



USAID
FROM THE AMERICAN PEOPLE

Family Planning in Eastern Europe and Eurasia: A LEGACY OF CHANGE

SEPTEMBER 2013



This paper details the U.S. Agency for International Development's (USAID's) wide-ranging contributions to family planning and women's reproductive health in many of the nations of Eastern Europe and Eurasia, and the legacy that its efforts have established.

Introduction

USAID began to support family planning programming in Eastern Europe and Eurasia shortly after the fall of the Soviet Union. At that time, abortion rates in Eastern Europe and Eurasia were among the highest in the world. Data showed that these rates ranged from one abortion per live birth up to as many as three abortions per live birth.¹ The rate of contraceptive use in the region was also well below the average for high- and middle-income nations.²

The aim of USAID's family planning investments in Eastern Europe and Eurasia was twofold: to increase access to and use of comprehensive family planning services and to reduce reliance on abortion. These Agency investments followed on the heels of The Tbilisi Declaration and Call to Action, which recognized the regional need for improved family planning services,³ and the International Conference on Population and Development in Cairo (1994). USAID initially supported family planning programs in Albania,

Moldova, Romania, Russia and Ukraine,¹ as well as several discrete activities in other countries. Going into the 2000s, several of these programs continued while others were added in Armenia, Azerbaijan and Georgia.

USAID's family planning programs in the region faced many obstacles. For example, considerable shares of the public and the medical community distrusted hormonal methods of contraception. Health care services were of low quality and poorly integrated. There was political opposition to family planning. Protocols and policies related to family planning were outdated and, in some cases, restrictive. Over time, implementation of effective and adaptive approaches enabled USAID and its partners to confront these and other challenges and to achieve positive results.

After nearly two decades of USAID investment in the region, attitudes toward modern contraception are more favorable and more supportive, and evidence-based policies and protocols are in place. Family planning counseling and services are widely available, and the quality of services is significantly improved. Abortion rates have fallen by more than half in many countries with USAID health programs, while modern contraceptive prevalence has increased.

This paper details USAID's legacy in family planning and reproductive health in Eastern Europe and Eurasia, focusing on experiences in Albania, Armenia, Azerbaijan, Georgia, Romania, Russia and Ukraine.

Creating a Supportive Environment for Family Planning

Women and their families, health care providers, civil society actors and government officials were positively affected by USAID's efforts to reduce reliance on abortion and increase modern contraceptive prevalence in the region. Among the many contributions USAID made to family planning and reproductive health, the following stand out as having had the most significant and sustainable impact:

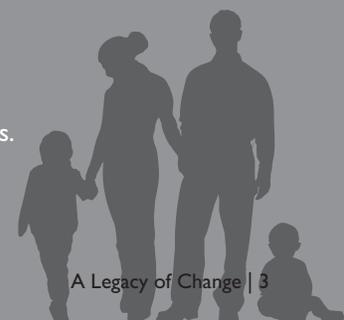
- Dispelling old prejudices and creating more favorable attitudes toward modern contraception

ⁱ USAID began working in family planning and reproductive health in the Central Asian Republics (Kazakhstan, Kyrgyz Republic, Tajikistan, Turkmenistan and Uzbekistan) around the same time. USAID also supported a long-standing reproductive health program in Turkey, ending in 1999.

{ 10 Best Family Planning Practices in Eastern Europe and Eurasia }

In the early 2000s, USAID identified a set of best practices in reproductive health and family planning in the Eastern European and Eurasian region that were intended to frame program development and implementation. These best practices enhanced the ability of USAID and its partners to address country-specific needs in family planning and reproductive health, strategically allocate limited resources and position programs for long-term sustainability after USAID assistance ended. Programs are more successful when:

1. Fewer restrictions exist on when, where and by whom family planning services are provided.
2. Family planning counseling, services and contraceptives are part of a Basic Health Benefits Package.
3. Up-to-date and evidence-based policies, regulations, guidelines, standards and supportive supervision systems are in place to ensure the quality of family planning services.
4. A broad range of family planning methods are available, accessible, affordable and acceptable.
5. Special programs that are designed to meet the needs of vulnerable groups are in place.
6. Family planning is part of pre- and in-service training programs for health care providers.
7. Contraceptive security is ensured through adequate planning within governments.
8. Adoption of a "culture" that promotes family planning counseling and informed choice.
9. Family planning is actively promoted through social marketing and behavior change/social mobilization efforts.
10. Well-functioning national health management information systems are in effect.





- Facilitating the adoption of pro-family planning national-level policies and clinical protocols
- Increasing the availability and integration of modern contraceptive services
- Improving the quality of family planning services
- Strengthening government capacity to plan and manage family planning programs

While each of these contributions is discussed separately, they are overlapping and interrelated; change in one area could not have been possible without changes in the others.

Changing Consumer Attitudes and Demand for Modern Contraception

When USAID began family planning programming in Eastern Europe and Eurasia in the early 1990s, concerns about the side effects of hormonal methods and doubts about the efficacy of modern contraception pervaded the general public, health care providers and policymakers in the region.

Since then, attitudes about the effectiveness and safety of modern contraception have become more favorable. Today, public support and demand for modern methods of family planning are growing.

USAID fostered favorable attitudes toward modern contraception and encouraged its use through information dissemination, education and communication activities that began in the mid-1990s and have continued through the present-day in many countries of the region. These activities conveyed accurate information about the safety and benefits of modern contraceptive methods. Key to their success was appropriate messaging, which positioned family planning favorably as modern, safe, reliable and healthy. In the late 1990s, for example, a video was developed and distributed in Ukraine with USAID support. The video depicted a young woman who is engaged to be married as she visits with a pharmacist and a health care provider. Because they provide her with accurate information about effective methods of contraception, the woman realizes that family planning will contribute to a healthy future for her and for her children. It will also help her to achieve her goal of

having a successful career and marriage.⁴ In 2008, Ukraine produced updated educational videos that were shown at health facilities, universities and workplaces in the presence of a trained health care provider to facilitate discussions.

Information and key messages about modern contraception were disseminated through various channels: trained family planning educators, public events and talks, hotlines, youth activities and point-of-service and point-of-sales educational materials. The use of mass media, including radio, television, newspapers, billboards and signs, was particularly effective. Websites and social media directed at youth were a source of updated information for both the general public and the medical, nursing and pharmacy students. USAID projects often used multiple communication channels concurrently to create large-scale family planning campaigns that were unified by a single logo and/or slogan. In Albania, USAID combined a mass media campaign, “For a Happy Life,” with a peer education program to reach university students in four urban areas in 2009 and 2010.⁵ In Azerbaijan, television spots, posters and

educational brochures were used as part of the “Pregnancy Planning – Choose the Right Time!” national campaign. Project staff also conducted a seminar for journalists that resulted in more than 70 published articles on family planning and reproductive health over a 2 ½-year period.⁶ In Romania, high-quality, client-centered services were branded, and all communications that promoted the clinics where these services and free contraceptives were available used a common logo.⁷

Communications also factored prominently in USAID’s social marketing activities, which were designed to increase the availability of and demand for modern contraceptives. USAID and its partners worked with pharmaceutical distributors and retailers to set affordable prices for contraceptives and to promote products among both retailers and consumers. Promotion efforts included educating pharmacists to improve their attitudes toward and knowledge about modern contraceptives and providing materials, such as posters and brochures, to retailers to generate demand for modern contraceptives at the point of sale. Social marketing in the region focused primarily on condoms and oral contraceptives, as was the case in Moldova and Russia in the late 1990s.^{8,9} However, some countries expanded social marketing to include other products. In Georgia, for example, USAID recently engaged in a new partnership to introduce the contraceptive implant to the commercial market at an affordable price.

USAID’s projects have also developed the capacity of community partners, such as local nongovernmental organizations (NGOs), community volunteers and peer educators, in behavior change communication. These resulted in networks of family planning champions that will last beyond USAID’s investment in the region. NGOs and community educators in each of 15 partner regions in Ukraine were trained on how and where to distribute educational materials, how to conduct interpersonal communication sessions and, in some cases, how to develop more complex communication activities. Today, a number of these NGOs continue to conduct educational and informational activities in family planning with funds from other sources. In Georgia, family doctors, pediatricians, local officials and young leaders were mobilized to speak

out in favor of modern contraception. In Albania, with USAID support, a Behavior Change Communication Center of Excellence was established within the Social Work and Social Policy Department at the University of Tirana.

Providing accurate information about family planning and emphasizing its health benefits for mothers, children and families, started to break down negative perceptions of family planning and contraception that were widespread in communities throughout the region. This attitude change not only occurred among consumers of family planning services but also among decision-makers in a position to create an enabling environment for family planning.

Building Sustainability: National Policies and Clinical Protocols

The Soviet medical system was heavily reliant on formal policies (called *prikaz*) and clinical protocols, many of which were outdated, restrictive or simply did not address family planning and reproductive health issues. In much of the region, for example, national-level policies only allowed obstetrician-gynecologists (OB/GYNs) to provide family planning counseling and services and contraceptive products. This restriction effectively limited family planning services to health facilities with specialty care providers, which were typically located in urban areas. National clinical protocols also did not consistently reflect international standards. This contributed to the over-medicalization of care, such as requiring more tests or clinical visits than were necessary to prescribe contraception, as well as inadequate and outdated family planning service provision.

Collaborating with central and regional health authorities, influential medical institutes and universities, private hospitals and providers and other local stakeholders, USAID capitalized on changing attitudes about family planning to assist policymakers and health authorities in adopting evidence-based, pro-family planning policies and protocols. USAID encouraged the adoption of policies that allowed family doctors, midwives and nurses, with appropriate training and supervision, to offer a range of contraceptive services and family planning counseling. In 2002, Romania was one of the first countries in the region to allow family doctors in rural areas to provide

“I always thought that family planning and contraception were the prerogative of OB/GYNs. But the training was easy to understand and encouraged me to apply my new knowledge in practice after returning to work. Now, when women and girls come to see me, I do my best to raise issues related to women’s health and contraception, telling them about the progress made in modern medicine. My clients view my practice differently now.”

– Sevilia Velilyaeva, a family doctor in Bakhchiseray rayon, AR, Ukraine

“As a result of the training in family planning ...

I have initiated a large campaign in the community. I began to inform women about the family planning cabinet in Fetesti, which offers free services and counseling. Shortly after that, I presented to them the advantages and disadvantages of birth control methods. I continued to meet women, sometimes at their request, in order to offer more information about family planning and reproductive health.”

— Jenica Ganea, Roma health mediator, Ialomita District, Romania



family planning services, including free contraceptives.⁷ The success of this policy change made Romania a positive model in the region. High-level decisionmakers from Georgia and regional health administration representatives from Ukraine participated in separate study tours to Romania to learn from their experience.¹⁰ Seeing the impact of the policy change and related task-shifting in a similar post-Soviet context was powerful. Regional governments in Ukraine became more supportive of family planning and allocated funding for the procurement of contraceptives. In Georgia, the Ministry of Labor, Health and Social Affairs issued

a decree allowing family doctors, pediatricians, nurses and midwives to provide family planning counseling and certain types of contraceptives.

Today, several countries in the region allow general practitioners/family doctors, pediatricians and, in some cases, midwives and nurses to provide contraception or contraceptive counseling and referrals. A summary of each country's policy is shown in Table 1.

USAID's involvement in updating clinical practice guidelines and protocols at the national level contributed to the institution-

alization of best practices on contraceptive service provision. Support for protocol development was achieved using a participatory process. Typically, committees or working groups made up of project staff, health officials, experts in family planning and reproductive health and representatives from professional associations and local organizations were brought together to review available evidence and draft protocols or guidelines. This process helped secure government approval at the national level. Several key achievements are highlighted below:

- In partnership with the Kulakov Federal Center on Obstetrics, Gynecology and Perinatology in Russia, USAID supported the development of an evidence-based national policy on Medical Eligibility Criteria for Contraceptive Use.¹³
- In Albania, in 2010, the Ministry of Health approved the first National Family Planning Clinical Protocols as a national standard for providing family planning services at all levels of care.¹⁴
- Up-to-date, evidence-based protocols for 12 family planning methods were signed into law and endorsed by the Georgian Ministry of Labor, Health and Social Affairs.¹⁵
- In Azerbaijan, USAID supported the development of nine national evidence-based guidelines and protocols on family planning methods. Subsequently, the project provided technical assistance to the Ministry of Health to roll out the new protocols, orienting and training 635 health providers from 40 districts.⁶ USAID played a key role in the introduction of evidence-based medical principles in the country and helped establish an evidence-based medicine department at the Public Health Reform Center in Azerbaijan. This department is now responsible for maintaining and updating clinical guidelines.
- Ukraine adopted clinical protocols and guidelines on family planning, postabortion and postpartum care and family planning for individuals living with HIV. The Ministry of Health approved an order on the organization of ambulatory obstetrical and gynecological care, family planning training guidelines and curricula for continuous education and contracep-

Table 1: Providers of Family Planning Services in Eastern Europe and Eurasia Countries
(in addition to obstetrician-gynecologists)

COUNTRY	PROVIDER TYPE AND SERVICES OFFERED
Albania	<ul style="list-style-type: none"> Family doctors and midwives can counsel on and provide hormonal contraceptives and condoms.¹¹
Armenia	<ul style="list-style-type: none"> Pediatricians can provide family planning counseling referral to contraceptive services. Family doctors can provide family planning counseling. Midwives and nurses are allowed to provide information on all methods and distribute condoms.
Azerbaijan	<ul style="list-style-type: none"> Internists and pediatricians can provide contraceptives other than intrauterine devices (IUDs) and permanent methods. Midwives can provide family planning counseling.¹²
Georgia	<ul style="list-style-type: none"> Midwives and nurses are allowed to provide information on all methods and distribute condoms. Neonatologists, midwives, general and infant nurses can provide postpartum family planning counseling. Family doctors can provide oral contraceptives and condoms; they can also provide counseling on all methods of family planning and referrals for IUDs, implants and long-lasting and permanent methods of contraception.
Ukraine	<ul style="list-style-type: none"> Family doctors can counsel clients on family planning methods and can prescribe contraceptives.
Romania	<ul style="list-style-type: none"> Family doctors in rural areas can provide family planning services and contraceptives.
Russia	<ul style="list-style-type: none"> Pediatricians, midwives and infant nurses can provide family planning counseling.

tive technology teaching recommendations for university faculty.¹⁶

- The National Guidelines for Normal Obstetrics, developed in Armenia, provided recommendations on postpartum care that included information on contraceptive options and counseling,¹⁷ while the National Preconception Care Program highlighted the importance of healthy timing and spacing of pregnancy.

Expanding the Availability of Family Planning Services through Integration

When USAID began investing in family planning activities in Eastern Europe and Eurasia, family planning services were typically found only in specialty care health facilities, primarily in urban areas. This left rural women, in particular, with limited access to contraception. Family planning was not well integrated into other health care services (e.g., postpartum care and postabortion care), such that numerous opportunities were missed to inform women about their family planning options and about healthy and safe alternatives to abortion.

In the 1990s, USAID began increasing the availability of family planning services by establishing model family planning clinics in several countries in the region. In Russia, Ukraine and Moldova, family planning clinics were first set up at a few tertiary care hospitals to serve as demonstration sites for training and the delivery of family planning services.^{4, 18} Obstetrician-gynecologists from these hospitals were trained in modern

contraceptive technology and in how to provide comprehensive family planning services. In the early 1990s, Romania focused on expanding service delivery in the private sector by establishing model family planning clinics through three local NGOs.¹⁹ Through the medical partnerships program managed by the American International Health Alliance, women's wellness centers were also established in Albania, Armenia, Belarus, Georgia, Moldova, Romania, Russia and Ukraine between 1997 and 2003.²⁰

The expansion of family planning services beyond model clinics largely took place in the 2000s. A key component of this expansion was the integration of contraceptive services, counseling and referral into other health care services. For example, with ample evidence for healthy timing and spacing of pregnancies, maternal and child health programs incorporated family planning into their efforts and discussed contraceptive options during routine antenatal care visits to inform women of optimal birth spacing intervals.¹³ Integration with primary health care, postpartum care and postabortion care were also emphasized.

In Georgia, USAID used a four-step approach to introduce family planning services into primary care at rural ambulatory clinics. The first step, program introduction and training, included a local needs assessment, engagement with local authorities and training of providers on counseling skills and contraceptive technology. Logistics/contraceptive distribution followed with the

distribution of USAID-procured contraceptives to the providers and linkage with the logistics management and information system. Supportive supervision, consisting of visits by a trusted supervisor, helped answer providers' questions as they began to offer the family planning services. Finally, counseling/information-education through the distribution of educational materials and community outreach allowed community members to be empowered consumers of these new services.¹⁰ By the end of 2012, full geographic coverage was achieved in Georgia, with more than 800 sites nationwide providing family planning services. These sites also experienced very few commodity stock-outs as a result of the highly effective logistics management information system.¹⁰

In Albania, the family planning program began with the goal of creating a network of family planning services across the country. To that end, a family planning unit was first established in each district at the maternity hospital. Later, when the concept of family medicine began to take hold in Albania, family planning services spread into the primary health care system and, specifically, into rural areas of the country. USAID implemented an innovative strategy in Albania to reach women during the extended postpartum period (defined as 12 months) through both routine postpartum care and pediatric services in local polyclinics (centers that provide specialized outpatient care).¹⁴ USAID also worked with partners to train providers in contraceptive methods that could be safely offered immediately



after abortion. Technical assistance provided to the Institute of Public Health in Albania on forecasting, procurement, warehousing and distribution of contraceptives allowed for increased access to contraceptives at service delivery sites nationwide.²¹

Integrating family planning into other aspects of health care proved to be a particularly effective strategy in expanding access to services. Integration of care led to greater acceptability of family planning by political opponents and coincided with invigorated government efforts to establish primary health care systems and improve maternal and child health. The number of service delivery points providing family planning in both rural and urban areas increased dramatically with USAID support, allowing more women across the region to access counseling and services when needed. In Ukraine, for example, over 3,500 facilities in the 15 supported regions provided high-quality family planning and reproductive health services in 2011 as compared to only 500 facilities in 2005.

Ensuring Quality of Services: Evidence-Based Medicine

Improving quality of care and positive health care provider practices in family planning and reproductive health went hand-in-hand with increasing the availability of family planning counseling and services in the region. Under the Soviet system, health care providers did not have routine access to the latest available medical research nor were they trained to appraise the scientific literature and incorporate clinical evidence into their practice. The information taught in medical schools was often outdated, as were teaching methodologies. This contributed to insufficient and, sometimes, inaccurate provider knowledge and biased attitudes about modern methods of contraception. Doctors often felt they knew what was best for their clients.²² They also tended to be directive, even authoritarian.²³ This discouraged women from having two-way dialogue with their doctors about reproductive rights and safe family planning options.

USAID introduced continuous quality improvement approaches and medical education reforms; all of them focused on evidence-based medicine. (Evidence-based medicine can be defined as the use of current and accurate practices identi-

fied through medical research to inform clinical decisions about treatment and care for patients.²⁴) As a result, medical systems that increasingly support high-quality family planning services across the region are part of the legacy of USAID family planning and reproductive health assistance.

Continuous Quality Improvement Approaches

USAID's projects in Eastern Europe and Eurasia introduced and institutionalized several quality improvement approaches²⁵ to promote health services that are safe, effective, patient centered, timely, efficient and equitable. Initially, family planning providers participated in trainings focused on the delivery of family planning services, such as use of contraceptive technologies, potential benefits and risks of family planning methods, misconceptions about contraception and client-provider interaction. USAID's training techniques introduced participatory teaching methods, such as role playing, discussion and practice on anatomical models, to strengthen providers' clinical and counseling skills. To assist those countries that were liberalizing their service provision policies, trainings were open not only to obstetrician-gynecologists but also to other health professionals, including family doctors, midwives and nurses, where permitted.

Most USAID projects used a "cascade" training approach in which health care providers were trained as master trainers. These master trainers then became local family planning champions and conducted trainings for other providers. For example, when the Government of Romania expanded family planning services nationwide, USAID implemented a three-step cascade training approach: (1) Master-trainer physicians received refresher training in family planning; (2) These physicians then conducted a training of trainers at the district level, which prepared a minimum of two local family planning trainers for service in each district in the country; and (3) In their respective districts, the district trainers educated family doctors and nurses in the provision of family planning services. By the end of the project, 80 percent of rural villages had at least one health care provider trained in the provision of high-quality family planning services.⁷

Training was not the only approach used to update provider knowledge and skills. In Ukraine, a series of 59 fact sheets were de-

veloped and disseminated to educate health care providers as well as other stakeholders, such as pharmaceutical representatives and private sector partners. These fact sheets summarized the body of evidence around discrete clinical topics, known as critically appraised topics. Roundtable discussions about the information presented in the fact sheets contributed to an open assessment of evidence about contraceptive methods and practices. The fact sheets also gave providers the skills and information needed to challenge – and change – long-standing

“I liked the idea of root cause analysis and the ‘Five Whys’ methodology as elements of a well-done supervisory visit. These were quite new to me, and I considered them very relevant to all of our work.”

– Supportive Supervision Training, participant from Ijevan MC, Armenia

misconceptions about the side effects of certain methods.

The majority of participants in USAID project interventions demonstrated improvements in their knowledge and skills. In Ukraine, providers performed better on many crucial quality of care measures, such as using the “no touch” technique to reduce the likelihood of infection with IUD insertions.¹⁶ In Armenia, providers' interaction with their clients markedly improved following family planning training. Active listening and the use of a respectful, nonjudgmental approach were nearly universal among providers trained at 96 and 97 percent, respectively. Furthermore, after project training, 94

percent of providers counseled clients about possible side effects, 90 percent of providers explained how to use a method correctly and another 73 percent clarified misperceptions that clients had about contraception.¹⁷

Skills learned in initial training needed to be reinforced in order to be sustained. A system of supportive supervision was introduced to several clinics in Georgia in 2008. In the following years, the supportive supervision methodology was applied to the majority of clinics participating in the USAID project. Supervisors trained in such areas as evidence-based approaches to effective supervision, team building and communication conducted training at each clinic and assisted with the development of internal quality improvement teams. These teams set quality improvement goals related to the provision of care, accessibility and affordability of services and community outreach and involvement. The team members then measured progress toward their goals and began to systematically collect and analyze data and to make performance improvements. As a result of their efforts, clinics saw a decrease in waiting times, a growth in client caseload and an increase in new and continuing contraceptive users.²⁶

In Azerbaijan, USAID introduced client-oriented, provider-efficient (COPE) services, as well as supportive supervision, at 38 project sites between 2006 and 2010.⁶ COPE is a process by which teams of administrators and staff at a health care facility routinely assess service quality with a focus on clients' needs, identify problems and find effective solutions. Several tools, such as self-assessment guides, client record review checklists and client interview guides, are used by facility staff to walk through the process.²⁷

Medical Education Reform

USAID worked to incorporate family planning training into pre-service education, continuing medical education and post-graduate education, creating a platform for high-quality family planning services over the long-term. Working with stakeholders from medical institutions and professional associations, staff from a regional USAID project developed a pre-service family planning curriculum for application across the region and introduced new teaching methods with a focus on active, student-centered learning. The concept of evidence-

“Can you imagine what freedom of choice means for rural women? This project gave me this freedom! I remember how it was in maternity hospitals back in the past: You got pregnant or came for an abortion and after an abortion for an IUD, and that was it. And you don’t have any right to choose. You don’t have clear information about the methods of contraception. I provided a lot of counseling session to so many families. They didn’t even know about these methods of contraception. The project enabled us to convey this information to women. And now women can make the right choice of contraception methods by talking with a family doctor.”

– Alina Dyshkant, a family doctor from Khmelnytsky Oblast, Ukraine



based medicine provided the foundation for education reform activities and was applied to both curriculum content and teaching methods. Key faculty members received training on how to appraise and interpret medical literature as well as how to impart skills to their students.²⁸

In Armenia, two working groups of faculty from three medical teaching institutions drew on existing training materials on family planning and reproductive health counseling and client-provider interaction to develop a pre-service curriculum for medical, nursing and midwifery students and clinical residents. A training course developed with support from USAID was also approved by the Ministry of Health and integrated into continuing medical education efforts.¹⁷

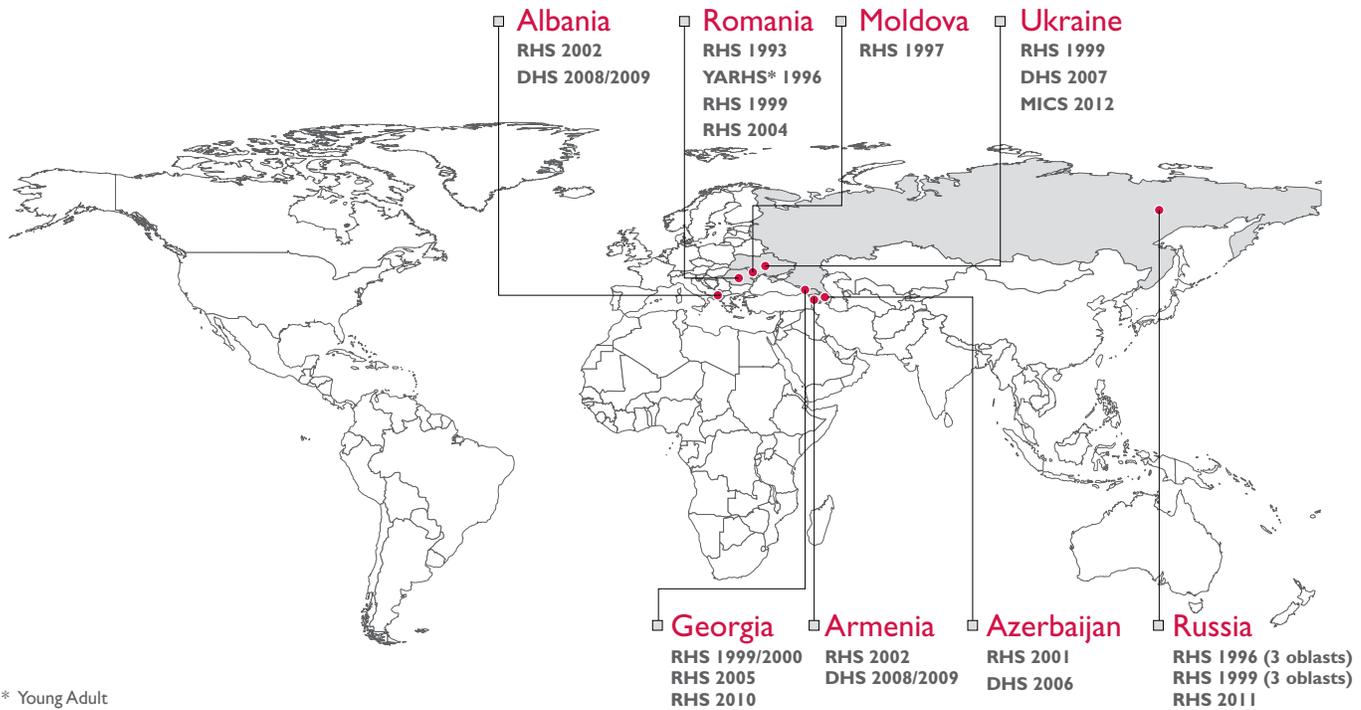
Family planning was also integrated into the pre-service curriculum for medical students in Georgia, Russia and Azerbaijan. In Georgia, this effort included the development of a comprehensive set of core competencies in the provision of family planning methods, counseling and promotion. It also included the development of a teaching curriculum and student examination materials for the Tbilisi State Medical University.²⁸ In Russia, the Institute for Family Health selected two medical schools in Siberia that had dedicated family planning champions to implement family planning pre-service reform efforts, thereby leveraging a curriculum that had been developed through USAID’s regional project. The Kemerovo State Medical Academy began implementing this curriculum in its undergraduate teaching program in

2010.²⁸ A family planning and reproductive health curriculum in Azerbaijan was developed in conjunction with trained faculty from the Obstetrics and Gynecology and Family Medicine departments at Azerbaijan Medical University; the curriculum was approved by both the Ministry of Health and the Ministry of Education in June 2010.⁶

In Ukraine, priority was given to postgraduate medical education because all practicing doctors were required to take postgraduate courses every 5 years to maintain their certification. A working group comprising representatives from the Ministry of Health and leading medical schools created a curriculum and instructional manuals incorporating evidence-based approaches in family planning and client-centered care for family doctors and obstetrician-gynecologists. These manuals were approved by the Ministry of Health and the Ministry of Education and Science as a formal part of postgraduate medical education.¹⁶ In addition, with USAID support, a center was established at the Ukrainian National Medical Academy for Postgraduate Education to serve as a resource center for evidence-based medicine.¹⁶

Of all the USAID family planning initiatives in Eastern Europe and Eurasia, the ones with the greatest value for the long-term included the introduction of evidence-based medicine. Continuous quality improvement approaches and the efforts to reform medical education were among the most important long-term legacies. These contributions allowed for adaptation and adoption of new technologies over time.

Figure 1: USAID-Supported Reproductive Health Surveys (RHS), Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS)



Increasing Government Commitment and Capacity

Policymakers and government institutions play an important role in the provision of family planning services, from committing and allocating government resources to collecting and analyzing data and managing family planning programs. In the 1990s, political support for family planning programs in the region was particularly weak, due in large part to concerns about low fertility rates and population declines.^{29, 30} Limited financial resources in the health sector were allocated for purposes that governments deemed more pressing than family planning, and health authorities did not have the capacity to manage large-scale regional or national family planning programs. To address these challenges, USAID invested in strengthening national commitments to reproductive rights and family planning and in building the capacity of ministries of health, national statistical agencies and other governmental entities.

In Ukraine, USAID supported the adoption and approval of the State Program, Reproductive Health of the Nation (2006–2015). Under this program, the government allocated financial resources to family planning for the first time. These resources included

funds to procure contraceptives for vulnerable population groups.¹⁶ Once the national program was authorized, USAID provided integral support to government authorities in establishing regional coordinating committees with representation from various government agencies, local service providers and NGOs. In conjunction with the Ministry of Health, a program-planning tool was designed for use by these committees for submitting proposals to the national program. An electronic monitoring and evaluation system was also developed to facilitate uniform data collection on regional family planning activities, program results and expenditures.¹⁶

In Romania, USAID assisted with the development of the National Sexual and Reproductive Health Strategy (2002–2006). Important policy changes accompanied this strategy, including the provision of complimentary family planning services for both insured and uninsured Romanians and expansion of the eligibility criteria for free modern contraceptives.⁷ To ensure program beneficiaries’ access to the free contraceptives, USAID assisted with the development and implementation of a logistics management information system to track commodities and provided technical

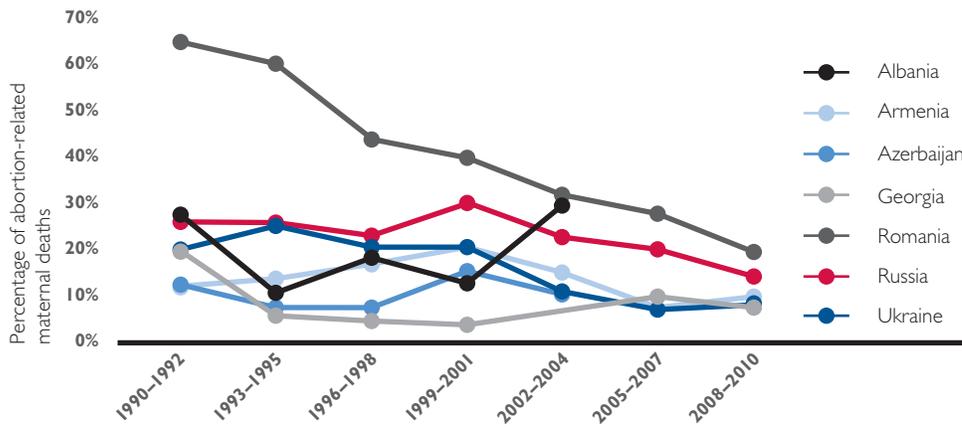
assistance to District Public Health Authorities to improve management of the supply chain.⁷ USAID also worked closely with the District Public Health Authorities across the country to improve their program management skills and develop tools to improve communication, assess local needs and make data-based decisions. As a result of these efforts, the districts were able to more effectively use their resources by changing or adding family planning services that met the specific needs of their communities.⁷

In all countries in the region with USAID-supported family planning programs, USAID invested in large-scale nationally representative surveys on reproductive health that were carried out in partnership with local statistical agencies (see Figure 1 for national surveys). These surveys collected information on the following: women’s understanding of contraception and reproductive health, their contraceptive and abortion practices, their fertility preferences and other health matters. This valuable information helped government authorities make strategic decisions regarding the management and implementation of family planning programs. Moreover, undertaking these surveys developed the capacity of state statistical agencies to use a variety of sampling, data collection and

Figure 2: Total Abortion Rate in Select Countries (1990–2011)^{31–44}



Figure 3: Percentage of All Maternal Deaths Attributable to Abortion (1990–2010)¹



analysis methodologies and tools. Analysis and dissemination of the surveys encouraged high-level dialogue on family planning policies. Through technical assistance provided to health ministries and departments at both the national and regional levels, USAID strengthened governments' abilities to effectively plan and manage family planning and reproductive health programs.

Trends in Abortion, Contraceptive Use and Fertility

As USAID invested in family planning and reproductive health activities in Eastern Europe and Eurasia over nearly the last two decades, important demographic and health-related changes took place. Declines in abortion rates were significant and contributed to improved maternal health outcomes. Women began to transition to modern methods of contraception, dramati-

cally in some countries, and reduced their reliance on the less effective traditional methods. Fertility rates, which had been on a steady decline in the region, appeared to stabilize – and in some countries increase – in the late 2010s.

This section will take a deeper look at these trends in abortion, contraceptive use and fertility in Albania, Armenia, Azerbaijan, Georgia, Romania, Russia and Ukraine.

Abortion Rates Plummet

In the 1990s and early 2000s, abortion rates in Armenia, Azerbaijan, Georgia, Romania, Russia and Ukraine were among the highest in the world, ranging from 1.6 to 3.7 abortions per woman over a lifetime. In 1990, there were nearly three abortions for every live birth in Romania, two abortions for every live birth in Russia and about 1.5

abortions for every live birth in Ukraine.¹ This reliance on abortion in the region had a detrimental effect on women's health. In Romania, abortion accounted for more than 60 percent of maternal deaths in the early 1990s.³¹ During the same time period, the percentage of maternal deaths attributable to abortion was also high in Albania, Georgia, Russia and Ukraine, ranging from 20 to 25 percent¹.

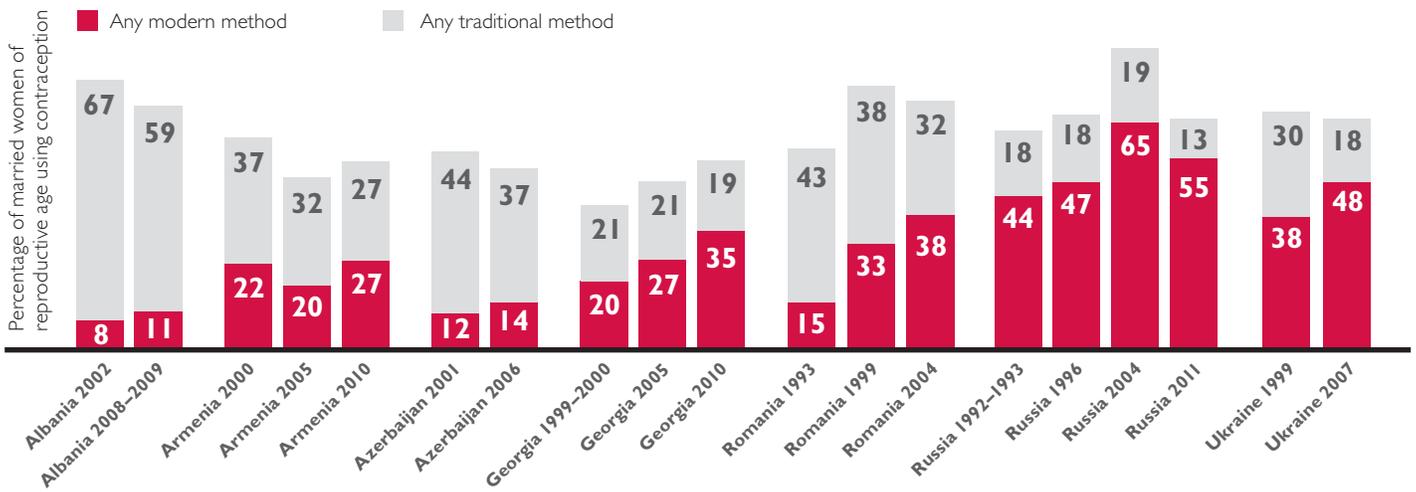
Nationally representative health surveys show that abortion rates in the region declined dramatically after that time, with the greatest decrease taking place in the 2000s (see Figure 2). Abortion rates declined by more than 50 percent in Armenia, Georgia, Romania, Russia and Ukraine; in Azerbaijan, the decline was by 28 percent. Today, abortion rates in these countries range from 0.4 to 2.3 abortions per woman over a lifetime. Although the use of abortion remains high in Eastern Europe and Eurasia relative to other regions of the world, the sharp drop in abortions observed over the last 20 years is quite remarkable. (Reliable abortion data were not available for Albania.)

The decrease in abortions in the region had a positive impact on maternal health. Figure 3 shows how, overall, abortion-related complications represented a smaller share of the cause of maternal deaths between 1990 and 2010 in most countries with USAID family planning programming. (Recent data from Albania and Azerbaijan were not available.) At varying points during this 10-year period, several countries experienced increases in the percentage of maternal deaths attributable to abortion. These increases were likely due to improved reporting and the small total number of maternal deaths. The overall trajectory for abortion-related maternal deaths was downward, highlighting an important achievement in women's health in the region.

Modern Contraceptive Use Rises

The reduction in abortion rates in Eastern Europe and Eurasia is attributed, in part, to increasing adoption of modern methods of family planning. In 1990, between 17 and 32 percent of married women of reproductive age were always using or sometimes using any method of contraception² compared to almost 75 percent of married women in Germany, the Netherlands, the United Kingdom and the United States.⁴⁵ Rates of

Figure 4: Contraceptive Prevalence (1992–2011)^{32–43, 45, 47, 48}

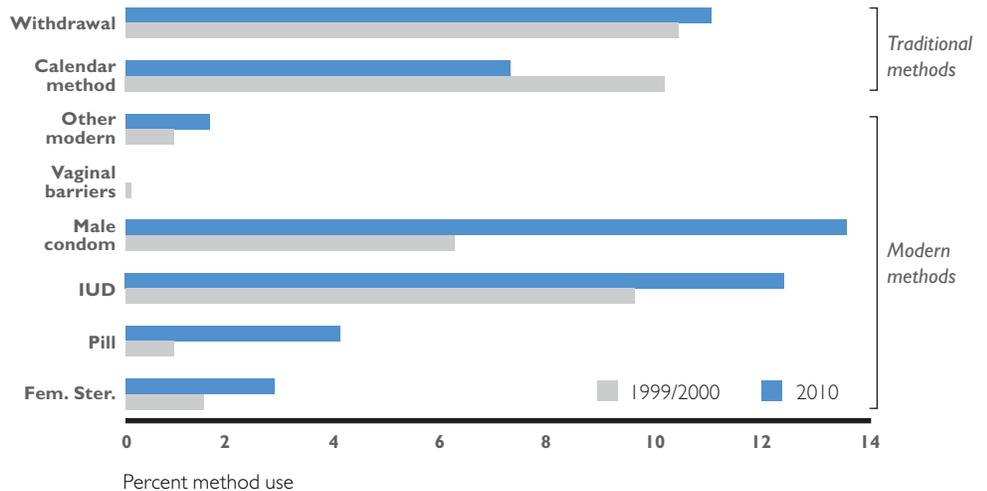


modern contraceptive use among women of reproductive age were even lower. Women who were using contraception typically relied on less effective traditional methods,ⁱⁱ such as withdrawal and the rhythm (calendar) method.

Since the 1990s and early 2000s, many countries in the region have seen considerable increases in the use of modern contraceptives by married women of reproductive age (see Figure 4). Use of modern methods more than doubled in Romania between 1993 and 2004, increasing from 15 percent to 38 percent. In Georgia, modern contraceptive prevalence increased from 20 percent in 1999 to 35 percent in 2010, marking the first time that the use of modern methods exceeded the use of traditional methods. Similarly, in Armenia, use of modern methods, which increased from 22 percent in 2000 to 27 percent in 2010, became almost as common as traditional methods. Both Russia and Ukraine saw modern contraceptive prevalence rise by about 10 percentage points over the last decade, and both are at about 50 percent today. Modern contraceptive prevalence increased in Albania and Azerbaijan over the same time period, but gains were smaller than they were in other countries in the region.

The change in contraceptive method mix over time showed that some women in the region replaced traditional methods of contraception with modern methods. In many countries, use of traditional methods, such as withdrawal and the rhythm method, declined since the early 1990s, while use of

Figure 5: Contraceptive Method Use in Georgia^{36, 37}



modern methods, such as condoms and oral contraceptives, increased. IUDs continued to make up a large share of modern method use, but this share remained relatively unchanged. The one exception is in Russia, where use of the IUD actually declined starting in the early 1990s. Overall, oral contraceptive use remained low relative to other methods, but the increase in the region pointed to a growing acceptance of hormonal methods.

The change in method mix over time in Georgia is presented as an example in Figure 5.

Women who do not want to become pregnant but are not using any method of contraception are said to have an unmet

need for contraception. As women shift from traditional methods to modern methods, the total unmet need for contraception may not change. However, the unmet need for modern methods will decline. Unmet need for modern contraception declined in Armenia, Azerbaijan, Georgia, Romania and Ukraine between the early 1990s and the present day (see Figure 6). In contrast, Albania has the region's largest proportion of married women of reproductive age with unmet need for modern contraception, and it is one that has not changed very much over time. No trend data for unmet need were available for Russia.

ⁱⁱ In the course of 1 year, about 22 of 100 women relying on withdrawal and 24 of 100 women using periodic abstinence will become pregnant.⁴⁶

Figure 6: Unmet Need for Modern Methods of Contraception³¹⁻⁴⁴

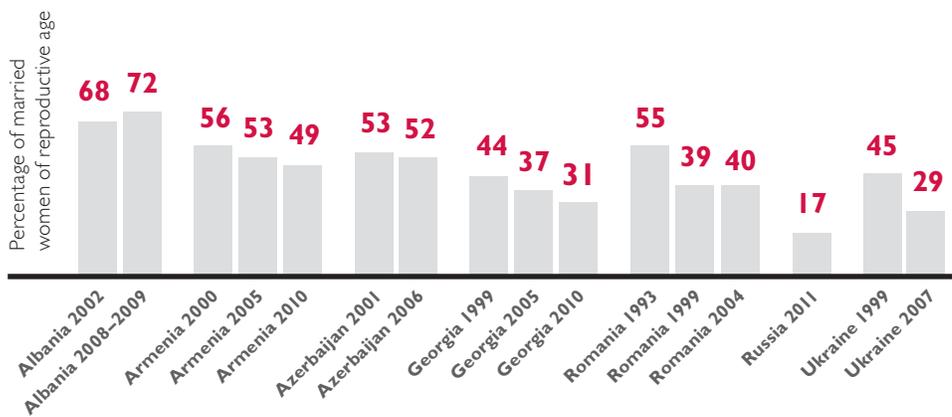
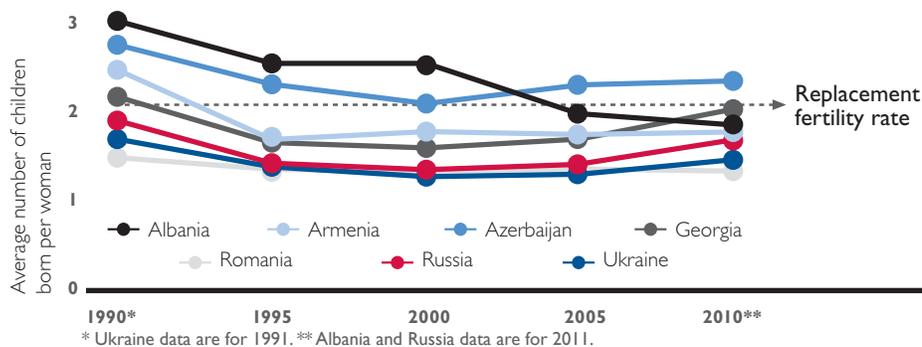


Figure 7: Total Fertility Rate (1990–2011)¹



Fertility Rates Stabilize and Increase

When USAID began working in Eastern Europe and Eurasia, many countries in the region had total fertility rates below the replacement level of 2.1 children per woman, and fertility rates continued to decline throughout the 1990s.⁴⁹ By the early 2000s, fertility in the region ranked among the lowest in the world; in Ukraine and Russia, for example, fertility rates reached as low as 1.2 children per woman.

Declining fertility rates contributed to strong opposition to family planning in the region, some of which remains today. In several countries, politicians and senior-level officials were concerned that promoting family planning would result in further decreases in fertility. This is due to the fact that, in high-fertility settings, fertility rates typically fall when contraceptive use levels increase.⁵⁰ However, this same pattern has

not been seen in low-fertility settings, such as Eastern Europe and Eurasia.

Instead, recent data suggest that fertility in the region increased over the last decade. Between 2000 and 2011, while modern contraceptive prevalence increased, fertility rates rose 15 to 34 percent in Azerbaijan, Georgia, Russia and Ukraine, and remained stable in Armenia and Romania (see Figure 7). The only country continuing to experience a decline in fertility during this time was Albania.

What Does the Future Hold?

The reproductive health environment in Eastern Europe and Eurasia in the 2010s is quite different from the environment that existed in the 1990s. New ideas and new attitudes about women's health and reproductive rights have permeated among many crucial players: health care providers, health consumers, medical education institutions,

NGOs and communities. When USAID began working in this arena, the support for modern methods of family planning was extremely limited in the region. Today, awareness and acceptance of modern contraception is much more widespread. National policies and clinical protocols have been put in place to create an enabling environment for family planning. Family planning services are more available to women and their families, and providers have tools to offer services that are client centered, high quality and evidence based. Families and couples are transitioning to modern methods of contraception, relying less frequently on traditional methods and on abortion as their means of fertility regulation.

Compared to Western Europe, other industrialized nations and many low- and middle-income countries, the Eastern European and Eurasian countries still have relatively high abortion rates and relatively low levels of modern contraceptive use, particularly of hormonal and long-term and permanent methods. Political support for family planning remains insufficient in much of the region, and in some places, religious opposition to contraception remains strong. With few countries embracing public financing for contraceptives, obstacles to long-term contraceptive security remain.

With the phase-out of USAID assistance in family planning and reproductive health in the region, it will fall to country governments (national, regional and local), other donors, civil society organizations and communities to continue to advance reproductive health and voluntary family planning. Opportunities, such as those highlighted below, abound for both sustaining and promoting change.

- Leverage the private sector to increase availability and improve affordability of modern contraceptives in both urban and rural areas.** Particularly in urban areas and among younger women, the demand for public family planning services appears to be shifting to the private sector, where women can more easily access a broader range of methods and brand-name commodities. Small pharmaceutical companies can play an important role in offering low-cost, high-quality modern contraceptives, allowing

for limited public resources to be devoted to meeting the family planning needs of vulnerable populations.

- **Focus on local government and civil society capacity for contraceptive procurement, service provision, advocacy and communication.** Where there is weak national-level support for contraceptive procurement and services, some regional and local governments, such as those in Russia, have stepped in to provide contraceptives and support family planning communication efforts when convinced of the return on such wise investments. Experiences from USAID projects also find that a vibrant nongovernmental sector can help fill the gap in reaching special population groups and advocate for government services.
- **Scale up the use of evidence-based medicine to continuously improve the quality of service provision.** The introduction of evidence-based medicine has contributed to significant improvements in knowledge, attitudes and skills related to family planning services. As this approach becomes more institutionalized and modern and evidence-based practices are continuously reinforced, the provision of high-quality family planning services can continue to be scaled up throughout the region.
- **Promote long-term and permanent methods.** Data from the region indicate that it is women who have completed their families who are relying more on abortion and traditional methods of contraception.⁵¹ Making long-term and

permanent methods of contraception more widely available can help these women achieve their fertility goals while also helping to reduce rates of abortion.

- **Use fertility and contraceptive use data to galvanize support for family planning.** As evidenced by several of the countries discussed here, increased contraceptive use does not necessarily lead to decreased fertility. This, and other data on fertility and contraceptive use, can be used to raise awareness and address concerns regarding family planning.
- **Educate and support the next generation of family planning users.** Data from the region indicate that the next generation of family planning users in the region has more favorable attitudes toward modern contraception than previous generations. Reaching youth with age-appropriate education, counseling and services can help break the pattern of abortion reliance in the region and encourage a shift to a culture of contraception.

Through its two-decade long commitment to reproductive health and family planning in Eastern Europe and Eurasia, USAID has both contributed to improved health outcomes and helped set the stage for future achievements. Many of the successful approaches implemented by USAID and its partners can be used to leverage the opportunities identified above. And USAID's legacy can provide a foundation for continuing to fulfill the promises made in Tbilisi in 1990, affirming women's reproductive rights throughout Eastern Europe and Eurasia.



“The attitude of a doctor to a patient has changed drastically. We are now aware that the client plays the main role in this process, while a health worker provides assistance. The client can enjoy her rights at last.”

– Director of the Oblast Family Planning Center, Novosibirsk, Russia

References

Below is a list of the USAID-funded activities that are referenced in this paper. They are among the many family planning and reproductive health initiatives that USAID supported in Eastern Europe and Eurasia over a period of nearly two decades.

Albania

ACCESS-FP/Albania
Communication for Change

Armenia

Innovations in Support of Reproductive Health (NOVA) Project I and II

Azerbaijan

Access, Quality, and Use in Reproductive Health (ACQUIRE)/
Azerbaijan Reproductive Health and Family Planning Project

Georgia

Healthy Women in Georgia
Sustaining Family Planning and Maternal and Child Health Services (SUSTAIN)

Romania

Romania Family Planning Project
Romanian Family Health Initiative

Russia

Contraceptive Social Marketing Project
Institutionalizing Best Practices in Maternal and Child Health

Ukraine

Women's Reproductive Health Initiative
Together for Health
Healthy Women of Ukraine Program

Regional

American International Health Alliance
Healthcare Partnerships
Europe and Eurasia Regional Family Planning Activity

Bibliography

1. World Health Organization (WHO). WHO Regional Office for Europe: European Health for All Database: WHO, 2012. <http://data.euro.who.int/hfad/b/>
2. Popov AA, Visser AP, Ketting E. Contraceptive Knowledge, Attitudes, and Practice in Russia during the 1980s. *Studies in Family Planning* 1993;24(4):227-35. <http://www.ncbi.nlm.nih.gov/pubmed/8212092>
3. World Health Organization (WHO). The Tbilisi Declaration. *Planned Parenthood in Europe* 1991;20(1):27-8. <http://www.ncbi.nlm.nih.gov/pubmed/12343178>
4. Bergthold G, Rooks J, Stewart G. Evaluation of The Women's Reproductive Health Initiative in Ukraine. Washington DC: Population Technical Assistance Project, 1998. http://pdf.usaid.gov/pdf_docs/PDABS347.pdf
5. Zazo A, Dragoti E, Karaj T, Volle J. Albania Family Planning: Improving Access to and Use of Modern Contraceptive Methods among Young Men and Women. Washington DC: C-Change, 2011. <http://c-change-program.org/sites/default/files/Albania-FP-Improving-Access-and-Use-MCM.pdf>
6. EngenderHealth, Meridian Group International, IntraHealth International, ADRA. USAID, Caucasus, Azerbaijan. ACQUIRE Azerbaijan Reproductive Health and Family Planning Project and Azerbaijan Reproductive Health and Family Planning One-Year Follow-on Project Final Report. October 1, 2004-September 29, 2010, 2010. http://pdf.usaid.gov/pdf_docs/pdacq903.pdf
7. JSI Research & Training Institute, Inc. Scaling Up Access to Reproductive Health Services in Romania: The Romanian Family Health Initiative 2001-2007. Final Project Report: JSI Research & Training Institute, Inc., 2008. http://pdf.usaid.gov/pdf_docs/PDACL694.pdf
8. Population Services International. Contraceptive Social Marketing Project. Final Project Report, 1997. http://pdf.usaid.gov/pdf_docs/PDABP562.pdf
9. Futures Group International. SOMARC Country Work Plans, 1997-1998. http://pdf.usaid.gov/pdf_docs/PDABU186.pdf
10. JSI Research & Training Institute, Inc. Healthy Women in Georgia: Making a Difference. Final Report of the Healthy Women in Georgia Project: October 2003 to September 2009, 2009. <https://dec.usaid.gov/dec/content/Detail.aspx?ctID=ODVhZjk4NWQtM2YyMi00YjRmLTkxNjktZTcxMjM2NDhmY2Uy&rID=MzEwNjQw&sID=Mg==&bckToL=VHJ1ZQ==&qcf=&ph=VHJ1ZQ==>
11. John Snow, Inc. Albania Family Planning Situation Analysis 2007: The Europe and Eurasia Regional Family Planning Activity, 2007. http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10330&lid=3
12. John Snow, Inc. Azerbaijan Family Planning Situation Analysis 2007: The Europe and Eurasia Regional Family Planning Activity, 2007. http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=10331&lid=3
13. Kenney A-M, Vartapetova NV, Eifler K, Karpushkina AV. Institutionalizing Best Practices in Maternal and Child Health. Final Technical Report. Unpublished, 2012.
14. Stolarsky G, Peshkatari A, Charurat E.. An Evaluation of ACCESS-FP's Work in Albania: Postpartum and Postabortion Family Planning: Jhpiego, 2010. http://pdf.usaid.gov/pdf_docs/PDAGR921.pdf
15. Ministry of Labor, Health and Social Affairs (MOLHSA) Tbilisi, Georgia. Family Planning Clinical Practice Guidelines [Georgian], undated. http://www.moh.gov.ge/index.php?lang_id=GEO&sec_id=68&info_id=93
16. JSI Research & Training Institute, Inc. Together for Health: Final Project Report, 2012. http://tfh.jsi.com/Resources/Docs/tfh_final_report_2005-11.pdf
17. Emerging Markets Group, Ltd. Five Years Together: Advancing Maternal & Child Health in Armenia. Project NOVA Final Report, 2010. <http://www.hs-star.net/wp-content/uploads/2011/05/Project-NOVA-Final-Report.pdf>
18. Antarsh L, Bowers G, Johnson T, Liskin L, Margolis A, Pressman W, Starbird E, Wear D. The Russia Reproductive Health Program Strategy and Action Plan, 1995. http://pdf.usaid.gov/pdf_docs/PDABK212.pdf
19. Kumar A, Langer N, Tyrer L. Mid-term Evaluation of the Romania Family Planning Project: Datex, Inc., 1994. http://pdf.usaid.gov/pdf_docs/PDABH882.pdf
20. American International Health Alliance. Women's Wellness Center Directory, undated. http://www.aiha.com/en/WhatWeDo/WomensHealth_WWCDirectory.asp

21. John Snow, Inc. Albania Final Report: The Europe and Eurasia Regional Family Planning Activity, 2009. http://pdf.usaid.gov/pdf_docs/PNADT901.pdf
22. Lule E, Singh S, Chowdhury SA. Fertility Regulation Behaviors and Their Costs: Contraception and Unintended Pregnancies in Africa and Eastern Europe & Central Asia. Health, Nutrition, and Population, World Bank, 2007. <http://www.dcp2.org/file/159/fertilityregulationsfinal.pdf>
23. Chalmers B. Maternity Care in the Former Soviet Union. BJOG: An International Journal of Obstetrics and Gynaecology 2005;112(4):495-9. <http://www.ncbi.nlm.nih.gov/pubmed/15777451>
24. Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence Based Medicine: What It Is and What It Isn't. BMJ 1996;312(7023):71-2. <http://www.ncbi.nlm.nih.gov/pubmed/8555924>
25. Health Care Improvement Project. Improvement Methods, undated. <http://www.hciproject.org/node/439>
26. Haffey J, Berdzuli N, Umikashvili L, Kajaia K. Managing Uncertainty: Piloting Supportive Supervision in Georgia: Europe and Eurasia Regional Family Planning Activity and Healthy Women in Georgia Program, 2009. http://pdf.usaid.gov/pdf_docs/PNADT906.pdf
27. Health Care Improvement Project. Client-Oriented, Provider-Efficient (COPE), undated. http://www.hciproject.org/improvement_tools/improvement_methods/approaches/COPE
28. Berdzuli N, Rossi E, Zlidar V. Improving Family Planning Pre-Service Education: Experience from the Eastern Europe and Eurasia Region. The Europe and Eurasia Regional Family Planning Activity: John Snow, Inc., 2009. http://pdf.usaid.gov/pdf_docs/pnadt909.pdf
29. David HP. Eastern Europe: Pronatalist Policies and Private Behavior. Population Bulletin 1982;36(6):1-49. <http://www.ncbi.nlm.nih.gov/pubmed/12338315>
30. Bradatan C, Firebaugh G. History, Population Policies, and Fertility Decline in Eastern Europe: A Case Study. Journal of Family History 2007;32:179-92. http://www.academia.edu/230396/History_Population_Policies_and_Fertility_Decline_in_Eastern_Europe_A_Case_Study
31. Institute for Mother and Child Health Care Bucharest, Romania; Centers for Disease Control and Prevention Atlanta, Georgia, USA. Romania Reproductive Health Survey 1993 Final Report, 1995. http://pdf.usaid.gov/pdf_docs/PNACH221.pdf
32. Adventist Development and Relief Agency; Azerbaijan Ministry of Health; State Committee of Statistics; Mercy Corps; Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC); U.S. Agency for International Development (USAID); United Nations Population Fund (UNFPA); United Nations High Commissioner for Refugees (UNHCR), Reproductive Health Survey Azerbaijan, 2001: Selected Findings, 2002. http://pdf.usaid.gov/pdf_docs/PNACQ853.pdf
33. National Statistical Service Yerevan, Armenia; Ministry of Health Yerevan, Armenia; ORC Macro. Armenia Demographic and Health Survey 2000, 2001. <http://www.measuredhs.com/pubs/pdf/FR126/FR126.pdf>
34. Kiev International Institute of Sociology; Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC); U.S. Agency for International Development (USAID). 1999 Ukraine Reproductive Health Survey: Final Report, 2001. http://www.google.com/url?sa=t&rcct=j&q=&esrc=s&source=web&cd=2&ved=0CEIQFjAB&url=http%3A%2F%2Fstacks.cdc.gov%2FobjectView!getDataStreamContent.action%3Fpid%3Dcdc%3A8269%26dsid%3DDDS1%26mime%3Dapplication%2Fpdf&ei=SbbSULLED_KN0QG VtoGgDg&usg=AFQjCNHa8kvKkTToeZeY_SAuvarHCDkK7w&bvm=bv.1355534169,d.dmQ
35. Federal State Statistic Service (ROSSTAT); Ministry of Health and Social Development of Russia; Information and Publishing Center "Statistics of Russia"; United Nations Population Fund (UNFPA); Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC). Georgia Reproductive Health Survey 1999-2000, 2001. <http://stacks.cdc.gov/view/cdc/8242/>
36. Georgia Center for Disease Control (NCDC). Georgia Reproductive Health Survey 1999-2000, 2001. <http://stacks.cdc.gov/view/cdc/8242/>
37. Georgia Center for Disease Control (NCDC); Georgian Ministry of Labor, Health and Social Affairs (MOLHSA); Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC). Georgia Reproductive Health Survey 2010, 2011. <http://stacks.cdc.gov/view/cdc/8251/>
38. National Center for Disease Control and Medical Statistics (NCDC); Ministry of Labor, Health and Social Affairs (MOLHSA); Department of Statistics Ministry of Economic Development Tbilisi, Georgia; Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC); United Nations Population Fund (UNFPA); U.S. Agency for International Development (USAID). Reproductive Health Survey, Georgia 2005. Final Report. In: Serbanescu F, Imnadze P, Bokhua Z, Nutsbidze N, Jackson DB, Morris L, editors, 2007. <http://www.google.com/url?sa=t&rcct=j&q=&esrc=s&source=web&cd=3&ved=0CEMQFjAC&url=http%3A%2F%2Fstacks.cdc.gov%2FobjectView!getDataStreamContent.action%3Fpid%3Dcdc%3A8275%26dsid%3DDDS1%26mime%3Dapplication%2Fpdf&ei=6R3JUNvxMMW60AHgm4HIAw&usg=AFQjCNE dngybo1ggL-RWnIveeFpcIrg7VQ&bvm=bv.1355272958,d.dmQ>
39. National Statistical Service Yerevan, Armenia; Ministry of Health Yerevan, Armenia; ORC Macro. Armenia Demographic and Health Survey 2005, 2006. <http://www.measuredhs.com/pubs/pdf/FR184/FR184.pdf>
40. National Statistical Service Yerevan, Armenia; Ministry of Health Yerevan, Armenia; ICF International. Armenia Demographic and Health Survey 2010, 2012. <http://www.measuredhs.com/pubs/pdf/FR252/FR252.pdf>

41. State Statistical Committee of the Republic of Azerbaijan; Macro International Inc. Azerbaijan Demographic and Health Survey 2006, 2008. <http://www.measuredhs.com/pubs/pdf/FR195/FR195.pdf>
42. Ukrainian Center for Social Reforms Kyiv, Ukraine; State Statistical Committee Kyiv, Ukraine; Ministry of Health Kyiv, Ukraine; Macro International Inc. Ukraine Demographic and Health Survey 2007, 2008. <http://www.measuredhs.com/publications/publication-FR210-DHS-Final-Reports.cfm>
43. Romanian Association of Public Health and Health Management (ARSPMS) School of Public Health; University of Medicine and Pharmacy “Carol Davila” National Commission for Statistics (CNS) Bucharest, Romania; Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC) Atlanta, Georgia, USA; U.S. Agency for International Development (USAID); United Nations Population Fund (UNFPA); United Nations Children’s Fund (UNICEF). Romania Reproductive Health Survey 1999, 2001. <http://stacks.cdc.gov/view/cdc/8249/>
44. Ministry of Health; World Bank; United Nations Population Fund (UNFPA); U.S. Agency for International Development (USAID); United Nations Children’s Fund (UNICEF); JSI Research & Training Institute, Inc.; World Health Organization (WHO); Swiss Agency for Development and Cooperation; Institute for Mother and Child Care. Reproductive Health Survey: Romania, 2004. Summary Report, 2005. http://www.unecp.org/fileadmin/DAM/stats/gender/vaw/surveys/Romania/Romania_Publication.pdf
45. United Nations Population Division (UNDP). World Contraceptive Use 2010: UNDP, 2011. http://www.un.org/esa/population/publications/wcu2010/WCP_2010/Data.html
46. Trussell J. Contraceptive Efficacy. In: Hatcher RA, Trussell J, Nelson AL, Jr. Cates W, Stewart FH, Kowal D, editors. Contraceptive Technology. 19th ed, 2007
47. Albania Institute of Public Health (IPH); Albania Ministry of Health; Albania Institute of Statistics (INSTAT); Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC); U.S. Agency for International Development (USAID); United Nations Population Fund (UNFPA); United Nations Children’s Fund (UNICEF). Albania Reproductive Health Survey 2002. Final Report, 2005. <http://stacks.cdc.gov/view/cdc/8243>
48. Institute of Statistics, Institute of Public Health [Albania], ICF Macro. Albania Demographic and Health Survey 2008-09, 2010. <http://www.measuredhs.com/pubs/pdf/FR230/FR230.pdf>
49. Haub C. Russian Birth Rate Continues to Rise. <http://prbblog.org/index.php/2011/04/22/russian-birth-rate-continues-to-rise/>
50. Zlidar VM, Gardner R, Rutstein SO, Morris L, H. G. New Survey Findings: The Reproductive Revolution Continues. Population Reports 2003; Series M(17)
51. Westoff CF. DHS Analytical Studies No. 8: Recent Trends in Abortion and Contraception in 12 Countries. Calverton, MD: ORC Macro International, 2005. http://pdf.usaid.gov/pdf_docs/PNADB984.pdf

U.S. Agency for International Development

1300 Pennsylvania Avenue, NW

Washington, DC 20523

Tel: (202) 712-0000

Fax: (202) 216-3524

www.usaid.gov