Ensuring Contraceptives for Disadvantaged Populations in Romania

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Executive Summary

In 2001, the JSI R&T project "Romanian Family Health Initiative", together with its partners UNFPA and the Society for Education in Contraception and Sexuality (SECS, the IPPF affiliate) began a process of training "Family Doctors" in 18 of 42 districts to provide family planning services. This process was due to the commitment of the Romanian MoHF to increase access to reproductive health including family planning services throughout Romania, by providing them through PHC providers. Previously, only OB/GYNs and FP doctors working in urban FP cabinets were allowed to provide family planning services. However, the vast majority of women at risk receive their primary health services from family doctors. It was felt that by training these providers, providing them with IE&C materials, as well as a supply of free contraceptives, access to these services would be greatly expanded. The training lasts 20 hours, and includes the clinical aspects of contraception, counseling skills, and instruction on the Logistics Management Information System (LMIS) used to manage supplies.

After one year's experience, the team was invited to carry out a review, particularly of the LMIS, and certain aspects of contraceptive security, namely an assessment of future needs for contraception and a targeting strategy based upon the concepts of market segmentation.

The team encountered a successful program. The program appears to be reaching an in-need client population, and seems to be valued, both by the providers and the clients. The logistics system and the LMIS appear to be functioning very well, with occasional malfunctions that can be corrected.

Many far-ranging recommendations were made for improving the already successful program and contraceptive access for the population. The most important of these recommendations follow:

Summary Recommendations:

The most urgent recommendation is that the program needs an emergency supply of combined oral contraceptives. The partners in the program should move to obtain these immediately.

The success and viability of the program has been proven. It should be expanded to all 42 of the districts in the country.

The LMIS, although collecting the necessary data, can be simplified. Detailed comments and recommendations are contained in Annex 2.

During the start-up of the program, it was important to collect monthly logistics data. However, re-supply is quarterly, and therefore data collection should become quarterly. This will significantly decrease paperwork and data processing.

The processing of data centrally using spreadsheet software should be replaced with data-based software processing.

Since the vast majority of families who lack the ability to pay and access to services and commodities live in rural areas, the program should concentrate the training and provision of free supplies to rural areas. This will encourage families of means living in urban areas to use the commercial sector to obtain their commodities, lessening the burden on donors and the Government of Romania.

In order to enhance contraceptive security for Romania, reimbursement for contraceptives should be re-instated by the National Health Insurance House.

Because of its utility for program planning and evaluation, another Reproductive Health Survey should be planned.

Introduction

This report is a joint effort by logistics advisors from three organizations: UNFPA, the JSI DELIVER Project, and the JSI R&T Romania Bilateral Project, reflecting the close collaboration between a group of active partners in trying to ensure the availability of contraceptives for disadvantaged populations in Romania.

The visit was carried out from February 17 to March 5, 2003.

Background

The Romanian family planning situation is one in transition. Until the revolution in 1989, contraception was forbidden by the pro-natalist government. In spite of this ban, the total fertility rate (TFR) remained very low, largely through the use of traditional methods (withdrawal) and illegal induced abortion. With the legalization of contraceptives, their use increased rapidly as a result of pent-up demand, and by 1999, 23.3 percent of women of reproductive age were using modern methods, with condoms being the most popular method, followed by pills and IUDs. However, family planning access remains a problem. The result is not high fertility. In fact, the TFR is very low at 1.3. However, the abortion rate is high – which concerns both the government and donors.

In 2001, the JSI R&T project "Romanian Family Health Initiative", together with its partners UNFPA and the Society for Education in Contraception and Sexuality (SECS, the IPPF affiliate) began a process of training "Family Doctors" in 18 of 42 districts to provide family planning services. This process was due to the commitment of the Romanian MoHF to increase access to reproductive health including family planning services throughout Romania, by providing them through PHC providers. Previously, only OB/GYNs and FP doctors working in urban FP cabinets were allowed to provide family planning services. However, the vast majority of women at risk receive their primary health services from family doctors. It was felt that by training these providers, providing them with IE&C materials, as well as a supply of free contraceptives, access to these services would be greatly expanded. The training lasts 20 hours, and includes the clinical aspects of contraception, counseling skills, and instruction on the Logistics Management Information System (LMIS) used to manage supplies.

Key to the success of the Project has been the development of a robust partnership. UNFPA supports 8 of the 18 pilot districts and JSI R&T (with USAID funding) supports 10 districts. The Ministry of Health and Family works closely with the Project, and has agreed to purchase contraceptives for the non-project districts; and to manage their distribution and the LMIS. In addition, UNFPA took advantage of a special UNFPA initiative for providing contraceptives funded by the Government of the Netherlands and the UK's Department for International Development to order a substantial quantity, which began arriving in 2001. UNFPA agreed that these supplies could be used in all the Project districts, not just the 8 supported by UNFPA. These contraceptives (plus some supplies provided by USAID) have sustained the start-up of the Project in all 18 pilot districts. However, as will be discussed later, the Project has been so successful that new supplies of combined oral contraceptives are urgently needed.

Scope of work for review

Because approximately one year's experience and data was available from a large number districts (18, targeted by USAID/UNFPA), and that the MoHF purchased contraceptives at the end of 2002 for distribution to the other 24, the partners agreed that two broad areas of assistance were needed: an assessment of the actual LMIS in the light of the recently approved technical norms for the National Program No. 3 (women, child and family health) and an assessment of implementation of the previous years policies regarding contraceptive security.

The terms of reference (TORs) for the mission were to review:

- The tools (forms, manuals,) of the logistics management and information system for free contraceptives in Romania;
- The implementation of the LMIS for free contraceptives in the 18 (out of 42) target Districts (districts) in Romania and assess the use of information from the LMIS in program management;

And make recommendations;

- For further actions and improvement to the LMIS;
- To assist the national institutions involved in contraceptive supply activities to prepare a realistic implementation plan for replication of the LMIS in the other 24 districts;
- Regarding policies to cover contraceptive needs according to the available data on market segmentation.
- Concerning forecasts of requirements to achieve contraceptive security.

Review process

We used several methods to assemble information and opinions on the LMIS and other issues related to achieving contraceptive security in the country. We met with the main partners involved in the system. This included the Director of the Social and Family Assistance Directorate and the Program Management Unit of the Ministry of Health and

Family (MoHF), UNFPA, the Society for Education on Contraception and Sexuality (SECS), JSI Research and Training (JSI R&T), Bucharest, the local office of USAID and Population Services International (PSI Romania).

We made field visits to Ialomita and Mures Districts and visited the District Public Health Authority (DPHA) offices and met with people responsible for authorizing distribution of contraceptives and for the district stores. We also visited several family health (FH) and family planning (FP) cabinets and discussed with the doctors and nurses working at these facilities the training they had received and their experiences with the implementation of the system for free contraceptives, including the forms for client registration, reporting and ordering. We also visited NGOs and private pharmacies and obtained information on the range and prices of available contraceptives (see annex 1 for our schedule and people met).

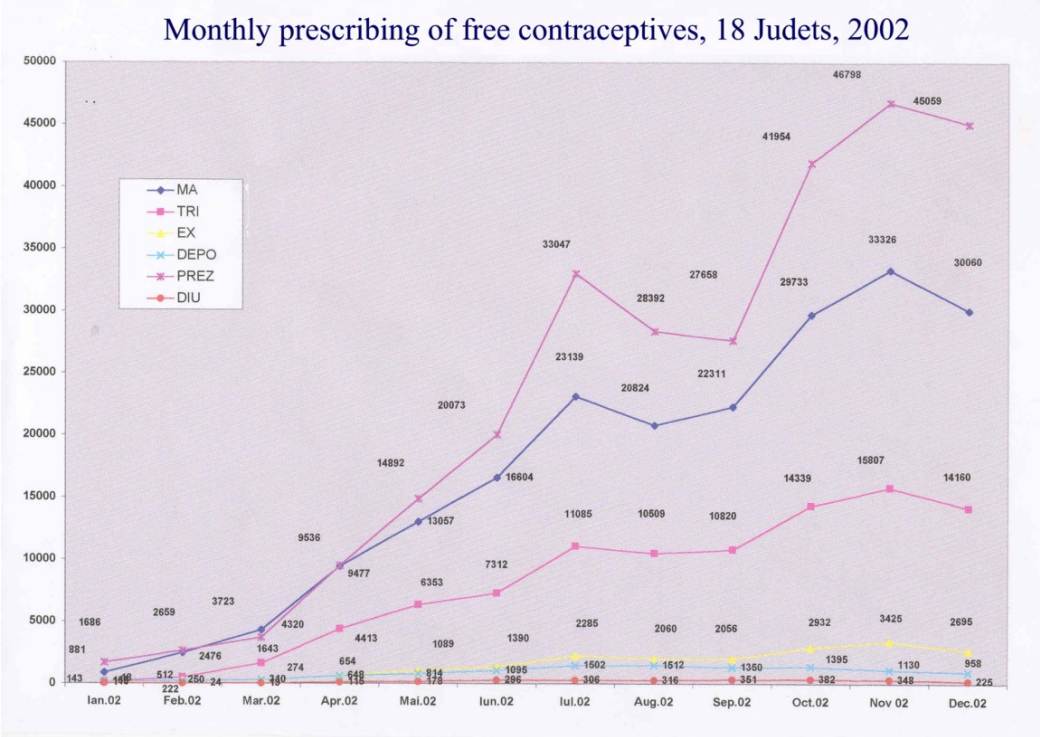
Key findings

The logistics management information system (LMIS)

The LMIS depends on data recorded on a set of forms that are regularly (either monthly or quarterly) completed and sent to the DPHA and SECS. They are analyzed and used to review workload (numbers of clients seen and different contraceptives prescribed and distributed) and to order re-supplies of contraceptives. The system uses six main forms[1], which were decided upon after much thought, and discussion amongst the main partners. Providers appear to understand the system and most providers said to us "it's easy", although some reported, "there is too much paperwork".
We consider that the LMIS is collecting the right logistics information to allow forecasting and program management. This is clearly demonstrated by the ability to track overall prescribing of contraceptives by month (see figure 1) and by individual family doctor (see figure 2 for an example).

[1] FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives; FH Cabinet Quarterly Report and Order Form for Free of Charge Contraceptives; FP Cabinet Daily Activity Register; FP Cabinet Monthly Report of Activities and Distribution of Contraceptives; FP Cabinet Quarterly and Order Form for Free of Charge Contraceptives; DPHA Quarterly Report and Order Form for Free-of-Charge Contraceptives.

Figure 1:


Monthly prescribing of free contraceptives, 18 Judets, 2002
MA
TRI
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45000
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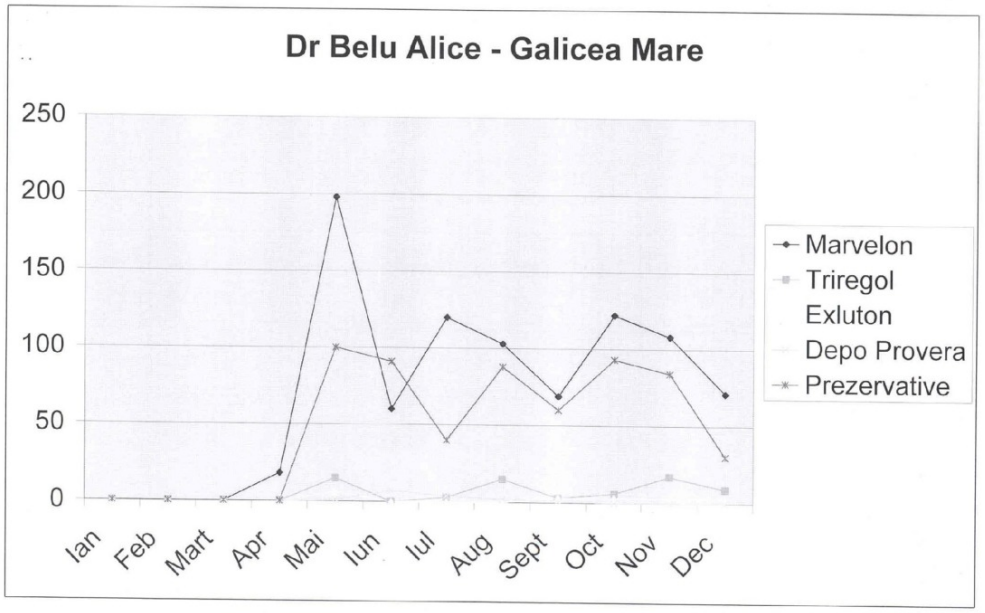
5000
0
Ian.02
Feb.02
Mar.02
Apr.02
Mai.02
Iun.02
Iul.02
Aug.02
Sep.02
Oct.02
Nov 02
Dec.02

Figure 2: Example of Monthly Prescribing by One Family Doctor



The LMISS also provides information, which is crucial for managing the supply of contraceptives. It enables stock levels of contraceptives at different levels in the service and locations to be monitored (see figure 3 for Marvelon ®, figure 4 for IUDs and figure 5 for Depo Provera ®).

Figure 3:

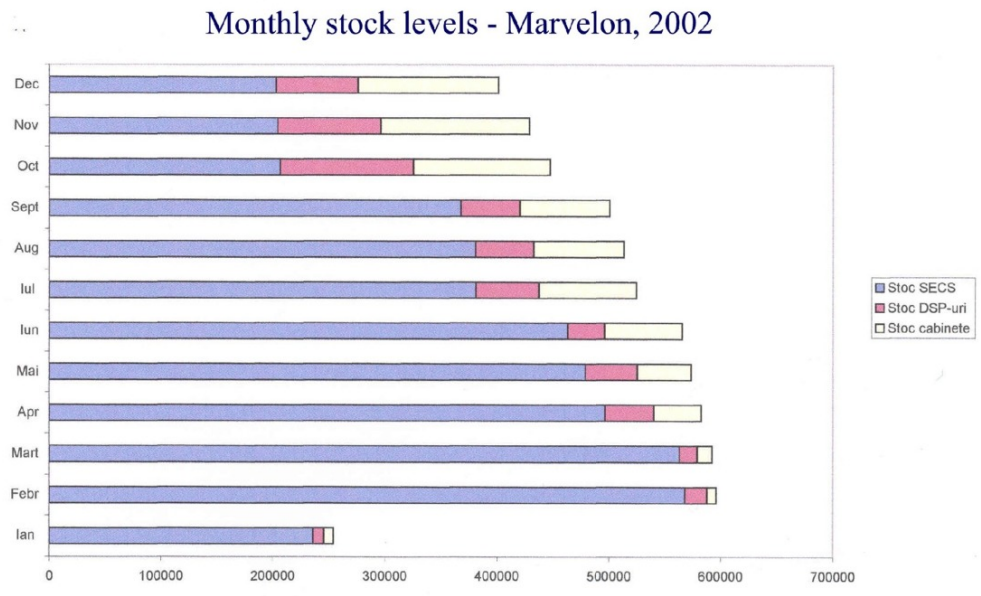


Figure 4:

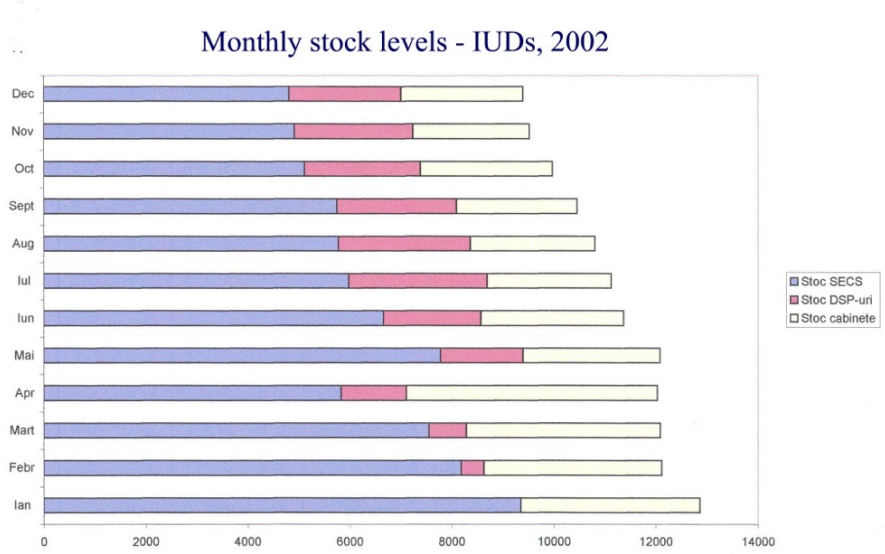
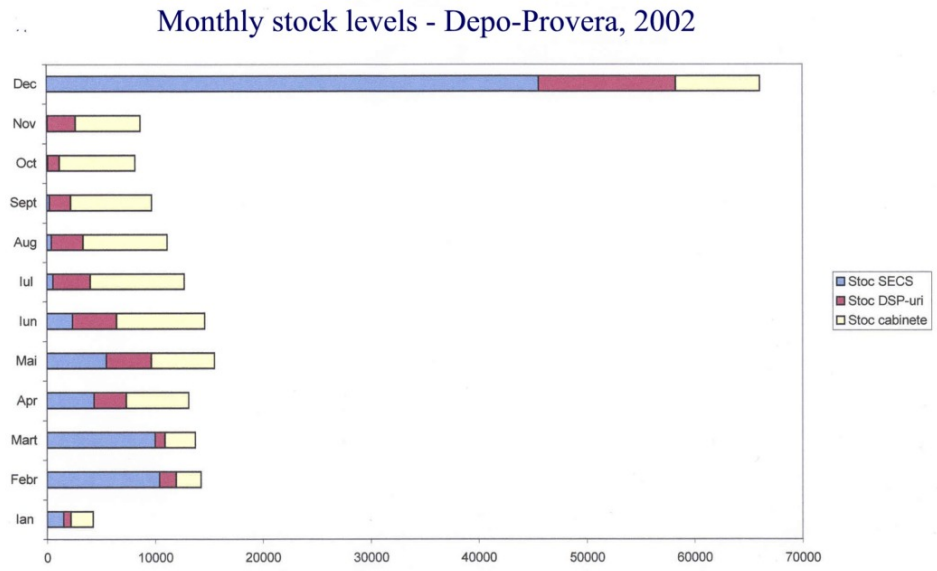


Figure 5:



It is clear from our discussions with doctors and nurses working at FH and FP cabinets who have taken part in the 20-hour training sessions and from a review of the learning objectives, materials and organization of the training sessions that these are focused and well organized. By the end of 2002, in the 18 Project districts, 870 family doctors have been trained in contraceptive technology and the completion of records for the LMIS.

In addition it is apparent that the implementation of the system for free contraceptives has been closely supported by a targeted IEC campaign which draws attention to who is eligible to receive free contraception and where these services are available.

We note that the Ministry of Health and Family have identified seven groups who are eligible to receive free contraceptives[2]. We feel that the targeting of free contraceptives can be improved and will comment on this in a later section.

General issues and recommendations

The system to provide free contraceptives is working successfully and clearly consumption of contraceptives is increasing quite markedly (see figure 1). This success is the result of a closely coordinated set of actions carried out through a partnership of the Ministry of Health and Family, SECS, UNFPA and JSI R&T. These activities have included the provision of contraceptives, training in appropriate prescription of contraceptives, the establishment of a LMIS for supplying and re-supplying them to where they are needed, monitoring of consumption and ongoing supervision, and supported by IEC.

From the records we have reviewed and the discussions we have had with people involved in the provision, distribution and prescription of free contraceptives, it appears to us that the correct population is receiving contraceptives. The system is highly valued by the providers and the clients. In fact several providers spontaneously expressed their anxiety about the possibility that the project might not be continued and emphasized that they thought the free contraceptive system was filling a very important need.

It is also very clear to us that the contraceptives included in the system can immediately be accounted for and this is a notable achievement of the program.

Current issues related to the contraceptive logistics system and suggested changes

The project is still in the relatively early stages of expansion and consolidation. The number of family doctors being trained and included in the program is steadily increasing. In 2003 it is planned that an additional 1,2000 family doctors will be trained and increasing numbers in 2004, 2005 and 2006. By the end of 2006 it is estimated that the program will cover all target areas and around 6,400 doctors will be dispensing free contraceptives. As the coverage of the system expands it is important that allowances are made for increased buffer stocks in Districts that are adding doctors. **The present order system provides a maximum of six months supply based on past consumption and this will probably be insufficient in these expanding Districts. It is also important that sufficient reporting and ordering forms are made available at all levels of the system**.

The "recommended contraceptive dispensing protocols" for pills and injectables are appropriate and are being followed. The recommendation that for emergency contraception (EC) Tri-Regol ® be used in two doses of four pills taken from the last 10 in the cycle is effective in pregnancy prevention but consideration should be given to recommending that instead of using the Yuzpe regimen a progestagen-only method (preferably using levonorgestrel) should be used as this is considerably more effective[3].

[2] Pupils (pupil card), students (student card), unemployed (unemployment certificate), persons receiving social assistance (social assistance certificate), women living in rural areas (identity card), women having had an abortion carried out in a public health facility and other population categories with low income (self declaration).

[3] Cheng L, Gulmezoglu AM, Ezcurra E, Van Look PFA. Interventions for emergency contraception. (Cochrane Review). In: The Cochrane Library, Issue 1 2003. Oxford: Update software; Helena von Hertzen et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial. Lancet 2002; 360: 1803-1810;

We also consider that the recommendation to provide a maximum of 12 condoms at any one visit by a client is too low and needs to be increased

All the providers we spoke with emphasized that they appreciated the training they had received and said it was the first occasion they had taken part in focussed training. Several providers mentioned that they would welcome additional training particularly on practical issues such as managing side effects and specifically for Depo Provera ®.

In both Districts which we visited the family doctors and physicians working at FH cabinets reported that they had to spend a considerable amount of time obtaining signatures from the District FSA Inspector, the District finance officer and then taking the order form to the District store and returning about two weeks later to collect the contraceptives.

We understand that a lot of effort went into designing the forms used in the LMIS and some people warned: us "don't change the forms!" However, we are convinced that there is a need for simplification of the forms used in the LMIS and for a reduction in the number of forms included.

We have made detailed comments on the individual forms used in the LMIS (see annex 2).

We recommend that:

A. Programmatic Recommendations

1. **As there is less than six months supply of low dose combined oral contraceptives (COCs) available in the system, there is an immediate need for procurement of more oral pills. UNFPA should be approached for the urgent supply of COCs;**
2. **There should only be one formulation[4] of COCs available in the free contraceptive system and this should be a monophasic[5] preparation;**
3. **Consideration should be given to including a progestagen-only oral contraceptive (POP) in the free contraceptive system. Only a minority (around 10 percent) of women may be suitable and decide to use POPs. However POPs are a very appropriate method for breast-feeding women[6], although they are slightly more expensive than COCs. They can also be used for emergency contraception and are the most effective EC hormonal method[3]**
4. **If it is decided that a progestagen-only contraceptive is included in the free contraceptive system (see recommendation 3) then consideration should be given to changing the "contraceptive dispensing protocol" and the associated training to use this for emergency contraception rather than the COC;**
5. **Depo Provera ® injectable hormonal contraception and IUDs should be continued to be provided as part of the free contraceptive system.**

Task Force on Post-ovulatory Methods of Fertility Regulation. Randomized controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. Lancet 1998; 352:428-33.

[4] Based on efficacy and cost this should be a combination of ethinylestradiol 0.03 mg and levonorgestrel 0.15 mg.

[5] There is no convincing evidence that clinically bi- or tri-phasic pills are more effective in terms of suppression of ovulation, cycle control and discontinuation due to side effects, see Van Vliet HAAM, Grimes DA, Helmerhorst FM, Schulz KF. Biphasic versus monophasic oral contraceptives for contraception (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software; Van Vliet HAAM, Grimes DA, Helmerhorst FM, Schulz KF. Biphasic versus triphasic oral contraceptives for contraception (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software. Monophasic preparations are cheaper than their equivalent bi- or tri-phasic forms.

[6] POPs should not be started before six weeks postpartum.

6. **Consideration should be given to training and empowering FP Doctors at FP Cabinets to insert IUDs.**
7. **The number of condoms dispensed at one contact should be increased from 12 to 36;**
8. **More time should be given in the training to counseling about the side effects and how to minimize them, particularly of Depo Provera ®;**
9. **If resources permit, consideration should be given to organizing follow-up training sessions, perhaps of one day annually, to discuss problems encountered in prescribing contraceptives, how they might be overcome and updating on contraceptive technology;**
10. **IEC efforts in support of the program should continue.**
11. **Success of the program in the 18 Districts should be replicated in the other 24 Districts by putting together a partnership to provide equivalent training and other inputs.**

B. Logistics Management Information System Recommendations

1. **The system should discontinue collection of the monthly forms and use only a quarterly order/report;**
2. **The amount of non-logistics data reported should be reduced;**
3. **Consideration should be given to adding Iron and Vitamin D to the system, as suggested by DPHAs and consequent changes should be made to the LMIS forms.**
4. **In Districts where additional family doctors are being included in the system consideration should be given to increasing supplies provided by national level (SECS for 18 districts for donations and MoHF procured contraceptives for the other 24 districts) based on consumption over the previous quarter by one third;**
5. **Supervisors should ensure sufficient forms are available at all levels in the system;**
6. **Changes to the LMIS should be implemented as soon as practically convenient;**
7. **The current system of processing data using spreadsheets, while useful for its flexibility at the beginning of the project, is too cumbersome for production work. A data based system, such as JSI's Supply Chain Manager, should be put in place.**
8. **Consumption graphs should be calculated in terms of Couple Years of Protection to more accurately show the contribution of each method to project outputs.**

Contraceptive security

Romania continues to face a challenge of meeting an increasing unmet need[7] for family planning commodities. Among married women of reproductive age, 52 percent or an estimated 2.6 million have an unmet need for modern contraception[8]. Romania has among the highest levels of maternal mortality in Europe and around a half of maternal deaths are due to complications of abortion[9]. However, while rates of abortion have been high by international standards with a lifetime abortion rate recently of 2.2 per Romanian woman[8], there are indications that the rate is now falling[9]. We were shown figures that in the project Districts where free contraceptives are becoming increasingly available that the number of abortions is falling.

Contraceptive security is important as Romania moves from a reliance on abortion to more widespread use of modern contraception for family planning choices. With increasing use of modern methods of contraception there will be a reduction in unwanted pregnancies, the need for abortion and maternal morbidity and mortality from obstetric and abortion complications.

a) National Health Insurance House subsidized drug list and MoHF funding

Although the Government began to establish family planning services in the early 1990s it was not until later in the decade as part of health reform that a set of policies were approved aimed at increasing access to family planning and reproductive health services more generally. In 1997 the Social Health Insurance Law was approved by parliament and gave the National Health Insurance House (NHIH) direct responsibility for financing health services throughout the country. In 1999 the Government approved a package of benefits to be provided under the NHIH and in 2002 revised health insurance norms made the FP cabinets a part of the health insurance system and gave approval for family doctors to provide FP services. Also in 2000 the Prime Minister, Minister of Finance and Minister of Health and Family signed a Government order that authorized Government budget allocations for contraceptives. In addition annually the NHIH and the MoHF compile a subsidized and free of charge drug list. This list determines which prescription drugs are covered by health insurance funds,. If a doctor indicates the generic name on a prescription, pharmacists must dispense the cheapest equivalent product. But, when the doctors indicates the brand name on the prescription (which are approximately 90% of the prescriptions), it is compulsory for the pharmacist to dispense the written product.

In 2002 a limited number of contraceptives were included on the subsidized drug list for which 70 percent of the reference price is reimbursed. In 2003 we understand that no contraceptives have been included on the approved list.

[7] The conventional definition of unmet need includes women currently married or in consensual unions who are currently sexually active, currently exposed to the risk of pregnancy, fecund and not using any form of pregnancy prevention. In the reproductive health surveys carried out in Romania with support from CDC the definition of unmet need has been expanded to give a more realistic indication of contraceptive needs to include users of traditional family planning methods (e.g. withdrawal and periodic abstinence).
[8] Sernbanescu F, Morris L, Marin M. Reproductive Health Survey Romania, 1999: Final Report. Bucharest: Romanian Association of Public Health and Health Management and CDC, March 2001.
[9] Ministerul Sanatatii si Familiei. Mortalitatea materna prin complicatiile sarcinii, nasterii si lauziei in Romania Anul 2001. Bucharest: Centrul de Calcul, Statistica Sanitara si Documentare Medicala, 2002.

In August 2000, the Government approved policies regarding contraceptive security. These covered the provision of free contraceptives to vulnerable groups and restated that District revolving funds could locally purchase and then sell at FP cabinets contraceptives at a lower price than available commercially.

Our main focus in this review is the system for making available free contraceptives and later in this report we deal specifically with the targeting of free contraceptives in line with market segmentation. We also present forecasts for quantities of contraceptive we consider will be required over the years 2003 to 2006.

However we have a few observations and recommendations that are related to the wider issues of contraceptive security.

We recommend that:

Selected contraceptives should be re-instated on the NHIH subsidized drug list preferably these should be stated as generic preparations[10] but this necessitates the registration of these generic formulations with the National Drug Agency.

The free contraceptives procurement and distribution of the government should continue for targeted populations, following the targeting strategy presented below.

b) Revolving contraceptive fund

This system was established to provide contraceptives through family planning cabinets at prices lower than those available through the pharmacies, by for profit commercial sector. We have reservations about scarce public resources (family planning cabinets doctors and nurses) being used by this fund rather than higher priority issues. At the FP cabinet we visited in the District Hospital in Targu Mures considerable time was being spent with women purchasing contraceptives from the revolving fund. Ten different oral contraceptives[11] were available ranging in price per cycle from 38,030 Lei to 200,358 Lei. These were about 15 percent cheaper than the same 'pills' on sale in private pharmacies. From our field visits the revolving fund appears to fill a limited niche for more affluent people living in urban areas.

We recommend that:

While we are neutral regarding whether the revolving funds should continue, we consider that they should not receive Government financial support.

c) The private sector and social marketing of contraceptives

Commercial sales in general were the largest source of contraceptives for men and women in Romania in 1999, the year for which national representative data is available[8]. They supplied 53 percent of male users' and 48 percent of female users' needs. Private sources accounted for the provision of 51 percent of all contraceptives, of which 48 percent were

[10] For instance, Oral, monophasic, low dose combined: ethinylestradiol + levonorgestrel, tablet, 30 μg + 150 μg or ethinylestradiol + norethisterone, tablet, 35 μg + 1.0 mg as monthly packs; Oral, progestagen-only: levonorgestrel, tablet, 30 μg or norethisterone, tablet, 35 μg as monthly packs.

[11] Tri regol ®, Diane 35 ® Marvelon ®, Triquillar ®, Femoden ®, Microgynon ®, Logest ®, Novynette ®, Mercilon ®, Exluton ®.

bought from a pharmacy and 4 percent a store or kiosk, but for different contraceptives, as is to be expected, the specific source varied. Most pills (67 percent) were obtained through direct commercial sales and 73 percent of condoms, while for IUDs 61 percent were obtained from public sources and 28 percent from private medical clinics.

Since 1999 both public and commercial sectors for the provision of contraceptives have increased, especially the commercial sector . PSI launched a Romanian social marketing of condoms program in the country in October 1998 and in early 2002 a COC triphasic preparation, (Coral 21 ®) was introduced. We found this to be among the cheaper COCs available in pharmacies, commercially priced at around Lei 48,000 per cycle (1,5 USD). PSI's condom social marketing activities are predominantly concentrated in urban areas of the country but through kiosks are also available to an extent in rural areas.

Both commercially and socially marketed oral contraceptives are exclusively available only through pharmacies, which are concentrated in urban areas.

The private, for-profit sale of contraceptives is not a good option for rural populations because access is poor to outlets, and above all most people living in rural areas cannot afford these relatively expensive products.

We recommend that:

> **The targeting of free contraceptives predominantly to people living in rural areas, as presented in the next section, should help to increase private sector participation in urban areas.**

Market Segmentation and the Target Population for Free Contraceptives

The concept of Market Segmentation is important to Contraceptive Security, because it targets different sources for contraceptives to different segments of the market. Essentially, it markets commercial sector and social marketing commodities to those families who can most afford to pay.

Romania can be considered a middle-income country. Romania defines 44% of their population as living under the poverty level: this means that 56% of the population lives above the poverty level. This portion of the population can probably afford to purchase their contraceptives through the active commercial market, including the relatively inexpensive orals and condoms sold through the PSI social marketing program. An additional issue is access. The commercial sector largely operates in urban areas, and access is severely limited in rural areas.

It is important, therefore, for the MoHF to target their limited free contraceptives to target groups most at-risk in order to encourage those living above the poverty level to avail themselves of the commercial sector and purchase their contraceptives. A strategy of this type is essential to contraceptive security in Romania, since the donors and the GoR cannot afford to supply an ever-expanding use of contraceptives as families choose them to reduce the dependence on abortion as a means of fertility control.

The strategy for targeting of free contraceptives was developed based upon work carried out by the POLICY Project and published as a draft by Sharma, Winfrey, and Marin in August 2001[12]. The segmentation report was developed through a secondary analysis of the data from the Reproductive Health Survey[8] carried out in 1999, and defined wealth quintiles based on assets of respondents. During this consultancy we developed the targeting strategy based upon the assumptions demonstrated in the following table:

Targeting the Right Population			
Quintile	**Percentage**	**In or out of target**	**Total Percentage**
Poor	20%	Target	40%
Near Poor	20%	Target	
Middle	20%	OK	20%
Upper Middle	20%	Not Target	40%
Rich	20%	Not Target	

Any targeting strategy should try to direct free contraceptives to the first two, poorest quintiles, while simultaneously avoiding the dispensing of contraceptives to the wealthiest two quintiles. Dispensing of free contraceptives, especially to the extent that it increases access and use, would be "OK" for the middle quintile. We therefore re-segmented the population to develop the following table. The percentages shown represent the percent of women of reproductive age in each of the cells.

[12] Sharma S, Winfrey W, Marin M. A Family Planning Market Segmentation Analysis: a First Step in Operationalizing Contraceptive Security Policies in Romania. Washington DC: The Policy Project, August 2001.

Why Target the Rural Population?		
Quintile	Urban	Rural
Poor	3.6%	16.4%
Near Poor	7.0%	13.1%
Middle	17.2%	2.7%
Upper Middle	18.4%	1.6%
Rich	19.0%	1.0%
Total	65.2%	34.8%

As can be seen, poverty is very strongly associated with residence.

Therefore, we recommend that:

Rural areas be targeted for free contraceptives by selecting Family Doctors who practice in rural areas for training and receipt of free contraceptives.

By doing this, you will:

- Directly serve 29.5% of the 40% (three-quarters) of women who are in the lowest two quintiles, plus 2.7% who are in the middle quintile, but may still have access problems because of their residence.
- You will offer free contraceptives to 2.6% of the population that should be outside the target. However, many of these families of relative wealth will self-select to use the private sector.
- Exclude 54.6% of the women, who are in the three highest quintiles and live in urban areas. These women have the greatest ability to pay, and have the greatest access to contraceptives through the private sector.

The remaining under-served groups are the 10.6% of women who are the urban poor and near-poor. It is suggested that they could be served with free contraceptives by the Family Planning Cabinets, and perhaps, by specifically targeting the training and free contraceptives to Family Doctors who work in poor urban areas. However, this group of women will continue to be hard to reach, as they often have other problems associated with poverty in urban areas. In the long term, some special programs may need to be designed to reach some of these populations. In any case, the National Program can have the greatest impact in decreasing unmet need by targeting the rural areas for the Project interventions of training, IE&C, and free contraceptives. The eventual result is that the 45% of women of greatest need get access to free contraceptives, and the 55% with the greatest access and relatively higher incomes will be steered to the private sector and the revolving fund to purchase their contraceptives.

We recommend that:

Urban areas of high poverty be specifically selected for interventions – either training of Family Doctors serving the population, or special programs to increase access to these hard-to-reach populations.

This analysis was based upon the 1999 Reproductive Health Survey. As can be seen, such surveys are important tools for program planning, as well as program evaluation. Another survey should now be planned.

Projections of Contraceptive Needs for Free Distribution

This is an unusual situation for developing reasonable projections, since it is a rapidly expanding program. Therefore, forecasts should be done based upon projected service capacity, rather than more traditional demographic projections, or purely logistics-based projections. Drs Koo and Stan developed a methodology using existing logistics data coupled with a life-table for doctors active in the program. The methodology uses the concept of a "doctor month", which is the commodities distributed by one active physician in one month. Using data for 2002, as well as a forecast of doctors to be trained each quarter, the following projections of needs were made. These projections include all 42 Districts in the country, and provide for buffer stocks:

	YEAR			
	2003	**2004**	**2006**	**2006**
Planned Doctors to provide free contraceptives (at the end of year)	2000	3500	5000	6400
OCs Needed	1.3 million	2.2 million	2.7 million	3.3 million
Injectables			3,500	200,000
IUD		4,000	10.000	11.000
Condoms		800,000	2.9 million	3.7 million
Cost				
At UNFPA prices	€ 450,000	€ 800.000	€ 1,050,000	€ 1,400,000
At current MoHF prices	€ 780,000	€ 1,450,000	€ 2,000,000	€ 2,700,000

Recommendation: The project partners (UNFPA, USAID and the MoHF) should move to obtain emergency shipments of combination oral contraceptives.

Recommendation: Plans should be developed for financing of supplies needed over the next 3 to 5 years. Ideally, procurements would be carried out through UNFPA because of the price advantage of their world-wide bulk procurements.

ANNEXES

Annex 1: Schedule for visit of Godfrey Walker, UNFPA and Tony Hudgins, JSI Washington, and people met

Monday 17th February

17:00 hrs Arrival in Bucharest

Tuesday 18th February

10:00-13:00 hrs Briefing in UNFPA Office with Dr Peer Sieben, UNFPA Representative, Dr Doina Bologa, UNFPA NPO, Dr Mihai Horga, Director, Family and Social Assistance Directorate, Ministry of Health and Family, Dr Laurentiu Stan, Program Coordinator, Romanian Family Health Initiative, JSI Research & Training Institute.

14:30-17:00 hrs Discussions at the offices of the Society for Education on Contraception and Sexuality (SECS) with Dr Borbala Koo, Executive Director, Ana Vasilache, Project Coordinator, Violeta Horhoianu, Information Officer, Cristina Coca, Project Coordinator

Wednesday 19th February 22, 2003

All day Field visit to:

Family Health Cabinet, Movilita, Dr Liliana Picorus
Family Planning Cabinet, Urziceni, Dr Iuliana Baltes
Slobozia District Health Authority, Dr Violeta Candea, SECS Regional Coordinator (Constanta), Dr Sebastian Radulescu, FSA Inspector, Jonita Denisa, Economic Deputy Director, Urzica Constanta, Accountant

Thursday 20th February

All day Annual Review Meeting for the UNFPA supported project "Support for the Reproductive and Sexuality Health Programme in Romania" held at the Continental Hotel

Friday 21st February

All day Working at the JSI Office

Sunday 23rd February

Travel to Targu Mures

Monday 24th February

09:00-10:00 FP cabinet, Targu Mures district hospital, including Dr Violeta Morianu, Dr Florica Sglimbea, FSA Inspector, Dr Adriana Melnic, SECS Regional Coordinator, Dr Mihaela Ionescu

10:15-10:45 East-European Institute for Reproductive Health, Dr Mihaela Poenariu, Ionela Cozos and other staff

10:45-11:15 Dr Ildiko Zoltai, FH cabinet, Acatari

11:30 12:00 Dr Carol Kovacs, Kolescar Kinga, FH cabinet

Returned to Bucharest

Tuesday 25th February

All day Working at JSI office

12:30-13:00 Met with Daun Fest, Director, Population Services International, Romania

13:30-14:30 Initial debriefing with JSI

Wednesday 26th February

All day Working at JSI office

15:00-16:30 Initial debriefing meeting with Dr Borbala Koo, Executive Director, SECS and Dr Doina Bologa, UNFPA NPO

Thursday 27th February

13:00- 14:00 Debriefing with interested parties

Friday 28th February

16:00 Godfrey Walker Departure to Bratislava

Monday 3rd March

12:00 Meeting with World Bank health specialist, Dr. Silviu Radulescu

Annex 2: Comments on forms used as part of the LMIS system for contraceptives

FH Cabinet Monthly Report for Distribution of Free of Charge Contraceptives

This a clear and logically laid out form which tabulates monthly summaries of contraceptives dispensed by family doctors trained in contraceptive prescribing and working at family health (FH) cabinets. One copy of the report is retained at the FH cabinet, one is sent to the DPHA and one to SECS head office for analysis.

At present, as the bottom half of the form contains a listing of clients and contraceptives dispensed per contact, it can serve a useful purpose where a check can be made on whether the clinical guidelines are being followed regarding the number of cycles of contraceptive pills are dispensed. When the system has achieved a reasonable steady state it is suggested that collection of this form by DPHA should be stopped.

In the 24 non-project districts we recommend that this form to be transformed, by eliminating the upper half, into a client register.

1. FH Cabinet Quarterly Report and Order Form for Free of Charge Contraceptives

This is a well-designed form. It should be the only form necessary at a district level to requisition, approve and authorize distribution of contraceptives for use at FH cabinets, but in some districts an "Avis" form for audit purposes supports it.

At present one copy of the form is retained at the FH outlet, one at the district office, one at district store and one returned to FH cabinet with approval signatures.

In the future if (when) the FH Cabinet Monthly Report is discontinued then one copy of this form should be retained at the district office, one at the district store, one with signatures returned to the FH outlet.

In the 24 non-project districts this form should be used.

Daily Activity Register for FP cabinets

This is a rather complex form. We note that no title is given on the form and there is no space to record the name of the cabinet. We are unclear why there are columns for categories of FP clients such as 'new', 'continuing', 'counseling', emergency contraception'; and under medical consultation 'new' and 'control'; then 'other types of services' and 'referrals'. We realize that definitions are given for these categories of clients e.g. new and continuing but experience elsewhere in the world indicates that these definitions are difficult to apply consistently and there is often not agreement concerning their use. We are also unclear regarding the need for so many columns

under ‘method and contraceptives distributed’. We do not consider it is necessary to have 16 columns for alternative brands of combined hormonal oral contraceptive or 3 progestagen-only orals, 3 different IUDs, 3 injectables and 3 types of condom. We would be interested to know what analysis and use is made of the data recorded in the set of double columns at the bottom of the page, i.e. numbers of ‘pregnancy tests’, ‘pap smears’, ‘emergency contraception’, HIV/ITS blood tests’, ‘other lab tests’, ‘its treatments’, ‘menopausal treatments’, ‘IUD insertion’, ‘IUD removal’, colposcopy’, ‘echogram’ and ‘other medical services’. Are IUDs inserted at this level?

We have reservations about whether there is the need to regularly collect and analyze all these items of data. If these items are not regularly analyzed and use made of the information then we recommend that the form be simplified and they are not collected.

We consider this form can be made less complex and suggest that it is replaced by a client register which is retained at the family planning outlet where it is clearly needed to check on the attendance of individual clients. **We do not consider that there is a need to send a copy of this form to the DPHA coordinator**.

We recommend that in the 24 non-pilot districts a simpler form or client register, along the lines suggested above, be used.

FP Cabinet Monthly Report of Activities and Distribution of Contraceptives

This is a clear and logically laid out form, which tabulates monthly summaries of contraceptives dispensed at family planning cabinets. One copy of the report is retained at the FP cabinet, one is sent to the DPHA and one to SECS head office for analysis.

We query whether it is necessary to collect the summary data on types of family planning clients, medical consultations and other types of activities and services. Is this data regularly analyzed and used? If it is not then this type of data could probably be more efficiently collected on an ad hoc basis, when there is a specific need for it.

When the system has achieved a reasonable steady state it is suggested that collection of this form by DPHA should be stopped.

When the decision to transform FH Cabinet Monthly Report into a client registers will be taken, we recommend that this form would be no longer collected.

FP Cabinet Quarterly and Order Form for Free of Charge Contraceptives

This is a well-designed form. It should be the only form necessary at a district level to requisition, approve and authorize distribution of contraceptives for use at FP cabinets.

At present one copy of the form is retained at the FP outlet, one at the district office, one at district store and one is returned to the FP cabinet with approval signatures.

In the future if (when) the FP Cabinet Monthly Report is discontinued then one copy should be retained at district office, one at district store, one with signatures returned to FP outlets
In the 24 non-project districts this form should be used.

DPHA Quarterly Report and Order Form for Free-of-Charge Contraceptives

This is a key form and is well designed.

We note that the Romanian form in the order row J indicates that this should be calculated by (2 x E) – G, while it is more usual to calculate this as indicated in the English version of the form by (2 x H) – G.

In the 24 non-project districts this form should be used and one copy retained at DPHA and a copy sent centrally to Program Management Unit.

DPHA Aggregate Contraceptive Distribution Worksheet

We have no comments on this form.