Contraceptive Use in the Countries of the Former Soviet Union: Two Decades of Transition

ABSTRACT

Over the past two decades the countries of the former Soviet Union have experienced unprecedented change in the accessibility of modern contraceptive methods. With the rise of the private sector, the influx of international donor assistance for family planning, and government commitments to reproductive health policy reforms, abortion rates have plummeted and contraceptive prevalence has risen. Where previously women had to rely on abortion for fertility control, in many countries women and couples now have access to a range of contraceptive methods through private pharmacies and even their primary healthcare providers. Recent survey data, however, signal a slowing of improvements in many countries as donor assistance wanes and pro-natalist policies stifle family planning efforts. Considerable work remains to ensure that the gains that have been made since independence are not lost and women, men, and couples in the region can realize their reproductive goals with safe, modern methods of contraception.

INTRODUCTION

"Wide acceptance of modern contraception requires (1) availability, (2) accessibility, and (3) a general perception that efficient contraceptive practice is preferable to reliance on abortion" (David 1999). In countries of the former Soviet Union, climbing contraceptive prevalence and decreasing abortion rates over the last two decades offer evidence of the continued realization of these three factors. Government and international donor coordination and commitment, along with the influx of Western ideas about sexual and reproductive health, have made possible the shift from abortion to contraception. As progress slows, and even stagnates in some countries, however, renewed attention must be paid to ensure that women and

men across Eastern Europe and Eurasia can realize their reproductive goals. This paper briefly describes and offers some explanations for recent trends in contraceptive and abortion use in twelve countries of the former Soviet Union: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

TRENDS IN CONTRACEPTIVE & ABORTION USE

Data on contraceptive use in the USSR were limited at best. Official national statistics did not include contraception and almost nothing is known about contraceptive practice up until the mid-1970s (Popov and David 1999). The little that is known about reproductive behavior in the two decades preceding independence comes from small surveys primarily conducted in Russia and one national survey carried out by the former Central Statistical Committee of the USSR, Goskomstat, in 1990 (Popov et al. 1993). These studies showed that traditional methods such as rhythm, vaginal douches, and withdrawal were the most common means of contraception, while about a quarter of users chose condoms and 10% used the IUD. Only about 1-3% of contraceptive users reported use of oral contraceptives (Popov et al. 1993). Measuring contraceptive prevalence from these data is not straightforward. The 1990 Goskomstat results report the percentage of women 15-49 who "always use" (18.7%) and "sometimes use" (57.7%) contraception. Using national data on the number of IUDs inserted and manufacturing and import data for other types of methods, Andeev (1994) estimated the contraceptive prevalence in the USSR to be approximately 29-35% between 1979 and 1988. However, over the decade the ratio of modern to traditional method use rose dramatically with the percentage of IUDs increasing from 4.3 to 41.5%.

Even given the dubious quality of Soviet era statistics, most of the Republics experienced an obvious increase in contraceptive use post-independence at least through the 1990s. Figure 1

compares modern contraceptive prevalence rates in twelve former Soviet Republics between 1990 and 2007[1]. Rates increased dramatically - at least doubling in every country except Armenia, which increased by 46% - between 1990 and the end of the decade. More recently, however, use has risen more slowly and even appears to have stagnated in some countries. Survey data collected since 2000 show that overall contraceptive prevalence has only increased in Georgia, Belarus, and Tajikistan. However, use of modern contraception has increased in six countries, while traditional method use has declined in eight (Figure 2). Though the reduction in traditional method use may signify an overall increase in contraceptive effectiveness, other changes in contraceptive method mix include increases in less effective barrier methods, i.e. condoms. As Table 1 shows, IUD use declined in eight countries between the two most recent surveys and Russia and Moldova experienced substantial decreases of more than 10 percentage points. At the same time, condom use increased in Russia, Ukraine, and Belarus. These increases may partly be due to increased HIV prevention efforts promoting condom use in these European former Republics, which, of course, should be viewed as a success. Every country in the region experienced an increase in hormonal method use ranging from an increase of 0.01 percentage points in Armenia to 4.25 points in Kazakhstan. Sterilization remained largely unchanged across the region.

[1] 1990 figures come from the Goskomstat All-Union Survey and are based on the percent of all women reporting always using a contraceptive method (Goskomstat 1991); other figures come from Demographic and Health Surveys (DHS), Reproductive Health Surveys (RHS), and Multiple Indicator Cluster Surveys (MICS) carried out between 1995 and 2007 (CDC 1998; Macro International 1998; Serbanescu 1998; Macro International 2000; Goldberg 2001; Macro International 2001a, 2001b; Serbanescu 2001, 2003; Macro International 2004; Serbanescu 2005; Macro International 2006a, 2006b; UNICEF 2007; Macro International 2008a, 2008b). Figures for Russia 2003 come from the Russia Longitudinal Monitoring Survey (RLMS) (Perlman and McKee 2009).

(WILL TALK HERE ABOUT AGE-SPECIFIC CHANGES; ESPECIALLY HOW CHANGES IN AGE AT MARRIAGE, ETC. IS AFFECTING TFR, CPR AND METHOD MIX.)

Data on unmet need present a varying picture in the region over the last five to ten years (Figure 3). Unmet need has clearly fallen substantially since Soviet times, and in some countries such as Georgia, Ukraine, Kazakhstan, and Tajikistan the most recent available data show a continued decline in unmet need for any type of contraception, including modern methods. In Armenia, Azerbaijan, and Moldova, however, unmet need increased between the two most recent population-based surveys. In Kyrgyzstan and Uzbekistan unmet need for any method fell while unmet need for modern methods increased slightly. Given the much higher reliance on traditional methods in the countries of the Caucuses (Armenia, Azerbaijan, and Georgia) and the European Republics (Belarus, Russia, Ukraine, and Moldova), the difference between unmet need for any method and that for modern method is as high as 37 percentage points in Azerbaijan (WILL ADD SOMETHING ABOUT RUSSIA).

In every country in the region, use of abortion has fallen substantially since independence. Nationally reported abortion statistics and those generated from surveys vary widely making comparison difficult, however. Since national statistics do not include abortions carried out in the private sector, a phenomenon occurring more and more often in every country, survey data likely present a more accurate picture of abortion practice. Unfortunately, reliable population-based survey data on abortion do not exist for every country. The multi-indicator cluster surveys (MICS) carried out in the Central Asian Republics do not collect data on abortion, therefore, for these countries the most recent figures come from DHS or RHS performed between 1997 and 2001. (WILL LOOK FOR TAR FIGURES FOR CAR) Table 2

shows that even in countries with stagnating CPR, for example in Armenia and Azerbaijan, total abortion rates have fallen substantially over the last few years. In Ukraine, the total abortion rate (TAR) fell from 1.6 to 0.4 abortions per woman putting the country on par with Western European nations. This decline occurred even though overall contraceptive prevalence did not change over the time period. It should be noted, however, that use of modern methods of contraception increased by more than 10 percentage points and traditional method use fell by the same amount. Age-specific abortion rates are not available from Soviet data, however estimates of the total abortion rate for the period just before independence range from 2-5.5 abortions per woman (Popov and David 1999).

An in-depth analysis of the changing fertility patterns in the former Soviet Republics is beyond the scope of this paper; however, it should be mentioned that the dramatic reduction in abortion rates and increase in contraceptive use that immediately followed independence coincided with declining fertility in every country. Between 1990 and 2000, fertility fell on average across the region by 1.1 children per woman (declines ranged from 0.6 in Ukraine to 1.94 in Turkmenistan). In contrast, average fertility actually increased by 0.18 children per woman (increase ranged from 0.03 in Uzbekistan to 0.64 in Kazakhstan) between 2000 and 2007 (Figure 4).

The early 1990s saw a continued decline in the age at first marriage and birth for women across the region. In 1989 the average ages of marriage and first birth for women in the former Soviet Republics were 22.4 years and 23.1 years, respectively. The average age of marriage and first birth fell to lows of 21.7 and 22.7 respectively in 1994, but since then they have rebounded to 23.7 and 23.9 (Figure 7). Interestingly, the gap between marriage and first birth appears to

have shrunk over the last 20 years (BUT MAYBE OTHER THINGS EXPLAINING THIS – WILL EXPLORE THIS MORE)

FACTORS ASSOCIATED WITH CHANGE

The political, social, and economic changes experienced by the countries of the former USSR over the past two decades have affected virtually every aspect of public and private life. The realm of health, and, specifically, reproductive health, has been no exception. The dramatic decline in the use of abortion and increased contraceptive prevalence across the region can be directly attributed to significant shifts in reproductive health policy, growth of the private healthcare market, and the introduction of evidence-based medicine in training and practice. The opening of the former Soviet bloc has allowed the influx of both ideas and resources that have made crucial contributions not only to ongoing health reform efforts, but also to the realization of reproductive rights across the region.

The Decline of "Abortion Culture"

The historical reasons for Soviet women's reliance on induced abortion for fertility control have been well documented (Remennick 1991; David 1992; Hutter 2003). Falling fertility desires coupled with a lack of effective contraceptives in the region resulted in the highest recorded abortion rates anywhere in the world (Popov 1990; David 1991). The USSR's so called "abortion culture" evolved not only from these immediate factors, but also from the political, economic, and social forces that kept reproduction in the public sphere and women's fertility a matter of significant state interest (Grant 2005). Family planning fell in the private realm and involved individual decision-making, while abortion and pregnancy were matters of medical, and, therefore, state interest. By providing all abortion services, restricting access to information about modern contraceptive methods from both providers and individuals, and not producing

sufficient contraceptive commodities to meet the need, the state kept a tight reign on reproduction.

The dissolution of state control across the region and the expansion of personal freedom and the private market have allowed women and couples newfound access to not only alternative technologies for controlling fertility, but also to new *ideas* about family planning and contraceptive use. In all but the Central Asian Republics, fertility had fallen to or below replacement level by the time of independence. Surveys carried out at the time in Russia reported desired fertility levels of two children (Haub 1994). To stay at these low levels of fertility, however, women relied heavily on abortion. Thornton and Philipov (2009) use a framework of "developmental idealism" to explain the relatively rapid changes in fertility control away from abortion and toward contraceptive use in Central and Eastern Europe over the past two decades. They posit that the disintegration of government structures and the fall of the Iron Curtain allowed for a new understanding and embrace of the social, economic, and family structures of the West, which includes the choice to use contraception instead of abortion. Though certainly a latent demand for contraception among women forced to rely on abortion existed in the region, the developmental idealism framework states that women and couples took up modern methods once they were available in part because they wanted to emulate the "modern" countries of the West.

Both Thornton and Philipov (2009) and Grant (2005) point out that the adoption of such new ideas about reproduction is most likely to occur among younger generations who were never entrenched in the abortion culture. This hypothesis is supported by recent research on the transition to modern contraception in Russia. In their analysis of the 1996 and 1999 Women's Reproductive Health Surveys, Troitskaya and Andersson (2007) show that the largest increase in

modern method use occurred among the youngest women and women who had not previously used traditional methods of contraception. Their analysis also found that the transition to modern contraception occurred more rapidly in the latter part of the 1990s, which they attribute to improving economic conditions across the country.

(WILL PERFORM ADDITIONAL AGE-SPECIFIC ANALYSIS)

The Rise of the Private Sector (INCOMPLETE SECTION)

Recently in the Eastern Europe and Eurasia region, as in emerging markets globally, the private market has played a crucial role in meeting the family planning needs of the population. The private health care market has grown rapidly, with the privatization of pharmacies and dental services occurring first. An increasing number of health care facilities now have commercial or nongovernmental status, though they often still receive a large portion of their funding through state contracts (Armand et al. 2007). With the reform of health systems across the region and decrease in state control over social services, the amount of private spending on health care has increased dramatically with private expenditures exceeding that of public sector in some countries (Table 3).

The private and public sectors work best when they coordinate to meet the family planning needs of different segments of the population. By identifying those who can pay for commercial contraceptives in the private sector and those who need subsidized public sector commodities, the "whole market approach" can "target subsidized more efficiently, address market inefficiencies, and engage private suppliers that may play a role in meeting public health goals." (Armand et al. 2007, p.8) The stage of private market development varies widely among the countries of the former Soviet Union with Kazakhstan, Russia, and Ukraine supporting advanced markets, Kyrgyzstan, Armenia, and Georgia exhibiting intermediate market

development, and Tajikistan and Uzbekistan with little to no private market presence (Armand et al. 2007).

In Ukraine, the Ministry of Health, with the support of USAID, has engaged the pharmaceutical sector to improve the availability and affordability of a range of contraceptive methods in the country. In 2006, seven pharmaceutical companies agreed to contribute in-kind resources, train health providers and pharmacists, and support marketing of contraceptives while the MOH committed to meeting the needs of those most at need in the population. Involvement of the private sector in this region has also expanded method choice by bringing in new types of hormonal and barrier contraceptives, which are widely available through private pharmaceutical networks, though mainly in urban areas.

International Donor Support for Family Planning

In addition to new ideas and opportunities for the private sector, the opening of the Soviet bloc also prompted an influx of international development activity, which included a focus on improving reproductive health in the region. The UNFPA/WHO/IPPF-sponsored 1990 conference, "From Abortion to Contraception" in Georgia brought worldwide attention for the first time to the record high abortion rates in the Soviet Republics. The conference resulted in the Tbilisi Declaration, which called for specific action by country governments to improve reproductive health and reduce abortion (David 1991). International donor organizations including USAID, UNFPA, and the World Bank, among others, took on the charge of expanding contraceptive access by partnering with country governments to develop national reproductive health strategies, reform FP/RH policies, and overhaul medical training. The vast majority of the FP/RH improvement activity has taken place within the context of primary health care reform, which every country in the region has undertaken to a varying degree since independence.

Family Planning Policy Reform and Strategy Development

The integration of family planning into primary health care (PHC) services provided by family doctors (FD), general practitioners (GP), and, in some countries, by midwives and nurses has required significant policy change. In all countries, provision of contraceptives was historically the domain of obstetricians/gynecologists and even the sub-specialty of "reproductologists". This specialty control has been slow to change even with the rise of GPs and FDs. Kyrgyzstan has lead the way in the implementation of policy changes that allow the provision of FP counseling and services, including IUD insertions, by FDs, midwives, and nurses at the health post level. In addition to a strong commitment on the part of the government for health care reform, the impetus for change in the mountainous Central Asian Republic was partly a pragmatic response to the challenging geography of the country that limits access to specialty services for large segments of the population. Donor support of Kyrgyzstan's reforms, including training of medical personnel and updating of family planning practice guidelines, has increased access to a range of contraceptive methods for the country's rural populations. Kyrgyzstan's reforms now serve as a model for other countries in the region. (WILL ADD SPECIFIC RESULTS FROM THE KYRG PROGRAM)

In addition to liberalizing provision of services, in many countries health reform efforts have focused on increasing access to contraceptives by including family planning in the national Basic Health Benefit Package which ensures low cost or free provision. Some countries, such as Kyrgyzstan and Kazakhstan, include contraceptives on their essential drug lists (WIL ADD MORE SPECIFICS INCLUDING ADDITIONAL EXAMPLES OF RH/FP STRATEGY DEVELOPMENT IN THE REGION)

Implementation of health reform has required the introduction of evidence-based medicine

both in medical training and clinical practice. With donor support, most countries in the region have developed and endorsed evidence-based guidelines and protocols for family planning service delivery. Russia, Georgia, and Ukraine have recently implemented new national guidelines and protocols. (WILL ADD SPECIFICS) In most countries, however, the existing health quality assurance procedures follow an outdated, punitive model. While supportive supervision that involves and assists providers to improve the quality of health care services is still not widely practiced, a USAID-funded program in Georgia has introduced and developed some elements of supportive supervision practices in pilot facilities and has plans to institutionalize the system. (WILL ADD AN UPDATE) Another USAID project in Azerbaijan is implementing quality improvement systems in pilot districts using the COPE[2] methodology developed by Engender Health. COPE enables health teams to assess their own work, become more aware of client needs, and find solutions to problems they encounter. (WILL ADD RESULTS)

Commitment to improve service provider education in family planning is evidenced in many countries by incorporation of WHO recommendations and other state-of-the-art evidence into in-service medical training curricula either on a national level as has occurred in Russia, Georgia, and Kyrgyzstan, in pilot regions such as in Ukraine, Tajikistan, and as part of a national the reproductive health strategy in Azerbaijan. In addition, in Georgia and Kyrgyzstan, existing regulations related to medical licensing require that every provider receive in-service training in planning through a continuing medical education program (CME) and take a licensing exam every five years.

[2] COPE is a process and tool for quality improvement in family planning and reproductive health services: http://www.engenderhealth.org/ia/sfq/qcope.html.

Advances in pre-service family planning teaching for undergraduate medical students, as well as postgraduates, have been slower to take hold, however. Across the region, family planning is not adequately addressed in the teaching curricula, both in terms of evidence-based information and time devoted to its study. Teaching methodology relies mainly on lectures and provides little opportunity for interactive learning and supervised clinical practice. Recently, a regional activity to update pre-service medical education in family planning has been working with medical school faculty in Georgia, Kyrgyzstan, and Russia to develop and implement new, evidence-based FP/RH curricula for medical students.

Contraceptive Security

Assuring the reliable and uninterrupted supply of contraceptives for all who want them, when they want them is the essence of contraceptive security and the key requirement for developing and maintaining a quality family planning program. While contraceptive donations to the region have been relatively small (SHOULD WE ADD FIGURES?), UNFPA, USAID, and other donors including the German Development Bank (KfW) have donated contraceptive supplies to countries of the Caucuses and Central Asia since the early 1990s. In most cases, donors have coupled contraceptive donations with long-term technical assistance in the development, implementation, and scale-up of logistic management information systems (LMIS), forecasting contraceptive need, and planning for national contraceptive procurement. In Kyrgyzstan, partnering between the MOH, UNFPA, and USAID-supported projects has resulted in the implementation of a nation-wide LMIS that coordinates distribution of donated contraceptives throughout the country (WILL CHECK ON STATUS). Similarly, in Uzbekistan, UNFPA and KfW have both provided extensive support to the government of Uzbekistan to institute a sophisticated contraceptive logistics system. While other countries in the region are

operating pilot-stage systems or are just beginning to develop LMIS plans, the experience will prove crucial for future national contraceptive procurement and distribution.

In addition to bringing valuable logistics assistance, contraceptive donations have also introduced new contraceptive methods to the region including new oral and injectable hormonal methods. Data from Central Asia show that use of injectable contraception has increased (Table 1). Much of the access to this method has been through donated commodities in the public sector.

THE WAY FORWARD

Ensure Sufficient Commodities

A fundamental shift has occurred among countries of the former Soviet Union from predominant reliance on induced abortion for fertility control to the use of modern contraceptive methods. Considerable work remains, however, to ensure complete contraceptive security in the region. Among the biggest and most immediate challenges facing countries is that of limited resources devoted to procuring and distributing contraceptive commodities. Faced with competing health priorities, the challenge of health reform, and concerns about population decline, no country in the region has yet begun procuring its own contraceptives. Donations of commodities will end in the very near future and governments must be ready to meet the contraceptive needs of their populations, especially vulnerable populations who cannot access methods in the private sector. Developing procurement plans and ensuring that health budgets include a line item for contraceptive commodities should be a primary focus of donor activities in the near term.

At the same time, countries should capitalize on their burgeoning private markets. Women and couples of Eastern Europe and Eurasia increasingly look to the West for their

understanding of modernity, including new patterns of reproductive health behavior. They want to use modern contraceptives and the private market is the place they will look for them. Country governments must work with the private sector to ensure that the two are targeting the appropriate segments of the population. Most countries include contraceptives in their basic benefit packages, but, so far, few countries have successfully targeted the subsidized supplies to the most in-need in the population. The legacy of the Soviet *Semashko* healthcare system that provided state-financed free services to everyone has made many countries reluctant to charge for family planning commodities, especially donated commodities. Though seemingly "the right thing to do", the public sector's magnanimity often stifles the private sector by giving away commodities to people who could (and would) otherwise buy methods from the private sector. By instituting appropriate market segmentation and targeting with subsidized products only those who could otherwise not afford to purchase contraceptives, countries can ensure the continued growth of the private market and better meet the needs of the entire population with a range of different methods at different price points.

Continue to Expand the Method Mix

Women and men in the countries of the former Soviet Union currently have access to a greater range of contraceptive methods than any time in history. High levels of unmet need for contraception along with continued reliance on abortion, however, indicate that effective methods are still not available to everyone who would like to use them. Data from across the region show that abortion rates are highest among older women who have completed childbearing. Since marriage and childbearing occur early, women spend many years trying to avoid pregnancy after they have reached their desired family size. Even with this obvious need

for limiting methods of contraception, however, expanding access to long-term and permanent methods has not received sufficient attention in the region. IUD use has fallen in many countries over the last two decades and implants are unavailable. Historically low sterilization rates have remained virtually unchanged.

Low use of these methods represents both supply and demand challenges. The IUDs available during Soviet times were of low quality and many women discontinued use (Hutter 2003). Demand must be built for newer versions of the IUD including the 380A and progestin-releasing versions. Sterilization was illegal during Soviet times and has only been available since the early 1990s. In many countries it is almost impossible to meet all the requirements for sterilization and if one does, finding a trained provider with the appropriate equipment may prove even more difficult. Though the socio-cultural barriers to sterilization – both male and female – are significant in this region, mitigating misinformation and fear of these methods should be a focus of FP/RH programs. Adequately expanding the method mix also means appropriately tailoring messages about different types of so that couples who want to space births and those who have completed childbearing are knowledgeable about their options. (WILL EXPAND)

Focus on Evidence-Based Medical Training and Clinical Guidelines

One of the most important (and challenging) aspects of health reform in countries of the former Soviet Union has been the introduction of evidence-based medicine and a perspective of prevention. Much of the effort so far has taken the form of training new primary care practitioners, providing in-service training, and incorporating new clinical practice guidelines. For the family planning field, updating provider knowledge has specifically involved challenging long held skepticism toward hormonal and permanent methods of contraception and, more

generally, the usefulness of modern methods of family planning when abortion has historically been their "bread and butter" work. In order to overcome the systemic bias and ensure family planning provision becomes a basic element of primary health care, providers must be reached early with accurate information about contraceptive technology and quality contraceptive provision. This type of training will require a complete revision and expansion of pre-service family planning education for physicians and nurses. Training should incorporate counseling skills, a focus on post-partum and post-abortion contraceptive provision, and the opportunity for interactive learning and supervised clinical practice.

Updating and introducing new clinical practice guidelines and protocols is a straightforward and relatively simple first step for improving family planning service delivery. Actually ensuring that the new guidelines are followed, however, presents a much more difficult task. Currently, few or no mechanisms for monitoring adherence to new family planning service protocols exist anywhere in the region, nor is there uniform evidence that service providers are fully aware of the new provisions. In most countries, the recently developed guidelines do not include protocols for postpartum and post-abortion family planning service delivery, an area of particular importance given the high reliance on abortion in the region.

PLAN TO ADD SECTION ON DEMAND CREATION

[NOT A LOT OF WORK IN THIS REALM…success in Armenia but with negative response from the government… "relatively untapped potential of media-based health promotion efforts in the post-Soviet Republics"]

Tracking Progress

The quality of national statistics on family planning and reproductive health related indicators unfortunately remains unreliable across the region. As evidenced by the major discrepancies between national statistics on abortion and those reported in surveys, national data often do not capture activity outside of the public sector. Similarly, women who access their contraceptive supplies through the private sector are often not counted in estimates of contraceptive prevalence. Since the early 1990s, population-based surveys such as the Demographic and Health Surveys and Reproductive Health Surveys have served as the primary means of tracking the swiftly changing demographic picture in the region. Over the last decade, however, funding for these types of surveys has dried up as overall health funding for the region has waned. In Central Asia, neither type of survey has been carried out since 2002. Though the UNICEF-sponsored Multi-Indicator Cluster Surveys provide information on a limited number of indicators related to family planning and reproductive health, they are not as extensive as the larger surveys. Because collection of these types of data is crucial for affecting policy change and encouraging greater commitment to family planning and reproductive health, health reform efforts in every country should include a focus on improving national capacity for collecting and analyzing demographic and health data. In addition, in the near-term, donors and governments should devote the necessary resources to carry out population-based surveys such as the DHS.

CONCLUSION

The countries of the former Soviet Union have seen extraordinary improvements in the availability, accessibility and quality of contraceptive methods over the last two decades; and, as a result, many countries have experienced unprecedented declines in the use of abortion and increases in modern contraceptive prevalence. With the opening of the private sector and substantial investment by internationals donor agencies soon after independence, change came

quickly, with the largest increases in contraceptive use seen by the end of the 1990s. Recently, much of the initial family planning and reproductive health focus of the early health reform efforts has waned, however. Only a very small percentage of total health aid to the region is devoted to FP/RH (WILL TRY TO GET THIS FIGURE, AT LEAST FOR USAID). Unfortunately, the decline in FP/RH funding has occurred before country governments have made sufficient commitments to ensure quality contraceptive supplies and services for their populations. The loss of focus has meant backsliding on some of the gains made in Armenia and Azerbaijan, for example, where contraceptive prevalence actually fell between the two most recent surveys. Additionally, national-level data mask huge regional, rural-urban, and population sub-group differences. While women and men in urban areas have seen their family planning choices expand tremendously over the past few years, the majority of people living in rural areas still must rely on the public sector for their supplies, which often means little, if any, choice. Furthermore, because such little progress has been made in most countries in targeting the most vulnerable populations – the poor, adolescents, high risk groups such as sex workers – with services and supplies, large portions of the population still are not close to realizing their reproductive goals.

Preoccupied with declining fertility, policy makers in many countries cast suspicion on efforts to expand contraceptive access. Advocacy around the health benefits and cost savings associated with family planning use must be stepped up. At the same time, provision of contraceptive services must be expanded beyond the purview of ob-gyns and other reproductive health specialists who have made a living off of providing abortions. As long as this financial incentive exists, expecting these providers to switch to contraceptive provision is futile.

Though the “abortion culture”, once entrenched in the former Soviet Republics, has certainly begun to fade and women and men now demand access to quality contraceptive methods across the region, meeting the reproductive health needs of everyone in the countries of the former Soviet Union will require much more work.

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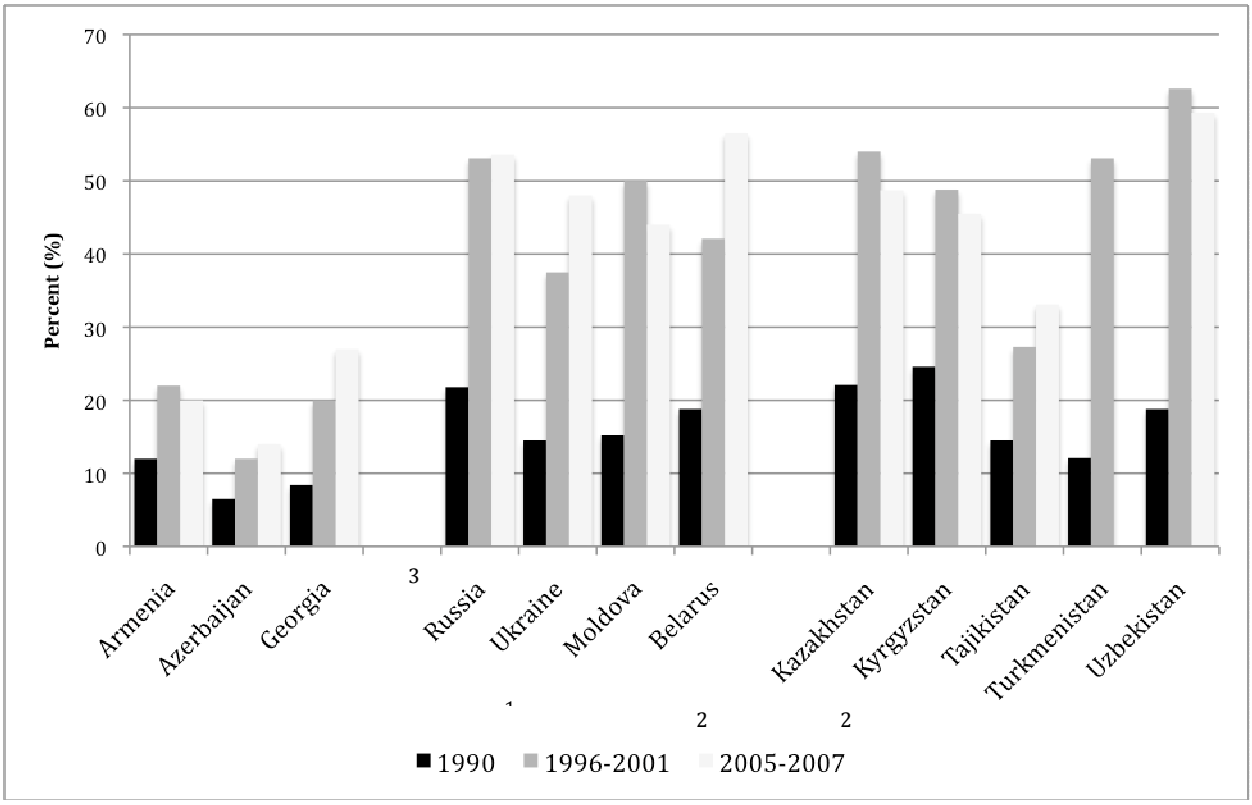
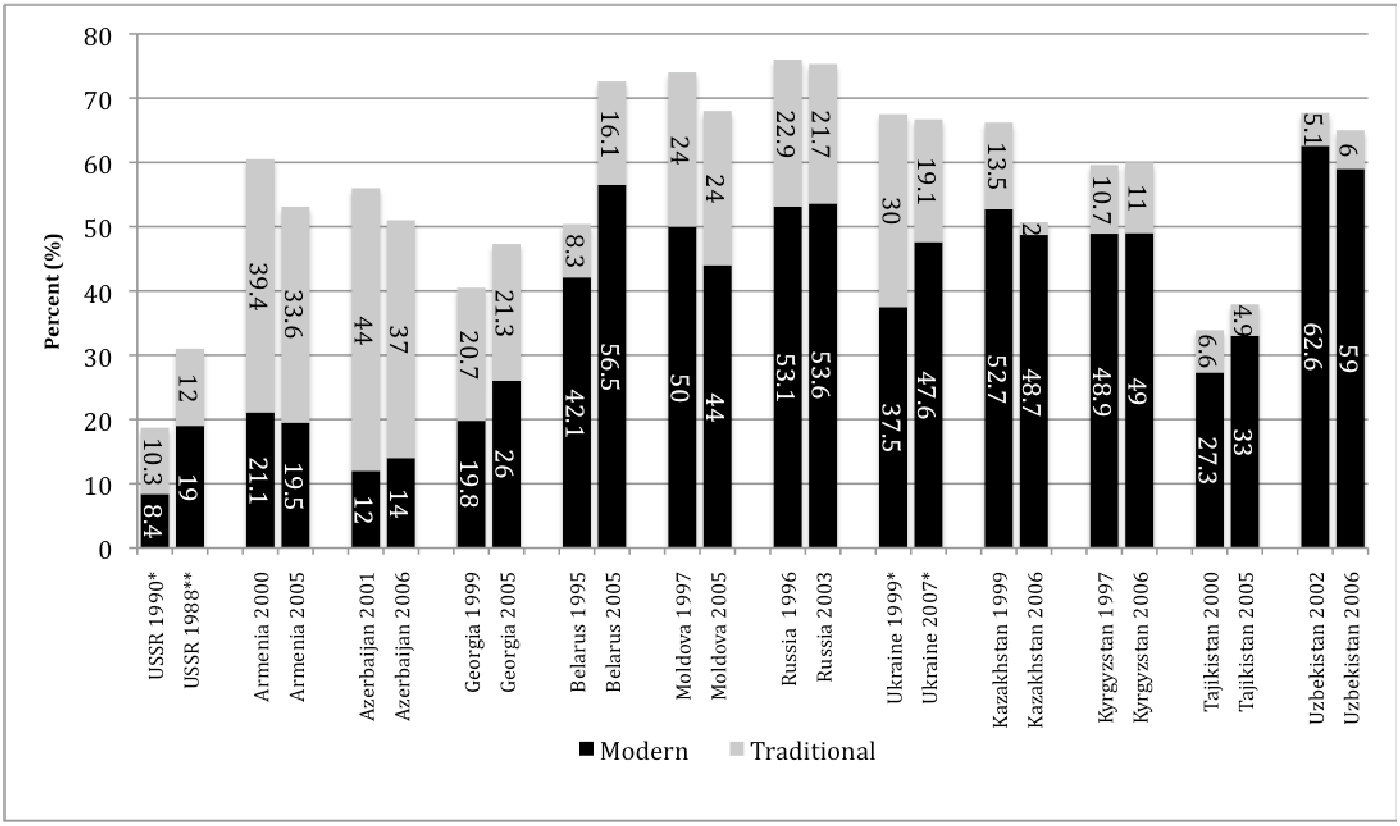
Figure 1: Contraceptive Use among Married Women Ages 15-49, 1990-2007



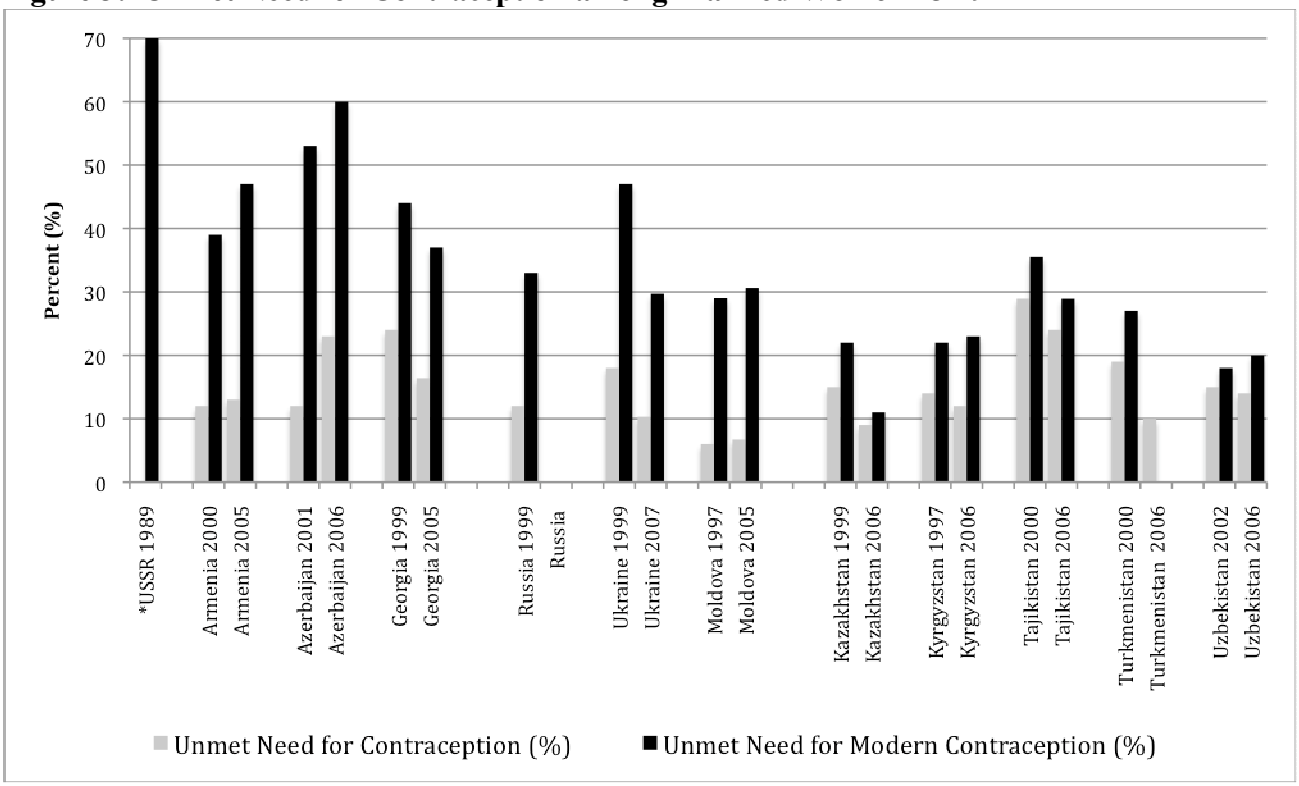
[1]1990 data are for all women 15-49 years
[2]DHS, RHS, or MICS carried out between these years.
[3]Russia 2005-2007 figure based on 2003 RLMS data reported in Perlman & McKee, 2009 (should be updated)

Figure 2: Traditional and Modern Contraceptive Use among Married Women 15-49, 1988-2007



*Includes all women 15-49
**Estimate based on official contraceptive service delivery, import, and manufacture reports (Avdeev 1994).

Figure 3: Unmet Need for Contraception among Married Women 15-49

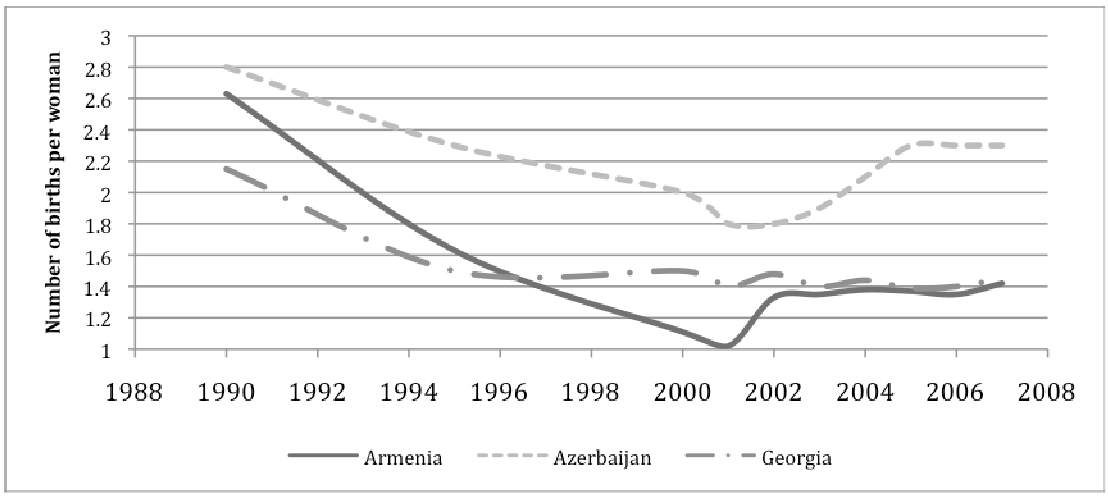


*Based on official USSR Ministry of Public Health statistics (Popov 1991).

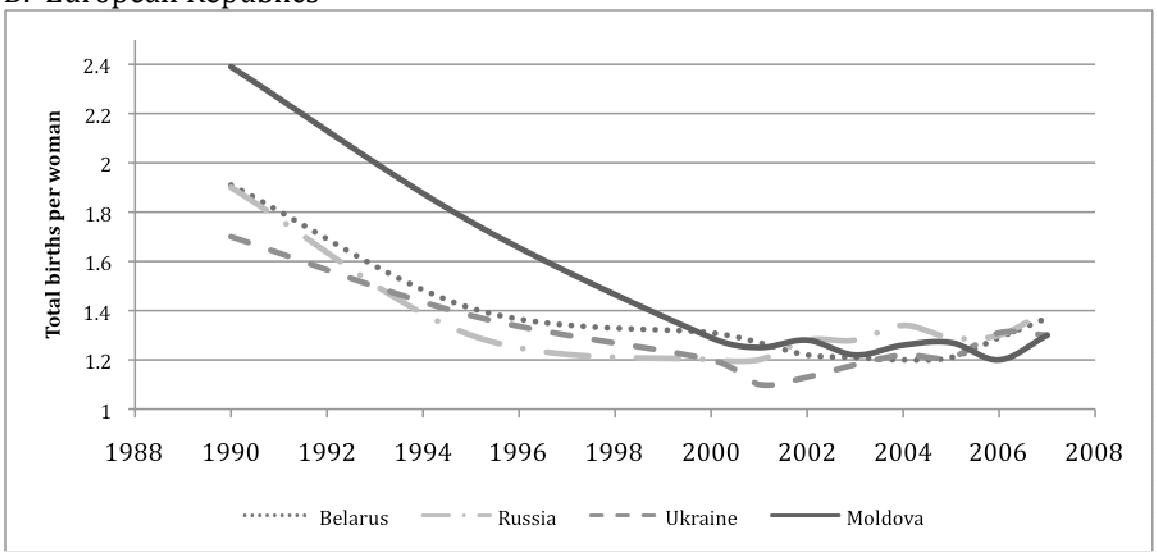
Unmet Need refers to the percentage of women in union who express a desire to space or limit births but who are currently not using a method of contraception. Unmet need for modern contraception includes all those with unmet need for contraception plus those currently using a less effective traditional method of contraception.

Figure 4: Total Fertility Rates by Country and Year (1990-2007)

A: Caucuses Countries



B: European Republics



C: Central Asian Republics

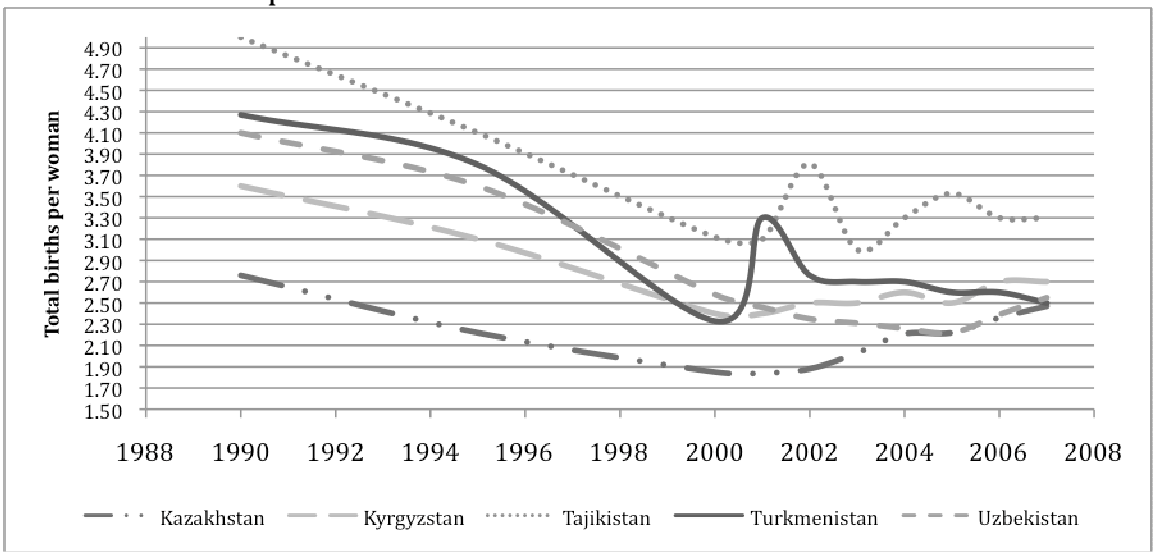
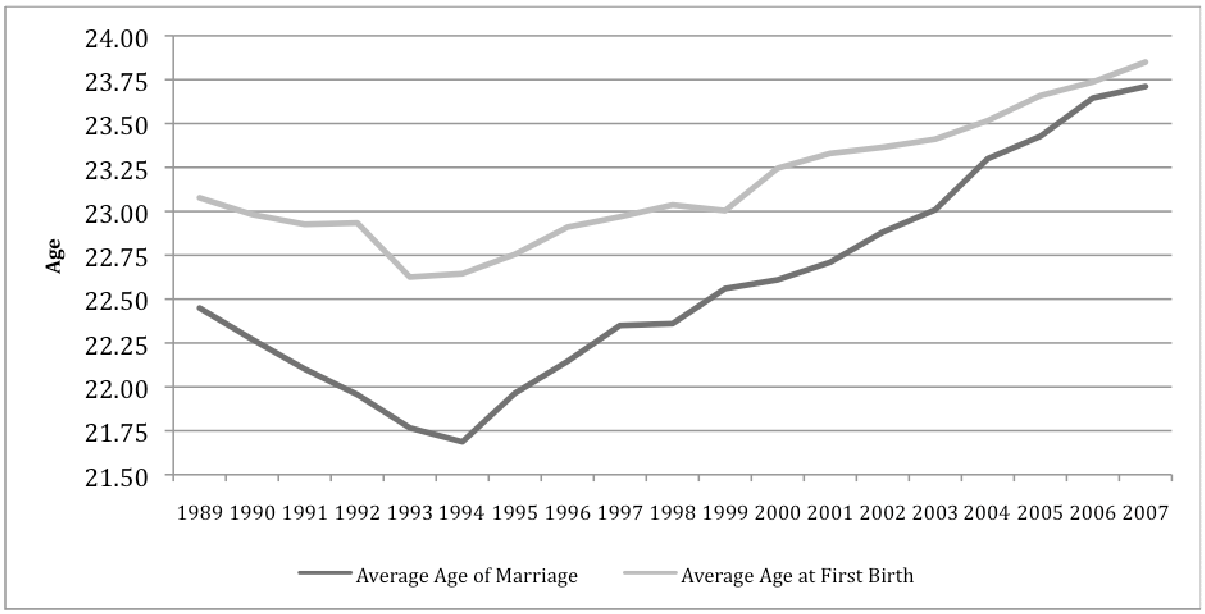


Figure 5: Mean Age of Marriage and First Birth for Women in Countries of the Former Soviet Union (excluding the Balkans), 1989-2007



Source: TransMONEE Database (UNICEF 2009)

Table 1: Contraceptive Method Mix for Married Women 15-49

Country	Survey Type and Date	F. ster.	Pill	Inject	Trad.	CPR
USSR est.	Estimate 1988	0	1.4	0	12.02	31.42
USSR	Goskomstat 1990	0	0.47	0.00	10.29	18.7
Armenia	DHS 2000	2.8	0.8	0.3	39.4	60.5
	DHS 2005	0.6	0.8	0.0	33.6	53.1
Difference		-2.2	0.01	-0.30	-5.83	-7.4
Azerbaijan	RHS 2001	1.2	1.0	0.0	43.6	55.4
	DHS 2006	0.4	1.1	0.0	36.8	51.1
Difference		-0.81	0.13	0	-6.81	-4.3
Georgia	RHS 1999	1.7	1.0	0.0	21.3	40.5
	RHS 2005	2.2	3.2	0.0	20.7	47.3
Difference		0.56	2.19	0	-0.64	6.8
Russia	RHS 1999	1.0	8.6	0.0	22.9	76
	RLMS 2003	1.7	10.5	0.0	21.7	75.3
Difference		0.67	1.95	0	-1.19	-0.7
Ukraine	RHS 1999	1.4	3.0	0.0	30.0	67.5
	DHS 2007	0.6	4.8	0.0	19.1	66.7
Difference		-0.82	1.76	0	-10.94	-0.8
Moldova	DHS 1997	3.4	2.1	0.0	23.7	73.7
	DHS 2005	4.7	3.6	0.0	23.9	67.8
Difference		1.29	1.46	0	0.20	-5.9
Belarus	UN Data 1995	0.8	6.7	0.0	8.3	50.4
	MICS 2005	2.4	10.4	0.0	16.1	72.6
Difference		1.59	3.68	0	7.8	22.2
Kazakhstan	DHS 1999	2.8	2.4	0.6	12.1	66.1
	MICS 2006	0.5	6.7	0.3	2.0	50.7
Difference		-2.34	4.25	-0.29	-10.12	-15.4
Kyrgyzstan	DHS 1997	1.8	1.7	1.3	10.7	59.5
	MICS 2006	0.9	5.1	1.2	2.3	47.8
Difference		-0.88	3.39	-0.11	-8.42	-11.7
Tajikistan	UN Data 2000	0.2	0.6	0.9	6.6	33.9
	MICS 2006	0.4	2.1	2.4	4.9	37.9
Difference		0.22	1.48	1.49	-1.71	4
Uzbekistan	DHS 2002	2.7	1.7	2.1	5.1	67.7
	MICS 2006	2.1	2.3	2.7	5.6	64.9
Difference		-0.63	0.58	0.63	0.44	-2.8

Table 2: Abortion Rate, Abortion Ratio, and Total Abortion Rate

	Rate per 1000 women 15-49[c]	Ratio per 1000 live births[b]	Total Abortion Rate (TAR)[c]
USSR 1988[a]	96	1161	3.3
Armenia 2000	81	343.4	2.6
Armenia 2005	54	291.3	1.8
Azerbaijan 2001	116	166.4	3.2
Azerbaijan 2006	--	140.1	2.3
Georgia 1999	130	390.9	3.7
Georgia 2005	104	419.7	3.1
Russia 1999	85	1695.7	2.3
Russia 2003	--	1156.9	--
Ukraine 1999	55	1204.5	1.6
Ukraine 2007[d]	--	498.8	0.4
Moldova 1997	43	839.3	1.3
Moldova 2005	--	441.5	1.1
Belarus 1995		804.8	
Belarus 2005	--	714.4	--
Kazakhstan 1999	48	652.4	1.4
Kazakhstan 2006	--	432.8	--
Kyrgyzstan 1997	51	212.4	1.5
Kyrgyzstan 2006	--	97.5	--
Tajikistan 2000		77.4	
Tajikistan 2006	--	54.4	--
Turkmenistan 2000	26		0.9
Turkmenistan 2006		153.8	
Uzbekistan 2002	--	105.4	0.9
Uzbekistan 2006	--	81.1	--

[a]Estimated TAR based on (find reference)
[b]Abortion ratio data from the WHO Health for All Database http://data.euro.who.int/hfadb
[c]Abortion rate and total abortion rate data from DHS and RHS
[d]Data from 2006

Table 3: Private Sector and Out-of-Pocket Health Expenditures by Country, 2005

Country	Private Sector Expenditure on Health as % of Total Health Expenditures	Out-of-Pocket Spending on Health as % of Total Private Health Expenditures
Armenia	56.5	89.2
Azerbaijan	75.2	84.6
Georgia	80.5	95.6
Belarus	24.2	69
Moldova	44.5	96.4
Russia	38	82.4
Ukraine	47.2	84.8
Kazakhstan	35.8	100
Kyrgyzstan	60.5	95
Tajikistan	77.2	96.6
Turkmenistan	33.3	100
Uzbekistan	52.3	97.1

Source: WHO Estimates, WHO Health for All Database, http://data.euro.who.int/hfadb/