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ROMANIA: SCALING UP INTEGRATED FAMILY PLANNING SERVICES

A CASE STUDY



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DELIVER

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Abstract

The Romanian Family Health Initiative (RFHI) rapidly expanded access to family planning services and supplies by integrating family planning into primary health care delivery. The program initially focused on reaching rural clients. The clients represented the majority of Romania's poor and had limited access to family planning services, which were located primarily in urban areas. The RFHI used an innovative *Three Pillars Approach* that focuses on creating the following three conditions at the same place and at the same time: (1) training rural family health doctors and nurses at primary health care centers in contraceptive technology and client-centered counseling, (2) contraceptive supplies, and (3) demand creation activities. Between 2001 and 2005, family planning services expanded beyond the 210 urban-based clinics to more than 2,200 primary health care centers in rural communities, representing 80 percent of the country's rural areas. As a result, contraceptive prevalence increased significantly, and there was a concurrent and dramatic decrease in abortion rates.

A number of innovative approaches were essential for the initiative to be successful; the nationwide scale up also resulted in important lessons learned. Because of the clear success of the initiative, USAID asked DELIVER to identify, through this case study, the successful strategies and key steps that can be taken to replicate the success and address some of the challenges that arose during program implementation. These strategies and key steps have been incorporated into guidelines that program managers and policymakers in Eastern Europe and Eurasia can use when facing similar challenges as they expand access to family planning.

A companion case study from the Russian Maternal and Child Health Initiative (MCHI) is also available (Cappa, Laurie, Natalia Vartapetova, Tatyana Makarova, and Polina Flahive. 2007. *Russia: Integrating Family Planning into the Health System: A Case Study of the Maternal and Child Health Initiative*. Arlington, Va.: DELIVER, for the U.S. Agency for International Development). The study offers a complementary approach to the rural-focused, family doctor-based strategy used by RFHI. The MCHI approach, which focused on integrating family planning counseling and services, especially for postpartum and post-abortion clients, into multiple project components (also including antenatal care, family-centered maternity care, essential newborn care, and exclusive breastfeeding), was introduced into almost 200 urban-based facilities in 16 of Russia's 89 regions.

DELIVER

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ACRONYMS

BCC	behavior change communication
BPS	basic package of services
CPR	contraceptive prevalence rate
DPHA	District Public Health Authority
FP	family planning
GOR	Government of Romania
IEC	information, education, and communication
ILO	International Labor Organization
IMCC	Institute of Mother and Child Care
IPC	interpersonal communication
IUD	intrauterine device
JSI	John Snow, Inc.
LMIS	logistics management information system
MCH	mother and child health
MCHI	Maternal and Child Health Initiative (Russia)
MOPH	Ministry of Public Health (formerly Ministry of Health and Family, and Ministry of Health)
MOU	Memorandum of Understanding
M&E	monitoring and evaluation
NHIH	National Health Insurance House
NGO	nongovernmental organization
OB/GYN	obstetrician/gynecologist
PHC	primary health care
PMU	program management unit
RFHI	Romanian Family Health Initiative
SRH	sexual and reproductive health
RHS	Reproductive Health Survey
SECS	Society for Education on Contraception and Sexuality
STI	sexually transmitted infection
TASC	technical assistance and support contract
TFR	total fertility rate

UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization
WRA	women of reproductive age
WRHI	Women's Reproductive Health Initiative

ACKNOWLEDGMENTS

This case study is the result of collaboration and support from many people and institutions. Harriet Destler, Health Team Leader for the Bureau of Europe and Eurasia, at the U.S. Agency for International Development (USAID) in Washington, DC, initiated the study. She recognized the importance of sharing the achievements and lessons learned from the Romania project, and she provided funding to support the case study. The DELIVER project provided the resources to research, write, edit, and publish the report; while the dedicated staff of the Romanian Family Health Initiative (RFHI), the Society for Education on Contraception and Sexuality (SECS), with many program managers, providers, and clients in Romania, provided invaluable input and guidance to the authors.

The authors thank Cate Johnson, Gabriela Paleru, and Alina Panait of USAID/Romania for their long-time support of the RFHI and for their enthusiastic encouragement for the case study. We extend special thanks to Patricia Mihăescu, Irina Dinca, Narcisa Murgea, Cornelia Maior, and Rodica Teodoroiu of John Snow, Inc. (JSI); and Borbala Koo and Nicolae Tarba of SECS, for their tireless assistance and gracious hospitality during the in-country research phase.

We thank the many stakeholders who gave freely of their time to meet with us. They provided insightful and candid perspectives. Taken together, they gave us the breadth and depth of information to substantiate the achievements and lessons learned and to support the guidelines presented in this case study. See appendix B for a complete list of stakeholders interviewed. We hope the stakeholders will recognize their contributions in the following pages.

The support of the Government of Romania through the Ministry of Public Health (MOPH) and the District Health Authorities has been the determining factor in the implementation and success of the national family planning program. Their partnership has been invaluable.

Last, but not least, we thank the many people in Romania for the kindnesses extended to us during our stay in their country.

EXECUTIVE SUMMARY

In the 1990s, access to family planning was primarily available in the urban areas of Romania. Abortion was the most widespread method of birth spacing and fertility control. In 2001, the U.S. Agency for International Development (USAID) contracted JSI Research & Training Institute, Inc., to implement the Romanian Family Health Initiative (RFHI) with the goal of scaling up integrated family planning nationwide, focusing on rural areas. The initiative was also tasked with improving district and central-level capacities in planning and management, service provider training, revising family planning policies, developing an effective logistics management information system (LMIS) for targeted free contraceptives, and implementing behavior change activities.

Romania is divided into 42 *județe* or administrative districts. To date, the RFHI has expanded integrated family planning coverage to 34 districts, and has collaborated with the United Nations Population Fund (UNFPA) to reach the remaining eight districts. It has strengthened district and central-level management and service provision; developed an effective LMIS; created information, education, and communication (IEC) materials; and funded behavior change campaigns.

Surveys have shown significant improvements in rural contraceptive use; the 2004 Reproductive Health Survey (RHS) in Romania showed that the modern contraceptive prevalence rate (CPR) in rural areas increased among women of reproductive age (WRA) in union from 20.9 percent in 1999 to 33 percent in 2004. This correlates to the total abortion rate (the number of abortions a woman has during her lifetime) in rural areas, which decreased from 2.4 abortions per WRA in 1999 to 1.06 in 2004. The total fertility rate (TFR) has remained relatively unchanged (1.8 in 1999 versus 1.7 in 2004) for rural women. There was a similar trend nationally. Modern CPR increased from 29.5 percent in 1999 to 38.2 percent, while the abortion rate declined from 2.2 to 0.8 in the same period; TFR remained stable at 1.3.

BUILDING ON THE EXPERIENCE OF A PILOT PROGRAM

To scale up the integration of family planning into the primary health care (PHC) services nationwide, RFHI built on the experiences and lessons learned from the Women's Reproductive Health Initiative, a two-year pilot program implemented by John Snow, Inc., from 1999 to 2001, under the Maternal and Child Health Technical Assistance and Support (JSI/TASC) contract. This innovative pilot program introduced the provision of family planning as an integrated component of PHC in 36 PHC clinics in three districts. The approaches or strategies used to develop the model clinics under the pilot program proved to be extremely successful. Findings from the evaluation of the pilot, *Romania: The Women's Reproductive Health Initiative: Building toward Sustainability*,¹ were disseminated by participating health providers and local authorities. They showed important advantages over the existing practices—only obstetrician/gynecologists and family planning doctors in urban-based clinics were allowed to provide contraception—including increased access for rural populations, lower rates of contraceptive discontinuity, and a decrease in abortion rates. Key policymakers were convinced to support the changes required to scale up the program based on these findings and the knowledge that the existing system of specialized family planning clinics were not meeting the needs of rural populations; there is sound evidence that the PHC-based approach was used successfully in Western Europe and the United States.

¹ Cappa, Laurie. 2002. *Romania: The Women's Reproductive Health Initiative: Building toward Sustainability*. Bucharest, Romania: John Snow, Inc./TASC.

In addition, the lessons learned provided invaluable information for mobilizing resources for national scale up and for developing the subsequent scale up strategy for a nationwide PHC-based family planning program.

STRATEGIC APPROACHES IN THE SCALE UP PROCESS

Using the RFHI implemented its scale up strategy in two stages, initially targeting 10 out of the 42 districts. One year later, it was expanded nationwide. The strategy addressed the most critical challenges for furthering Romanian health reform, using the following approaches:

1. *Creating a policy environment favorable to family planning-primary health care integration.* To scale up and institutionalize the innovations tested and evaluated in the pilot sites, policies were changed or augmented with regulations, norms, standards, and protocols. This was accomplished through a national steering committee and multi-sectoral working groups with broad representation.
2. *Implementing a multi-sectoral approach.* Health reforms involving the integration of services and the decentralization of health management provided opportunities and challenges for family planning expansion that could only be met by coordinating stakeholders at the local level. Multi-sectoral working groups were established at the local level to ensure local needs were being addressed.
3. *Coordinating program implementation using a Three Pillars Approach.* At the center of RFHI's strategy is the Three Pillars Approach, which focuses on creating the following three conditions at the same place and at the same time: (1) a trained provider, (2) contraceptive supplies, and (3) demand creation activities.
4. *Training health care professionals and conducting supportive supervision.* To address the technical complexity of scaling up with limited local training and supervision capacity, a training of trainers approach was adopted. Trainers were identified in each district and curricula were developed for patient counseling in contraceptive technology, in using the LMIS to maintain supplies of contraceptives, and in using IEC materials and service promotion tools. Representatives from district public health authorities were teamed with nongovernmental organization (NGO) partners and equipped with tools to strengthen supportive supervision.
5. *Providing and targeting free contraceptives.* Ninety percent of Romania's poor live in rural areas; they have limited access to contraceptives in their communities. Therefore, eligibility for free contraceptives was expanded to include all rural clients that could receive contraceptive supplies directly from their primary health care center.
6. *Developing and implementing an LMIS.* To ensure the availability of free-of-charge contraceptives at PHC centers, a three-tiered² national *pull* logistics system was designed, and included an LMIS tailored to local needs but coordinated at the district level. Provider training in the LMIS proved crucial to its implementation.
7. *Operationalizing the IEC/behavior change communication (IEC/BCC) pillar.* Decentralized health management required local rather than donor-driven IEC activities managed by local stakeholders; local IEC/BCC working groups were formed in each district, and primary care providers were given IEC materials and trained to use service promotion tools and techniques. This, with support from the Ministry of Public Health (MOPH) health promotion staff that had also received training, resulted in the development of innovative local marketing efforts and materials.

² The three tiers of the logistics system are the central level, district level, and clinic level.

8. *Providing technical assistance at the central level.* The MOPH had a limited ability to provide supervision, monitoring, and evaluation and performance improvement support to local health managers. Therefore, a program management unit (PMU) was established at the Institute for Mother and Child Care; it was given technical assistance and training to manage the national program and to support district program managers.
9. *Assessing and strengthening managerial capacity at the district level.* Decentralization resulted in greater local responsibility for health management, but local management capacity was limited. District public health authorities' (DPHA) management capacity was strengthened through technical assistance from RFHI's NGO partner, SECS; multi-sectoral district maternal and child health commissions were established to support DPHAs in planning, budgeting, monitoring and evaluation, resource mobilization and allocation, and other critical areas.

The impact of the RFHI has been significant. The integration of family planning into more than 80 percent of the primary health care services nationally has dramatically increased access to contraceptives—by 40 percent between 1999 and 2004. This has contributed to a drastic reduction in the rate of abortion by more than 260 percent during the same period, with a concomitant reduction in the rate of maternal mortality due to abortion of nearly 37 percent. Quality services are available in most rural communities now that family health doctors have the authority, updated knowledge, and supplies they need to provide quality, client-centered family planning services. Free contraceptives are available for clients who cannot afford to pay for them, while the vibrant private sector continues to grow and meet the needs of people who are able to buy their supplies. With the improvements in counseling and access to a wide variety of information, clients can make well-informed choices about their family planning options.

In addition to continuing to expand the reach of the program to the remaining 20 percent of rural PHC clinics that lack family planning services, as well as to Roma and other disadvantaged communities, the RFHI is now focusing on improving the knowledge and skills of providers at urban family planning cabinets, as well as at secondary and tertiary facilities, so that referral clients receive quality services at these levels.

INTRODUCTION

This case study presents the story of the USAID-funded Romanian Family Health Initiative (RFHI) from 2001 to 2005, and how it succeeded in expanding access to and use of family planning services and supplies. It presents both the achievements of the program as well as lessons learned during the preceding 1999–2001 pilot program³ and during the scale up phases of the program. The study is intended primarily for program managers, policymakers, donors, and providers of technical assistance in Eastern Europe and Eurasia. Countries in this region share a common legacy of high reliance on (1) abortion as a primary method for fertility control, (2) providers’ reluctance to prescribe or offer modern contraception, (3) highly structured health delivery systems focused on curative services rather than prevention and primary health care, (4) low fertility rates, and (5) high rates of abortion and maternal mortality due to abortions. In most cases, countries in the region are also undergoing dramatic health sector reforms.

Intended as a reference, this case study suggests ways to design and implement similar programs in other countries in the region where health reforms are emphasizing expanded primary health care (PHC) services, particularly in rural areas. Therefore, it not only provides information about the Romania situation and what was done, learned, and accomplished by the RFHI, it also provides a set of guidelines based on the experiences in Romania. The guidelines identify key strategies and steps that were essential to the success of the RFHI effort, and that were the result of lessons learned over the course of implementing the program.

A companion case study from the Russia Maternal and Child Health Initiative (MCHI) is also available;⁴ it offers a complementary approach to the PHC-centered strategy. The MCHI approach focused on integrating evidence-based family planning practices into the existing reproductive health services in 16 regions of the Russian Federation, before expanding to the emerging PHC level.

Included are views from many of the people who were interviewed during the development of the case study, including program managers, service providers, and RFHI implementing partners. By quoting some of them directly, the authors’ give voice to their insights, critiques, and experiences and, thereby, reveal their perceptions of reality.

Serving clients is the ultimate goal of any health program, but too often the voice of the client is lost amid the statistics and descriptions of how a program is implemented. Therefore, this case study also includes personal accounts from a number of clients who agreed to share their stories (appendix A). It is to Maria, Mariana, Lucica, and all their compatriots that this case study is dedicated.

³ The RFHI expanded the successful pilot model of rural clinics providing family planning/reproductive health services through family doctors and nurses implemented under a USAID-funded TASC contract during 1999–2001.

⁴ Cappa, Laurie, Natalia Vartapetova, Tatyana Makarova, and Polina Flahive. 2007. *Russia: Integrating Family Planning into the Health System. A Case Study of the Maternal and Child Health Initiative*. Arlington, Va.: DELIVER, for the U.S. Agency for International Development.

SCALING UP INTEGRATED FAMILY PLANNING SERVICES IN ROMANIA

BACKGROUND

With a population of 22.3 million, Romania is the third most populous country in Central and Eastern Europe. Romanians are almost universally literate (98 percent) and are nearly evenly divided between urban (54 percent) and rural (46 percent) residency. The population includes a number of ethnic minorities, including Hungarian (6.6 percent), Roma (2.5 percent), and other nationalities (1.4 percent).

Since the December 1989 revolution ended nearly 45 years of Communist rule, Romania has undergone profound changes in its economic, political, and social structures. The transition to a democratic civil society with a market economy has been difficult, but the country's progress has resulted in Romania's accession to membership in the European Union in January 2007.

During the 1970s and 1980s, under the Ceaușescu dictatorship, family planning and abortions were highly restricted in Romania as the government pursued a rigidly enforced pro-natalist policy. After the fall of the Ceaușescu regime in 1989, restrictions on family planning and abortion services were lifted. The desire for small family size resulted in low fertility rates, but modern contraceptives were not available or affordable; and there was a dramatic lack of access to family planning (FP) among the poor, particularly those living in rural areas. Abortion was the most widespread method of birth spacing and fertility control, as it was during that time in many countries in Central and Eastern Europe and Eurasia.

“After years when abortions were strictly forbidden,” explained Dr. Alin Stanescu of the Institute for Mother and Child Care, and former Counselor to the Minister of Health, “things simplified a lot for women wanting to resort to an abortion. The procedure itself was very inexpensive at a certain point. All this made it really hard for us to tell them ‘you know it’s a bad thing for you to have an abortion’.... The family planning program was something of a novelty for Romania, since there were no specialized institutions, there was no tradition. Before 1989 such programs were forbidden and, immediately after, in the 1990s we had to resort to the existing services and institutions.”

In the late 1990s, the ongoing process of Romanian health reform introduced the family health doctor (a general practitioner) as the gatekeeper for the health system. This began the shift from a vertical model based on medical specialists to a primary health care (PHC) system that became widespread throughout Romania. One important feature of the new system is that the providers are not salaried employees of the Ministry of Public Health (MOPH). Instead, they are independent contractors paid by the National Health Insurance House, basically on a capitation basis—based on the number of people in the area served by the family health clinic.

The continuous development of the private sector in the mid-1990s, combined with the development of a government network of 210 family planning cabinets in hospitals and polyclinics in urban areas, led to an improvement in access to modern contraceptives for the urban population and an increase in the modern

contraceptive prevalence rate (CPR) for women of reproductive age in union (from 13.9 percent in 1993 to 29.5 percent in 1999).⁵

Despite this success, problems remained. The incidence of unintended pregnancy, the abortion rate and the maternal mortality due to abortion remained high, and access to modern contraceptives continued to be extremely limited, particularly in rural areas. By 1999, although the large new cadre of providers—family health doctors—was offering a considerable range of services, their role as family planning providers was being questioned. Some felt that legislation and lack of training constrained the ability of the family health doctor to serve the family planning needs of a population that was increasingly reliant on the new family planning services.

PILOT PHASE

The newly created network of primary health care providers (family health doctors and nurses) as gatekeepers of the health system offered an opportunity to test the provision of family planning as an integrated component of primary care services. In 1999–2001, the USAID-funded Women’s Reproductive Health Initiative (WRHI), implemented by John Snow, Inc., under the Maternal and Child Health Technical Assistance and Support Contract (John Snow, Inc./TASC), piloted the integration of family planning services in 36 rural primary health care units in three of Romania’s 42 *județe* or administrative districts. In this innovative project, family health doctors were trained in client-centered counseling and modern contraceptive technology; supplied with contraceptives to distribute free to clients (based on the client’s informed choice); and given information, education, and communication (IEC) materials and service promotion tools to attract new clients for family planning services.

This pilot phase was an essential step in the program because it demonstrated that the PHC system was able to integrate family planning services into the primary health care package without compromising the quality of either family planning or the other services provided. At the beginning of the pilot phase, the MOPH was skeptical that the family health physicians could handle the additional workload of family planning services—an early attempt to train 400 family health physicians under a World Bank program in the mid-1990s had failed to significantly expand access. In addition, there was skepticism within the community of obstetrician/gynecologists (OB/GYNs) that family health doctors would be able to provide quality family planning services. Finally, there was concern among the new cohort of family planning doctors that decentralizing family planning services to the family health centers would take clients away from the existing family planning cabinets, putting the family planning doctors’ jobs at risk. The pilot phase proved that these concerns were unfounded.

Evidence collected from the 36 pilot sites clearly showed that, with minimal training and support, family health doctors were able to provide high-quality counseling services and correctly dispense contraceptives or refer clients to specialist when warranted. The evidence also showed that the majority of clients served by PHC units were additive—they were primarily new adopters. As a result, contraceptive use increased and abortion rates declined in the areas served by the model sites.

This evidence was vital in building a case for scaling-up the integration family planning in PHC services nationwide. But, there was a secondary benefit to the pilot phase. The providers who participated in the pilot program—including OB/GYN and family planning doctors who served as trainers—became champions for changing the existing system. These local champions were very influential in convincing their peers in the OB/GYN community that new policies, standards, and protocols were needed to increase access to family planning. They also helped build and maintain the momentum within the MOPH

⁵ Serbanescu, Florina, Leo Morris, and Mona Marin (editors). 2001. *Reproductive Health Survey Romania, 1999*. Atlanta: Centers for Disease Control and Prevention.

to develop the necessary standards and protocols, with the implementing policies, needed to scale-up the integration of family planning into primary health centers nationwide.

Furthermore, the experience gained in developing the model clinics under the WRHI project provided fundamental findings and lessons learned that informed the strategy for the subsequent scale up phase, presented in this study.

SCALE UP PHASE

The scale up phase of the family planning program has been implemented by the Romanian Family Health Initiative (RFHI), a six-year (2001–2007) U.S.\$19 million partnership between the Romanian Ministry of Health and Family, USAID, and John Snow, Inc. (JSI) Research & Training Institute, Inc. The program is also supported by United Nations Population Fund (UNFPA), which is providing contraceptives and implementing the program in eight districts. The goals of the initiative are to expand and improve equitable access to family planning and other reproductive health (RH) services and to work at the policy and service provision levels to ensure that FP/RH services are fully integrated into the framework of Romanian health reform.

The initial objective of the RFHI was to expand the integrated family planning model to 10 out of the 42 districts. However, in 2002, after less than one year of successful program implementation, the MOPH decided to expand the model nationwide. This decision was made because of a concern about geographical inequities and the need to focus on all of the rural areas. It is important to mention that this request for scaling-up was initiated by the district health authorities, who learned about the achievements of the pilot program from their peers working in the original three districts and in the 10 scale up districts. As a result of the support from the MOPH and the interest of the other donors, UNFPA agreed to implement the integrated family planning program in its eight priority districts, while RFHI implemented the program in the remaining 34 districts.

The scaling up of integrated family planning services through primary care providers has been carefully planned to ensure a balance between quality of care, equity (geographic and socio-economic coverage), and cost efficiency. Special care has been taken to reduce inequalities afflicting the poor and most vulnerable, including minorities. The program has focused on achieving optimal quality and maximum public health impact to meet the national goals and objectives of the family planning program.⁶

In Romania, scaling up has not been simply a replication of key activities in new geographical areas, but rather a challenging exercise to simplify the approach at model sites and strengthen the district level for decentralized management and sustainability of services. The methodology has included the use of a competency model to determine the provider's ability to deliver services and training to strengthen the capacity of primary care providers to provide high-quality client-centered services after being trained.

At the center of RFHI's strategy is the *Three Pillars Approach*, which focuses on creating the following three conditions at the same place and at the same time—

1. trained provider
2. contraceptive supplies
3. demand creation activities.

⁶ Details on goals and objectives of the family planning program are included in the national *Sexual and Reproductive Health Strategy of the Ministry of Health and Family, 2003* at http://www.jsi.com/romania/Docs/MOHStrategy_SRH.pdf.

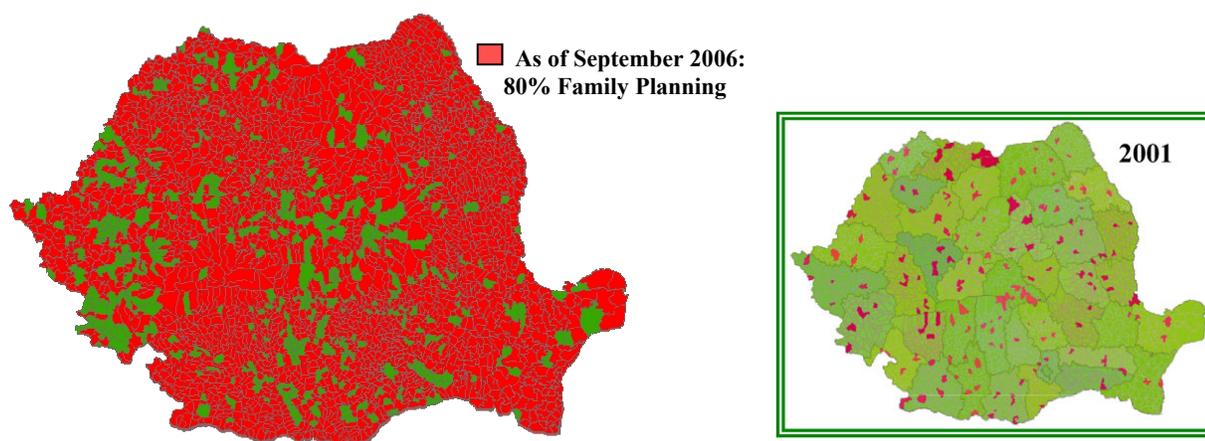
RESULTS

INCREASED ACCESS TO FAMILY PLANNING SERVICES

By September 2006, after five years of implementing the program, more than 5,100 family health doctors and more than 3,000 nurses in 42 districts were trained and are now providing basic family planning services.

Prior to the program, family planning services were not available in rural areas. Currently, Romania has 2,285 *communes* (rural administrative units) with at least one family health doctor trained and providing family planning services and offering free contraceptives. This is 80 percent of the total 2,850 administrative units in rural Romania, and a dramatic change over the situation in 2001 when family planning services were only provided through 210 urban-based family planning clinics located in district or city hospitals and polyclinics (see figure 1).

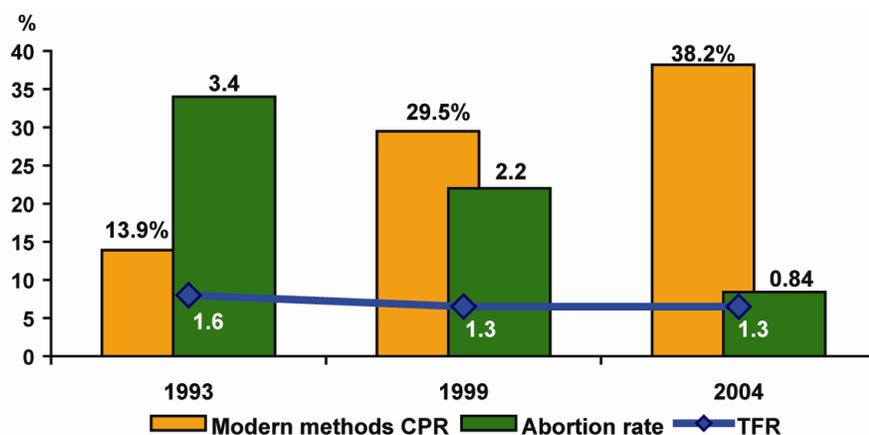
Figure 1. National Coverage with Trained Family Planning Providers, December 2005 Compared to September 2001 (Baseline)



INCREASED USE OF MODERN CONTRACEPTIVES AND DECREASED ABORTIONS

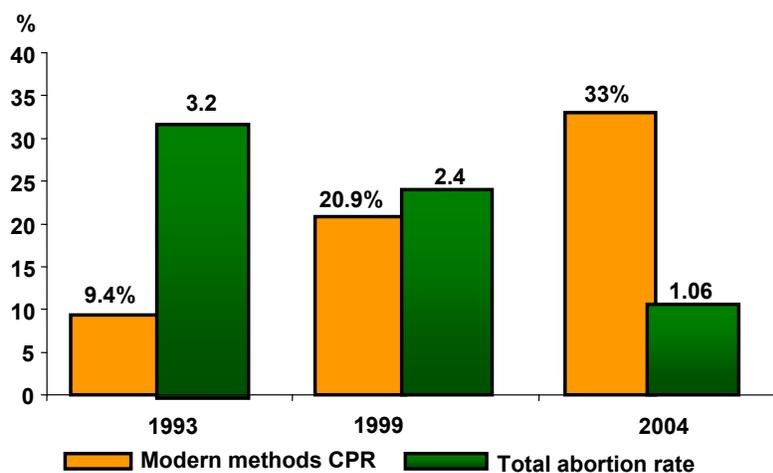
The 2004 Reproductive Health Survey (RHS) conducted in Romania showed a significant increase in CPR among women of reproductive age in union, from 29.5 percent in 1999 to 38.2 percent in 2004, and a decrease in the total abortion rate (number of abortions a woman would have during her lifetime) compared with data provided by the 1993 and 1999 RHS. The total fertility rate remained stable at 1.3 between 1999 and 2004 (see figure 2). In addition, abortion-related maternal mortality decreased 36.8 percent between 1999 (0.19 per 1000 WRA) and 2004 (0.12).

Figure 2. Trends in Contraceptive Prevalence Rate, Total Fertility Rate, and Total Abortion Rate Among Women in Union, 15–44 years (Romania RHS 1993, 1999, 2004)



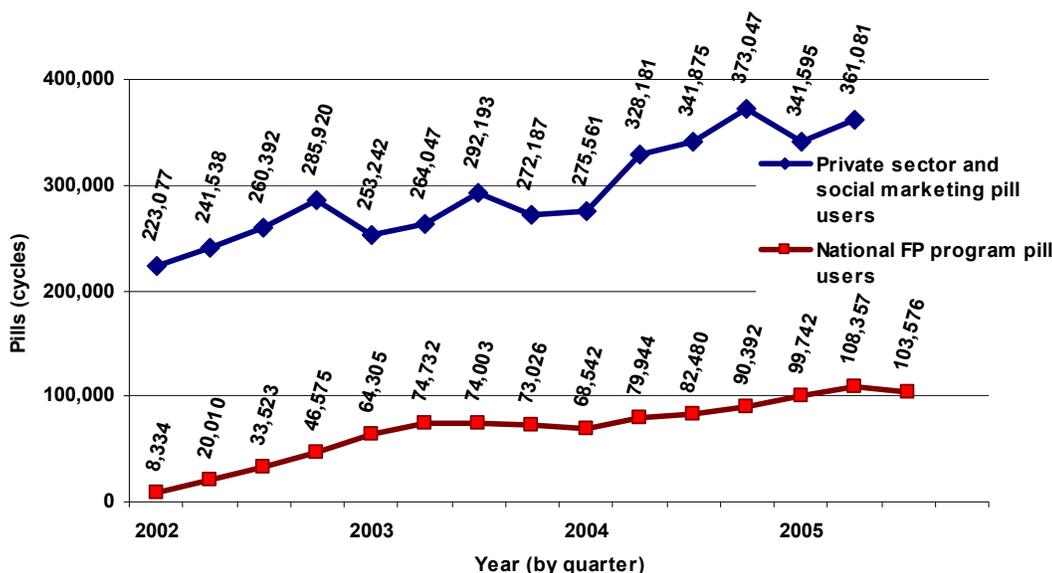
A comparison for rural women showed a substantial increase in contraceptive use among WRA in union of 12 percent over five years (see figure 3).

Figure 3. Trends in Contraceptive Prevalence Rate Among Women in Union, 15–44 Years, and Abortion Rate in Rural Areas (Romania RHS 1993, 1999, 2004)



The provision of free contraceptives has made a significant contribution to increasing CPR and decreasing the rate of abortion; this has been achieved without negatively affecting the private market for contraceptives. As use of free contraceptives has expanded, the private market for contraceptives has also expanded (see figure 4). This phenomenon is due to the halo effect of the IEC/BCC and marketing activities promoting family planning. This trend shows that the strategy of targeting rural clients is working, which is extremely important for the sustainability of the program in Romania. While the government is striving to meet the needs of the poor, it cannot afford to become a majority supplier of free contraceptives. A middle-income country like Romania must ensure that the private sector provides the majority of contraceptives.

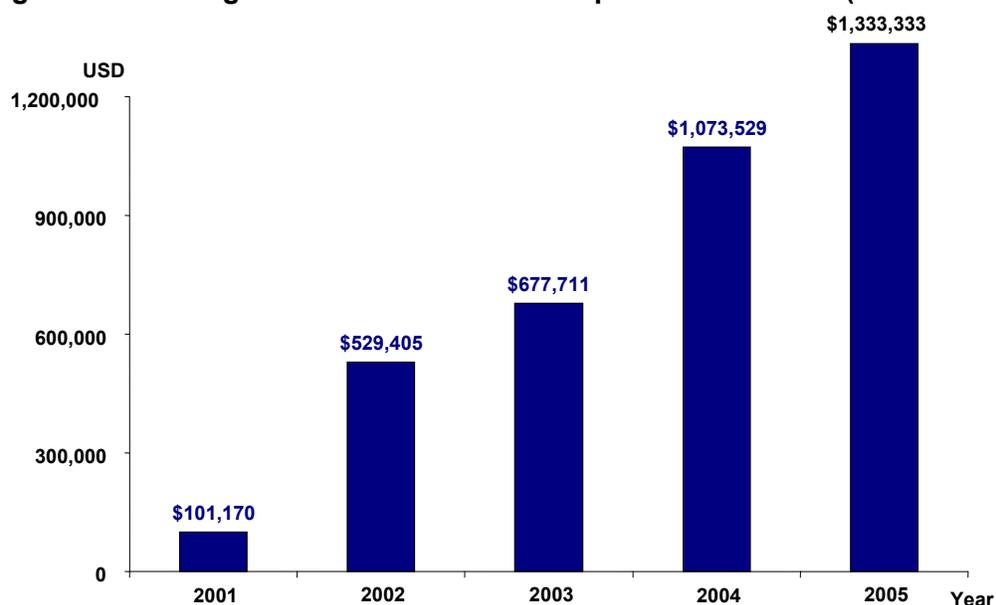
Figure 4. Active Users of Pills from Family Planning Program and Private Sector



INCREASED RESOURCES WITHIN THE HEALTH SYSTEM

By facilitating policy dialogue on the allocation of FP/RH funding and presenting evidence of concrete results, the RFHI has helped address resource mobilization issues within the health system, which includes the MOPH and the National Health Insurance House (NHIH). As a result, the MOPH increased resources allocated for the purchase of contraceptives for the family planning program (see figure 5), from U.S.\$100,000 in 2001 to more than U.S.\$1.3 million in 2005. This is in addition to the significant new investments made by the national and district governments in supporting behavior change campaigns, and funding for the family planning program management unit, the distribution system for free contraceptives, and other hidden program costs. The commitment of the Government of Romania (GOR) has grown as the program has yielded impressive results, which has helped the family planning program gradually gain political support and financial resources. This is particularly notable because Romania, like many middle-income countries, has limited budgetary resources and many competing demands and priorities.

Figure 5. Financing for Public Sector Contraceptive Procurement (Romania MOPH)



Health sector reform has offered other avenues for mobilizing resources. Romania’s national health insurance scheme, established in 1998, now covers 80 percent of the population through payroll contributions. The remaining 20 percent either do not qualify for unemployment benefits, are indigent, or lack proper documentation (such as birth certificates) required for social benefits—as in some cases with Roma. In 2002, family planning services (counseling and free contraceptive method provision, referral or prescription) were included in the basic package of services (BPS) guaranteed to all Romanians, regardless of whether they are enrolled in the national health insurance scheme. The NHIH compensates PHC providers on a per capita basis to provide BPS services to those who are insured and pays the provider a per-service supplement for providing any BPS service to the uninsured. Therefore, family planning services are free to the client regardless of whether she or he is insured. This also gives a monetary incentive to the provider to serve the needs of the uninsured and permits targeting populations that are underserved and uninsured.

STRATEGIC APPROACHES IN SCALE UP PROCESS

To scale-up the integration of family planning into primary health care nationwide, the RFHI built on the experiences, achievements, and challenges uncovered during the pilot work implemented by the WRHI. The RFHI implemented its scale up strategy in two stages, initially targeting 10 out of 42 districts. However, nationwide implementation was driven by the enthusiasm of the MOPH and demand from other districts that had become aware of the benefits and wanted to participate in the program. The scale up strategy addressed some of the most critical challenges for furthering Romanian health reform. Nine specific approaches were used to respond to these challenges (see table 1 for summary).

Table 1. Summary of RFHI's Approaches in Scaling Up Access to Family Planning in Rural Romania

Pilot Program Experience	Challenge Identified	Scale Up Response
1. Policy and management barriers to FP program implementation identified	Champions are needed to advocate for and implement changes to FP policy barriers.	Created an MOU to establish a steering committee between the main partners to prioritize and address policy barriers; worked with providers and program managers from district and local levels.
2. Need to consider integration of FP and primary care services in the context of health sector reform	Health reforms that include integration of services and decentralization of health management provide opportunities and challenges for FP expansion.	To improve local level coordination, established stakeholder working groups to ensure that local needs were being addressed.
3. Need for a strategic approach to link service provision to commodity availability to IEC/BCC	A lesson learned from the pilot phase was that clinics need skilled providers, contraceptive supplies, and IEC/BCC materials to sustain and increase demand.	The Three Pillars strategic approach emphasized the essentials of service provider training, contraceptives, and an LMIS for commodity management, and IEC/BCC campaigns.
4. Need for training of service providers to provide local training capacity and supportive supervision to sustain quality improvements	Technical complexity of scaling-up with limited local training and supervision capacity was an important barrier.	Adopted a training of trainers approach; trainers were identified in each district, and curricula developed for patient counseling in contraceptive technology, and using the LMIS and IEC and service promotion materials. Supervisors are mentored by local NGO partners.
5. Need for providers in rural areas to be able to offer their clients free contraceptives	Ninety percent of Romania's poor live in rural areas, and have limited access to contraceptives in their communities.	PHC clinics provide free contraceptives to all rural clients.
6. LMIS needed to track commodity availability	There was no effective nationwide system that could operate in a decentralized setting to ensure contraceptive availability at the clinic level.	Designed a 3-tiered national <i>pull</i> logistics system with an LMIS tailored to local needs but coordinated at the district level. Provider training for LMIS proved crucial to its implementation.
7. Importance of IEC/BCC activities needed to promote services	With decentralized health management, sustainability requires local rather than donor-driven IEC activities managed by local stakeholders.	Formed an IEC/BCC working group, involved primary care providers, and developed of local innovative marketing efforts. Materials supported by training of MOPH health promotion staff.
8. Need for mechanism to support national program and local managers	The MOPH had a limited ability to provide supervision, monitoring and evaluation, and performance improvement to support local health managers.	Established a program management unit (PMU) at the Institute of Mother and Child Care; staff from PMU supports district program managers.
9. Need for local management capacity crucial to implement program	Decentralized health management has given greater responsibility to the local level, but there were widespread local management weaknesses.	Society for Education on Contraception and Sexuality (SECS) provided technical assistance to the DPHAs to strengthen management capacity. District-level MCH commissions were established to support DPHAs. Regional coordinators from the SECS to facilitated the Mother and Child Health (MCH) commissions' work.

In the following pages, we elaborate on these nine areas of experience in moving from pilot to nationwide implementation of family planning services.

1. STRENGTHEN THE POLICY, LEGAL, MANAGEMENT, AND INFORMATION SYSTEMS ENVIRONMENT

RFHI's overall approach to policy activities was rooted in the idea that policies must, first and foremost, support practical efforts to strengthen service delivery and, therefore, required broad consultation with multiple stakeholders, including providers and program managers from the local district and levels, and representatives from national institutes, the College of Physicians, and nongovernmental organizations (NGOs). This approach ensured that policies were informed by conditions in the field rather than academic studies and theoretical models.

In September 2001, at the end of the WRHI pilot program, a national dissemination conference was held to highlight the achievements of the pilot program and to present evidence that national scale-up would improve access to family planning services, increase contraceptive prevalence, and decrease the abortion rate. However, to scale up and institutionalize the innovations tested and proven in the pilot sites, a supportive policy environment needed to be established. Because of Romania's unique history with family planning, there were no specific policies that prohibited physicians or nurses from providing family planning service. However, few physicians other than OB/GYN and a limited number of family planning doctors were trained to provide these services, and the standards and protocols needed to define provider competencies and referral procedures and to ensure quality services were largely absent. In the absence of training, information, and guidelines, most family health doctors were unwilling to provide family planning services.

To address these policy deficiencies, an effective partnership needed to be established among stakeholders. In November 2001, a Memorandum of Understanding (MOU) was signed between the governments of Romania and the U.S. that launched RFHI and committed both parties to certain guiding principles of cooperation in the health sector. The MOU included a partnership convention that specifically named the MOPH, USAID, and JSI (on behalf of RFHI) as partners and that assigned clear objectives and the roles and responsibilities of each organization.

This partnership agreement was essential to the success of the program because it provided an overarching framework for cooperation and collaboration between the stakeholders (this was particularly important when elections in 2004 resulted in a change of government). The agreement established a steering committee for the program, which included representatives from the three key stakeholders plus ex-officio representatives of civil society. The steering committee was created to provide strategic guidance to program implementation; it proved to be a very useful and functional instrument, especially for dealing with policy issues and for maintaining program momentum. Subcommittees were formed to ensure quality, create standard approaches and norms, and review national contraceptive forecasts and procurement plans.

Through the MOU steering committee, RFHI and its partners were able to prioritize legislation or policy elements that needed to be developed or changed, such as the legislation specifically allowing family health doctors to provide family planning services and contraceptives, and the eligibility criteria for free contraceptives. RFHI also worked closely with other ministries and public institutions and with Romanian NGOs and international agencies to build a consensus on these policy reforms and to ensure a commitment from decision makers. The process took more than two years but, in 2003, resulted in the development and adoption of the National Sexual and Reproductive Health (SRH) strategy by the GOR. The SRH strategy was a critical element in consolidating the program and establishing a supportive policy environment for scaling up in the first 10 districts, as well as for expansion to the remaining districts.

The family planning component of the SRH strategy, which is based on the World Health Organization's (WHO) European SRH strategy, is implemented under National Program #3: Women and Child Health.

This national program is annually approved and budgeted with a specific line in the MOPH's general budget. The national program includes regulations, norms, guidelines, protocols, and ministerial orders that allow trained family health doctors and nurses to provide family planning counseling and contraceptives. Some of the most important policy achievements include—

- New regulations emphasizing the role of trained family health doctors in providing family planning and prenatal care services. These have had a dramatically positive effect in the use of services.
- The MOPH-NHIH annual Framework Contract, which regulates health services provision at all levels of the public system (including primary care), gives the entire population the right to access and use family planning services free of charge, regardless of insurance status. This inclusion is a step forward toward diminishing inequalities in access to services for poor and vulnerable populations.
- New MOPH regulations on health system management, standards, and protocols for family planning service delivery in primary health care, including contraceptive supply distribution and characteristics of the LMIS for free contraceptives.
- The inclusion of the WHO eligibility criteria for modern contraception within Romanian family planning norms for service provision, ensuring the use of evidence-based practices by the national family planning program, and improving the quality of services provided at the PHC level.

Simultaneously, the program addressed management issues, for example, the institutionalization of the district task forces, which are now formalized as district commissions for mother and child health; the quality of the care provided; and the quality of reporting on activities, such as number of free contraceptives dispensed.

The dynamic efforts to develop legislation, standards, protocols, and national management information systems were based on the experience and input from the local level and were combined with the bottom-up approaches that adapted national strategies to local needs and resources. Throughout the process, substantial efforts were made to build institutional capacity, both at the national level in the program management unit (PMU) and at the local level in the DPHA.

Institutionalizing Protocols and Standards for Quality of Care

Although protocols and standards were developed as part of the family planning program, not all programs have them, and there is no national system for monitoring adherence to protocols and standards to ensure quality of care. Fortunately, this need is recognized. “Until now, only the national college of physicians has been involved in quality of care,” said Dr. Gabriela Cristișor, who was the coordinator of the Mother and Child Care Program from 2001 to 2005 and is now with the National Health Insurance House. “But this year, with the new legislative package, we’re trying to involve the National Health Insurance House in quality of care and in accreditation of the providers. We are working out the protocols and standards for the quality of care for each type of service—family health doctors, ambulatory, hospital, home-based care. It’s a big step. We’re trying to implement protocols for services for which we pay, and for other national health programs—cancer, HIV, post-transplant, etc.”

2. IMPLEMENT A MULTI-SECTORAL APPROACH

The RFHI used an approach to reproductive health and family planning services that was designed by a wide range of stakeholders and forms a comprehensive national strategy. The program strategy promotes not only coordination among partners but also the functional integration of services. It is aimed at delivering services to the entire population through family health doctors at primary care centers. After the assessment of the pilot sites confirmed the effectiveness of this innovative approach in providing family planning services, the Romanian partners recognized the need to begin coordinating their efforts

through a stakeholders' working group. This coordination allowed the MOPH, donors, NGOs, and other implementing partners to identify key service availability gaps and issues and to improve coordination and collaboration.

This approach was central to the development of supportive policies and legislation, standards, and protocols, which culminated with the approval of the SRH strategy in 2003. The strategy, which reflected the experience accumulated during the first years of the family planning program, was developed through a series of multisectoral working groups—for strategy, training, LMIS, and IEC/BCC—acting as consultative committees, and through national conferences that allowed policy dialog and participatory consensus building among multiple partners. This participatory approach among stakeholders was the most important factor in achieving policy improvements.

Furthermore, by strengthening and empowering district authorities to manage the family planning program, districts are able to tailor or add new services that meet the specific needs of their people.

3. COORDINATE PROGRAM IMPLEMENTATION USING THE THREE PILLARS APPROACH

One of the most important lessons learned during the pilot phase implemented under the WRHI was the need to ensure that clinics had the skilled providers, contraceptive supplies, and IEC and promotional materials they needed to sustain and increase demand. Competency-based training curricula had to be developed to give providers the knowledge about contraceptive technology and the interpersonal communication skills they needed to counsel clients effectively. Free contraceptives were needed at the PHC clinics to improve access for the rural poor; and a contraceptive supply chain with an effective, user-friendly LMIS needed to be designed to ensure that a reliable supply of contraceptives was always available at the clinics. Information, education, and communication materials, behavior change communication (BCC) approaches, and service promotion tools needed to be developed and tested. This combination of program elements became known as the Three Pillars Approach.

After the training curricula, the LMIS, and the IEC/BCC messages, channels and materials were tested and made ready to roll out. Providers were trained not only on contraceptive technology and counseling, but also on how to use the LMIS and manage their contraceptive supplies, and to use IEC/BCC materials and techniques to build demand for family planning services in their communities. The timing of district and national IEC/BCC campaigns was coordinated with the training schedule to ensure that BCC activities did not build demand in areas where the providers were not yet trained or supplied.

Appropriate regulations were often lacking to support elements of the Three Pillars Approach within the local health care system, so RFHI and its partners worked to develop or revise regulations into a favorable framework that facilitated a smoother program implementation. The convergence of the Three Pillars Approach was essential to the program's success and was constantly monitored through the LMIS, which provided reliable data on contraceptive consumption at each facility.

The impact of the Three Pillars Approach was significant. As Dr. Stanescu explained, “Before, when you just wrote [a client] a prescription, she would go to the drugstore and, if she didn't find the necessary medicines and got pregnant, she would either remain pregnant or have an abortion. But now, when you give her counseling and you also give her the contraceptives, there is definitely a higher percentage of women who will actually take them. And when women realized that this method helped them have a sexual life without fear and without stress, they would return for more and, of course, they were 'hooked' on the program.”

4. CONDUCT TRAINING OF TRAINERS AND PROVIDERS, AND SUPPORT SUPERVISION

During the program planning phase, the technical complexity of scaling-up and the lack of capacity at the local level became clear. One of the primary constraints identified during the assessment was the lack of training capacity and trained human resources.

Therefore, RFHI and its partners decided to build in local training capacity by conducting a training of trainers, thereby ensuring that all districts had at least one FP/RH trainer. After the trainers had been trained, this approach allowed further decentralization of training activities including the selection of health professionals to be trained in each district and the implementation of supportive supervision.

After the program was launched, the RFHI and its key partners rapidly provided training to 54 new district trainers, who trained district-level health professionals selected by the DPHA. Training included client counseling in family planning; contraceptive technology, including the WHO eligibility criteria for contraceptive provision; management of contraceptive supplies and use of the LMIS; and IEC/BCC and service promotion techniques. Following the training, family health doctors were given their first supply of contraceptives and IEC materials, including the logo to identify their clinics. This comprehensive package resulted from the Three Pillars Approach.

During the WRHI pilot phase, the project had used a complex approach to training that relied on providing high-quality FP/RH training in model sites. JSI developed a comprehensive FP/RH service provision curriculum, including service management and marketing, which was reviewed and updated by a small group of national trainers under RFHI. Participants were brought to more centralized training venues during the initial phase of RFHI.

In the subsequent national scale up phase, this methodology was changed to allow participant training at sites close to the clinics in each district, usually organized at the headquarters of district public health authorities. A cohort of 80 physicians—mainly family planning doctors—working in district family planning cabinets or referral clinics were trained as trainers. It is noteworthy that this approach decreased the expense of the training by organizing non-residential training and using the existing infrastructures of the RFHI partners—mainly meeting rooms of the DPHA or the local college of physicians. This decentralized approach enabled more providers to be trained while spending less time away from their clinics. It also transferred new training skills—particularly in participatory training methodology—to district trainers, who were accredited as trainers by the post-graduate Institute for Training Health Professionals. The combination of training skills and official accreditation has enabled these trainers to provide effective training in other subjects. Enthusiasm for the trainings was so high that many doctors funded their own transportation to subsequent seminars.

“We went to college in a period when it was strictly prohibited to mention any contraceptive measures,” said Elvira Marinciuc, a family health doctor at the Prundu Bârgăului primary health center. “From a medical point of view, information was quite scarce. Therefore, the course was more than welcomed. The accumulation of knowledge gave us more self-confidence and helped us better communicate with women patients.”

Supportive supervision was an important component in the training design. During the WRHI project, the supportive supervision visits to providers proved to be very useful in improving the management of newly introduced services and in assessing the needs of providers for follow-up training.

Under RFHI, this activity continued. However, the roll-out of the family planning training activities and free contraceptive distribution in all 42 districts in Romania, and the high number of newly trained providers every quarter, made it difficult to ensure periodic supervision to all providers included in the program. Therefore, the supervision visits became a problem-solving intervention employed to identify, assess, and address possible dysfunctions in program implementation at the provider level and to provide on-site and in-service technical assistance for trained providers distributing free contraceptives. The LMIS was an essential tool in identifying clinics that were under-performing, not reporting, or not using the LMIS reports correctly. A standard supervision visit methodology and checklist was developed, and used by a collaborative team that included staff from the DPHA and the Society for Education on Contraception and Sexuality (SECS). During supervision visits, the team would evaluate the quality of

family planning services, monitor the availability and visibility of IEC/BCC materials (logo and posters), and assess the implementation and functioning of the logistics system for free contraceptives, including accuracy and timeliness of reporting, availability and correct use of LMIS forms, and appropriateness of contraceptives storage.

5. PROVIDE AND TARGET FREE CONTRACEPTIVES

During the WRHI pilot program, one of the pilot districts did not receive contraceptives due to local bureaucratic impediments. All other activities—training, support for promotion of the services, etc.—were implemented in all three pilot districts. This situation, although unplanned, provided an opportunity to compare the results of the clinics providing contraceptives free of charge and those that only provided counseling and information. There were substantially more new users at the clinics providing contraceptives than there were at the second group of clinics that had no free contraceptives to offer. This finding provided critical evidence to support the provision of free contraceptives for eligible clients in the program scale up strategy.

Initially, there were three categories of clients eligible for free contraceptives: (1) the poor, (2) students, and (3) women who had an abortion in a public institution during the previous six months. However, these criteria were difficult to put into practice because of the difficulty of determining whether a client was poor. Because almost 90 percent of the rural population is considered poor (based on the government's own criteria as well as World Bank data), the MOPH decided to make all rural clients eligible to receive contraceptives free of charge. This decision was instrumental to the success of the program.

6. DEVELOP AND IMPLEMENT A LOGISTIC MANAGEMENT INFORMATION SYSTEM

To ensure that free-of-charge contraceptives were always available at the clinic level, a contraceptive logistics management information system (LMIS) had to be developed that would be appropriate to the health system's structure; would be simple enough to be used at the provider, district, and national levels; but also sophisticated enough to manage the contraceptives provided by several different sources (USAID, UNFPA, and eventually from GOR procurements). The system also had to be able to forecast the quantities of each method that would be dispensed by the increasing numbers of doctors and nurses trained and entering into the system in each district. In other words, the challenge was to combine a strong national contraceptive LMIS that could also be used at the district level as a tool for a decentralized management.

Lessons Learned in Logistics and the Logistics Management Information System

While the logistics management information system (LMIS) has been essential in helping to ensure that a reliable supply of contraceptives are available at the clinic, there have been challenges in designing and operating the system. Among the lessons learned is the importance of incorporating training on the LMIS and inventory management into integrated provider training that also includes improved clinical skills, updated information on contraceptive technology, and client counseling. This reinforces the importance of the LMIS—especially the need to adhere to reporting requirements—in providing family planning services and supplies. In addition, supportive supervision must be an explicit part of the design of and training on the system, because the LMIS is only as good as the data it contains.

“We have had some problems,” said Dr. Anca Andritoiu, the program manager for the Bistrița DPHA. “Most participants reported just fine because the courses are very explicit, they all understood what they had to do, they all received cards with calculation instructions. We helped out those who faced reporting difficulties in the beginning, by showing them how to perform the calculations. The result was that the second time their calculations were all right...As for participants that fail to turn in their reports in due time, we don’t supply them with contraceptives until the situation is remedied.”

A national logistics system was designed with one intermediary level—the district—between the national and provider levels, with each level pulling supplies from the next level up the supply chain. An LMIS was developed tailored to local needs and coordinated at the district level to improve contraceptive forecasting, financing, procurement, and distribution at national, district, and provider level. A set of eight forms—consumption records, stockkeeping records, and report and requisition forms—and step-by-step LMIS guides were developed through a participatory process involving stakeholders from each level of the system, and modeled in part on the successful vaccine LMIS at the district level. They were then tested and approved by the MOPH, and the various forms were printed initially with USAID’s support and later from governmental resources. Family health doctors and nurses were trained in how to use and complete the forms. The training in LMIS was integrated into the basic family planning training workshops for providers, which also included client counseling in family planning and modern contraceptive technology. The DPHAs were asked to identify the people responsible for the contraceptive LMIS; those people were trained. The RFHI regional coordinators provided ongoing technical assistance to those people in charge at the district level. In addition, the program supports the introduction of the LMIS at the national level in the PMU, and provides ongoing technical assistance to collect and analyze data coming from the districts and to resupply the districts efficiently. The effort to ensure the quality and consistency of reporting and to promote the use of the data produced by the LMIS was one of the key elements in establishing and maintaining the effectiveness of the logistics system.

The LMIS is now functioning in all districts and, in addition to ensuring reliable distribution of free contraceptives for the eligible population, the use of the LMIS has increased the national capacity to monitor and generate evidence on family planning–related achievements. The quality and reliability of information collected in the LMIS (as compared with the routine health statistics provided by the traditional health information system) made it useful for monitoring and managing other programs that distribute products free to the client, such as vitamin D and iron supplements.

“When I started working in the ministry, I didn’t know what LMIS meant,” said Dr. Cristișor, the former coordinator of the Mother and Child Care Program at the MOPH. “But I developed the capacity to work with the LMIS and to use [the information] for decisions. The LMIS was very helpful for the Ministry of Health to make good decisions. It’s a very credible system.... I was coordinating 18 or 20 programs, and family planning was one of them. A lot of people asked me why the family planning program works, and the others don’t, and [the LMIS] is why; it has easy control.”

7. OPERATIONALIZE THE IEC/BCC PILLAR

One of the main challenges in scaling-up BCC in the family planning program has been the shift from centralized, and in some cases, donor-driven activities, to local implementation of strategies managed by local stakeholders. The BCC strategy has included training and equipping local staff in community-based approaches, interpersonal communication (IPC) activities, and family planning services promotion, developing and disseminating new IEC materials, and establishing a multi-stakeholder IEC/BCC working group.

Initially, primary care providers working in pilot facilities were trained on how to promote their services. With the help of small grants (U.S. \$200–\$450) provided by the project, providers developed their own innovative plans for service promotion (including combinations of community mobilization activities, in-school initiatives, women’s meetings, TV and radio commercials, celebrity spokespersons or RH promoters, posters, brochures, etc.) and implemented outreach activities to target beneficiaries.

These activities were the foundation for the third pillar of the Three Pillars Approach. The IEC/BCC pillar for promoting available family planning services complements the presence of trained providers and the availability of contraceptives supplies at the same time and place. Providers’ contributions in promoting services were later enhanced by the involvement of health promotion staff with the MOPH, which gradually took the lead in managing and implementing IEC/BCC campaigns. The comprehensive and coordinated approach of the BCC work was ensured by the IEC/BCC working group, which coordinates the efforts of the main stakeholders in the field of the reproductive health IEC/BCC activities.

The RFHI has built capacity within different levels of the MOPH to plan and carry out effective health communication programs, developed community-based approaches to changing and maintaining desired health behaviors, and implemented IPC activities.

To support the promotion of FP/RH services, RFHI designed a logo identifying all clinics (rural PHC and urban) where quality family planning services are available and built promotional activities around it (see photograph on this page). The purpose of the logo is not simply to identify clinics that provide family planning services. It also indicates quality. The clinic is staffed by a trained client-centered family planning provider. In addition to the logo, RFHI designed and distributed IEC support materials, produced a six-episode enter-education program that was aired (for free) on national television, and supported the IEC/BCC consultative committee.

Special approaches were designed and implemented to address certain population groups. Starting in 2002, Populations Service International, an RFHI partner, launched the program “Among Us Women,” which reached 160,000 women through 9,500 IPC sessions in 957 factories across the country.



Clinic displays logo so clients know that quality family planning services are available here.

Another innovation was working with the Roma population, estimated to be 1–2 million people in Romania, making it the largest Roma community in any country in Central and Eastern Europe. The health status of Roma is significantly worse than that of the rest of Romania’s population because of a complex set of issues, including poverty, educational status, discrimination and exclusion, and lack of communication between Roma and non-Roma. Therefore, the community needed special outreach that addressed real concerns. The program worked with the MOPH Counselor for Roma, Roma community health centers, and Roma NGOs to train Roma Health Mediators to provide information and referrals for reproductive health to Roma communities. These mediators are hired by the MOPH or local authorities, to facilitate the Roma community members access to health and other social services.

Among the successful IPC innovations for Romania was the pairing of family health doctors with their nurses during provider training—the PHC nurses trained as counselors and community outreach workers. This training leveraged the nurses’ position within the community, because most PHC nurses live in the communities they serve and are seen as trusted friends and neighbors who speak a common language and can influence health seeking behaviors.

8. PROVIDE TECHNICAL ASSISTANCE AT THE CENTRAL LEVEL

The RFHI has provided support to the MOPH centrally, particularly the family planning PMU, in managing family planning services and contraceptive supplies. This support is designed to instill confidence and attract resources to expand the delivery of PHC-based family planning services and improve cost allocations to primary health care from the NHH.

Originally, the PMU was proposed under a World Bank–funded reproductive health and family planning project that created 210 family planning cabinets in urban polyclinics and hospitals in the 1990s. However, it was not established until, under THE RFHI, a small family planning PMU was created within the Institute of Mother and Child Care (IMCC), and charged with day-to-day management of the program. This occurred largely because MOPH officials realized that, to launch a nationwide program to integrate family planning services into primary health care centers, it would need a management unit specifically focused on implementing what the MOPH recognized would be a very complex program.

There are four broad-based national programs—including mother and child care, of which family planning is one of 17 subprograms—but the MOPH is not structured to work on a program basis, and, therefore, lacks the human and other resources needed to implement programs effectively. Program implementation is an added responsibility over and above regular MOPH staff duties. In contrast, the PMU has a small dedicated staff and budget, and is able to focus full time on managing and monitoring the family planning program. This is the only PMU of its kind in the MOPH, but it has been recognized as a model that, in 2006, is being replicated for other MOPH programs.

With technical assistance from RFHI, the PMU implements all policies, ensures quality, handles donor coordination, coordinates with NGOs, conducts monitoring and evaluation, reports to the MOPH, manages the LMIS, conducts forecasts for budgeting and procurement of contraceptive supplies, and develops technical specifications for procurement.

Being housed at the IMCC, which is located outside of the MOPH headquarters building, has been both a benefit and a challenge for the PMU. It has a dedicated budget through the IMCC from the MOPH, a stable staff, and its own facilities, phone lines, etc., but communication and coordination with MOPH officials is more difficult because PMU staff are out of sight and often out of mind. As a result, MOPH officials sometimes make decisions without quality data that the PMU should be providing. This is particularly problematic when advocating within the MOPH for resources to sustain the family planning program. Therefore, the family planning program has been heavily reliant on a small number of influential people, such as Dr. Stanescu, Deputy General Director of the Institute for Mother and Child Care, and former Counselor to the Minister of Health.

9. ASSESS AND STRENGTHEN MANAGERIAL CAPACITY AT THE DISTRICT LEVEL

The family planning program scale up strategy had to accommodate a certain level of program management at the district level. Therefore, RFHI began by conducting a realistic assessment of local management capacity. Weaknesses were identified and managerial capacity at the district level was strengthened by—

- improving management skills of district public health authorities in service planning, budgeting, resource mobilization and allocation, and coordination with local partners
- forming district-level mother and child health (MCH) commissions
- using regional coordinators from one of the RFHI’s NGO partners, the SECS, as MCH commission facilitators
- encouraging DPHAs to work with their MCH commissions to manage the LMIS for free contraceptives, manage the family planning program’s training plan for PHC providers, and coordinate with other health workers, such as the community nurses and the Roma health mediators.

The multi-sectoral District Maternal and Child Health Committee has played an important role in helping to mitigate the burden placed on the DPHAs by decentralization, system fragmentation, and the weakness of the new insurance system. The MCH commissions assist with program planning and, monitoring and analyzing key indicators; as well as facilitate cooperation among government agencies and between the government, NGOs, and the private sector. They have been essential to successfully decentralizing program management, acting as local consultative committees and facilitating the participation of NGOs and local government in FP/RH strategy development and implementation. Their multiple roles and responsibilities include setting local priorities, drafting local implementation plans and annual budgets, providing input for and coordinating activities in the district, monitoring and evaluation, and reporting on the program results. The MCH commissions include a broad array of local stakeholders: the family planning program manager; the chief OB/GYN and chief pediatrician; representatives from the health promotion unit, social services, the health insurance agency, and the local college of physicians; as well as hospital administrators, education officials, and local NGO representatives. This multi-stakeholder forum has resulted in local innovations that adapt the national strategy to local conditions.

The role of SECS in this process was vital, according to Dr. Criștor. “Because the Ministry of Health doesn’t have the capacity to control the program at each level, and SECS has regional coordinators, they sustain the local commission of mother and child health. The regional coordinator from SECS was the key person to get all these people (from the DPHA, college of physicians, social services, education, etc.) together at the same table. And, SECS is another perspective—it’s not Ministry of Health or an international organization that people look at and think ‘oh they are here now, they will help us, but after that they will leave and we will be alone.’ Civil society is another thing. ‘Oh, you are here, you will be here tomorrow, and next year. You are from here.’ That’s why SECS is very important.”

The involvement of SECS as the facilitator of the MCH commissions has provided needed technical assistance and guidance, as well as a respected independent voice that can help moderate intra-governmental friction, particular between the district and central levels.

WHAT WE LEARNED

WHAT WORKED AND BEST PRACTICES

In Romania, geographical scale up of successful primary care clinics that provide family planning services has required innovative and simple solutions, such as the provision of care by family health

doctors. Services must be functionally integrated and the institutional capacity at local and national level must be strengthened. This is what worked:

- The timing of the program was critical, because it leveraged and helped guide ongoing health sector reform. Scale up was accelerated because the national and district governments were supportive and were prepared to adopt new approaches and practices that built on recent reforms, particularly related to decentralization and primary health care.
- Partnership with local NGOs—particularly SECS—has been crucial to the success of the program. SECS is not only an affiliate of International Planned Parenthood Federation providing reproductive health services, it is also adept at community outreach, building networks, and conducting participatory training. As an NGO working in FP/RH in Romania, SECS was an obvious partner for RFHI, as it already had a track record of advocating for policy change, developing IEC materials, and providing evidence-based training and technical assistance. It continues these activities in partnership with RFHI, provides ongoing supervision at the district level, and helps manage the national LMIS for contraceptive distribution. SECS, with a number of other local NGOs, have been able to pilot innovations on a small scale, and which eventually have been used more widely. They have helped ensure the success of the program and now have the capacity to provide sustainable support for these activities.
- Access to modern contraceptives has been an important factor in the success of the program. By ensuring reliable availability of supplies, the national LMIS is a key component of the increased access to modern contraception in Romania.
- A robust monitoring and evaluation plan was included in the original strategic design of the RFHI, which has allowed program managers to quickly identify what was working and what adjustments needed to be made to the scale up process. In particular, the use of Geographic Information Systems mapping technology has been useful in managing, monitoring, and evaluating program scale up.
- Community participation is critical to increasing the demand for and quality of family planning services. Multi-stakeholder district MCH commissions proved to be effective forums for identifying and addressing local health priorities.

Accepted best practices will help strengthen the program:

- A pilot phase is vital in demonstrating new approaches; it builds local evidence that the approaches work, and it helps develop local champions to advocate for policy changes that will support national scale up.
- After receiving adequate training, primary health care providers (family health doctors and nurses) can provide quality family planning services, including counseling to their clients.
- Focusing on providing integrated FP/RH services has worked well; it successfully increased the use of modern contraception and reduced the number of abortions.
- Training should be decentralized and the trainers should be peers of the providers rather than specialists or academics. The training methodology should be participatory and competency-based rather than theoretical and academic.
- Culturally sensitive service promotion is essential for clients to be able to identify primary health care units that provide family planning services; culturally appropriate interventions are needed for specific groups, such as the poor, youth, and Roma communities.

CHALLENGES AND LESSONS LEARNED

Not everything went as planned; some problems arose that could not be foreseen, but they became clear during implementation. For instance, some policy barriers proved insurmountable, vested interests sometimes narrowed options for implementation, and the ongoing process of decentralization resulted in unpredictable changes in management and supervision structures. Some lessons were learned along the way:

- The still-incipient decentralization process, with the lack of fluid communications among the different programs at all levels of the MOPH, reduced the number of IEC/BCC activities; and at times, caused them to be disconnected from the availability of the new services. More focused and intensive BCC activities could help in reaching the most vulnerable populations.
- Technical assistance at national and district levels proved to be a key to scaling up. However, formal program management training for the DPHA, which includes program specifics and is tailored to national regulations, is also necessary.
- The family planning program is focused on family health doctors who provide counseling and contraceptives to *healthy* clients. Many of the family health doctors are reporting difficulties, however, when they refer clients with certain health conditions to the secondary level of care (OB/GYN and other medical specialists) for contraception consultations. This is caused by the lack of updated contraceptive knowledge at the secondary level. To increase the effectiveness of the referral system, the RFHI found that all levels of the health system and a broad array of providers (including pediatricians) should be given updates on modern contraceptive technology and counseling.
- Neither family health doctors nor family planning doctors are allowed to insert intrauterine devices (IUDs), which prevents them from offering any long-term methods. Some have expressed the desire to be trained on IUD insertion. However, this requires changing the existing protocols, which are largely under the control of OB/GYNs, who provide the long-term methods and have a vested interest in maintaining exclusive control over them.
- The method mix needs to be expanded to promote the use of long-term and permanent contraceptive methods. Vasectomies are very rare, and the prevalence of female sterilization is only 2.8 percent (2004 RHS);⁷ partially because of misinformation on the part of both clients and providers, and partially because few providers are trained to perform the procedures, particularly vasectomies. All family planning providers need updated information and training in counseling clients about IUDs, vasectomy, and female sterilization.
- The implementation of ongoing in-service training for providers still depends on support from SECS. SECS is accredited by the College of Physicians to provide in-service training. It takes the lead in organizing training seminars, assists DPHAs in selecting providers to train, and maintains the pool of trainers to ensure quality of content and training methodology. SECS also works closely with district Mother and Child Health inspectors to monitor provider quality and to conduct supportive supervision visits when problems are identified. Although this partnership between the public sector and civil society is worthwhile, its sustainability depends on the NGO securing alternative sources of funding. One avenue currently being pursued is establishing a mechanism (currently lacking) for the MOPH to contract for services with outside firms; if this occurs, SECS could be contracted to continue providing training and supervision, managing the LMIS, providing technical assistance, etc.

⁷ Romanian Ministry of Health, United Nations Population Fund, United Nations Children's Fund, USAID, JSI Research and Training Institute, the Swiss Agency for Development and Cooperation, World Health Organization, and the Institute for Mother and Child Care "Alfred Rusescu" (IMCC). May 2005. *Reproductive Health Survey: Romania, 2004. Summary Report*. Buzău, Romania: n.p.

- Capacity building is needed at the district level for supportive supervision, combined with a monitoring and evaluation mechanism that includes a formal feedback component in the LMIS to address service delivery and logistics deficiencies. Because of the decentralized nature of Romania's healthcare system, some districts have developed effective supervision systems while others are bureaucratic and ineffective. Standard procedures and feedback mechanisms need to be tested and implemented in all districts, and supervisors need to be trained to use them on a regular basis.
- Provider in-service training was not complemented by comparable efforts to develop pre-service training curricula for medical students, which is essential for sustainability. Pre-service curricula development will require buy-in from influential academic OB/GYNs, who still question the ability of general practitioners to provide family planning services. Nonetheless, in 2006 RFHI began collaborating with relevant academic institutions and other organizations to begin developing an integrated family planning curriculum for medical students.
- Integrating contraceptive logistics training into provider training is essential, because the added burden of reporting must be clearly connected to the provision of services. It must also emphasize the benefits to providers of ensuring access to contraceptives—greater ability to meet the needs of their clients, increased job satisfaction, etc.—in addition to the benefit to their clients. In the pilot phase, providers did not receive logistics training at the same time they received technical training, and reporting from this cohort has lagged behind those who received the integrated training.
- Partnership with the private commercial sector needs to be part of the initial program strategy. For RFHI, this was a missed opportunity, although the program did work with pharmaceutical distributors to lower their initial bid prices for the first contraceptive procurement by the GOR. Contraceptive manufacturers and distributors can be partners in a multisectoral program, particularly in market segmentation and IEC/BCC efforts. Market segmentation considers both economic and geographic conditions, and improves the private sector's ability to offer a variety of contraceptive methods at a range of prices to specific segments of the population who are able to pay for family planning supplies and services, while helping public programs to better target free-of-charge contraceptives to the people who most need them. Generic family planning promotion efforts and IEC materials increase demand across all market segments; in Romania, it resulted in increased market share for the private sector. In addition, distributors and manufacturer representatives regularly visit physicians and provide training on a range of topics, but they do not stress contraceptives. By collaborating with the private sector, their strengths can be leveraged to help programs provide information and training, improve access, and target public resources more strategically.
- Primary health care providers working in rural areas are isolated from their peers and need a forum for peer-to-peer interaction and support. Such a forum provides an opportunity to share experiences, learn from each other, and identify common challenges that can be addressed through advocacy for resources or policy change at the district or even national level. PHC providers in the Cluj district have established an innovative provider support group that meets biweekly; it focuses on improving capacity to provide quality services, not just for family planning, but for all primary health services.
- The unfinished health reform in Romania, mainly at the hospital-level, made it extremely difficult to reallocate funds from secondary and tertiary levels to the level of primary care. Experimental approaches to reallocating funds, which include all levels of the system, should be explored. For example, the demonstrated cost-effectiveness of low-cost approaches at the primary care level may shift attention from curative to preventive services, increasing the funds at the PHC level.
- PHC providers are paid by the NHIH on a per capita basis to provide the basic package of services (BPS), which includes family planning. While this has resulted in greater access to family planning services, it has not provided any monetary incentive for the physician to provide those services, except

to the uninsured. But many PHC providers do not understand how the NHIH reimbursement system works, and, therefore, do not know what services or which clients are covered under the BPS. As a result, the uninsured, including many Roma, are turned away, even though they are covered by the BPS and the provider receives a supplemental fee from the NHIH for providing them with services. The NHIH is developing a system for monitoring primary health providers to ensure they are offering all BPS services, with specific penalties for failure. On the other hand, the MOPH is considering direct payments to PHC providers for family planning services as an incentive to support this priority public health program. However, both proposals are still in the development phase.

GUIDELINES FOR REPLICATING A SUCCESS

INTRODUCTION

Key strategies and steps, which are required to replicate the achievements of the Romanian family planning program, were developed during focus group and key informant discussions with the following groups and individuals:

- JSI/Romania staff
- Society for Education on Contraception and Sexuality staff
- Program Management Unit/Institute for Mother and Child Health representatives
- Bistrița District Public Health Authority representative
- National Health Insurance House representative
- family planning service providers in Cluj and Bistrița districts.

While it may appear that some steps are obvious standard operating procedure for any program, the results in Romania were due largely to the correct combination and timing of the approaches, strategies, and activities, as well as to certain innovations applied by the program implementers. In some cases, the innovation itself was the right combination and timing of activities, such as the Three Pillars Approach. Finally, none of this would have been possible without the collaboration, commitment, and creativity of the principal RFHI partners and collaborators: the MOPH, SECS, UNFPA, and the many family planning champions who were already working to improve access to quality family planning services in Romania.

It is also important to note that the scale up of activities in two stages (initially in 10 and later in all 42 districts) was based on an excellent foundation of experience from the pilot phase in Romania, which was conducted in three districts during 1999–2001 under the USAID-funded Women’s Reproductive Health Initiative. This was implemented by JSI in cooperation with SECS and the MOPH. This pilot phase was essential for testing approaches, building evidence for what works, and gaining the trust and confidence of both the program partners and the providers who participated in the program. The second stage of scaling-up that attained national coverage resulted from the demand from both the national and local governments and was built upon lessons learned during the pilot phase and the initial scaling up stage.

The strategies presented here are not necessarily sequential in their implementation—some steps must precede others, some must be concurrent, some cannot be accomplished until some or all strategies have achieved results. Therefore, this is not intended as a checklist for implementation, but as an outline of steps needed; the implementation will depend on local circumstances.

KEY STRATEGIES FOR EXPANDING ACCESS TO FAMILY PLANNING SERVICES

BROADEN THE POOL OF PROVIDERS

The pool of trained family planning service providers can be increased, targeting the service level closest to the clients in the greatest need. The choice of provider will greatly depend on where the people with the greatest unmet need are located, and whether they can afford to pay for services or for transportation to the nearest service delivery point currently offering family planning.

Strategic Steps:

1. Identify the target population most in need of improved access to family planning services and supplies. Conduct formative research that considers both socioeconomic and geographic access.
 - a. Review demographic and health data to identify gaps in coverage.
 - b. Conduct market research to evaluate availability and cost of contraceptive supplies in the commercial, NGO, social marketing, and public sectors, in both rural and urban areas.
 - c. Conduct ability-to-pay analysis to identify economic constraints on client access.
 - d. Review national health insurance policies to determine whether contraceptive services and supplies are covered under the basic package of essential health services (if a package exists).
 - e. Establish criteria for targeting population for free and/or subsidized contraceptives based on the results of the formative research.
2. Segment the market to target free and/or subsidized contraceptives.
 - a. Review existing national/government policies on access to health services for the poor, indigent, vulnerable groups, etc.; determine if family planning services are included in the package of basic services provided to these groups.
 - b. Survey the contraceptive market to determine whether the existing sources of contraceptives meet the needs of all clients; and which sector (commercial, nongovernmental, social marketing, and public) best serves particular types of client (urban or rural; upper, middle, or lower income).
 - c. Target free or subsidized contraceptives to people unable to access contraceptives in the market because of economic or geographic barriers or any additional established criteria (post-abortion, for example).
3. Identify the appropriate level of provider to train in family planning service provision.
 - a. Survey the existing pool of medical/health practitioners at each level of the health system; determine the services each type of practitioner is allowed to provide.

Use the Three Pillars Approach

Success depends on the presence of three program *pillars* at the same place and at the same time:

1. Trained providers.
2. Contraceptive supplies.
3. Demand-creation activities and IEC materials.

Integrate Family Planning into Primary Health Care

If the national system will provide a package of essential services at the primary health level, ensure that family planning is integrated into the primary health care level and included in the essential services package.

- b. Determine the skills required to provide quality services for the most commonly used contraceptive methods.
 - c. Determine what type of provider is most accessible to the largest number of women/couples with unmet need.
 - d. Target the providers with the right skills that provide the greatest access to the largest number of women/couples with unmet need.
4. Expand the pool of providers in a number of pilot sites to test and refine the implementation approach, training materials, supply systems, and IEC/BCC materials and to generate evidence-based recommendations for national scale up.
 - a. Obtain a Ministry of Public Health (MOPH) or equivalent regulatory authority waiver of restrictions on family planning service provision, covering select pilot sites and targeting providers.
 - b. Train a pool of providers in pilot sites in contraceptive technology, client counseling, inventory management and LMIS, and service promotion.
 - c. Provide sites with contraceptive supplies, LMIS forms, and IEC and promotional materials for counseling, informative waiting rooms, and service promotion.
 - d. Conduct community outreach in communities served by the pilot sites to generate awareness of and demand for new services.
 - e. Establish supervision procedures, including checklists and other materials, to monitor quality and provide on-the-job training and technical assistance.
 - f. Identify key indicators that illustrate the impact of the program interventions. Indicators can also serve as evidence that can be used to counter concerns or biases among health/medical professionals and policymakers that hinder national policy change.
 - g. Collect evidence of improved access, acceptable quality of care, and client satisfaction that can be used to advocate for national scale up.

DEVELOP A NATIONAL STRATEGY

Develop a national reproductive health/family planning strategy through a participatory, multi-stakeholder approach. A broad range of stakeholders should be made aware of the evidence resulting from the pilot phase of the program, and then engage in developing a national strategy based on the successes and lessons learned in the pilot phase. These stakeholders should represent different perspectives from the public, private, and NGO sectors. They should include a variety of government agencies, and different levels within each sector, including—

- MOPH policymakers and program managers from a variety of ministry programs
- officials from social services, education, and finance ministries
- representatives from the national health insurance agency
- NGOs working in health, family planning, women’s rights, consumers’ rights, etc.
- national and local parliamentarians and legislators
- experts from institutes of medicine and health, medical universities, and professional organizations

Respect Local Priorities

Allow local stakeholders to define priorities (with guidance from technical assistance providers as needed) to create local/national ownership, rather than *parachuting in* and making recommendations for change.

- district and local health officials
- service providers—physicians, midwives, and nurses—from the public and private sectors
- commercial pharmaceutical companies and pharmacies
- technical assistance providers, donors, United Nations (UN) agencies (WHO, UNFPA, UNICEF, International Labor Organization [ILO], etc.), the World Bank, and others.

The participation of this multi-sectoral, multi-level group of stakeholders will help ensure a comprehensive strategy based on broad consensus and specific evidence, with concrete and achievable objectives that consider available resources and enable the broadest possible reach.

Strategic Steps:

1. Change national policies to allow a broader array of providers to offer family planning services, and to target free or subsidized contraceptives only for those people unable to access contraceptives in the market due to economic or geographic barriers, and based on any additional established criteria (post-abortion clients, for example).

Choose the right time to offer solutions. This requires a realistic assessment of the political climate, the socioeconomic situation in the country, and the larger health context to determine if policy change is feasible. Pay particular attention to the status and pace of health reform in the country. If the environment is conducive for change, it is important to be at the right place, at the right time, to influence health policies; and with the right set of champions/advocates and those empowered to make change. It is also important to allow policy change to start with stakeholders at the grass roots—which includes the local and sub-national levels—rather than being imposed from above.

- a. Disseminate pilot site results by having local partners brief key policymakers, publish papers, and promote results to the news media.
 - b. Organize a national conference that features local stakeholders presenting results to policymakers, opinion leaders, legislators, academicians, educators, journalists, and practitioners from the national and local levels.
 - c. Organize site tours for key policymakers and legislators to meet and speak with providers and their clients and to learn about results first-hand.
 - d. Propose and draft national policies and evidence-based standards to support the national scale up of the program.
2. Establish minimum acceptable levels of competency for providers. This requires input from many stakeholders, including officials from the MOPH; medical professionals at national institutes and medical universities; internationally recognized experts in family planning and reproductive health; medical associations; and NGOs working in family planning or healthcare, and women's, consumers', and/or human rights. The purpose is to develop consensus on how to extend the reach—or quantity—of services while ensuring an acceptable quality of care. While it may not be appropriate for every level of health practitioner to provide all contraceptive methods (e.g., IUDs, implants, surgical methods), the focus should be on expanding access to an adequate method mix based on the most common methods used in the country.

Use Local Champions

Reinforce local ownership, empowerment, and leadership by featuring local stakeholders (providers, local officials, leading academicians, etc.) to present pilot results and international evidence on standards of care. Do not rely on presentations by donors, international consultants, or technical assistance providers.

- a. Conduct a stakeholder workshop to review international standards of care, present different models of care (nurses, midwives, nurse practitioners, physicians assistants, family physicians, etc.), and model protocols.
 - b. Develop a consensus on competencies for different provider levels (nurse, general practitioner, specialists) and the services they can provide.
 - c. Develop protocols and standards of care based on competencies and services.
 - d. Develop and issue regulations to adopt protocols and standards.
 - e. Print protocols and standards, and disseminate to all relevant providers, including information on how providers can attain the required competency for their level.
3. Build capacity to implement the national strategy and policy within the MOPH, at the sub-national level, within NGOs, and among other stakeholders.
 - a. Create and staff a PMU within the MOPH to manage the national implementation of the strategy and national policies, coordinate with donors and other stakeholders, manage the contraceptive logistics system, conduct forecasts of contraceptive needs for budgeting and procurement, develop technical specifications for procurement, monitor and evaluate (M&E) program indicators and impact, and make adjustments based on M&E results.
 - b. Identify and partner with a local organization (NGO, independent academic or training institution, parastatal agency, etc.). Develop and transfer skills to the local organization so they can provide sustainable technical assistance, and empower the organization by funneling technical assistance and funding through it, from the earliest stages of the program. Work with the organization in strategic planning for sustainability and mentor them in seeking additional funding within their community or from outside sources.
 - c. Draft and sign a Memorandum of Understanding (MOU) between the MOPH, relevant donors, the technical assistance provider and partners, NGOs, and other stakeholders to ensure collaboration and cooperation and to define roles and responsibilities.
 - d. Establish an MOU steering committee with broad stakeholder representation to provide strategic guidance, to advise the MOPH, to assist in stakeholder coordination—particularly related to quality assurance and national contraceptive forecasting and procurement—and to provide a mechanism for creating standard approaches and norms. Steering committee members can also help the MOPH advocate for budgetary support for the program.
 - e. Build capacity to manage the program at the sub-national levels that are charged with implementation and to allow opportunities for local innovations to be tested.
 - f. Set up multisectoral, multi-disciplinary teams—coordinating commissions, health committees, or similar—at the local level to help local health authorities conduct program planning and budgeting; to monitor and analyze key indicators; and to facilitate cooperation among government agencies and between the government, NGOs, and the private sector.

Consider Special Needs

It is important to expand access for healthy women through a broader pool of providers, but remember that women with health conditions that limit their contraceptive options also need services. Make sure that protocols and standards consider the needs of these women, and that training and information are available to serve or refer them to the appropriately trained provider.

Institutionalize the Strategy

A Memorandum of Understanding between a broad group of stakeholders facilitates continuity and progress during changes in administrations or governments. It also helps build commitment and cements relationships.

- g. Incorporate a robust system of monitoring and evaluation into the MOPH program, with specific indicators and durable data sources on type and quality of services provided, consumption and stock status of contraceptive methods and IEC materials, and any other relevant data that can be routinely collected and analyzed for decision making. Strategic indicators typically include maternal mortality, contraceptive prevalence, and abortion rates; while program indicators include geographic coverage by trained providers, contraceptive use (couple-years of protection), use and consumption of IEC materials, and implementation of BCC campaigns at the local level.
4. Incorporate family planning services into the essential package of services provided to everyone regardless of ability to pay.
 - a. If there is a national health insurance scheme, negotiate a framework contract with the national insurance agency to include family planning (as well as prenatal care, treatment for sexually transmitted diseases, and other essential reproductive health services) in the BPS.
 - b. Establish standards and protocols for monitoring quality, as well as quantity of services; and determine if all services are being provided as required under the BPS.
5. Include in the program strategy the eventual integration of family planning services into other reproductive and family health services, including maternity and post-abortion care, therapeutic services, pediatric care, sexually transmitted infection (STI) treatment, HIV/AIDS prevention and treatment, etc.

ENSURE PRODUCT AVAILABILITY

Ensure the availability of contraceptive supplies at the service delivery point. An essential element of any health program that relies on commodities for effectiveness is a reliable supply chain that ensures those commodities are available when and where they are needed. This idea of *No Product, No Program* is critical to every family planning programs because the programs cannot succeed without the contraceptives that clients rely on. A robust and effective supply chain must exist to—

- Forecast or estimate how many and what type of contraceptives are needed.
- Finance or mobilize the financial resources needed to procure them.
- Procure quality contraceptives in a timely and cost-effective process.
- Deliver contraceptives consistently to the storage facilities, service delivery points, and ultimately to the clients who need them.

At the heart of this system is an LMIS that provides the data to run the supply chain and to make fundamental program decisions about product selection, budgeting, procurement, etc.

Strategic Steps:

1. Design a basic logistics system and develop an LMIS that collects and reports data on consumption at the service delivery point, stock on hand, and losses and adjustments at the service delivery level, and at any intermediate storage level. Three critical data items must be part of an effective LMIS: the system should be (1) logical, (2) user-friendly, and (3) effective, which means keeping it simple and uncomplicated.

- a. Determine the minimum number of levels needed in the logistics system, including storage facilities at the national, sub-national, and local levels; and how supplies should move through the system.
 - b. Establish standard operating procedures for the logistics system, including push versus pull, inventory management, order intervals, delivery mechanisms, supervision, M&E, and problem resolution.
 - c. Design and test consumption records, report and requisition forms (transaction records), stockkeeping records, and supervisor feedback forms.
 - d. Ensure continuous availability of LMIS forms at all levels, and advocate for adequate funding for additional LMIS supplies and maintenance and updating of LMIS software. Ensure that LMIS forms are included in the MOPH's annual procurement plans.
2. Train providers and program staff on logistics functions, and distribute an initial stock of contraceptives at each level of the system, ensuring adequate buffer stocks and inventory for resupply from higher levels in the system.
 - a. Assign and train dedicated staff to manage the logistics system and the LMIS at the national and district levels.
 - b. Establish stocks of contraceptive supplies at the national and sub-national levels, with special attention to the storage facilities that will resupply providers.
 - c. Incorporate training on the LMIS and on inventory management into integrated provider training that also includes improved clinical skills, updated information on contraceptive technology, and client counseling.
 - d. Supply newly trained providers with an initial stock of contraceptives and the necessary LMIS forms to take with them at the end of their training seminar.
 - e. Provide training to national and sub-national program managers on using LMIS data for decision making (e.g., forecasting and procurement, planning, system monitoring, and adjustments), supportive supervision, the use of feedback forms, and other M&E mechanisms.
 3. Create a forum for coordinating sources of donated supplies, reviewing national stock status and forecasts, and advising on procurements and budgets.
 - a. Create an LMIS Working Group at the national level that includes program managers, logistics personnel, and stakeholders, such as donors, NGOs, and technical assistance providers.
 - b. Establish monthly/quarterly LMIS working group meetings to review national stock status, reporting compliance, and other data; and to recommend adjustments as needed.
 - c. Institute an annual LMIS Working Group meeting with local LMIS users and district managers to identify and address system performance issues.
 4. Advocate for dedicated financial resources to fund the provision of public sector free or subsidized contraceptives for eligible target populations. This could involve creating dedicated budget lines in national and/or local budgets to fund the procurement of public sector contraceptives, and then

Make Reporting Work

Combine requisition vouchers for ordering supplies with reporting forms for program management. This makes the resupply dependent upon regular reporting of the critical data that is needed to make effective program decisions.

Give the Contraceptive to the Client

When providing free contraceptives, especially to new users, make sure that the provider can give the user a supply of contraceptives at the conclusion of the counseling session rather than just giving the client a prescription. This reinforces client confidence and confidentiality.

ensuring the annual obligation of funds for those lines. It could also include covering contraceptive supplies and services by national and private health insurance schemes. Successful mobilization of financial resource is essential for ensuring reliable supplies of contraceptives over the long term.

- a. Use updated forecast to estimate the future cost of meeting the demand for public sector contraceptives.
 - b. Identify known sources of public sector contraceptives (donors, national budget-funded procurements).
 - c. Determine whether there is a gap between known sources and future demand.
 - d. If there is a gap, use this information to advocate to policymakers, legislators, opinion leaders, the media, etc.
 - e. Using logistics data, incorporate evidence-based budget planning into the development of the program's annual budget request for contraceptive supplies.
5. Partner with private-sector contraceptive sources by training private pharmacists to counsel clients in contraceptive methods.
- a. Determine which methods are available from private pharmacies.
 - b. Design a training curriculum for pharmacists in rapid counseling in contraceptive methods that are available from pharmacies.
 - c. Develop relevant IEC materials for the methods that are available from pharmacies.
 - d. Conduct training and provide pharmacists with IEC materials.

CAREFULLY TIME BEHAVIOR CHANGE ACTIVITIES

Implement behavior change activities only when trained providers and contraceptive supplies are available. A fundamental feature of success for any behavior change effort is to ensure that quality services and sufficient products are in place to meet demand. Creating demand that cannot be met results in a loss of confidence in the program, distrust of the provider, and even despair for the disappointed client. Therefore, behavior change activities must be synchronized with the scale up of the national program, occurring only when the providers have been trained and supplied.

Strategic Steps:

1. Develop program IEC materials and BCC tools and approaches.
 - a. Design and test materials, messages, and tools with providers and client focus groups.
 - b. Provide IEC/BCC materials to trained providers.
 - c. Conduct community outreach campaigns in areas where newly trained providers are located.
 - d. Conduct national media campaigns only when a critical mass of providers has been trained.
 - e. Provide small grants to fund provider-driven IEC, BCC, and service promotion activities.

Specify Which Pills Are Free

When promoting free contraceptives, be specific in IEC materials about which brand of oral contraceptives or IUDs are free—clients might assume that all brands, including costly brand names provided at a clinic, are free unless they are clearly told otherwise.

2. Provide interpersonal communication and client-centered counseling training to the target provider, as well as to the nurse (if the primary provider is a physician).
 - a. Identify and target nurses who live in the communities they serve.
 - b. Train nurses and physicians in IPC and counseling from the same facilities and at the same time.
3. Tailor communications approaches to better target special clients (e.g., youth, ethnic minorities, urban poor, etc.).
 - a. Train volunteers in the target communities as peer counselors and educators; provide them with IEC materials designed specifically to address target group needs and concerns.
 - b. Transfer the *tailoring* concept to sub-national level so that program managers at this level are empowered to adapt the approach to the local context or to design new outreach programs to address local priorities.

SCALE UP THE PROGRAM

Accomplishing each of these strategic steps will result in a strong foundation on which a national program can be built and sustained. One key consideration in determining where and when to expand the program is the commitment of local authorities, including health policymakers and political leaders. In some cases, there will be resistance or lack of interest, while, in others, there will be enthusiasm and leadership. Focus at first on those locales where the greatest support exists, and use these *easy wins* to continue building an awareness of the program—through media and national and local dissemination events—and support local champions who can advocate for action in areas that lack sufficient commitment.

CONSIDERATIONS FOR TRAINING

While training is an activity rather than a strategy, certain lessons learned should be applied to the design of training activities within the overall program design and implementation strategy.

USE THE THREE PILLARS APPROACH TRAINING

Simultaneously train providers in clinical skills, IPC/client counseling, and contraceptive technology; LMIS and inventory management; and IEC/BCC, service promotion, and community outreach. This design directly supports the Three Pillars Approach, because it sends the provider back to the community with the knowledge, contraceptive supplies and LMIS forms, and IEC/BCC materials and skills needed to begin offering services and attracting clients immediately.

DEVELOP LOCAL TRAINING CAPACITY

Create a cadre of trainers at the sub-national level to enable local experts to provide initial and follow-up training and supportive supervision. This helps lower training costs by creating expertise closer to the service delivery level, minimizes travel time and expense for providers, and empowers local trainers to create other training activities based on the needs of the providers in their area. To keep the trainers motivated, it's also important to ensure continuous support and mentoring to the trainers, update their technical knowledge and training skills, and monitor the quality of training sessions.

INSTITUTIONALIZE TRAINING

Adapt the in-service family planning training curricula and incorporate it as a compulsory topic into pre-service education and in-service professional development/continuing education for providers. This requires close collaboration with academia and relevant accreditation institutions. Advocate for dedicated funding to support providers' continuing education.

ENCOURAGE PROVIDER SUPPORT GROUPS

While not a training intervention per se, this step is critical for providing a forum where training can continue informally. Provider support groups offer an opportunity for providers to meet regularly (biweekly, monthly, or quarterly) at the sub-national level to discuss program effectiveness, share experiences, provide peer education and counseling, and collaborate in improving services.

CONCLUSIONS

The Romanian Family Health Initiative has had a significant impact. The integration of family planning into more than 80 percent of the primary health care services nationally has dramatically increased access to contraceptives—by 40 percent between 1999 and 2004. This has contributed to a drastic reduction in the rate of abortion—more than 260 percent—during the same period, with a concomitant reduction in the rate of maternal mortality due to abortion of nearly 37 percent. Quality services are available in most rural communities now that family health doctors have the authority, updated knowledge, and supplies they need to provide quality, client-centered family planning services. Free contraceptives are available for clients who cannot afford to pay for them, while the vibrant private sector continues to grow and meet the needs of people who are able to buy their supplies. Counseling and access to a wide variety of information have improved so that clients can make well-informed choices about which method they want to use.

But while progress has been made, challenges remain. The RFHI is now focusing on improving the knowledge and skills of providers at urban family planning cabinets, as well as at secondary and tertiary facilities, so that referral clients receive quality services at these levels. The program is working to improve the integration of family planning in maternal, post-partum, post-abortion care, and STI treatment services. Significant work is being done to reach vulnerable groups in urban areas, such as youth and the urban poor, and to Roma populations throughout the country. To reach the remaining 20 percent of rural areas that lack trained family planning providers, support continues to be provided to districts. The RFHI is working with its Romanian NGO partners to assist them in organizational development, improving management skills, and increasing their financial sustainability. At the same time, the RFHI continues to work closely with its partners in the Ministry of Health and Family, and the National Health Insurance House to ensure that integrated family planning services are fully supported within the continuing reform process of the health sector in Romania.

The RFHI has been instrumental in building upon the benefits of the health care system reform that gave primary care physicians a central role in service delivery. It has helped guide and improve upon the reforms by strengthening primary care, not only by giving family health doctors the chance to act as gatekeepers of the health system when providing family planning services for healthy people, but also by enabling them to open gates for clients in need for more specialized care.

Because the Romanian family planning program has achieved such impressive results, it has provided a foundation on which to build many other reproductive health services—such as safe motherhood, post-abortion care, cervical and breast cancer screening, HIV/AIDS prevention and treatment, and domestic violence interventions—into comprehensive, sustainable, and high-quality health services at every level. These improvements will enable Romania's health system to gradually improve its capacity to meet the needs of its citizens regardless of what care they need, where they live, or how wealthy they are. Romania's family planning program is also a model for other countries in the region, offering innovative ideas and practical approaches that can be adapted by program managers and policymakers throughout Europe and Eurasia.

APPENDIX A

THREE CLIENTS' PERSPECTIVES

The following stories illustrate the impact of the Romanian family planning program on the lives of three clients. *Maria's story* highlights the importance of reaching out to populations that are underserved, such as the Roma, and the impact family planning services has on their families and their communities.

Mariana's story describes one woman's personal reasons for wanting to control her fertility while seeking alternatives to abortion. *Lucica's story* demonstrates how critically important access to family planning is to the health of women and mothers.

The three women gave written permission to share their stories, and their photographs, as did the providers who appear with them. It is the authors' intent to honor their courage and honesty by letting them speak for themselves.

PROVIDING CHOICE FOR THE UNDERSERVED

Family planning services have been available since January 2000 in the small rural village of Sinpaul, in the western Romanian district of Cluj. The two family health doctors at the PHC were trained in contraceptive technology and client counseling under the pilot program that preceded RFHI's national roll-out of family planning through the rural PHCs. The impact on women's lives was significant. "You can see this in the number of abortions," said Dr. Laura Hâncu, one of two family health doctors in Sinpaul. "In the last five, six years, we didn't have many abortions... maybe one or two women a year. Before 2000, I think, more than 20, 30 each year, for each of us [providers]. So the number of abortions is very low now."

Sinpaul has a large population of Roma, a group that traditionally has lacked many social and health services. "There's been a spectacular development in the Roma community, both in terms of discipline and social problems which have started to diminish," says Sinpaul Mayor Ovidiu Colceriu. "This is due to the fact that they have fewer children now, as a result of... family planning."

Maria, a client of the Sinpaul clinic is a 39-year-old Roma woman with a husband, son, and three daughters. Maria eloped when she was 14. "I didn't want to have any children at that time," she said, "I am from... a poor family, and we knew it was hard to raise children." Although she had no access to contraceptives, Maria managed to avoid becoming pregnant for 13 years. "It just didn't happen. I had my first child at 27." Although Maria wanted to have only two children, she didn't have the means or knowledge to control her fertility. Nonetheless, "I take great pride in my children," she said. "I never went to school, because my mother died, but my children attend school." After the birth of her last daughter four years ago, Maria started receiving injections of Depo-Provera at the Sinpaul primary health center. The providers were making a special effort to reach out to the Roma community, whose leaders typically frowned on family planning. "My husband did not know in the beginning," she said. "When I told him he didn't say anything, he just wanted another son. I didn't want to have any more babies." Maria suffers from a heart condition and a duodenal ulcer and buys medicines when they aren't available through the public system. "My greatest dream is to be healthy," she says, "there's nothing I want more." Although she is covered by Romania's national health insurance scheme, which now covers family planning services and contraceptives, she said she's prepared to buy pills as well if she had to. Maria is so committed to the benefits of family planning that she has become an advocate within her community. "Most of my friends use contraceptives, but I was the first one," she explained with pride. And after she started using contraceptives, "they all agreed to take them."



Maria (right) has been a client since 2002. She receives regular counseling and injections of Depo-Provera from Dr. Monica Morea at the Sinpaul village primary health center.

OFFERING AN ALTERNATIVE TO ABORTION

Mariana is 29 and lives with her husband, son, and daughter in Prundu Bârgăului, a community of about six thousand people, 45 minutes from the city of Bistrița in northern Romania. She is a client of the local primary health center, which is staffed by three family health doctors; since 2004, they have been providing Mariana and her neighbors with family planning services.

For Mariana, access to free contraceptives has had a large impact on her life. Her son, who is six, was born with major physical disabilities. “My child can’t walk, doesn’t speak, mentally he is OK, but not physically,” she said. “After giving birth to my first child, who is physically impaired, I was not exactly sure whether I wanted to have a second one.” But

Mariana didn’t have many options after the birth of her son. “My husband was careful enough, also [we used] condoms and abortion. After the abortion I found out that free contraceptives were available...[but] I didn’t take any before my second pregnancy. I was afraid I might become overweight.”

The next time Mariana got pregnant, she and her husband decided to have the baby. “I wanted to have a healthy baby, but I was afraid. It wasn’t planned. When I found out I was pregnant, I had to make a decision: whether to keep the baby or have an abortion. I yearned for the crying of a normal baby and for the steps of a normal baby.” Mariana got what she’d hoped for—she gave birth to a healthy daughter four years ago. But Mariana came to a decision. “I didn’t want any more babies,” she said.

When her local clinic began offering free contraceptives, Mariana decided to give them a try. “I learnt about them from other patients. This was the doctor’s idea, to spread the news through the patients themselves,” she said. “I started taking pills, but there was one day during the month when I forgot to take them. [And] at first I was a little bit afraid to take them because some of my colleagues had grown fat.” Mariana decided to switch to Depo-Provera. “It’s much more convenient to do it by injections. It really made a difference; I had two children.”

Mariana works full time caring for her children. Her family receives a small monthly allowance from the government to help cover the cost of her son’s care and support, but her husband was recently laid off from his job at a factory in Bistrița, so money is tight. “I would like to work. I graduated from college specializing in finance and accounting. It’s my childhood dream to go to work, but I can’t, because my children—at least the older one—need all my care.” Mariana is particularly grateful that she can get contraceptives for free. “It is a great idea to provide them for free, because otherwise...I wouldn’t be able to buy them. I can’t give up our daily bread for them, they are too expensive.”



Mariana (right) receives counseling on injectable contraceptives from her family health doctor, Viorica Bonia.

ENSURING THE HEALTH OF MOTHERS

Lucica is 39 and lives with her husband and 14-year old daughter in Prundu Bârgăului, a community of about six thousand people, 45 minutes from the city of Bistrița in northern Romania. She is a client of the local primary health center, which is staffed by three family health doctors who, since 2004, have been providing Lucica and her neighbors with family planning services. During her pregnancy, Lucica was diagnosed with pregnancy-related hypertension which, if not properly managed, can cause damage to the mother's eyes during labor and delivery and even result in permanent blindness.

"I gave birth to my daughter at my own risk," said Lucica. "The doctors did not really agree, but I could not go on living without seeing a baby. It was really difficult during labor, the doctors even said that because of the affliction with my eyes I might never have children again.... They didn't perform any injections on me during labor as they did with the others, there were four or five doctors around me teaching me how to breathe and forcing me to keep my eyes closed. It was like in the movies."

When Lucica was first married, she and her husband didn't want to start a family right away. "We didn't own a place of our own, we were tenants and never thought of having babies," said Lucica. "We took care, we didn't use any condoms; we just based our judgment on the calendar principle. Once I got pregnant, I gave birth. After birth, I bought contraceptives as the doctor had told me, until they were available free of charge."

For the first 12 years after the birth of her daughter, Lucica took an oral contraceptive—Rigevidon. After they were offered for free from the family planning cabinet in Bistrița, Lucica started traveling there regularly to pick them up, but the trip took time and cost money. Two years ago, that changed. "It is free of charge at the cabinet in our commune," said Lucica, "so I don't have to travel all the way to Bistrița. It's much more convenient this way."

But the change in the source of her contraceptives also resulted in a change in the brand of the pill she had access to. "At first, they brought Marvelon here in our commune," said Lucica. "I called the doctor in Bistrița to ask her if it was OK to take them and she told me they were better than Rigevidon. I was afraid to take them without asking after 12 years, because I don't want to have any more children, running the risk of going completely blind. I have been taking Marvelon for two years now, ever since the doctor [was trained] in our commune."



Lucica (right) receives counseling on contraceptives from her community nurse.

APPENDIX B

KEY INFORMANTS

The following individuals were interviewed or participated in focus group discussions as part of the research for this case study.

- JSI/RFHI Project staff: Mihai Corciova, Irina Dinca, Katherine Farnsworth, Diane Hedgecock, Dana Iancu, Cornelia Maior, Patricia Mihaescu, Narcisa Murgea, and Rodica Teodoroiu
- Dr. Borbala Koo, Executive Director, Society for Education on Contraception and Sexuality (SECS)
- Cristina Coca, National Coordinator, SECS
- Ana Vasilache, Program Coordinator, SECS
- Dr. Nicolae Tarba, Regional Coordinator, SECS/Cluj
- Dr. Alin Stanescu, Deputy General Director, Ministry of Health and Family Institute for Mother and Child Care, Counselor to the National Health Insurance House, former Counselor to Minister of Health and Family
- Luminita Marcu, Program Coordinator, MOPH Institute for Mother and Child Care, Family Planning Program Management Unit
- Clients at the Sinpaul community primary health clinic: “Sanda” (pseudonym), Maria, Alina, Simona, Aurora, and Ioana
- Dr. Laura Hancu, family physician, Sinpaul community primary health clinic
- Mayor Ovidio Colceriu, Sinpaul community, Cluj
- Dr. Anca Andritoiu, Inspector for Mother and Child Care Programs and Deputy Director, Bistrita District Public Health Authority
- Dr. Viorica Bonia, family physician, Prundu Bârgâului community primary health clinic
- Dr. Elvira Marinciuc, family physician, Prundu Bârgâului community primary health clinic
- Dr. Stefania Banciu, family physician, Prundu Bârgâului community primary health clinic
- Clients at the Prundu Bârgâului community primary health clinic: Gabriela, Mariana, Lucica, Ioana, Maria, and Mariana B.
- Dr. Cristina Botusan, family planning physician, Cluj Napoca Family Planning Cabinet and Referral Center
- Dr. Gabriela Cristisor, Director of Health Services Planning, National Health Insurance House, and former coordinator of the mother and child care program, MOPH.

APPENDIX C

ADDITIONAL RESOURCES

Additional information about technical components of the Romanian Family Health Initiative, as well as logistics system design and management, can be found online. The Web addresses are shown below.

ROMANIAN FAMILY HEALTH INITIATIVE RESOURCES

<http://www.jsi.com/romania>

- Domestic Violence technical fact sheet
- Human Capacity Development and Training technical fact sheet
- The Health of Roma in Romania technical fact sheet
- Adolescent Reproductive Health in Romania technical fact sheet
- Behavior Change Communication technical fact sheet
- Reproductive Health Policy Development technical fact sheet
- Contraceptive Security and LMIS technical fact sheet
- National Family Planning Program technical fact sheet
- *The Sexual and Reproductive Health Strategy of the Ministry of Health and Family*
- Romania National Family Planning Program
- Counseling Curriculum.

LOGISTICS SYSTEM DESIGN AND MANAGEMENT

<http://www.jsi.com/JSIInternet/Publications/healthlogistics.cfm>

- *Concepts of Logistics System Design*
- *Guidelines for Implementing Computerized Logistics Management Information Systems (LMIS)*
- *The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs*
- *The Contraceptive Forecasting Handbook for Family Planning and HIV/AIDS Prevention Programs.*

ROMANIAN FAMILY HEALTH INITIATIVE PARTNER NGOS

- ACCEPT Association: www.accept-romania.ro
- Association for the Emancipation of Roma Women (AFER): afer_asoc@yahoo.com
- Center for Health Policy and Services (CHPS): www.cpss.ro

- East European Institute of Reproductive Health: office@eeirh.org
- National Institute for Research and Development in Health (NIRDH): www.incds.ro
- National Union of the Organizations of Persons Affected by HIV/AIDS (UNOPA): www.unopa.ro
- Population Services International/Romania : www.psi.org
- Renasterea Foundation for Education, Culture and Youth (no email or web address)
- Romanian Anti-AIDS Association (ARAS): www.arasnet.ro
- Romanian Cancer Society: www.geocities.com/srccj/ (Romanian only)
- Romani Criss-Roma Center for Social Intervention and Studies:www.romanicriss.org
- Societatea de Educație Contraceptivă și Sexuală (SECS): www.sexdex.ro (Romanian only)
- Youth for Youth Foundation (Fundația Tineri pentru Tineri): www.tineripentrutineri.ro (Romanian only).

For more information, please visit deliver.jsi.com
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