

Ukraine Contraceptive Availability Assessment

Prepared for USAID/Ukraine

Tony Hudgins
Chris Wright

November 2004



DELIVER
No Product? No Program. Logistics for Health

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Abstract

A variety of contraceptive methods are widely available in Ukraine through commercial pharmacies. Low-cost options exist, as do expensive brands, but a large segment of Ukrainian couples cannot afford to purchase contraceptives, and the public sector has no supplies to offer them. This report recommends that USAID donate contraceptives for a targeted segment of the population for the near- and medium-term while they advocate for the government provision of commodities in the long-term, update provider knowledge of contraceptive technology, and expand family planning service provision to include training of non-OB/GYNs, particularly in rural areas.

DELIVER

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Acronyms

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral (drugs)
ATP	ability to pay
CPR	contraceptive prevalence rate
CPT	Contraceptive Procurement Table
CYP	couple-years of protection
GNI	gross national income
GOU	Government of Ukraine
HIV	human immunodeficiency virus
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
LMIS	logistics management information system
MOH	Ministry of Health
MWRA	married women of reproductive age
NGO	nongovernmental organization
NRHP	National Reproductive Health Program
OB/GYN	obstetrician/gynecologist
PATH	Program for Appropriate Technology in Health
PDG	Policy Development Group
POPTECH	Population Technical Assistance Project
PPP	purchasing power parity
STI	sexually transmitted infection
TAR	total abortion rate
TB	tuberculosis
TFR	total fertility rate
U.S.	United States
UHR	Ukraine Hryvna

UNFPA	United Nations Population Fund
URHN	Ukraine Reproductive Health Network
USAID	U.S. Agency for International Development
WRHI	Women’s Reproductive Health Initiative
WTP	willingness to pay
WB	World Bank

Executive Summary

A contraceptive availability assessment, conducted in Ukraine in September/October 2004, looked at the availability in the public and private sectors, in clinics and pharmacies, and in urban and rural areas.

Beginning in the early 1990s, the United Nations Population Fund (UNFPA) provided donated contraceptives to Ukraine's government system, but they phased out donations in 2003. From 1995 to 2000, under the Women's Reproductive Health Initiative (WRHI), USAID provided donated contraceptives to six oblasts (an administrative territorial division); they are exploring the possibility of renewing contraceptive donations to the government system in the short- and intermediate-term. One purpose for this assessment was to determine whether the existing outlets for contraceptives provide Ukrainians seeking to achieve ideal family size with sufficient access and choice, without resorting to abortion.

The family planning situation in Ukraine is similar to many of the republics of the former Soviet Union. Compared to the country's level of development and education, the use of modern contraception is modest, and families continue to depend on abortion to limit fertility. According to official Ministry of Health statistics, Ukraine has a higher total abortion rate (TAR)—1.6—than its total fertility rate (TFR)—1.3. This means there are more abortions than live births. While official TAR statistics have shown a decline during the past decade, abortions remain a common method of fertility control, because of a significant unmet need and to a reliance on traditional contraceptive methods that frequently fail. Although 68 percent of married couples report using contraceptives, only 38 percent use a modern method.

Facility and human resource infrastructure exists but it is poorly equipped and the staff are poorly paid. Also, while prejudices against safe, hormonal contraceptives appear to be fading, there is a concerted effort by some manufacturers to market more expensive third-generation hormonal pills with a lower hormonal dose as healthier than lower priced (and still relatively low-dose) second-generation pills—a strategy that plays to provider bias, which originated from adverse health effects associated with the original high-dose pills.

Certain limitations are placed on who can provide family planning services and supplies. Obstetrician/gynecologists (OB/GYN) are usually the only group that can provide family planning services. Because they are largely employed at the rayon facility (district level) and above, access to contraception by rural women is problematic.

None of the government facilities visited had unexpired contraceptives in stock, with the exception of some intrauterine devices (IUDs). Providers could not provide free supplies, and could only refer clients to pharmacies where clients had to purchase contraceptives. Providers consistently stated that many of their clients could not afford to buy even low-priced contraceptives from pharmacies, and they were frustrated because there were no supplies to give them.

We visited a convenience sample of private and parastatal pharmacies to assess availability in the commercial sector, and found that commercial pharmacies have good contraceptive availability, and they offer a wide selection of methods—oral contraceptives, condoms, IUDs, and spermicides—at a range of prices, in both urban and rural areas. Depo-Provera® is available in many pharmacies, but is used mainly as a treatment of pathology, not as a contraceptive. An inexpensive oral contraceptive is usually available (Rigevidon), at a median price of U.S.\$1.10 per cycle. The manufacturer plans to continue to supply this product for at least the next four years. While this price may seem low by American standards, an ability to pay (ATP) analysis, using data from the World Bank (WB), found that even this low-priced product was out of reach for 40 percent of the population.

The assessment found significant interest among policymakers and providers, at all levels, in providing family planning services and in contraception as a desirable option to continued reliance on abortion. This support, coupled with the existing infrastructure and apparent rising demand, led to the following summary recommendations:

- USAID/Kiev should consider donating oral contraceptives, IUDs, and condoms to the Ministry of Health of Ukraine for a limited period. A methodology should be developed to target the free contraceptives to those with the greatest need and the least ability to pay.
- To ensure sustainability, the Government of Ukraine should commit to some future support for free contraceptive supplies.
- USAID/Kiev should provide assistance to strengthen the contraceptive logistics system within the Ministry of Health to maintain a full supply of contraceptives at the facilities that currently provide family planning services.
- Family planning services providers should receive an update on contraceptive technology.
- The MOH should expand the availability and family planning services by training non-OB/GYNs to provide basic family planning services, or alternatively, to expand the services of OB/GYNs to more rural areas.
- The MOH should consider implementing a pilot introduction of injectable contraceptives.

Introduction

Purpose

The United States Agency for International Development (USAID) Mission for Ukraine, Belarus, and Moldova contracted with the John Snow, Inc./ DELIVER project to conduct an assessment of contraceptive availability in Ukraine, and to provide options for the future design of a USAID reproductive health activity aimed at improving contraceptive security in Ukraine.

Many documents have been written about the family planning situation in Ukraine. As is the case in many of the republics of the former Soviet Union, the use of modern contraception is relatively low for the socioeconomic and educational levels of the population, and there is a heavy reliance on abortion. This document will not provide extensive background, which is available in the excellent 2003 Ukraine Reproductive Health Assessment produced by Population Technical Assistance Project (POPTech) (Selzer, Bryan, and O'Hanley 2003). This document will assess current contraceptive availability, and later in the document will suggest possible opportunities for intervention.

Methodology

As a team of two advisors from the DELIVER project, we conducted a three-week assessment from September 19 to October 8, 2004. We reviewed documents related to ongoing and previously completed activities in family planning and reproductive health, including Government of Ukraine (GOU) decrees and the Ministry of Health (MOH) strategy documents; and USAID-supported assessments, surveys, and policy papers. We interviewed a variety of key informants, including officials from the MOH, USAID, and other donors; representatives from family planning and youth-oriented nongovernmental organizations (NGOs); educators and researchers from medical institutes; program managers and service providers at the oblast, rayon, and local levels; technical advisors working on USAID-supported health projects, and representatives from the private sector. See figure 1.

Figure 1.
Map of Ukraine



In the following cities, we visited family planning services and program sites: Kiev, Vizhgorod (Kiev Oblast), Tores (Donetsk Oblast), Krasni Luch (Luhansk Oblast), Mykolaev, Odessa, and Zhovkva (Lviv Oblast). The sites were selected to ensure that a broad range of facilities were assessed. Public sector sites included city reproductive centers, rayon reproductive centers, a rural ambulatory clinic, and a rural feldsher point. Nongovernmental organization (NGO) sites included family planning consultative centers and two NGOs that serve underprivileged and at-risk youth. In addition, we visited the Ukraine Reproductive Health Network and one of the pharmaceutical representatives (Gedeon-Richter). See appendix B for a complete list of key informants and agencies visited.

To assess the availability of contraceptives in the private sector, the team visited a convenience sample of approximately 15 pharmacies during the site visits, including both public (parastatal) and private pharmacies in cities, small towns, and villages. Again, to gain more representative information about the availability of contraceptives in the private sector, we tried to include diverse sites.

Availability in the Public Sector

During the past 10 years, the MOH and the Ukraine Reproductive Health Network (URHN), with significant support from the USAID-funded Women's Reproductive Health Initiative (WRHI), have worked to strengthen family planning services in Ukraine. As a result of this work, it appears that the country is ready for increased activity in family planning. Considerable infrastructure has been put in place, including reproductive health centers; information, education, and communication (IEC) materials for providers and clients have been developed; and both government facilities and NGOs have been active in demand creation. Another important advance is that traditional prejudice against hormonal methods seems to be disappearing, at least among the clinicians that we met. We also found the clinicians were open-minded to the increased use of oral contraceptives. In fact, clinicians often stated that women in their clinics—particularly young women—were shifting their preference away from intrauterine devices (IUDs) and toward oral contraceptives.

However, the current situation in the public sector is a classic demonstration of the motto: *No Product, No Program*. None of the government clinics visited had oral contraceptives or condoms in stock. There were a few remaining IUDs available in a few locations. Depo-Provera® is not a popular method of contraception and is used only for the treatment of pathology.

Clinicians consistently reported that their clients could not afford to purchase contraceptives in the pharmacies, and they felt some distress that this was the case. While abortions also require payment (we heard at least U.S.\$10), regular contraceptive use is a preventive measure and, therefore, a lower priority, while an abortion is an acute need and the family will scrape up the necessary funds. During our visit, a poignant story was told by a clinician who was struggling with the issue of a particular client's inability to pay:

A remote village in the Carpathian Mountains pooled its resources to send a very sick child with her mother to the Institute of Pediatrics in Kiev. While examining the child, I noticed that the mother was also not well, and clearly should not become pregnant at this time. She was willing to take contraceptives, but could not afford to buy them. I am now looking for a year's supply to give her to take back home with her, but the Institute has no supplies. I don't know whether I will be able to find free supplies or not.

This anecdote typifies the situation in Ukraine. While the major cities exhibit considerable wealth, the rural areas have few cash resources. In addition, there are vulnerable populations in the cities, particularly youth,

and the unemployed and underemployed who have not adapted well to the new economy.

Figure 2 shows the relative wealth of the urban versus rural areas. As can be seen, more than half (57 percent) the women in the rural areas are in the lowest two quintiles, and presumably would have difficulty purchasing contraceptives in the commercial market. In the urban areas, two-thirds of the women (67 percent) are in the top three quintiles, and presumably would have resources to purchase contraceptives, particularly the less expensive brands.

Figure 2.
Distribution of Women in Reproductive Age (15–44 yrs.)
by Wealth Quintile, by Residence, Ukraine 1999

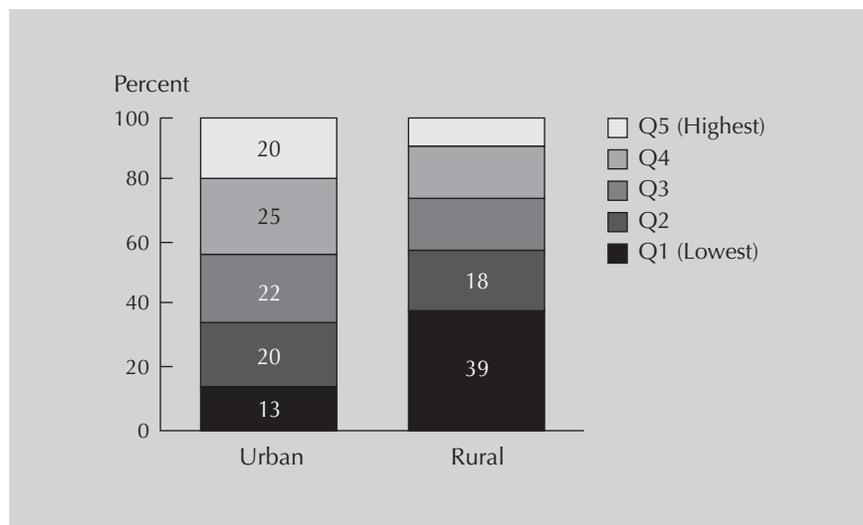
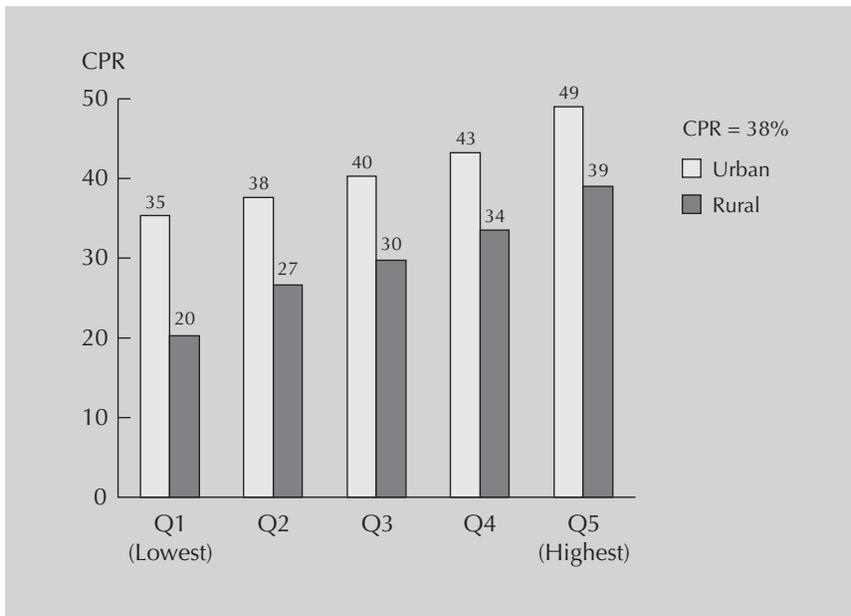


Figure 3 shows the current use of modern contraception in the rural versus urban areas. The gap between use, even within the same wealth quintile, indicates a lack of four things: (1) family planning knowledge; (2) family planning services; (3) in the rural areas, access to pharmacies; and (4) funds. Figures 2 and 3 underscore the need to find a way to target family planning services and to provide free supplies to the rural areas, as well as to the especially underserved segments of the urban population.

Figure 3.
Modern Method CPR among MWRA
Urban vs. Rural Area, Ukraine 1999
(Contraceptive Prevalence Rate [CPR])



Availability in Pharmacies

The commercial pharmaceutical sector is well established in Ukraine, and consists of private commercial firms and privatized state pharmacies, which are now partially owned by oblast health administrations. These parastatal or *joint stock company* pharmacies are regulated more tightly than commercial firms and manage many of the national *budgetary* medicines—such as tuberculosis (TB) medicines, antiretroviral (ARV) drugs, etc.—that are procured by the MOH and provided free or at subsidized prices to target populations. They are allowed to charge a maximum mark-up of 30 percent on other products, although contraceptives are usually marked up only 15–20 percent.

Private commercial pharmacies can be found throughout Ukraine in cities and towns. They carry a full range of health products and offer a wide choice of contraceptives—particularly hormonal pills, spermicides, and condoms—from a variety of manufacturers and at a broad range of price points. IUDs and Depo-Provera®, if they are not stocked onsite, can be ordered and delivered within a few days. Some private pharmacies offer discount cards for regular customers, who earn 5–15 percent discounts based on their purchasing history.

State pharmacies are located in cities, towns, and even villages, and also provide a good selection of methods, brands, and prices. All sites visited (with the exception of the feldsher point) were served by a pharmacy—and sometimes both a state and private pharmacy—either on the health facility premises or nearby.

Oral Contraceptives

There is wide availability of oral contraceptives throughout the country, indicating a growing market for and, therefore, greater acceptance of hormonal pills. Ninety-five percent of orals are purchased through pharmacies, and a number of companies are active in or are entering the oral contraceptives market, including Schering, Gedeon-Richter, Organon, Solvé (a Ukrainian-Canadian joint venture), and NishPharm (Russian, but not yet registered). Demand for particular brands depends on geography and wealth, as expected. Pharmacies report better sales of more expensive orals in urban areas that have a greater concentration of wealth and a higher demand for less expensive brands in poorer rural areas. Consequently, urban areas have a broader and more expensive range of products, while poorer areas focus on the lower range products. Prices range from U.S.\$0.90–\$1.32 per cycle for the lowest cost brand (Rigevidon) to as much as U.S.\$10.56 for the newest product (Jeanine-35). Table 1

displays additional details about brands and price ranges. There is some price variation between private and state pharmacies, and between rural and urban pharmacies. However, no general rule was found because, in most cases, brand A was priced higher but brand B was priced lower than the same brands elsewhere.

In table 1, Rigevidon, a standard low-dose second-generation pill is clearly the most affordable. It is noteworthy that the more expensive, third-generation pills were preferred by the physicians—sometimes with strong convictions. A preference for “micro-dose” 20 microgram pills was also stated. Schering Corporation has been very active in promoting the third-generation pills. Jeanine was mentioned most frequently, along with Diane-35 (marketed as beneficial for the complexion) as well as Marvelon.

Table 1. Price of Oral Contraceptives, per Cycle

Method/Brand	Unit Cost (in U.S.\$)
Diane-35	7.21 – 9.05
Jeanine	9.81 – 10.56
Logest	6.28 – 7.55
Marvelon	5.66 – 6.60
Microgynon	3.54 – 4.14
Minisyston	1.45
Mircelon	7.55 – 8.97
Non-Ovlon	1.50 – 3.53
Noviner	3.20
Ovidon	1.32 – 1.50
Regulon	2.26 – 2.77
Rigevidon	0.90 – 1.32
Triquilar	2.30 – 4.34
Tri-Regol	1.10 – 3.58
Trisiton	1.83 – 3.58
Yirina	10.19

Particularly in poorer locations, the cheapest pill, Rigevidon, was the most popular choice. This product was commonly available for about U.S.\$1.00. The representative for Gedeon-Richter stated that the registration had 3–4 years left, and the company would continue to import and distribute it, although it is not being aggressively marketed. The continued availability of this product is an important factor in deciding whether to introduce a socially marketed pill.

Other Methods

Condoms are also widely available, with prices ranging from \$0.15 per piece for Russian-made condoms (usually dismissed as poor quality), to \$0.80–\$1.85 for a packet of three brand name condoms.

The price for IUDs range from \$2.83 for a Russian brand to \$7.90–\$9.50, and availability is more limited, reflecting a reported decreased demand for this method. However, pharmacies that do not stock IUDs can order them and expect delivery within a few days.

Depo-Provera® is available in many pharmacies for between \$6.03 and \$7.55 per 150 mg dose, and can be ordered when not in stock. However, demand is low because of a lack of information among providers and clients about its family planning—as opposed to therapeutic—application.

A number of spermicidal suppository brands are available at all pharmacies visited, with prices for a packet of 10 ranging from \$1.06 to \$7.33.

Ability to Pay in the Private Sector

Ukrainian gross national income (GNI)¹ per capita has risen over the past several years from U.S.\$760 in 1999 to U.S.\$970 in 2003 (World Bank 2004). Despite this, pharmacy retail prices for contraceptives remain relatively high for significant segments of the population. However, the commercial sector is an important source for contraceptives, and will continue to grow in importance. Certainly, when one observes the relative wealth and sophistication of Kiev, with its surfeit of expensive automobiles, it is difficult to understand that much of the population may not be able to afford even the inexpensive contraceptives available in the market. To assess the magnitude of the problem, we carried out the Ability to Pay Assessment.

Key Concepts

The *ability to pay* (ATP) refers to how easy it is for consumers to find the money necessary to pay for, in this case, contraceptives. The analysis assumes that the lower the relative cost of contraceptives, in relation to income, the greater the ability of users to pay for them. The approach used to measure ATP will involve deriving the average annual income of potential users by *income quintile* (five equal population sub-groups) and comparing this to the cost of couple-years of protection (CYP) for different methods and brands and from different sources. An estimate frequently used to measure ATP assumes that expenditure on contraceptives should be no more than 1 percent of per capita income (Harvey 1994). Users exceeding 1 percent of income on contraceptives are considered to be unable or less likely to pay. The *1 percent* estimate may be biased toward middle income populations with more disposable income than poorer income groups. Therefore, estimates of ATP sometimes consider a lower income threshold, such as 0.5 percent, for the poorest 40 percent of the population. Analysis of reproductive health accounts in South Asia (IPS 2004) suggest estimates of around 0.5 percent of income on contraceptives may be more realistic given household expenditures on other (reproductive) health care services and commodities. Contraceptive costs by method, brand, and source are then compared to income quintiles, producing a cost to income ratio expressed as a percentage. This analysis provides an indication of what methods and brands are affordable to each income quintile.

1. GNI per capita was used to provide an absolute comparison between income and prices. This method does not take into account purchasing power parity (PPP), which considers the relative cost of goods and services when calculating income.

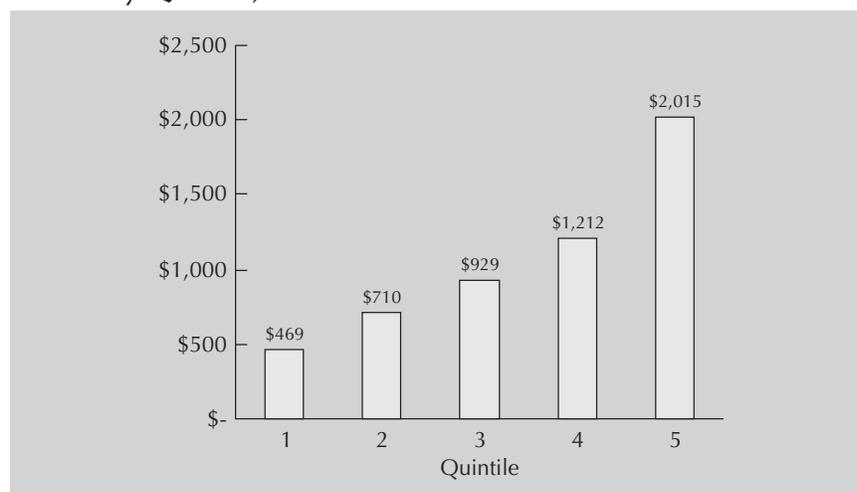
In contrast to ATP, willingness to pay (WTP) reflects the value customers place on contraceptives. Consumers, of course, may decide to spend more than 1 percent of income because of the value they place on the product. Interviews with pharmacists and physicians in the former Soviet Union often indicated that some women were willing to pay very high prices for the oral contraceptive *Diane-35* because of the positive affect it has on skin complexion. While this evidence is only anecdotal, there is a marked distinction between the ability and willingness to pay. In the absence of an alternate, defining benchmark, this analysis will categorize users as unable to pay if the price exceeds 1 percent of annual per capita income. This does not mean households are unwilling to pay, but certainly less likely, given their income. Users will be considered able to pay if the price is below 2 percent of income. It should be noted that some assessments use couple income, with a higher affordability threshold (1.5 to 2 percent), and some have postulated that household income should be used. We were told that most Ukrainians had extra sources of income, and particularly in rural areas, there are non-monetary sources of income. Therefore, this analysis used a relatively high threshold of 2 percent of per capita income.

Average Income by Population Subgroups

Estimating the ability to pay for contraceptives first requires data on the percentage of national income by population sub-groups (World Bank 2003).² For the purposes of this analysis, total population is divided into five separate income groups or quintiles. Each group represents 20 percent of the population. The quintiles run along a continuum: Q5 represents the wealthiest 20 percent of the population and Q1 represents the poorest. Mean per capita income for each quintile was calculated using World Bank income data for 2003 and income distribution data from 2001. As shown in figure 4, the wealth disparity between Q5 and Q1 (the wealthiest and poorest 20 percent of the population) is significant. Quintile 1 earns only 23 percent of the income of quintile 5. The top 40 percent (Q4 and Q5) account for more than 60 percent of total income. The bottom 40 percent account for 22 percent. This inequity of income distribution by quintile is common in many countries in the region and even in much wealthier countries. However, the vast majority of total health expenditures, including contraceptives, are paid out-of-pocket, making income levels an important determinant of health care.

2. Percent income by quintile figures are from 2001.

Figure 4.
Income by Quintile, Ukraine



Comparing Contraceptive Prices to Income Levels by Quintile

The annual cost for each brand is determined by multiplying the unit price by the CYP factor for each method. CYP factors used for the analysis were 120 condoms per year, 15 cycles of pills per year, 3.5 years per IUD, and 4 injections per year. Cost as a percentage of annual income can then be determined by dividing the annual cost per CYP for each brand by contraceptive couples income for each wealth quintile (see table 2).

Table 2. Cost as a Percentage of Annual Income by Quintile

Income and Distribution: World Bank Prices: Commercial Pharmacies			Quintile				
			Q1	Q2	Q3	Q4	Q5
Per capita income (U.S.\$1,067)			\$ 469	\$ 710	\$ 929	\$ 1,212	\$ 2,015
Method	Brand	Cost per CYP					
Condom	Russian	\$18.00	3.83%	2.53%	1.94%	1.49%	0.89%
	Cheapest	\$32.00	6.82%	4.51%	3.45%	2.64%	1.59%
	Highest	\$72.00	15.34%	10.14%	7.75%	5.94%	3.57%
Pill	Jeanine	\$152.70	32.53%	21.50%	16.44%	12.60%	7.58%
	Diane-35	\$152.70	32.53%	21.50%	16.44%	12.60%	7.58%
	Marvelon	\$91.05	19.39%	12.82%	9.80%	7.51%	4.52%
	Nonovion	\$37.65	8.02%	5.30%	4.05%	3.11%	1.87%
	Regulon	\$37.65	8.02%	5.30%	4.05%	3.11%	1.87%
	Rigevidon	\$16.65	3.55%	2.34%	1.79%	1.37%	0.83%
	Triregol	\$35.25	7.51%	4.96%	3.80%	2.91%	1.75%
IUD	Modern*	\$2.49	0.53%	0.35%	0.27%	0.21%	0.12%
Injectable	Depo-Provera*	\$27.00	5.75%	3.80%	2.91%	2.23%	1.34%

*supplies only

The estimated contraceptive user income was derived by using the percentage of income by quintile (World Bank 2001) and the 2003 GNI figure for Ukraine. The 2003 per capita GNI figure of \$970 was increased by 10 percent to estimate the 2004 per capita GNI of \$1,067. Contracepting couples may be *willing to pay* in excess of 1.5, 2.0, or 3.0 percent of income. However, the standard assumption made by Harvey was that 1 percent of per capita income was the maximum ability to pay for contraception. For the Ukrainian context, where non-monetary income is a notable portion of an individual's livelihood, the maximum was set *at 2 percent of income*. In table 2, percentages of income at or exceeding 2 percent are shaded light gray; figures below 2 percent are shaded dark gray, and are considered *affordable*.

Observations

- Table 2 indicates that Q1 and Q2—the poorest 40 percent of the population—cannot afford any commercial brand of contraceptive except the IUD (and the price does not include insertion).
- For Q3 and Q4, Rigevidon dominates as the affordable oral contraceptive, underscoring the importance of its continued availability in the market.
- Even Q5 may have difficulty in paying for the most expensive brands of orals; such as *Jeanine*, *Diane-35*, and *Marvelon*. Notably, these brands, at least in part because of heavy promotion, are often preferred by the providers.
- There is a significant scope for continued *commercial sales* among the *top 60 percent* of income earners. This group can afford brands within each method.
- Many of the higher priced oral pills and condoms remain unaffordable to middle-income earners (Q3).
- By method, both the IUD and injectable provide the greatest cost effectiveness. This is a distortion, in a sense, because the supply cost does not include insertion or injection of the method.

The scope of the ATP analysis is not intended to be comprehensive or final. Rather, it is one examination, among several, that seek to support a broader range of contraceptive supply initiatives. Incomes, prices, and the accuracy of data change. Therefore, analyses of pricing, affordability, and willingness to pay should be regularly performed. Notably, the rider survey that was being carried out before the end of 2004 will produce additional data on *willingness to pay*.

Logistics Findings

There are two supply chain systems that offer some promise for handling public sector contraceptives. The first is a vertical system, established within the MOH, that has been used to distribute *humanitarian assistance* contraceptive donations, primarily from USAID (in six oblasts) and UNFPA. The second system, *UkrMedPostach*, is a parastatal national medical store that distributes most of the national *budgetary* medicines procured by the MOH to oblasts. In addition, the GOU and MOH decrees (*prykaz*) identify a variety of populations that are targeted for free or subsidized medicines and contraceptives.

Private distributors do operate in the Ukrainian market, but they are primarily associated with commercial pharmaceutical companies serving both private and parastatal pharmacies. While there might be a potential to contract a private firm to handle storage and distribution of donated commodities, a cost recovery mechanism would be required to cover their associated costs.

Vertical Ministry of Health/Family Planning System

Past contraceptives donations were managed by the MOH's Maternal and Child Health Department. The MOH took delivery of the supplies, which were distributed and stored at three different offices of the Ukraine Family Planning Association—Kiev, Odessa, and Vinitza. Based on a *prykaz* from the MOH, the supplies were allocated and distributed to oblast family planning centers, which are either stand-alone specialty sites or simply a room in a central oblast clinic. From the oblast level, supplies were then distributed to rayon and city facilities. However, not every rayon in every oblast has a family planning center, which limits access to free supplies for clients in those rayons.

Allocations of UNFPA-donated supplies in 2001 to 2003 (condoms, orals, IUDs, and spermicides) appeared to be based initially on population distribution. Supplies were usually one-time push distributions to the oblast level, which were then pushed to lower levels, again based on population. Providers maintained stocks within their family planning facilities and ordered additional supplies from their oblast family planning center when needed (and available). However, every facility reported that there were never enough supplies to meet the needs of the target population and, with the exception of a few IUDs in some facilities, all providers reported being stocked out of free contraceptives since 2003 (the last year UNFPA provided contraceptives).

One complaint mentioned by some key informants was that UNFPA supplies had short shelf lives. However, the demand was so great that expiry was not a problem because supplies were depleted before their expiry dates—for example, orals expired in October 2004 but were stocked out by late 2003.

A 1999 assessment of the logistics system used for USAID-donated contraceptives found that they reached their target populations, and they did not appear to leak into the private market. However, the report also found a lack of dispensed-to-user data at the oblast or central level, making the collection of data for decision making—and for reporting back to donors—problematic.

According to UNFPA, in 2001–2003 a computerized logistics management information system (LMIS) was installed in all oblast family planning centers and in the MOH. Training on the system was provided to oblast family planning coordinators, most recently, in the spring of 2004. In addition, some service providers stated that there are paper-based (LMIS) forms used to report on stock status (received, dispensed-to-user, and stock on hand), that they used when UNFPA supplies were available. However, given the subsequent lack of supplies, neither LMIS is currently in use, and none of the oblasts visited mentioned the computerized UNFPA system. Therefore, additional efforts would be needed to ensure an operational LMIS if donated products were reintroduced.

Integrated Medical Supply Chain

UkrMedPostach, a parastatal organization, operates as a private company but is regulated by and reports to the MOH. It procures, stores, and distributes some medicines and supplies funded under the national budget, such as tuberculosis drugs, some cancer drugs, ARV drugs, and HIV tests. To cover its costs for handling free and subsidized supplies, *UkrMedPostach* charges a flat fee against the gross value of each commodity. For example, when it procured insulin on behalf of the MOH, it charged 1.2 percent against the 132 million *Hryvna* (U.S.\$24.9 million) allocation provided for the procurement. It is charging International AIDS Alliance 2.7 percent of the total declared customs value of the ARV drugs that it manages on their behalf. This fee covers expenses for customs clearance, storage, distribution, relabeling into Ukrainian, insurance, and data collection and reporting.

UkrMedPostach distributes to oblasts and, in some instances, down to rayon levels. Because some oblasts have very limited storage facilities, deliveries typically occur monthly rather than quarterly. According to Program for Applied Technologies in Health (PATH) advisors working on procurement of HIV/AIDS commodities with International AIDS Alliance, *UkrMedPostach* is very competent and accountable, and their ARV distribution has been flexible and responsive. It maintains a warehouse in Kiev and a small fleet of vehicles, as well as contracting for additional transport from a bonded trucking firm. Inventory management is not automated.

In each of the 26 oblasts and Crimea, there is a parastatal pharmaceutical distributor, usually known as *Farmacia*, that operates the state pharmacies in their oblast. Each oblast *Farmacia* is autonomous, answering only to the oblast health administration. They manage the supplies from UkrMedPostach, as well as procure additional pharmaceuticals, contraceptives, and medical supplies from commercial distributors, which are then distributed to state pharmacies and public hospitals and clinics. Although there is a national *Farmacia* association, not all oblasts *Farmacias* are members, and there is no mechanism to pool procurement for contraceptives or other non-budgetary supplies. *Farmacias* manage products for most of the national programs that provide subsidized or free health commodities to the targeted populations—such as veterans, orphans, victims of Chernobyl, etc. Multiple regulatory authorities monitor *Farmacias*, and this oversight apparently results in a high degree of accountability.

While UkrMedPostach and the *Farmacias* might be potential distributors of public sector contraceptives for targeted populations, a financial mechanism would be required to recover costs for supply chain management. This might be a modest fee for the user—for instance, 1.00 Ukraine Hryvna (UHR) for a cycle of pills. However, given the lack of a central coordinating body for the *Farmacias*, negotiating a fee could be arduous. In addition, UkrMedPostach has had problems in determining their true costs and in pricing their services appropriately for other national programs. Nonetheless, the GOU has an established relationship that addresses the costs for handling its centrally budgeted and procured medicines through this system.

Targeted Populations

As a result of social sector reforms initiated in the 1990s, the GOU defined a variety of target populations that should receive free or subsidized services and commodities—from rent subsidies to free contraceptives. These populations are defined in part on poverty level and age, as well as on certain social factors (orphans, veterans, pensioners, victims of Chernobyl, etc.). Under a Cabinet of Ministers decree, three categories of women should receive free contraceptives: youth (defined as up to 28 years old), those affected by *Chernobyl*, and women with a health contraindication for pregnancy. The MOH maintains aggregated data on the total target population.

In addition, we heard from service providers that the MOH has issued regulations (*prykaz*) on who should receive free contraceptives—a list that appears to be much broader (or perhaps better defined) than the categories mentioned above. Each service delivery point maintains a list of target groups that fall into the following categories:

- clients with extra-genital pathology (for example, high blood pressure, diabetes, etc.)
- clients with gynecological diseases
- drug addicts
- alcoholics

- clients with sexually transmitted infection (STIs)
- HIV+ women (and men)
- psychologically disturbed
- unemployed (male and female)
- ultra-poor/homeless
- adolescents (male and female)
- women with many children
- women who have had multiple abortions.

These categories have been used to identify clients who received UNFPA- and USAID-donated products in the past. It was our impression that contraceptives were managed locally with a fair amount of accountability to ensure that the free contraceptives were distributed to the target population. This existing concept of targeting, combined with possible geographic targeting of free contraceptives, may serve to increase contraceptive use in Ukraine while protecting the growing public sector.

One area of concern is whether there are systems in place to maintain the client's confidentiality (particularly if the client is HIV-positive). It appeared that some providers maintain a register with the names of clients who should receive free contraceptives, but we were unable to determine whether or not that was a standard operating procedure.

Other Activities

Input to the Rider Survey

We met with the team at the POLICY Project to review the Rider Survey Questionnaire. While the entire contraceptive portion of the questionnaire was reviewed and discussed, our major contribution to changing the questionnaire related to price points in the *willingness to pay* questions. For example, the question that asked how much an individual would be willing to pay for a cycle of oral contraceptives had the choice of 0 Hrivni, 5, 10. . . up to 100. Based on the price of contraceptives encountered in private pharmacies, we were able to suggest price points that will result in much more definitive information from the survey. For example, for orals, the cheapest brand cost about 5 Hrivni, the middle range about 25 Hrivni, and the most expensive, about 50 Hrivni. Therefore, these prices became the price points available as an answer, and this change will result in more definitive information than using the randomly spaced price points.

Opportunities for Increasing Access to Contraceptives

Several issues that could be addressed by donor interventions were noted both in this assessment and in the POPTECH assessment. The situation in Ukraine is not simple, and the intervention needs to be designed for optimal impact. Such an intervention could have an impact over a relatively short time period.

Improving Access to Contraceptive Supplies

Provision of Donated Contraceptives

Several issues argue for the provision of donated contraceptives for free distribution through the public system.

- The Reproductive Health Survey of 1999 clearly documents an unmet need. The relatively low use of modern contraceptives and the high use of traditional methods and abortion demonstrate a need for more access.
- Clinicians consistently report that many clients cannot afford to purchase contraceptives in the pharmacies. While Ukraine is a middle-income country, there are major income inequities, and the rural areas and broad categories of the urban population have a very low cash income. The ability to pay analysis shows that a large percentage of the population would need to spend more than 2 percent of their income to pay for modern contraception.
- There seems to be a more general acceptance of oral contraceptives. Improving their availability through donated supplies, to be provided free to targeted users, could substantially increase the use of this method.

We, therefore, recommend the following regarding donations of supplies:

USAID should consider donating oral contraceptives, IUDs, and condoms to the Ministry of Health of Ukraine. Increasing demand for oral contraceptives suggests that more availability of free supplies may result in substantial increase in use, particularly among younger women. IUDs continue to be a popular method in the region, and are particularly suitable for long-term use in Ukrainian families who have a strong desire to limit their family size to one or two children. Condom availability is also an important issue because of their role in dual protection, particularly in a country like Ukraine, which is at the beginning of the epidemic cycle of the HIV/AIDS pandemic.

Registration will be an issue for the donation of Lo-Femenal. The Mission should enlist the MOH to assist with the registration or a waiver for donated products.

Estimation of needs should be based on the expansion of use in the population of those who cannot now afford to pay for contraceptives. This is related to the targeting recommendation that follows. Results of the rider survey carried out in 2004 should provide valuable information on which to base these forecasts.

A methodology should be developed to target the free contraceptives to those with the greatest need and least ability to pay. Ukraine is a middle-income country, and substantial private sector sales of contraceptives dominate the market at this time. While increasing overall use of contraceptives is an important goal, protection of the private sector is also important. As the economy inevitably improves, the private sector should dominate, so it is important that any donations go to those who do not currently participate in the private sector supply.

The MOH already has some methods for developing lists of high-risk groups. To the extent that such lists are feasible and equitable, this practice could continue. In addition, the donated contraceptives could be targeted on a geographic basis to rural areas and to urban areas with the greatest economic distress. Geographic targeting could also be coupled with training non-obstetrician/gynecologist (OB/GYN) physicians who provide services to the poor (this is discussed later in this paper).

To ensure sustainability, the government should commit to some future support for free contraceptive supplies. While Ukraine is a middle-income country, with an economy that will continue to improve, there will always be segments of society that will lack the resources to purchase their commodities in the private sector. The MOH should agree that they will begin to procure contraceptives as other donated contraceptives are phased out.

A cost-benefit analysis that compares the cost to the MOH system of providing abortion services versus the cost of meeting unmet need for free contraceptives would make a compelling case for creating a budget line for contraceptives. For example, Dr. Nadiya Zhylyka, deputy head of the MOH Maternal and Child Health Department estimated the annual cost of providing abortion services was about one billion UHR, compared to approximately 500,000 UHR to provide family planning commodities to clients who had abortions during the past year. While this estimate seems extreme, it indicates a high degree of awareness about the potential cost-benefit of providing free contraceptives.

USAID/Kiev should provide assistance to design/improve the supply chain. The MOH should probably manage the supply chain. However, the current system is now stocked out of commodities and is not functioning. Furthermore, it appears that procedures have been somewhat informal, with annual supplies of contraceptives allocated by population. Ukraine needs a system that allocates supplies on a needs basis (always more complicated than a demand basis). It also needs a functioning LMIS. Alternative delivery mechanisms should also be explored.

Social Marketing

Social marketing of oral contraceptives should not be attempted at this time. The least expensive oral—Rigevidon—is commonly for sale for approximately \$1.00. The current registration has more than three years left, and the manufacturer plans to continue its distribution in Ukraine. This does not leave enough of a price niche to warrant a socially marketed product. Condoms, on the other hand, are fairly expensive for the quality products, which may present an opportunity to begin social marketing of condoms, but as part of an HIV prevention program rather than as a family planning program.

Training to Improve Service Access

Training interventions that could be carried out to improve contraceptive availability would have two different forms:

Providers of family planning services should receive an update on contraceptive technology. As the POPTECH report noted, a generic counseling approach is used for women, and most are now being directed toward oral contraception. There is a concern about the use of IUDs in a population with a rising STI rate. However, providers do not differentiate between women at high risk of STI and at low risk. This has resulted in an unwarranted shift away from IUDs to oral contraceptives, with their attendant high rate of discontinuation. For women that need long-term protection to limit their fertility, the IUD may be an ideal method. Contraceptive technology updates, with a balanced message that details the advantages and disadvantages of each method, may be helpful in achieving an appropriate method mix.

Another issue, which could be addressed as part of this effort, is the misinformed opinions held by many providers about levonorgestrel combination pills. Some providers, because of active promotion of third-generation pills by the manufacturers, believe that the levonorgestrel pills are inferior (contrary to the opinion of the International Planned Parenthood Federation (IPPF) International Medical Advisory Panel—which also has representation from the World Health Organization). It should be noted that USAID-supplied pills—Lo-Femenal—are levonorgestrel combination pills.

It may be advisable to expand the availability and family planning services by training non-OB/GYNs to provide basic family planning services.

Providing family planning services is now done exclusively by OB/GYNs, who almost never practice outside the rayon-level facilities. For rural populations receiving most of their primary care at the local ambulatory, this is a barrier to services and supplies. By following a model developed in Romania—training rural physicians to provide family planning counseling and services and supplying these facilities with contraceptive supplies and IEC materials—underserved rural populations can have easier access to quality health care. This approach will need careful negotiations, because it will be politically sensitive among the OB/GYN community and should be carried out in partnership with an established organization, such as the Ukraine Reproductive Health Network.

As an alternative to the above recommendation:

It might be possible to find a way to expand the services of OB/GYNs to more rural areas. While visits of OB/GYNs from the rayon-level to rural ambulatories and feldsher points were mentioned, we had the impression that this rarely happened. Perhaps some type of incentive, such as a travel stipend or per-diem could be implemented to expand the services (together with supplies) into the rural areas. In addition, after the OB/GYN started a user on oral contraceptives, a local physician or nurse could resupply the client under standing orders.

There is an opportunity to carry out a pilot introduction of injectable contraceptives. This method is rarely used in the region—with most providers saying that the side effects are problematic. Most women will have disruptions in their menstrual cycle (break-through bleeding) during the first year of use, and many will stop having periods during the second year of use. It is, therefore, very important that the user is appropriately counseled to know what to expect. However, with appropriate training of providers in careful and complete counseling, as well as management of side effects, this method has the potential of becoming as popular in Ukraine as it is in other regions of the world.

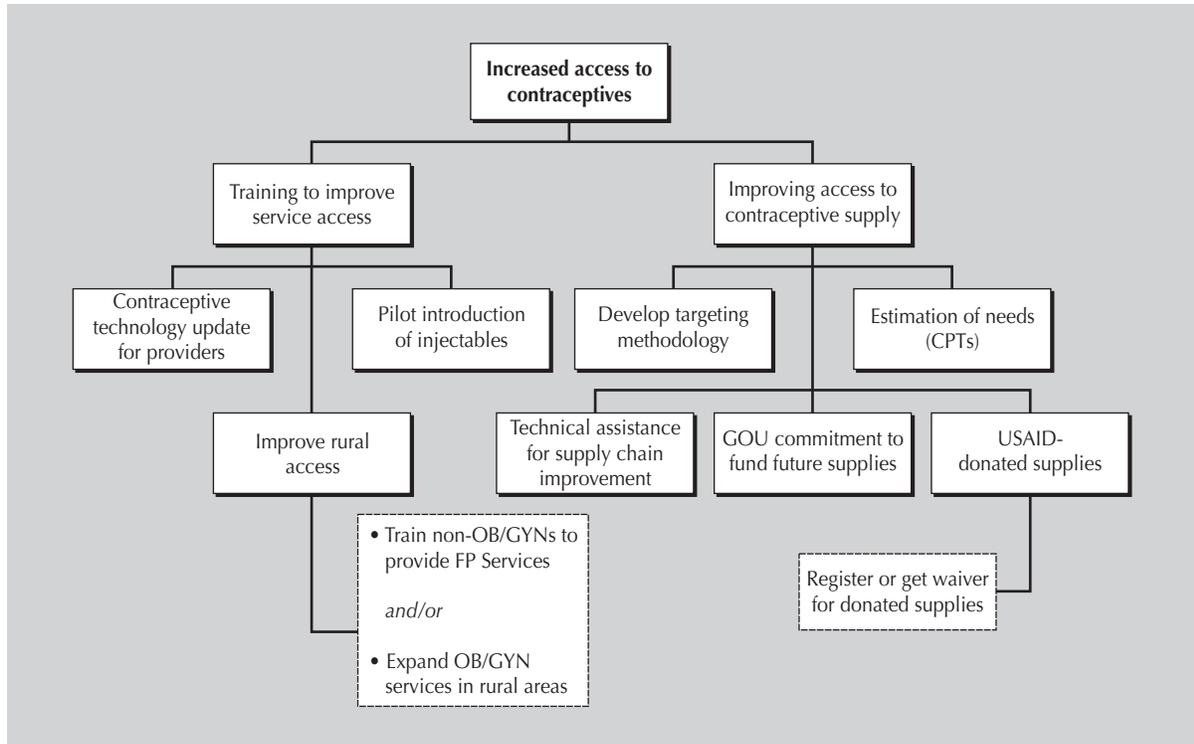
Note: On November 17, 2004, the Federal Drug Administration announced a new requirement that may rule out this recommendation: they will require that a black box warning is placed on all Depo-Provera® packaging. This decision was made after research showed significant bone mass loss among users. In addition, they will also recommend that women use Depo-Provera® for no longer than two years unless other contraceptives cannot be used.

Other

While tubal ligation may seem an ideal method for Ukraine, it is not politically feasible to carry out an intervention at this time. Currently, surgical contraception occurs almost exclusively after a caesarean section or surgery for a tubal pregnancy, and is essentially unknown for men. Most families have one or two children after marriage, and then want no more—making them ideal candidates for surgical contraception. However, with a declining population, most Ukrainians reject family planning methods that would eliminate fertility. In fact, many see temporary contraception as a way to avoid abortions, and *preserve* a young woman's fertility.

These recommendations are summarized in the framework below (see figure 5), which presents a hierarchy of the key areas for action.

Figure 5.
Recommendations Framework



References

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Appendix A

Scope of Work

Background

Ukraine has family planning issues that are common to many of the countries in the former Soviet Union, as well as other countries that fell under the Soviet Union's influence:

- A very low fertility rate, which gives rise to macroeconomic concerns of a decreasing and aging population.
- A low level of modern contraception. Ukrainian women report a prevalence of 68 percent; however, only 38 percent of couples used a modern method. The balance of 30 percent use traditional methods, which have a high failure rate.
- A dependence on abortion to control fertility.
- Inequities in access that results in a large differential between the rich and poor in the use of modern methods.

The report, *Assessment of Reproductive and Maternal Health in Ukraine*, briefly explains the problem:

A one-child family is rapidly becoming the norm in Ukraine. The majority of women do not want additional children, and yet most women do not use the most effective long-term methods. Therefore, there is a significant gap between women's stated fertility intentions and contraceptive method choice. This gap helps explain why abortion levels continue to be high despite the increasing use of contraception. Furthermore, a large proportion of couples lack adequate knowledge about the effectiveness and safety of modern contraception, resulting in inappropriate method choice given fertility intentions or ineffective or no use of methods.

In other words—*Ukraine suffers from contraceptive insecurity*. Contraceptive security exists when people are able to reliably choose, obtain, and use high-quality, affordable contraceptives and condoms for family planning and HIV/AIDS STI prevention. This is a goal to strive for, and it requires ongoing commitment and continuous progress. It approaches security from the client's perspective. Unless people can choose, obtain, and use the contraceptive methods and condoms they want, there is no contraceptive security.

Response to the Problem

From 1995 to 2000, USAID/Kiev supported the WRHI to improve the use of modern family planning and to reduce abortion. The institutional infrastructure and availability of reproductive health and family planning services was improved after upgrading providers' skills, providing contraceptive supplies, facilitating policy dialogue among governmental and nongovernmental entities, and creating a training-of-trainers program. Following the WRHI, USAID/Kiev's focus was expanded to maternal and infant care. Attention has continued on national-level policy change and advocacy with the POLICY Project, the Policy Development Group (PDG), and URHN, with less focus on the implementation of family planning programs. Some support continues for the Women's Wellness Centers in the MOH system and Ukrainian Railways clinics, through the American International Health Alliance.

Few donors have supported family planning projects in Ukraine nor have they comprehensively addressed family planning issues, and few ongoing projects directly address family planning/contraceptive security. For example, UNFPA has developed a program for 2003–2007 and is seeking funds to work with governmental and non-governmental counterparts in the areas of provider training and IEC in reproductive health. Some provision of equipment and supplies is envisioned but contraceptive provision is not. UNFPA is also exploring the feasibility of a national-level condom social marketing project that could expand to contraceptives.

The Government of Ukraine has shown its commitment to family planning and reproductive health by adopting the National Family Planning Program and now the National Reproductive Health Program (NRHP) for 2001–2005. The outlines of this project support the NRHP and are consistent with the findings of a diverse array of surveys, studies, and other analytical work. From them emerges a clear consensus on the way forward for contraceptive security in Ukraine.

Objectives

The objectives of this activity fall under the USAID/Kiev's Strategic Objective 5, "Improved social conditions and health status." The primary objective of this activity is to better inform the future design of a USAID reproductive health activity aimed at improving contraceptive security in Ukraine.

Methods

DELIVER proposes to send two contraceptive security and logistics advisors for three weeks to carry out an assessment of the following issues:

Contraceptive Security

- availability of contraceptives through the public sector
- availability of contraceptives through the private sector
- relative availability in urban and rural areas
- recommendations for reducing barriers to access
- options for public/private approaches to contraceptive supply

- options for government procurement
- options for donations from various donors
- an estimation of needs for contraceptives.

Logistics System

The team will evaluate existing logistics systems for their current movement of contraceptives through initial procurement to delivery to the end user. They will also examine the potential for adding contraceptives to the distribution systems for other essential drugs.

Information Needs

The last major reproductive health survey was carried out in 1999. While the consultants are not demographers, they are cognizant of such surveys and will review potential questions for inclusion in a rider survey.

The consultants will use existing DELIVER tools, and, perhaps, some specially designed tools to carry out key informant interviews and facility visits throughout the health system. This work will require travel by two teams within the country.

Logistics

If needed, USAID/Kiev will arrange for a logistician/interpreter to work with DELIVER and the team in arranging all in-country travel and transportation (including airport pickup), lodging, assistance with providing key documents, scheduling meetings and appointments, and hiring additional interpreters, when needed. Once in country, the team will schedule additional meetings, as appropriate. USAID/Kiev will be available to the team for consultations regarding sources and technical issues, before and during the assessment process.

Timeline

USAID/Kiev anticipates that the entire review would be completed within a seven-week period. This would include preparation days, in-country work in Kiev and the regions, and report writing and finalization. The assessment should take place no later than September/October 2004.

Preparatory Materials

USAID/Kiev will provide DELIVER with a list of background and other relevant materials to be duplicated and distributed to team members. The team members will be expected to review the materials prior to arrival in Ukraine and will be given preparation time prior to departure from the United States. The materials will include, but not be limited to—

- recent reproductive health assessment
- relevant prykazs addressing reproductive health
- materials produced under the USAID-funded POLICY project
- current national reproductive health program and protocols being developed by the MOH, and draft program and protocols currently under development.

Meetings and Briefings

Orientation meeting with Mission staff: The first day of the team's visit will include meetings with Mission staff and other relevant personnel. In addition to other matters, the Statement of Work will be explained, discussed, and amended, as appropriate.

Debriefing to Mission staff: The team will present an out-brief, including a presentation of main findings and recommendations.

Deliverables

The first draft of the final report will be due at end of the team's visit. This draft, which will form the basis of the Executive Summary, will include findings and recommendations for Mission review.

Final report: The team leader will prepare the final draft of the report for submission and processing to DELIVER, who will, in turn, solicit further input from the Mission before issuing the final edited report. The Mission would like 10 hard copies and an electronic version of the final report by or before November 30, 2004. This final report will be considered a public document and at DELIVER's and USAID's discretion may be available both electronically and in printed form to all interested parties.

Estimated Budget

USAID/Kiev estimates a total cost of not more than \$130,000.

Appendix B

Key Informants

United States of America

U.S. Agency for International Development (USAID/Washington)
Alan Bornbusch, Contraceptive Security Team Leader, GH/PRH/CSL

Ukraine

Kiev

Business-Credit Company (pharmaceutical market research)
Dr. Ludmilla Sassina, Marketing Director

Compass Club (Youth NGO)
Ludmila Loggina, Head

Gideon Richter (Ukraine office)
Dr. Oleksander Gorbenko, Product Manager for Gynecological Products

Hormonalnikh Preparatov (private pharmacy)
Inna Krystych, Chief Pharmacist

Mother & Infant Health Project (JSI/Ukraine)
Dr. Tamara Irkina, Deputy Director (formerly with the MOH)

Kiev Oblast Mother and Infant Health Center
Dr. Natalia Dankovich

Ministry of Health of Ukraine
Dr. Nadiya Zhylyka, Deputy Head, Maternity and Childhood Health Care Department

Mothers & Sisters for Youth of Ukraine (NGO)
Alla Belska, Head

PATH (Ukraine office)
Amie Bishop, Senior Program Officer
Dr. Katherina Gamazina, Senior Program Officer
Betsy Wilskie, Senior Procurement Associate

Pechersk Rayon Women's Consultative Clinic (Kiev city administration)
Dr. Natalya Volkova, Chief Doctor
Dr. Olena Gopchuk, Adolescent Gynecologist

POLICY Project Ukraine
Andriy Huk, Program Operations Manager
Elena Trukhan, Deputy Manager, POLICY Project Ukraine

Ukrainian Academy of Medical Sciences

Institute of Pediatrics, Obstetrics, and Gynecology

Dr. Zoreslava Skhiryak-Nyzhnyk, Chair, Department of Pediatrics and Reproductive Health, Member of the Board of Directors, Ukrainian Family Planning Association.

Dr. Natalia Chyslovska, Senior Researcher, Department of Pediatrics and Reproductive Health, and Deputy Director, Ukrainian Family Planning Association.

Dr. Emilia Nepochatia, Deputy Chair, Department of Gynecology, and Director of the Kiev Chapter, Ukrainian Family Planning Association.

Ukrainian Family Planning Association

Dr. Irina Vovk, Director

UkrMedPostach (Ukraine's parastatal national medical store)

Mykola Petrenko, Director

United Nations Development Programme

Helen Petrozzola, Programme Manager

United Nations Population Fund (UNFPA)

D. Borys Vornyk, Programme Coordinator

USAID/Kiev

Tim Clary, Senior Advisor for HIV/AIDS and Reproductive Health

Alina Yurova, Program Management Assistant

Irina Gladun, Program Management Assistant

Vyzhgorod Rayon, Kiev Oblast

Vyzhgorod Rayon Polyclinic

Svitlana Pankratova, Deputy Chief of Administration

Dr. Tamara Patrivna, Chief Pediatrician

Dr. Oksana Nykolaevna, Family Planning Doctor

Nadya Besarab, Chief Pharmacist of Rayon

Representatives from secondary education, after-school education, health and family planning practitioners, Red Cross representatives, and social workers.

Donetsk Oblast

Tores Central City Hospital

Dr. Ludmila Kucherova, Deputy Chief Doctor

Dr. Irina Safonova, Chief Obstetrician

Luhansk Oblast

Krasni Luch Family Planning Center

Dr. Natalya Federenko, Chief of the Center

Dr. Anna Stoyanovskaya, Chief OB/GYN

Mykolaev

Mykolaev Physicians Association

Dr. Victor Glukhovsky, President

Dr. Yuriy Frolov, Hospital Administrator, Oblast Police Hospital

Odessa

Odessa Oblast Farmacia (parastatal oblast pharmaceutical distribution company)

Dr. Valentina Bespoyasnaya, Deputy Director

Lviv Oblast

Zhovkva Rayon Hospital and Polyclinic

Dr. Zinovya Ivasika, Deputy Director, Lviv Oblast Center for Reproductive Health

Dr. Mykhaelo Horbach, Chief of the Obstetrics Unit

Dr. Marianna Yakovuk, District Family Planning Coordinator

Zibolky Sub-district Clinic

Dr. Yaroslav Paramud, Chief Therapeutist

Hlinskye Village Feldsher Point

Vasil Vereschak, Feldsher