mainly due to the substantial USAID contraceptive donation (described below) and secondary due to GOU procurement improvements.

Contraceptives became more accessible

The project began the task of helping USAID order, import and distribute a contraceptive donation to Ukraine by facilitating a decision between the MOH and USAID that the donated contraceptives would support the Government's agenda of providing access to free contraceptives for the four population groups defined in SPRHN and that priority would be given to targeting the donation to family doctors and primary health care (PHC) providers trained by the project to start providing family planning services. The targeting strategy was important because, to the extent that free contraceptives had been available in the past, they had only been distributed by health facilities providing women's health care—and not PHC providers. The expectation was that having free contraceptives would encourage newly-trained, but reticent, health workers to actually provide FP/RH services.

The process of ordering, shipping and importing the USAID donation was complicated and time-consuming, taking about two and half years and is documented in more detail in Annex 3. Many factors contributed to this, including the complex and ever-changing requirements of Ukrainian legislation and regulation and a shift in the supplier of USAID-donated oral contraceptives in mid-stream. An important factor, too, was new

Government restrictions on accepting donated drugs not already registered in Ukraine, following a major public scandal in 2008 about a child's death after receiving a dose of donated vaccine not already registered in-country. The entire process involved obtaining several resolutions from the Cabinet of Ministers, submitting product samples for quality testing, gathering reams of original documents from all over the world on the products to be donated, identifying a Ukrainian NGO as the recipient of the donation, collecting numerous documents for Customs—and other steps.



A young woman in Vinnytsya Oblast receives counseling before getting USAID-donated pills. *Photo: Natalia Antonyuk*

Ultimately, almost 1.8 million cycles of *Microcynon* combined oral contraceptives, 288,000 *Optima* IUDs and 57,600 vials of *Depo-Provera* (with syringes) were imported. Once these were released by Customs, they were quickly transferred to partner regions and training was provided to almost 2,800 providers and administrators on their distribution. The training centered on use of the Logistics Management Information System (LMIS) developed by the project to ensure that the contraceptives reached the intended beneficiaries and to provide accountability in the use of stocks. The LMIS tracked the quantities of each contraceptive method distributed from the central to the regional level, down to the district/city level, and finally on to individual health facilities. The system worked in reverse to report each quarter on the quantities used and how many people in each eligible population group benefited from donated supplies. The LMIS allowed each level of the health system to track consumption and project the quantities needed to ensure an uninterrupted supply. The system was automatised duirins last project year and became electronic at the central, regional and (some) district/city levels (http://www.tfhcc.org.ua/), but paper-based at the health facility level and was formalized in MOH policy.[xxii] TfH supported the Ministry in consolidating the data at the national level for Government reporting purposes and for reporting to USAID.

In addition to working on distribution of the USAID contraceptive donation, TfH worked closely with the HIV-AIDS Alliance as early as the second project year to order, import and distribute condoms for prevention of HIV and STIs. While the Alliance distributed condoms through AIDS Centers and NGOs, TfH concentrated on working with partner RHDs to distribute them through PHC facilities for STI prevention, reinforcing the messages in the project's clinical training and BCC activities. A total of about 10.5 million condoms were distributed.

- A total of more than 400,000 people benefitted from the USAID donation: 60% of them from low income families, 26% youth aged 18-20, 11% women at risk of pregnancy and 3% women living with HIV. It is clear that TfH's efforts to expand the eligibility criteria for free contraceptives was of enormous benefit to groups who chose to use contraception, as compared to the old criteria of benefiting only women for whom pregnancy would be a health risk[xxiii].
- A total of over 360,000 new couples from vulnerable populations (identified in SPRHN) were provided by free contraceptives donated by USAID or procured by Government—rising from 65,000 in 2007/2008 to 158,000 in 2010/2011.

The affordability of contraceptives improved

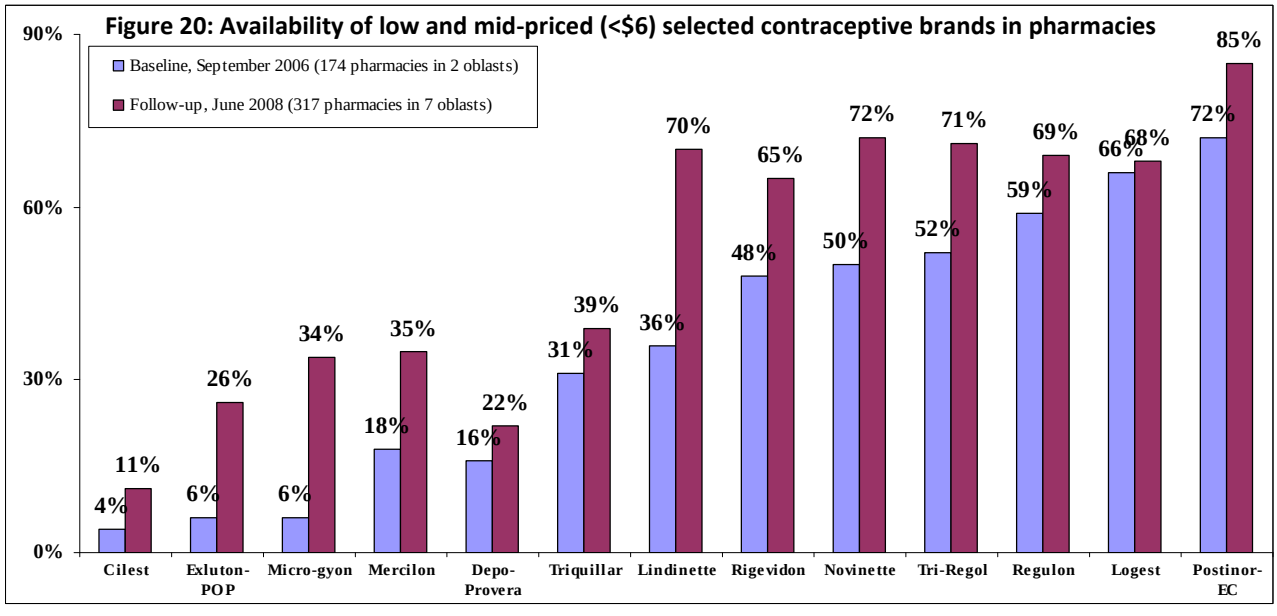
To launch its work with the private sector, TfH began by brokering a Public-Private Partnership (PPP) between seven Private Sector Partners (PSPs)—contraceptive manufacturers or distributors and a pharmaceutical market research firm—with the MOH as the public sector partner. Under the partnership agreement, MSD (Organon at the time) reduced the prices of two oral contraceptive products nationwide by almost 50%, including the only progestin-only pill on the Ukrainian market, and Tespro reduced the price of its *Pregna* (Copper-T) IUD by 15%. Other partners agreed to provide marketing support for mid- or low-priced brands they would not otherwise be promoting. Over the life of the project, the partners contributed about $600,000 in price reductions and free samples donated for the project's clinical training and BCC activities. (See page 32 for more details of the PPP.)

To support the PSP's commitments and help make contraceptives more affordable, the project also worked with pharmacists. They play a key role in providing access to contraception in Ukraine, where the prescription system has fallen apart and most people go directly to a pharmacy, rather than to a doctor, for most health concerns. At the beginning of the project, TfH's PSPs reported that 85% of users got their method from pharmacies, generally without a doctor's prescription. Later, the 2007 UDHS came up with similar findings: that over 90% of pill-users and 60% of condom-users get their method from a pharmacy.[xxiv]

Launch of the Public-Private Partnership with former USAID Mission Director, Earl Gast, former First Deputy Minister of Health, Oleksandr Orda, the Private Sector Partners and TfH staff. *Photo: Laurentiu Stan*

So TfH worked with faculty members from academia to develop a one-day training program for pharmacists, supplemented by a reference manual, to ensure that pharmacists have accurate, up-to-date information about modern contraception for their customers and to build support for increasing the availability of a range of affordable contraceptive methods in their pharmacies. A key point of the training was to dispel misinformation about the relationship between high-priced contraceptive brands and quality. A cadre of 232 trainers was prepared, mostly from pharmacy departments in universities or from pharmacy chains—almost all of them in positions where they could pass on the new information in their professional capacities as well as through TfH trainings. Pharmacists who participated in the project workshops were asked to stock a range of modern methods, including affordable brands, and to display a poster and free brochures for clients on the contraceptive methods in exchange for a logo to place on their door (see page 27) and promotion of the logo by the project. They also received monitoring/follow-up visits by the project's market research partner, SMD, during its ongoing visits to pharmacies, with a short specific message on FP conveyed during each wave of visits. For example, "Most women can use low-dose combined oral contraceptives safely and effectively" or "Oral contraceptives can be started immediately after a woman has had an abortion or at any time recommended by her physician." The training was also reinforced by articles in pharmacy newspapers and journals.

The project trained 2,786 pharmacists (94% women, 6% men), bringing about substantial changes in their knowledge, from an average pre-test score of 55.9% across all the groups to 85.5% at the post-test. More importantly, there was significant progress in terms of participating pharmacies stocking a broader range of methods and improved availability of the cheaper brands as can be seen in the graph 20 below. This was likely due to the synergistic effect of the PSPs' efforts and the pharmacy training coupled with clinical training and BCC. Unfortunately, once the pharmacy trainings were discontinued, these improvements stalled.



Source: TfH pharmacy baseline and endline assessments in Lviv and Kharkiv regions

A pharmacy in Kharkiv displays the "FP-friendly" logo and TfH brochures on contraceptive methods. *Photo: Natalia Rakhmail*

Pharmacy training, however, proved to be more complicated than clinical training. It was difficult to convince pharmacy chains to release their staff for training, because for them time is money. And pharmacists themselves often did not see the benefit of learning about contraception, which was a tiny market for them. Moreover, pharmacists were reluctant to display project materials because they were accustomed to being paid by pharmaceutical companies to display posters and other materials.

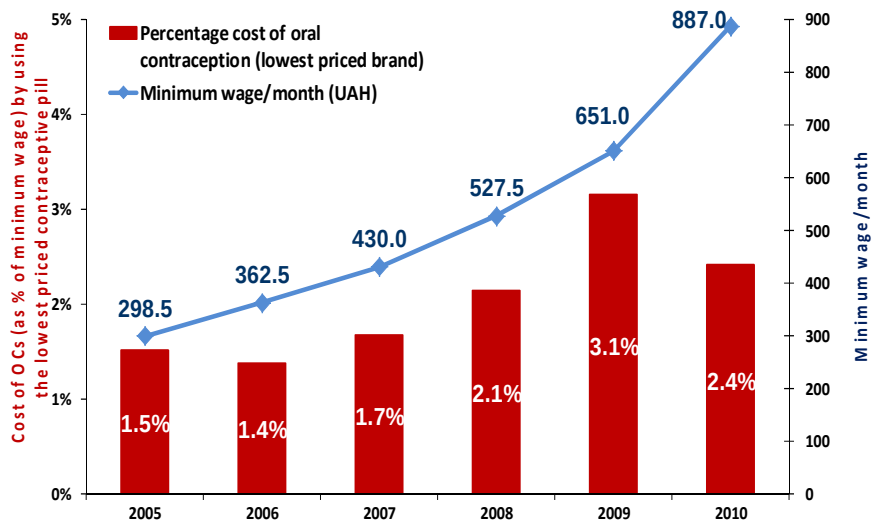
Thus, the project shifted strategies to work with pharmaceutical education. It supported a working group from pharmaceutical departments in medical schools to incorporate updated contraceptive information into postgraduate pharmacy education, which all pharmacists are required to take once every five years. The resulting manual, *Pharmaceutical Care for Contraceptive Use*, was approved by the MOH and MOES for use in postgraduate pharmacy education. The material is now a formal part of these academic programs and every pharmacy department in medical schools around the country has TfH-trained faculty members to teach the material, ensuring that, over time, practicing pharmacists will be exposed to the new information in a sustainable way.

Looking at the big picture of how contraceptive availability (including private sector sales and some free distribution) changed over the life of the project:

- The total number of CYPs (public and private sectors) in Ukraine as a whole grew more than 50% from 485,655 in 2005 to 745,857 in 2011. In TfH's 15 partner regions it increased more steeply—by over 60%--from 328,065 in 2005 to 529,900 in 2011.
- The number of CYPs from condoms increased about 80% nationwide, from 155,377 to 280,986. In TfH's partner regions, it grew more slowly—only 53%--from 122,170 in 2005 to 187,018 in 2011.
- Although various project assessment and monitoring data, as well as independent sources, noticed improvements in supplies availability and affordability, the endline assessments and end of project statistics data (GOU) revealed that these changes were relative and not conclusive (see Figure 21 below and Figure 22 at page 34).

Figure 21: Population Ability to Pay for Oral Contraceptives, Ukraine, 2005-2010

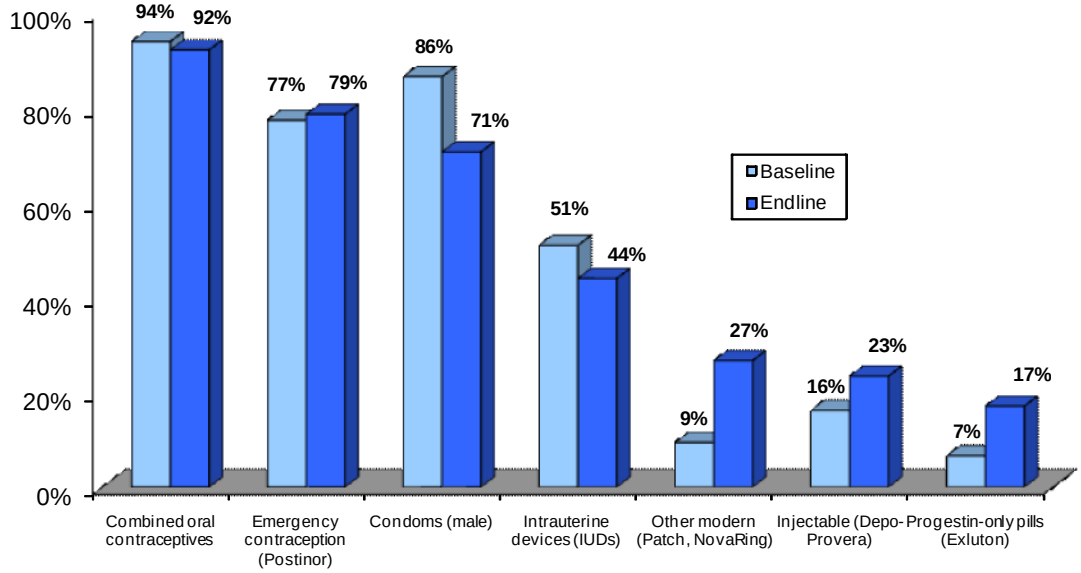
For example, project calculations on the price of contraceptives relative to the minimum wage showed a worsening of the situation as compared with 2005. One cycle of the cheapest COC on the market in Ukraine was priced in 2005 at around $0.9, while in 2010 at around $2.6. Consecutively, in 2005 the cheapest COC cycle cost was 1.5% of the minimum monthly wage ($60/month), while in 2010 it was 2.4% of the same minimum monthly wage ($111/month). A the beginning of the project, the minimum wage could have bought 66 cycles of the lowest priced COC brand, while in 2010 it could have bought 44 cycles of the lowest priced COC (see Figure 21 at left).[vii]



Source: Support in Market Development and GOU Statistics Committee

- Finally, project surveys of about 500 private pharmacies showed controversial results (see Figure 22 below). In one hand the availability of lowest priced COCs (less than 20 UAH/cycle) halved, but the overall availability of at least one COC brand stayed high at over 90%. The availability of affordable condoms (≤6 UAH per 3 pack) declined from 83.8% to 59.8%. Like COCs and condoms, the availability of affordable IUDs (≤25 UAH per unit) decreased. Like COCs, there was a slight decline in the availability of IUDs between the time periods, although it is not statistically significant. Despite the financial implications of the overall Ukrainian economy on pharmaceutical profit margins, the TfH project saw remarkable success in terms of the proportion of pharmacies carrying injectables, POPs, the patch and the ring. [xix]

Figure 22: Population Ability to Pay for Oral Contraceptives, Ukraine, 2005-2010



Source: TfH baseline and endline assessments in seven regions

The limited progress in contraceptive affordability and availability in the private sector may be explained through the changes determined in Ukraine by the international financial meltdown: a rapid devaluation of the local currency drastically reduced the population purchasing power, while the average price of retail contraceptive prices increased, probably due to pressures on maintaining companies' revenues at an acceptable level. The decrease in affordable options is of concern, although it correlates with the decline in the Ukrainian economy and the increase in contraceptive prices following on the depreciation in value of the local currency.

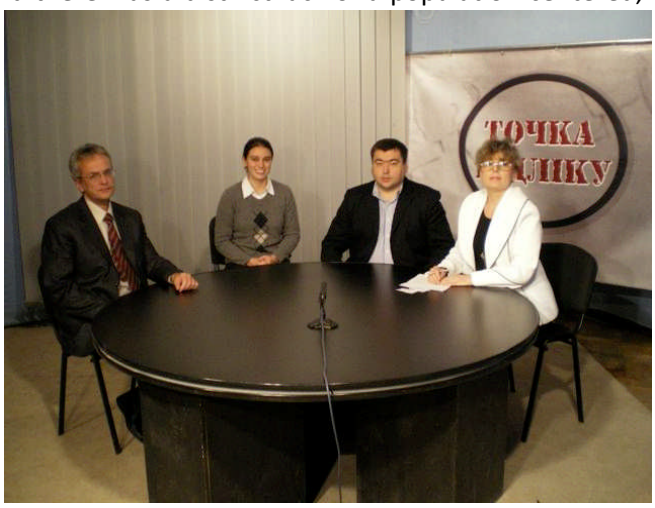
Intermediate Result 4: Increased capacity and commitment of the public and private sectors to support policies and systems for improved RH.

At the start of the project, the National Program *Reproductive Health 2001-2005* was set to expire and the USAID Policy Project was working with the MOH and other partners to extend it. TfH was charged with continuing this work and thus had the opportunity to shape a new national RH Program building on the momentum of the existing one. Project staff saw this as an opportunity to build a sustainable platform for Government investment in FP/RH; a vehicle to strengthen management of these services; a dissemination platform for FP policy and program interventions (to share best practices); and to reinforce the importance of Government support for FP/RH. Adoption of a new national RH Program, and effective implementation of the Program, would constitute compelling evidence of Government commitment to FP/RH.

TfH also recognized that FP/RH management in the public sector, at all levels, needed to be strengthened. Following Soviet tradition, program managers generally awaited orders from above, rather than taking responsibility for making changes themselves. Management tended to center on issuing orders; investing in buildings, drugs and equipment; assigning skilled personnel; and keeping health workers on their toes with

frequent inspections. The orientation was very clinical and there was a distinct lack of a population-centered, public health perspective. Transparency in program and budget decisions was an alien concept.

With FP/RH services provided almost entirely in the public sector—except for pharmacies, many of which are privately owned—the private sector amounted to contraceptive manufacturers and distributors. The latter interacted with the MOH on matters concerning their business interests and they made important contributions in providing clinical updates to doctors and educating the population, but they had not been engaged with the national RH program or with broader issues of improving access to contraception. Since expansion of the contraceptive market was in their best interests, it was clear that the project needed to work closely with these private sector partners (PSPs.)



Representatives from Poltava Oblast Health Department and TfH discuss the Oblast Reproductive Health Program on local television.

The main emphases of TfH's work to build public and private sector capacity and commitment were:

- Building a sustainable platform for FP/RH through the State Program *RH of the Nation* (SPRHN);
- Strengthening FP/RH management, especially at the regional level;
- Building the commitment of contraceptive manufacturers and distributors to improving FP information, products and services.

Built a sustainable platform for FP/RH through SPRHN

In working with the Government to renew the RH Program, TfH's challenge was to incorporate some critical preventive health approaches to FP/RH and to break the existing mold of using national programs largely to procure high-priced medical equipment and drugs deemed necessary by the MOH in Kyiv. Then, assuming the Program was adopted, the next step would be to support more effective Program implementation by advocating for GOU investment in FP/RH and promoting greater transparency in the allocation and expenditure of funds. A special challenge at every step in the process would be the Government's strongly pronatalist policies and the general perception among policy-makers that FP was a population control measure that would accelerate population decline.

Development of the new Program was a lengthy process, starting with a concept paper and global budget that had to be adopted by the Cabinet of Ministers before proceeding to develop the full Program, following strict regulations on the format of National Program objectives, activities, budgets and indicators. While the MOH took the lead, the Ministry of Education and Science (MOES), Ministry of Family, Youth and Sports (MFYS) and the National Committee for Radio and TV were involved since they would be partners in implementation. The ministries of Finance and Economics were also closely involved in their roles as financial watchdogs and overseers of the macroeconomic situation. The latter proved to be challenging partners, since they took it upon themselves to make programmatic decisions in order to cut the Program budget. Most notably, they sought to delete the budget for contraceptive procurement in the Program.

The *State Program "Reproductive Health of the Nation" (SPRHN) up to 2015,* as finally adopted by the Cabinet of Ministers in December 2006, aimed to improve the demographic situation and the socio-economic potential of the country and authorized a potential investment of almost $150 million over a 10-year period for five overriding objectives:

- Making pregnancy safer;
- Preventing unintended pregnancy and improving adolescent RH;
- Improving FP services, reducing unintended pregnancy and abortion, and increasing contraceptive use;
- Reducing the incidence of cervical and breast cancer and STIs; and
- Strengthening the management and implementation of FP/RH programs at the national and regional levels.

Measures of success would be reduced maternal and infant mortality, fewer unintended pregnancies, decreased rates of abortion and STIs, increased contraceptive use and decreases in certain RH morbidities.

Within the FP objective, the SPRHN authorized the equivalent of $21 million in local currency for FP over the 10 years, including $17 million for contraceptive procurement, and it expanded the eligibility criteria for free contraceptives (see page 37) Other FP activities included the development of standards/protocols for FP service provision in line with WHO recommendations, postgraduate training for doctors on FP/RH counseling, and public education campaigns.

Adoption of the SPRHN was significant for several reasons. It was the first time the Government had allocated significant budget resources for FP, including funds for contraceptive procurement for vulnerable populations—a major step forward in a pronatalist environment. In addition, the program was well-structured, paralleling WHO's Reproductive Health Strategy and introducing concepts specific to Millennium Development Goals. The new Program also went beyond the traditional approach of National Programs in the health sector in Ukraine, which generally focused on procurement, instead of adopting more public health-oriented strategies with greater potential to benefit the population and reduce corruption. These included updating policies, training health workers, educating the population, procuring preventive medications, conducting research, and improving overall program management.

Adoption of the national Program, however, was only the first step in an ongoing process that involved helping regions advocate for adoption of their own regional RH Programs and then actually mobilize funding on an annual basis to implement them.

The experience of helping advocates promote adoption of SPRHN and the recognition that advocacy for the Program would be an ongoing process, led TfH to develop an "advocacy package" to help convince policy-makers that FP is an essential health intervention with important social benefits and that it has little or no impact on fertility rates in countries such as Ukraine where fertility is already very low. TfH partner Harvard School of Public Health developed a publication entitled *The Rationale for FP in Ukraine: Evidence from Europe, Eurasia and the US*[xxv] that marshaled the evidence that:

- FP is a human right;
- Contraception is safe and benefits health, especially maternal and child health;
- Contraception can lower use of abortion;
- The benefits of FP outweigh the costs; and
- Most governments support FP and free or affordable contraceptives as critical public health measures.

Arguments from this publication proved invaluable to justify including FP in regional RH Programs and to help mobilize funding, especially for contraceptive procurement. Indeed, USAID in Washington recognized the value of the publication for much of the former Soviet Union—where many countries are making the transition from abortion to contraception in the context of rapid population declines—and asked the Europe and Eurasia Regional FP Activity to adapt it for use throughout the region.[xxvi] With this document in hand, TfH worked with selected NGOs to join with RHD officials in advocating for funding of regional RH Programs, using the "advocacy package." Later, when reports on activities and results became available, these were important tools for advocacy, too.

In working at the regional level, TfH promoted an open, democratic process for Program development and use of the evidence from the "advocacy package" to argue for the Program—both new concepts in Ukraine. The project promoted establishment of regional coordinating committees to design regional RH Programs, with representation from different Government agencies involved in implementation, from local authorities and service providers, from mass media as well as NGOs. Some regions were more transparent and democratic than others in developing their programs but the most progressive (e.g. Dnipropetrovsk, Vinnytsya, Poltava) held public consultations, presented the draft Program at meetings, conferences and on the regional administration's web site.

To facilitate the complex process of Program development at the regional level, the project worked with the MOH to develop an RH Program planning tool. This included all key documentation governing State Programs and their implementation, templates for the required regional concept papers and program descriptions, along with an automated Excel file that greatly simplified the process of planning activities, indicators and budgets over the 10 year period.[xxvii] The tool allowed regions to plan their Programs by simply filling in blanks and letting pre-programmed formulas calculate budgets and indicators over the years. It was presented to

regional officials at a national conference cosponsored by the MOH, TfH, the Health Policy Initiative and MIHP, and was used by almost all regions to develop their Programs. The tool was greeted with great interest and enthusiasm by staff of the parliamentary health committee, the MOH State Programs Department and Ministry of Finance officials as a model for planning future National Programs in the health sector.

Figure 23: Twenty-one Regions Allocates Funding through Adoption of Local FP/RH Programs, Ukraine, 2007-20011

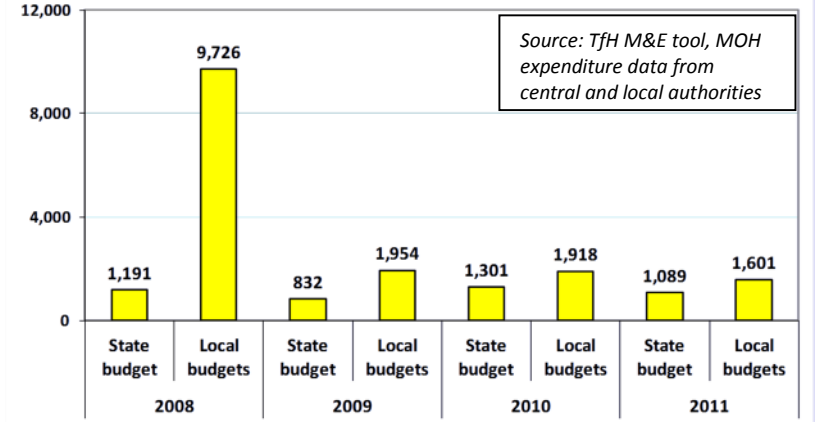
Source: MOH official documents

With the MOH encouraging regions to adopt RH Programs, eventually 21 of the 27 regions in Ukraine did so, including all TfH partner regions except AR Crimea and Donetsk.[xxviii]. This was another significant "first" for Ukraine, since regions hadn't traditionally adopted local Programs in line with National Programs (see Figure 23). The 21 regions authorized initially about $28 million for FP, including $24.5 million for contraceptive procurement. The regional committees that had taken the lead in developing regional RH Programs evolved into regional coordinating committees (RCCs) after Programs were formally adopted.

Project staff worked with these committees to use their meetings to plan advocacy for Program funding, to determine Program priorities, plan and coordinate activities at the regional level, review accomplishments and identify issues and gaps that need to be addressed. It also tried to foster more transparent government and decision-making about public funds, with some regions bringing in mass media representatives to disseminate information on Program plans and accomplishments to the broader public. The project also supported a National Coordinating Committee for the SPRHN at the central level and collaborated closely with its working groups responsible for clinical, BCC and policy activities under the Program.

Another important project contribution to SPRHN implementation was the development, with the MOH, of a monitoring and evaluation (M&E) tool[xxix] (along with a users manual) that allows for uniform data collection from the regions about Program activities, funding and indicators at the regional level and below and that automatically consolidates information to facilitate preparation of reports at the regional and national levels. The tool was launched and demonstrated at a national conference sponsored by the MOH and TfH and it was used by almost all regions to report on their RH Programs. It greatly simplified data aggregation and the preparation of regional reports and the Ministry's annual report on the Program to the Cabinet of Ministers. The M&E tool also became an important vehicle for accountability as project staff encouraged counterparts to use the data produced by the tool to demonstrate the results of the Program to Government authorities at all levels, to RCC members and the media and to advocate for funding.

Figure 24: FP Objective Expenditures within SPRHN, Ukraine 2008-2011 (thousand UAH)



Continuous advocacy for FP produced results. Between 2008 and 2011, over 19.5 million UAH (~$3.3 million) were spent for the FP objective–about 4.4 million UAH at the central level and 15.2 million by regions. The MOH and regions that received technical assistance from the project spent a larger share of their authorized FP funds than regions that didn't receive this assistance. Unfortunately, just as the Program was getting off the ground in 2008, the economic crisis led to sweeping budget cuts at all levels of Government that took a heavy toll on SPRHN. Overall central and local budgets spending on FP/RH plummeted from 10.9 million in 2008 to 2.7 million in 2011[xxxviii] (see Figure 24 above).

FP/RH management was strengthened, especially at the regional level

A key TfH strategy to strengthen management was to use the SPRHN to help the MOH and regional authorities see how FP/RH could be managed in ways that could bring larger benefits to the population than traditional approaches taken in national Programs.

- Project staff helped counterparts recognize that Government has a responsibility to focus scarce public funds on poor and vulnerable populations that might not otherwise be able to obtain services. It did this by targeting Government contraceptive procurements to some of the neediest populations, as outlined on pages 29-30.
- Another approach was to work with counterparts to use their contraceptive procurement funds cost-effectively, buying products by specification rather than by brand name, so they would benefit as many people as possible.
- It helped government officials better manage FP/RH activities in their regions by using RCCs to strengthen and advocate for FP/RH. It worked with them to advocate for these activities and services, to assess needs for services and commodities, to establish priorities, to coordinate related programs and projects in their territories, and to use data objectively to plan and evaluate programs.
- It fostered accountability by using the SPRHN planning, M&E and LMIS tools and helping regions to share the information coming from these tools with a broader audience and to use the data for decision-making about Program management.

The project worked closely with Regional FP/RH Centers (RFPCs), which had been minimally involved in FP/RH in most regions when the project started, to help them provide leadership for their regional RH Programs and become resource centers in their regions to lead FP efforts in the future. RFPCs played a pivotal role in all facets of the project's work. By the end of the project, they had a track record of advocating for and managing their regional RH Program, they had extensive exposure to modern public health management techniques; they had experience in organizing CME events using cadres of clinical trainers and experts to update front-line service providers on modern, evidence-based information and approaches to FP/RH; they were connected to a cadre of BCC educators and to NGOs to help educate the public; they had reference manuals, training models, IEC materials and other resources; and they had a functioning LMIS for contraceptive distribution.

The project encouraged sharing of Program results, successes, best practices and lessons learned between regions and at the national level. Regions that were quick to adopt their RH Programs shared lessons learned about Program development, adoption and implementation with those following on later. They also shared their experiences in expanding FP provision to family doctors and mid-level staff, in conducting BCC activities and campaigns and other activities. At national conferences on the SPRHN, the most successful regions presented their work to a national audience and a few regions had the opportunity to present to the SPRHN National Coordinating Committee.

As a result of TfH's work, majority of partner regions were implementing SPRHN more effectively and accountably, drawing on the M&E tool, the LMIS and RCCs.

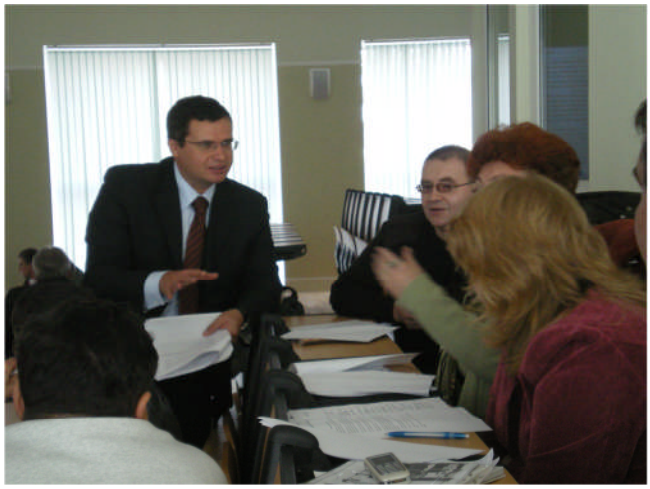
A Participant in TfH's Management Training comments…..

"This training is not typical, because it draws on concrete Ukrainian experience, and often we had teachers with no practical experience, but a great academic background. We also had the opportunity to attend a training formally accredited by one of the most respected institutions and we were able to discuss real issues with lecturers and trainers with a long track record of practical experience."

Beyond using SPRHN as a vehicle to strengthen program management, TfH partner Harvard School of Public Health worked with the Department of Public Health Management at NMAPE to develop a training course introducing public health-oriented approaches to FP/RH for health care managers going through mandatory postgraduate education. The course was based on a book developed by NMAPE faculty with TfH/Harvard assistance, *New Approaches to Teaching Management of Family Planning & Reproductive Health Services: the Case Approach*[xxx]. The book addresses the most critical topics in FP/RH program management identified by a working group and TfH: a public health approach to planning, promoting healthy lifestyles, use of information, the role of the manager, quality of care and client-centered care, managing human resources and financing. Also important, the course adopted a case-based teaching methodology, which was new in medical schools in Ukraine. A lengthy process of mentoring NMAPE faculty in how to research, write and teach case studies based on Ukrainian experience planted the seed for this effective method of teaching management to be used more widely in medical education. While only a few managers in project oblasts benefited from management training provided by the

project, the course was formally adopted by the MOH as a part of the curriculum for postgraduate medical education, making it a sustainable program that would benefit large numbers of health care managers in the future. Indeed, as the project was ending, NMAPE faculty were teaching modules from the program and orienting their colleagues to case-based teaching methods.

TfH also helped the MOH broaden the base of support for FP/RH by involving new stakeholders. These partners showed that they could serve as a valuable springboard to broaden public understanding and support for a sensitive topic. These included many players involved in BCC: MFYS and social services for youth, the education system, mass media and NGOs. A foundation was also laid for closer collaboration between Government and PSPs.



NMAPE faculty facilitating an interactive training session by using the case-based technique.

Adoption of policy, particularly at the national level, is clear evidence of institutionalization. A total of 72 policy documents in support of FP/RH were adopted by the Government over the life of the project: 31 at the national level and 41 at the local level. Key policies have already been mentioned in this report and include the SPRHN and local RH Programs, clinical standards and protocols, documents endorsing material for inclusion in the academic curriculum and policies indicating commitment to BCC.

Built the commitment of contraceptive manufacturers and distributors

TfH embarked on a Public-Private Partnership (PPP) with pharmaceutical manufacturers and distributors in order to increase access to mid- and low-priced contraceptives in the private sector and in recognition of their long-term stake in expanding the contraceptive market in Ukraine.

The PPP was launched at a high-profile signing ceremony with the First Deputy Minister of Health, the USAID Mission Director and all seven private sector partners, in front of the media. Its aim was to improve the provision of quality, affordable FP services and supplies by making available a broader range of modern contraceptive methods through public and private providers at affordable prices, along with accurate information. Initial partners were:

- Bayer Health Care (formerly Bayer-Schering Pharma), contraceptive market leader in Ukraine
- Jansen-Cillag, manufacturer of hormonal contraceptives
- Medcom, Ukraine's largest condom distributor
- Tespro, importer/distributor of IUDs
- MSD (formerly Organon, then Schering-Plough), manufacturer of hormonal contraceptives
- Richter-Gedeon, manufacturer of several mid- and low-priced contraceptive brands
- Support for Market Development (SMD), a pharmaceutical market research firm

The partnership evolved over time, with some of the initial partners becoming less active and new ones entering:

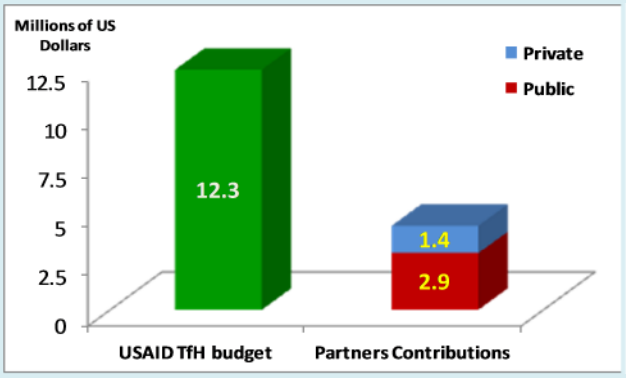
- Berlin-Chemie Menarini, oral contraceptive manufacturer
- Innotech, a major spermicide and condom manufacturer
- Sperco, a major spermicide manufacturer

As described earlier, under the partnership agreement, MSD (Organon at that time) and Tespro reduced the prices of some contraceptive products; other PSPs agreed to provide marketing support for mid- or low-priced brands they would not otherwise promote; all the partners undertook to contribute contraceptive samples for TfH training and public education activities; Medcom contributed in-kind and direct support for BCC activities; and SMD provided contraceptive sales data from pharmacies for the partnership to monitor sales trends. The Government contribution was the activities and resources in the FP component of the SPRHN. And TfH provided the "glue" to hold the partnership together.

The project sought to link the stepped-up marketing efforts by the PSPs for affordable contraceptives with project activities, particularly its clinical and pharmacy training and BCC activities—especially promotion of the logo. It did not take long, however, for it to become plain that most of the PSPs lacked enthusiasm for the task of making contraceptives more affordable, while they were requesting other types of collaboration with the project. Sperco, however, came into the partnership and maintained the initial direction, supporting trainings for pharmacists, using the project's training materials and trainers, until the economic crisis—and slashed marketing budgets--forced it to stop.

Contributions from Public and Private Sector Partners Amount to a Third of the Project's Value

The project encouraged its public/private sector counterparts to invest in FP/RH, recognizing that this is the clearest demonstration of commitment. The Figure below shows that TfH attracted almost $4.3 million—35% of the total project value—in counterpart contributions. The public sector contribution amounted to an estimated $2.9 million from the public sector and $1.4 million from the private sector.



The public sector contribution included funds used for contraceptive procurement; workshops, roundtables, conferences and BCC events on FP/RH conducted at the regions' expense; time and space in Government-owned mass media. The private sector contribution included the value of reductions in contraceptive prices by two PSPs; mass media time and space in private media; CME and BCC events supported by PSPs; SMD's donation of contraceptive sales data; NGO cost-sharing and other items.

Bayer Health Care moved the PPP in a new direction when it expressed interest in evidence-based "detailing" for oral contraceptives, using the CATs* being developed by the project (see text box, page 16), to help them dispel the myths and misinformation that were common among ob-gyns. The project was enthusiastic about working with Bayer on this topic, since it would reinforce the messages of TfH's training in regions where the project was already working and expand the project's reach by disseminating evidence-based information about contraception throughout the country at minimal cost. Bayer asked its field forces to identify common misinformation they encountered when visiting doctors and these became the topics for CATs that were developed by TfH. Then Bayer and TfH held two joint workshops for Bayer's medical representatives and "key opinion leaders" who conducted roundtables/seminars for doctors. The workshops provided an introduction to EBM, discussed the evidence on the topics addressed by the CATs, and featured role-plays on use of the CATs when visiting doctors. Participants welcomed receiving concrete evidence to share with doctors—instead of just arguing with them as they had customarily done—and they left eager to adopt evidence-based detailing. Judging from Bayer's "consumption" of CATs after the workshops, the information was, indeed, used.

SMD, TfH's pharmaceutical market research partner, was quick to express interest in using the CATs to disseminate accurate information to pharmacists during visits to pharmacies to conduct market research. They asked TfH to train their pharmacy monitors and then sent them out around the country armed with CATs. Once other PSPs saw that Bayer had invested in, and appreciated, evidence-based detailing, they also began to show interest. Richter-Gedeon and Bayer sponsored highly successful EBM roundtables on combined oral contraceptives and IUDs for health workers in AR Crimea, using program outlines, presentations and the CATs developed by the project. Later, TfH developed another "package" for roundtables on progestin-only methods. In the final project year, Bayer, Innotech, MSD, Richter-Gedeon and Tespro were sponsoring EBM roundtables on all these topics, using the prepared programs and CATs.

Meanwhile, building on the successful collaboration on EBM, in the final years of the project, Bayer expressed interest in working with TfH on BCC activities. They identified young women students in universities as their priority audience. After reviewing TfH's BCC manual and observing educational sessions conducted by TfH-trained educators using the manual, Bayer began supporting 2-3 hour sessions conducted by TfH-trained educators, initially in AR Crimea and then, in ever-increasing numbers, in other project regions.

Many lessons were learned during the TfH project about collaboration with the private sector (see Lessons Learned, page 42), but key among them were to work with each partner individually to address its particular needs and priorities and to be willing to change course as the partners' needs change. As for the PSPs, they have gained exposure to how modern public health management approaches can help them grow the contraceptive market in systematic ways.

* CATS (Critically Appraised Topics) are one- or two-page fact sheets summarizing the evidence on a specific clinical topic.

V. Compliance with USAID Requirements on Family Planning, Abortion, HIV and Environmental Considerations

Family Planning, Abortion and HIV Requirements

The principles embodied in the USAID FP and abortion requirements lay at the very heart of what the project was seeking to do. TfH sought to help Ukrainians shift from the widespread practice of abortion to the use of modern contraceptive methods; to make a broader range of contraceptive methods available, accessible and affordable in a variety of settings; to make doctors, pharmacists, other health workers and the population aware of the benefits of contraception over abortion, and act accordingly; and to make doctors, pharmacists, other health workers and the population aware of the range of contraceptives on the market in Ukraine, along with the benefits and risks of each method, to help them support clients in making informed choices about whether to use contraception (or use it themselves), and which method to use. These principles ran throughout the project's work: its training activities, public education materials and messages, contraceptive distribution, work with pharmacies and policy activities.

It should be noted that the MOH has a number of policies in place that recognize the principles of voluntarism in FP and it has approved a range of safe and effective contraceptive methods that are available on the market. While abortion is legal, for years the Government has been seeking to reduce reliance on abortion and encourage the population to shift to contraception.

One of the first project activities was to develop a Tiahrt-compliant poster and brochure with key information for clients about the different contraceptive methods available in Ukraine, including the health benefits and risks of each one. These were widely disseminated in partner oblasts, and all participants in clinical and pharmacy trainings were given copies to display in their facilities. They were enormously popular and were widely displayed.

Early in the life of the project, TfH also developed *Guidelines on Compliance with USAID Family Planning and Abortion Requirements,* which were revised after the project began working with RHDs on distributing USAID-donated condoms as *Guidelines on Compliance with USAID Family Planning, Abortion and HIV Requirements* (see Annex 1). These guidelines (produced in both English and Ukrainian) explained in simple language each of the provisions with which JSI was required to comply concerning family planning, voluntary surgical sterilization, abortion and HIV; the project's procedures for compliance; and how to handle suspected violations. It also provided monitoring tools for health facilities, for clinical training, pharmacy training, BCC training and community education sessions. All project staff were oriented to the guidelines, received a copy and signed statements acknowledging the orientation and agreeing to ensure that TfH complied with these requirements.

When the project began working with its partner RHDs on distribution of USAID-donated condoms and contraceptives, each RHD was required to sign an Agreement on Donated Contraceptives stating that they would adhere to the principles of voluntarism and informed choice in the provision of family planning services and distribution of contraceptives; that they would display the TfH poster describing the major contraceptive methods available in Ukraine; and that health workers in facilities receiving USAID-donated condoms would provide information to clients about correct and consistent condom use.

Throughout the life of the project, staff monitored numerous health facilities, clinical and pharmacy trainings, BCC training and community education sessions for compliance with the guidelines and no violations were found.

When the NGO grant program was launched in the second year of the project, a separate set of guidelines was developed, *Guidelines for NGOs on Compliance with USAID Family Planning and Abortion Requirements*. While in many respects similar to the basic project guidelines, these were more stringent, in order to comply with the so-called "Mexico City" policy. Project guidelines laid out the following special procedures that were applied by the project:

- Screening NGOs during the application/proposal process for possible involvement in abortion-related activities;
- Visiting all NGOs that were finalists for a grant to ensure they were not involved in abortion-related activities or coercive FP practices;

- Obtaining a signed certification from each NGO that they would not perform or actively promote abortion as a method of family planning *before* receiving the grant;
- Passing on the FP and abortion provisions in JSI's Cooperative Agreement in the subgrant agreements with NGO grantees;
- Monitoring compliance once the project was under way.

NGOs were oriented to the guidelines and given copies, along with materials needed to comply. And their activities, financial and administrative procedures were closely monitored.

Environmental Compliance

From the beginning of the project, TfH included key environmental considerations in its training and technical assistance. Its five-day FP/RH training delivered to thousands of ob-gyns, family doctors, nurses, midwives and other clinicians over the life of the project disseminated best management practices related to storage, use and disposal of medical supplies. It also reinforced compliance with Ukrainian and USAID environmental protection requirements (see Annex 2). When the project began distributing USAID donated commodities, it developed Ukrainian-language *Guidelines for Proper Storage of Contraceptives and Other Health Commodities* which were distributed to health facilities together with the commodities.

TfH also developed a monitoring tool it used to assess the storage, use and disposal practices of selected health facilities and reinforce the importance of compliance with Government of Ukraine regulations on disposal of medications and medical supplies, as well as with the environmental requirements of the Government of the United States. During these field monitoring visits, TfH staff also provided consultation and hands-on training to designated personnel of health facilities to improve the medical waste use, storage and disposal practices at these facilities.

VI. Lessons Learned and Recommendations

- ***It is possible to expand and improve contraceptive services in a pronatalist environment such as Ukraine's.*** Although the Government of Ukraine has adopted strongly pronatalist policies, the MOH, RHDs and the MCH community are supportive of FP as a key MCH intervention and the most direct means to reduce abortion. In addition, most Ukrainians, especially young people, are eager for information about contraception and to find out where it is available. The TfH project was very open about working on FP/RH as a discrete program and was able to make important progress. The main political barrier was the belief among political and administrative authorities outside the health sector that FP will accelerate the country's population decline. Broad-based advocacy is needed to convince these opinion leaders that FP is critical to improve the health of mothers and babies in Ukraine and that most developed countries include it in health benefit packages.
- ***TfH's experience with the SPRHN has shown that a strong focus on policy implementation has the potential to build a sustainable national FP/RH Program for Ukraine in the longer term.*** Through the SPRHN, the Government has laid out a framework for a more public health-oriented approach to FP/RH; has begun to implement this approach; has invested Government money in FP/RH, including for contraceptive procurement; has developed more effective program management skills; and the more progressive regions have instituted more open, democratic procedures for governance. However, in an environment where national Programs have traditionally been all about procurement by the MOH, bringing about these modest steps forward has been very labor-intensive. Much more work is needed, even in TfH's 15 partner regions, to sustain the momentum, to maintain and increase financial investment in FP/RH and to deepen Program managers' understanding of the Program's potential.

  In other regions, where TfH has not worked to date, the current tools for SPRHN Program management should be rolled out: the M&E tool for reporting on SPRHN activities, indicators and expenditures and the web-based LMIS for free contraceptives. In addition, the RCC mechanism should be supported as a means for more effective, transparent Program implementation. In addition, at the central level, efforts to identify an individual or group to manage SPRHN need to be pursued. And in an effort to keep SPRHN and FP/RH on

the national agenda, policy dialogue should address national and local SPRHN implementation in the context of current health reform efforts*.*

- ***SPRHN will come up for renewal in 2015 and it would be beneficial to have an independent review by local and international stakeholders*** (MOH, UNFPA, USAID, WHO, NMAPE, etc.) of Program implementation and the results achieved as well as an examination of the FP/RH needs for a follow-on Program.
- ***The project's systems approach, represented by the triangle on page 12 proved effective.*** By linking (1) clinical interventions with (2) BCC and (3) efforts to improve the availability of free and affordable contraceptives at the regional/district level, TfH effectively improved the supply of FP services and supplies at the same time as building up demand. It is unlikely that the project would have achieved such positive results if all three sets of interventions had not been included or if they had been separated into different projects.
- ***The project's innovative approach to scaling up proved effective.*** The core of TfH's approach to expand coverage to more than half of Ukraine's regions, covering almost two-thirds of the Ukrainian population, was:
    - "Twinning" regions, so that a region that had been in the project for some time took a lead role in mentoring a neighboring region with which it had good relations: sharing its accomplishments with the "new" region, describing how the project worked, hosting a study tour, sending its most accomplished trainers and educator, etc.
    - Building on the practice of regions convening health workers for various technical and management updates to have them use those meetings to conduct one-day and half-day mini-trainings on FP/RH to reach thousands of health workers in districts where the project was not working. The regions drew on TfH trainers and training materials for these sessions and the project provided key reference materials.
    - Seeking to reach more than half the ob-gyns and family doctors in as many partner regions as possible, so there would be a critical mass of providers to influence the practice of others in the region.
- ***Working with the MOH is essential—but results of work at the regional level are faster and more apparent.*** The MOH is a critical partner because of its national policy-making role and because it still retains substantial control over regional health programs and budgets. However, the MOH is under-staffed, suffers from frequent turn-over in mid- and senior level managers and is continuously buffeted by the political winds. Working with regions brings more rapid results because there have more staff in managerial and senior technical positions, staffing is more stable and the regions are closer to the people, so they need to respond to their needs. TfH's experience of working with the regions was mostly positive. They were willing to write proposals to compete for participation in the project, they were open to new ideas and they were effective in rolling out project interventions and investing their own resources to expand the reach of project interventions. Nevertheless, it would be impossible to work *only* at the regional level, because of the MOH's role in approving project activities and also because new and successful approaches would not be understood and institutionalized at the national level. In the long term, however, staffing both in the MOH and RHDs needs to be expanded, so they have the capacity to actually manage programs effectively, now that their role has expanded beyond passing on decrees to lower levels of government.
- ***Working groups are a best practice to build support among opinion leaders for new, evidence-based approaches and to build sustainability for project activities.*** The project undertook almost all of its policy development work—from training curricula and protocols to lists of activities to be conducted during FP Week—through working groups on clinical, BCC, commodities and policy. These working groups were invaluable in facilitating adoption of the policies and ensuring a network of important supporters to build momentum for implementation of the new policies.
- ***Sustain and expand the TfH gains in building the FP/RH capacity of PHC providers.*** The project made important gains in expanding the scope of work of PHC providers in FP/RH, with large numbers starting to provide these services for the first time. This success was achieved through:
    - Adoption and dissemination of policy authorizing this scope of work;

- A one-week competency-based training course that provided FP/RH information and skills, including a strong counseling component;
- Linking PHC providers with nearby ob-gyns in the same training, so they knew where they could turn for help, if necessary, and where to refer for services they could not provide themselves;
- The provision of resource materials to support the learning from the training;
- Free contraceptives to distribute to poor and vulnerable populations; and
- Short CME events to reinforce key points of the training.

As much of this package as possible should be rolled out to other regions, so it reaches PHC providers in the entire country. In addition, PHC providers in the project's 15 regions will need continuing support to ensure that they remain actively engaged in these services. The most critical types of support needed to consolidate existing gains:

- Ensuring that supportive supervision is undertaken by trained/qualified officials from RHDs and/or district health departments at least once a year, using TfH's follow-up tools;
- Continuing CME updates on FP/RH topics;
- Development of additional job aids (e.g. counseling cue-cards or flip charts) and or more reference manuals better targeted at the PHC level and needs;
- A continuing supply of free contraceptives for a minimum of 3-4 more years.

- ***Postpartum and postabortion FP training and support should be introduced around the country, including in the 15 partner regions where the project worked.*** Postpartum and postabortion FP is very much needed, as can be seen from the 2007 UDHS report which shows that only 6% of users of modern contraception get their method from a hospital[xxxi], where virtually all deliveries and abortions take place. According to the 1999 URHS, only 25% of women who had given birth recently had been counseled by a health worker on contraception after the delivery and only 4% left the hospital with a method or a prescription for one; and just 39% of women who had had a recent abortion said that they had been counseled about FP after the procedure and only 16% of women left with a contraceptive method or a prescription for one.[xxxii] TfH helped the MOH develop and approve a manual for such training and provided a full three-day training[5] for 376 provides in seven regions. However, USAID asked the project to concentrate on reaching PHC providers in rural areas, so postpartum/postabortion training was discontinued. Regions conducted conferences and short CME events on the topic which was a good start, but is unlikely to be sufficient to change providers' practices.

- ***Modern FP/RH content, competency-based skill development and adult education techniques should be integrated into pre-service medical education for ob-gyns and family doctors and, to the extent possible, into pre-service and postgraduate education for midwives and feldshers.*** The project worked with schools of postgraduate medical education and the MOH to develop modern curriculum on FP/RH and teaching methods, to ensure that the program was adopted as a formal part of postgraduate education for ob-gyns and family doctors, and to train faculty on this material. This guarantees that thousands of practicing doctors will learn this material for years to come. However, the next step is to incorporate the material into *preservice* medical education, so coming generations of doctors begin practicing with up-to-date knowledge and basic skills on FP/RH. In addition, while the project trained significant numbers of midlevel staff, particularly midwives, nurses and *feldshers*, it did not work either with preservice or postgraduate education for these cadres. The priority should be to work with midwives, who are PHC providers in many rural communities as well as helping ob-gyns with women's health care in larger health facilities. Feldshers are also important, since they often serve as PHC providers in rural areas.

- ***There should be a strong emphasis on building understanding of EBM, particularly among mid- and senior managers in the ob-gyn community, and developing expertise on using EBM methodology to update clinical policies and practices on a continuing basis.*** TfH improved the understanding of many ob-gyns on EBM and left behind a small cadre of trained and committed EBM methodologists and a resource center for them to work in. Several other projects have also sought to advance EBM, but much work is still needed before leaders in the ob-gyn community promote evidence-based policy and practice and can draw on trained human resources with the expertise to stay abreast of ob-gyn developments around the world

[5] The training did not cover practical skills for immediate PP IUD insertion, although the topic was discussed in theory and in the manual.

and to develop evidence-based policy and practice for Ukraine. Until then, modern manuals and training programs, such as those left behind by TfH, will not be updated and Ukraine will lag behind medical policies and practices in the rest of the world, depending on foreign projects to catch up.

- ***The STI system badly needs strengthening and modernization.*** From the beginning, TfH sought to include STI *prevention* in all facets of its work: clinical, BCC, contraceptive availability and policy. However, it also wanted to include simple *diagnostic and treatment* methods for common STIs—most significantly syndromic case management—in its program. Project staff worked with HIV-AIDS Alliance, WHO and UNAIDS to review the major policies, protocols and systems governing STI diagnosis and treatment and found them badly outdated and non-evidence-based. Meetings with key leaders in the STI field, however, found them resistant to international approaches and, since any work on STI diagnosis and treatment involved cooperation with them, the project could not move forward on these issues. STIs are a serious problem in Ukraine and undoubtedly contribute to the high incidence of HIV, so it would be important to seek avenues to help STI leaders recognize the need to modernize STI-related services.

- ***Working with WHO is a best practice that facilitates innovation in Ukraine.*** Leaders in the health sector hold WHO in very high regard and are open to most WHO recommendations. TfH smoothed the way for its work by inviting the RH and Research Advisor from WHO/Europe to conduct workshops for ob-gyn leaders at key points in the life of the project. It also drew heavily on WHO tools such as the *Medical Eligibility Criteria for Contraceptive Use* and *Family Planning: a Global Handbook for Providers*.[xxxiii] These moves did much to ease the way for the project's work, particularly as it was getting started.

- ***Large-scale social and behavior change communication are needed to help Ukrainians adopt modern contraceptive methods, particularly oral contraceptives and other hormonal methods.*** There is strong demand for accurate information about modern contraceptives, especially about the safety of hormonal methods. The project made progress in promoting more positive public attitudes by positioning these methods as "modern" and "safe" and these efforts merit continuation. However, to change behavior, a more emotional appeal will also need to be developed and promoted, alongside existing messages, on a large scale over time.

- ***A high-level committee representing the MOH and donors should seek consensus about how to strengthen BCC and health promotion in the health sector.*** One of the challenges faced by the project was the lack of a viable structure in the MOH system to conduct BCC or related functions such as health promotion or marketing. TfH found that MFYS and its regional-level departments had greater capability and interest in BCC functions than the MOH and RHDs. NGOs were also valuable partners. However, it is unlikely that MFYS or NGOs can perform BCC functions for MOH/RHD priority health objectives in the long run because of the challenges of working across agencies. The MOH would benefit from gaining a better understanding of BCC, leading to development of a plan to build in-house capabilities in BCC.

- ***Efforts to make contraceptive security a permanent reality in Ukraine still need work.*** The project made significant progress toward contraceptive security by working with the Government to include budget lines in the SPRHN to procure contraceptives for vulnerable populations; and by helping the MOH and partner regions advocate for funding for contraceptive procurement on an annual basis. However, these efforts need continued technical assistance to become firmly rooted in the Government agenda at all levels—even in the project's 15 partner regions.

- ***Improving procurement procedures and practices for contraceptives (and other commodities) should be continued.*** TfH worked with counterparts in the MOH and RHDs to improve their procurement practices and met with some success. However, it will take a more long-term effort, broader procurement reform and Government commitment at the highest levels to bring about the real changes needed. The project's work to formalize international procurement procedures in national guidelines and in a training course are small but important steps that are still in the early stages and merit continuation.

- ***The process of ordering and importing the USAID-donation was much longer and more complicated than in most countries.*** This was due to the unclear and onerous paperwork requirements for a humanitarian assistance donation in Ukraine and constant changes in the system and regulations governing pharmaceuticals and humanitarian assistance. What in most countries would have been a six-month process, between placing the order and receiving it in-country took two years of intensive effort. This delay

was deleterious to the whole effort to support newly-trained FP providers (such as family doctors and midwives) as they began providing FP/RH services and undermined the institutionalization of the LMIS.

- ***Giving the full quantity of donated contraceptives to the regions from the beginning had a number of unintended adverse consequences.*** These included:
    - It effectively undermined the key purpose of the LMIS, to track the availability and consumption of contraceptives at all levels of the system and ensure that stocks are always available. The LMIS became just another reporting system that providers and administrators completed—not always very accurately—because they were required to do so;
    - It was extremely difficult to engage counterparts in genuine dialogue about the system because the stocks were already juridically theirs. Thus the utility of the LMIS for managing distribution, the importance of a buffer stock and the need to have a range of free contraceptives available for eligible populations at all times was not apparent to many (if not most) counterparts.
    - It removed the incentive for regions to report—and report accurately--on use of the contraceptives as a prerequisite to receiving a further tranche of stocks. This left TfH struggling to collect reports from some regions at the end of the month.
    - Some regions decided not to procure contraceptives with their own funds because of the availability of large supplies of donated commodities.
    - It precluded resupplying regions that used their stocks rapidly, while other regions may allow some of their stocks to expire.

  It would be more useful to provide regions with a 6-12 month initial supply, keeping some stock at the central level to resupply regions that use their supplies quickly.

- ***It takes time to introduce an LMIS designed to ensure continuous supplies of pharmaceuticals.*** This is particularly true when concepts such as buffer stocks, regular counting of quantities consumed and stocks remaining, first-in-first-out and resupply are new. Such systems are also best introduced in an environment where the commodities will be available in the long-term. It would be beneficial to expand the current system to include Government-procured contraceptives so counterparts would better see the benefits of such a system in the long-term.

- ***Partnerships with the Private Sector need to benefit the private sector.*** TfH's work with the private sector evolved from seeking to involve them in a role that TfH wanted them to assume –increasing the availability of affordable contraceptives—into a role driven by *their* needs, but that also advanced TfH's agenda: strengthening their contraceptive marketing. TfH learned a number of valuable lessons along the way:
    - In the pharmaceutical sector, manufacturers' and distributors' marketing networks are an invaluable resource that reaches almost every doctor and pharmacy in a country. Building on that network can dramatically broaden a project's reach.
    - PSPs have to be approached individually. At first, the project sought to unite the pharmaceutical manufacturers and distributors in Ukraine into a single larger effort, along with the MOH and the project, to expand the contraceptive market. It learned that marketplace competition was too fierce to allow them to coalesce in that way.
    - PSPs are in a constant state of flux, at least in Ukraine. Most of the project's PSPs went through mergers, acquisitions and major staff turnovers that made it impossible to pursue a longer-term agenda with them. Progress could only be made by working with each one to take advantage of opportunities to move forward at that time, with the current staff.
    - Activities must be synchronized with PSPs' budget cycles. Even if a PSP is enthusiastic about an idea for collaboration with a project, if funds are needed for joint activities, the PSP may well have to wait for its next budget cycle. So a longer-term perspective is needed.

- ***Training pharmacists is important—but difficult and labor-intensive.*** Pharmacists are a very important avenue for reaching the public in a country such as Ukraine where the prescription system has fallen apart and pharmacists have assumed a role similar to that of primary care providers. However, the project found it difficult to reach pharmacists. The best approach proved to be working with pharmacy chains to see if they were interested in building the knowledge of their staff and expanding contraceptive sales. Some were interested, usually because they valued educational opportunities for their staff and were willing to pay their salaries while they attended a seminar—but others weren't. In addition, front-line pharmacists were

often reluctant to leave their pharmacies even for a single day to attend a free training workshop, because they were concerned about losing sales. They also did not see public education or advancing a social aim, such as reducing abortion, as their role. They were focused on their mandate to sell products. The project also learned that pharmacies are reluctant to display posters or brochures free-of-charge because pharmaceutical companies pay them to do that.

While the project's work with pharmacies showed promising results, integrating up-to-date information into pharmacy education—both preservice and postgraduate—and publishing articles in pharmaceutical newspapers and journals is probably a more cost-effective way to reach large numbers of pharmacists.

- ***Health financing reform is needed in Ukraine to give managers at all levels more responsibility and flexibility in how they manage their work.*** TfH was unable to fulfill an item in its scope of work that involved defining alternative sources of income for ob-gyns as PHC grows. Although some possible avenues for financing reform related to FP/RH were identified, the project was unable to find local partners willing to work on financing for FP/RH services without tackling broader health financing reforms—which were well beyond TfH's scope of work.

  In the course of working with RHDs to invest in FP/RH, project staff also learned about a host of budget code provisions that tie health managers' hands in conducting many important activities. For example, there is no mechanism for direct financing of training workshops, no mechanism to reward PHC staff for taking on new responsibilities (like the provision of FP/RH services), no mechanism to give raises to high performing staff, etc. Moreover, important changes to the health system cannot be carried out, e.g. merging hospitals, laying off staff, etc. And the constitutional requirement for free health care prevents establishment of a system to charge for services and reduce the inequity inherent in a system of under-the-table payments.

- ***The MOH's health information system (HIS) for FP needs to be updated.*** The FP component of MOH's current HIS is limited to collecting data about IUDs and hormonal methods from women's health care facilities. As the country moves toward a more modern FP program that provides a range of methods for couples to choose from, the HIS should also collect data on a broader range of methods—at a minimum, IUDs, oral contraceptives, injectables, condoms, surgical methods and traditional methods. And as the FP service delivery network expands beyond women's health care facilities, the HIS should also collect information about FP services provided in other facilities, such as ambulatories, FAPs and HIV centers. It would also be beneficial to include basic STI information in the HIS for a range of health facilities, as more patients seek STI care from providers other than the STI network. It should be noted, however, that making changes in the HIS will be a complicated undertaking because the current indicators have been in place for many years and the Center of Medical Statistics in the MOH believes in the data it produces and is reluctant to change. Ideally, a strengthened HIS should go hand-in-hand with institution of periodic surveys of the population's RH behavior.

There is also a need for health facilities and health administrators around the country to collect and report data accurately, instead of tending to produce "politically correct" data. This would be an essential change to support better use of data to accurately monitor trends, identify health problems and develop and test solutions.

VII. Together for Health Monitoring and Evaluation

Sources of Key Information and Data

The most reliable data sources for FP/RH information in Ukraine at the start of the TfH project were the *1999 Ukraine Reproductive Health Survey* (URHS[I]) and preliminary data from the 2004 *Survey on Willingness and Ability to Pay for Contraceptives in Ukraine* (WAPS.)[XXIV] During the life of the project, the 2007 *Ukraine Demographic and Health Survey (*UDHS)[IX] became available. These three surveys provided a wealth of valuable data for program development, but they were national in scope and data were not available at the regional level; their timing did not coincide with project interventions; and there were differences in methodology that precluded comparisons between the three surveys. Thus, the project did not use them to evaluate to evaluate its work on a regular annual basis.

Three main data sources were used to measure project impact:

- National and regional *statistics on abortion and contraceptive use* came from the MOH which provides data nationally and by region on an annual basis. It should be noted, however, that MOH abortion statistics are well-known to be underestimated because they do not take into account abortions performed by private providers or under ministries other than the MOH (ministries of defense, internal affairs, transportation and communications and other ministries, as well as from the Academy for Medical Sciences). And MOH statistics on contraceptive use cover only registered users of IUDs and hormonals (mostly oral contraceptives) in certain public sector health facilities. Since large numbers of women using contraception do not go to these facilities, and others are protected by methods other than hormonal contraceptives and IUDs, this figure is thought to significantly underestimate actual users. Moreover, the numbers reflect doctors' formal or informal prescriptions and, in most cases, not actual provision of a method.
- *Couple-Years of Protection (CYPs)*[*] were used as another measure of contraceptive use to capture the broader picture, including the private sector. CYPs were calculated from contraceptive sales data in pharmacies nationwide (by region) as well as contraceptives procured by the MOH and regional health departments and distribution of USAID-donated commodities in partner regions. Contraceptive sales data were donated to the project by one of its private sector partners, SMD, a market research company specializing in pharmaceutical sales data. The following conversion factors were used to calculate CYPs:

Oral Contraceptives (OCs)	13
IUDs	3.5
Condoms	120
Spermicides	120
Injectable	4
Patch	13
NuvaRing	13
Emergency Contraception (EC)	20

- Data on the *impact of project interventions* were collected through assessments conducted by the project before starting activities in an oblast and, on average, about 20 months later, with sites for endline assessments randomly selected from areas that had benefited from project interventions. The assessments looked at the status of FP/RH knowledge, attitudes and practices among clients and providers, the quality of services, and the availability of commodities. The following tools were used:
  - *Facility Assessment Tool* to collect basic information on health facilities to assess resources available such as IEC materials, health providers, and free contraceptives.
  - *Client Exit Questionnaire:* This was a self-administered questionnaire designed to assess clients' knowledge, attitudes towards different methods of contraception, abortion and STIs, their practices and their overall satisfaction with the health care provider who saw them that day. Women of reproductive age (15 - 49 years) and at risk of unintended pregnancy were included.

[*] CYPs estimate the protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.
(Source: http://www.usaid.gov/our_work/global_health/pop/techareas/cyp.html, accessed February 4, 2012)

- *Pharmacy Assessment Tool:* This covered general information on pharmacies, including IEC materials on display, modern contraceptive methods available (by brand) and their prices.
- *Provider Knowledge, Attitudes and Practices Questionnaire:* This was a self-administered anonymous questionnaire designed to assess providers' knowledge, attitudes towards different methods of contraception, and their practices.

The assessments were conducted in only nine of the project's 15 partner regions, since it would have been too costly to do them in all 15 regions and project interventions were too limited in some regions to produce useful results. However, the provider interview tool was not administered at baseline in the first two regions where the project worked and the facility and pharmacy assessments were not conducted in AR Crimea and Sevastopol City due to the short time-frame between the baseline and endline surveys there. A more detailed methodology for the assessments can be found in the report, *Baseline & Endline Assessments Report, Lviv, Kharkiv, Dnipropetrovsk, Odessa, Poltava, Volyn and Vinnytsa Oblasts*.[iii] The sample sizes across all the regions appear below, along with the number of regions where each tool was used:

Sample size	Baseline	Endline	Number of Regions
Provider survey	631	672	7
Client survey	3,085	3,006	9
Health facility assessment	167	169	7
Pharmacy assessment	501	428	7

In addition to these data sources, in the early years of the project TfH also conducted follow-up visits to trained health providers to examine the *impact of its clinical training* and reinforce the information and skills taught in the TfH training. Seventy TfH-trained providers (ob-gyns, family doctors and midlevel staff) were observed, using a checklist and compared with 70 providers not trained by TfH.[x]

TfH Indicator Matrix (October 2005 – September 2011)

Baseline	Project Year 1/FY 2006	Project Year 2/FY 2007	Project Year 3/FY 2008	Project Year 4/FY 2009	Project Year 5/FY 2010	Project Year 6/FY 2011	Comments:
USAID Strategic Objective 5: Improved Social Conditions and Health Status **USAID Intermediate Result 5.1: Changed behaviors and systems to improve health**							
Project Goal: Reduce the number of abortions and unintended pregnancies and incidence of sexually transmitted infections by improved provision of and access to quality RH/FP services through the public and private sectors.							
Baseline	**Project Year 1/FY 2006**	**Project Year 2/FY 2007**	**Project Year 3/FY 2008**	**Project Year 4/FY 2009**	**Project Year 5/FY 2010**	**Project Year 6/FY 2011**	**Comments:**
Abortion rate (for Ukraine & TfH oblasts)			*Definition:* Number of induced abortions per 1,000 women aged 15-49 *Source:* MOH statistics				
Calendar Year 2005: **Ukraine - 19.5** Kharkiv - 14.2 Lviv - 13.5 Dnipropetrovsk - 22.6 Odessa - 26.4 Poltava - 21.5 Vinnytsya - 22.2 Volyn - 17.8 Cherkasy - 14.4 Donetsk - 22.2 Ivano-Frankivsk - 9.2 Khmelnytsky - 13.8 Rivne - 10.0 Zaporizhya - 21.5	*Calendar Year 2005:* **Ukraine - 19.5** Kharkiv - 14.2 Lviv - 13.5	*Calendar Year 2006:* **Ukraine - 18.6** Kharkiv - 12.8 Lviv - 13.3 Dnipropetrovsk - 21.3 Odessa - 25.4 Poltava - 20.0 Vinnytsya - 20.4 Volyn - 16.3	*Calendar Year 2007:* **Ukraine - 17.2** Kharkiv - 10.8 Lviv - 11.2 Dnipropetrovsk - 19.4 Odessa - 24.9 Poltava - 20.5 Vinnytsya - 18.4 Volyn - 15.5 Cherkasy - 12.5 Donetsk - 18.8 Ivano-Frankivsk - 8.4 Khmelnytsky - 13.9 Rivne - 10.2 Zaporizhya - 18.2	*Calendar Year 2008:* **Ukraine – 16.6** Kharkiv – 10.3 Lviv – 11.2 Dnipropetrovsk – 18.8 Odessa – 23.5 Poltava – 20.8 Vinnytsya – 19.2 Volyn – 15.4 Cherkasy – 11.2 Donetsk – 18.3 Ivano-Frankivsk – 7.8 Khmelnytsky – 13.2 Rivne – 10.2 Zaporizhya – 16.4 AR Crimea – 18.4 Sevastopol City – 21.8	*Calendar Year 2009:* **Ukraine – 15.1** Kharkiv – 9.2 Lviv – 10.7 Dnipropetrovsk – 17.5 Odessa – 17.1 Poltava – 28.4 Vinnytsya – 19.0 Volyn – 14.1 Cherkasy – 11.5 Donetsk – 17.6 Ivano-Frankivsk – 7.7 Khmelnytsky – 12.1 Rivne – 7.7 Zaporizhya – 14.6 AR Crimea – 17.5 Sevastopol City – 23.3	*Calendar Year 2010:* **Ukraine – 13.9** Kharkiv – 9.3 Lviv – 9.9 Dnipropetrovsk – 15.9 Odessa – 14.3 Poltava – 15.2 Vinnytsya – 17.5 Volyn – 13.2 Cherkasy – 11.7 Donetsk – 16.2 Ivano-Frankivsk – 7.7 Khmelnytsky – 11.7 Rivne – 6.5 Zaporizhya – 13.2 AR Crimea – 16.3 Sevastopol City – 20.5	Data reported here are based on MOH facilities only
Abortion ratio (for Ukraine & TfH oblasts)			*Definition:* Number of induced abortions per 1,000 live births *Source:* MOH statistics				
Calendar Year 2005: **Ukraine - 587.2** Kharkiv - 513.2 Lviv - 354.9 Dnipropetrovsk - 723.2 Odessa - 712.1 Poltava - 737.1	*Calendar Year 2005:* **Ukraine - 587.2** Kharkiv - 513.2 Lviv - 354.9	*Calendar Year 2006:* **Ukraine - 503.0** Kharkiv - 419.2 Lviv - 329.8 Dnipropetrovsk - 595.1 Odessa - 637.8	*Calendar Year 2007:* **Ukraine - 448.0** Kharkiv - 332.8 Lviv - 274.1 Dnipropetrovsk - 523.1 Odessa - 579.6 Poltava - 598.0	*Calendar Year 2008:* **Ukraine – 399.6** Kharkiv - 292.8 Lviv - 261.1 Dnipropetrovsk - 461.4 Odessa - 515.3 Poltava - 549.3	*Calendar Year 2009:* **Ukraine – 357.0** Kharkiv - 257.2 Lviv - 239.8 Dnipropetrovsk - 425.9 Odessa - 366.8 Poltava - 477.0 Vinnytsya - 435.5	*Calendar Year 2010:* **Ukraine – 333.4** Kharkiv - 263.7 Lviv - 231.0 Dnipropetrovsk - 397.0 Odessa - 308.8 Poltava - 400.6 Vinnytsya - 408.6	Data reported here are based on MOH facilities only

Baseline	Project Year 1/FY 2006	Project Year 2/FY 2007	Project Year 3/FY 2008	Project Year 4/FY 2009	Project Year 5/FY 2010	Project Year 6/FY 2011	Comments:
Vinnytsya - 641.1 Volyn - 379.7 Cherkasy - 475.5 Donetsk - 766.0 Ivano-Frankivsk - 226.0 Khmelnytsky - 407.1 Rivne - 226.7 Zaporizhya - 648.4		Poltava - 572.1 Vinnytsya - 527.5 Volyn - 314.4	Vinnytsya - 461.9 Volyn - 293.9 Cherkasy - 357.6 Donetsk - 551.9 Ivano-Frankivsk - 186.7 Khmelnytsky - 344.8 Rivne - 197.3 Zaporizhya - 495.5	Vinnytsya - 450.3 Volyn - 266.4 Cherkasy – 303.9 Donetsk - 487.2 Ivano-Frankivsk - 166.8 Khmelnytsky - 305.1 Rivne - 181.8 Zaporizhya - 418.8 AR Crimea – 399.6 Sevastopol City – 521.4	Volyn - 240.8 Cherkasy – 302.3 Donetsk - 465.9 Ivano-Frankivsk - 159.4 Khmelnytsky - 275.2 Rivne - 130.9 Zaporizhya - 375.3 AR Crimea – 379.1 Sevastopol City – 532.4	Volyn - 230.0 Cherkasy – 310.7 Donetsk - 442.1 Ivano-Frankivsk - 167.2 Khmelnytsky - 266.7 Rivne - 112.3 Zaporizhya - 333.6 AR Crimea – 353.3 Sevastopol City – 472.4	
Registered IUD and hormonal contraception rate (for Ukraine & TfH oblasts)			*Definition:* Number of women 15-49 registered as users of IUDs or hormonal contraceptives per 1,000 women 15-49 *Source:* MOH statistics				
Calendar Year 2005: **Ukraine - 289.5** Kharkiv - 310.5 Lviv - 272.4 Dnipropetrovsk - 251.4 Odessa - 330.6 Poltava - 297.7 Vinnytsya - 305.1 Volyn - 270.7 Cherkasy - 176.1 Donetsk - 341.6 Ivano-Frankivsk - 328.4 Khmelnytsky - 400.1 Rivne - 265.7 Zaporizhya - 387.1	*Calendar Year 2005:* **Ukraine - 289.5** Kharkiv - 310.5 Lviv - 272.4	*Calendar Year 2006:* **Ukraine - 297.2** Kharkiv - 328.0 Lviv - 282.7 Dnipropetrovsk - 268.5 Odessa - 335.2 Poltava - 295.3 Vinnytsya - 303.9 Volyn - 249.5	*Calendar Year 2007:* **Ukraine – 302.5** Kharkiv – 362.0 Lviv – 279.8 Dnipropetrovsk – 280.5 Odessa – 341.6 Poltava – 296.7 Vinnytsya – 301.7 Volyn – 229.0 Cherkasy – 182.2 Donetsk – 353.2 Ivano-Frankivsk – 387.1 Khmelnytsky – 390.9 Rivne – 253.9 Zaporizhya – 383.5	*Calendar Year 2008:* **Ukraine - 308.4** Kharkiv - 355.4 Lviv - 286.7 Dnipropetrovsk - 308.1 Odessa - 331.4 Poltava - 302.0 Vinnytsya - 284.8 Volyn - 234.3 Cherkasy - 196.2 Donetsk - 366.3 Ivano-Frankivsk – 369.1 Khmelnytsky - 400.3 Rivne - 248.6 Zaporizhya - 394.1	*Calendar Year 2009:* **Ukraine - 313.8** Kharkiv - 368.5 Lviv - 306.5 Dnipropetrovsk - 311.7 Odessa - 339.2 Poltava - 285.8 Vinnytsya - 289.2 Volyn - 225.9 Cherkasy - 224.3 Donetsk - 362.3 Ivano-Frankivsk – 399.2 Khmelnytsky - 367.8 Rivne - 227.5 Zaporizhya - 390.3 AR Crimea – 227.9 Sevastopol City - 220.1	*Calendar Year 2010:* **Ukraine - 319.4** Kharkiv - 376.2 Lviv - 315.5 Dnipropetrovsk - 303.7 Odessa - 355.5 Poltava - 306.6 Vinnytsya - 280.1 Volyn - 228.2 Cherkasy - 195.3 Donetsk - 361.7 Ivano-Frankivsk – 401.0 Khmelnytsky - 425.3 Rivne - 211.7 Zaporizhya - 398.3 AR Crimea – 233.0 Sevastopol City - 245.3	

Baseline	Project Year 1/FY 2006	Project Year 2/FY 2007	Project Year 3/FY 2008	Project Year 4/FY 2009	Project Year 5/FY 2010	Project Year 6/FY 2011	Comments:
Couple-Years of Protection (CYPs) in USG-supported oblasts from condoms (for Ukraine & TfH oblasts)			*Definition: See Notes on Data in this Report (page 28)* *Source:* Private sector data on contraceptive sales from SMD; public sector data on contraceptive procurements from MOH and partner oblasts plus project data on USAID donations				
August 2004 – July 2005 **Ukraine - 155,377** Kharkiv &Lviv – 22,445	*August 2005– July 2006* **Ukraine - 224,360** Kharkiv&Lviv – 38,317	*August 2006 – July 2007* **Ukraine - 263,568** Kharkiv&Lviv – 46,204	*August 2007– July 2008* **Ukraine - 305,384** 7 Oblasts–131,023	*August 2008– July 2009* **Ukraine – 322,078** 13 TfH Oblasts – 193,484	*August 2009– July 2010* **Ukraine – 261,584** 15 TfH Oblasts – 172,525	*August 2010– July 2011* **Ukraine – 280,986** 15 TfH Oblasts – 187,018	See Supple-mentary Table 3 for details by oblast
Result 1: Improved service provider skills and behaviors related to FP/RH							
Number of people trained on FP/RH during the year with USG funds, disaggregated by type of participant			*Definition:* N/A *Source:* TfH training data **(Includes ALL clinical and pharmacy trainers, health providers, pharmacists, BCC educators, health care managers and opinion leaders)**				
0	**Total: 51** Kharkiv - 2 Lviv - 3 Dnipropetrovsk - 3 Odessa - 1 Vinnytsa - 1 Donetsk – 4 Zaporizhya – 1 Ivano-Frankisk - 1 Kyiv, other - 35	**Total: 2,974** Kharkiv - 1,267 Lviv - 1,005 Dnipropetrovsk - 126 Odessa - 0 Poltava - 201 Vinnytsa - 144 Volyn - 124 Kyiv, other - 107	**Total - 3,147** Kharkiv - 597 Lviv - 496 Dnipropetrovsk - 462 Odessa - 292 Poltava - 445 Vinnytsya - 452 Volyn - 397 Kyiv, other – 6	**Total – 2,520** Kharkiv – 187 Lviv – 143 Dnipropetrovsk – 102 Odessa – 88 Poltava – 158 Vinnytsya – 123 Volyn – 143 Cherkasy – 204 Donetsk – 194 Ivano-Frankivsk – 262 Khmelnytsky – 211 Rivne – 209 Zaporizhya – 271 Kyiv, other – 225	**Total – 3,840** Kharkiv – 135 Lviv – 149 Dnipropetrovsk – 107 Odessa – 100 Poltava – 106 Vinnytsya – 139 Volyn – 137 Cherkasy – 210 Donetsk – 285 Ivano-Frankivsk – 249 Khmelnytsky – 234 Rivne – 295 Zaporizhya – 286 AR Crimea – 1,227 Sevastopol City -152 Kyiv, other – 29	**Total – 8,034** Kharkiv – 461 Lviv – 475 Dnipropetrovsk – 546 Odessa – 229 Poltava – 611 Vinnytsya – 719 Volyn – 607 Cherkasy – 387 Donetsk – 456 Ivano-Frankivsk – 454 Khmelnytsky – 760 Rivne – 636 Zaporizhya – 405 AR Crimea – 878 Sevastopol City -148 Kyiv, other – 262	See Supple-mentary Table 4.a for further detail

Baseline	Project Year 1/FY 2006	Project Year 2/FY 2007	Project Year 3/FY 2008	Project Year 4/FY 2009	Project Year 5/FY 2010	Project Year 6/FY 2011	Comments:
Percent (%) of FP/RH providers with positive attitudes to more effective contraceptive methods			*Definition:* "Positive attitude" means that the provider rated the method as "good" or "very good;" modern contraceptive methods means condoms, IUDs, COCs, LAM, EC, female sterilization, male sterilization, patch, ring, depo-provera, POPs. *Source:* TfH assessments (Provider Knowledge, Attitudes and Practices)				
N/A	N/A	N/A	*Baseline in Dnipro-petrovsk, Odessa, Poltava, Vinnytsya, Volyn:* **59%**	*Endline in Dnipro-petrovsk, Odessa, Poltava, Vinnytsya, Volyn:* **71%**	*Baseline in AR Crimea and Sevastopol City* **61%**	*Endline in AR Crimea and Sevastopol City* **66%**	
Average pre- and post-test scores of trained health providers (by TfH oblast, %)			*Definition:* N/A *Source:* TfH training data				
N/A	N/A	**Total – 59/91** Kharkiv - 48/87 Lviv - 56/89 Dnipropetrovsk – 59/90 Poltava – 68/98 Vinnytsya – 73/93 Volyn – 68/99	**Total – 56/93** Kharkiv – 54/91 Lviv – 57/95 Dnipropetrovsk – 60/89 Poltava – 59/92 Vinnytsya – 49/98 Volyn – 53/95 Odessa – 59/91	**Total – 58/93** Kharkiv – 67/89 Lviv – 51/95 Dnipropetrovsk – 57/85 Odessa – 60/96 Poltava – 54/92 Vinnytsya – 48/98 Volyn – 51/95 Cherkasy – 64/96 Donetsk – 60/92 Ivano-Frankivsk – 53/83 Khmelnytsky – 57/96 Rivne – 53/97 Zaporizhya – 68/92	**Total – 58/91** Kharkiv – 61/90 Lviv – 60/91 Dnipropetrovsk – 63/92 Odessa – 55/93 Poltava – 56/94 Vinnytsya – 48/98 Volyn – 51/95 Cherkasy – 57/94 Donetsk – 57/95 Ivano-Frankivsk – 60/93 Khmelnytsky – 59/99 Rivne – 56/98 Zaporizhya – 65/89 AR Crimea – 57/85 Sevastopol City – 67/84	**Total – 60/95** Kharkiv – 66/90 Lviv – 52/91 Dnipropetrovsk – 67/92 Odessa – 62/96 Poltava – 57/94 Vinnytsya – 55/98 Volyn – 58/97 Cherkasy – 58/93 Donetsk – 64/97 Ivano-Frankivsk – 58/95 Khmelnytsky – 59/100 Rivne – 62/97 Zaporizhya – 66/90 AR Crimea – 57/99 Sevastopol – 67/97	
Result 2: Improved client knowledge, attitudes and use of appropriate FP/RH services and products							
Number of people reached by BCC			*Definition:* Includes people reached through education sessions/interpersonal communications, special events, mass media and IEC materials during the year *Source:* Project documents				
N/A	**55**	**Total 7 TfH oblasts 2,024,397**	**Total 7 TfH oblasts 3,829,974**	**Total 13 TfH oblasts 8,416,213**	**Total 15 TfH oblasts 9,878,043**	**Total 15 TfH oblasts 13,884,328**	

Baseline	Project Year 1/FY 2006	Project Year 2/FY 2007	Project Year 3/FY 2008	Project Year 4/FY 2009	Project Year 5/FY 2010	Project Year 6/FY 2011	Comments:
Percent (%) of RH clients with positive attitudes to more effective contraceptive methods			*Definition:* "Positive attitude" means that the client rated the method as "good" or "very good;" modern contraceptive methods means condoms, IUDs, COCs, LAM, EC, female sterilization, male sterilization, patch, ring, depo-provera. *Source:* TfH assessments (Client Exit Questionnaire)				
	Baseline in Kharkiv and Lviv: **29%**	*Endline in Kharkiv and Lviv:* **43%**	*Baseline in Dnipropetrovsk, Odessa, Poltava, Vinnytsya, Volyn* **29%**	*Endline in Dnipropetrovsk, Odessa, Poltava, Vinnytsya, Volyn* **37%**	*Baseline in AR Crimea and Sevastopol City* **30%**	*Endline in AR Crimea and Sevastopol City* **42%**	
Result 3: Increased availability, accessibility and affordability of contraceptives							
Couple-Years of Protection (CYPs) in USG-supported oblasts (for Ukraine & TfH oblasts)			*Definition: See Notes on Data in this Report (page 41)* *Source:* Private sector data on contraceptive sales from SMD; public sector data on contraceptive procurements from MOH and partner oblasts plus project data on USAID donations				
August 2004 – July 2005 **Ukraine - 485,655** Kharkiv – 30,874 Lviv – 28,979	*August 2005– July 2006* **Ukraine - 643,836** Kharkiv – 57,731 Lviv – 35,263 *Baseline:* Dnipropetrovsk – 61,251 Odessa – 22,696 Poltava – 39,966 Vinnytsya – 13,392 Volyn – 12,648	*August 2006 – July 2007* **Ukraine - 716,013** Kharkiv – 52,507 Lviv – 37,475 Dnipropetrovsk – 67,030 Odessa – 33,568 Poltava – 44,455 Vinnytsya – 14,128 Volyn – 15,752 *Baseline:* Cherkasy – 22,894 Donetsk – 44,723 Ivano-Frankivsk – 19,45 Khmelnytsky – 16,299 Rivne – 16,502 Zaporizhya – 34,037	*August 2007– July 2008* **Ukraine – 796,889** Kharkiv – 56,205 Lviv – 43,075 Dnipropetrovsk – 85,929 Odessa – 36,518 Poltava – 44,697 Vinnytsya – 18,047 Volyn – 18,790 Cherkasy – 21,173 Donetsk – 43,011 Ivano-Frankivsk – 9,433 Khmelnytsky – 17,977 Rivne – 14,831 Zaporizhya – 29,914	*August 2008– July 2009* **Ukraine – 839,470** Kharkiv – 51,678 Lviv – 29,143 Dnipropetrovsk– 106,236 Odessa – 39,446 Poltava – 30,593 Vinnytsya – 20,296 Volyn – 19,628 Cherkasy – 18,642 Donetsk – 40,706 Ivano-Frankivsk – 13,878 Khmelnytsky – 22,678 Rivne – 14,244 Zaporizhya – 33,991 AR Crimea – 78,801 Sevastopol City – 14,937	*August 2009– July 2010* **Ukraine – 667,557** Kharkiv – 45,515 Lviv – 26,462 Dnipropetrovsk– 62,784 Odessa – 40,076 Poltava – 21,297 Vinnytsya – 19,006 Volyn – 12,041 Cherkasy – 13,595 Donetsk – 59,948 Ivano-Frankivsk – 9,371 Khmelnytsky – 12,238 Rivne – 16,286 Zaporizhya – 27,723 AR Crimea – 50,386 Sevastopol City – 10,193	*August 2010– July 2011* **Ukraine – 745,857** Kharkiv – 46,266 Lviv – 36,686 Dnipropetrovsk– 76,880 Odessa – 50,172 Poltava – 27,610 Vinnytsya – 22,303 Volyn – 26,253 Cherkasy – 18,758 Donetsk – 67,591 Ivano-Frankivsk – 16,244 Khmelnytsky – 20,087 Rivne – 16,571 Zaporizhya – 26,661 AR Crimea – 65,366 Sevastopol City – 12,453	

Baseline	Project Year 1/FY 2006	Project Year 2/FY 2007	Project Year 3/FY 2008	Project Year 4/FY 2009	Project Year 5/FY 2010	Project Year 6/FY 2011	Comments:
Couple-Years of Protection (CYPs) in USG-supported oblasts from condoms (for Ukraine & TfH oblasts)			*Definition: See Notes on Data in this Report (page 28)* *Source:* Private sector data on contraceptive sales from SMD; public sector data on contraceptive procurements from MOH and partner oblasts plus project data on USAID donations				
August 2004 – July 2005 **Ukraine - 155,377** Kharkiv – 7,833 Lviv – 14,612	*August 2005– July 2006* **Ukraine - 224,360** Kharkiv – 20,036 Lviv – 18,281 *Baseline:* Dnipropetrovsk – 24,095 Odessa – 10,756 Poltava – 12,709 Vinnytsya – 4,224 Volyn – 3,447	*August 2006 – July 2007* **Ukraine - 263,568** Kharkiv – 25,791 Lviv – 20,413 Dnipropetrovsk – 28,182 Odessa – 15,306 Poltava – 15,177 Vinnytsya – 4,605 Volyn – 5,204 *Baseline:* Cherkasy – 6,586 Donetsk – 16,547 Ivano-Frankivsk – 4,553 Khmelnytsky – 3,928 Rivne – 4,850 Zaporizhya – 14,211	*August 2007– July 2008* **Ukraine - 305,384** Kharkiv – 26,258 Lviv – 22,623 Dnipropetrovsk – 37,756 Odessa – 16,622 Poltava – 16,595 Vinnytsya – 5,216 Volyn – 5,953 Cherkasy – 5,982 Donetsk – 16,652 Ivano-Frankivsk – 4,440 Khmelnytsky – 6,504 Rivne – 5,877 Zaporizhya – 14,047	*August 2008– July 2009* **Ukraine – 322,078** Kharkiv – 22,982 Lviv – 14,859 Dnipropetrovsk – 37,259 Odessa – 16,634 Poltava – 15,005 Vinnytsya – 7,348 Volyn – 6,915 Cherkasy – 8,265 Donetsk – 16,910 Ivano-Frankivsk – 8,433 Khmelnytsky – 11,447 Rivne – 8,249 Zaporizhya – 19,178 AR Crimea – 33,488 Sevastopol City – 7,097	*August 2009– July 2010* **Ukraine – 261,584** Kharkiv – 18,146 Lviv – 12,031 Dnipropetrovsk – 25,324 Odessa – 16,365 Poltava – 9,064 Vinnytsya – 4,999 Volyn – 3,866 Cherkasy – 4,700 Donetsk – 22,495 Ivano-Frankivsk – 4,221 Khmelnytsky – 6,288 Rivne – 7,720 Zaporizhya – 14,220 AR Crimea – 19,699 Sevastopol City – 3,388	*August 2010– July 2011* **Ukraine – 280,986** Kharkiv – 17,963 Lviv – 13,112 Dnipropetrovsk – 28,405 Odessa – 17,940 Poltava – 12,028 Vinnytsya – 8,019 Volyn – 5,609 Cherkasy – 5,716 Donetsk – 22,441 Ivano-Frankivsk – 4,339 Khmelnytsky – 6,446 Rivne – 5,950 Zaporizhya – 12,360 AR Crimea – 22,338 Sevastopol City – 4,350	

Baseline	Project Year 1/FY 2006	Project Year 2/FY 2007	Project Year 3/FY 2008	Project Year 4/FY 2009	Project Year 5/FY 2010	Project Year 6/FY 2011	Comments:
Cumulative number of new access points for FP/RH services with at least one health provider trained by TfH (TfH oblasts)			*Definition:* These are cumulative numbers. *Source:* Project documents				
0	N/A	**Total - 343** Kharkiv - 139 Lviv - 159 Dnipropetrovsk - 7 Poltava - 19 Vinnytsa - 6 Volyn - 13	**Total – 743** Kharkiv - 196 Lviv – 211 Dnipropetrovsk – 53 Odessa – 20 Poltava – 87 Vinnytsya – 92 Volyn – 79	**Total - 1,155** Kharkiv – 211 Lviv – 234 Dnipropetrovsk – 84 Odessa – 50 Poltava – 122 Vinnytsya – 117 Volyn – 107 Cherkasy – 35 Donetsk – 17 Ivano-Frankivsk – 29 Khmelnytsky – 48 Rivne – 61 Zaporizhya – 40	**Total – 2,475** Kharkiv – 248 Lviv – 277 Dnipropetrovsk – 134 Odessa – 70 Poltava – 205 Vinnytsya –167 Volyn – 142 Cherkasy – 138 Donetsk – 121 Ivano-Frankivsk – 150 Khmelnytsky – 132 Rivne – 163 Zaporizhya – 122 AR Crimea – 382 Sevastopol City - 23	**Total – 3,637** Kharkiv – 322 Lviv – 335 Dnipropetrovsk – 244 Odessa – 144 Poltava – 337 Vinnytsya –239 Volyn – 291 Cherkasy – 205 Donetsk – 204 Ivano-Frankivsk – 198 Khmelnytsky – 209 Rivne – 229 Zaporizhya – 161 AR Crimea – 476 Sevastopol City - 43	
Result 4: Increased capacity and commitment of the public and private sectors to support policies and systems for improved reproductive health							
Number of documents adopted by GOU (at national and local levels) that demonstrate commitment to FP/RH.			*Definition:* Includes legal/policy documents as well as FP/RH manuals/curricula/ guidelines/protocols developed/updated and approved by relevant government institution *Source:* Project documents				
0	**2**	**5**	**25**	**16**	**11**	**16**	
Estimated contribution of *public* sector partners (MOH, OHDs, local health facilities, etc.) to FP/RH in cash or in-kind			*Definition:* N/A *Source:* Project documents				
$0	**$9,934**	**$162,062**	**$560,521**	**$613,815**	**$641,000**	**$744,100**	

Baseline	Project Year 1/FY 2006	Project Year 2/FY 2007	Project Year 3/FY 2008	Project Year 4/FY 2009	Project Year 5/FY 2010	Project Year 6/FY 2011	Comments:
Estimated contribution of *private* sector partners (pharmaceutical manufacturers and distributors, SMD, NGOs, mass media, etc.) to FP/RH in cash or in-kind			*Definition:* N/A *Source:* Project documents				
$0	**$29,398**	**$250,551**	**$428,609**	**$223,487**	**$161,700**	**$128,131**	

TfH's NGO Partners

TfH collaborated with the following NGOs. Those that received subgrants appear in **bold.**

National Partners

All-Ukrainian Youth NGO Ukrainian Federation of Young Doctors**,** Kyiv City
Family from A to Z**,** Kharkiv City

Autonomous Republic of Crimea

Crimean Republican NGO, *Crimean Press Club*, Simferopol City
Youth NGO, *Crimean Republican Center for Intellectual Development*, Simferopol City
Trade Union Organization of the Railroad, Crimean Department, Simferopol City
Bakhchisaray Rayon NGO Ukrainian House, Bakhchisaray City

Cherkasy Region

Cherkasy Region Youth Resource Center, Cherkasy City
All-Ukrainian Charity Foundation Network of People Living with HIV/AIDS, Cherkasy Region

Dnipropetrovsk Region

Novomoskovsk City Rayon NGO Center for Family Support*, in Novomoskovsk City*
Women's Information and Coordination Center, Dnipropetrovsk City

Ivano-Frankivsk Region

Charity Foundation Solidarnist, Ivano-Frankivsk City

Kharkiv Region

Kharkiv Charity Foundation Dobrota, Kharkiv City
Rainbow of Life, Kharkiv City
STEL Kharkiv City Foundation for Childrens' Creativity, Kharkiv City

Lviv Region

Union of NGOs Center for Uniting European Youth for a Common Future, Lviv City
Harmony Charity Foundation for Psychological and Social Assistance, Lviv City
Lviv Region Association of Reproductive Health, Lviv City
Natalia Kobrynska Youth and Gender Center, Lviv City
Students' Union of Lviv Oblast**,** Lviv City
Yunka Girls' Club, Lviv City

Poltava Region

Our Future is the 21st Century, Kremenchuk City

Rivne Region

Shkola Mum, Rivne City

Sevastopol City

NGO Youth Center *Volunteer*
Women's Alternatives

Vinnytsya Region

Garmoniya, Vinnytsya City
Vis, Vinnytsa City
Volunteer Regional Youth Center, Vinnytsya City

Volyn Region

Liubystok Center for Family Practical Psychology, Lutsk City
Volunteers' Club of Lutsk City**,** Lutsk City
Youth Regional Institute of European Development, Lutsk City

Zaporizhya Region

Charity Foundation Spodivannya, Zaporizhya City

VIII. Report on USAID's Contraceptive Donation in Support of the TfH Project

The Cooperative Agreement (CA) for the Together for Health (TfH) project anticipated that the project would facilitate a $400,000 USAID donation of contraceptives to support the project goal of reducing the number of abortions and unintended pregnancies and the incidence of sexually transmitted infections by improved provision of and access to quality family planning/reproductive health (FP/RH) services through the public and private sectors. The CA highlights the importance of reaching underserved populations, and targeting free supplies to family doctors serving poor, rural populations: "…target these free supplies to the family doctors trained and certified in FP," so contraceptives "get to the right people and that the continued success of the private sector is not interfered with. This calls for a targeted approach. The initial targeting would be to supply the family doctors serving a poorer, rural population." The CA also states that data management for the free contraceptives "will be focused at the oblast[6] level, with consumption being reported to the national level" and that development of a logistics system will serve as a tool to "work with MOH [Ministry of Health] Statistical Department and the Institute of Public Health to strengthen the capacity to monitor FP/RH program activities and products."

The CA also required that the final project report "provide a summary of the activities related to the distribution of AID/W donated contraceptives including information on the quantities and types of contraceptives actually distributed to each recipient facility." In addition, the Mission requested a report covering the following topics:

- A summary of activities related to the distribution of the USAID/Washington-donated contraceptives including information on the quantities and types of contraceptives actually distributed;
- The steps undertaken to import the contraceptives into Ukraine, to set up the Logistics Management Information System (LMIS) and the content of the training for medical professionals;
- The challenges encountered during the process of distribution and how they will be addressed in the future;
- The lessons learned from this first experience of importing and distributing free contraceptives;

The main end-of-project report summarizes key activities and results relating to the USAID contraceptive donation, but this Annex provides more detail and includes information on the quantities and types of contraceptives actually distributed to each recipient facility (see Annex 4.) It is structured to:

- Describe the steps taken to order and import the donated contraceptives;
- Describe the steps taken to set up the LMIS;
- Outline the content of the training for medical professionals;
- Present the challenges encountered in contraceptive distribution and how they will be addressed in the future;
- Present the lessons learned;
- Present detailed information on the quantities and types of contraceptives distributed.

TfH began working intensively on the USAID contraceptive donation in the third project year (October 2007-September 2008), building on its work to support adoption by the Government of the *State Program Reproductive Health of the Nation up to 2015* (SPRHN), which allocates funds (for the first time in Ukraine) for contraceptive procurement for vulnerable populations as well as its work to build a Public-Private Partnership to improve the availability of affordable contraceptives in the private sector.

Steps Taken to Order and Import the USAID-donated contraceptives

- TfH began by working with the Mission, USAID/Washington and the DELIVER project to identify funds in addition to the $400,000 already earmarked for Ukraine, so as to increase the amount of funding available for a donation. A total of **$743,830** was identified and contraceptive order was planned based on that figure.

[6] For purposes of this document the Autonomous Republic of Crimea and the City of Sevastopol are included in the term "regions"

- Project staff facilitated agreement between the Mission, Bayer Health Care and the MOH to use the USAID donation to support the SPRHN which designated four vulnerable population groups eligible to receive free contraceptives:
    - Women with low incomes/from poor families;
    - Youth aged 18-20;
    - Women living with HIV; and
    - Women with "extragenital pathologies" for whom pregnancy is contraindicated.

  It was also agreed that the donated contraceptives would be distributed to facilities with TfH-trained health workers; would reach outlying health facilities with non-traditional FP/RH providers (family doctors, midwives, etc.) as well as traditional FP/RH providers; and would go through the same system as Government-procured commodities.
- TfH went on to work with the regions to forecast the quantities of each method needed, based on SPRHN eligibility criteria and the regions' assessments of unmet needs, in such a way that USAID's donation and locally procured contraceptives would complement each other and better meet the needs of the designated priority populations. Assumptions were made about the needs of regions that would enter the project in the future. Estimating needs for commodities turned out to be an entirely new exercise for regional health departments (RHDs.)
- A Ukrainian NGO was identified as the recipient of the donation, since JSI, as the implementing agency for the project, did not have the legal status in Ukraine to receive a donation of humanitarian assistance.
- Two drafts of the contraceptive order were prepared but had to be revised in light of shifts in product in the US. The first final order for combined oral contraceptives (COCs), progestin-only pills (POPs), IUDs and injectable contraceptives was submitted to USAID/Ukraine in April 2008. This included products from Wyeth, not registered in Ukraine.
- Meetings were held with GOU counterparts, mainly in the MOH and Cabinet of Ministers, to determine the list of documents needed for the donation. This was followed by discussions about the documents required with partners in the US, specifically USAID, JSI, Wyeth and Pfizer (contraceptive manufacturers), and all parties started to prepare the paperwork to meet Ukrainian requirements.
- TfH was required to get samples of the products to be donated for quality testing in Ukraine, but bureaucratic procedures made that impossible.
- The process was greatly complicated when the Government imposed restrictions on importing donated medical supplies not registered in Ukraine, after a misidentified death in 2008 during distribution of a vaccine not registered in the country. With two of the oral contraceptives proposed for donation (Wyeth's *Lo-Femenal* and *Ovrett*e) not registered locally, TfH decided to ask the MOH for support in registering or issuing a temporary registration waiver for the donated products. This proven to be impossible in light of new legislation.
- At about the same time, there were two important changes in the system for drug registration, policy and quality control that created considerable confusion around the steps required to receive the USAID donation. The State Inspection for Quality Control of Medical Products was reorganized and transferred from the jurisdiction of the MOH to the Prime Minister's office and the Cabinet of Ministers approved the formation of an inter-ministerial committee for regulating all aspects of drug registration, policy and quality control.
- In February 2009, USAID informed TfH that the Ukraine contraceptive order should be revised, since USAID was shifting its procurements of oral contraceptives from Wyeth to Bayer Health Care (at that time it was Bayer-Schering Pharma.) TfH staff discussed responsibilities for importation of the contraceptives into Ukraine with USAID/DELIVER project staff and with Bayer representatives in Berlin and Ukraine. With one of the COCs becoming available from USAID, *Microgynon,* already registered and sold in Ukraine, it was agreed that TfH would take the lead on importing *Microgynon* as a humanitarian donation, while Bayer would support the donation with the necessary paperwork. However, Bayer's progestin-only pill, *Microlut,* was not yet registered in Ukraine and USAID agreed

with Bayer representatives in Berlin that they would start on the process of registration. The DELIVER project was the responsible party to prepare the documentation for importation on the US side.

- After numerous revisions of the order, due to Ukrainian requirements for drug imports and humanitarian donations, as well as due to product availability, the final order, valued at $765,000—was placed in April 2009. In included COCs (*Microgynon)*-1,780,320 cycles, Injectable (*Depo-Provera*)-57,600 vials, and IUDs (*Optima)*-288,000 pieces. Unfortunately, the POP *Microlut* had to be omitted, since the producer was slow to initiate the registration process.
- The next step was to prepare an array of documents (in the original) needed to request various approvals, accreditations and import certificates from different government agencies in order to start the importing process. These included a Customs certificate for the NGO *Federation of Young Doctors* to be accredited in Customs as the recipient of the USAID donation; a Customs certificate for the shipment to be cleared as humanitarian assistance, free of taxes; letters from the MOH and the MOH drug committee certifying registration of *Microgynon* and *Depo-Provera*; an MOH drug committee one-time import certificate for the *Optima* IUDs which were not registered in Ukraine; a certificate of quality for the IUDs from the Kiev Toxicology, Ecology and Hygiene Institute; and other documents.
- By December 2009, all the paperwork required by the Ukrainian authorities from USAID/Washington and the contraceptive manufacturers was assembled and formally submitted to the Cabinet of Ministers' Commission on Humanitarian Assistance, which approved the donation in January, 2010.
- By the first week of March 2010, all the requisite documents had been issued and the shipper (Agility Logistics) was given a "green light" to release the shipment from the Amsterdam warehouse and send it to Kyiv. TfH had requested to transport the order over land, rather than by sea, to make the process faster and easier to handle.
- The shipment arrived safely in the Kyiv Customs Office for humanitarian donations in the second half of March, but the Customs Office requested some clarifications, mostly concerning the country of production of *Microgynon* and the registration status of *Optima* IUDs. Once the requisite documents were in hand, the project had to request a special meeting of the Humanitarian Commission of the Cabinet of Ministers to review the documentation requested by the Kyiv Customs Office and to adopt a new resolution with the necessary clarifications. Meanwhile the contraceptives were placed in a Customs warehouse, under government seal.

  It took about two years to place the contraceptive order, have it shipped and cleared through Customs--but it was a major accomplishment to bring the contraceptives into the country at a time when the Government was very reluctant to accept donated drugs, due to a major public scandal in 2008 about a death during distribution of a donated vaccine not registered in Ukraine.
- As soon as the new Cabinet of Ministers resolution was released on April, Customs clearance was finalized and the contraceptives were moved to a Kyiv warehouse identified by the project and contracted by the NGO *Young Doctors Federation* which was responsible for the donation in the eyes of the Government of Ukraine. From that point on, distribution of the contraceptives was done in line with TfH's distribution plans.

Steps Taken to set up the LMIS

- Even before the USAID contraceptive donation arrived in Kyiv, TfH had been collaborating with the HIV-AIDS Alliance on distribution of USAID-donated condoms. So it already had a simple paper-based logistics and reporting system in place and agreements with partner RHDs on how to distribute those condoms, including compliance with USAID's family planning and "ABC" requirements. During the importation process, TfH had worked with counterparts to discuss refinements to that system to establish a basic Logistics Management Information System (LMIS) for the donated contraceptives. The LMIS was designed to facilitate the contraceptives reaching outlying health facilities and non-traditional FP/RH providers in rural areas—such as family doctors, midwives and others who had been trained on FP/RH by the project—who had never before received contraceptives as well as to provide accountability. Once finalized, an initial orientation on the LMIS and contraceptive distribution was

conducted for TfH's regional technical coordinators (project staff based in the oblasts) in June 2010, paving the way for the development of region-level distribution plans and guidelines**.**

- The project also worked on agreements with RHDs to supplement the existing partnership agreements for project participation. These outlined the conditions of the donation and the responsibilities of partners when distributing contraceptives to the four eligible population groups (specified in the agreements) and they were a precondition for a region to receive the donation. To ensure that regional counterparts recognized the importance of complying with the Tiahrt Amendment requirements on voluntarism and informed consent, regions were required to provide assurances that receipt of a contraceptive method would be strictly voluntary and that clients would be counseled about their contraceptive choices and the advantages, disadvantages and side-effects of the method chosen. These separate agreements also required RHDs to issue an order for all health facilities receiving the donated contraceptives reiterating these requirements. TfH also attached labeling to all packages of USAID-donated contraceptives as a reminder to health providers on free distribution. By early summer 2010, all TfH partner regions had signed the supplementary agreements.

- Regional authorities required an order from the MOH enabling them to receive and distribute the contraceptives and include them in their financial monitoring system, so project staff worked with the MOH to prepare that order, which was issued in September, 2010. It specified the initial quantities of contraceptives recommended for allocation to health facilities and the buffer stock to be kept at the regional level. Following that order, the MOH's Department of Maternal and Infant Health (DMIH) disseminated a letter to regional and district health departments outlining the LMIS system. The letter explained USAID and MOH requirements for an LMIS to facilitate distribution and reporting on the free contraceptives; stated the requirement to include family doctors, ob-gyns and other TfH-trained PHC professionals in the contraceptive distribution system; and reiterated the four priority populations designated in the SPRHN to receive the donated supplies.

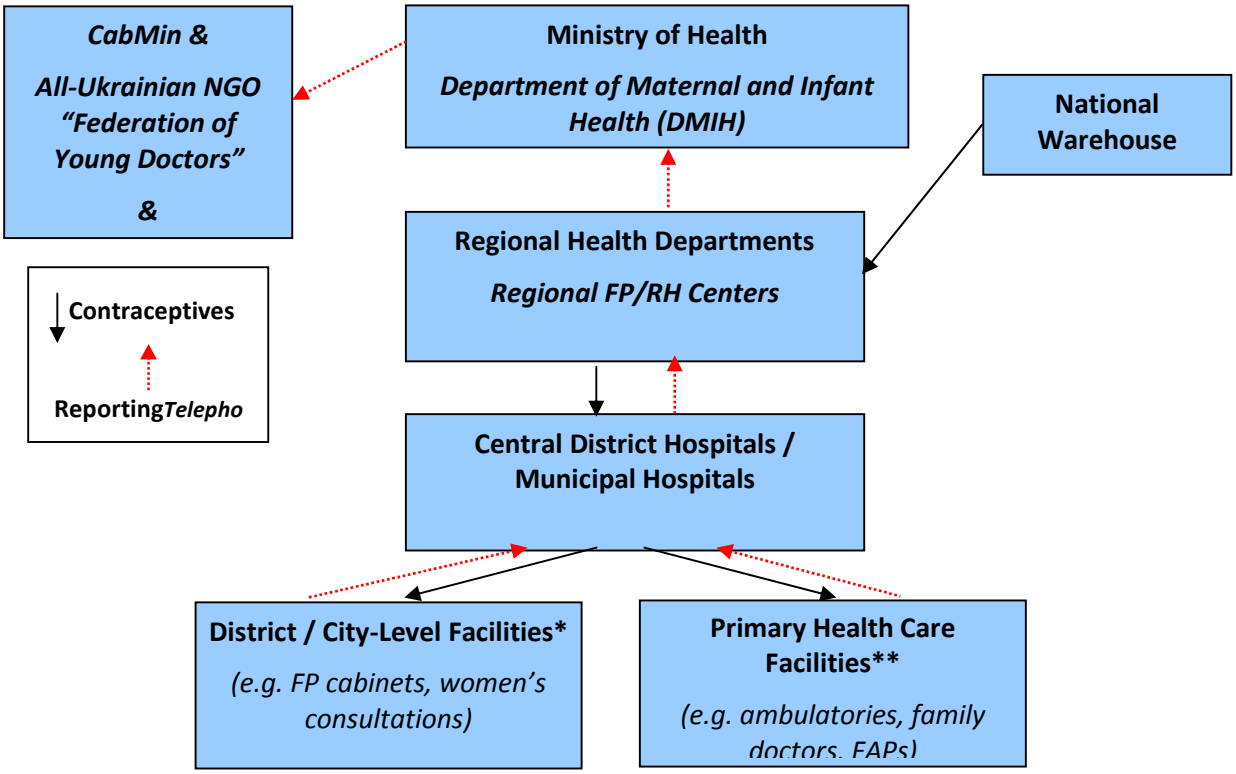
- As TfH was working on these arrangements, USAID requested a detailed written contraceptive distribution plan, specifying the quantities of each method to be donated to each health facility and sub-facility. Over a period of about six months, this detailed *Contraceptive Distribution and Logistics System Implementation Plan* was prepared, describing the overall distribution chain, the reporting system and reporting requirements, the start-up quantities to be distributed to each of the 15 regions and 400 districts where TfH was working at the time, the names of over 2,500 facilities and sub-facilities to receive donated contraceptives and the initial quantities of each method to go to each one. The plan also explained the mechanisms and tools to be used by the project and its 15 partner RHDs to implement the distribution and reporting systems in such a way as to ensure that the donated contraceptives reach PHC providers and other health professionals serving poor and vulnerable populations. USAID approved the 100+ pages plan in late October 2010. (The plan appears as Annex 3)

  The plan laid out a system designed to give each health facility a six month stock of each contraceptive method at any time, so as to meet the needs of eligible populations and provide couples with a real choice of method. (See diagram on next page.)

  At the central level, DMIH/MOH would be responsible for providing guidance to the regions on standard procedures for contraceptive distribution and the LMIS. It would also collect, compile and analyze data from the oblasts, consistent with its obligation to report to the Cabinet of Ministers on humanitarian assistance donations related to maternal and child health and its role in estimating needs and developing specifications for MOH contraceptive procurements. The *Federation of Young Doctors* NGO had a key role at the central level as the named recipient of the donation, since it was impossible for the MOH or TfH to receive the donation directly. However, its role was limited to the paperwork required for MOH reports to the Cabinet of Ministers on use of the donation.

  At the regional level, RHDs were given responsibility for the donation, in most cases through the Regional FP/RH Center (RFPC). Their tasks were:
  - Ensuring transportation of the contraceptives (at no expense to the project) to districts where TfH had trained providers;
  - Storage of the buffer stock and resupplying districts/cities when needed;
  - Aggregating lower level reports and preparing program and financial reports for various authorities—most significantly for the RHD itself and MOH/DMIH.

Logistics Management Information System (LMIS) for USAID Contraceptive Donation



At the district/city level, the Central District Hospital or Municipal Hospital was required to designate an entity such as the district FP/RH center/cabinet or the district/city women's consultation to assume responsibility for the donation. Their tasks were:

- To store the contraceptives (including a buffer stock as applicable);
- To supply and resupply PHC facilities and district/city level facilities;
- To collect data and compile reports for the Regional FP/RH Center.

Finally, the responsibility of primary health care service providers was to provide donated contraceptives to eligible populations and to report to the Central District Hospital or Municipal Hospital, as applicable.

The LMIS relied on four reporting forms[7] to provide data for use in tracking contraceptive stocks; the quantities used, by method; and the numbers of beneficiaries, by category for eligibility. The reporting forms were also stock management tools allowing providers and managers to ensure that front-line health facilities had at least a six-month supply of all methods in stock at any time and that facilities holding buffer stocks had adequate quantities on hand.

- Once USAID had approved the contraceptive distribution plan and the MOH had issued its order and letter, TfH worked intensively with RHDs and RFPCs to implement the distribution, management and reporting plans. The contraceptive donation was shipped from Kyiv to the regions in November 2010 and to individual health facilities in December.
- As soon as RHDs confirmed receipt of the donation, TfH's regional technical coordinators helped the officials responsible for distribution with a number of critical activities. These included:
  - Securing the buffer stock in line with USAID and MOH storage requirements;
  - Developing regional orders for local distribution and reporting;

[7] *Contraceptive Daily Activity Register Form,* which tracks distribution of the donated contraceptives at the facility level; *Contraceptive Distribution Reporting Form* for PHC facilities to report to the district/municipal level; *Contraceptive Distribution Consolidated Reporting Form* for district/municipal facilities to report to the regional level responsible facility; *Regional Report for Contraceptive Distribution* for regions to report to the MOH/DMIH (and to the Ukrainian Federation of Young Doctors).

- Ensuring that contraceptive packaging was clearly marked with the USAID identity and stickers stating that "This product is for free distribution, not for sale;"
- Designating the parties responsible for the donation at the district and city levels; and
- Conducting initial training on the LMIS (see below) and contraceptive distribution plans.

- Training was key to implementation of the LMIS. The first two trainings in each region were for district- and municipal-level officials responsible for contraceptive distribution and data collection, while subsequent trainings were conducted by RHDs, with TfH assistance, for family doctors and as well as other health professionals trained by the project and involved in contraceptive distribution in hospitals, polyclinics or women consultation centers. The training enabled participants to understand the role of the LMIS in supporting the provision of free contraceptives to the designated population groups, their own roles and responsibilities in the system, the distribution, storage and reporting requirements and the reporting forms and timelines. (See pages 65 for an overview of the content of the training.) A total of 125 LMIS trainings were conducted for 2,756 health workers.
- By spring 2011, TfH was working intensively with RHDs and RFPCs not only to implement the contraceptive distribution plan but also to ensure that the first reports on contraceptive use travelled up the logistics system to the central level and that they were summarized and analyzed by RFPCs. Since, in the past, donated commodities had been distributed without setting up a modern, effective logistics system, it took time for providers and administrators to understand it and grow accustomed to it. So supporting correct and timely reporting entailed the provision of further technical assistance from project staff in some regions over the remainder of the life of the project.
- Meanwhile, TfH had been working to develop a simple automated web-based reporting system to be used at the district level and above to facilitate the consolidation of reports from health facilities. The system was introduced to RFPC representatives at an all-regions meeting in April 2011 where they were invited to test it and comment on it. Subsequently, it was upgraded to incorporate participants' suggestions and, by the end of the project, it was functioning in all TfH partner regions, facilitating the amalgamation of data on the quantities of contraceptives distributed and how many were distributed to the different groups of beneficiaries.
- The web-management and reporting system for the free contraception distribution is an Internet application that simplify the monitoring and reporting on the free of charge contraceptives dispensed to the eligible population under the State Program "Reproductive Health of Nation up to 2015": poor, youth 18-20, HIV+, women with extra-genital pathologies. This web-based tool supports automated reporting from the rayon, oblast and central level, and helps monitor timeliness of reporting by family planning services providers from primary care, FP cabinets, women consultation centers, and hospitals. It also allows for accurate and real time consolidation of information related to number and types of contraceptives distributed and the number of clients reached. The application was developed using the paper-based Logistics Management Information System for free contraceptives, and can be accessed via the web browser (recommended Internet Explorer version 5.0 or higher) at the address www.tfhcc.org.ua.
- As the LMIS began to produce data, TfH ensured that these were shared and discussed with stakeholders, such as the MOH's DMIH and State Programs departments, other experts and coordinating committees for regional FP/RH Programs. As the project was ending, TfH was starting to provide technical assistance to the RFPCs to use the LMIS data for decision-making about contraceptive procurement under the SPRHN.
- To determine whether the donated contraceptives were being used in compliance with USAID requirements, to monitor storage conditions, and to see first-hand whether the LMIS was operating properly and producing accurate data, TfH staff integrated monitoring of the LMIS into their ongoing visits to monitor compliance with USAID family planning, abortion and environmental requirements. These visits were conducted jointly with regional counterparts.

Content of the training for medical professionals

TfH's training curriculum drew heavily on models used by the USAID/DELIVER project and the former JSI projects in Romania and Georgia. While the training had slightly different emphases at different levels of the logistics system, it covered the following topics:

- The purpose and components of the LMIS in Ukraine;
- The roles and responsibilities of various levels of the system and of providers involved in contraceptive distribution, particularly PHC providers;
- Data collection tools and reporting methodology and timelines;
- Proper storage and disposal of contraceptives;
- Distribution of the USAID-donated commodities to the four eligible population groups and proof of eligibility (including USAID requirements for priority targeting of poor populations);
- Eligibility criteria for the free contraceptives and dispensing guidelines;
- Protocols for contraceptive distribution;
- A review of the WHO eligibility criteria for contraceptive use;
- Key points of the MOH order on FP/RH; and
- Requirements for compliance with USAID FP, abortion and HIV requirements.

The training methodology was based on the principles of adult learning and was highly interactive and practical, so as to ensure that participants were competent to perform the required tasks. This training was also a key tool to build a cadre of people knowledgeable about the system and to promote institutionalization.

Quantities and types of contraceptives distributed

As can be seen in the Table below, by the end of December, 2011 TfH's 15 partner regions reported distributing over 477,900 cycles of *Microgynon* (a COC), 47,500 IUDs and 17,200 vials of injectable contraceptives (DMPA) during the year.[8] Beneficiaries were the four priority populations designated in SPRHN. Low-income persons were the primary beneficiaries, with 235,825 receiving free contraceptives, but 116,606 young people aged 18-20 also benefitted, as well as 47,068 women with "extragenital pathologies" and 14,216 people living with HIV. Details of the quantities and types of contraceptives distributed by individual health facility can be found in Annex 4.

Distribution of USAID-Donated Contraceptives and Number of Beneficiaries, Oct. 2010 – Dec. 2011

Region	Distributed to Clients				Number of Beneficiaries			
	Microgynon	IUDs	Depo	Condoms	Low-inc.	Youth 18-20	EGP	HIV+
AR Crimea	40,472	5,026	1,558	497,757	18,250	6,194	4,691	637
Cherkasy	15,370	1,963	634	135,534	11,785	5,426	1,474	225
Dnipropetrovsk	55,430	7,352	2,179	723,108	37,100	23,707	4,256	3,636
Donetsk	67,975	7,481	2,236	284,786	28,389	8,009	4,999	1,215
Ivano-Frankivsk	22,253	2,792	882	124,095	9,065	3,635	1,934	1
Kharkiv	41,124	3,964	1,546	836,057	19,823	8,761	4,212	325
Khmelnytsky	30,282	2,714	905	399,716	13,009	4,056	3,639	72
Lviv	36,750	2,508	1,147	334,029	18,028	10,027	3,624	146
Odessa	34,575	4,093	1,218	441,703	14,012	14,188	6,283	1,753
Poltava	25,857	1,667	1,028	956,473	13,744	17,537	4,587	3,117
Rivne	10,353	1,755	440	36,121	5,910	1,657	1,001	36
Sevastopol	5,096	413	381	160,739	5,466	3,208	365	1,825
Vinnytsya	32,828	1,896	882	572,993	16,736	2,547	2,193	277
Volyn	37,752	2,707	1,292	220,838	16,239	3,346	2,254	119
Zaporizhya	21,862	1,189	907	297,338	8,269	4,308	1,556	832
Total	**477,979**	**47,520**	**17,235**	**6,021,287**	**235,825**	**116,606**	**47,068**	**14,216**

[8] Since TfH works with the RHDs to facilitate their cooperation with HIV/AIDS Alliance on distribution of USAID-donated condoms for HIV/AIDS and STI prevention, the quantities of condoms reported here represents only the condoms distributed by facilities that are also involved in contraceptive distribution.

Challenges in Contraceptive Distribution

- The Cabinet of Ministers has stringent requirements for management of humanitarian donations that emphasize financial accountability, rather than the effectiveness of the donation. This made it difficult to convince providers and administrators of the importance of recording and reporting data on actual *use* of the donation—not just financial data. In addition, the fact that this LMIS was the first system established in Ukraine to ensure continuous supplies of pharmaceuticals to meet the needs of eligible clients, meant that providers often did not fully recognize the benefits of such a system. This also contributed to some health facility staff's reluctance to compile and submit reports as required.
- It takes time to introduce an LMIS designed to ensure continuous supplies of pharmaceuticals, particularly when concepts such as buffer stocks, regular counting of quantities consumed and stocks remaining, first-in-first-out and resupply are new. Such systems are also best introduced in an environment where the commodities will be available in the long-term.

Key Lessons Learned

- The main lesson learned was that giving the full quantity of contraceptives to the regions from the beginning on had a number of unintended adverse consequences:
    - It effectively undermined the key purpose of the LMIS, to track the availability and consumption of contraceptives at all levels of the system and ensure that stocks are always available. The LMIS became just another reporting system that providers and administrators completed—not always very accurately—because they were required to do so;
    - It was extremely difficult to engage counterparts in genuine dialogue about the system because the stocks were already juridically theirs. Thus the utility of the LMIS for managing distribution, the importance of a buffer stock and the need to have a range of free contraceptives available for eligible populations at all times was not apparent to many (if not most) counterparts.
    - It removed the incentive for regions to report—and report accurately--on use of the contraceptives as a prerequisite to receiving a further tranche of stocks. This left TfH struggling to collect reports from some regions at the end of the month.
    - Some regions decided not to procure contraceptives with their own funds because of the availability of large supplies of donated commodities.
    - It precluded resupplying regions that used their stocks rapidly, while other regions may allow some of their stocks to expire.

  It would be more useful to provide regions with a 6-12 month initial supply, keeping some stock at the central level to resupply regions that use their supplies quickly.
- The process of contraceptive ordering and importation should have started in the Day one of TfH, back in October 2005 instead of project year 3. The process of ordering and importing the USAID-donation was much longer and more complicated than in most countries due to the unclear and onerous paperwork requirements for a humanitarian assistance donation in Ukraine and constant changes in the system and regulations governing pharmaceuticals and humanitarian assistance. What in most countries would have been a six to twelve-months process, between placing the order and receiving it in-country**,** took two years and half of intensive effort. This delay was deleterious to the whole effort to support newly-trained FP providers (such as family doctors and midwives) as they began providing FP/RH services and undermined the institutionalization of the LMIS.

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IX. Annexes

Annex 1: TfH Guidelines on Compliance with USAID Requirements on Family Planning, Abortion and HIV

Annex 2: TfH Actions to Implement and Monitor the USAID Cooperative Agreement Environmental Compliance Requirements

Annex 3: Approved Contraceptive Distribution and Logistics System Implementation Plan

Annex 4: Updated Contraceptive Distribution Plan: Summary of quantities and types of contraceptives distributed to the recipient regions and facilities by September 30, 2011

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