

Ukraine

Results from the 2002 Survey

Worldwide, over 500,000 women and girls die of complications related to pregnancy and childbirth each year. Although over 99 percent of those deaths occur in developing countries, transitioning countries such as Ukraine continue to experience maternal death rates twice as high as countries in Western Europe.¹ But maternal deaths only tell part of the story. For every woman who dies as a result of pregnancy-related causes, some 30 women will develop short- and long-term disabilities, such as a ruptured uterus, pelvic inflammatory disease, or obstetric fistula² (see box on page 2).

Ukraine's maternal mortality rate continues at an unacceptably high level for a developed country. Although maternal mortality figures vary widely by source and are highly controversial, the best estimates for Ukraine suggest that some 140² women and girls die each year due to pregnancy-related complications. Additionally, approximately another 2,800³ Ukrainian women and girls will suffer from injuries or disabilities caused by complications during pregnancy and childbirth each year.

The tragedy—and opportunity—is that many of these deaths can be prevented with cost-effective health care services. Reducing maternal mortality and disability will depend on

identifying and improving those services that are critical to the health of Ukrainian women and girls, including post abortion care, antenatal care, emergency obstetric care, adequate postpartum care for mothers and babies, and services for family planning and sexually transmitted infections (STIs), including HIV/AIDS. With this goal in mind, the Maternal and Neonatal Program Effort Index (MNPI) is a tool that reproductive health care advocates, providers, and program planners can use to

- assess current health care services
- identify program strengths and weaknesses
- plan strategies to address deficiencies
- encourage political and popular support for appropriate action
- track progress over time

Health care programs to improve maternal health must be supported by strong policies, adequate training of health care providers and logistical services that facilitate the provision of those programs. Once maternal and neonatal programs and policies are in place, all women and girls must be ensured equal access to the full range of services.

At-a-Glance: Ukraine

Population, mid-2004	47,432,000
Births attended by skilled personnel	100%
Total fertility rate (average number of children born to a woman during her lifetime)	1.2
Percent TFR attributed to births by ages 15-19	13
Contraceptive use among married women, ages 15-49, modern methods	38%

Sources: Population Reference Bureau – 2002 *Women of Our World*; 2004 *World Population Data Sheet*; *The World's Youth, 2000*; and 1999 *Breastfeeding Patterns in the Developing World* (see www.prb.org/datafinder).



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Understanding the Causes of Maternal Mortality and Morbidity

Maternal mortality refers to those deaths that are caused by complications due to pregnancy or childbirth. These complications may be experienced during pregnancy or delivery itself, or may occur up to 42 days following childbirth. For each woman who succumbs to maternal death, many more will suffer injuries, infections, and disabilities brought about by pregnancy or childbirth complications, such as ruptured uterus, hemorrhage, and obstetric fistula.⁴

Some of the direct medical causes of maternal mortality include hemorrhage or bleeding, infection, complications from abortion, hypertensive disorders, and obstructed labor. Other causes include ectopic pregnancy, embolism, and anesthesia-related risks.⁵ Conditions such as anemia, diabetes, hypertension, STIs, and others can also increase a woman's risk for complications during pregnancy and childbirth, and, thus, are indirect causes of maternal mortality and morbidity.

Efforts to reduce maternal mortality and morbidity must also address societal and cultural factors that affect women's health and their access to services. For example, societal norms, such as taboos around sex and a lack of confidentiality, may also discourage women and girls from seeking needed health care services—particularly if they are of a sensitive nature, such as family planning or treatment of STIs.

Ensuring safe motherhood requires recognizing and supporting the rights of women and girls to lead healthy lives in which they have control over the resources and decisions that affect their health and safety. It requires raising awareness of complications associated with pregnancy and childbirth, providing access to high-quality health services (antenatal, delivery, postpartum, family planning, etc.), eliminating harmful practices, and encouraging healthy behaviors.

The Maternal and Neonatal Program Effort Index

In 2002 and 2003, around 900 reproductive health experts evaluated and rated maternal and neonatal health services as part of an assessment in 55 developing and transitional countries.⁶ The results of this study comprise the MNPI, which produced both international and country-specific ratings of relevant services. Using a tested methodology for rating programs and services,⁷ 10 to 25 experts in each country—who were familiar with but not directly responsible for the country’s maternal health programs—rated 81 individual aspects of maternal and neonatal health services on a scale from 0–5. For convenience, each score was then multiplied by 20 to obtain an index that runs from 0–100, with 0 indicating a low score and 100 indicating a high score.

The 81 items are drawn from 13 major components:

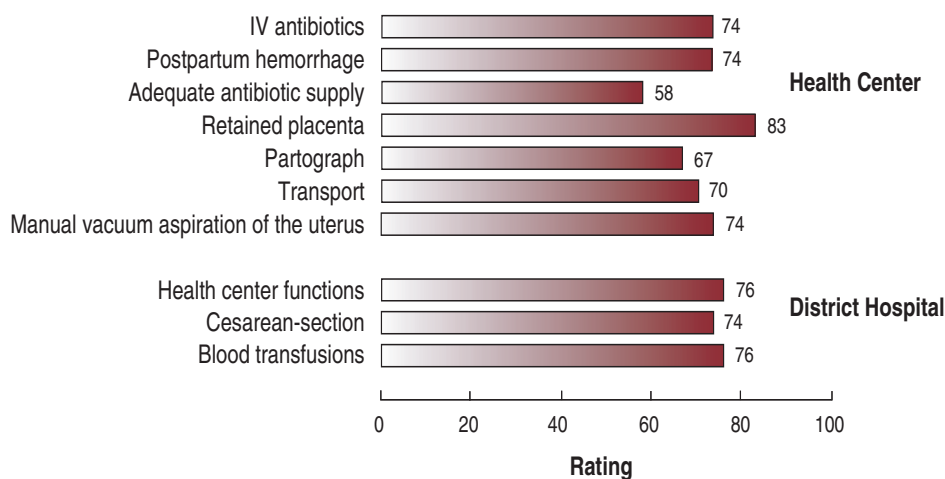
- Health center capacity
- District hospital capacity
- Access to services
- Antenatal care
- Delivery care
- Newborn care
- Family planning services at health centers
- Family planning services at district hospitals
- Policies toward safe pregnancy and delivery
- Adequacy of resources
- Health promotion
- Staff training
- Monitoring and research

Items from these categories can be further classified into five types of program effort: service capacity, access, care received, family planning, and support services. The following five figures, organized by type of program effort, present the significant indicators from the 2002 Ukraine study.

Service Capacity

Overall, Ukraine’s capacity to provide emergency obstetric care received a rating of 73 out of 100. Figure 1 shows ratings of the capacity of health centers and district hospitals to provide specific services. The manual removal of a retained placenta (83) is the most commonly available service at health centers in Ukraine, whereas having an adequate supply of antibiotics available (58) is the least available service. District hospitals received moderately high ratings for all three areas; providing the basic set of health center functions and transfusions (both 76) and performing Cesarean-sections (74).

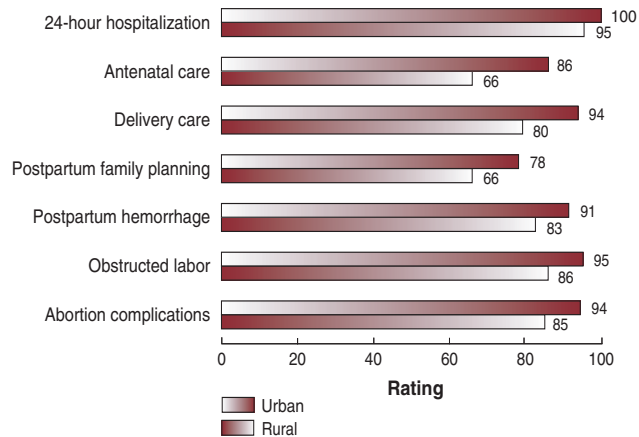
Figure 1. Service capacity of health centers and district hospitals in Ukraine



Access

In most countries, access to safe motherhood services in rural areas is more limited than in urban areas. This issue is important for Ukraine, with 32 percent⁸ of its population living in rural areas. Overall, Ukraine received a rating of 85 for access, with an average of 79 for rural access and 91 for urban access. Figure 2 presents the rural and urban access ratings for seven services. For all service areas, there are gaps in the ratings for rural and urban access. Rural access scores ranged from a low of 66 for both antenatal care and postpartum family planning to a high of 95 for 24-hour hospitalization—suggesting a need to increase access to a variety of services. Even urban access leaves definite room for improvement.

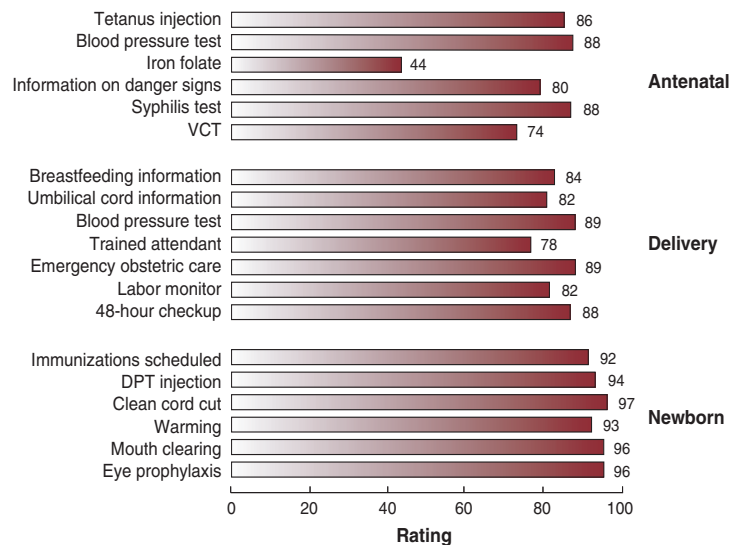
Figure 2. Comparisons of access to services in rural and urban areas in Ukraine



Care Received

In most countries, newborn services are rated higher than delivery care or antenatal care, and this was the case for Ukraine as well. Overall, care received was given a rating of 85, with newborn care receiving an average rating of 95 compared with 77 for antenatal care and 85 for delivery care. Figure 3 presents key indicators for each type of care. One of the more important indicators of maternal mortality is the presence of a trained attendant at birth,⁹ which received a rating of 78. Other crucial elements that reduce maternal mortality are emergency obstetric care and the 48-hour postpartum checkup, which are rated 89 and 88, respectively. Provision of iron folate received the lowest rating (44), whereas having newborns’ umbilical cord cut with a clean blade received the highest rating (97).

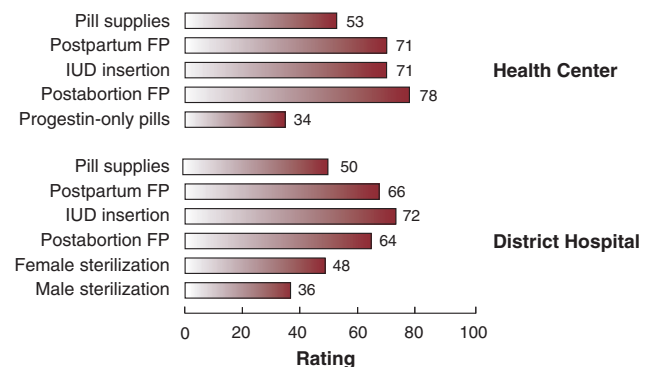
Figure 3. Antenatal, delivery, and newborn care received in Ukraine



Family Planning

Ukraine’s family planning services provided by health centers and district hospitals together received an overall rating of 59. Figure 4 presents the ratings for individual family planning services provided by health centers and district hospitals. These ratings consider facility capacity, access, and care received. Family planning scored higher at the health center level (62) than the district level (56), but both scores are tragically low. Availability of postabortion family planning in health centers scored the highest of all categories with the still low score of 78. The availability of progestin-only pills (34) was the lowest-rated service for health centers, whereas access to male sterilization was the lowest for district hospitals (36).

Figure 4. Provision of family planning services at health centers and district hospitals in Ukraine



Policy and Support Functions

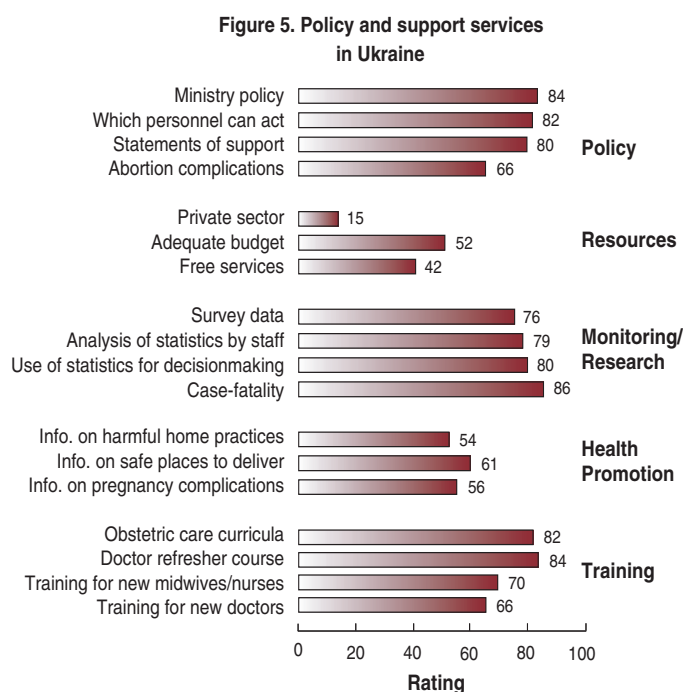
Policy and support functions in Ukraine received an overall rating of 66. Ratings for support functions, shown in Figure 5, are divided into the following categories: policy, resources, health promotion, training, and monitoring. In relation to the other support functions, policy received the highest average ratings. Ukraine's ministry-level policy on maternal health received a fair rating of 84. Commitment to this policy and safe motherhood, however, needs to be reinforced through policies on the treatment of abortion complications—an aspect of policy that only received a rating of 66 and is extremely important in Ukraine, where the abortion rate is 36.4 per 1,000 women age 15–44.¹⁰

Policies, even when they have been adopted, do not automatically translate into high-quality services at the local level. Many of the support functions in Ukraine, including resources and health promotion, are in need of further development. Although the government budget scored the highest in available resources, the score was only 52, clearly highlighting the need to increase resources from all possible avenues.

Health promotion and education of the public are important adjuncts to the provision of health services. Topics such as harmful home practices (54), pregnancy complications (56), and safe places to deliver (61) all require attention in Ukraine. Mass media should be used to educate the public about safe pregnancy and delivery, and community-based organizations should assist these efforts through systematic programs.

The education and training of health professionals is an integral part of providing good-quality care and preventing maternal death and disability. Although ratings suggest that curricula (82) have been developed, actual training in Ukraine is generally poorer, and was found to be weakest in the area of training for new doctors (66).

Finally, the ratings also suggest that Ukraine is in need of improved monitoring and research capabilities, particularly the availability of survey data on maternal events (76) and regular analysis of results from routine statistics (79).



Global Comparisons

All ratings in the study are also organized under 13 major components (see page 3), which overlap the five types of program efforts above. The 13 main components capture facility capacities, as in the first two items, but also the percentage of the whole population that has reasonable access to those facilities, in the third item. The next three items measure effort for antenatal, delivery, and newborn care. The next two concern the provision of family planning in health centers and the district hospitals, because the prevention of unintended pregnancies considerably reduces the numbers and rates of maternal mortality. The last set of items concerns support and back-up functions: policies and resources from the central level, then health promotion and training, and finally monitoring and research.

Table 1 compares Ukraine's scores with the global averages for these 13 components, and the overall total of the MNPI. For Ukraine, neonatal care has the highest rating. Access to services rates fairly high (85), but this is mainly because of high access in urban areas. Delivery care also scored 85. The lowest rating occurs for resources (37). Family planning in district hospitals and health promotion also scored low with each receiving a 56.

When comparing the profiles for Ukraine and all countries, Ukraine scored higher. This is expected as the majority of the countries used to calculate the average score are developing countries. However, this does not suggest that Ukraine has no room to improve. An overall score of 72 shows that substantial effort is still needed to reduce maternal and neonatal mortality and morbidity.

Table 1. Component Scores for Ukraine and All 55 Countries in the International Study for 2002

Selected MNPI Indicators	Ukraine	All Countries
Health center service capacity	72	49
District hospital service capacity	75	62
Access to services	85	53
Antenatal care services	77	62
Delivery services	85	59
Neonatal services	95	71
Family planning at health centers	62	58
Family planning at district hospitals	56	58
Policies	81	62
Adequate resources	37	48
Health promotion programs	56	50
Provider training	77	53
Monitoring and research	80	57
Overall MNPI Rating		
Total (average score for all 13 major components of maternal and neonatal health)	72	57

Summary

The MNPI ratings indicate that Ukraine's program efforts for better maternal and neonatal health have come a long way but still have far to go. The ratings for general policies are relatively high, but implementation for family planning in both health centers and district hospitals is not strong. In particular, availability of sterilization services, for both men and women, and availability of contraceptive pills scored very low. As increased usage of family planning services has shown a decrease in maternal mortality, it is important that

these services are available to all women who desire them. Indeed, family planning and resources are the only two components that scored below the score for all countries.

Favorable policies are common in most countries, but implementation typically lags behind. Ukraine needs to ensure that wise intentions are translated into high-quality, accessible, and affordable services and programs at the local level. In some respects, there are large disparities in access to services between rural and urban populations.

Priority Action Areas

The following interventions have been shown to improve maternal and neonatal health and should be considered in Ukraine's effort to strengthen maternal and neonatal health policies and programs.

- **Increase access to reproductive health, sexual health, and family planning services, especially in rural areas.** Due to the lack of access to care in rural areas, maternal death rates are higher in rural areas than in urban areas. In addition, many men and women in rural and urban areas lack access to information and services related to HIV/AIDS and other STIs.
- **Strengthen reproductive health and family planning policies and improve planning and resource allocation.** Although the MNPI scores demonstrate that many countries have strong maternal health policies, implementation of the policies may be inadequate. In some cases, advocacy can strengthen policies and increase the amount of resources devoted to reproductive health and family planning. In other cases, operational policy barriers—barriers to implementation and full financing of reproductive health and family planning policies—must be removed.
- **Increase access to and education about family planning.** Another feature that relates closely to preventing maternal mortality is the provision of family planning. Family planning helps women prevent unintended pregnancies and space the births of their children. It thus reduces their exposure to risks of pregnancy, abortion, and childbirth. Improved provision of a range of contraceptive methods can prevent maternal deaths associated with unwanted pregnancies.
- **Increase access to good-quality antenatal care.** High-quality antenatal care includes screening and treatment for STIs, anemia, and detection and treatment of hypertension. Women should be given information about appropriate diet and other healthy practices and about where to seek care for pregnancy complications. The World Health Organization's recommended package of antenatal services can be conducted in four antenatal visits throughout the pregnancy.
- **Increase access to skilled delivery care.** Delivery is a critical time in which decisions about unexpected, serious complications must be made. Skilled attendants—health professionals such as doctors or midwives—can recognize these complications, and either treat them or refer women to health centers or hospitals immediately if more advanced care is needed. Some women in rural areas lack easy access to high-quality obstetric care, so improvements depend greatly on early recognition of complications, better provisions for emergency treatment, and improved logistics for rapid movement of complicated cases to district hospitals. Reliable supply lines and staff retraining programs also are critical.
- **Provide prompt postpartum care, counseling, and access to family planning.** It is important to detect and immediately manage problems that may occur after delivery, such as hemorrhage, which is responsible for about 25 percent of maternal deaths worldwide. Postpartum care and counseling will help ensure the proper care and health of the newborn. Counseling should include information on breastfeeding, immunization, and family planning.
- **Improve postabortion care.** About 13 percent of maternal deaths worldwide are due to abortion complications. Women who have complications resulting from abortion need access to prompt and high-quality treatment for infection, hemorrhage, and injuries to the cervix and uterus.
- **Strengthen health promotion activities.** Mass media should be used to educate the public about pregnancy and delivery, and community-level organizations should assist this through systematic programs. An important step for health promotion, in order to prevent negative maternal health outcomes, is to have the Ministry of Health supply adequate educational materials regarding safe practices.

References

- ¹ AbouZahr, Carla and Tessa Wardlaw. 2004. *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA*. Geneva: WHO.
- ² UNFPA. 2003. *Maternal Mortality Update 2002: A Focus on Emergency Obstetric Care*. New York: UNFPA.
- ³ www.unfpa.org/mothers/index.htm
- ⁴ Obstetric fistula occurs as a result of a prolonged and obstructed labor, which in turn is further complicated by the presence of female genital cutting. The pressure caused by the obstructed labor damages the tissues of the internal passages of the bladder and/or the rectum and, with no access to surgical intervention, the woman can be left permanently incontinent, unable to hold urine or feces, which leak out through her vagina. (UNFPA Press Release, July 2001)
- ⁵ World Health Organization. 2001. *Advancing Safe Motherhood Through Human Rights*. Available: www.who.int/reproductive-health/publications/RHR_01_5_advancing_safe_motherhood/RHR_01_05_table_of_contents_en.html
- ⁶ The MNPI was conducted by Futures Group and funded by the U.S. Agency for International Development (USAID) through the MEASURE Evaluation Project. For more information on the MNPI, see Bulatao, Rodolfo, A., and John A. Ross. 2002. "Rating Maternal and Neonatal Health Services in Developing Countries." *Bulletin of the World Health Organization* 80: 721–727. Also see Ross, John A., Oona Campbell, and Rodolfo Bulatao. 2001. "The Maternal and Neonatal Programme Effort Index (MNPI)." *Tropical Medicine and International Health* 6(10): 787–798.
- ⁷ This methodology for rating policies and programs was originally developed for family planning and has also been used for HIV/AIDS. See Ross, John A., and W. Parker Mauldin. 1996. "Family Planning Programs: Efforts and Results, 1972–1994." *Studies in Family Planning* 27(3): 137–147. Also see Stover, John, Joel Rehnstrom, and Bernhard Schwartlander. 2000. *Measuring the Level of Effort in the National and International Response to HIV/AIDS: The AIDS Program Effort Index (API)*. Geneva: UNAIDS.
- ⁸ United Nations Department of Economic and Social Affairs, Population Division. 2002. "Urban and Rural Areas 2002." Retrieved from www.un.org/esa/population/publications/wup2003/2003UrbanRural2003_Web.xls.
- ⁹ In the MNPI survey instrument, the term *trained* was used (as opposed to the term *skilled*) because it is empirically concrete for the respondent. Asking respondents about skill levels would require them to judge the probable quality of the original training and the deterioration of skills over time. Although knowing about skills is really more critical, it throws more subjectivity into the data, and as a factual matter, skills weren't measured.
- ¹⁰ *Ukraine Reproductive Health Survey*. 1999. Atlanta: Centers for Disease Control and Kiev: International Institute of Sonology.

For More Information

A complete set of results, including more detailed data and information, has already been sent to each of the participating countries. For more information, contact:

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