



USAID
FROM THE AMERICAN PEOPLE

РАЗОМ ДО ЗДОРОВ'Я  **TOGETHER FOR HEALTH**

ПРОЕКТ ПОКРАЩЕННЯ ПЛАНУВАННЯ СІМ'Ї ТА РЕПРОДУКТИВНОГО ЗДОРОВ'Я В УКРАЇНІ
буль. Т. Шевченка, 46-в, офіс 15, Київ 01032, Україна
Тел.: (+380 44) 581-1520, факс: (+380 44) 581-1521, e-mail: info@mprh-ksi.org.ua

IMPROVING FAMILY PLANNING & REPRODUCTIVE HEALTH IN UKRAINE
46-v (46-a) T. Shevchenko Boulevard, Office 15, Kiev 01032, Ukraine
Tel.: (+380 44) 581-1520, Fax: (+380 44) 581-1521, e-mail: info@mprh-ksi.org.ua

The Rationale for Family Planning in Ukraine:

Evidence from Europe, Eurasia and the US

Thomas J. Bossert, Diana M. Bowser
Harvard School of Public Health

Asta M. Kenney, Laurentiu M. Stan
JSI Research & Training Institute, Inc.

Anthony A. Hudgins, Consultant

August 2007



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

TOGETHER FOR HEALTH IS FUNDED BY THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
AND IMPLEMENTED BY JSI RESEARCH AND TRAINING INSTITUTE INC. IN COLLABORATION WITH
THE ACADEMY FOR EDUCATIONAL DEVELOPMENT AND HARVARD SCHOOL OF PUBLIC HEALTH

The Rationale for Family Planning in Ukraine: Evidence from Europe, Eurasia and the US

**Thomas J. Bossert, Diana M. Bowser
Harvard School of Public Health**

**Asta M. Kenney, Laurentiu M. Stan
JSI Research & Training Institute, Inc.**

Anthony A. Hudgins, Consultant

August 2007

This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID).

The contents are the responsibility of JSI Research & Training Institute, Inc. and do not necessarily reflect the views of USAID or the United States Government.

Цей документ було розроблено завдяки щедрій підтримці американського народу з допомогою Агентства США з міжнародного розвитку. Відповідальність за зміст цього документу несе Корпорація Інституту дослідництва та тренінгів JSI. Інформація, яка відображена в цьому документі не завжди поділяє погляди Агентства США з міжнародного розвитку або уряду Сполучених Штатів.

Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control and Prevention
EU	European Union
HFA-DB	European Health for All database
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
MOH	Ministry of Health
ORC	Opinion Research Corporation
PID	Pelvic Inflammatory Disease
STI	Sexually transmitted infection
TFR	Total Fertility Rate
UAH	Ukraine Hryvnia (local currency)
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WAPS	Willingness and Ability to Pay Survey
WHO	World Health Organization

Introduction

Ukraine, similar to many other countries in Europe, has a very low birth rate. The one-child family has become the norm, resulting in a Total Fertility Rate (TFR – the number of children the average woman will have in her lifetime) of only 1.22 per woman. (United Nations, 2007) This low birth rate--along with emigration and increasing mortality rates which, in turn, are causing shortened life expectancy (World Health Organization (WHO) European Health for All database (HFA-DB))--contributes to an aging and decreasing population. From a population of 51.0 million in 1995, the population has declined to 46.9 million in 2005 and further declines are projected. (United Nations, 2007)

Because of the economic and societal effects of such a population decline, most policy-makers in Ukraine consider the birth rate to be too low, and support policies to raise the birth rate. So some people may ask why the government should support readily available, high quality contraception through improved access to family planning? This paper will discuss five compelling reasons to support increased access to family planning in Ukraine:

1. **Family planning is a human right:** Ukraine, along with most countries in the world, is a signatory to major human rights declarations and international consensus documents, including the right of women to have access to adequate health care facilities, including information, counseling and services in family planning; the right of a child to be born wanted and healthy; and the right of couples to decide freely and responsibly the number, spacing and timing of their children.
2. **Contraception is safe and benefits health:** Many studies, over many years, have clearly documented the safety of contraceptive methods. In fact, major health benefits have been proven to accrue from their use. To the extent that these health benefits protect a woman's fertility, they may even serve to increase total family size when couples decide at a later date to have more children.
3. **Contraception can lower the use of abortion:** While the abortion rate in Ukraine has shown a recent decline, it is still much higher than other European countries. There are many reasons to support the continued decline in the abortion rate, including positive benefits to women and families and overall cost savings. Experience in other low-fertility countries in the region has shown that increased use of modern contraception replaces abortion, rather than lowering the fertility rate.
4. **The benefits of family planning outweigh the costs.** Evidence from Ukraine and other countries indicates that family planning and contraception is a highly cost-effective intervention.
5. **Most governments support family planning and affordable contraceptives.** Because of the strong positive benefits of contraception, its effect in lowering abortion, its cost/benefit, and respect for human rights, most governments have developed funding and structures to provide ready access to family planning services, counseling, and commodities.

I. Human Rights and Family Planning

In recent years there has developed a broad international consensus that there is a government responsibility to protect and promote the rights of individuals and couples to control their reproductive lives and have access to family planning information and services. International agreements such as the declaration of the International Conference on Population and Development in Cairo in 1994 and the World Health Organization's Reproductive Health Strategy of 2004, among others, have made both reproductive health and family planning major international priorities. Most recently, world leaders at the 2005 World Summit agreed to make universal access to reproductive health by 2015 a national strategy to attain the United Nations' Millennium Development Goals, asserting that "progress for women is progress for all." (United Nations Population Fund (UNFPA), 2005)

Enshrined in many international and national proclamations, laws and international agreements (see below), the importance of reproductive health and family planning has been a long term doctrine of many countries. Ukraine is a signatory to many of the international agreements on human rights, including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, and the international consensus documents from the International Conference on Population and Development and the Fourth World Conference on Women.

A. *The rights of couples and individuals*

The decision whether to have a child, and when, is internationally recognized as a fundamental human right. International declarations and agreements have explicitly identified reproductive health and, more specifically, access to family planning options as a basic human right.

- The Universal Declaration of Human Rights in 1968 asserted the human right "to marry and to found a family."
- The 1994 International Conference on Population and Development (ICPD) in Cairo: Paragraph 7.16: ..."All countries should take steps to meet the family-planning needs of their population as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice."
- The European Union has several of its own human rights treaties, beginning with the European Convention on the Protection of Human Rights and Fundamental Freedoms (1950) which formally asserts that "men and women of marriageable age have the right to marry and found a family" and the European Social Charter (1961) which guarantees social and economic human rights, with a specific mention of the right to "accessible, effective health care facilities for the entire population." The European Convention on Human Rights also established the European Court of Human Rights, through which persons who feel their rights have been violated under these conventions may bring their case to the court. The importance of reproductive rights has been confirmed through several cases including the right to abortion for a woman in Poland, the paternity of a stillborn child in Russia, and the costs associated with the disabilities of a child that were not detected during the pregnancy of a woman in France (European Court of Human Rights, www.echr.coe.int).

B. The rights of women

Although the rights of women are implied within all Human Rights declarations and conventions, their special reproductive status has also resulted in declarations that specifically address women's rights. Among these declarations are:

- The Convention on the Elimination of All Forms of Discrimination Against Women (1981): Article 12.1. "State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those relating to family planning." Article 14.2. "State Parties ... shall ensure to ... women [in rural areas] the right ... (b) To have access to adequate health care facilities, including information, counseling and services in family planning."
- The WHO Reproductive Health Strategy of 2004 defines a strategy for countries to use to improve reproductive and sexual health services. It cites as one of the core aspects of reproductive health: "...providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including Human Immunodeficiency Virus (HIV), reproductive tract infections, cervical cancer and other gynecological morbidities; and promoting sexual health." (WHO, 2004a).
- The 1995 United Nations Fourth World Conference on Women (Beijing Conference) reaffirmed the need to continually guarantee that reproductive rights are considered an integral part of human rights.
- Other organizations, such as the International Federation of Gynecology and Obstetrics have acknowledged the need for women's rights in order to achieve reproductive and sexual health. FIGO recognizes that "women's health is often compromised not by lack of medical knowledge, but by infringements on women's human rights."
- The Millennium Development Goals are an ambitious agenda for reducing poverty and improving lives agreed upon by 189 Member States (including Ukraine) at the Millennium Summit in 2000. At least three of the eight goals are directly related to sexual and reproductive health. As of October 2006, universal access to reproductive and sexual health services through the primary healthcare system by 2015 was confirmed as a new target toward the goal of "improving maternal health" (Family Care International, 2007 and International Planned Parenthood Federation (IPPF), 2006). This additional goal was proposed by the Millennium Project Task Force on Child Health and Maternal Health and endorsed by United Nations (UN) Secretary-General, Kofi Annan who said:

"The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And this means stronger efforts to promote women's rights and greater investment in education and health, including reproductive health and family planning."

C. The rights of the child

In many of the statements calling for access to family planning services, avoidance of "unwanted pregnancies and/or "unwanted births" is mentioned. Inherent in this reasoning is the basic concept that every child should be "wanted". The 1994 International Conference on Population and Development (ICPD) Program of Action made this concept explicit, stating:

“First and foremost among these responsibilities is to ensure that every child is a wanted child. The second responsibility is to recognize that children are the most important resource for the future and that greater investments in them by parents and societies are essential to the achievement of sustained economic growth and development.”

In addition, The Convention of the Rights of the Child (1990) stipulates: “State Parties shall ... take appropriate measures: (a) to diminish infant and child mortality ... (d) to ensure appropriate pre- and post-natal health care for expectant mothers ... (f) to develop preventive health care, guidance for parent and family planning education and services.”

As discussed in the coming pages, effective family planning is a successful intervention leading to healthier infants, decreasing infant and child mortality.

Although formal agreements are important assertions of rights, it is in the implementation of these rights at the national level that these guarantees are put into practice. In many countries, implementation has been inhibited by a variety of factors, including inadequate funding for reproductive health and family planning services, inadequate health systems and weak administrative structures, competing legal barriers, as well as broader social conditions of gender inequality and social norms about reproductive choices.

Key point 1: There is worldwide consensus that access to family planning services, counseling, and commodities is a basic human right, essential to the rights of the couple, the woman, and the child.

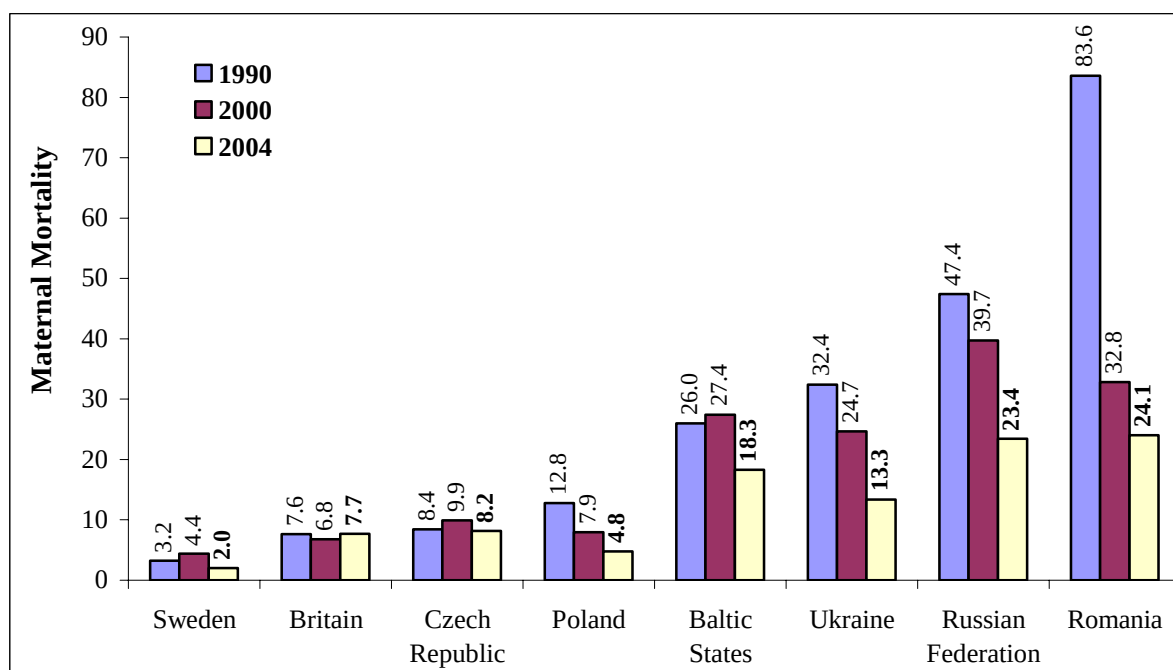
II. Family Planning as a Health Issue

Many of the declarations above make the link between family planning and health. That’s because family planning has long been shown to provide health benefits for mothers and infants that come from the ability to choose not to have a pregnancy at early and late ages, increasing intervals between births, and lower parity rates. Modern contraception as the main means to enable couples to plan their families has long been proven to be safe. In fact, there are also demonstrated health benefits unrelated to fertility that come from contraceptive use. We review the evidence of these health benefits below.

Family Planning contributes to healthy children and healthy mothers:

Avoiding unplanned and high-risk pregnancies is a key strategy to reduce infant and maternal mortality. Ukraine’s maternal mortality has decreased markedly over the last 15 years from 32 per 100,000 live births in 1990, to 25 in 2000, and 13 in 2004, and it is lower than in the Russian Federation and Romania. Yet it is still high relative to other Eastern and Central European countries such as Poland and the Czech Republic, as well as Western European countries (see Figure 1).

Figure 1. Maternal Mortality (maternal deaths per 100,000 live births) in selected European Countries



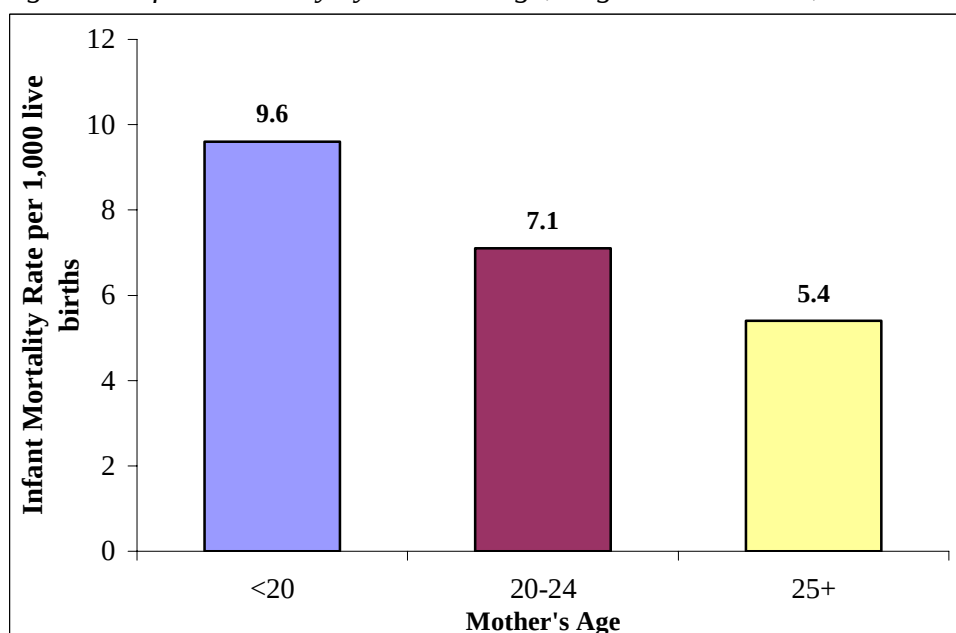
Source: WHO/Europe Health for All Database

Baltic States is an average of maternal mortality rates for Estonia, Latvia and Lithuania

By postponing early childbearing:

Delaying the first birth of a child until age 20 is beneficial to both mother and child. Young mothers are more likely to have low birthweight babies and are less likely to breastfeed their infants. Infant mortality rates are also higher for infants born to young mothers (Botting et al., 1998), as can be seen in the example from England and Wales in Figure 2. The risk of death in childbirth is twice as high among 15-19 year olds as among 20-24 year olds (UNFPA, 1997). Postponing adolescent childbearing also benefits young women by allowing them time to mature physically and mentally, to complete their education and be better prepared for the economic costs of supporting a newborn child (WHO, 2004a).

Figure 2. Infant Mortality by mother's age, England and Wales, 1994-1996



Source: Botting, 1998

Many Ukrainian teenagers are at risk of pregnancy. A study conducted by the Ministry of Health (MOH) of Ukraine, using key informant interviews, found that the average age of first sexual intercourse was 14 years old (Centers for Disease Control (CDC), 2003 and Cromer and Seltzer, 1999). A WHO adolescent study found, that 24% of 15 year old girls and 47.2% of 15 year old boys in Ukraine had had sexual intercourse (WHO, 2004c).

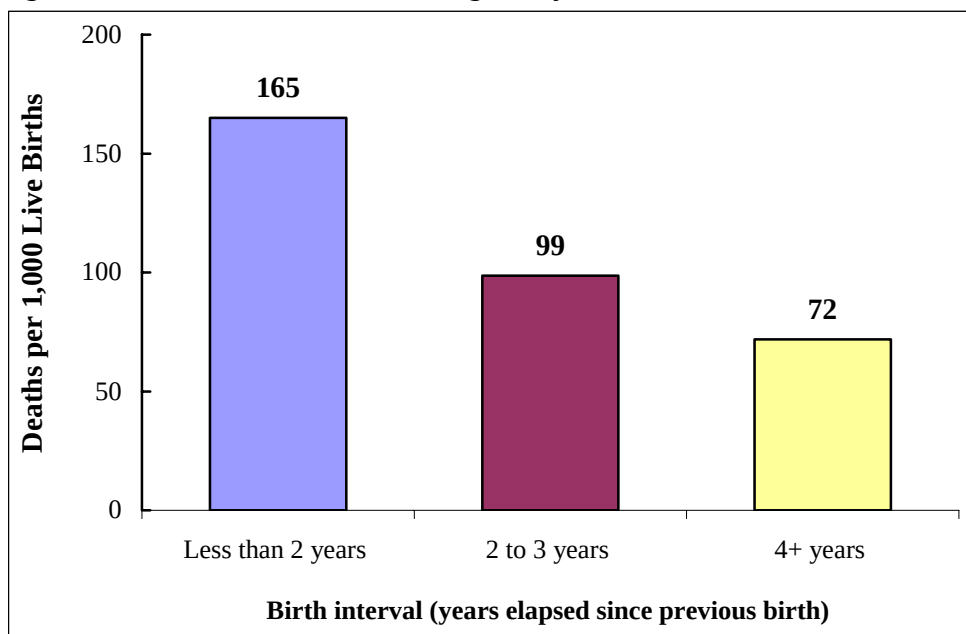
By avoiding risky late pregnancies:

A second concern is pregnancies at later ages. As age of pregnancy increases, there are significant increases in some health risks, including the risk of miscarriage, stillbirth, death of the newborn, gestational diabetes, pregnancy-induced hypertension, severe preeclampsia, and *placenta previa* (Hanson, 1986; Jacobsson et al., 2004). Births to women over age 40 were found to be 2.68 times as risky as those in the lowest risk groups (Chen et al., 1974).

By increasing birth spacing:

Another significant health benefit for both mother and child comes from longer intervals between births. Based on population surveys in 35 countries between 2001 and 2005, under-five mortality fell as the interval between births grew. As can be seen in Figure 3, deaths among children under age 5 were more than twice as high for children born less than two years after their sibling as they were for those born four years or more later. (ORC Macro, 2007) Other research reinforces this point, showing that children born three years after a previous birth are healthier at birth and more likely to survive at all stages of infancy and childhood through age five. (Setty-Venugopal, 2002) Increased birth spacing leads to less risk of premature (Fuentes-Afflick, 2000) and/or low birth weight infants (Gribble, 1993). Women who have children at an interval of 27 to 32 months, compared to women who give birth at 9 to 14 month intervals, are more likely to avoid anemia, avoid third-trimester bleeding, and survive childbirth (Conde-Agudelo and Belizan, 2000.)

Figure 3. Deaths to children under age 5, by mother's birth interval



Source: ORC Macro, 2007. Average for 35 countries based on surveys conducted between 2001 and 2005

By preventing too many pregnancies

Too many pregnancies are not beneficial for mother or child. Most studies show that having more than four births results in substantial increased risk for the mother. For example, uterine prolapse and postpartum hemorrhage are much more common among high-parity women. (WHO, 2003).

Other studies show that low income families with large numbers of children may be detrimental to children's health through malnourishment, failure to recognize illness, inadequate attention and care, unsanitary living conditions, unfit clothing and shelter, and failure to take a child to see a doctor (Heaton, 2005).

Key point 2: Use of contraception leads to healthier mothers and infants through birth spacing and prevention of pregnancies in the very young, very old, and women with many children.

Contraceptives are Safe

Contraceptives are among the most-studied drugs and devices in the world. These studies are conducted to ensure the safety and appropriateness of contraceptive methods so that governments, policy makers, medical personnel, women and men can be sure that the benefits of contraception outweigh the risks.

The risk of death from use of contraceptives is very low. To put that risk into perspective, it is interesting to look at the risks involved in pregnancy and childbirth—risks that women, couples and society are glad to assume for the sake of having a child and starting a new generation. From a strictly health perspective, though, the risk of death from pregnancy and childbirth¹ is 20 times higher than the risk of death from oral contraceptive-use for a young, healthy woman; and 1,000 times higher than the risk of death from using an intrauterine device (IUD). The risk of death from using a condom, and/or spermicides is zero.² (Hatcher et al., 2004).

Historical Concerns in Ukraine

Many in Ukraine believe some contraceptives are harmful to health. This has a historical basis which no longer applies. For example, studies conducted in the 1960s in the United States and Britain, and by WHO in other countries, found that high dose contraceptives containing more than 50mcg of estrogen, were linked to risks of blood clots, heart attacks and stroke (Snider, 1990). High dose pills were commonly available in the former Soviet block for longer than in these countries. Current pills available in Ukraine have less than 35 mcg of estrogen (Hudgins, 2004), which has been found to be a safe level for reducing the side effects in earlier studies. The legacy of the risks of the older, high-dose pills may contribute to the reluctance of Ukrainian physicians and patients to use oral contraceptives.

Current research does not support many commonly held beliefs about oral contraceptives. While lower dose oral contraceptives (20 mcg) have been found to lead to changes in patterns of menstrual bleeding (Gallo et al., 2007a), other research has shown that there is no association between oral contraceptives and weight gain (Gallo et al., 2007b). Studies of the relationship between oral contraceptives and depression are inconclusive, given confounding influences associated with unintended pregnancies (Gardner, 1983). There had been lingering concern about an association of oral contraceptives with breast cancer. However, a careful study involving over 9,000 women has shown no relationship (Marchbanks, et al, 2002). In fact, research shows a strong *protective* effect of oral contraceptives against some common cancers (to be discussed below). Recent evidence shows no association with breast cancer (Dumeaux, et al, 2003 & 2005; Kahlenberg, et al, 2006; Kumle, et al, 2005; Vessey, et al, 2006) or weight gain. (Gallo, et al, 2007b)

¹ These data are for women who have passed the 20th week of pregnancy.

² These risks are based on data from the United States or England

There is some concern in Ukraine that oral contraceptives can impair future fertility. Actually, on average, women who stop taking orals have only a 2-week delay in return of ovulation (Hatcher, 2004). In fact, use of oral contraceptives may actually enhance future fertility by improvement of general health, and reduction of reproductive cancers, pelvic inflammatory diseases (PID) and ectopic (tubal) pregnancies.

For certain women with specific health risks and conditions (such as smoking, obesity, heart disease), there are more risks with taking certain contraceptives than others. However, these specific conditions and their associated risks have been studied by experts, and, based on this evidence, a physician is able to recommend the most appropriate methods. WHO has reviewed the medical eligibility criteria for 18 different family planning methods. Their reference manual shows exactly which contraceptives are appropriate for which types of patients based on the newest clinical and epidemiological data (WHO, 2004d).

Key point 3: Modern contraceptive methods have been extensively studied for many years. Their safety and effectiveness has been well established.

Oral Contraceptives provide other health benefits to women

Oral contraceptives have also been found to provide other health benefits in addition to controlling fertility. Recent results from an important (British) Royal College of General Practitioners' oral contraceptive study found a 12% reduction in the risk of any cancer (Hannaforde et al., 2007). Orals have been found to have a strong protective effect against ovarian and endometrial cancer and cancer of the large bowel or rectum (Hatcher et al., 1998; Schlesselman, 1995; and Hannaforde et al., 2007). The risk of endometrial cancer is reduced by 54% with four years of use, 66% with eight years of use and 72% with 12 years of use (Schlesselman, 1995). The risk for ovarian cancer decreases by 40% with short term use and up to 80% with long term use (>10 years) (McLaughlin et al., 2007, Burkman, 2001). These findings are consistent and robust over the years and even more recent studies looking at specific gene sequences for ovarian cancer show similar findings (McLaughlin et al., 2007). Recent results from the Royal College of General Practitioners' study found a 46% reduction in the risk of ovarian cancer (Hannaforde et al., 2007). A new study has been conducted examining the effects of both obesity and oral contraceptive use on endometrial cancer in European women. It found that increased Body Mass Index was related to increased risk of endometrial cancer, but that this risk was reduced for women who had been using oral contraceptives (Friedenreich, 2007).

While the risk of endometrial, ovarian and uterine cancer tends to decrease with increased use of oral contraceptives (Schlesselman, 1995, McLaughlin et al., 2007, Burkman, 2001; and Hannaforde et al., 2007), there is evidence of an increased risk of certain other cancers with more than eight years of oral contraceptive use (cervix and central nervous system or pituitary) (Hannaforde et al., 2007).

Table 1. Non-contraceptive health benefits of oral contraceptives

Health Benefit	Details and Results from Published Studies
Endometrial Cancer	Endometrial cancer decreases by 40% with short term use and up to 80% with long term use (>10 years) (McLaughlin et al., 2007, Burkman, 2001).
Ovarian Cancer	Oral contraceptive use for 12 years reduces ovarian cancer risk by 60% (McLaughlin et al., 2007). 46% reduction in the risk of ovarian cancer (Hannaforde et al., 2007).
Benign breast cancer	Studies in both Canada (Rohan and Miller, 1999) and France (Charreau, 1993) have shown a decreased risk of benign breast disease with the use of oral contraceptives.
Colorectal Cancer	Using oral contraceptives for 96 months or longer leads to a 40% lower risk for colorectal cancer than never using oral contraceptives (Martinez, 1997). Others, using different study designs, find similar results. (Fernandez, 1998).
Rheumatoid arthritis	Oral contraceptives have been found to lead to a 30% decrease in rheumatoid arthritis (Spector, 1990). Those who use oral contraceptives have a 0.1 risk of developing mild rheumatoid arthritis (Jorgenson, 1996).
Ectopic Pregnancy	Oral contraceptive use is associated with a lower rate of ectopic (tubal) pregnancy than other highly effective methods of reversible contraception or tubal sterilization (Kaunitz, 1999, Franks, 1990 and Mol, 1999) ³ .
Pelvic Inflammatory Disease	Oral contraceptive use for 12 consecutive months decreases the risk of Pelvic Inflammatory Disease by 60% (Pasner, 1991).
Treatment of Acne	Oral contraceptives have been shown in randomized control trials to decrease acne more in the treatment group than in the placebo group (Redmond, 1997; Lucky, 1997; Arowojolu, 2007).
Prevention of Osteopenia	Oral contraceptives may increase bone mineral density (Warren et al., 2005).
Dysfunctional uterine bleeding	Oral contraceptives reduce dysfunctional uterine bleeding in a randomized control setting (Davis, 2000).
Ovarian Cysts	Oral contraceptives are associated with a reduction in rate of functional ovarian cysts in some studies (Holt et al., 2003). In other studies this reduction is not considered to be very large or significant (Grimes et al., 2006).
Dysmenorrhea	Although some studies have shown oral contraceptives reduce risk of dysmenorrhea by 60% (Mishell, 1982) other reviews have shown that no conclusions can be made about the efficacy of commonly used modern lower dose combined oral contraceptives for dysmenorrhoea. (Proctor et al., 2001).

³ There is an increased risk for ectopic pregnancy in those women who have previously used oral contraceptives (Mol, 1999).

Other non-contraceptive health benefits from using oral contraceptives include decreased risk of benign breast cancer, colorectal cancer, rheumatoid arthritis, ectopic pregnancy, and pelvic inflammatory disease. Oral contraceptives have also been used in the treatment of acne, prevention of osteopenia, dysfunctional uterine bleeding and possibly dysmenorrhea⁴ and ovarian cysts (Hatcher, 1998 and Kaunitz, 1999). The table below highlights several of the more recent results.

Non-contraceptive benefits of other modern contraceptives

While the health benefits of oral contraceptives are most striking, virtually all modern methods have some non-contraceptive benefits for the user. The following table presents some of these benefits:

Table 2: Non-contraceptive benefits of other contraceptives

<i>Method</i>	<i>Non –contraceptive benefits</i>	
IUD	Decreased endometrial cancer	5 of 6 studies found reduction in endometrial cancer among IUD users (Hatcher et al., 2004)
Condoms	Prevention of Sexually Transmitted Diseases	Numerous clinical studies show that condoms can reduce the risk of a wide variety of STIs in addition to HIV infection, including gonorrhea, chlamydia, trichomoniasis, syphilis, and genital herpes. (Hatcher et al, 2004)
	Prevent Infertility	By preventing STIs and their long-term sequelae, condoms protect fertility (Ibid)
Implants, Injectables	Decrease cancer	Decreased endometrial and ovarian cancer (Hatcher, 1998)
	Decrease Pelvic Inflammatory Disease	

Key point 4: Most modern contraceptives have health benefits in addition to their fertility regulation effects. These are most striking for combined oral contraceptives, which, for example, have strong protective effects against some deadly cancers.

Contraceptives, HIV/AIDS and Sexually Transmitted Infections

Some methods of contraception, especially condoms, have an impact on the incidence of HIV/AIDS and sexually transmitted infections (STIs) (UNAIDS, 2004 and Holmes et al., 2004). Ukraine has one of the fastest growing HIV/AIDS epidemics in the world (Human Rights Watch, 2005), which could pose a threat to the country's development (Zhylka, 2005). According to data from the Ukrainian MOH and the Center for AIDS Prevention, the number of individuals infected with HIV increased 16.5 times between 1995 and 1998. This increase has continued more recently, with HIV prevalence rising from 10.67 per 100,000 in 1999 to 24.02 per 100,000 in 2005 (WHO, HFA-DB). The frequency of STIs increased in Ukraine in the 1990s, especially among adolescents. According to data from the MOH, syphilis increased from 9.7 in 1990 to 292.4 1998 per 100,000 female population aged 15-17. This trend has reversed in recent years, with reported incidence of syphilis decreasing from 114.34 per 100,000 in 1999 to 10.52 per 100,000 in 2006. However, the rate is

⁴ Dysmenorrhea refers to menstrual pain severe enough to limit normal activities or require medication

still double the rate for the European Union (EU), and almost four times the rate for the older (pre-2004) EU Countries (WHO, 2007, HFA-DB).

Key point 5: Use of condoms protects against HIV and other STIs, including chlamydia, which is a major cause of infertility.

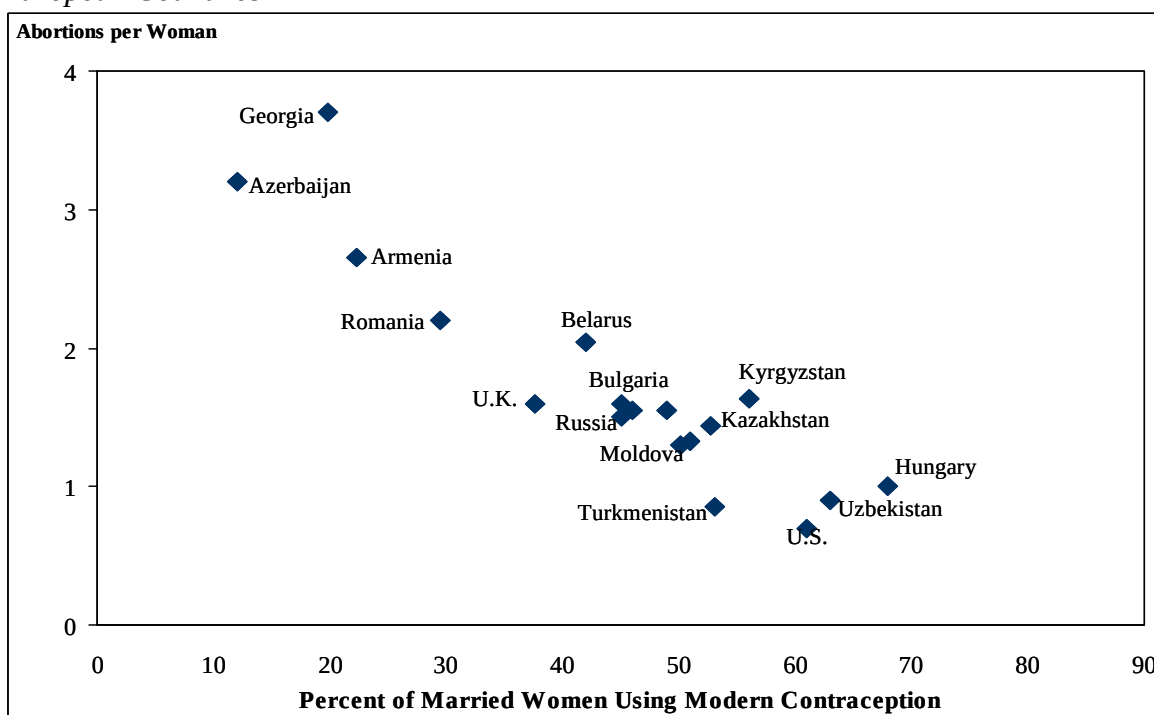
III. Contraception and Abortion

The 1994 International Conference on Population and Development (ICPD) in Cairo declared that all governments should try to “reduce the recourse to abortion through expanded and improved family planning services” (WHO, 2004b and ICPD). Contraception has been shown to be a better alternative to abortion as a means of fertility control and there is evidence in several low fertility countries that the shift from abortion to contraceptives does not change overall fertility rates.

Increased use of contraception is related to fewer abortions

There is ample evidence that the availability of contraceptives contributes to reductions in abortions. Empirical evidence from a varied selection of countries shows that countries with higher contraceptive use tend to have lower abortion rates (see Figure 4 below).

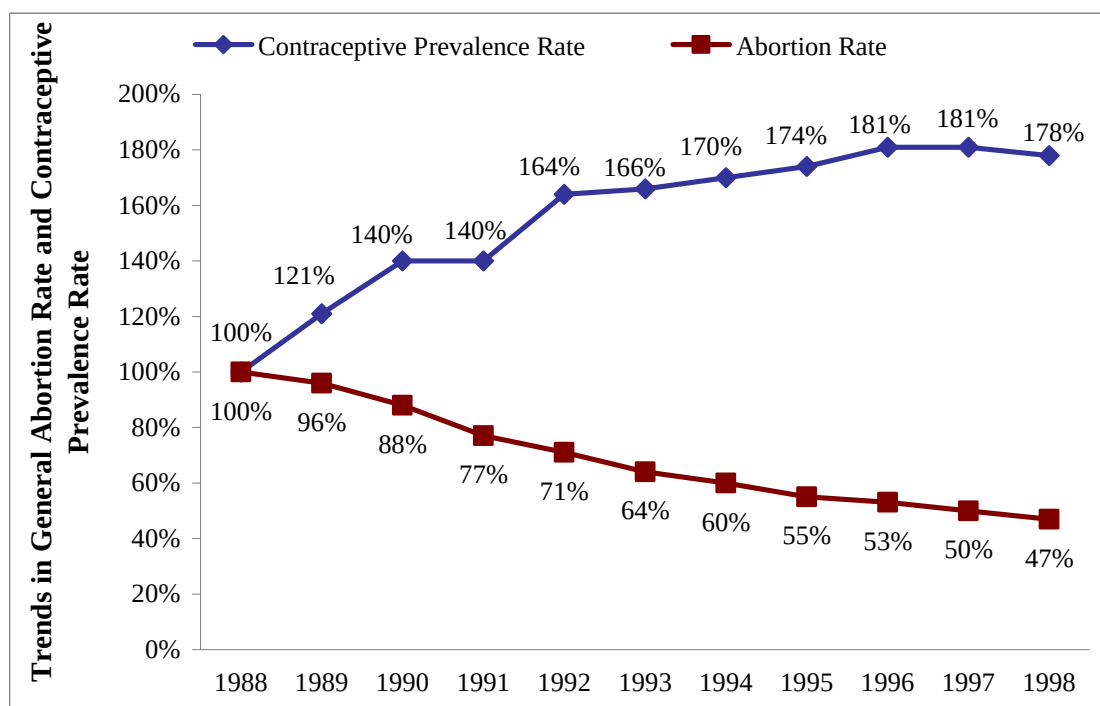
Figure 4. Total abortion rates and prevalence of modern contraceptive methods in selected European Countries



Source: Westoff, 2005.

Similar patterns of decreasing abortions with increasing contraceptive prevalence have been observed through longitudinal analysis during the 1990s of 12 countries in Eastern Europe and Central Asia (Westoff et al, 2005). There was an increase in the use of modern contraception in each country during the decade. This usually coincided with a steady decrease in abortion rates. Figure 5 shows the trends in contraceptive prevalence rates and general abortion rates in Russia over a decade. It shows a clear pattern of modern contraceptive use increasing by 78%, concurrent with a 53% decrease in abortion.

Figure 5. Trends in abortion and contraception in The Russian Federation (1988 = 100%*)



Source: adapted from Westoff, 2005

* This figure shows the relative trends in abortion and contraceptive prevalence rates, starting from the values reported in 1988, which are considered to be 100%.

** The general abortion rate is the number of abortions per thousand women age 15-49; the contraceptive prevalence rate is the percentage of women using modern contraceptive methods.

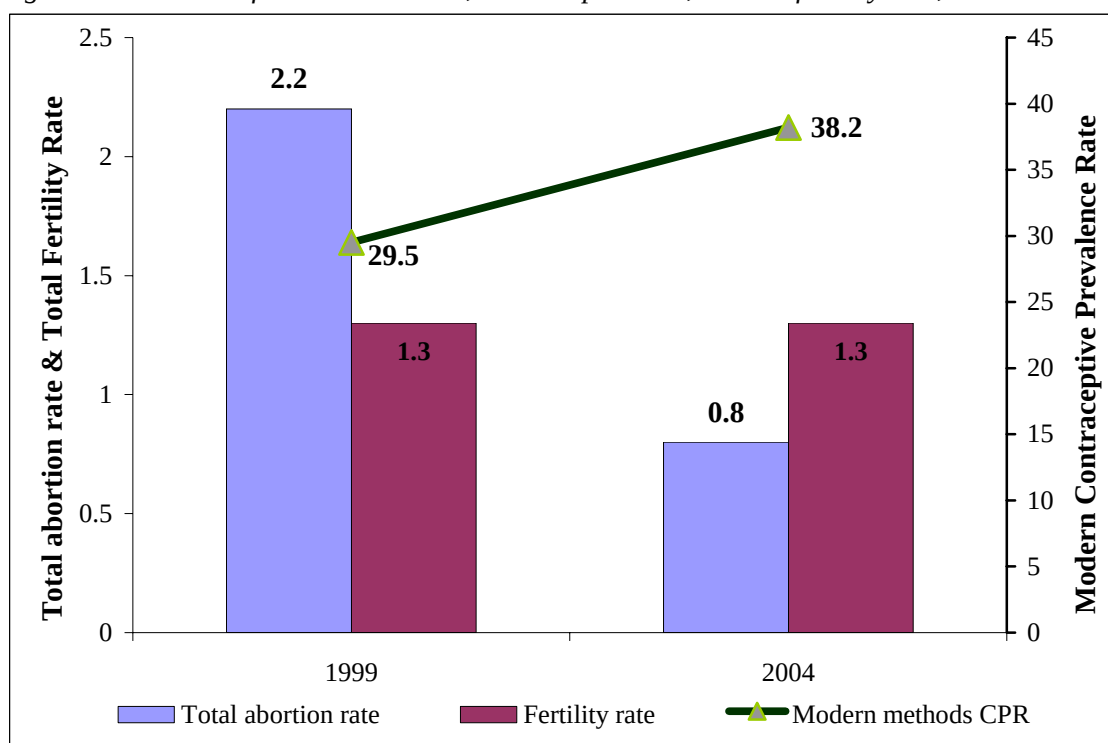
Contraception, Abortion and Fertility

There is evidence in several countries (Denmark, Netherlands, United States and Cuba) that, before fertility declines to a stable level, both abortion and contraceptive use has tended to increase (Marston and Cleland, 2003). Once fertility levels have stabilized at lower levels, contraception replaced abortion as the preferred method of fertility control and did not contribute to continuing declines in fertility.

A more recent example of the replacement of abortion with contraception, accompanied by stable fertility, is shown below. In Romania, since the end of the pronatalist policies of the Ceausescu regime in 1989, there has been an increase in access to, and use of, reproductive health services. As the level of contraceptive use—primarily oral contraceptives and condoms—increased from 1999 to 2004, the total abortion rate per woman decreased from 2.2 to 0.8 and the total fertility rate did not change (remaining at 1.3 births per women aged 15-44) (see Figure 6).

Key point 6: In low fertility countries (like Ukraine and many European countries), there is strong evidence that increased use of modern contraception lowers abortion, rather than further lowering fertility.

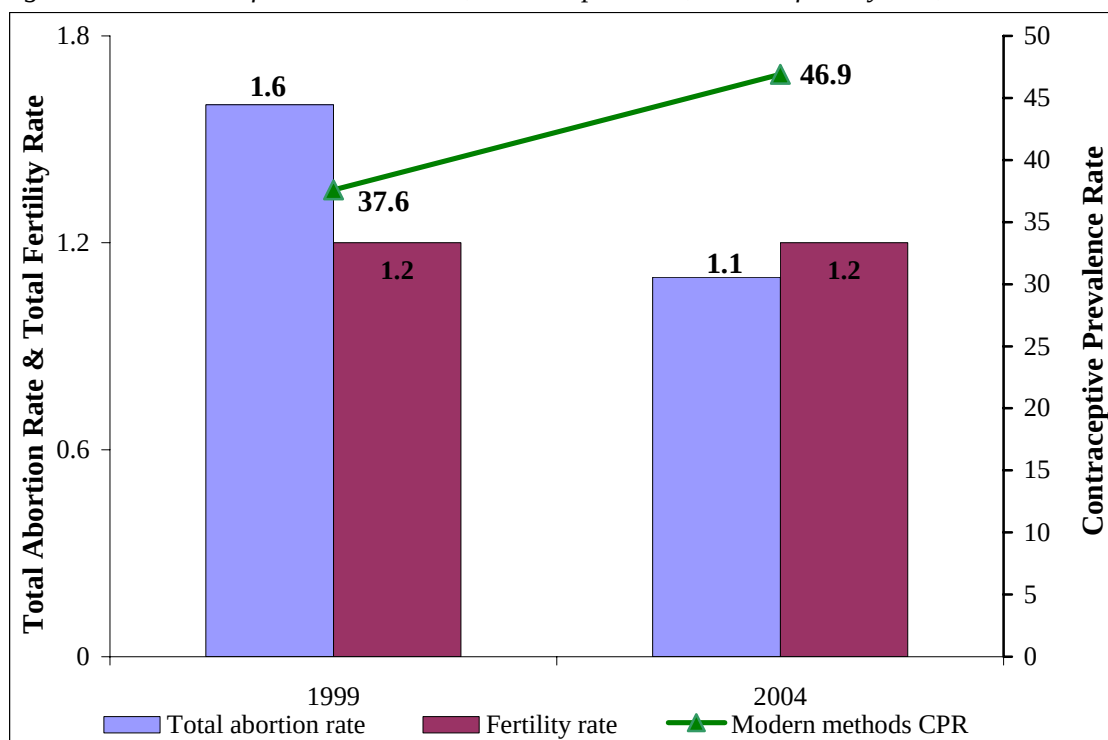
Figure 6. Evolution of the abortion rate, contraceptive use, and the fertility rate, Romania 1999-2004



Source: Reproductive Health Survey(s), Romania 1999 and 2004.

A similar pattern has been seen in recent years in Ukraine. Figure 7 shows that the abortion rate has decreased considerably, while contraceptive prevalence rates have increased and fertility rates remained constant.

Figure 7. Evolution of the abortion rate, contraceptive use, and the fertility rate, Ukraine 1999-2004.



Source: UN, 2005; Ukraine State Statistics Committee, 2004/05; Westoff, Olds 2005.

Health Effects of Abortion

There are health risks to using abortion as a means of regulating fertility

Worldwide, of the 210 million women who became pregnant in 2000, 46 million pregnancies were voluntarily terminated by abortion. Forty-one percent (41%) of these terminations (19 million) took place outside the legal health system, often by unskilled providers or in unhygienic conditions (WHO, 2004b; IPPF, 2006). At the 1994 ICPD in Cairo, governments agreed that abortion is risky and that all governments should try to “reduce the recourse to abortion through expanded and improved family-planning services” (WHO, 2004b and ICPD). There are clear negative health implications of unsafe abortions; the most severe include death, sepsis, hemorrhage, genital and abdominal trauma, perforated uterus and poisoning if harmful substances are ingested. Other possible secondary complications of unsafe abortions include reproductive tract infections, chronic pelvic pain, and pelvic inflammatory disease.

Health Effects of Safe Abortion

While the evidence about unsafe abortions seems clear, numerous studies have examined some of the potential negative health effects of safe or uncomplicated abortions, often coming to inconclusive findings. For example, there is some concern that abortion may have a negative impact on a woman’s future fertility (Ministry of Health Ukraine, 2000 and Steshenko and Irkina, 1999). However, studies have found no association between safe induced abortion and secondary infertility (the inability to conceive or maintain a pregnancy after having successfully done so before) or ectopic (tubal) pregnancy (Atrash, 1990). The International Planned Parenthood Federation (IPPF) has concluded that there is no evidence that having an uncomplicated abortion has any bearing on future fertility (IPPF, 2006).

There is some evidence, however, that abortion has an effect on low birthweight for subsequent births. A case control study in France shows that women with a history of induced abortion were at higher risk of very preterm delivery than those with no history of abortion (Moreau, 2005) and several other studies in France (Henriet, 2001) and Germany (Martius, 1998) also show that preterm birth is associated with induced abortion. However, a study in China did not find a statistically significant relationship between a history of medically induced abortion and low birthweight for the first subsequent pregnancy (Yimin et al., 2004) and a second Chinese study found that women who had an abortion using mifepristone (an antiprogesterone drug) had lower odds for preterm delivery than women who had no abortion (Chen, 2004).

Similarly, there is conflicting evidence that abortions have an effect on the risk of breast cancer. Comprehensive review and meta analysis studies in 1996 and 2005, which combined evidence from several studies, showed that women who had had an abortion had a significantly elevated risk of breast cancer (Brind, 1996 and 2005). However, the US National Cancer Institute, the British Government and IPPF conclude that there is no association between abortion and breast cancer (National Cancer Institute, 2006 and Collaborative Group on Hormonal Factors in Breast Cancer, 2004; IPPF, 2006)

Evidence from studies in other countries does not clearly support an argument that safely performed abortions are related to infertility, breast cancer, low birthweight or mental disorders. Note, though, that IPPF’s conclusion about fertility is related to *uncomplicated* abortion. However, the Ukraine Reproductive Health Survey of 1999 found that 5% of women having abortions reported a re-hospitalization or extended hospitalization as a result, and 6% reported long-term complications. (Kiev International Institute of Sociology, et al., 2001). Therefore, to the extent that these

complications are related to infection, there may be some effect on fertility. Recent studies have estimated that there are 5-9 unsafe abortions in Ukraine per 1,000 women of fertile age, which is twice the rate of Europe as a whole (3 unsafe abortions per 1,000 women aged 15-44) (WHO, 2004b, Glasier et al., 2006). Worldwide, studies indicate that of every five women who have an unsafe abortion, at least one suffers a reproductive tract infection as a result; and some of these infections are serious, leading to infertility (WHO, 2004d).

Key point 7: Safe, legal abortions have few long-term health effects. However, as recently as 1999, 5% of abortions in Ukraine were reported to involve a re-hospitalization or extension of hospitalization. Such complications may have a health effect, including infertility.

It should be noted that there is also anecdotal information that abortion techniques in Ukraine are changing from dilation and curettage (with its 50% higher complication rate in Ukraine (Kiev International Institute of Sociology, 1999)) to vacuum aspiration. Therefore, the rates of complications reported in 1999 may now be lower.

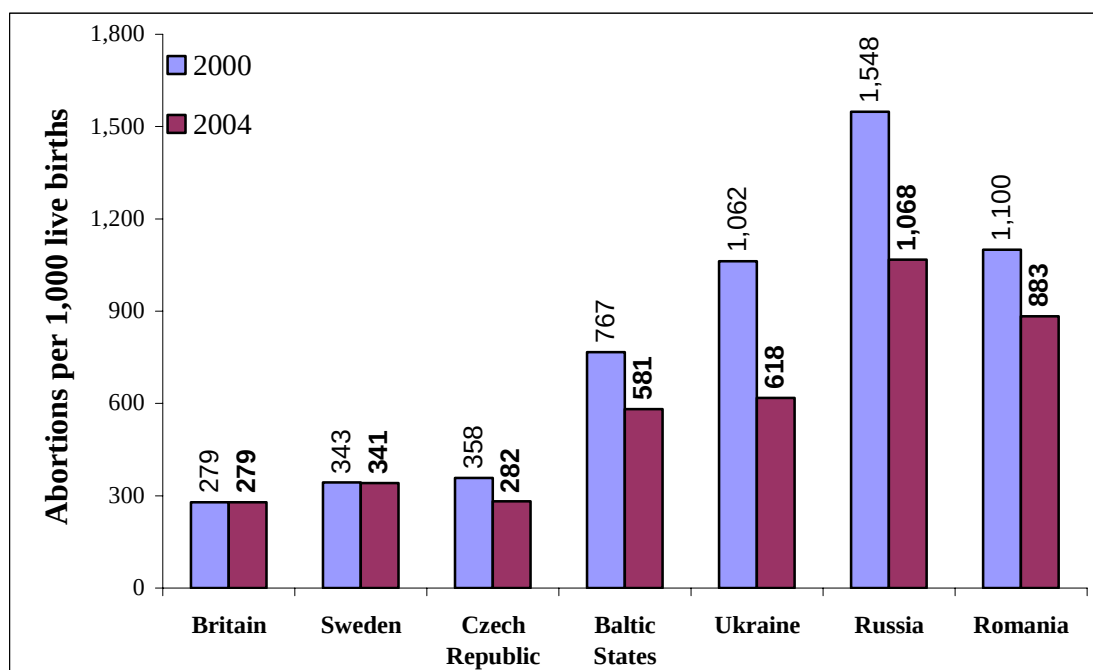
Contraception and Abortion Rates in Comparative Perspective

Abortion rates

In Ukraine during the Soviet period, abortion, along with IUDs, was one of the most commonly used means of fertility control. In recent years, the number of abortions per woman has declined significantly. Two studies showed that abortions declined from 57.2 per 1,000 women of fertile age in 1996 to 36.7 in 1999 (Alan Guttmacher Institute 1999) and recent data from WHO's Health for All database, using a different metric, found that the number of abortions decreased from 1,061 per 1,000 live births in 2000 to 618 in 2004 (WHO, HFA-DB).

Despite the decline in abortions in Ukraine, the most recent comparative data show that abortion rates are still quite high. Ukraine in 2004 had the fifth highest abortion rate among 25 EU, post-Soviet and Central and Eastern European countries (WHO, HFA-DB), and still remains much higher than Western European countries (see Figure 8).

Figure 8. Abortions per 1,000 live births in selected European Countries



Source: WHO/Europe Health for All Database

Baltic States is an average of maternal mortality rates for Estonia, Latvia and Lithuania

Key point 8: While abortion rates have declined in Ukraine, they are still significantly higher than in Western European countries.

Contraceptive Method Mix

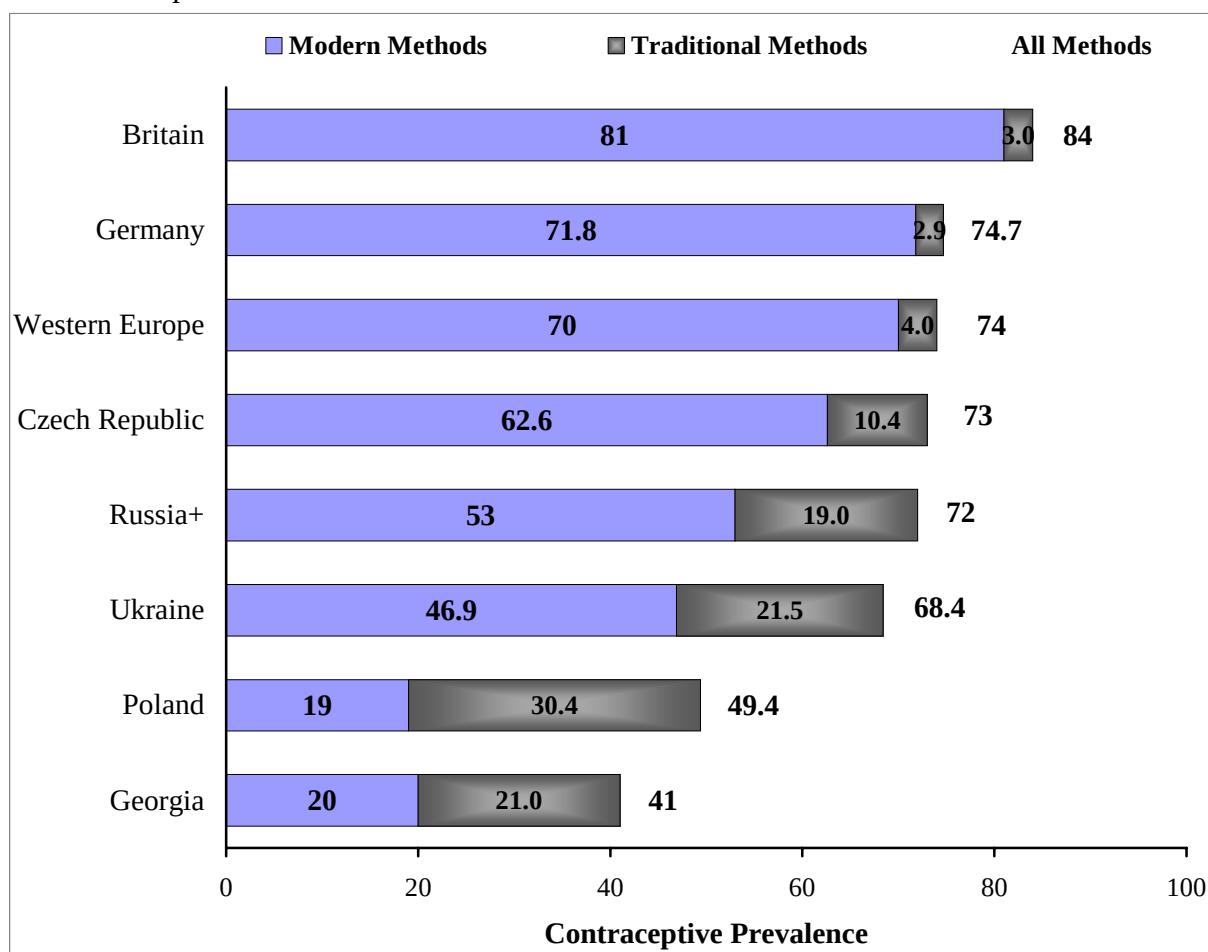
Contraceptive method mix—the relative use of various contraceptive methods by a population—is important not only for the effectiveness of contraceptive use but also for offering women a choice of desirable alternatives to abortion. The following section analyzes the method mix in Ukraine in comparative perspective.

The contraceptive method mix in Ukraine is different from that in Europe and other developed countries. Use of *modern* contraception is lower in Ukraine than in European Union countries and use of less effective *traditional methods*, particularly withdrawal, is higher.

Figure 9 compares the most recent data available for several European countries. Not only are Ukraine's contraceptive prevalence rates⁵ for all methods, including modern methods, lower than the average for Western Europe, but its use of less effective traditional methods is much higher.

⁵ The definition of contraceptive prevalence used in this report is that of the WHO: Percentage of women of reproductive age (15-49) who are using (or whose partner is using) a contraceptive method at a particular point in time. *Modern Contraceptive Methods* include female and male sterilization, injectable and oral hormone, intrauterine devices, diaphragms, hormonal implants, spermicides, and condoms. *Any contraceptive method* includes modern (see above) and *traditional methods* such as the calendar method (or rhythm), withdrawal, abstinence, lactational amenorrhoea (lack of menstruation during breastfeeding), and folk methods. http://www.who.int/reproductive_indicators/definitionofindicators.asp#2

Figure 9. Contraceptive prevalence rates, modern methods, traditional methods and all methods, selected European Countries



Source: UN, 2005, CDC, 2003 (for Russia), Ukraine State Statistics Committee, 2004/05; for relevant years

Traditional methods are more likely to fail

Women in Ukraine still rely heavily on several traditional methods of contraception. For example, 10% of married women rely on withdrawal, which is more than the 6% who use oral contraceptives (Ukraine State Statistics Committee, 2004/05). Traditional methods have some of the highest failure rates, which represent the percentage of couples who will experience an unintended pregnancy in a year while using a method. The failure rate for withdrawal is 27% and for periodic abstinence 25%. In comparison, the failure rate for oral contraceptives is 8% and for the most common IUD, only 0.8% (WHO, 2004d.). This is important because failures of traditional methods are very likely to lead to abortion.

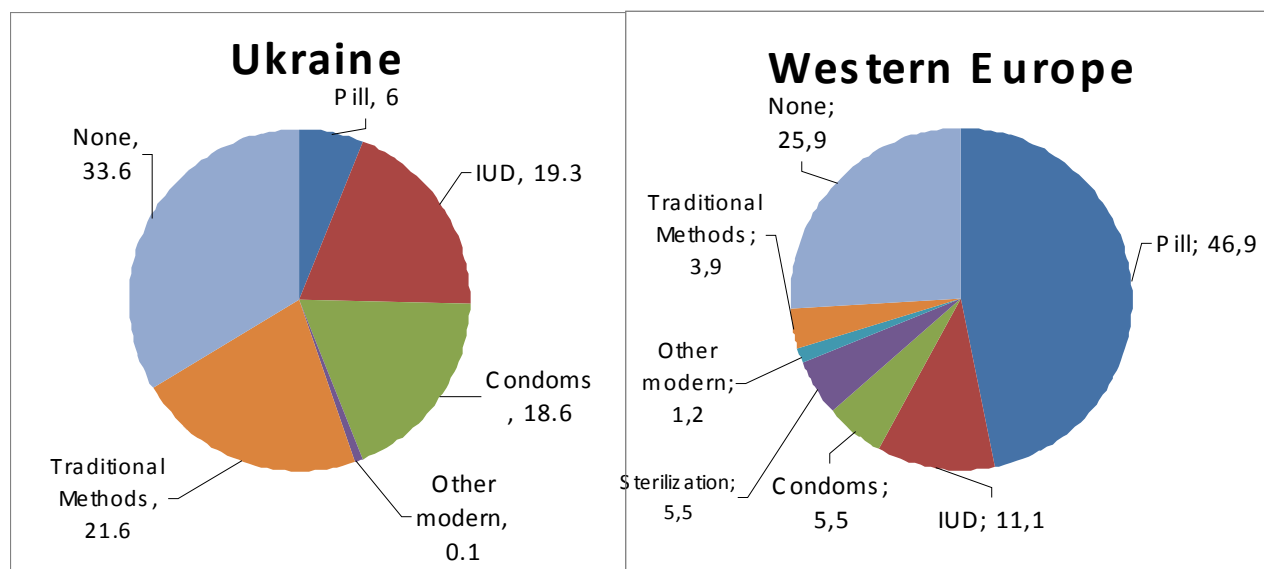
Key point 9: Most developed countries have a lower use of traditional methods in their method mix, leading to fewer method failures, and consequently, fewer abortions.

Oral Contraceptive Use is Low in Ukraine

Use of pills and other hormonal methods and sterilization is low in Ukraine compared to traditional methods, IUDs and condoms. In the most recently available survey, only 6% of women reported using oral contraceptives, while 19% reported using IUDs and 18.6% reported using condoms (Ukraine State Statistics Committee, 2004/05). The two charts below show the pattern in Ukraine,

compared to Western Europe.⁶ The most striking difference is in the use of oral contraceptives in Western Europe, at 46.8%. However, there is higher use of voluntary surgical sterilization, as well, at 5.5%. Sterilization, either male or female—hardly ever used in Ukraine—is the method of choice for many women in other developed countries – 30% in Britain and 37% in the US.

Figure 10. Method Mix in Ukraine compared with Western Europe.



Source: Data for Western European countries (Austria, Belgium, France, Germany, Netherlands, Switzerland) from UN, 2005 World Contraceptive Use. These data are for women aged 15-49 who are married or in union. Data for Ukraine are from the WAPS survey and are for married women aged 15-49 (Ukraine State Statistics Committee, 2004/05)

While very different from the European Union countries, where use of oral contraceptives and other modern methods is much higher, the method mix in Ukraine is not very unusual compared to other Eastern European countries, where IUDs and traditional methods are chosen over oral contraceptives and sterilization.

Key point 10: Other developed countries have a very different method mix, making much more use of oral contraceptives and sterilization, and much less use of traditional methods.

IV. Cost benefit of Family Planning

Evidence from other countries, as well as Ukraine, indicates that family planning is a cost-effective intervention—especially compared to abortion.

The World Bank’s landmark 1993 report, “Investing in Health,” advised governments, at a minimum, to spend their resources on a package of five essential clinical services of high cost effectiveness. One of these essential interventions was family planning, because it “could save as many as 850,000 children from dying every year and eliminate as many as 100,000 of the maternal deaths that occur annually”⁷ (World Bank, Investing in Health, 1993). The report goes on to state that adequate investment in family planning could avert 3% of the burden of disease worldwide (World Bank, Investing in Health, 1993).

⁶ Austria, Belgium, France German, Netherlands, Switzerland

⁷ Other highly cost-effective interventions cited in the report were: pregnancy-related care, tuberculosis control, STI control and care for common serious illnesses of young children.

Studies in Ukraine and other places have shown that the provision of contraceptive services is more cost-effective than reliance on induced abortion to control fertility. A recently conducted costing simulation calculated that if those who use traditional methods and abortion shifted to modern contraceptive methods, the result would be a cost savings of at least 17 million Hryvnia (US\$3.38 million)⁸ (Policy Project, 2005). Recent studies conducted by the Ukrainian MOH and international agencies (2004/2005) also showed that contraceptive provision could save costs related to abortion and abortion complications valued at more than 3 million Ukrainian Hryvnia (UAH) annually.

Unfortunately, annual contraceptive costs in Ukraine have been noted by some to be as high as US\$45 for oral contraceptives, US\$2.58 for IUD, US\$36 for condoms, and US\$32.61 for spermicides (Zhylka, 2005). The Willingness and Ability to Pay Survey (Ukraine State Statistics Committee, 2004/05) found the median annual cost for women of oral contraceptives to be US\$78 (390 UAH), for condoms, US\$48 (240 UAH), and US\$15 (75 UAH) for an IUD, including insertion. Experts in Ukraine agree that the cost of abortion, compared to contraceptives, may be relatively low, providing an unintended incentive for abortion. If a Ukrainian woman opted to use contraception for family planning, she would have to spend 1-15% of her monthly salary for one package of oral contraceptives (Muscato, 2003) or, according to another study, 1-33% of annual income for various brands of the pill available in Ukraine (Hudgins, 2004). Some oral contraceptive brands are as expensive as US\$9.4 (47 UAH) (Zhylka, 2005), which according to the Willingness and Ability to Pay Survey would not be affordable to more than 70% of the population. By comparison, in the US, on average, a woman spends about 0.5% of her monthly salary on oral contraceptives.

The 2004 Willingness and Ability to Pay Survey found:

“Over 90 percent of respondents currently using oral contraceptives, an IUD, or condoms felt that their current method of contraception was inexpensive or affordable. However, among non-users of these specific contraceptives, there was a higher share that felt these methods were too expensive. In particular, among married women age 15-49 years who were not using oral contraceptives, 34.6 percent felt that this method was too expensive.”

Focus group results in Ukraine found a range of costs for abortion. Some women paid as little as US\$6.90, while others paid as much as US\$60 (this includes only costs incurred directly by clients, without government expenses). The results of the focus groups show that the price is flexible for different groups within the population and comparable or less than the cost of contraception. (Together for Health, 2006). In general, the women interviewed reported that cost was only one factor in the higher levels of abortion and lower levels of contraceptive use. They also thought that more information about modern contraceptives would be an important factor in increasing contraceptive prevalence.

A study on the cost of abortion conducted by the Health Policy Initiative in 2007 in two oblasts of Ukraine showed that government expenses for abortion varied between US\$9 and \$23 per procedure, depending on where the procedure was performed (oblast or rayon level hospital) and the technique used (vacuum aspiration or dilation and curettage) (Health Policy Initiative, 2007). If these figures on government expenditures are combined with the focus group data (above) on what women paid for abortion, we can conclude that the total cost of an abortion (to the government and the client) may be in the range of US\$16 to \$83.

⁸ This is a costing study, where the savings were calculated for the period between 1999 and 2015.

In Romania, a WHO Strategic Assessment recommended that increasing access to contraception and lowering the price of modern contraceptives relative to abortion could influence attitudes toward contraception and lead to increased use of modern contraceptive methods. They based this recommendation on the finding that high costs of contraception were the key factor in women choosing abortion over contraception. Oral contraception cost women approximately US\$2 per month and emergency contraception cost US\$4. Upon this recommendation, in 2004, the MOH doubled the fee for an abortion in a public clinic from US\$2 to US\$4. At the same time they offered free contraceptives to women who had abortions (Johnson et al., 2004). Reducing costs to women could also lead to a reduction in system costs, which are often not accounted for and include costs for staff, the facility, equipment, drugs and supplies, pain medication used, whether any complications occurred, the time for the procedure, overall time spent in the hospital and overhead costs. Including these costs, the real cost of abortion in Romania was found to vary from US\$5-15 in the public sector and US\$12-33 in the private sector (Horga, 2001).

In Ukraine, findings from surveys suggested that in 2002 the costs of abortion and management of abortion complications were 380,000 US\$ (1,900,900 UAH), almost twice as high as the costs of providing contraception, estimated at 200,000 US\$ (994,900 UAH) (Zhylka, 2005).

Key point 11: Public sector investments in modern contraceptives may be cost-effective because they lead to lower expenditures for abortion and/or abortion-related complications in the public and private sectors.

V. Government Support for Family Planning

Most governments support family planning and affordable contraceptives.

Although modern contraception is legal in Ukraine, access is sometimes limited by the lack of government financing for contraceptives for disadvantaged populations, such as the poor, those with chronic conditions, young people and others. As of 2003, the central government of Ukraine did not cover IUDs, oral contraceptives, and/or surgical sterilization (Muscato, 2003). Many other countries, especially those in the EU, have significant government programs to increase access to contraceptives, especially for low income populations.

After ICPD, developed countries agreed to increase allocations to reproductive health programs by US\$6.1 billion annually by 2005 (Semelela, 2006). Many countries in Europe have taken this commitment seriously and invested in strong family planning and reproductive health programs. The table below highlights the details of several of these programs.

Public Provision of Contraceptives in Europe and the US

France: Medical contraceptives (oral contraceptives and IUDs) are reimbursed by the public social security system. Health care for pregnant women and babies is free (Sandier et al., 2004 and Toulemon and Leridon, 1998). Voluntary surgical sterilization is free of charge (Oddens, 1993). France began a national campaign to promote contraceptive use in 2000, when it was found that abortion rates had stabilized after a period of decline. The program was called “Contraception: It’s up to you to choose your own” designed to educate women on contraceptive choices and help them choose the method they would most consistently use (Boonstra, 2000).

Germany: Germany has a comprehensive health insurance policy that ensures virtually universal access to a wide range of health services, including prescription drugs, and family planning services. Specific family planning services are mandated by law. The Social Code sets forth legally required health insurance with explicit rights to medical examinations and prescriptions for birth control devices (Busse, 2004 and Center for Reproductive Rights, 1995). Voluntary surgical sterilization is free of charge (Oddens, 1993).

Great Britain: Family planning services are provided free by family doctors and a network of family planning clinics. Contraceptives for certain population groups are fully reimbursed by the National Health Service. A study conducted on expenditures for contraceptives showed that users in the UK paid nothing for oral contraceptives and IUDs and paid the least (compared to Italy, France, Spain, West Germany, Austria, Sweden, and Denmark) for condoms (Oddens, 1993).

Italy: The Italian health care system is based on a national health service that provides universal coverage free of charge at the point of service. Contraceptives are provided through both public and private pharmacies (WHO, 2007)

Romania: Family planning services are included in the minimum package of the public social insurance system, which is provided free to all population groups (insured or not) by public family doctors, family planning clinics and obstetrician-gynecologists. Contraceptives are procured by government for rural areas and poor urban areas, pupils, students and women with extra-genital pathologies. In 2005, the Romanian government spent more than US\$1.3 million for contraceptive procurement of pills, injectables and IUDs (Gasco, 2006).

Sweden: One of the initiatives of the National Institute of Public Health, established in 1992, is a focus on sexual and reproductive health programs. Preventive health care has been integrated into the primary health care system with midwives, district nurses and general practitioners providing family planning services. There are small fees for all services; however, some services, such as IUDs, are free (Glenngard et al., 2005; Oddens, 1993).

Ukraine: Ukraine has adopted National Reproductive Health Programs since 1995. The current Reproductive Health of the Nation Program up to 2015 has as one of its key objectives to improve the family planning system and allocates US\$18.7 million (95.6 million UAH) over a 10-year period to update the legal and regulatory framework for family planning, procure contraceptives for certain disadvantaged populations, establish a National Family Planning/Reproductive Health Center, ensure postgraduate training on family planning for health workers, conduct public education campaigns and undertake research (Ukraine Cabinet of Ministers Decree No. 1849, December 27, 2006, State Program “Reproductive Health of the Nation” up to 2015).

United States: Family planning services and contraceptive methods are provided at prices based on people's ability to pay in federally funded family planning clinics. The public health insurance program for the poor, Medicaid, fully pays for family planning services, including contraceptive methods, and many private insurance companies reimburse a significant part of contraceptive costs for their beneficiaries. (Alan Guttmacher Institute, 2005 and Benson Gold, 1999). Governments at various levels procure contraceptives for disadvantaged populations. For example, the Washington State health department paid US\$1.35 per cycle for combined oral contraceptives in 2001--about 20 times lower than the price charged by the same manufacturers to a private pharmacy chain. (Hatcher et al., 2004)

Key point 12: Most governments in the world support access to family planning and contraception, in recognition of their positive health benefits, their capacity to reduce abortion, the cost/benefit advantage, and their support of basic human rights.

Annexes

Annex 1: Abortion Ratios in an International Context—Core EU countries, Post-Soviet and Central/Eastern European Countries

Region and Country	Abortions per 1,000 live births (2004)		
	<20 years old	>35 years old	All ages
Core EU			
Britain	840.5	214.86	278.63
France	1883.26**	307.33**	274.71**
Germany	876.63	187.96	183.74
Spain	876.14**	142.55**	186.95
Italy	---	---	228.13
Denmark	2785.19	329.97	236.52
Norway	1704.08	287.74	247.07
Sweden	4165.21	362.51	341.37
Post-Soviet and Central/Eastern European Countries			
Russia	---	---	1067.9
Baltic States*	800.66	1132.87	581.52
Czech Republic	668.76	835.3	282.34
Bulgaria	402.82	2111	675.71
Hungary	942.23	1104.64	552.25
Poland	---	---	0.54
Romania	687.08	2359.92	883.37
Ukraine	546.68	1860.53	618.07
Moldova	---	---	---
Caucasus			
Armenia	130.59	1599.73	283.72
Azerbaijan	62.86	349.25	150.49
Georgia	242.44	554.96	371.12
Central Asia			
Kazakhstan	309.38	862.92	474.29
Kyrgyz Rep.	153.84	180.68	129.18
Turkmenistan	---	---	---

*average of Estonia, Latvia, and Lithuania

**only available for 2003

Source: WHO, Health for All Database

Annex 2: Contraceptive Prevalence (percentage contraceptive use among women who are married or in a union)

<u>Region and Country.</u> <u>Year of Survey</u>	Types of Methods							
	Any	Modern	Pill	IUD	Condom	Female Sterilization	Other Modern ^a	Traditional
<u>Core EU</u>								
Britain, 2002	84.0	81.0	22.0	6.0	18.0	13.0	1.0	5.0
France, 1994	74.6	69.3	35.6	19.9	5.0	8.0	0.0	5.3
Germany, 1992	74.7	71.8	58.6	6.0	4.4	0.9	0.0	2.8
Spain, 1995	80.9	67.4	14.6	7.6	24.3	12.1	0.0	13.6
Italy, 1995/96	60.2 ^b	38.9	13.6	5.5	13.7	5.8	0.0	21.4
Denmark, 1988	78.0	72.0	26.0	11.0	22.0	5.0	0.0	6.0
Norway, 1988/89	73.8	69.2	17.8	24.1	12.5	10.4	0.0	4.6
<i>Mean</i>	<i>75.2</i>	<i>67.1</i>	<i>26.9</i>	<i>11.4</i>	<i>14.3</i>	<i>7.9</i>	<i>0.1</i>	<i>8.4</i>
<u>Post-Soviet and Central/Eastern European Countries</u>								
Russia, 1999	73	53	7	25	16	2	3	20
Baltic States	55	42.1	5.0	23.2	12.9	0.0	0.0	12.8
Czech Rep., 1997	72.0	62.6	23.1	13.9	12.7	7.2	0.0	9.5
Bulgaria, 1997	41.5	25.6	7.0	6.9	10.9	0.1	0.0	15.7
Hungary, 1992/93	77.4	68.4	37.7	17.4	7.8	4.8	0.0	9.0
Poland, 1991	49.4	19.0	2.3	5.7	9.1	0.0	0.0	30.4
Romania, 2004	70.3	38.2	14.1	6.7	12.1	2.8	2.5	32.2
<i>Ukraine, 2004</i>	<i>68.4</i>	<i>46.9</i>	<i>6.0</i>	<i>19.3</i>	<i>18.6</i>	<i>0.8</i>	<i>0.1</i>	<i>21.6</i>
Moldova, 2000	62.4	42.8	3.3	34.5	3.5	1.1	0.0	19.6
<i>Mean</i>	<i>62.5</i>	<i>43.3</i>	<i>11.0</i>	<i>17.0</i>	<i>11.1</i>	<i>2.1</i>	<i>0.4</i>	<i>19.2</i>
<u>Caucasus</u>								
Armenia, 2000	60.5	22.3	1.1	9.4	6.9	2.7	1.9	38.2
Azerbaijan, 2001	55.4	11.9	1.0	6.1	3.2	1.2	0.1	43.5
Georgia, 2005	47.3	26.6	3.2	11.6	8.7	2.2	0.0	20.7
<i>Mean</i>	<i>52.1</i>	<i>18.0</i>	<i>1.0</i>	<i>8.4</i>	<i>5.5</i>	<i>1.8</i>	<i>1.0</i>	<i>34.1</i>
<u>Central Asia</u>								
Kazakhstan, 1999	66.1	52.7	2.4	42.0	4.5	2.8	0.0	13.5
Kyrgyz Rep., 1997	59.5	48.9	1.7	38.2	5.7	1.8	0.1	10.7
Turkmenistn, 2000	61.8	53.1	1.2	39.0	2.0	1.8	7.9	8.7
<i>Mean</i>	<i>62.5</i>	<i>51.6</i>	<i>1.8</i>	<i>39.7</i>	<i>4.1</i>	<i>2.1</i>	<i>2.7</i>	<i>11.0</i>

Note: all methods may not add to the total because some methods are used in combination.

^a Other modern methods include emergency contraception, female condom, and modern methods not reported separately.

^b Includes some cases of sterilization for non-contraceptive reasons

Source: Data for core EU, Post-Soviet and Central/Eastern European countries (except Russia and Baltic States), Caucasus, and Central Asia are from UN, 2005 World Contraceptive Use. These data are for women 15-49 who are married or in union. Baltic States is the average of rates for Latvia, Lithuania and Estonia.

Data from Russia are from CDC, 2003, and are for women 15-44 who are currently married from three urban oblasts.

Data for Ukraine are from WAPS report and are for married women 15-49 years of age (Ukraine State Statistics Committee, 2004/05)

Data for Romania and Georgia are from the respective Reproductive Health Surveys and are for married women 15-44 years of age.

References

- Alan Guttmacher Institute. 1999. *Sharing Responsibility: Women, Society and Abortion Worldwide*. New York: Alan Guttmacher Institute.
- Alan Guttmacher Institute. *Issues in Brief: Medicaid Family Planning Expansions Hit Stride*, copyright 2005.
- Arowojolu AO, Gallo MF, Lopez LM, Grimes DA, Garner SE. Combined oral contraceptive pills for treatment of acne. *Cochrane Database of Systematic Reviews* 2007, Issue 1. Art. No.: CD004425. DOI: 10.1002/14651858.CD004425.pub3.
<http://www.mrw.interscience.wiley.com.ezp1.harvard.edu/cochrane/clsysrev/articles/CD004425/frame.html>
- Atrash HK and Hogue CJR. The effect of pregnancy termination on future reproduction. *Bailliere's Clinical Obstetrics and Gynecology*, 1990, 4(2):391-405.
- Benson Gold, Rachel. State Effort to Expand Medicaid-Funded Family Planning Show Promise. *The Guttmacher Report on Public Policy*. April 1999.
- Boonstra, Heather. Promoting contraceptive use and choice: France's approach to teen pregnancy and abortion. *The Guttmacher Report on Public Policy*. June 2000; Vol 3, No. 3.
- Botting, Beverley, Michael Rosato and Rebecca Wood. Teenage mothers and the health of their children. *Population Trends*. Autumn 1998 (93): 19-28.
- Brind, J et al., Induced abortion as an independent risk factor for breast cancer: a comprehensive review and meta-analysis, *Journal of Epidemiology and Community Health*, 1996, 50 (5):481-496.
- Brind, Joel. Induced abortion as an independent risk factor for breast cancer: a critical review of recent studies based on prospective data. *Journal of American Physicians and Surgeons*. Volume 10, No. 4, Winter 2005.
- Burkman, Ronald T, John A. Collins, Lee P. Shulman, and J. Kell Williams. 2001. Current Perspectives on Oral Contraceptive Use. *American Journal of Obstetrics and Gynecology*. Volume 185(2): S4-S12.
- Busse, Reinhard and Annette Riesberg. 2004. *Health Care Systems in Transition: Germany*. European Observatory on Health Systems and Policies, vol. 6(9).
- Centers for Disease Control and Prevention (CDC), USAID, and Measure DHS+. 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*. Washington, D.C.: U.S. Department of Health and Human Services.
- Center for Reproductive Rights. 1995. *Women of the World: Formal Laws and Policies Affecting Their Reproductive Lives*.
- Charreau I, Plu-Bureau G, Bachelot A, et al. Oral contraceptive use and risk of benign breast disease in a French case-control study of young women. *Eur J Cancer Prevention* 1993;2:147-54.
- Chen, LC, Melita C., Gesche, Shamsa Ahmed, AI Chowdhury, and WH Mosley. 1974. Maternal mortality in rural Bangladesh. *Studies in Family Planning* 5, no. 11:334-341.
- Chen A et al., Mifepristone-induced early abortion and outcome of subsequent wanted pregnancy. *American Journal of Epidemiology*, 2004, 160(2):110-117.
- Collaborative Group on Hormonal Factors in Breast Cancer, Breast cancer and abortion: collaborative reanalysis of data from 53 epidemiological studies including 83,000 women with breast cancer from 16 countries, *Lancet*, 2004, 363(9414):1007-1016.
- Cromer, Charlotte and Judith Seltzer. *Reproductive Health Strategies for Ukraine 1999-2002*. Takoma Park, MD: Monitoring, Evaluation and Design Support (MEDS) Project and USAID, June 1999.
- Conde-Agudelo, Agustin and Jose M. Belizan (2000). Maternal Morbidity and mortality associated with interpregnancy interval: cross sectional study. *BMJ*; 321;1255-1259.

Davis A, Goodwin A, Lippman J, Olson W, Kafrissen M. Triphasic norgestimate-ethinyl estradiol for treating dysfunctional uterine bleeding. *Obstetrics and Gynecology* 2000;96:913-20.

Dumeaux et al 2003: 96,362 Norwegian women randomly selected from a central persons registry, aged 30-70, followed prospectively for two to eight years.

Dumeaux et al 2005: 68,670 French women selected from a national health insurance scheme, aged 40-64 years, followed prospectively for up to 10 years.

Family Care International. Global Sexual and Reproductive Health: highlights. <http://www.familycareintl.org/en/issues/24>. Accessed April 9, 2007.

Fernandez E, La Vecchia C, Franceschi S, Braga C, Talamini R, Negri E, et al. Oral contraceptive use and risk of colorectal cancer. *Epidemiology* 1998;9:295-300.

Franks AL, Beral V, Cates W Jr, Hogue CJR. Contraception and ectopic pregnancy risk. *American Journal of Obstetrics and Gynecology* 1990;163:1120-3.

Friedenreich, Christine et al. 2007. Anthropometric factors and risk of endometrial cancer: the European prospective investigation into cancer and nutrition. *Cancer Causes Control*. DOI 10.1007/s10552-006-0113-8.

Fuentes-Afflick, E. and N.A. Hessol. Interpregnancy interval and the risk of premature infants. *Obstetrics and Gynecology* 95 (3): 383-390. March 2000.

Gallo, MF, K Nanda, DA Grimes, and KF Schulz. 20 mcg versus >20 mcg Estrogen combined oral contraceptives for contraception. *Cochrane Database of Systematic Reviews*. Issue 1.

Gallo, MF, LM Lopez, DA Grimes, KF Schulz, and FM Helmerhorst. 2007b. Combination contraceptives: effects on weight. *Cochrane Database of Systematic Reviews*. Issue 1.

Gardner, Maureen B. 1983. Facts about Oral Contraceptives. Office of Research Reporting, National Institutes of Child Health and Human Development (NICHD).

Gasco, Merce, Christopher Wright, Magdalena Patruleasa, and Diane Hedgecock, 2006. Romania: Scaling Up Integrated Family planning Services: A Case Study. Arlington, VA.: DELIVER, for the U.S. Agency for International Development.

Glasier, Anna, A Metin Gulmezoglu, George P Schmid, Claudia Garcia Moreno, Paul FA Van Look. Sexual and reproductive health: a matter of life and death. *Lancet*. Published online November 1, 2006.

Glenngard, Anna H., Frida Hjalte, Marianne Svensson, Anders Anell, and Vaida Bankauskaite. 2005. Health Systems in Transition: Sweden.. WHO, European Observatory on Health Systems.

Gribble, J.N. Birth intervals, gestational age, and low birth weight: Are the relationships confounded? *Population Studies* 47(1): 133-146. Mar. 1993.

Grimes DA, Jones LB, Lopez LM, Schulz KF. Oral contraceptives for functional ovarian cysts. *Cochrane Database of Systematic Reviews* 2006, Issue 4. Art. No.: CD006134. DOI: 10.1002/14651858.CD006134.pub2. <http://www.mrw.interscience.wiley.com.ezp1.harvard.edu/cochrane/clsysrev/articles/CD006134/frame.html>

Hannaford, Philip C., Sivasubramaniam Selvaraj, Alison M. Elliott, Valerie Angus, Lisa Iversen and Amanda J. Lee. Cancer risk among users of oral contraceptives: cohort data from the Royal college of General Practitioner's oral contraceptive study. *BMJ* published online 11 Sep 2007; doi: 10.1136/bmj.39289.6494 10.55.

Hanson, JP. Older maternal age and pregnancy outcome: a review of the literature. *Obstet Gynecol Surv*. 1986;41:726-42.

Hatcher, Robert A., James Trussell, Felicia Stewart, Williard Cates, Gary Stewart, Filicia Guest, and Deborah Kowal. Contraceptive Technology. Seventeenth Revised Edition. Ardent Media, Inc. New York. 1998.

Hatcher, Robert A., James Trussell, Felicia Stewart, Anita Nelson, Williard Cates, Filicia Guest, and Deborah Kowal. Contraceptive Technology. Eighteenth Revised Edition. Ardent Media, Inc. New York. 2004.

Health Policy Initiative (Constella Futures and USAID), unpublished data, 2007

- Heaton, Tim B, Renata Forste, John P. Hoffman, and Dallan Flake. 2005. Cross-national variation in family influences on child health. *Social Science and Medicine* 60: 97-108.
- Henriet L and Kaminski M, Impact of induced abortions on subsequent pregnancy outcome: the 1995 French national prenatal survey, *British Journal of Obstetrics and Gynaecology*, 2001, 108 (10):1036-1042.
- Holmes, K, Levine R, Weaver M. Effectiveness of condoms in preventing sexually transmitted infections. *Bulletin of the World Health Organization*. Geneva. June 2004.
- Holt VL, et al. 2003. Oral contraceptives, tubal sterilization, and functional ovarian cyst risk. *Obstet Gynecol* August 2003; 102:252-8
- Horga, M. Contraception and abortion in Romania: background paper for the strategic assessment of policy, programme and research issues related to pregnancy termination in Romania. 2001 (unpublished).
- Hudgins, Tony and Chris Wright. 2004. Ukraine Contraceptive Availability Assessment. John Snow, Inc. and USAID.
- Human Rights Watch, 2005. Opportunity for Reform: Human Rights Agenda for Ukraine. From Human Rights News.
- International Conference on Population and Development. 1994. Programme of Action.
- International Planned Parenthood Federation (IPPF). 2006. Press Release: No. 2006.10.04 (Published: 2006.10.4). "United Nations General Assembly Adopts "Universal Access" Target for Reproductive Health"
- International Planned Parenthood Federation (IPPF). IMAP Statement on safe abortion. IPPF Medical Bulletin. Volume 40, Number 3, September 2006.
- Jacobsson, Bo, Lars Ladfors, Ian Milsom. Advanced Maternal Age and Adverse Perinatal Outcome. *Obstetrics and Gynecology*. 2004; 104: 727-33.
- Johnson, Brooke R., Mihai Horga, and Peter Fajans. 2004. A Strategic Assessment of Abortion and Contraception in Romania. *Reproductive Health Matters*; 12(24 Supplement): 184-194.
- Johnston, Robert WM. Abortion Statistics and Other Data-Johnston Archive. Last update February 18, 2007. <http://www.johnstonsarchive.net/>
- Jorgensen, C, Picot MC, Bologna C, Sany J. Oral Contraception, parity, breast feeding, and severity of rheumatoid arthritis. *Ann Rheum Dis* 1996;55:94-98.
- Kahlenborn C, Modugno F, Potter DM, Severs WB. Oral contraceptive use as a risk factor for premenstrual breast cancer: A meta-analysis. *Mayo Clin Proc* 2006;81:1290-1302. Level of evidence: 3a (meta analysis of case control studies)
- Kaunitz, Andrew M. Oral contraceptive health benefits: perception versus reality. *Contraception*; 1999; Volume 59, Issue 1, Supplement 1, January 1999: 29S-33S.
- Kiev International Institute of Sociology. 1999 Ukraine Reproductive Health Survey. Final Report, 2001. In collaboration with CDC and USAID.
- Kumle M, et al. Use of oral contraceptives and breast cancer risk: The Norwegian-Swedish women's lifestyle and health cohort study. *Cancer Epidemiology* 2002; 11:1375-1381.
- Lucky AW, Henderson TA, Olson WA, et al. Effectiveness of norgestimate and ethinyl estradiol in treating moderate acne vulgaris. *Journal of American Academy of Dermatology* 1997;37:746-54.
- Martinez, ME, Grodstein F, Giovannucci E, Colditz GA, Speizer FE, Hennekens C et al. A prospective study of reproductive factors, oral contraceptives use, and risk of colorectal cancer. *Cancer Epidemiological Biomarkers Prevalence* 1997;6:1-5.
- Marchbanks, Polly A. McDonald, Jill A., Wilson, Hoyt G. et al. Oral contraceptives and Risk of Breast Cancer. *New England Journal of Medicine*, June 2002 Volume 346:2025-2032

- Martius JA et al., Risk factors associated with preterm and early term birth: univariate and multivariate analysis of 106,345 singleton births from the 1994 statewide perinatal survey of Bavaria. *European Journal of Obstetrics and Gynecology and Reproductive Biology*, 1998, 80(2):183-189.
- Marston, Cicely and Cleland, Tom. 2003. Relationships Between Contraception and Abortion: A Review of the Evidence. *International Family Planning Perspectives*. Volume 29(1): 6-13.
- McLaughlin, John R., AR Harvey, J Lubinski, et al. 2007. Reproductive risk factors for ovarian cancer in carriers of BRCA1 or BRCA2 mutations: a case-control study. *Lancet Oncology*; 8:26-34.
- Mishell Jr, D.R. Noncontraceptive health benefits of oral steroidal contraceptives. *Am J Obstet Gynecol* 142 (1982), pp. 809–816.
- Ministry of Health of Ukraine. National Reproductive Health Program 2001-2005, Draft December 2000.
- Mol BW, Van der Veen F, Bossuyt PM. 1999. Implementation of probabilistic decision rules improves the predictive values of algorithms in the diagnostic management of ectopic pregnancy. *Hum Reprod* Vol:14:2855-62.
- Moreau C et al., Previous induced abortion and the risk of very preterm delivery: results of EPIPAGE study, *British Journal of Obstetrics and Gynaecology*, 2005, 112(4):430-437.
- Muscato, L and R.S. Kidd. Contraception and abortion attitudes and practices of Western Ukraine women. *The European Journal of Contraception and Reproductive Health Care* 2003;8:80-86.
- National Cancer Institute, Summary Report: early reproductive events and breast cancer workshop, 2003. <http://www.cancer.gov/cancerinfo/ere-workshop-report>, accessed July 25, 2006.
- Oddens, B.J. 1993. Evaluation of the effect of contraceptive prices on demand in eight Western European Countries. *Advanced Contraception*. Volume 9(1):1-11.
- ORC Macro, 2007. MEASURE DHS STATcompiler. Accessed online at <http://www.measuredhs.com> on August 5 2007.
- Pasner LA, Phipps WR. Type of oral contraceptive in relation to acute, initial episodes of pelvic inflammatory disease. *Contraception* 1991;43:91-99.
- Policy Project (2005). Application of the Allocate Model in Ukraine. Washington, DC. Policy Project.
- Proctor ML, Roberts H, Farquhar CM. Combined oral contraceptive pill (OCP) as treatment for primary dysmenorrhoea. *Cochrane Database of Systematic Reviews* 2001, Issue 2. Art. No.: CD002120. DOI: 10.1002/14651858.CD002120. <http://www.mrw.interscience.wiley.com.ezp1.harvard.edu/cochrane/clsysrev/articles/CD002120/frame.html>
- Redmond GP, Olson WH, Lippman JS, et al. Norgestimate and ethinyl estradiol in the treatment of acne vulgaris: a randomized, placebo-controlled trial. *Obstet Gynecol* 1997;89:615-22.
- Rohan, TE and AB Miller. A cohort study of oral contraceptive use and risk of benign breast cancer. *International Journal of Cancer*. July 1999; 82 (2): 191-196.
- Sandier, Simone, Valerie Paris and Dominique Polton. 2004. Health Care Systems in Transition: France. WHO, European Observatory on Health Systems and Policies.
- Schlesselman, JJ. Net effect of oral contraceptive use on the risk of cancer in women in the United States. *Obstetrics and Gynecology*. 1995; 85:793-801.
- Semelela, N. 2006. Women's access to modern methods of fertility regulation. *International Journal of Gynecology and Obstetrics*, Vol. 94:292-300.
- Setty-Venugopal, V. and Upadhyay, U.D. *Birth Spacing: Three to Five Saves Lives*. USAID, Bureau of Global Health, Office of Population. Birth Spacing: A Call to Action—birth intervals of three years or longer for infant and child health. March 2002.
- Snider, Sharon. 1990. The Pill: 30 years of safety concerns. U.S. Food and Drug Administration.

- Spector, TD, Hochberg MC. The protective effect of the oral contraceptive pill on rheumatoid arthritis: an overview of the analytic epidemiological studies using meta-analysis. *Journal Clinical Epidemiology* 1990;43:1221-30.
- Steshenko, Valentina and Tamara Irkina. Some aspects of the Demographic Situation in Ukraine: Reproductive Health and Family Planning. United Nations and Government of Ukraine. 1999.
- Toulemon, Laruent and Henri Leridon. 1998. Contraceptive Practices and Trends in France. Vol. 30(3): 114-120.
- Together for Health. 2006. Report of the Focus Group Discussions (FGDs). JSI, Ukraine.
- Ukraine Cabinet of Ministers Decree No. 1849, December 27, 2006, "Reproductive Health of the Nation Program up to 2015"
- Ukraine State Statistics Committee, "Survey on the Willingness and Ability to Pay for Contraceptives in Ukraine, 2004," Kiev, 2004-2005
- United Nations, 2005a. World Contraceptive Use 2005. New York, Department of Economic and Social Affairs, Population Division, United Nations, 2005.
- United Nations, World Population Prospects, the 2006 Revision, Population Database, Population Division, United Nations, 2000, 2004.
- United Nations, World Population Prospects, the 2006 Revision Population Database, Population Division, United Nations, 2007
- UNAIDS. Position Statement on Condoms and HIV Prevention, July 2004.
- UNFPA. 1997. UNFPA Annual Report 1997. Adolescent Reproductive Health.
- UNFPA. 2005. World Summit Commits to Universal Access to Reproductive Health by 2015, Press Release. 19 September 2005.
- Vessey M, Painter M. Oral contraceptive use and cancer. Findings in a large cohort study, 1968-2004. *Brit J Cancer* 2006;95:385-389.
- Warren, MP, Miller KK, Olson WH, Grinspoon SK, and Friedman AJ. Effects of an oral contraceptive (norgestimate/ethinyl estradiol) on bone mineral density in women with hypothalamic amenorrhea and osteopenia: an open-label extension of a double-blind, placebo-controlled study. *Contraception* (September 2005); 72(3): 206-11.
- Westoff, Charles F. Olds, Suzanne. 2004. Abortion and Contraception in Georgia and Kazakhstan, Open Society Organization, New York
- World Bank. 1993. World Development Report, Investing in Health
- World Health Organization, 2003. Effective Contraception—more benefits than meet the eye. Progress in Reproductive Health Research, No. 62.
- World Health Organization, 2004a. Reproductive Health Strategy. http://www.who.int/reproductive-health/publications/strategy_small_en.pdf
- World Health Organization, 2004b. Unsafe Abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000. Fourth Edition.
- World Health Organization, 2004c. Health Policy for Children and Adolescents, No. 4. Young people's health in context. Edited by Candace Currie, Chris Roberts, Antony Morgan et al. <http://www.euro.who.int/Document/e82923.pdf>
- World Health Organization, 2004d. Medical Eligibility Criteria for Contraceptive Use. Third Edition. <http://www.who.int/reproductive-health/publications/mec/index.htm>
- World Health Organization, 2007. Programmes and Projects: Pharmaceuticals, Italy. http://www.euro.who.int/pharmaceuticals/Topics/Overview/20020417_3

World Health Organization, Reproductive Health Indicators Database. http://www.who.int/reproductive-health/global_monitoring/RHRxmls/RHRmainpage.htm

World Health Organization, 2007, Regional Office for Europe. European Health for All database. <http://www.euro.who.int/hfadb>

Yimin C et al. 2004. Mifepriston-induced abortion and birth weight in the first subsequent pregnancy, International Journal of Gynecology and Obstetrics, Vol. 84 (3):229-235.

Zhylka, N. 2005. Contraceptive Security Situation Analysis in the Ukraine. Rayevsky Scientific Publishers, Kyiv.

Together for Health

**46-v (46-в) T. Shevchenko Boulevard, Office 15, Kyiv 01032, Ukraine
Tel: (+38 044) 581-1520, Fax: (+38 044) 581-1521, e-mail: info@fprh-jsi.org.ua**

Разом до Здоров'я

**бул. Т. Шевченко, 46-в, офіс 15, Київ 01032, Україна
тел: (+38 044) 581-1520, факс: (+38 044) 581-1521, e-mail: info@fprh-jsi.org.ua**