

**Contraceptive**

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**Security Situation**

**Analysis in Ukraine**

UDC 613.888.(477)

**Contraceptive Security Situation Analysis in Ukraine.** Zhylyka N. Ya. — Kyiv, Rayevsky Scientific Publishers, 2005: 40 с.

This publication was produced for review by the United States Agency for International Development. It was prepared by Nadiya Yakivlina Zhylyka (Head of the Mother and Child Health Care Office of the Department of the Organization and Development of Medical Aid to the Population, Ministry of Health of Ukraine) with the support of the POLICY Project.

The POLICY Project is funded by the United States Agency for International Development (USAID) under contract No. HRN-C-00-00-00006-00 of July 7, 2000. The project is implemented by the Futures Group in collaboration with the Center for Development and Population Activities (CEDPA) and Research Triangle Institute (RTI).

The author's views expressed in this publication do not necessarily reflect the views of the Agency for International Development or the United States Government.

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Post Box 108, 01034 Kyiv-34, Ukraine

ISBN 966-7016-26-9

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Підписано до друку 1.09.2005 р. Умовн. друк. арк. 3,5; обл.-видав. арк. 2,7. Наклад 1000 прим. Зам. №5-.

Друк: АТ «Книга», Київ-53, Артема, 25. Свідоцтво про внесення до Державного реєстру вигоновників Серія ДК №1911

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## Acronyms

AIDS	Acquired immunodeficiency syndrome
CDC	Center for Disease Control and Prevention (U.S.)
CPR	Contraceptive prevalence rate
CS	Contraceptive security
FOPs	Feldsher-Obstetrician Points
FP	Family planning
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
IUD	Intrauterine device
MDG	Millennium development goals
MIS	Management information system
MOH	Ministry of Health
NGO	Nongovernmental organization
NRHP	National Reproductive Health Program
Ob-Gyn	Obstetrician/gynecologist
PDG	Policy Development Group
RH	Reproductive health
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
STI	Sexually transmitted infection
TES	Technical-economic substantiation
UAH	Ukrainian Hryvna
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
URHN	Ukraine Reproductive Health Network
URHS	Ukraine Reproductive Health Survey
USAID	U.S. Agency for International Development
USSR	Union of Soviet Socialist Republics
VAT	Value-added tax
WHO	World Health Organization
WRHI	Women's Reproductive Health Initiative

## Preface

Family planning is an important component of reproductive health, which can have a significant impact on the demographic situation in a country. A family planning system enables individuals and married couples to either avoid unintended pregnancy or plan to have children when desired. In this context, the use of contraceptives is vital to successful family planning and preventing unintended pregnancy and unsafe abortion. Abortion complications can do irreparable harm to health, particularly reproductive health, and thus, abortion should not be used as a birth control method. Although family planning programs in Ukraine have improved, the country's abortion rate is still higher than in many developed countries. Therefore, addressing contraceptive security issues take on a particular importance. Men and women must receive adequate information and have access to a mix of safe, legal, effective, and affordable family planning (FP) methods and other contraceptive methods. They must also have access to health services that help women go through pregnancy and childbirth safely and enable parents to have healthy children. According to the definition of reproductive health, reproductive health protection is a set of methods, techniques, and services that influence reproductive health and well-being through the prevention and resolution of reproductive health (RH) disorders.

This paper, which serves as a working document, analyzes contraceptive use in Ukraine, demand for contraceptives, contraceptive availability in the market, method mix, citizens' access to contraceptives, and the quality of family planning services. It also includes up-to-date information on policies, programs, and regulatory documents related to family planning and reproductive health; and on the prevention of unintended pregnancy, sexually transmitted infections (STIs), and HIV/AIDS. Finally, it discusses key problems to achieving contraceptive security and ways to address them through advocacy, a multisectoral approach, and community involvement. The information is intended to raise awareness of FP/RH and contraceptive security issues among Ukraine's population, especially policymakers working in the area of FP/RH at the national and local levels; medical, pharmaceutical, social, and pedagogical workers; journalists; political analysts; nongovernmental organization (NGO) representatives; private sector specialists; and all other interested parties working in the area.

The author would like to express her sincere gratitude to the Ministry of Health of Ukraine, POLICY Project staff (in Ukraine and Washington D.C.); the Deliver and PSP projects; UNFPA; UNAIDS; representatives of the Institute of Demography, AT Biznes-Kredit, NGOs, pharmaceutical companies (Shering and Organon); and the Policy Development Group experts for their support and assistance in the preparation of this material.

## Introduction

ince the early 1990s, family planning in Ukraine has gained importance amid a deteriorating demographic situation, including a declining standard of living for the majority of the population, a worsening of reproductive health, and a high rate of abortion. Abortion is still the primary method of fertility control in Ukraine: in 1999, the abortion ratio (the ratio of induced abortions to live births) was 1.10, indicating slightly more abortions than live births (CDC, 2001). However, the situation has improved recently. The abortion ratio was 73 abortions per 100 births in 2003 (Ministry of Health Center of Medical Statistics, 2003). Like many countries, Ukraine faces a growing need for contraceptives, and therefore, contraceptive security—when individuals can choose, obtain, and use contraceptives and reproductive health services when they need them—is an important priority for the country. (See Box 1 for a history of abortion in Ukraine and the movement toward contraceptive security).

Ukraine's current efforts to strengthen its reproductive health program are in line with the 1994 Program of Action from the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs): ICPD calls for ensuring general access to reproductive health (RH) services by 2015; the MDGs call for reducing maternal and infant mortality by 2015, halting the spread of HIV/AIDS and eradicating extreme hunger and poverty. It is impossible to achieve the ICPD objectives and MDGs, and reduce the abortion rate without achieving contraceptive security. In recognition of this fact, the Ministry of Health (MOH) and the Policy Development Group (PDG) are including contraceptive security (CS) as a component within Ukraine's new National Reproductive Health Program for 2006-2010.

This working paper includes an analysis of the current situation and outlines a range of challenges and opportunities for achieving CS. The information will help Ukraine develop a five-year CS strategic plan.

## Section 1: Background

The MOH, in collaboration with the USAID-funded POLICY Project initiated contraceptive security activities in 2004. The MOH conducted an assessment of Ukraine's current reproductive health situation, using a framework called The Strategic Pathway to Reproductive Health Commodity Security (SPARHCS). This work included a series of key informant interviews and a review of current state statistics, socio-demographic surveys, and recent studies conducted in Ukraine by various collaborating agencies. The SPARHCS assessment provides information on:

The **demographic situation** in Ukraine;

The **clients** (the users of contraceptives)-the level of their awareness of family planning (FP) methods, contraceptive demand as a client's informed decision, characteristics of those groups that do not use contraceptives, and Ukraine's contraceptive market;

The **service delivery system**, including sources of contraceptives and the quality of FP service delivery in Ukraine;

**Sources of financing**, including public, household, and alternative forms of financing for FP supplies and services;

**Procurement and logistics** surrounding the capacity of the contraceptive provision system (forecasting, procurement of supplies, and distribution of contraceptives);

The **policy and regulatory framework** for family planning and reproductive health, as well as the political environment;

The **leadership and commitment** to contraceptive security at the government, sector, and community levels; and

**Coordination mechanisms** of the contraceptive provision system in Ukraine.

Following the assessment, POLICY and the MOH held a workshop with a multisectoral group of stakeholders to generate a common understanding of CS and the issues affecting it and to introduce the SPARHCS framework and methodology and disseminate findings from the SPARHCS assessment. Stakeholders working in RH validated the findings and identified additional information that should be included in the assessment report. (See the workshop report for an overview of the activities). The following sections present the assessment findings.

## Notes

### History of abortion in Ukraine and the movement toward contraceptive security

During the past century, abortion has been a common method of birth control in Ukraine. At the beginning of the 20th century, Russian physicians understood and officially recognized in the Pirogov Society declaration that the only alternative to abortion, and its dangerous consequences, was to produce effective contraceptives. By the late 1920s, the Soviet Union was among the world's leaders in studying issues related to abortion and family planning. However, despite this knowledge regarding the benefits of family planning, the Soviet Union still had some of the highest abortion and unintended pregnancy rates in the world in the 1950s (Zhilka, 2005).

Using abortion as a birth control method is still an international problem. According to the World Health Organization (WHO), about 50 percent of pregnancies that occur every day are unplanned, about 25 percent are unintended, and almost 150,000 pregnancies end in abortion, which annually amounts to 55 million abortions. Demographers' data confirm that one third of women of reproductive age have at least one abortion in their history (Zhilka, 2004), and on average, 35 of every 1000 women in the world have an abortion.

The WHO estimates that since 1990, nearly 7 million abortions have been performed in the newly-independent states of the former Soviet Union. In developed countries the annual percentage of women who have abortions is 5%, in Eastern Europe (14%), in Western Europe (3%), in Latin America (9%), and in Africa (11%). The highest abortion rate in the world is observed in Central and Eastern Europe (Hatcher et al., 2002). In most European countries, there are only 10-15 abortions per 100 pregnancies; in Ukraine, this number is 74 (Nikolayeva and Vikhliayeva, 1997). Ukraine makes up 6.7 percent of the world's abortions, while contributing only 0.9 percent of the world's total population.

In addition to the potential harmful affects of abortion on women's health, using abortion as a birth control method is a more costly alternative to using contraceptives. The findings of a 1999 survey on reproductive health in Ukraine show that abortion-related costs and costs of managing abortion complications remain a heavy economic burden for the state (CDC, 2001). Even though abortions have been decreasing from year to year while the number of contraceptive users has been increasing (1999: 37.3%, 2002: 56.8%), abortion and abortion complications management costs (1,900,900 and UAH) are almost twice as high as contraceptive provision costs (994,900 UAH) (Zhilka, 2005).

Historically, despite indirect and direct harm to the health of women caused by unsafe abortions and the related economic costs, abortion prevention activities have not been effective in Ukraine because of the lack of a comprehensive approach to contraceptive security. Unlike developed countries, family planning and unintended pregnancy prevention has not been considered a national priority, and the production or purchase of contraceptives in Ukraine has been inadequate. The population, especially youth and adolescents, has lacked the opportunity to access high-quality information about reproductive behavior, prevention of unintended pregnancy, and protection against sexually transmitted infections (STIs).

## **The Demographic Situation in Ukraine**

Since the early 1990s, Ukraine's population has decreased as a result of a declining birth rate, an increased mortality rate, and out-migration. The population decreased from 50.9 million in 1993 to 47.5 million in April 2004, while fertility rates declined from 1.83 to 1.12 between 1991 and 2003 (Ministry of Statistics of Ukraine). The country's current demographic situation is considered critical as it affects Ukraine's future development (Lakiza-Sachuk, 1999). Although the fertility rate has risen over the past three years, it has not reached a level that will resolve the depopulation problem.

The demographic indicators presented below reflect a problem that must be addressed through multiple approaches of which CS is one. The indicators should be integrated into a CS strategic plan, and ongoing monitoring should occur to detect improvements in demographics over time.

### **Total Population**

Between 1994 and 2003, Ukraine's population decreased by 9 percent. Total mortality exceeds total fertility, thus the population growth rate has been negative since 1991. According to Ukrainian demographers' projections, in five years the population will have decreased by another 4 percent and in ten years by an additional 7 percent. Currently, the percentage of the population residing in urban areas is 67.3 percent (Stefanovskyy and Rudnitskiy, 2003).

The number of women of reproductive age was 125,167 in 2003. This is the main indicator used to determine the need for contraceptives. Reproductive health, being a component of general health, is an important factor in ensuring favorable demographic prospects for the country and in forming its demographic and socio-economic potential in the context of sustainable development (Zhilka et al., 2001, UNDP 2003).

### **Maternal Mortality Rate**

In addition to reducing abortion rates and its adverse impact on reproductive health, contraceptive use improves maternal health, decreases perinatal mortality, has the potential to reduce HIV incidence, and thus, decreases the general mortality of the population. **Figure 1** shows that maternal mortality in Ukraine increased from 34.8 per 100,000 live births in 1993 to 36.2 per 100,000 live births in 1995. Since 1995, it has decreased steadily to reach 13.5 per 100,000 live births in 2004 (MOH, Center of Medical Statistics).

### **Infant Mortality Rate**

**Figure 2** illustrates the changes in Ukraine's infant mortality rates since 1975. The IMR decreased by over one half between 1975 and 2004, despite fluctuations between 1990 and 2000.

Number of deaths per 100,000 births

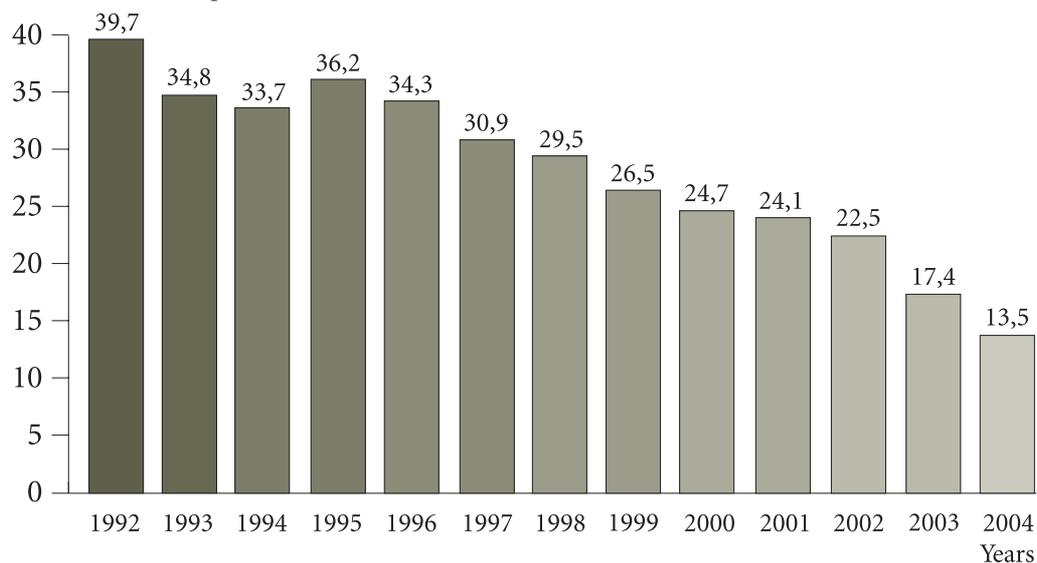


Figure 1. Maternal mortality rate in Ukraine, 1992–2004  
(Source: State Committee for Statistics of Ukraine)

Number of deaths under the age of 1 per 1,000 live births

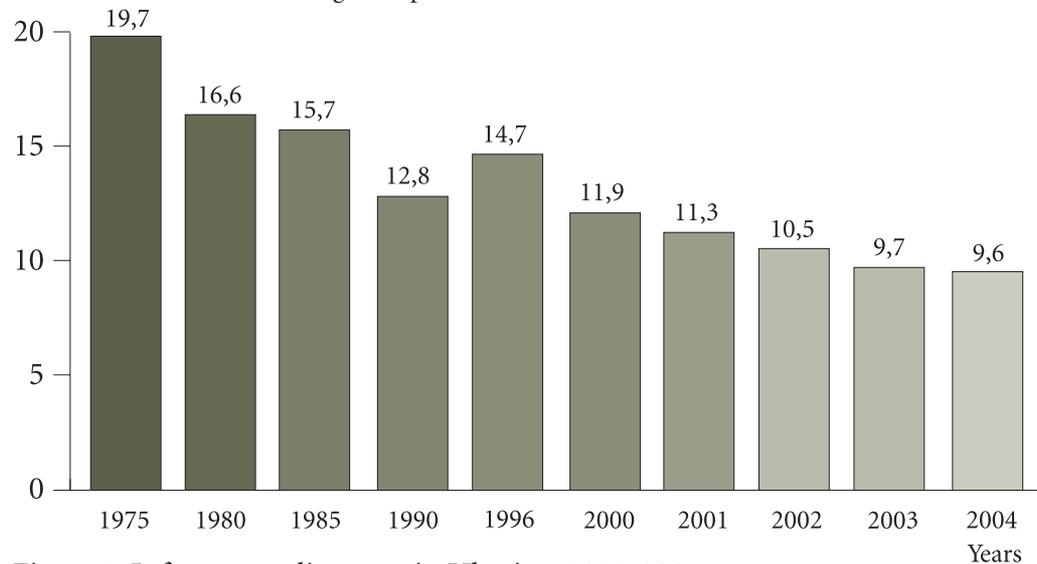


Figure 2. Infant mortality rates in Ukraine, 1975-2004  
(Source: State Committee for Statistics of Ukraine)

## HIV Prevalence Rate

HIV prevalence rates in Ukraine pose a threat to the country's development and will continue to do so in the future. The number of reported cases of HIV, AIDS, and AIDS-related deaths, increases annually (see Table 1), and half of those infected with HIV are people ages 25-34.

According to sero-epidemiological HIV monitoring, in 2004, the total number of diagnosed HIV-positive cases in Ukraine was 751,000. However, registered HIV/AIDS cases constitute only a small portion (10-12%) of the actual number of HIV-positive cases. In the last ten years, the HIV prevalence rate has increased from 0.16 percent of the population in 1995 to 1.87 percent in 2003, and forecasts show that in the next 5 years the rate will increase to 2.48 percent and then decrease to 2.38 percent by 2015 (UNAIDS, 2005).

Table 1. Number of registered HIV/AIDS cases and AIDS-related deaths in Ukraine, 1987-2004

Indicator	Years												
	1987-1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	Total
Total number of HIV+ cases	354	44	1,499	5,422	8,934	8,512	5,830	6,216	7,009	8,761	10,013	12,494	75,166
Total number of reported AIDS cases	24	13	45	146	193	400	586	648	868	1,356	1,916	2,745	8,939
Total number of AIDS-related deaths	13	5	20	70	85	156	253	415	474	837	1,285	1,775	55,382

Source: Ukraine Sero-epidemiological Surveys, Ukrainian AIDS Center, 2005.

## Section 2: Diagnoses

### Client Utilization

Contraceptive security (CS) depends on the clients' ability to choose, obtain and use contraceptives. As use of contraceptives grows, the requirements for achieving CS also expand. To understand how progress can be made toward greater security, client use must be examined.

Modern methods of contraception include pills, intrauterine devices (IUDs), condoms, spermicides, injectables, and female/male sterilization; traditional methods include withdrawal, natural method, periodic abstinence, etc.). The method's effectiveness is based on the contraceptive failure rate. As shown in Appendix A, modern contraceptives have relatively low failure rates and high effectiveness, while traditional methods have higher failure rates and are less effective. The data also indicate that a method's effectiveness is higher if it is used correctly, when providers are well trained and when users are aware of side effects.

In Ukraine, use of contraceptives is one of the health issues monitored through state statistical registration and data are used for analysis and ongoing decision-making. However, it is difficult to interpret trends since different surveys use different methodologies and some surveys do not collect data on the full range of methods used in Ukraine. The data do suggest that increased use of contraceptives in Ukraine has resulted in fewer unintended pregnancies and abortions. The data in Table 2, although difficult to compare, suggest that modern method use is increasing. This increase demonstrates a growing demand for effective methods in Ukraine and suggests that awareness-raising activities have been effective in increasing demand for contraceptives. The percentage of traditional method use, according to the 2003 survey, is still high at 30-35 percent.

To make decisions regarding strategic planning for CS, stakeholders need information on the demand for each contraceptive method, the accessibility and quality of contraceptives, and ability and willingness to pay. However, state official data are available for only two contraceptive methods: hormonal contraceptives and IUDs. Thus, it is necessary to use data from previous surveys to help inform decision makers. Three surveys from international organizations describe patterns in method use in 1996, 1999, and 2003 (see Table 2). As mentioned, different organizations using different methodologies conducted these surveys making it difficult to interpret trends. Nonetheless, the surveys support government statistics, which illustrate a rise in modern methods. Although IUD use is decreasing, use of hormonals is on the rise. This suggests that women who once used IUDs may be switching to other modern methods.

#### Changes in method preference

Historically, the most popular methods have been IUDs. Recently, however, the number of IUD users has been decreasing, while the number of users of condoms and pills has been increasing, as shown in Tables 2 and 3. IUD users

Table 2. Current Contraceptive Use Among MWRA in Ukraine, Three Population Surveys

Category	1996 (%)	1999 (%)	2003 (%)
CONTRACEPTIVE USE – ALL METHODS	92.2	67.5	92.0
CONTRACEPTIVE USE – MODERN METHODS	53.4	37.6	65.0
IUD	23.9	18.6	12.4
Oral contraceptives	5.4	3.0	14.5
Injectables	0.1	0.1	*
Vaginal methods	4.1	0.6	3.4
Condom	19.9	13.5	29.9
Lactation amenorrhea	1.5	*	*
Diaphragm	0.1	*	*
Female sterilization	*	1.4	*
Other methods	*	0.3	1.0
Natural method	19.9	*	*
Withdrawal	17.3	10.4	19.4
Chemical contraceptives	4.0	*	5.3
Periodic abstinence (calendar method)	*	19.5	6.5

\* The category was not studied.

Sources: Zdorovia, K. 1996. Women and Children’s Health in Ukraine. In population survey of Kyiv International Institute of Sociology. (Steshenko, V. (ed.)); 1999 Ukraine RH survey, CDC 2001; Zhilka, N.Y. 2004. Aspects of Socio-Economic Efficiency of Contraception as an Alternative to Unintended Pregnancy Termination in Ukraine. Ukraine medical almanac. No.1 (annex): p.5–7.

Table 3. Percentage distribution of current contraceptive use by method for adolescents in union

Contraceptive Method	Aged 15-19	Aged 20-24
Modern method	27.2	33.9
Pill	1.2	4.3
Condoms	20.8	15.8
IUD	3.4	12.9
Spermicide	1.9	0.8
Sterilization	0.0	0.1
Other methods	0.0	0.1
Traditional method	20.2	29.2
Withdrawal	13.8	24.2
Periodic abstinence	6.4	4.9
Using no method	52.6	37.0
Total	100.0	100.0

Source: 1999 Ukraine Reproductive Health Survey (CDC, 2001)

decreased from 23.9 percent in 1996 to 12.4 percent in 2003, while hormonal contraceptive users increased from 5.6 percent in 1996 to more than 14.5 percent in 2003. The number of condom users has also increased by 10 percent during this time. A survey to assess method preference among women showed that

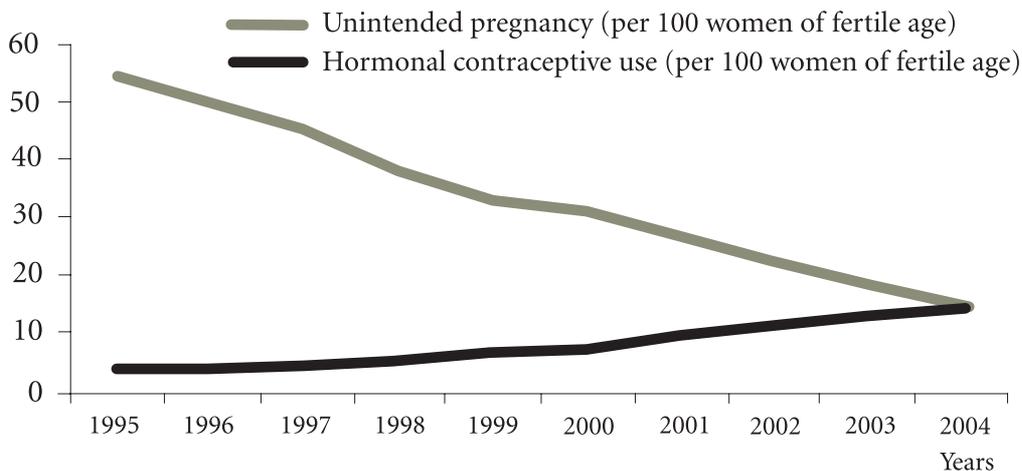


Figure 3. Changes in unintended pregnancy rates vs. hormonal contraceptive use in Ukraine

the most preferred method was condoms, followed by hormonals and then IUDs (Goida and Zhilka, 2004). This reduction of IUD prevalence can be attributed to several factors: (1) the spread of STIs, which some providers believe to be a contraindication for IUD use, and (2) the shift toward oral contraceptives because of decreased prejudice among clinicians against hormonal methods.

Due to the shift to modern methods, the number of unintended pregnancies and abortions are falling. Between 1992 and 2004, the number of unintended pregnancies per 1,000 women of reproductive age decreased by 75 percent. This suggests that strengthening contraceptive security has a positive impact on reducing abortions. Figure 3 shows the correlation between increasing contraceptive prevalence and decreasing abortion rates.

In developed European countries, abortion rates are low (5-10 per 1,000 women of reproductive age) and contraceptive prevalence rates are high, with 60-70 percent of the population using modern contraceptive methods (Ventsovskiy and Tovstanovska 2002; Zdorovia, K., 1996; CDC, 2001). To achieve these low rates of abortion, Ukraine needs to ensure that all Ukrainian men and women can choose, obtain, and use contraceptives.

### Factors affecting utilization/non-utilization

On average, contraceptive use among married women was 67.5 percent for all methods in 1999, with 38 percent using modern contraceptives and 30 percent using traditional methods (periodic abstinence or withdrawal methods only<sup>1</sup>). Although no observable differences in overall contraceptive use exist between the eastern, western, northern, southern, and central regions of the country, the western region relies more heavily than other regions on traditional methods, with 42 percent using traditional methods and 25 percent using modern methods (CDC, 2001). The western region is the most rural and ethnically Ukrainian

and abortion rates are also lower here. In the CDC 1999 survey, 28 percent of women in this region reported any abortions (compared with 43 percent nationally) and only 9 percent reported having more than one abortion (compared with 20 percent nationally). Abortions were highest among women who described themselves as ethnically Russian and least common among ethnically Ukrainian women. Abortions also decreased with the level of education (CDC, 2001).

Disparities in use of modern methods exist between urban and rural areas. In 1999, in urban areas, 42 percent were using a modern method, while 27 percent were using a traditional method, whereas in rural areas, modern and traditional method use was 27 percent and 36 percent respectively (CDC, 2001). According to the paper by Deliver/John Snow Inc., 49 percent of urban women and 39 percent of rural women used modern methods in 2004 (Hudgins and Wright, 2004). These urban-rural disparities are also observable by method: 6.4 percent of women in rural areas use condoms and 1.4 percent use oral contraceptives, compared with 16.5 percent and 3.6 percent respectively in urban areas. Rural residents exhibit higher use of traditional methods and lower use of modern methods. Most women in both rural and urban areas are aware of at least one modern method but awareness in urban areas is higher than in rural areas (CDC, 2001). These data suggest the need to more closely examine underlying factors for not using contraceptives through population surveys, to better address these issues.

During the 1999 survey, the major reasons women cited for not using contraceptives include: not being sexually active (25%), sub fecund (13.5%), pregnant (13%), engaged in only occasional sex (9%), or want to become pregnant (8%). Note that while cost was not cited as a major factor for not contracepting, cost was a major factor affecting use of a preferred method. For those not using a preferred method, 27 percent of women said the reason is cost (CDC, 2001). The most affordable contraceptive is an IUD, which helps explain the high use of IUDs.

Other reasons for not using contraceptives include a lack of awareness of contraceptives as methods to prevent unintended pregnancy and the bias of some healthcare providers who believe that contraceptives negatively affect health. For example, 30 percent of women interviewed in 2003 found it difficult to answer the question about the impact of contraception on health (Goida and Zhilka, 2004). Furthermore, according to a sociological survey, 25 percent of healthcare providers believe that contraceptives have an adverse effect on health (Goida and Zhilka, 2004).

Education level is also a factor affecting use of contraceptives. In 1999, modern method CPR was 29 percent among users with less than a secondary education; 36 percent among individuals with secondary education; and 47 percent among individuals with more than a secondary education (CDC, 2001). (See Appendix C for a list of all reasons).

## **Discontinuation and failure rates**

Discontinuation rates of modern methods are high in Ukraine, as noted by the 1999 Ukraine RH Survey (CDC, 2001). For example, within the first year of using contraception, 54 percent of pill users discontinued use, and within three years, 74 percent of pill users discontinued use. IUD users were the least likely to discontinue use. According to the survey, the main reason for discontinuing use of pills is to "give the body a rest." This reason, which has no medical justification, suggests that the quality of family planning services and access to reliable information about methods is low. This should be taken into account during trainings for providers. (See Appendix C for a full list of reasons for discontinuation.)

The failure rate of a specific method is calculated as the probability of becoming pregnant while using a particular method. The survey found that on average, about 9 percent of contraceptive users in 1999 became pregnant within one year of using a method. After three years, this failure rate rose to 19 percent (with modern method failure rates being lower than traditional ones). Failure rates for IUDs ranged from 1.4-3.5 percent within one to three years; oral contraceptives ranged from 5.9-13.2 percent; and condom failure rates ranged from 7.1-18.7 percent (CDC, 2001). Improved dissemination of information to the client and healthcare provider could help increase the effectiveness of contraception.

## **Contraceptive use among adolescents**

Table 3 provides an overview of contraceptive use by method for adolescents in union. Modern methods, mainly condoms, are more commonly used among adolescents. Very few adolescents use pills. Furthermore, over half of adolescents ages 15-19 do not use any contraception. The data make a clear case for increasing awareness-raising activities for adolescents.

## **Projected unmet need**

To meet the population's contraceptive needs, it is important to understand unmet need among two groups of women. The first group includes women who are sexually active, not pregnant, able to become pregnant, do not want to become pregnant, and are not using any contraceptives. Unmet need for this group was 15 percent in 1999, which is considered high in comparison with other developed countries (CDC, 2001). The second group includes women who want to prevent pregnancies and are using ineffective methods. Unmet need is 37 percent among these women and correlates with a high abortion rate. Thus, the overall unmet need for contraception is 52 percent. Across both groups of women, unmet need was highest among the women with no living children and women with a secondary education but no post-secondary education. There was no variation across regions of the country but rural women were more likely to have unmet need than urban women (CDC, 2001).

## **IEC activities**

Contraceptive demand depends on multiple factors including population awareness, training of specialists, quality of service delivery, effectiveness of methods, patients' commitment to use a specific method, ease-of-use, reversibility of the method, and the cost of contraceptives.

To meet the growing contraceptive demand in Ukraine, the MOH department responsible for medical care for mothers and children is reorganizing and reforming the FP system. The Ukraine Reproductive Health Network (URHN) has worked to strengthen FP services in Ukraine, with significant support from the USAID-funded Women's Reproductive Health Initiative (WRHI). Specifically, this initiative aims to improve the regulatory framework for FP/RH to raise awareness about contraceptives, improve health providers' knowledge about FP, provide the population with contraceptives, develop budgets, and strengthen the FP service delivery system at all levels through reorganization and staff development. Considerable infrastructure has already been established, 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 IEC.

Included in the draft national RH program for 2006-2010 is a plan to make changes in the legislative framework that will help establish appropriate mechanisms for distribution of contraceptives. This plan is part of the revisions to MOH order #180, which aims to convert the structure of FP centers into independent facilities and to increase demand for contraceptives.

The MOH also plans to work with all parties, including men, in formulating FP strategies. A special focus will be on raising awareness of contraceptive methods and use among adolescents in union and incorporating abstinence into the strategy for those who are not in union, while taking into account legislative changes that recognize adolescents' reproductive needs.

Another important factor contributing to increased demand for FP services is the decreased prejudice against hormonal methods among clinicians (Hudgins and Wright, 2004). An increased open-mindedness to the use of oral contraceptives increases demand for oral contraceptives, which may result in an increased CPR and not just a shift from one method to another.

## **FP Service Delivery**

### **Levels of service delivery**

The Ukraine FP service delivery system consists of the Ukrainian national FP center, 25 oblast centers, Kyiv and Sevastopol FP centers, and 415 FP rooms at central rayon hospitals. In Ukraine, there are seven RH centers for teenagers (Autonomous Republic of Crimea, Donetsk, Odessa, Lviv, Lugansk, Zaporizhzhia oblast, Kyiv city). High-quality specialized care for teenagers is provided at the Center of Children and Adolescent Gynecology (OHMATDIT); the Institute of Pediatrics, Obstetrics, and Gynecology of the Academy of Medical Sciences of Ukraine; the Child Gynecology Department of Kharkiv Institute of Children and Adolescent Health; and the Donetsk Regional Mother and Child Health Center.

The FP service structure has four levels. Every level deals with specific issues, and facilities at each level have specific objectives. The higher the level the more complex and technologically advanced the provision of services. However, this brings forth organizational challenges. The four levels of service structure are listed below and discussed in detail in Appendix B.

- Level 1: District hospitals and ambulatories and family practice ambulatories with established FP functions.
- Level 2: Women's consultations and maternity departments providing post-partum and postabortion counseling on individual choice of contraceptive methods.
- Level 3: Medico-genetic centers/FP consultations.
- Level 4: Educational establishments of level III-IV of accreditation.

The role of the private sector in healthcare delivery is to provide information and special data to the population and health providers and also to distribute and sell contraceptive commodities. The private sector in Ukraine includes, but is not limited to, NGOs, private hospitals, and commercial pharmaceutical companies. NGOs provide mostly IEC although recent regulatory changes allow them to provide FP services and recover costs.

### **Quality of services and provider training**

Clients must have access to high-quality services in order to choose, obtain, and use contraceptives. The quality of FP services in Ukraine is primarily dependent on three factors: whether family planning is a priority for the state; the level of organization involved in FP service delivery; and the extent to which providers are trained in FP methods.

The existing FP system does not fully meet modern sector restructuring requirements. The following problems exist:

- At the first level of healthcare, family physicians are not involved in FP service delivery;

- Contraceptive security is not a priority for the government at any level
- There is a lack of postabortion and postpartum counseling on contraception because of the poor qualifications of providers' working in women's consultations, gynecology, and obstetrics departments;
- Medical geneticists do not adequately provide FP services;
- NGO involvement in RH activities is extremely limited;
- There is a lack of training among healthcare providers and pharmacists in modern contraceptive methods, and they regard contraception as harmful for health;
- In most oblast, FP centers are not considered legal entities. Only in some oblasts are FP centers stand-alone health facilities, making it difficult to enforce quality standards;
- The FP system lacks adequate human resources development (training and continuing education).
- A lack of awareness and financial capacity among the population limits the demand for contraceptive commodities, especially in rural areas.
- At the local level, among healthcare providers and decision makers, there is a lack of awareness of RH problems and how to address them, especially regarding contraceptive provision. Raising healthcare providers' awareness will help clients make informed method choices, increase the quality of FP/RH services, and reduce contraceptive failure rates.

The quality of services could be improved by introducing new structures and organizational technologies, while retaining the existing elements of the FP system. One suggestion made in the contraceptive security national workshop was to improve the referral system between levels of the FP service delivery system.

The quality of services could also be significantly improved through building staff qualifications. Primary providers of obstetric and gynecologic care and hospital and pharmacy workers need to upgrade their knowledge of modern contraception issues. There are standards in place for ensuring skills are up-to-date but in reality, these standards are not upheld<sup>2</sup>. These orders ensure that physicians provide reliable information to patients about modern contraceptive methods. Ob-Gyn providers are required to know and be able to use modern methods, whereas specialists in gynecology only for children/adolescents are not required to have the knowledge and skills needed to use modern methods.

Employment standards for nursing staff providing obstetric-gynecologic care do not require nurses to have FP/RH skills but do require midwives to have knowledge of modern contraceptive methods and to promote healthy lifestyles, including prevention of unintended pregnancies and AIDS<sup>3</sup>.

Ob-Gyn providers receive some training on prescribing contraceptive methods; however, the curriculum does not focus heavily on FP. There is a 156-hour thematic course "Issues of Preventive Perinatology and Family Planning"

intended for a small number of specialists. Midwives receive 648 hours of training prior to obtaining their diplomas and 243 of these hours are spent on obstetrics and gynecology (54 are spent on family planning). At the post-graduate level, only eight hours are dedicated to FP issues.

According to WHO recommendations regarding individual prescription of contraceptives, providers should take into account information regarding the following: modern contraceptive methods and the health, ages, reproductive plans, informed consent, and economic capacity of a client or couple. Such an approach requires that training be ongoing at oblast FP centers in order to provide up-to-date information to providers.

The best training for specialists often comes from donors working in Ukraine. A number of donors provide ongoing training to healthcare providers involved in FP service delivery.

- From 1995-2000, UNFPA provided FP/RH training to 4,000 specialists. Three thousand of these specialists were Ob-Gyns. Due to changes in the contraceptive method mix and new staff involved in FP service delivery, there is a need for ongoing training.
- Pharmaceutical companies provide training through seminars. From 1996-2004, the pharmaceutical company, Schering, under mutual agreement with Kyiv Medical Academy of postgraduate education, trained 10,859 physicians, pharmacists, and students (6004 Ob-Gyns, 875 family physicians, 779 endocrinologists, 1773 pharmacists, and 1428 students). In 2004, the pharmaceutical company, Organon, trained 2,000 Ob-Gyns at individual sessions. More than 150 presentations were made at physicians' conferences and fifteen mini-conferences were conducted.
- In 1999, an FP guide was widely disseminated in Ukraine (more than 12,000 copies); it provides detailed information based on WHO recommendations on modern approaches to family planning and also an overview of effective modern method use, including prevention of complications and contraceptive failures.

To integrate the provision of counseling and medical care in the area of family planning and upgrade FP service providers' skills, FP standards have been developed and introduced through MOH orders<sup>4</sup>. These standards call for mandatory postabortion and postpartum counseling on preventing unintended pregnancy with contraceptives. Clinical protocols on FP state the need to provide full information on prescription practices for specific methods of contraception, their use, registration, and storage. However, these standards are not yet enforced.

### **Accessibility of contraceptive services**

#### Rural versus Urban

Unlike urban residents, rural residents have limited access to public FP services and have to go to the central rayon hospitals or FP centers to receive con-

traceptives Exacerbating the problem is the fact that family physicians and specialists authorized to provide FP services are often concentrated in urban areas. Rural residents also have limited access to private sector outlets.

Because of the lack of access to FP services in rural areas, the cabinet of Ministers of Ukraine, on November 17, 2004, issued directive #1570 "On approving the rules of trade of medications at pharmacies", which promotes increased access in rural areas where there are currently no pharmacies. The MOH established a list of medications, including contraceptives, that can be sold through feldsher-obstetrician points (FOPs) and rural ambulatories on the basis of contracts with a pharmacy and with written permission from the local government. A person with secondary pharmaceutical education can be responsible for ensuring the quality of medications in a rural pharmacy.

#### Vulnerable groups

Legislation in Ukraine mandates that specific groups of women can receive free contraceptives (women with contraindications for pregnancy, women who suffered due to the Chernobyl accident, and adolescents); however, this is merely a declaration as there is no targeting mechanism to provide and finance contraceptives.

#### Method mix/choice at various service delivery points

Ukraine's contraceptive market has a broad contraceptive mix: oral contraceptives, IUDs, condoms, injectables, spermicides, and male/female sterilization, among others. However, method mix in urban areas is broader than in rural areas, due to urban areas' higher demand, greater awareness of methods, and higher ability to pay for contraceptives, relative to rural areas.

#### Sources of contraceptives

The sources of the three most widely supplied methods (oral contraceptives, IUDs and condoms) are listed in Table 4. Women's consultation centers and pharmacies are the leading sources of pills, supplying about three of every four users. Women's consultations centers were also the predominant source for

Table 4. Distribution of users of modern contraceptives by methods (%)

Source	Oral contraceptive	IUD	Condom
Women's consultation, including FP centers	39.3	66.0	10.0
Pharmacies (public sector)	34.6	3.7	56.6
Hospitals	6.6	20.4	2.1
Drug kiosks	1.7	0.1	7.3
Maternity homes	2.1	5.3	0.5
Private clinics	1	0.4	0.3
M&C centers	0.4	0.1	0.4
Other	15.7	4.4	22.8
Total	100.0	100.0	100.0

Source: 1999 Ukraine Reproductive Health Survey (CDC, 2001).

IUDs, accounting for two thirds of IUD insertions, with the remaining supplied by hospitals. Almost all IUDs are disbursed through health facilities because IUDs can be inserted only by a physician. Condoms are mainly available at pharmacies and other facilities, such as women consultation centers and drug kiosks.

### **Availability of contraceptives**

#### Private sector

The limited availability of contraceptives in the private sector is affected by the lack of pharmaceutical kiosks in rural areas, insufficient awareness of modern contraception methods among the population, and the costs of contraceptives. Commercial outlets offer various methods depending on the manufacturer or company they represent in Ukraine. Generalized data on contraceptive sales in Ukraine's private sector are not available. However, it was concluded that 35 types of contraceptives are available in the private market.

According to the study by Hudgins and Wright (2004) the pharmaceutical sector is well established in Ukraine and consists of private companies and privatized state pharmacies, which are now partially owned by oblast health administrations and are regulated more closely than commercial firms. They are located in cities, towns, and villages, and provide a good selection of methods, brands and prices. They also disburse most of the drugs procured by the MOH. Although these state pharmacies charge a maximum mark-up of 30 percent on other products, contraceptives are usually marked up only 15-20 percent.

Private commercial pharmacies exist throughout Ukraine in cities and towns and offer a wide choice of contraceptives from a variety of manufacturers at a broad range of price points. IUDs and Depo-Provera are not always stocked onsite but 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 (Hudgins and Wright, 2004).

#### Public sector

During the past 10 years, donors have provided public health facilities with contraceptives, but this has recently been phased out. As a result, there seems to be a deficit in oral contraceptives, IUDs, spermicides, and condoms at public FP centers.

To enhance availability, some types of contraceptives (Logest, Janin, Depo-Provera, Mercilon) have been included in the list of medications of domestic and foreign production and are bought by health facilities using full or partial finances from local and public budgets. This enables health facility managers to purchase these types of contraceptives from local budget funds if necessary.

## **Logistics**

High-quality services that permit clients to choose, obtain, and use contraceptives require a logistics system that distributes contraceptives in an effective, reliable, and efficient manner. The capacity of current distribution systems must be reviewed to understand how to meet future needs. Ukraine has two supply chain systems for handling contraceptive provision to the public sector. The first is a vertical system established by the MOH and has been used to distribute donated commodities, primarily from USAID (in six oblasts) and UNFPA. The second system, Ukr MedPostach, is a parastatal national medical store that distributes most public sector medications. These medicines are procured by the MOH for oblasts (Hudgins and Wright, 2004).

According to a JSI/DELIVER study, private distributors do operate in Ukraine but are associated with commercial pharmaceutical companies serving both private and parastatal pharmacies. There might be potential to contract a private firm to handle storage and distribution of donated commodities, but a cost recovery mechanism would be required to cover their associated costs (Hudgins and Wright, 2004).

## **Forecasting and Procurement**

For clients to choose, obtain, and use commodities, the system must first forecast the correct quantity and type of products and then procure those products in a timely manner. The capacity to accurately forecast and procure quality contraceptives at a reasonable cost is critical to contraceptive security.

### **Forecasting**

Very few people receive training in forecasting and, therefore, lack the skills needed to estimate contraceptive requirements. Regional FP centers forecast the need for contraceptives, and the information is sent to local health authorities and the MOH. The MOH, using this information, is then responsible for forecasting required types and number of contraceptives.

The private sector collaborates with FP centers in collecting information. Each month, private sector representatives in some regions collect information about the availability of, and need for, various types of contraceptives at FP centers. This helps ensure that the private sector is aware of the market and will be able to meet the demand in each region.

The system in Ukraine uses multiple sources of data to calculate need: demographic data and sociological survey data (non-usage of contraceptives, usage of traditional contraception methods, planning of births, etc.), as well as service statistics (rates of abortions, unintended pregnancies, contraceptives users).

## **Contraceptive procurement**

Despite maternity and family planning being priorities in Ukraine and the National Reproductive Health Plan (NRHP) being implemented, the GOU does not currently procure contraceptive commodities. Given that the MOH is procuring medicines, it is clear that there is a mechanism to procure contraceptives; however, approval needs to be granted by the MOH tender committee.

## **Distribution and inventory tracking**

In general, there is a need to strengthen the capacity of the public sector contraceptive provision system, improve the regulatory framework, and improve the FP/RH service infrastructure.

The levels of the contraceptive distribution system correspond with the health service delivery system. Level 1 includes FP centers; level 2 includes national and oblast health facilities; level 3 includes city and rayon health facilities; level 4 includes FOPs and rural ambulatories.

A contraceptive is delivered within 2-4 weeks after it clears customs. Standards are in place to ensure adequate quality and storage conditions for all imported contraceptives but these standards are not necessarily adhered to.

The MOH distributes contraceptives to each region, according to the number of women of reproductive age. A transparent plan of distribution (covering every region) is established for organizing the transportation of contraceptives to and within regions. Regional health authorities are in charge of transportation.

Inventories on stock and usage are conducted during annual evaluations of the FP center operations and the results are reported to humanitarian aid donors and oblast FP centers.

In Ukraine a computerized logistics management information system (LMIS) was introduced to oblast FP centers and the MOH in 2001-2003, and UNFPA provided related training to oblast FP coordinators, most recently, in spring 2004. There are also paper-based (LMIS) forms used to report on stock status (received, dispensed to user, and stock on hand) during the time of UNFPA donations. Currently, the LMIS is not in use, as contraceptives are in short supply. If donated or MOH-funded products were re-introduced, additional efforts would be needed to strengthen the LMIS (Hudgins and Wright, 2004).

## Finance

Procuring contraceptives and making them available to those who desire them require adequate financing. Knowing the major sources and uses of funds for RH commodities, identifying resource gaps, exploring future scenarios for financing, and developing actions to ensure financial security are all important aspects of contraceptive financing. Clients' willingness to pay and the appropriate allocation of resources (market segmentation) also affect finance options.

### Current Funding

FP services and supplies in Ukraine are relatively expensive, underutilized, and inefficient. Fees are charged for contraceptives at the point of delivery. The public sector does not control prices<sup>5</sup>. Indirect evidence suggests that many residents cannot pay for contraceptives. Food expenditures, one of the main indicators of welfare, are the main item of household consumer expenditure. Since the majority of the population spends more than half their income on food, there is limited capacity to pay for medical services. In 2001, the poorest households spent 2.7 UAH per month on health. All urban households spent 2 percent of their total expenditures on health and services, while rural households spent 1.1 percent on health services (Berezina et al., no date).

Table 5 shows findings of the pricing policy study conducted in the Ukraine pharmacy network.

Table 5. Prices of contraceptives (UAH)

Name of Hormonal	Price of one pack
Rigevidon	5.10
Microgenon	22.60
Ovidon	6.45
Logest	30.65
Diana	33.45
Triregol	5.50
Exliuton	21.45
Lindinet	23.00
Novinet	10.01
Regulon	18.00
Janin	47.00
Depo-provera	28.00

Name of IUD	Price of
Multiload - 250	50.00
Multiload - 375	50.00
Unon-bio-T	35.10

Name of Spermicide	Price of One Pack
Pharmatex	28.00
Patentex	9.15
Contraceptin	5.65
Erotex	9.15

Name of Condom	Price of one pack (3 condoms)
Sico	7.55
Vizit	7.55
Contex	5.30
Masculap	6.45
Gussarskiye	4.40
Invotex	6.50
Erotica	4.30
Condom	0.80
Grive	0.74
DOTTED	1.65

Source: Zhilka, 2005.

The estimated average annual cost of contraceptives per individual is as follows:

- Hormonals: 229 UAH
- IUD: 13 UAH
- Condoms: 181 UAH
- Spermicides: 164 UAH

The living annual wage in Ukraine averages 4,440 UAH (370 per month), and therefore, according to calculations, the cost per capita income for hormonal contraceptives is 5%; IUDs (0.3%); condoms (4.1%), and spermicides (3.7%). Since many studies suggest expenditure on contraceptives should be no more than 1 percent of per capita income (Harvey 1994, cited by Hudgins and Wright, 2004), the data illustrate that the majority of the population is unable to pay for contraceptives. Abortion, which is more affordable, is often the alternative. This information is of particular importance because, with a current state budget deficit, receiving high-quality care depends more and more on the economic status of families.

There is a need for a study to better understand what people are willing to pay for contraceptives. In Ukraine, more than half of women (57%), live in rural areas have a low income, and they find contraceptives expensive. In urban areas two-thirds of women (67%) have a high income and have more access to contraceptives (Lakiza-Sachuk, 1999) According to a DELIVER/JSI desk study that attempted to identify ability to pay, 60 percent of the population cannot access modern types of contraception due to their high cost on Ukraine's market, and the poorest 40 percent of the population cannot afford any commercial brand of contraceptive, with the exception of IUDs <sup>6</sup> (Hudgins and Wright, 2004). The same study also found that (based on the methodology used in this analysis) the middle income population can afford Rigevidon, an oral contraceptive, but cannot afford many of the other supplied methods; and even the highest income quintile has difficulty paying for the most costly oral contraceptives, such as Janin, Diane-35, and Marvelon (Hudgins and Wright, 2004).

According to the population survey findings (CDC 2001) in most cases, women found it difficult to remember how much they spent on a specific method. Substantial changes in the costs of goods and services and the value of Ukrainian currency also made it difficult to determine payments made (CDC, 2001). The following [Table 6](#) illustrates the distribution of types of payments women or couples made in 1999 for their contraceptive method. Among oral contraceptive users, 82 percent paid for their pills; while only 72.4 percent of IUD users and 76 percent of condom users paid for their contraceptives. The difference in payments for methods among urban and rural populations is small.

Table 6. Method of payment for users of OCs, IUDs, and condoms, 1999 (%)

Type of payment	Oral contraceptives	IUD	Condoms
Money (UAH)	82.3	72.4	76.0
Goods or services	0.2	1.4	0.3
Free	16.8	26.1	10.8
Don't remember	0.7	0.1	12.7
Total	100.0	100.0	100.0

Source: 1999 Ukraine RH Survey, (CDC 2001)

Article 49 of the Constitution of Ukraine mandates that public health facilities provide care free, including free contraceptives. This places a restriction on public sector facilities' ability to recover costs. However, in recent years, private forms of healthcare provision have been actively developing in Ukraine. In the private sector, the cost of one visit at an outpatient provider of obstetric-gynecologic care is 40-80 UAH (Telephone survey of private clinics, 2005).

### **Public finance**

Health facility funding is regulated by the Budgetary Code and funded by national and local budgets. The national healthcare budget is developed annually on the basis of finance proposals. Research and development institutes and some level III health facilities are financed from the national budget; level III oblast health facilities are financed from the oblast budget; and level I and II health facilities are financed from rayon and municipal budgets.

The total amount spent on reproductive health care is equivalent to 1.9 percent of the national budget but no financing was allocated to the National RH Program from 2001-2005. There was also no allocation for the state and local budgets to procure contraceptives and donors have not provided contraceptive commodities supplies.

FP budgets exist only for the maintenance of FP centers and staff salaries. Since they are structural subdivisions of delivery facilities there is no separate line item provided for them. There is no state accounting of such expenditures but according to independent sources, nine months of 2004 contraceptive sales for the network of public and private pharmacies amounted to 4,445,100 UAH, which is 0.06 percent of the national budget and 0.09 percent of local budgets for the time period (Personal communication with AMS, RMBS, AT Business-Credit).

## Alternative mechanisms of funding

Collaboration with international agencies and donors decreased between the 1980s and 1990s, as shown in Table 7.

Table 7. Sources of funding for the family planning program\*

Sources of contraceptive funding	1980s	1990s
UN Population Fund	\$300,000	\$300,000
USAID	\$700,000	\$70,000
Other donor: CDC	\$176,960	
Company Organon		\$80,000
Company Shering		\$40,000
Company Gedeon-Richter		\$100,000
Private sector		\$186,940**

\* The accounting of the international funding sources was started in the MOH of Ukraine in 2004.

\*\* The average exchange rate for 1990s=3,2 UAH.

## **The Policy Environment**

### **The National Reproductive Health Program**

The FP system is one of the youngest sub-systems of Ukraine's health sector. It was launched in 1995—the year the Cabinet of Ministers adopted the National FP Program with a presidential decree, "On the National RH Program 2001-2005," to encourage the expansion of the network of FP and child-adolescent gynecology services and the appropriate equipment of these services. The program was launched during a period of demographic, economic, and population health crises that gave nationwide importance to RH issues. Reproductive health is an essential factor in ensuring favorable demographic prospects for the country and is now a program that is recognized as a precondition to creating the country's demographic and socio-economic potential to achieve sustainable development of the Ukrainian society.

### **Policies affecting access to contraceptives**

To improve access to contraceptives, a government policy mandates inclusion of contraceptives in the list of medications that can be bought by health facilities, either with full funding or partial funding from the public budget.

A Cabinet of Ministers' directive mandates free provision of contraceptives to women with high risk of pregnancy and delivery complications, youth, and women who suffered from the Chernobyl accident<sup>7</sup>. However, this policy is mostly declarative in nature and not operationalized. The government is still not procuring contraceptives and there is no local production, with the exception of some types of condoms, and no financing to purchase contraceptives for target groups<sup>8</sup>.

Numerous policies exist to regulate delivery of family planning services and products, but it is important to understand how these policies can be operationalized. Although the following sections refer to established policies, it is not yet clear whether the policies are operationalized, and whether they enhance or hinder contraceptive security; an in-depth legal and regulatory barriers analysis will be needed to understand the impact of these policies.

### **Policies affecting contraceptive quality**

Quality of contraceptives is regulated through a number of legislative and regulatory documents, the most relevant of which are summarized below:

- "Substances and chemical substances...are subject to sanitary-hygienic expertise"<sup>9</sup>;

- Imported medications can be registered in Ukraine on the condition that a quality certificate from the manufacturer is available<sup>10</sup>;
- Imported medicines (including contraceptives) are subject to state inspection for quality control<sup>11</sup>;
- All medicines (including contraceptives) are subject to control of quality, safety and production<sup>12</sup>;
- There is a need to enhance the effectiveness of state regulation in the provision of medications and health products for the population<sup>13</sup>;
- Medical equipment and products can be registered based on approval by the state<sup>14</sup>;
- An interdepartmental database has been established for medications registered in Ukraine in order to regulate quality, safety, and production of medication, including contraceptives<sup>15</sup>;
- Importation of donated medications is classified as humanitarian aid and is subject to approval by customs<sup>16</sup>.
- Regulation of the private sector's involvement in sales of contraceptive commodities is done through licenses to carry out medical practice and sell retail health products<sup>17</sup>.
- NGOs act on their own statutes that must not contradict the healthcare legislation<sup>18</sup>.
- An MOH order #582 (12.15.2003), "On approving clinical protocols on obstetric and gynecological care," approves a clinical protocol on family planning, which is based on an individual approach to addressing FP issues and to prevent unintended pregnancy and STIs.

### **Policies and barriers affecting access and choice of services and products**

- The need for a prescription hinders access. Contraceptives require a prescription, with the exception of some methods included in the list of medications permitted for use in Ukraine and issued without prescription at pharmacies and pharmaceutical kiosks (for example, Diane-35, Logeisti, Mercilon, Pharmatexks and Patentexks). This restricts access since only physicians are authorized to write prescriptions.
- The need for informed consent hinders access for adolescents. The use of hormonal contraceptives is considered to be a medical intervention<sup>19</sup>, and informed consent is required for a medical intervention to be used<sup>20</sup>. For persons under 15, a medical intervention is impossible without the consent of their parents or other legal proxies, thereby limiting access to contraceptives for adolescents.
- Laws governing provider responsibilities hinders access in rural areas. For women in rural areas, some types of contraceptives are less accessible than for

women living in urban areas. To have an IUD inserted, women in rural areas (where there is no Ob-Gyn) have to go to a hospital in another populated locality where such a specialist is available (family physicians, feldsher, and midwives do not provide such services). The same goes for hormonal contraceptives that are issued by prescription.

- Categorization of pills contributes to negative attitudes about oral contraceptives and other methods. The categorization of pills as substances with carcinogenic properties has contributed to a poor understanding of oral contraceptives and a fear of side effects<sup>21</sup>.
- Lack of funding to procure contraceptives locally hinders access. The inclusion of contraceptives on the essential drug list makes it possible to plan local budgets for contraceptive commodities according to the needs determined by regional FP centers. However, due to resource constraints contraceptives are not procured.

Orders that would enhance access to services and products if they are operationalized include the following:

- A cabinet's directive and MOH order mandate that the pharmacy network have a required mix of medications, including contraceptives<sup>22</sup>.
- The MOH order #503 (12.29.2002), "On improving outpatient obstetric-gynecological care in Ukraine," mandates that at level 1 of the FP system family physician positions be created at health facilities with FP functions, as a way of improving access to FP services. The order also mandates post-abortion counseling on FP issues, and individual selection of contraceptive methods at women's consultations or at the gynecology department in accordance with Who requirements.
- The MOH Order #620 (12.29.2003), "On the organization of inpatient obstetric-gynecological and neonatological care in Ukraine," requires that upon discharge from the obstetric post-abortion care inpatient setting a specific method of contraception is disbursed.
- Order #641/84 of the MOH and Academy of Medical sciences of Ukraine (12.31.2003), "On improving medico-genetic care in Ukraine," mandates to include FP functions in the medical genetics activity of health facilities, specifically, preconception preparation for pregnancy, and examination of future married couples for medico-genetic pathology.

### **Tax and customs regulation of the contraceptive market**

The tax and customs regulations are favorable for importation and local production of contraceptives, making them less expensive than if they were subject to import duties, taxes and VAT. The exception to this is condoms. The following is a summary of the import taxes and regulations:

- Although hormonals and spermicides are imported duty-free, condoms incur incentive and import duty rates of 5 and 10 percent respectively<sup>23</sup>.
- Medications and health products that are legally registered in Ukraine are exempt from tax (including services provision by pharmacies)<sup>24</sup>. Health services provided by facilities licensed to provide such services are also exempt from taxes.
- Humanitarian aid goods are exempt from import duty in money or in kind (on medications that are legally registered in Ukraine)<sup>25</sup>.
- Oral contraceptives and IUDs can be sold VAT-free<sup>26</sup>.

### **Policies affecting demand for RH commodities**

According to pharmaceutical companies, the lack of information on modern methods and high prices of contraceptives hinder use of contraceptives. Changes in legislation and operational policies that encourage adequate financing of contraceptives, upgrading of provider skills, and improvements in quality will have an impact on use in the public and private sector.

The law prohibiting advertisements of prescription drugs restricts awareness-raising activities through brand advertising, which includes contraceptives<sup>27</sup>. The pharmaceutical sector does most of their advertising of prescription drugs through medical providers so it is up to medical providers to pass on this information to FP clients. In contrast, there are no restrictions on the advertisement of condoms or other mechanical contraceptives in Ukraine's legislation.

### **Procedure of licensing the activity of the contraceptive distribution system**

The following regulations govern the process of licensing for the contraceptive distribution system:

- Medications are sold wholesale and retail based on licenses issued to business entities in accordance with legislation<sup>28</sup>. It is prohibited to sell wholesale or retail medications without a license.
- When Ob-Gyns are licensed, FP issues are included in the general package of obstetric-gynecological care for physicians working in private health facilities. There are no restrictions on the distribution of contraceptives among the population as long as the contraceptive is registered in Ukraine.
- NGO activities lack regulation in the provision of FP services but regulations demand that new mechanisms be explored and developed to collaborate with public sector facilities. Two orders specify which staff can provide FP services: family physicians, Ob-Gyns, specialists in gynecology for children and adolescents, and midwives can provide counseling on contraceptive methods; only a physician can prescribe a contraceptive method or insert IUDs (MOH order #503 and #620).

- Basic principles of logistics on storage of contraceptives is given to specialists in accordance with a MOH order<sup>29</sup> to ensure that medications are properly stored in pharmacies, pharmacy kiosks, and health facilities. These principles are also covered at regular training seminars conducted jointly by the MOH and UNFPA.

## **Leadership and Commitment**

Contraceptive security cannot be attained without well articulated and strong political commitment and leadership at all levels of government and across a broad range of stakeholders. Despite some operational and regulatory issues, political commitment has grown in Ukraine as indicated by many recent updates to the family planning program:

- Changes to the regulatory framework governing family planning;
- Increases in staff training for FP issues and introduction of FP standards;
- A new National Reproductive Health Program 2006-2010 that addresses the need to promote contraceptive use as an effective method to prevent unintended pregnancy; to implement a strategy that provides free contraceptives to target groups; and to establish domestic contraceptive manufacturing;
- Establishment of juridical entity status at FP centers;
- The addressing of staffing problems in FP structures;
- The additional awareness-raising activities regarding contraceptive use and harmful consequences of abortion, especially in rural areas;
- Attempts to improve access to services and a broader method mix, particularly in rural areas;
- Training for health specialists and pharmacists on the issues of modern contraception methods;
- The building of awareness among managers of regional administrative structures on family planning;
- The allocation of local budget resources for procurement of contraceptives;
- Advocacy and lobbying to garner support and funding from the government for FP/RH activities.

## Coordination

Achieving contraceptive security in a resource constrained environment requires a multiparty, multisectoral, collaborative approach based on joint action planning. The main purpose of the SPARHCS approach is to bring all stakeholders together to develop a multipartner CS strategy. Coordination is required among donors within the government, among programs, and across sectors to support service delivery channels. Such coordination can ensure that the needs of all clients are met and resources are used most efficiently.

Until recently, coordination in Ukraine has been weak. The MOH of Ukraine is the coordinator of FP activities at the national level, and although there is not a great deal of coordination between the public and private sectors, the MOH is interested in establishing linkages of coordination. As the MOH considers contraceptive security issues during the development and approval of program documents related to RH, one suggestion for collaboration is to foster joint CS projects with NGOs and international organizations.

Another suggestion for collaboration is to work together with representatives of pharmaceutical companies who show interest in contraceptive security. General mechanisms for collaboration between the MOH and the private and public sectors include: involvement of leaders in the organization of RH care in awareness-raising campaigns; joint educational projects; development of information materials for the public and healthcare workers; and promoting the involvement of as many specialists as possible in information dissemination activities, etc. Collaboration will ultimately raise the population and health providers' awareness about modern contraceptive methods and help involve the private sector in distributing contraceptive methods—thus increasing the number of contraceptive users.

## Conclusion

The information presented in this working paper illustrates the importance of strengthening the FP service delivery system to raise awareness among the population of CS issues; build the skills and capacity of healthcare providers to disseminate information and effectively counsel on and provide contraceptive methods; improve and implement relevant policies; and review sources of financing.

Ukraine's experience over the last ten years clearly demonstrates the expediency of and need for family planning. In the mid-90s morbidity among children and women of reproductive age, and infant and maternal mortality were much higher than in European countries and began to pose a threat to the sustainable development of the society.

The adverse impact of high abortion rates on maternal and infant mortality is also well known. Annually, approximately 70,000 women in the world die from abortion-related causes, which is 13% of all maternal deaths. In Ukraine this indicator is 11%, due to in large part to the availability of family planning and post abortion care services.

Abortion is not only a cause of poor reproductive health, but also an economic burden for the country and family. The economic impact of FP is becoming more and more important as are abortion and its complications. For example, only one third of the population uses modern contraceptive methods and unmet need for FP is 52 percent. The abortions that occur as a result of this cause significant hardship on families and absorb large amounts of resources and funding available for health, all of which negatively influence the economy.

The economic impact of providing access to contraception for all who need or want it and for the health system provides a strong argument for prioritizing contraceptive security in the government finance policy, and for improving the FP system. Enhancing FP capacity in providers and health facilities will assist Ukraine to meet European standards of care and reproductive health indicators.

Creating adequate conditions through contraceptive security for the population to realize its reproductive function and family planning needs is a guarantee of the preservation and optimal development of forces without which the nation cannot be preserved and reproduced.

Appendix A

Table A-1. Estimated contraceptive failure rates (resulting in pregnancies) in various countries of the world \* (assessment of 1993)

Method	Estimated percentage of failures (ideal use)(%)	Estimated percentage of failures (standard use)(%)	Number of users** (Abs.)	Number of resulting pregnancies in ideal use setting (Abs.)	Number of resulting pregnancies in standard use setting (Abs.)
Female sterilization	0.5	0.5	201 000	1005	1005
Male sterilization	0.1	0.15	41 000	41	62
Injectables	0.3	0.3	26 000	78	78
IUD	0.6	0.8	149 000	894	1192
Pills	0.1	5.0	78 000	78	3900
Condoms	3.0	14.0	51 000	1530	7140
Barrier vaginal methods	6.0	20.0	4000	240	800
Periodic abstinence	3.0	25.0	26 000	780	6500
Withdrawal	4.0	19.0	31 000	1240	5890

Sources: \* T russel (1998) – US estimated data. The failure percentage reflects those women who became pregnant while using a given method during one year.

\*\*WHO population department (2002). Estimated number of married women aged 15–49.

Appendix B: Levels of FP Service Delivery

At level 1 of the FP deliver system, services are provided by contraceptive points based in feldsher-obstetrician and feldsher points, district hospitals and ambulatories. The main objectives of level 1 are to provide the population with information on family planning and methods of preventing unintended pregnancy. Information is provided both individually and through lectures, mass media, and casework.

Currently, providers at Level 1 can counsel on where and when clients can receive medical care and on the use of contraception. At this level, providers conduct classes at educational institutions on sexual education and healthy lifestyles. The creation of "FP counseling rooms," where the main types of contraception are provided, has the potential to increase access to FP services in rural areas. Medical specialists refer women from selected groups to FP rooms to provide them with free contraceptives. Because primary care providers are not authorized to prescribe contraceptives (only physicians are authorized), physicians must be available and have the right skills to prescribe contraceptives and provide information. Lack of training among family physicians on FP issues prevents rural populations from accessing these services and women have to go to rayon centers or to a city FP center to receive medico-consultative care on

issues of contraception. Current approaches to FP service delivery at this level cannot ensure full accessibility and quality, which is evident by high unintended pregnancy rates.

At level 2, FP services are provided at FP rooms in rayon and central rayon hospitals and during city and rayon women's consultations. An expert on FP issues is assigned to every rayon and s/he will provide methodological guidance on preventing unintended pregnancy and training on FP issues for Ob-Gyns, family physicians, physicians of district hospitals and ambulatories, feldshers, midwives, and nurses of FOPs.

Level 3 of the FP service delivery system includes the republican FP center of the Autonomous republic of the Crimea, and oblast, Kyiv, and Sevastopol city FP centers with consulting-diagnostic and inpatient departments. Today such structural subdivisions exist in all 27 regions. The functions of the FP centers are regulated by the MOH and provide outpatient consulting and therapeutic-diagnostic care on problems related to family planning and reproductive health. The centers also provide STI prophylaxis; andrological care; prevention, diagnosis, and treatment services for infertility; and awareness-raising and training among medical, social workers, psychologists, and teachers on the basics of family planning, children's gynecology, sexology, and andrology.

Regional FP centers are responsible for managing organizational-methodological activities of the FP delivery system and other health facilities, including the region's obstetric-gynecologic facilities; introducing modern methods of prophylaxis, diagnostics, and treatment for reproductive tract disorders; upgrading skills of physicians of various specialties and nursing staff in this area; monitoring at-risk pregnant women's health; keeping a register of key RH indicators; collaborating on issues of social protection of the population with the family and youth service representatives, education authorities, state registry offices, law enforcement, and other authorities; carrying out mass media campaigns; working with faith-based organizations on issues of medico-social protection of families' interests and rights regarding reproductive health; and identifying the oblast population's needs for various contraceptives and methods.

At level 4, FP services are provided by the Ukrainian state FP center and the Institute of pediatrics, obstetrics, and gynecology of the Academy of Medical Sciences of Ukraine with the consulting-diagnostic inpatient department for the provision of tertiary care.

The Ukrainian state FP center functions as an organizational-methodological center for FP service delivery on a national level. Also, it develops strategic activities in reproductive health and regulations on improving FP services; introduces international experiences and WHO recommendations; coordinates and interacts with NGOs, international associations, and other stakeholders on family planning; provides high-tech outpatient and inpatient FP/RH services; coordinates scientific developments in reproductive health; analyzes the FP/RH service delivery system and develops activities to address relevant problems; organizes scientific-practical conferences on issues of reproductive health; and develops information-analytical materials for government bodies to outline RH problems and their key factors.

## Appendix C

Table C-1. Primary reasons for not using contraceptives

Reason for not using contraception	Total
Reasons related to pregnancy, fecundity, or sexual activity	66.7
Not sexually active	25.4
Sub fecund	13.5
Pregnant	12.6
Want pregnancy	8.2
Difficult to get pregnant	7.0
Other reasons	33.3
Occasional sex only	8.8
Partner objections	2.7
Fear of side/health effects	2.7
Cost/availability/difficult to use	2.6
Breastfeeding/postpartum	1.9
Doctor will not prescribe	1.6
Haven't bothered	1
Previous side effects	0.6
Religion	0.6
Prefer abortion	0.1
Other	2.6
Don't know	8.2
Total	100

Table C-2. Percentage distribution of primary reason for discontinuing selected contraceptive methods, 1999

Reason for discontinuing method	Oral Contraceptives	IUD	Condoms
Pregnant while using	10.7	9.4	21.0
No sex/relationship ended/can't get pregnant	5.5	2.8	11.3
Wanted better method	3.5	0.9	14.7
Wanted to get pregnant	9.8	8.2	12.9
Inconvenient method	3.2	1.3	5.9
Side effects	12.5	7.2	1.6
Physician's decision	8.6	21.4	3.0
Health concerns	11.9	15.6	1.6
Partner objected	0.9	0.4	11.8
Supply/Cost	7.9	0.2	6.6
Give body a rest	21.2	25.8	3.6
Other	2.3	6.4	3.3
Don't remember	2.1	0.6	2.8
Total	100.0	100.0	100.0
# of contraceptive episodes	517	829	1423

Source: 1999 Ukraine Reproductive Health Survey, Final Report (CDC, 2001).

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## Endnotes

1. For the purpose of this calculation, the percentage of users of traditional methods of contraception does not include users of methods considered to be of very poor or no effectiveness, such as douching and folk methods.
2. Job specifications for physicians are set forth in MOH order #208 (09.20.1993) for Ob-Gyns and child-adolescent gynecologists, "On approving temporary job specifications of doctors/physicians."
3. MOH order #146 (10.23.1991), "On appraisal of nursing staff."
4. MOH order #503 (12.28.2003), "On improving outpatient obstetric-gynecological care in Ukraine"; MOH order #620 (12.29.2003), "On the organization of inpatient obstetric-gynecological and neonatological care in Ukraine"; MOH order #582 (of 12.15.2003), "On approving clinical protocols on obstetric and gynecological care."
5. In accordance with joint order #265/101 (08.01.1997), between the MOH and Ministry of Economy, contraceptives are not included in the list of domestic and import medications and medical products (the prices of which are subject to state regulation).
6. Price of IUDs does not include insertion.
7. Directive #1303 (08.17.1998).
8. Perfect condoms (Lviv oblast, Novoyarivsk) and latex condoms (VISIT UKRAINA, Kyiv).
9. Law of Ukraine #4004-XII (02.24.1994), "On ensuring sanitary and epidemic well-being of the population (Articles 9 and 11)."
10. Law of Ukraine #123/96-BP (04.04.1996), "On medications," (Article 17), provides for the import of medications registered in Ukraine on condition the quality certificate from the manufacturer is available.
11. Law #123/96-BP (04.04.1996), "On medications."
12. MOH orders #229 (09.26.2000) and #486 (10.15.2003).
13. Presidential decree #91 (02.07.2003), "On activities to improve the provision of medications and health products for the population, and enhance the effectiveness of state regulation in this sphere."
14. Directive #1497 (11.09.2004), "On approving the procedure of state registration of medical equipment and products."
15. The procedure of operating this database was approved by order # 224/387 (06.08.2001) of the MOH and state customs service.
16. MOH order #175 (07.22.1999) on the "Procedure of importation of medications to the territory of Ukraine, which are provided as humanitarian aid," and order #510 (07.12.2004) of the state customs service, "On approving the Procedure for the State customs service's inventory of commodities in the Ukrainian classification of commodities of foreign economic activity at the national level."
17. Cabinet's directive #1020 (06.03.1998), "On the procedure of licensing entrepreneurial activity," and an appropriate instruction approved by joint order #III-6/60 (03.22.1996) by the Licensing Chamber of the Ministry of Economy and MOH of Ukraine.
18. The law "On associations of citizens" and the law "On charity and charitable organizations."
19. According to Section One of Article 42 of the healthcare fundamental legislation of Ukraine.
20. According to Article 43 of this fundamental legislation.
21. MOH order #25 (02.07.97) on approving the state hygienic norm, "List of substances, products, production processes, social, and natural factors that are carcinogenic for a human being," includes estrogen-containing oral contraceptives.
22. The Cabinet's directive #1570 (11.17.2004), "On approving rules of sale of medications at pharmacies in order to improve the provision of medications for the population," and MOH order #569 (25.11.2004), "On approving mandatory minimal mix of medications for pharmacies."
23. In accordance with the law of Ukraine (05.21.200) "On customs duty of Ukraine," chemical pharmaceuticals based on hormones and spermicides are imported duty-free. However, since condoms belong to group 40 "Rubber and rubber products" incentive and full import duty rates are incurred.
24. 5.1.7 of Article 5 of the law of Ukraine "On value-added tax."
25. In accordance with the law of Ukraine "On humanitarian aid" and MOH order #873 (of 12.07.2004). "On amendments to order #307 (07.09.97N) of the State Customs Service (annex 6 of order #307 "On approving the Instruction on the procedure of filling out a cargo customs declaration")."
26. The Cabinet of Ministers' directive #1949 (12.17.2003); order #510 (07.12.2004) of the state customs service in pursuance of the customs code of Ukraine; and the Cabinet's directive #1863 (12.12.2002), "On approving the procedure of maintaining the Ukrainian classification of goods of foreign economic activity."
27. In accordance with section 3, article 26 of the law "On medications," and section III of Article 21 of the law "On advertisement."
28. In accordance with the Cabinet's directive #1570 (11.17.2004), "On approving the rules of sale of medications at pharmacies."
29. MOH order #211 (of 05.14.2003), "On amendments to MOH of Ukraine orders."