Strategic Support for Reproductive Health in the Former Soviet Union

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This paper was prepared to assist the Public Health Program of the Open Society Institute (OSI) in its strategic planning for a larger and broader investment in reproductive health (RH) in the Former Soviet Union (FSU) and Central and Eastern Europe (CEE). It sets forth a summary of RH indicators and trends in this region, provides an overview of major donors' RH initiatives in the region since transition and related lessons learned, and suggests areas of intervention and concentration by OSI.

I. Reproductive Health Indicators and Trends in the Region

Since transition, RH indicators in FSU/CEE have been mixed, and there is room for much improvement on many fronts. In most FSU/CEE nations, the **birth rate** fell steadily through the 1990s. Belarus' birth rate fell by almost half from 1986 to 1987. (WHO HoH Belarus, 2000) With the exception of Albania and several Central Asian republics, **total fertility rates** in this region are now below replacement level. Significant population losses are projected in the decades to come.

Access to RH services is uneven, and there are numerous illustrations of poor and even declining RH in the region. In the late 1990s, the incidence of cardiovascular, renal and thyroid diseases in pregnant women in Belarus increased by 16 percent. (WHO HoH Belarus, 2000) The incidence of endometriosis in the Russian Federation (RF) rose 46 percent from 1994 to 1999, and complications of pregnancy (both pre- and post-natal) rose 21.8 percent during this same time period, while anemia increased sixfold from 1989 to 1999. (WHO HoH RF, 1999) The percent of births without complications has fallen steadily in RF from 55.8 percent in 1985 to 31.8 percent in 1997, so that more than two thirds of all births now have complications. (WHO HoH RF, 1999) Sixty percent of pregnant Uzbek women and 47.8 percent of pregnant Moldovan women are anemic. (WHO HoH Uzbekistan, 1999; WHO HoH Moldova, 2001) Interestingly, the few nations reporting the percentage of attended births reported that the vast majority of births were attended by a skilled clinician; in Azerbaijan, for example, the Ministry of Health (MOH) reported 99.9 percent but a UNICEF survey found 69.4 percent, (UNFPA Azerbaijan Programme Annual Report 2001) which suggests that these reported figures may be inflated. Cervical cancer remains the most frequent cancer of women in developing nations, yet in Moldova (typical for the region), 57.2 percent of women aged 15-44 had never had a Pap smear. (Moldova Reproductive Health Survey 1998)

The Soviet Union decreased fertility rates by providing free induced abortions on demand. Modern contraceptives were rare. Thus, by tradition in FSU/CEE, lack of information about **family planning** (FP) and the cost and scarcity of contraceptives have led to reliance upon induced abortion as the standard method of contraception. Although absolute numbers of abortions throughout the region are falling, abortion remains the

primary method of birth control and abortion rates here remain some of the highest in the world. Abortion is often available at lower cost than expensive, imported contraceptives, and some service providers still have negative attitudes about modern contraception (attitudes that get passed on to clients). Moreover, abortion remains a lucrative practice for some service providers. Abortion rates have dropped in some nations (sometimes remaining in tandem with falling birth rates), most notably in Kazakhstan, perhaps due to the country's strong FP policy, the Kyrgyz Republic, and Uzbekistan, which has an FP policy of mass education about preventing unwanted pregnancies and making contraception available. No rate has been reported for Poland following a 1993 law permitting induced abortion only under limited circumstances. From 1991 to 2001, the abortion rate in RF dropped by 45 percent due to increased use of contraceptives and greater knowledge about birth control; however, even in 2000, abortion remained the leading method of RF birth control, with nearly two million abortions outnumbering births. Anecdotally, it is claimed that the average Russian woman experiences four to five abortions during her reproductive years, and that some may have had 15 to 20 abortions. (Kantner et al., 2001) The pattern of abortions matching or exceeding live births is also seen in Belarus, Bulgaria, Estonia, Romania, and Ukraine. A woman in some parts of CEE is 13 times more likely to have an abortion than her counterpart in Western Europe. (IPPFEN, 2000)

Contraceptive prevalence rates (CPR) are available for approximately two thirds of the nations in this region; the data suggest that modern contraception is increasingly available but that rates are still lower (by Western standards) across most of the region. Where **modern contraception** is used, women are markedly more likely to have intrauterine devices (IUDs)[1] than to employ oral or injectable contraceptives, which providers have been slow to accept. The public sector for most of the decade since transition was the dominant supplier of contraceptives (through hospitals, pharmacies, and polyclinics); contraceptive security is increasingly recognized as a problem. In several nations, such as Estonia and Latvia, use of oral contraceptives rose from 1992 to 1999, while use of IUDs declined proportionally. While most nations that reported a CPR fell in the 50 percent range, most did not report higher than 50 percent usage of modern contraceptives. Condom use is low by Western standards. There is still significant reliance on traditional contraceptive methods, such as withdrawal, temporary abstinence or the calendar method, and douching. Knowledge about modern contraception is often low among the general public and health professionals, and public contraceptive services are often sporadic outside major cities. Sterilization is rare in this region.

Although it fell steadily in many FSU/CEE nations during the 1990s, **maternal mortality** remains high, due in part to poor prenatal care. The most frequent immediate causes of maternal mortality in FSU/CEE are hemorrhage, hypertensive disorders, complications associated with abortions, toxicosis, other complications of pregnancy, infections, eclampsia, and sepsis. Illegal abortions accounted for 27 percent of all maternal deaths in Moldova in 1998; (WHO HoH Moldova, 2001) abortions accounted for one fourth of maternal deaths in Lithuania from 1995 to 1999. (WHO HoH Lithuania,

[1] In Central Asia, some physicians routinely perform a dilation and curettage (D&C) after IUD removal, which is not medically justified; this may increase morbidity and mortality. (M. Tiedemann, 2002)

2001) Maternal mortality in Romania was extremely high in the late 1980s due to illegal abortions; the rate has since fallen significantly yet remains above average for the region. The maternal mortality rate (MMR) is highest in Georgia, Tajikistan, Kazakhstan (where it is rising), Latvia and RF, and lowest in Croatia, the Czech Republic and Poland. There are conflicting numbers for Uzbekistan; it is noteworthy that, in recent years, Uzbekistan has no reported cases of maternal mortality due to abortion.

Infant mortality is high, and is most often connected to malformations and perinatal conditions. In several nations it appears to be linked to a high rate of teen pregnancy and/or a high proportion of low birth weight (LBW) infants (i.e., less than 2500 grams). Perinatal mortality is particularly high in Central Asia and Georgia, but decreased in Latvia through the 1990s. Because several nations have not adopted the internationally recognized WHO definition of a live birth, their reported infant mortality rates (IMR) are lower than they might be under the WHO standard; inaccurate reporting from rural areas may also deflate this rate in some nations. The IMR has declined significantly in Armenia and Hungary since the 1980s, in Belarus since 1995, and in Croatia from 1985 to 1997 (latest available data). Infant mortality is highest in Central Asia and lowest in Belarus, Estonia and Lithuania. The **proportion of LBW infants**, a marker for newborn health and for the quality of perinatal care, ranges from under five percent in two Baltic nations to a high of nine percent in Bulgaria and Romania; most FSU/CEE nations fall above the average (six percent) in nations of the World Health Organization's (WHO) European Region.

Sexually transmitted diseases (STDs), including sexually transmitted infections (STIs) such as HIV/AIDS, have risen dramatically since transition, particularly among young people. The incidence of HIV/AIDS has escalated most strikingly in Ukraine, Russia, Belarus, and Moldova, with infection spreading from injecting drug users (IDUs) – those primarily at the epicenter of the epidemic in this region – to their sexual partners and further into the 'general population.' Syphilis incidence rose sharply from 1990 to the middle of the decade and beyond, and increased at an epidemic level in Ukraine from 1993 to 1996.

There is a paucity of data on adolescent sexual behavior and knowledge. The **teen birth rate**, a surrogate marker for adolescent sexual health, is (where data were reported) appreciably higher than the European Union average of eight. The rate is as high as 41 in Romania; this suggests that many teens in FSU/CEE still lack information about or access to contraception.

WHO has suggested utilization of a short list of 15 RH indicators;[2] unfortunately, for most FSU/CEE countries, many of these indicators are not routinely measured. Selected health indicators for this region are set forth in Tables 1 and 2, below.

[2] These WHO suggested indicators are listed in Appendix 1.

Table 1. Selected Health Indicators in FSU/CEE

Country	**Live Births*** (per 1000 population)	**Total Fertility Rate***	**Infant Deaths*** (per 1000 live births)	**Maternal Deaths*** (per 100,000 population)	**Teen Births**** (per 1000 women 15-19)	**Low Birth Weight Infants**** (percent of all births)
Albania	16.081246	2.4	12.1413024	Unknown	Unknown	Unknown
Armenia	9.0143755	1.11	15.7544638	32.9	Unknown	8
Azerbaijan	14.5359441	1.9	12.8297178	43.4	Unknown	5.9
Belarus	9.3644571	1.31	9.3071907	28.0	Unknown	5.2
Bosnia-Herzegovina	10.3545929	1.56	15	Unknown	Unknown	Unknown
Bulgaria	9.0180476	1.27	13.314513	18.8	48	9
Croatia	9.9845892	1.5	7.4063914	6.6	9.86	Unknown
Czech Republic	8.8498392	1.16	4.102959	6.3	14	5.9
Estonia	9.5590453	1.39	9.4858509	16.0	26	4.8
Georgia	10.5040318	1.08	12.2099861	51.5	Unknown	7
Hungary	9.7361385	1.33	9.2215949	12.9	25	8.4
Kazakhstan	14.6195906	1.7	19.08188	77	Unknown	6
Kyrgyzstan	19.7994885	2.4	22.9823292	35	Unknown	5.3
Latvia	8.5325404	1.23	10.3713947	44	19	5
Lithuania	9.2404906	1.27	8.6093297	14	Unknown	4.5
FYR Macedonia	14.4634441	1.9	11.8056503	Unknown	Unknown	Unknown
Moldova	10.1492145	1.39	18.4357996	28.6	Unknown	5.6
Poland	9.7900438	1.37	8.1089367	8.6	19	6.6
Romania	10.4532586	1.3	18.6337258	43	41	9.0
Russian Federation	8.7667539	1.2	15.2241869	44	Unknown	6.2
Slovakia	10.2118641	1.29	8.5764537	Unknown	Unknown	Unknown
Slovenia	9.1633291	1.26	4.5590951	Unknown	Unknown	Unknown
Tajikistan	27.025874	3.4	17.8	58	Unknown	8
Ukraine	7.820404	1.2	11.9597223	25.2	Unknown	5.5
Uzbekistan	21.4024925	2.8	22.3171315	9.6/28.6	Unknown	5.2
FR Yugoslavia	11.662981	1.7	20	Unknown	Unknown	Unknown

***** Source: WHO Health for All Database <http//www.euro.who.int/hfadb>
NB: these latest available data are from 1998-2000.

****** Source: WHO Highlights on Health country profiles (where available).
NB: these latest available data are from 1997-2000.

Table 2. Selected Reproductive Health Indicators in FSU/CEE

Country	**Contraceptive Prevalence*** (any method)	**Contraceptive Prevalence*** (modern methods)	**HIV Prevalence*** (15-24YO) (percent) M/F	**Births with Skilled Attendants*** (percent)	**Abortions**** (per 1000 live births)
Albania	Unknown	Unknown	Unknown	Unknown	Unknown
Armenia	Unknown	Unknown	Unknown	97	395
Azerbaijan	Unknown	Unknown	Unknown	100	178

Belarus	50	42	0.40/0.19	Unknown	1566
Bosnia-Herzegovina	Unknown	Unknown	Unknown	Unknown	Unknown
Bulgaria	86	46	Unknown	Unknown	1000
Croatia	Unknown	Unknown	Unknown	Unknown	295
Czech Republic	69	45	0.06/0.03	Unknown	575
Estonia	70	56	0.16/0.08	Unknown	1159
Georgia	41	20	Unknown	95	390
Hungary	77	68	0.08/0.02	Unknown	782
Kazakhstan	66	53	0.07/unk.	98	675
Kyrgyzstan	60	49	Unknown	98	200
Latvia	48	39	0.18/0.06	95	910
Lithuania	59	40	Unknown	95	518
FYR Macedonia	Unknown	Unknown	Unknown	Unknown	Unknown
Moldova	74	50	0.28/0.11	Unknown	725
Poland	49	19	Unknown	Unknown	Unknown
Romania	64	30	0.02/0.02	Unknown	1144
Russian Federation	73	53	0.25/0.12	Unknown	1860
Slovakia	74	41	0.02/0.01	Unknown	Unknown
Slovenia	Unknown	Unknown	0.03/0.01	Unknown	Unknown
Tajikistan	Unknown	Unknown	Unknown	79	161
Ukraine	68	38	1.29/0.79	Unknown	1200
Uzbekistan	56	51	Unknown	98	118
FR Yugoslavia	55	12	Unknown	Unknown	Unknown

***** Compiled from United Nations Population Fund, State of World Population 2001.

****** Compiled from WHO Highlights on Health country profiles (where available).
NB: these latest available data are from 1997-2000.

II. Major Donors' Work in Reproductive Health in FSU/CEE

Although many international donors are or have been active in RH in this region, including the governments of Finland, Germany, Japan and the Netherlands, there are really three primary players that have supported RH throughout the region: the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), and the International Planned Parenthood Federation (IPPF). This section focuses on the work of those three donors. In addition, the United Kingdom Department for International Development (DFID) has integrated some RH work into its health programs in the FSU; these are described briefly below.

United Nations Population Fund (UNFPA)

Globally, UNFPA has three primary foci in reproductive health: 1) delivering RH education and services, 2) ensuring healthier pregnancies, and 3) reducing pregnancy-related mortality. UNFPA has been supporting programs in FSU/CEE since the collapse of the Soviet Union in 1991 and has concentrated its efforts in this region primarily in the first area. In several nations, this has included a significant push to strengthen the management capacity of the Ministry of Health (MOH) to provide quality RH information and services. UNFPA's premise is that poor RH in the transition countries is not due to poor access to health care services but to the poor quality of RH information and services. Accordingly, projects and programs in FSU/CEE have been formulated to:

- Integrate quality RH services into primary health care (PHC) and expanding choices;
- Improve adolescent RH to prevent unwanted pregnancies, STIs/HIV/AIDS;
- Prevention of STIs/HIV/AIDS
- Increase capacity of CEE countries in population analysis and data systems; and
- Integrate gender and RH rights into social planning.

UNFPA began to work in CEE in 1994-1995 following the 1994 International Conference on Population and Development ICPD), but has always operated on a project-by-project basis in this sub-region. In the past decade, UNFPA has provided emergency relief in many nations in this region, including Bulgaria, Croatia, Georgia and Kosovo. In FSU/CEE, UNFPA works through a regional program, in-country programs, and a Bratislava-based technical assistance program. Within this region, UNFPA has had country programs only in the six Central Asian republics (CAR) and Albania. Field offices were established in Albania[3] and Romania[4] in 1996 to better coordinate and monitor UNFPA-supported activities in the region. Appendix 2 provides a snapshot of UNFPA's activity in this region.

As UNFPA funds in this region are quite limited, the organization operates mostly on a project-by-project basis, a pattern that has been followed since transition. FY 2000 allocations were US$300,000 each for Albania and Romania, US$200,000 for RF,

[3] The Albania field office also covers Armenia, Bulgaria and Georgia.
[4] The Romania field office also covers Belarus, Moldova and Ukraine.

US$130,000 each for Bosnia-Herzegovina and Georgia, US$120,000 for Armenia, and less than US$100,000 each for all other countries. Other than CAR, the current annual budget allocates US$2.8 million for this region, of which some funds are sent to the countries and some managed regionally.

UNFPA views as its key RH strategic partners in FSU/CEE other UN partners such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Joint Programme on AIDS (UNAIDS), and the United Nations Educational, Scientific and Cultural Organization (UNESCO), as well as Population Services International (PSI), which is also a UNFPA implementing institution. UNFPA offered that OSI, with whom UNFPA already works closely in-country (e.g., in harm reduction) should also be in this select group of strategic partners. UNFPA sees as its significant executing agencies: Medecins Sans Frontiers (improving RH information and services in northeast Armenia), International Federation of the Red Cross (IFRC) in Bosnia, Marie Stopes International in Bosnia and Croatia, International Planned Parenthood Federation (IPPF) in Lithuania, UNESCO (1995-2000 teen education program in RF), U.S. Centers for Disease Control and Prevention (CDC), and PSI.

- **Regional**

In the late 1990s, UNFPA supported advanced training in RH/FP for FSU/CEE clinicians at the Medical School at Debrecen University, Hungary. In all, 143 providers trained in basic RH skills[5] and 30+ trained in advanced contraceptive technologies[6] from 1995 through 1999. A program at the Netherlands School of Public Health from 1998-2001 provided management training for 120 RH/FP clinicians.

In conjunction with UN interagency partners WHO and UNICEF, UNFPA is now engaged in a push to enhance life skills education programming for adolescents as part of a comprehensive, multilateral approach to adolescent health, development and protection. In the initial phase, the project will conduct a baseline analysis of NGO practices in this area and launch pilot education programs in the Baltics, Bulgaria, the Czech Republic, Poland and Slovakia; consultations will be conducted in CAR and the Caucasus.

- **Baltics**

UNFPA support to this region has been quite limited. A few small advocacy projects were funded in Estonia beginning in 1994, but assistance here has ended. UNFPA began supporting Latvia on a small scale in 1995, supporting development of a national RH strategy and a demographic survey. UNFPA has worked in Lithuania since 1995, most recently supporting five youth centers.

[5] STD/HIV prevention and management, emergency contraception, skills to manage unsafe abortion, concepts of human rights, reproductive rights, gender; access to computer skills, bibliography review.
[6] Skills in mini-laparoscopy and other surgical contraceptive and gynecological techniques, including emergency obstetric care and neonatal care.

- **Caucasus**

UNFPA was the first international donor to provide large-scale assistance to **Armenia** in establishing RH services, beginning in 1996. The first program, which ended in 2001, was a major UNFPA success: the establishment of 77 FP cabinets in a nation with no background in providing FP services. These cabinets insure availability and access to quality modern services, and have been supplied with medical equipment and contraceptives. Two reference works were produced: a Johns Hopkins text, *Essentials of Contraceptive Technology* (translated into Armenian), and the *Atlas on Diagnosis and Treatment of Syphilis*, the first such publication in Armenian. A new three-year project, launched in 2001, was developed in light of the new national RH program and has two foci: 1) supporting sexual and RH by improving and integrating RH services into primary care delivery, including antenatal care, FP, STI management, and HIV/AIDS information and counseling, and 2) introducing peer education for youth, training teachers, and offering information, education, and communication (IEC) and advocacy activities at the community level.

The five-year US$5.5 million 2000-2004 program is UNFPA's first in **Azerbaijan**, which was part of a 1995-1999 subregional program also involving CAR. The earlier support was vital in the government's effort to implement the ICPD Programme of Action, including adoption of protocols and regulations pertaining to certain methods of contraception and guaranteeing the rights of contraceptive users. It also facilitated establishment of a network of RH/FP training and service delivery centers, augmented by community-based services and outreach, in six pilot districts.[7] The CPR rose from 2.7 to 23.6 percent from 1995 to 1998 at the project sites. (UNFPA Azerbaijan Proposal, 1999) The current US$3.7 million RH subprogram's tripartite foci of enhancing RH services, expanding contraceptive options, and reducing abortions are based on a 1998 country assessment. The current effort seeks to 1) strengthen national capacity to develop and implement a national RH strategy, 2) to enhance RH services and outreach, including support to NGOs, 3) to expand access to a reliable supply of quality contraceptives, medical equipment, and related services, and 4) to expand public awareness and knowledge of RH and reproductive rights through IEC. By December 2001, a national strategy had been developed and was being circulated. A comprehensive RH service delivery manual has been developed, with which 285 providers have been trained; an additional 73 providers have been trained in communication skills and community outreach. New IEC materials have been developed. All seven UNFPA-supported pilot sites offer at least three modern methods of contraception.

UNFPA began providing assistance to **Georgia** in 1993 in FP and sexual health, IEC, population data collection and analysis, STD screening and treatment, and HIV/AIDS prevention. UNFPA has assisted the Georgian government in implementing the ICPD Programme of Action. The ratio of contraception to abortion changed from 1:4 in 1993 to 1:1 in 2001. (UNFPA Georgia Annual Report, 2001) UNFPA has assisted the Ministry of Labour, Health, and Social Affairs in strengthening capacity to plan, coordinate, manage and evaluate RH activities at local, regional, and national levels. It has assisted the

[7] These are Baku, Ganja, Kusar, Masali, Nakhichevan, and Sheki.

Ministry in building its MIS. Access in underserved areas has been expanded by mobile teams based in Tbilisi, Kutaisi, and Batumi; from March to December 2001, these teams visited 55 sites and provided RH services to 10,000 women.

- **Central Asian Republics**

In 1992, UNFPA extended emergency assistance to Kazakhstan in the form of basic medical equipment, contraceptive supplies and training health providers. In 1992-1994, it fielded three programming missions to CAR and Azerbaijan for needs assessments. A US$23 million, three-year program for CAR (UNFPA's first effort here) was launched in 1995 to assist Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan in addressing four issues: the high rate of induced abortion, the frequency of births, the lack of choice of methods of fertility regulation, and inadequate information about modern RH/FP interventions. This project focused on RH/FP interventions, such as 1) improving access to quality RH services (including client-centered counseling), 2) increasing access to updated information and international experience in all aspects of RH, FP and population issues in general, 3) strengthening population-oriented institutions' technical capacity, and 4) identifying priority audiences and regional variations for IEC interventions. During the course of this program, CPR rose by 32 percent and the abortion rate fell by 15 percent; demand for contraceptives increased as did the supply. The program was extended through 1999.

In 2000-2004, UNFPA's support for RH programs in this region remains strong with the first-ever individual country programs in five Central Asian republics. **Kazakhstan** will receive US$6.0 million over five years to support the government in achieving its population and development objectives as set forth in its 1997 strategic vision, *Kazakhstan 2030*. The program builds on a 1998 UNFPA assessment, and is delivered through three subprograms (US$4.8 million in RH, US$0.5 in population and development, and US$0.3 million in advocacy). The RH subprogram emphasizes expansion of availability and access to quality RH information and services as part of integrated primary care, with particular emphasis on reducing the MMR, reducing rates of birth trauma and abortions, addressing deterioration of existing RH/FP services, and strengthening providers' capacity. The advocacy program includes supporting RH in the context of health system reform. Perhaps due to funding constraints, the percentage of Kazakh delivery sites offering RH IEC to adolescents decreased significantly (from 45 to 28.6). A recent, rapid needs assessment of five pilot sites in Kazakhstan revealed low awareness of RH services, especially FP services; survey results will be used for IEC.

In the **Kyrgyz Republic**, the government following independence developed a national FP policy to ensure low-risk pregnancies and good maternal health, and developed a national RH policy and action plan following ICPD. UNFPA concentrated on reducing the high abortion rate, increasing the short intervals between births, broadening the contraceptive method mix, and promoting informed choice of contraceptives through counseling and IEC. UNFPA supported a safe sex education campaign (in collaboration with the city of Bishkek), which was extended to all oblasts, in the process strengthening the health system's outreach capacity. The US$5.0 million 2000-2004 UNFPA program,

formulated in consultation with the Kyrgyz government and other major stakeholders, builds on the Kyrgyz government's 1997 National Strategy of Sustainable Human Development. In the US$3.5 million RH subprogram, foci include 1) coordinated implementation of an RH management information system (MIS) (including contraceptive supply and distribution),[8] linking the various levels in selected oblasts where pilots have been introduced, and 2) continued efforts to broaden the contraceptive method mix, employing social marketing, engaging the private sector, and by mobilizing support from other donors. Training of nurses, midwives and feldshers in selected oblasts is improving access to RH services in primary care outlets. The Kyrgyz Republic recently enacted its first Law on Reproductive Rights (developed with UNFPA collaboration).

In **Tajikistan**, RH centers in the capital, Dushanbe, and in the Kathlon province were modernized during the 1995-1999 regional program, and a resultant decline in abortion rates was attributed to increased contraceptive availability. The current five-year, US$6.0 million program seeks to improve quality of life through better RH care and to support sustainable development and gender equity via expansion of RH services outreach (especially in selected rural areas) and adoption of a comprehensive population and development strategy. The US$4.7 million RH subprogram, implemented at the national level and in selected oblasts, seeks development of a comprehensive national RH policy and an action plan for its implementation. UNFPA will strengthen existing health MIS and strengthen capacity to deliver quality RH services to underserved populations. Following the Kyrgyz Republic, Tajikistan also enacted a law on reproductive rights. Improvement of quality RH services in Tajikistan is facing many barriers, and knowledge of RH issues remains low among target populations here.

In **Turkmenistan**, the current five-year, US$5.0 million UNFPA program is consistent with the 1995 State Health Program. The US$3.5 million RH subprogram has four foci: 1) to strengthen the MOH and medical industry's policy making and management capacity, 2) to strengthen provision of RH services from the household to the etrap to the velayat level, 3) to increase reliability in the management of services and in the supply and distribution of a balanced mix of modern contraceptives, and 4) increased knowledge and awareness of RH and related concerns, especially by adolescents.

In **Uzbekistan**, the current five-year, US$7.5 million program includes US$5.5 for RH efforts designed to achieve increased utilization of quality RH services. The program is strengthening operations of a cost-efficient RH network (e.g., equipment and supplies, training providers, establishing clinics for adolescents), broadening knowledge and awareness of RH and reproductive rights via IEC, and improving the supply and distribution of a balanced mix of modern contraceptive methods. Uzbekistan had conducted 23 training sessions for 1112 obstetrician/gynecologists and general practitioners and 86 midwives, including one midwife from each district who will become a master trainer.

[8] Such an MIS was a high priority of the Manas Health Care Reform Programme.

- **Albania**

From 1983-1990, UNFPA devoted US$1.5 million to maternal and child health (MCH), FP, and data collection, all on a project-by-project basis. The first country program began in 1991. A second country program, developed with the Albanian MOH, focused exclusively on RH and was designed to assist the country in meeting by 2000 its national RH goals: reducing MMR to less than 25, reducing IMR to less than 25, increasing CPR to 20 percent, and reducing prevalence of STDs and incidence of HIV. The program was extended by one year and has now ended.

UNFPA tapped PSI to deliver a three-year behavior change social marketing program in Albania to encourage condom use to avoid unwanted pregnancies and STIs/HIV/AIDS. This program expanded PSI's existing social marketing effort in Albania and was begun at the behest of the MOH because Albania has Europe's highest proportion of people under age 30. The program emphasized both behavior change communication and condom distribution.

- **Bulgaria**

UNFPA has supported Bulgaria since 1979, with US$2.6 million over the years. Prior to 1997, most support was for demographic activities. In 1997, UNFPA approved a six-month emergency supply of contraceptives. In 1999, UNFPA began to assist the MOH with its national RH strategy.

- **Moldova**

UNFPA supported the Reproductive Health Survey in 1999. A current, two-year project supports the government's national RH/FP program and builds upon a small one-year pilot project in 2000 that established an RH clinic in Drochia. UNFPA supports a network of three RH/FP clinics in Chisinau,[9] Drochia and Cahul that provide quality RH/FP services and information. Given the current emphasis on family medicine, training family doctors in RH/FP has been an important component of this project: in addition to training staff physicians and nurses at the pilot sites, the project has supported training by national trainers in contraceptive technology and counseling for 90 family physicians, 30 gynecologists, and 60 nurses from rural areas of the three target districts. Twenty-seven IEC workshops were conducted in schools in 2001, in which approximately 300 students learned about STIs/HIV/AIDS.

- **Romania**

UNFPA investment in Romania began in 1996 with launch of Youth for Youth (YfY) Foundation, which targeted unwanted pregnancies among young people. This project developed, produced, and broadcast a 10-part video series and supporting IEC materials on preventing unwanted pregnancies and STDs/HIV/AIDS among young people. The project established a network of volunteer peer educators in Bucharest (12 per school),

[9] The Chisinau center has also received support from USAID/AIHS; see below.

Vasui and Sibiu. The project proved so successful that other districts (e.g., Cluj) sought replication.

- **Russian Federation**

UNFPA conducted RH needs assessments in RF in early 1992 and late 1993, identifying patterns of high abortion rates, high maternal mortality, and increasing incidence of STIs among young people. In 1995, the MOE and MOH asked UNFPA to initiate a three-year project to develop school-based sex education for Russian teenagers. It was envisioned that integration of sex education into the standard public school curriculum would enhance Russian teenagers' knowledge, attitudes, and practices regarding sexuality, safe sex, and contraception. However, conservative forces and the Russian Orthodox Church actively opposed integration of this material into the curriculum and conducted a vigorous campaign that ultimately caused the collapse of this project.

Also in 1995, UNFPA began a project to promote healthy lifestyle among Russian teenagers. This three-year project (also implemented by the MOE) was deemed successful at its ultimate completion in 2000. Didactic materials on adolescent healthy lifestyle were produced and distributed, and teachers' guides on healthy lifestyle were published in education journals. However, the project was pared down due to funding constraints.

The two-year (1998-2000) Adolescent Sexuality and Reproductive Health Peer Education project, conducted in conjunction with the Russian Family Planning Association (RFPA), was designed to improve adolescent reproductive health (ARH) and quality of life through meeting their RH information needs. Training included training of RFPA staff and volunteers in interpersonal communication and counseling, and training of 947 adolescent peer counselors. The project was implemented in 16 regions, reaching more than 600,000 adolescents and more than 1,000,000 people in all. A three-volume RFPA training manual was reprinted (2700 copies) for use during training. Numerous IEC materials were developed and distributed.

Current RF efforts involve continued work with the MOH to implement a national RH policy, training youth specialists on ARH, strengthening integrated RH services in Smolensk region and Sakha Republic, and working with RFPA to support peer educators. UNFPA also continues its advocacy work with events such as media breakfasts at the press club. Additional projects will likely be developed to address HIV/AIDS.

- **Ukraine**

Although it has no country program in Ukraine, UNFPA has assisted in the establishment of RH/FP centers in all 28 regions, and has provided medical supplies, laboratory equipment, IUDs, condoms and spermicides to these centers. From 1997-2000, UNFPA supported development and implementation of the national RH plan; a current (2000-2002) project continues to support this implementation. A manual on sexual abuse prevention and patient care was produced in 2000, and 500 copies distributed. UNFPA

supported development of a model computerized RH MIS, which was operational in six regions in 2001. A youth peer education network now includes 140 educators, and IEC materials for adolescents and youth have been developed and distributed. In conjunction with the Ministry of Defense, UNFPA funded an STI/HIV/AIDS prevention project targeted at the armed forces. This has included curriculum development, training of trainers, and IEC efforts. Another current project seeks to increase knowledge and awareness of STIs/HIV/AIDS, unwanted pregnancies, and drug abuse among students at three universities.

The following chart sets forth selected major UNFPA programs in this region since transition, the implementing institutions and/or strategic partners, materials produced, and outcomes of those programs. This illustration was developed with the assistance of UNFPA staff and demonstrates the range of UNFPA's programs as well as its current foci.

Table 3. Selected UNFPA Results

UNFPA Program	**Implementing Institutions (Strategic Partners)**	**Significant Outcomes**
Advanced training in RH/FP technologies (regional) (1995-1999)	Debrecen University, Hungary Medical School Ob/Gyn Dept	• 143 providers from FSU/CEE trained in basic RH skills and 30+ trained in advanced contraceptive technologies • hands-on training in advanced technologies for OB/GYNs from countries with highest MMR • enhanced skill in providing quality, integrated RH/FP services
Training in RH management (regional) (1998-2001)	Netherlands School of Public Health	• Expanded capacity in development, implementation and management of sexual and RH programs
Partnership for Adolescent RH (regional)	WHO	• Strengthened NGOs' peer education capacity • Established CEE network of 36 peer ed institutions and 98 members/educators • National peer ed networks in Bulgaria, Ukraine, Yugoslavia and Bosnia-Herzegovina • Subregional training for 81 peer educators from 18 countries • Promotion of sex education through life skills
CAR (1995-1999)		• CPR increased 32% • Abortion rate declined 15% • Replication of Bishkek safe sex education campaign to all oblasts in Kyrgyz Republic
Establishment of 77 Family Planning Cabinets (Armenia)		• 321% increase in CPR 1990-1998 • abortion rate decreased 25% 1990-1998 • maternal mortality decreased 32% 1996-1998 • 25 training modules developed • 17 national trainers led 196 RH/FP providers in 11-day training • Add-on IEC included 20,000 copies of safe sex booklet, 500 copies of STD poster, TV and radio spots • Two publications produced in Armenian

UNFPA Program	Implementing Institutions (Strategic Partners)	Significant Outcomes
Sex Education Curriculum for Youth in Russia		• planned to integrate sex education into standard curriculum of 16 pilot schools in 6 regions • textbooks on RH/SH (unused)
Reduction of STIs/HIV/AIDS in army (Ukraine)	(UNAIDS)	• Training of faculty trainers at MOD and 210 military psychologists • Post-project behavior study showed improved knowledge, attitudes and positive behavior change • STI/HIV/AIDS prevention education curriculum prepared and implemented • 8500 copies of prevention manual printed
Adolescent sexuality and RH Peer education (RF)	Russian Family Planning Association	• >600,000 adolescents and >1 million people reached • enhanced communication and training skills of health providers • TOT workshops for 18 specialists selected by RFPA • 42 training workshops for 1036 peer educators
Youth for Youth peer education (Romania)		• 12 per educators available per school at 3 pilot sites • replication under discussion
Social marketing of condoms (Albania, Kosovo)	PSI, UNICEF, MOH, Japan	• 5.6 million condoms sold in Albania since 12/96; sales up 40% through 1998 • STD/HIV brochures distributed in FP and health clinic waiting rooms
Entre Nous Regional Information Project (2001-2003)	WHO	• One issue published online in 7 languages

U.S. Agency for International Development (USAID)

The U.S. Agency for International Development (USAID) has supported RH[10] throughout the region for the past decade through in-country missions, with contractors, and in coordination with other major bilateral and multilateral donors. USAID introduced modern family planning to Romania in 1991 and to Central Asia in 1993; its RH efforts expanded to other NIS countries in 1995 and to the Caucasus in 1998. USAID places its RH efforts within the context of women's health and the family practice model, and in this region emphasizes introduction and use of modern contraceptive methods and the movement away from abortion as the primary means of birth control. USAID also supports WHO's STD Task Force, which collaborates with UNAIDS on STD prevention and care in Romania, RF and Ukraine. Its strategic partners on RH in this region include UNFPA, WHO and the World Bank.

[10] It is noteworthy that USAID has a separate funding stream for HIV/AIDS, and thus does not view HIV/AIDS prevention and care as part of RH, despite the obvious overlap. USAID staff cited this as a concern.

- **Regional**

Beginning shortly after transition, USAID has sponsored Demographic and Health Surveys (DHS) and Reproductive Health Surveys (RHS) in the region with technical assistance from the CDC; these surveys (sample size 3800-7000) provide baseline data and enhance survey methodology and implementation skill of in-country demographers. Reproductive Health Surveys conducted at the national level measure fertility, infertility, abortion and pregnancy experience; pregnancy, delivery, maternal morbidity and mortality, and maternal health; knowledge, attitudes and opinions about contraceptives, and current and past contraceptive use and counseling; RH attitudes; sex education; health behaviors; infant and child mortality; and knowledge and attitudes about STIs/HIV/AIDS. CDC has conducted an RHS in the Czech Republic (1993), in Georgia (1999), in Moldova (1997), in Romania (1993 and 1999), in Russia (1996), and in Ukraine (1999). An RHS has been completed for Azerbaijan; results are pending. CDC conducts Young Adult Reproductive Health Surveys (YARHS) to assess RH knowledge and behaviors of males and females aged 15-24; a YARHS was completed in Romania in 1996. CDC also conducts RH program evaluation surveys, and did so most recently in Russia. CDC and Macro International are now conducting a technical comparative report of all surveys conducted in 12 FSU/CEE countries since 1993; from this meta-analysis, the Population Reference Bureau will produce a non-technical booklet geared toward policy makers and program officials.

In the mid-1990s, a task force of the American International Health Alliance (AIHA) created the **Women's Wellness Center** (WWC) model as a prototype ambulatory care facility (either at a partnership institution or in a freestanding clinic) for delivering comprehensive health care services: FP and RH services, including fertility education and contraceptive services; antenatal and perinatal care, including childbirth classes and breastfeeding education; HIV/AIDS prevention, detection and management; cancer and chronic disease screening, including Pap smears, mammography screening or referral, and breast self-examination education; mental health services; health promotion, including healthy lifestyle, nutrition and exercise counseling; and patient education. Each WWC offers services to improve pregnancy outcomes, to prevent unwanted pregnancies, abortions, and STIs, and to promote healthy lifestyles; each provides comprehensive care to approximately 4,000 (and some to as many as 8,000) women annually. AIHA provides a standard set of materials and equipment to each WWC.[11]

The initial network of 12 WWCs, built upon the resources of the then-existing hospital-based partnerships, opened in stages beginning in late June 1997; they share a WWC database and clinical practice guidelines. Since the first WWC was opened in Chisinau, Moldova in late June 1997, 22 WWCs have been established throughout the region.[12] In

[11] The list may be accessed at <http://www.aiha.com/english/programs/womens/equip.cfm>

[12] These are located in Tirana, Albania (2); Yerevan, Armenia (2); Minsk, Belarus; Mozyr, Belarus; Kutaisi, Georgia; Almaty, Kazakhstan; Chisinau, Moldova; Cahul, Moldova; Iasi, Romania; Dubna, Russia; Essentuki, Russia; St. Petersburg, Russia; Moscow, Russia; L'viv, Ukraine; Odessa, Ukraine; Kyiv, Ukraine; Uzhgorod, Ukraine; Kramatorsk, Ukraine; and Tashkent, Uzbekistan (2).

Albania, Armenia, Belarus, and Moldova, the WWC model has been replicated[13] in new locations with funding from AIHA, the MOH and/or UNFPA; in Ukraine, the model is being replicated throughout the nation. MOH officials in Romania have also approached AIHA seeking to replicate the model. The Kutaisi (Georgia) WWC introduced Pap smear testing for cervical cancer, previously unavailable in Georgia, in September 2000. Partners at the Chisinau WWC hosted the first AIHA conference on domestic violence, an increasingly recognized problem in FSU/CEE. The Almaty WWC sponsors Kazakhstan's lone Lamaze program. On occasion, the WWCs collaborate closely with country family planning associations (FPAs), as in Moldova and Romania.

USAID has tapped PSI to conduct condom social marketing efforts in Georgia, Romania, and RF. A needs assessment is now underway for a regional program in Southeastern Europe (Bulgaria, Bosnia, and Croatia).

- **Caucasus**

USAID's RH work here began in 1998. Work in **Armenia** began with an IEC campaign conducted by Johns Hopkins University/Population Communication Services (JHU/PCS). An NGO/PVO Networks Project was discontinued after two years with little success. Consistent with the Armenian government's current priorities, USAID is supporting the PRIME II Project, which seeks to improve RH services in two pilot sites (Yerevan and Lori Marz), with an emphasis on maternal and newborn health. This effort is closely linked with a project to enhance the skills of primary care/family medicine providers, which is being implemented by Abt Associates.

An RHS conducted in **Georgia** in 1999 showed one of the highest abortion rates in the region and one of the lowest CPRs. JHU/PCS has worked with the MOH, NGOs, and private sector groups to address both issues through mass media campaigns and communication training for personnel in FP cabinets. In the latest media campaign, more than 1000 people attended 30 community mobilization events. Since September 2000, JHPIEGO has been working to enhance providers' knowledge and skills relating to RH/FP and modern contraceptive technology. PSI launched a condom social marketing project in October 2000. The Safe Motherhood Initiative (October 2000-October 2001) was designed to improve maternal and infant health by strengthening integrated perinatal health services; this project will test interventions in eastern Georgia.

- **Central Asian Republics**

Because early RH assessments in Central Asia revealed high use of abortion as a means of birth control and low use of modern contraception, USAID from 1993 through 1996

[13] At a December 2001 assessment conference in Kiev, a panel of MOH and oblast representatives from Armenia, Belarus, Georgia, Moldova, Russia, and Ukraine suggested that 1) the WWC model be replicated in all NIS cities, and 2) each nation's MOH should officially recognize the WWC as an independent, legal entity. The Ukrainian Ministry of Health is working to implement this plan, and the Ukrainian government is focusing on RH as a multi-year priority. There was consensus that the WWCs can and should play a greater role in working with their respective MOHs on development of RH policy.

supported the Reproductive Health Services Expansion Project (RHSEP), which was designed to modernize and expand the quality and sustainability of RH services. The RHSEP provided technical assistance and support for training, policy, institutional development, patient education, and demographic efforts. The CAR Mission worked with the private sector to enhance RH services, including development of a commercial market for contraceptives, which had been previously distributed by the government.

Family Health International (FHI) trained clinicians, including physicians, nurses, midwives and feldshers in Kazakhstan (1995-96), Kyrgyzstan (1995-96), Tajikistan (1995) and Uzbekistan (1996) in modern contraceptive technology (including emergency contraception, postpartum contraception, lactational amenorrhea method, and STIs/HIV/AIDS and infection prevention) and counseling, and in qualitative research strategies.[14]

An analysis of data from the DHS effort in Kazakhstan, Kyrgyz Republic and Uzbekistan determined that, from 1988 to 1995, there was a dramatic increase in contraceptive use and a concomitant drop in the rate of induced abortion. (Westoff, et al., 1998) The Kyrgyz Republic has been a model for integrating RH services into primary care, and similar work has been done in Kazakhstan. Enhancing RH in Uzbekistan is a current USAID focus.

- **Albania**

The Service Expansion and Technical Support (SEATS) II Project, implemented by JSI, worked in Albania from January 1996, when modern contraception was still unfamiliar to most Albanian women, through December 1999, although turmoil in the country limited activities at the end of this timeframe. Working with the MOH and the fairly nascent Albanian Family Planning Association to increase availability of and access to RH services, the project found young people eager to obtain RH/FP information and services. This project established three regional RH/FP training teams; equipped seven training facilities; trained physicians, nurses, and midwives in FP and STIs; trained Tirana providers in post-abortion/postpartum FP; and trained pharmacists in FP and client counseling. It also trained service providers to deliver youth-friendly services, including training in interpersonal communication. PSI distributed many of the IEC materials (FP brochures for clients; reference cue cards for providers) in conjunction with its social marketing initiative.

- **Romania**

USAID began working in RH in Romania in 1991, and has supported activities to expand RH service delivery, particularly through a nationwide system of dispensaries staffed by general practitioners. Since 1993, when the first RHS was conducted here, use of modern contraceptives has increased significantly. The POLICY Project assisted in obtaining

[14] FHI also supports Fellows in Contraceptive Technology Research each year; these persons spend one year at FHI learning the latest research methodologies and developing a research protocol for implementation upon their return home.

health insurance coverage of RH/FP services, and worked with the Ministry of Health and Family to establish contraceptive security policies, including financing, targeting, and rural access. The project worked with NGOs to establish local advocacy networks to support contraceptive security in the three priority judets (Cluj, Constanta, and Iasi). PSI's social marketing of condoms began in Romania in late 1998, and has been well received.

The new Minister of Health has embraced the notion of integrating RH services into primary care, and USAID and UNFPA have provided technical assistance to the MOH to create and implement a national strategy for ensuring broad access to RH services. USAID recently issued a Request for Applications to assist with a new five-year, US$8-10 million initiative that will include, with support from the MOH, creation of pilot service delivery sites that integrate RH services.

- **Russian Federation**

The Women's Reproductive Health Project (WRHP), implemented in partnership with Russian counterparts from 1994 to 1999, represented a significant and quite successful effort to decrease maternal morbidity and mortality due to unwanted pregnancies and associated risks (particularly risks associated with repeat abortions). Consistent with USAID's RH strategy to reduce reliance on abortion as a primary means to prevent unwanted births and shift to the use of modern contraception, the WRHP promoted widespread change in the FP information and service delivery system and sought greater adoption of modern methods of contraception. The project established six pilot demonstration/training sites[15] at which more than 6,500 clinicians received training in modern contraceptive technology. A national IEC campaign was developed and implemented utilizing national TV and radio, as well as brochures, posters, and local promotional activities; this IEC effort sought to provide the general public with sufficient information to make the desired behavior changes. The RF portion of the Service Expansion and Technical Support (SEATS) II Project, operative in Vladivostock and Novosibirsk oblast from January 1996 to December 1997, was part of the WRHP and concentrated on training providers in a client-centered approach to RH services.

Building on the success and the lessons of WRHP, USAID initiated the Women and Infant Health (WIN) Project in June 1999 with three demonstration sites (Novgorod and Perm cities, and Berezniki, Perm region). Its objective is to reduce maternal and infant mortality and morbidity by improving the quality of selected women and infant health services. Implemented by John Snow, Inc. (JSI), the WIN Project seeks to reduce overall abortion rates (particularly a significant reduction in repeat abortions[16]), to increase contraceptive use among sexually active women, to increase the number of women

[15] The six sites were Ivanovo, Yekaterinburg, St. Petersburg, Tver, Novosibirsk, and Vladivostock. Master trainers went on to roll out the training for health care workers at eight additional sites: Yaroslavl, Penza, Tomsk, Omsk, Cheboksary, Moscow, Tyumen, and Perm.

[16] USAID is approaching this issue on several fronts. It has tapped the Population Council to conduct operations research in RF to determine which interventions prevent repeat abortions; this work is now underway.

exclusively breastfeeding, to increase the number of hospitals offering rooming-in to mothers and/or family-centered maternity care (FCMC)[17] as a birthing option, to develop guidelines and protocols, and to decrease perinatal mortality in targeted hospitals. Services include STI prevention, screening, treatment and counseling; comprehensive FP counseling; and antenatal, labor, birth, newborn, and postpartum care. The WIN Project is scheduled to conclude in June 2002, but may be extended one year

In RF, the **POLICY Project** seeks to strengthen capacity of the Advocacy Network for Reproductive Health to advocate for policy change promoting and sustaining access to quality FP and RH services and education, maternal health and STI/HIV/AIDS prevention. Prior technical assistance has enabled NGOs to advocate successfully on their own for RH policy initiatives at oblast and national levels.

- **Ukraine**

The Women's Reproductive Health Initiative was instituted in 1995 to reduce abortion and increase access to modern FP. By 2000, the project had developed model FP and maternity care services in Odessa, Donetsk, L'viv, Crimea, Kharkiv, Ivano-Frankivsk, and Zaporizhya. The project supported training of RH specialists in modern contraception and FP services and counseling and improved availability of high quality contraceptives. USAID is assisting the Ukrainian Reproductive Health Network (UNRHN), a group of NGOs which successfully lobbied for RH funds to be included as a separate line in a new budget code approved by Presidential order in March 2001; that budget included a national RH program for 2000-2005. USAID is assisting with implementation of the national RH program by providing assistance to a policy development group at two local sites, and by aiding the URHN to advocate for adoption and funding of the national RH program at regional levels. In October 2001, MOH officials reported a 30 percent decline in infant mortality at USAID pilot sites (compared to the overall IMR).

Selected USAID RH projects and significant results are set forth in Table 4.

[17] USAID is actively promoting training in FCMC, i.e., evidence-based medicine (EBM) applied to the care of pregnant women and their newborns. At one such training, it was discovered that participating physicians, who had been given translated copies of Niswander and Evans' *Manual of Obstetrics* up to one year earlier, had not opened the treatise. One participant explained that the content diverged so radically from their actual daily practice that they had been unable to use the manual.

Table 4. Selected USAID Results

USAID Program	Implementing Institutions (Strategic Partners)	Significant Outcomes
Reproductive Health Services Expansion Project (CAR) (1993-1996)	TFGI	• Development of technical and operational capacity of private pharmaceutical sector
AIHA Women's Wellness Centers	PATH, WHO, CDC, JHPIEGO, AVSC/ EngenderHealth, UNFPA	• 22 state-of-the-art facilities each provide comprehensive care to 4,000+ women annually • integrated model has been implemented and replicated • STI screening is now part of normal gynecological exam • At inception of breast health program, most women presented with stage 4 carcinomas; today, most present with stage 1 or stage 2 • expanded clinician capacity through training-of-trainers • partners/husbands now involved in labor and birth process
International Reproductive Health Surveys	CDC	• capacity building in demographics Czech Republic, Moldova, Romania and Russia • baseline data on RH/FP
Social marketing of condoms (Georgia, Romania and Russia)	PSI, UNAIDS	• >334,000 condoms sold in Georgia since June 2001 launch • >10,000,000 condoms sold in Romania since October 1998 • >9,900,000 condoms sold in Russia since December 1995
Women's Reproductive Health Project (Russia 1994-1999)	JSI, AVSC, JHPIEGO, TFGI, CDC, JHU/CCP, MOH, Russian Family Planning Association	• Created demonstration service and training (OB/GYN) centers in 6 oblasts, with 27 master trainers used for training at 8 additional sites • 20 curricula/courses on modern contraception, FP, RH developed and delivered to 6500 service providers • Provided 4,000,000 women access to FP info and services • 14 % decline in abortion rates at all project sites • >1,000,000 IEC materials printed and distributed • two hospitals completed requirements for WHO certification as baby-friendly
Women and Infant Health (WIN) Project (Russia 1999-2002)	AIHA, UNICEF, WHO, DFID, JSI, EngenderHealth, JHU/CCP, URC/QAP	• trained 3,788 clinicians in, e.g., post-abortion care and STD counseling • issuance of 35 official documents (federal, oblast, city and facility) building WIN practices and services into Russian health care system • distribution of brochures on IUD, oral contraceptives and injectable contraception (150,000 each) to medical facilities as part of FP campaign • 39 training seminars and workshops prepared and conducted for 857 providers on FCMC, antenatal and postpartum care, neonatal resuscitation • internationally recognized textbooks and treatises translated into Russian and disseminated

USAID Program	Implementing Institutions (Strategic Partners)	Significant Outcomes
POLICY Project	UNFPA	• strengthened capacity of Advocacy Network for RH to advocate for policy change (access to FP, maternal health and STD/HIV/AIDS services) • trained advocates in 2 oblasts • reestablished contraceptive supplies following discontinuation of national central procurement program • advocacy manual translated into Russian
Service Expansion and Technical Support (SEATS II) Project (Albania, RF, Ukraine) (1995-2000)	PSI; MSI; AVSC; CDC; JHPIEGO, JHU/CCP	• providers trained to deliver youth-friendly services and counseling • IEC materials developed and distributed • Limited technical assistance for outreach by consortium of Albanian youth services agencies • Decline in abortions among Russian teens

International Planned Parenthood Federation

IPPF is the largest voluntary organization in the world devoted to FP and RH. With a global base in London, IPPF has established an extensive network of member and affiliated family planning associations (FPAs) in over 180 countries worldwide; the European regional office in Brussels is responsible for FSU/CEE. The network of FPAs inform and educate the public on FP and RH rights, advocate with MOH, Ministry of Education (MOE) and other government officials for RH policies and services, train service providers, and offer sex education, particularly for youth. IPPF's key strategic partners are UNFPA, UNICEF, WHO and the World Bank.

Since 1991, IPPF has assisted as national FPAs slowly began to emerge in FSU/CEE following the breakup of the Soviet Union. The IPPF European Network (IPPFEN) membership grew from 22 in 1990 to 33 by early 1998. As elsewhere, these FPAs run FP clinics, develop and support implementation of national FP policies, organize and develop FP information and education services, and otherwise bolster a climate supportive of FP activities. Central Asia, the Caucasus, and Southeastern Europe are areas where FPA establishment is still largely nascent. Most FPAs in this region are in either stage 1 (pioneer stage) or stage 2 (pilot clinic stage) of development. (Thomas, 2000) As of 2000, IPPFEN was providing core funding for 17 FPAs in CEE and CAR, with another five in the region on tap;[18] The 1997-2003 IPPFEN strategic plan asserted that assistance to these nascent FPAs could not occur with the then-current funding base, but funds were later generated to sustain programs in Bosnia-Herzegovina, Georgia, and Ukraine. However, this funding will lapse in 2007, and sustainability thus becomes increasingly important. (IPPFEN, 2000)

[18] See Appendix 2 for a list.

IPPFEN has provided technical assistance and training as these FPAs emerged, including meetings with national policy makers, health professionals, and NGOs, and lessons learned from the first part of the decade led to improved assistance to later FPAs. Other FPAs within the region have offered formal and informal assistance to the nascent FSU/CEE FPAs. IPPFEN provides support with an aim of ensuring that the new, grant-receiving FPAs will rapidly develop technical and managerial capacity to be self-sustaining. To this end, in 2000, the regional office organized a sustainability and resource mobilization workshop for 30 volunteers and senior staff from 15 FPAs in CEE; the program was designed to strengthen capacity in program, financial, and organizational sustainability. Also in 2000, the regional office assisted with project evaluation for the Bulgarian, Romanian, and Ukrainian FPAs.

Albania, which at one point had the highest rates of infant and maternal mortality in the world, founded its FPA in 1992, after which the Albanian MOH began to incorporate FP services into the delivery system. The Albanian FPA established the first modern FP clinic in the country.

The **Romanian** FPA, founded in 1990, was a pioneer in promoting FP and RH education, made even more crucial as Romania has yet to implement a national FP service delivery program. Two thirds of volunteers at this FPA are under the age of 26; it is recognized as a national youth organization by the Ministry of Youth and Sport. It has opened a new FP clinic in Constanta, providing RH/FP services and training medical and non-medical personnel.

From its inception in 1991, the **RF** FPA has focused on advocacy with government officials; on training clinicians, social workers, and teachers; and on information dissemination to youth.

FPAs in **Albania, Bulgaria, Estonia, Lithuania, Romania, and RF** have been involved in development of new RH legislation. The IPPF Charter on Sexual and Reproductive Rights, developed and published in 1996, has been translated into every language of FSU/CEE and used for advocacy; the Charter has been used to assist the **Hungarian** government in drafting RH legislation. Although Lithuania has no national FP policy, the **Lithuanian** FPA is working with government officials to train midwives.

In several nations in this region, FPAs are working with MOE officials to develop sex education curricula and materials for school use. The **Armenian** FPA has developed policy guidelines for school-based sex education that have been submitted to the MOE; it has also set up a network of 16 urban and rural school projects to train peer educators. The **Estonian** FPA has developed three sex education projects aimed at youth. The **Bulgarian** FPA is piloting peer group sex education counseling for 14- to 18-year-olds in 20 schools in four cities. The **Moldovan** FPA provides resources and training to introduce school-based sex education for 14- to 16-year-olds. The **Slovak** FPA has trained sex education teachers; there is a new curriculum at the secondary school level.

Violence against women, particularly trafficking in women, is an increasing problem in this region. The **Ukrainian** FPA worked with other NGOs to assist victims of sexual trafficking. The **Estonian** and **Poland** FPAs worked with counterparts from Belgium, France, Italy, and Spain to research prevention of sexual abuse in institutions and developed guidelines that were translated into six languages and disseminated to policy makers and residential institutions. Following the Trans Nistria armed conflict, which saw a sharp rise in violence against women, the **Moldovan** FPA trained staff and volunteers in sexual and reproductive rights and prevention of violence against women, and provided technical assistance to its Trans Nistria branch.

Some FPAs have focused on internally displaced persons and other vulnerable populations. The **Georgian** FPA established an FP clinic for internally displaced persons in Akhaltsikhe, for which special education materials were developed and distributed. The **Bulgarian** FPA has addressed the RH needs of the Roma community, establishing FP centers in three Roma districts and conducting workshops and seminars for this population.

FPAs in **Lithuania** and **Ukraine** have organized HIV/AIDS prevention efforts targeted at youth. The **Bulgaria** FPA is a founding member of a coalition of NGOs that is charged with developing a national HIV prevention strategy.

IPPF and the **Latvian** FPA piloted a Contraceptive Social Marketing (CSM) Project in Latvia in late 1995, one of the first such projects in CEE. The CSM Project was patterned after similar work by the Dominican Republic FPA and others in the IPPF Western Hemisphere. The project's initial success led to its expansion to **Lithuania** in February 1998, and to **Bulgaria, Estonia, and RF** in 1999. The project branded and sold two condoms and an oral contraceptive

Table 5. Selected IPPF Results

IPPF Program	**Implementing Institutions (Strategic Partners)**	**Significant Outcomes**
New FPAs		• 17 new FPAs established in region since transition, with at least 5 more nascent FPAs
National RH Strategy implementation		• FPAs in 7 nations have assisted MOH in developing new legislation
School-based sex education		• FPAs in Armenia, Bulgaria, Estonia, Moldova, and Slovakia have assisted with in-school programs or developing national guidelines
HIV/AIDS prevention		• FPAs in Bulgaria, Lithuania and Ukraine are organizing prevention efforts
Contraceptive Social Marketing Project (Bulgaria, Estonia, Latvia, Lithuania, RF)	ODA/DFID	• >1,460,000 condoms sold in Latvia 1/97-6/98 •
Sustainability Initiative (7 FPAs globally)	Moldova FPA	• Strengthened capacity for self-sufficiency • Developed business plan for contraceptive distribution system

Department for International Development

The United Kingdom Department for International Development (DFID) has supported RH programs in the Eastern Europe and Central Asia Division (EECAD); it primarily approaches RH through collaborative work with others, such as IPPF, PSI, and JSI/UK. In CAR, DFID has supported adolescent RH education and funded a research program on RH in Kazakhstan; it has supported strengthening and expansion of family group practice (including RH/FP services) in the Kyrgyz Republic; has provided maternity and pediatric kits to hospitals in Tajikistan; and has supported training of general practitioners in a postgraduate program at all six medical schools in Uzbekistan. DFID has several projects in RF involving HIV/AIDS prevention (including collaboration with OSI's Harm Reduction program). Since 1998, DFID has supported social marketing activities by PSI/Europe in FP, HIV/AIDS, and MCH; PSI/Europe has also implemented a youth-oriented HIV awareness effort in St. Petersburg, Russia. In 2001, DFID joined the government of the Netherlands in a contraceptive security initiative, supplying male and female condoms, IUDs and OCs.

DFID has no RH activities in its Central and South Eastern Europe Division (CSEED), but is formulating an HIV/AIDS strategy for this subregion.

III. Lessons Learned

This section sets forth a compilation of key lessons learned from the donors' perspective; these lessons are based on conversation with staff and on review of project reports, annual reports, evaluations, and other materials produced. The lessons encompass several spheres: rationale, methodology, relationships with others, and perceptions and attitudes.

- **Rationale**

The work of FPAs throughout this region has revealed that envisioning RH as a basic human right can be a compelling rationale and thus an effective approach to expanding RH services and education to young people. SEATS Project outcomes in Albania and RF support this as well.

- **Methodology**

1. Dual-Prong Approach

Given the complexities of RH issues and the newness of many of these notions and programs in FSU/CEE societies, donors have often found the best success when working simultaneously with community-based initiatives and political/MOH/policy approaches. UNFPA staff offered that the most effective way to achieve desired results is by starting at this level, and later engaging the policy makers and MOH officials. At the grassroots level, public education (frequently adolescent peer-to-peer education) expands

knowledge and empowers women to make informed RH choices. Successful initiatives have typically found grassroots involvement in the design phase of a project.

At the MOH level, necessary support for policy implementation and perhaps even funding can be attained. Depending on a project's success and the MOH level of involvement and awareness, the MOH may be a source of sustainable funding.

2. High-level Government Support

Linked with the dual-level approach is a third major lesson from RH work in FSU/CEE, that the need for political buy-in at the highest levels is paramount. The tremendous success of USAID's WRHP would not have occurred without this buy-in, which lent credibility and impetus to the effort. Where the MOH was involved (e.g., in WRHP information dissemination and AIHA WWC programs), its support has increased the likelihood of sustainability of the initiative. As witnessed by the unfortunate outcome of UNFPA's Russia curriculum project, the lack of political support at the highest level is tantamount to failure.

In a twist on this notion, SEATS Project evaluators assert that it demonstrates that willingness to take on new approaches to RH services for young people are not limited to the private sector; this, in turn, suggests that local governments should be involved as well as MOH. One colleague suggested that the local government support is vital even in the absence of buy-in by MOH representatives.

3. Capacity Building

In CAR, UNFPA learned that capacity building should incorporate strengthening community participation and local leadership.

4. In-Country Presence

UNFPA has found itself to be most effective where it has staff in residence in-country. This seems to be partly a matter of smooth logistics in program implementation, but may also have some bearing on the donor's image in-country. Similarly, USAID found that in-country advisors typically ensured program continuity and progress, and that the lack of such personnel made program implementation more difficult; a notable exception was USAID's work in Turkey from 1990 through 2002.

5. Tailored Training

UNFPA's work in CAR and RF amply demonstrated the need to tailor training to trainees' needs.

6. Institutionalization of Training

The WRHP determined that working with established training institutions ensured a greater chance for ongoing, sustainable training. WWCs have served as important training sites for RH providers and are likely to continue to serve as training sites because they are well respected by the health professions community.

7. Information, Education, and Communication

Where IEC efforts are targeted at both high-risk populations and the general population, different messages must be used for the two audiences, preferably by designing two different programs. Where such interventions have tried to craft a single message for different audiences, the program has met with less success.

- **Relationships with Others**

1. Donors

Because UNFPA's funds in this region are so limited, a major lesson (also a major strength of its work here) is to leverage impact by collaborating with other major donors. UNFPA staff enthusiastically cited existing work with OSI and appear eager to expand such collaboration. The WIN Project successfully draws on the strengths of four implementing organizations.

2. Funding Constraints

Dual protection may be problematic where funds are donated and targeted *either* for STIs/HIV/AIDS prevention and services *or* for FP and RH education and services, but not for both. Particularly in light of the explosion of HIV/AIDS and other STIs in this region, donors with this constraint must find ways to increase synergy between these two types of programs.

3. Work with Media

A related matter is donors' work with media to expand general knowledge and education about FP and RH. IPPFEN's strategic plan for 1997-2003 placed enhancement of FPA staff media skills as a high priority.

- **Perceptions and Attitudes**

1. Behavior Change

The WRHP found that behavior change requires a supportive environment with trained physicians and pharmacists, as well as exposure to an integrated communication program (TV and radio, plus brochures, posters, and local promotional activities) accomplished more than simply utilizing TV and radio (although this combination may be somewhat

effective). Early assessment of the WIN Project indicates that it may have been unrealistic to expect a rapid (3-year) increase in contractive use sufficient to reduce dramatically the number and rate of abortions. However, at one WIN site, the percentage of abortion clients accepting FP rose from just eight percent to 57 percent; this suggests that women who have had one abortion may be open to other means of birth control. (Kantner, et al., 2001)

2. Public Perception

For better or worse, the public perception of an organization or program will markedly impact receptivity. In CAR, UNFPA found community trust to be essential for effective, community-based services, especially those provided through partnerships between medical and non-medical organizations. The AIHA WWCs are seen by patients as offering not only comprehensive, high-quality care, but also added value, perhaps most notably in the patient education facilities and services. Similarly, the WIN Project has received favorable reviews from clinicians, who indicate that the project has changes the way in which physicians and midwives relate to their patients.

IV. Opportunities for OSI

UNFPA, USAID, and the national FPAs have all devoted considerable attention to assisting Ministries of Health with developing and implementing national RH/FP programs. Where such national plans are in place, the effort shifts to oblast/regional and local levels. Advocacy training has also been conducted quite successfully in many parts of the region. Peer educators are found in most countries, and are deemed effective. Over the past decade, many health professionals have received RH training; some have gone on to train others. IEC materials on RH/FP have been developed and disseminated widely. Yet notwithstanding tremendous progress in some aspects of RH in this region in the past decade, many RH indicators in FSU/CEE are lagging and much work remains:

- Abortion, rather than modern contraception, remains the primary means of preventing unwanted births; this legacy has been difficult to break.
- There is still limited access to modern contraceptives and no clear strategies for maintaining contraceptive supply. With growing demand for RH services and supplies, contraceptive security becomes increasingly problematic.
- Birth practices have room for improvement.
- Equipment is far from abundant.
- Some critical areas, such as breast and cervical cancer screening, domestic violence, and mental health (e.g., postpartum depression) remain largely unaddressed.
- Training and retraining of practitioners is needed.
- Although some advocacy networks are strong, NGO capacity is uneven.

Thus far, OSI's Public Health Program has had two primary focal points in RH: abortion and cervical cancer screening treatment. Although abortion rates are declining, these two areas remain significant concerns in this region and, in particular, insufficient attention has been devoted cervical cancer. The Program has addressed violence against women,

which is a growing problem in this region. As it expands its RH programs in FSU/CEE, OSI capitalize on its own competitive advantages. These advantages include tremendous respect at both the MOH and the grassroots level, an established network of community health and social service providers, and the ability to implement programs quickly. A significant advantage for OSI in RH is the lack of constraints regarding policies on sensitive topics, such as abortion and needle exchange to prevent transmission of HIV. It is also noteworthy that other donors expressed eagerness to collaborate with OSI on RH in this region.

The following are preliminary ideas for interventions in policy, training, or support of pilot projects.[19]

- OSI should support production and dissemination of a manual on best practices in reproductive health in this region. This would supplement ongoing training programs by establishing an up-to-date primer for new health professionals and assist in retraining current providers. If developed as separate modules, the material would be more easily updated and expanded. This resource could be translated into appropriate languages and made available electronically as well as in print form.

- OSI should support a regional summit on reproductive health. Attendance would include key stakeholders, such as government representatives (MOH and oblast/regional), FPA representatives, health professionals, health professions educators, media representatives, and representatives of NGOs. Topics to be discussed would include decreasing the abortion rate, adolescent reproductive health, reproductive cancers, contraceptive security, prevention of STIs/HIV/AIDS, mental health, and violence against women. This might be done as a Salzburg Seminar.

- OSI should advocate for contraceptive security with MOH officials throughout the region. USAID's work in Romania will be instructive here.

- OSI should support pilot RH training projects, utilizing the best practices manual, concentrated in those nations where the need is greatest as implied by RH indicators: Georgia, Kazakhstan and Tajikistan (maternal mortality), RR, Belarus, Estonia, Ukraine and Romania (abortion rate), or Romania and Bulgaria (teen birth rate). Training should be made available for physicians, nurses, midwives and feldshers, in both urban and rural areas.

- OSI should support pilot training projects for providers on violence against women. This might build on work in nations where FPAs are addressing this issue.

- OSI should support pilot community outreach projects to strengthen NGO capacity in this area. These might be linked with OSI's harm reduction work.

[19] The Kyrgyz Republic and Ukraine appear to be nations with great government impetus for progress in RH, but are also nations already receiving support to this end; it is unclear whether additional assistance here is warranted.

- OSI should expand its pilot cervical cancer screening and treatment project widely. In addition to provider training, public education should be a significant part of this expansion.

V. Methodology

This paper was developed following an extensive review of project documents and assessments, a literature search, and personal interviews with staff at selected donor institutions. The recommended areas for exploration are based in part upon other donors' existing work, in part upon lessons learned and suggestions as expressed by other donors, in part upon OSI's existing programs and strengths, and in part upon the author's experience in this field and in this region.

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ACRONYMS

AIDS	acquired immune deficiency syndrome
AIHA	American International Health Alliance
ARH	adolescent reproductive health
AVSC	Association for Voluntary Sterilization; now EngenderHealth
CAR	Central Asian Republics
CDC	Centers for Disease Control and Prevention
CST	Country Support Team (UNFPA)
D&C	dilation and curettage
DFID	Department for International Development, United Kingdom
DHS	Demographic and Health Survey
EBM	evidence-based medicine
FCMC	family-centered maternity care
FHI	Family Health International
FP	family planning
FPA	family planning association
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IDU	injecting drug user
IEC	information, education, and communication
IMR	infant mortality rate
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JHU/PCS	Johns Hopkins University/Population Communication Services
JSI	John Snow, Inc.
MCH	maternal and child health
MIS	management information system
MOD	Ministry of Defense
MOE	Ministry of Education
MOH	Ministry of Health
MMR	maternal mortality rate
MSH	Management Sciences for Health
MSI	Marie Stopes International
NGO	nongovernmental organization
OC	oral contraceptive
ODA	Overseas Development Agency, United Kingdom
PATH	Program for Appropriate Technology in Health
PSI	Population Services International
PVO	private voluntary organization
RFPA	Russian Family Planning Association
RH	reproductive health
RHS	Reproductive Health Survey

SH	sexual health
STD	sexually transmitted disease
STI	sexually transmitted infection
TFGI	The Futures Group International
TOT	training of trainers
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC/CHS	University Research Corporation/Center for Human Services
URHN	Ukrainian Reproductive Health Network
USAID	United States Agency for International Development
WHO	World Health Organization
WIN	Women and Infant Health Project
WRHP	Women's Reproductive Health Project

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Appendix 1
WHO Proposed Short List of Reproductive Health Indicators

- Total fertility rate
- Contraceptive prevalence rate
- Maternal mortality ratio
- Percentage of women attended, at least once during pregnancy, by skilled health personnel (excluding trained or untrained traditional birth attendants) for reasons relating to pregnancy
- Percentage of births attended by skilled health personnel (excluding trained and untrained traditional birth attendants)
- Number of facilities with functioning basic essential obstetric care per 500 000 population
- Number of facilities with functioning comprehensive essential obstetric care per 500 000 population
- Perinatal mortality rate
- Percentage of live births of low birth weight (<2500 g)
- Positive syphilis serology prevalence in pregnant women (15-24)
- Percentage of women of reproductive age (15-49) screened for hemoglobin levels who are anemic
- Percentage of obstetric and gynecology admissions owing to abortion
- Reported prevalence of women with FGM
- Percentage of women of reproductive age (15-49) at risk of pregnancy who report trying for a pregnancy for two years or more
- Reported incidence of urethritis in men (15-49)

Appendix 2. Overview of UNFPA and IPPF Activity

Country	Year UNFPA Began	Current UNFPA Program?	Year FPA Established	Current IPPF Affiliate?
Albania	1991	Yes	1992	Yes (1997)
Armenia	1995	Yes	1999	Yes (1999)
Azerbaijan	1995	No	In process	Yes
Belarus	1994	Yes	Nascent effort	No
Bosnia-Herzegovina	1995	Yes	Nascent effort	Yes
Bulgaria	1979	Yes	1992	Yes (1975)
Croatia	1995	No	Unknown	No
Czech Republic	N/A	No	Unknown	Yes (1994)
Estonia	1994	Yes*	1994	Yes (1995)
Georgia	1993	Yes	Unknown	Yes
Hungary	N/A	No	Unknown	Yes (1975)
Kazakhstan			Unknown	Yes
Kyrgyzstan			In process	Yes
Latvia	1995	Yes*	1994	Yes (1995)
Lithuania	1995	Yes	1995	Yes (1995)
FYR Macedonia	N/A	No	Unknown	No
Moldova	1998	Yes*	1993	Yes (1996)
Poland	1980	Yes	1957	Yes (1997)
Romania	1990	Yes	1990	Yes (1992)
Russian Federation	1995	Yes	1991	Yes (1993)
Slovakia	N/A	No	1991	Yes (1994)
Slovenia	N/A	No	Unknown	No
Tajikistan			In process	Yes
Ukraine	1997	Yes	Unknown	Yes
Uzbekistan			In process	Yes
FR Yugoslavia	N/A (2000 assessment)	No	Nascent effort	No

* These funds are extremely limited.