Chapter 1

FAMILY PLANNING AND REPRODUCTIVE HEALTH FOR HEALTH CARE MANAGERS

By Rachel Criswell

Ukraine and the other countries of the former Soviet Union are in a unique position in the world with respect to family planning and reproductive health. With unusually high abortion rates and relatively low rates of modern contraceptive use when compared to Western Europe, these countries are now faced with the challenge of enacting positive changes. This will include increasing the availability of modern contraceptives as well as the population's knowledge of modern family planning and reproductive health. Health care managers in Ukraine have the exciting opportunity to incorporate family planning and reproductive health into current advances in the Ukrainian health care system, especially since the United Nations, the World Health Organization and governments worldwide have identified family planning/reproductive health as international priorities.

WHAT IS REPRODUCTIVE HEALTH?

According to the WHO, reproductive health is:

> A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. ***Reproductive health*** therefore implies that people are able to have a satisfying and safe life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal relations[1].

In addition, reproductive health encompasses several fields related to sexual health and human reproduction[2]. Much of the basic reproductive health care package involves attending to the direct reproductive needs of an individual or couple. **Family planning** allows men, women and couples to access a full range of voluntary contraceptive options so that they can plan when and how many children they want to have. As a result, they can avoid unwanted pregnancy and abortion. Health care providers have a duty to provide family planning clients with the full range of available contraceptive methods and all information necessary for choosing and using a given method effectively. While abortion is not a method of family planning, reproductive health services

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[1] World Health Organization. *Reproductive Health Indicators: Guidelines for their generation, interpretation and analysis for global monitoring*. Geneva: World Health Organization, 2006, 5.

[2] This information and the subsequent details are provided by UNFPA. "Reproductive Health Services." Reproductive Health: United Nations Population Fund. 24 Oct 2008. Available at <http://unfpa.org/rh/services.htm>, 2.

include **safe alternatives to abortion** that support the patient both before and after the procedure. **Another basic service is the prevention and treatment of infertility**. This includes basic gynecological care, such as infection prevention to avoid damage of the reproductive system (e.g. pelvic inflammatory disease), counseling and treatment services, such as medication or in-vitro fertilization.

Reproductive health also encompasses maternal health care. A basic reproductive health care package includes **prenatal, perinatal and postnatal care as well as a skilled attendant at delivery**. Pregnant women should receive regular checkups to monitor the health of both woman and fetus prior to delivery. They should be informed on how to stay healthy during pregnancy, what to expect during delivery and postpartum care for both mother and infant. The delivery should be attended by a trained professional who employs modern birthing techniques such as mobile delivery and partner-accompanied birth. Postpartum, mothers and their children should have access to medical care as needed as well as family-friendly services. These include allowing mother and child to share the same hospital room, providing the mother with adequate information and education on breast feeding immediately after childbirth. Should any complications occur, a basic reproductive health care package ensures **proper management of obstetric and neonatal emergencies**.

Prevention and management of reproductive diseases is another part of the basic reproductive health care package. Health care facilities should be equipped to screen for **sexually transmitted infections (STIs), reproductive tract infections and HIV/AIDS** and offer the appropriate counseling, support and treatment if necessary. They should also provide preventive services, such as voluntary counseling and testing, condoms, distribution of informational materials and promotion of dual protection[3]. **Early diagnosis and treatment of breast and cervical cancers** are also an important part of a reproductive health care package that can be accomplished through self- and clinical breast examination, mammography and Pap smears.

Finally, health care facilities that offer the basic reproductive health care package need to support freedom from reproductive harm, especially for vulnerable populations. This involves providing medical care as well as links to legal, psychological and social organizations that can aid in the **prevention and treatment of gender-based and domestic violence as well as harmful reproductive practices, such as human trafficking.** Even in non-emergency or non-violent situations, **at-risk groups require special attention in fulfilling their reproductive health needs**. The reproductive health of youth, rural populations, the poor and the chronically ill should be of particular concern to health care facilities.

REPRODUCTIVE HEALTH ON THE INTERNATIONAL STAGE

Several international agreements have identified reproductive health as a global priority. Reproductive health is addressed in at least three of the United Nations' eight Millennium Development Goals (MDGs). Goals three, five and six aim to "promote gender equality and empower women," "improve maternal health" and "combat HIV/AIDS, malaria, and other diseases" respectively. Each of these has direct links to improving reproductive health. In order to achieve these MDGs, leaders at the 2005 World Summit reinforced this initiative by agreeing to make universal access to reproductive health a strategy at the national level by 2015.

[3] The "dual protection method" of contraception is using a method or a combination of methods that prevent both unintended pregnancies and STIs/HIV.

The particular importance of reproductive health in Europe, especially in the countries of the former Soviet Union, has been highlighted in the 2001 Regional Strategy on Sexual and Reproductive Health of WHO's Regional Office for Europe[4]. This document underlines the need for a commitment to "further develop and strengthen…reproductive health programs[5]." Its strategy aims to address the gap in reproductive health and reproductive health care services between "the market economies of the West and the transitional economies of the East,"[6] by recommending that all 51 European member states work to improve reproductive health by:

- Decreasing maternal, perinatal and neonatal mortality;
- Reducing reliance on abortion as a form of fertility regulation;
- Focusing on the reproductive health needs of adolescents and the aging;
- Decreasing the incidence of STIs and HIV/AIDS and improving treatment;
- Implementing prevention measures to decrease the incidence of breast and cervical cancers and improve methods of early diagnosis and treatment of these cancers;
- Implementing prevention measures to decrease the incidence of infertility and ensure treatment for couples who suffer from infertility;
- Addressing the reproductive health needs of refugees, displaced persons and migrants;
- Improving services to prevent, treat and stop sexual abuse, domestic violence and trafficking.[7]

Implementation of these goals is proposed through four major strategies, including strengthening health promotion, strengthening health systems and services, forging partnerships between the public and private sectors and conducting and publishing research on the status of reproductive health in Europe.[8]

Ukraine has already begun to implement the WHO regional strategy with the institution of the State Program *Reproductive Health of the Nation* up to 2015 (SPRHN).[9] Adopted in 2006, and planned to cover the period up to 2015, the SPRHN aims to address the strategic areas set forth by WHO by ensuring safe conditions for maternity, shaping reproductive health among youth, improving the family planning system, maintaining the reproductive health of the population and ensuring efficient program management. Though family planning and reproductive health care programs have been implemented in the past in Ukraine, the SPRHN is one of the first to include concrete indicators, partners from multiple sectors and financial backing.

The SPRHN adapts specific recommendations from WHO's strategy to the Ukrainian context. In order to strengthen health promotion, systems and services in accordance with the objectives of the WHO Regional Strategy, the SPRHN includes funding for procuring equipment, providing free contraceptives to vulnerable populations, conducting health education campaigns, training family doctors and midlevel health professionals, improving services for youth and rural populations and updating medical protocols. In order to create and strengthen cross-sector and multi-level partnerships, the SPRHN is designed as a joint program implemented by the Ministries of Health; Finance; Family, Youth and Sport, with support from Social Services and private sector partners. Governments at the oblast and levels have already launched complementary

[4] For the complete text of the WHO Regional Strategy on Sexual and Reproductive Health, see http://www.euro.who.int/document/e74558R.pdf.

[5] WHO Regional Office for Europe. *WHO Regional Strategy on Sexual and Reproductive Health*, Copenhagen: World Health Organization, November 2001, 1.

[6] WHO Regional Office for Europe, 2.

[7] WHO Regional Office for Europe, 2-6.

[8] WHO Regional Office for Europe, 16-18.

[9] See Appendix 2 for the complete text of the SPRHN.

programs, ensuring partnerships across administrative levels. Finally, as an investment in reproductive health research, the SPRHN is built on sound, evidence-based research that includes concrete indicators as well as monitoring and evaluation systems.[10]

THE CASE FOR FAMILY PLANNING IN UKRAINE

Implementation of the SPRHN is an important step as Ukraine seeks to strengthen its national health care system. As mentioned before, Ukraine has a high abortion rate and a low rate of modern contraceptive use compared to Western European countries. The maternal mortality rate in Ukraine is over twice the European Union (EU) average. In recent years, HIV and STIs have become significant concerns in the country, as incidence rates increase dramatically.[11]

Research has shown that the population of Ukraine is poorly informed about contraception and that women rely heavily on abortion for fertility control. Women question the need for contraception, asking, "Why would I use contraception? Whatever happens, happens." Information, education and communication channels—including health services—are inadequate in their promotion of positive, evidence-based messages about contraception. Women say that contraception is not accessible and is often too costly, sometimes even presenting a choice between "buying contraceptive pills or sausage to feed my kids [12]." Both qualitative and quantitative research proves the need for reproductive health and family planning improvements in Ukraine.

Investments in family planning and reproductive health are important in Ukraine because 1) improved reproductive health means improved overall health for the population, 2) access to family planning services is a human right, and 3) governments worldwide have made investments in family planning and reproductive health with positive results[13].

Advances in family planning and reproductive health will **improve the health of the population** in several ways. By giving clients the ability to choose the timing of pregnancy, family planning programs contribute to healthy mothers and children by postponing early childbearing, increasing child spacing, preventing late or high-risk pregnancies and preventing unintended pregnancies. Increased use of contraception has been shown to lower the rate of induced abortion among women. When women and men use condoms, they protect themselves from STIs and HIV, decreasing the overall prevalence rates in the country. Countries benefit when men and women are empowered, through contraceptive use, to make informed choices about their futures and families. Reproductive health is a key part of the overall health of a nation, affecting men and women of all socioeconomic classes and ages.

The international commitment to improving reproductive health is as much rooted in **a commitment to human rights** as it is in a commitment to health. Freedom of choice is an essential part of family planning and reproductive health, especially when it pertains to family planning and contraceptive options, that has been established by several major human rights declarations and international consensus documents. In a more concrete sense, this means that all individuals should be able to choose whether or not to use contraception and to use their preferred method.

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[10] See Appendix 2 for reproductive health indicators used internationally and for those used in particular by the SPRHN.

[11] Bossert, Thomas J. et al. *The Rationale for Family Planning in the Former Soviet Union: Evidence from Europe, Eurasia, and the US*. Kyiv: John Snow Research and Training Institute, 2008.

[12] Criswell, Rachel. *Planning Parenthood in Ukraine: Motivations and Obstacles to Use of Contraception and Abortion Services in Ukraine*. Presentation given at University College of London School of Slavic and Eastern European Studies, September 15, 2008.

[13] Bossert, 5.

Individuals and couples should be able to decide for themselves the size of their family, when they want a pregnancy and how they want to make those choices. Individuals should be able to choose their partners and to be free from sexual coercion. These issues are key to having control over one's own future.

According to the United Nations Population Fund (UNFPA), people are entitled to:

— Reproductive health as a component of overall health, throughout the life cycle, for both men and women;
— Reproductive decision-making, including voluntary choice in marriage, family formation and the determination of the number, timing and spacing of one's children, and access to the information and means needed to exercise voluntary choice;
— Equality and equity for men and women so as to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender;
— Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy.[14]

Policymakers, health care professionals and managers have a duty to invest in family planning/reproductive health with these principles in mind, ensuring that individuals are not only assured the freedom to be reproductively healthy, but also to do so free from coercion, fear or harm. There are a variety of ways that governments can, and have, supported these principles:

— Creating an enabling policy environment that promotes reproductive health and freedom to choose, including building capacity to strengthen health systems, partnering with civil society and community-based organizations, and monitoring budgetary appropriations to ensure that family planning and reproductive health care is covered;
— Widening access to reproductive health services, with an emphasis on disadvantaged groups;
— Building awareness of the rights of women, men and adolescents so that they can exercise their choices with respect to reproductive health;
— Encouraging, involving and building the capacity of individuals and communities to participate in the design, implementation, monitoring and evaluation of reproductive health programmes and services that affect their lives.[15]

While the Ukrainian government has taken important steps toward protecting the reproductive health of its citizens through the development and implementation of the SPRHN, there is still work to be done. The government can continue to increase access to improved services for the population by allocating resources to health care facilities, training health care professionals, building cross-sectoral partnerships and ensuring access for at-risk groups. In addition, research has shown that many Ukrainians are unaware of their choices with respect to reproductive health, with one woman pointing out, "We need to work to change women's opinions of themselves. They don't think about their health or about the future."[16] The Ukrainian government needs to ensure that the population is aware of its choices.

Governments worldwide are demonstrating an international commitment to family planning/reproductive health by developing, funding and implementing programs to improve the health of their populations. Ukraine's SPRHN represents a significant commitment to family planning and

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[14] UNFPA. "Supporting the Constellation of Reproductive Rights." Population Issues: Human Rights. 27 Oct 2008. < http://www.unfpa.org/rights/rights.htm>, 1.

[15] UNFPA. "The Human Rights-Based Approach." Population Issues: Human Rights. 27 Oct 2008. < http://www.unfpa.org/rights/approaches.htm>, 1.

[16] Criswell.

reproductive health. However, the SPRHN is only a first step in ensuring reproductive health for Ukrainians. Contraception is legal in Ukraine but often access is limited by cost and availability, especially for at-risk populations. As of 2003, the Ukrainian government did not cover the costs of IUDs, surgical sterilization or oral contraceptives.[17] Several European countries have and are investing in programs to cover the costs of family planning in an effort to provide their populations with access to improved reproductive health care. Such investments in family planning will benefit Ukraine as it seeks to integrate with international standards of health care in the 21st century.

One of the key misconceptions about family planning and reproductive health programs, especially in Ukraine, is that such programs contribute to the declining fertility rate by preventing couples from having babies. The evidence does not support this argument. In countries with high fertility rates, such as India or many African countries, family planning programs and increased contraceptive use have been associated with a decrease in the fertility rate.[18] However, in countries with low fertility rates, such as Ukraine, which has negative population growth,[19] it has been shown that family planning programs do not affect the fertility rate. Instead, as family planning programs increase the contraceptive prevalence rate, the abortion rate decreases and fertility remains the same. This indicates that new contraceptive users are women and couples who were previously using induced abortion as a method of fertility control and not those who would otherwise be having babies. This trend has been seen in family planning programs in Ukraine, Romania, Georgia and elsewhere, as displayed in the graphs below[20] (Fig. 1.1 – Fig. 1.2).

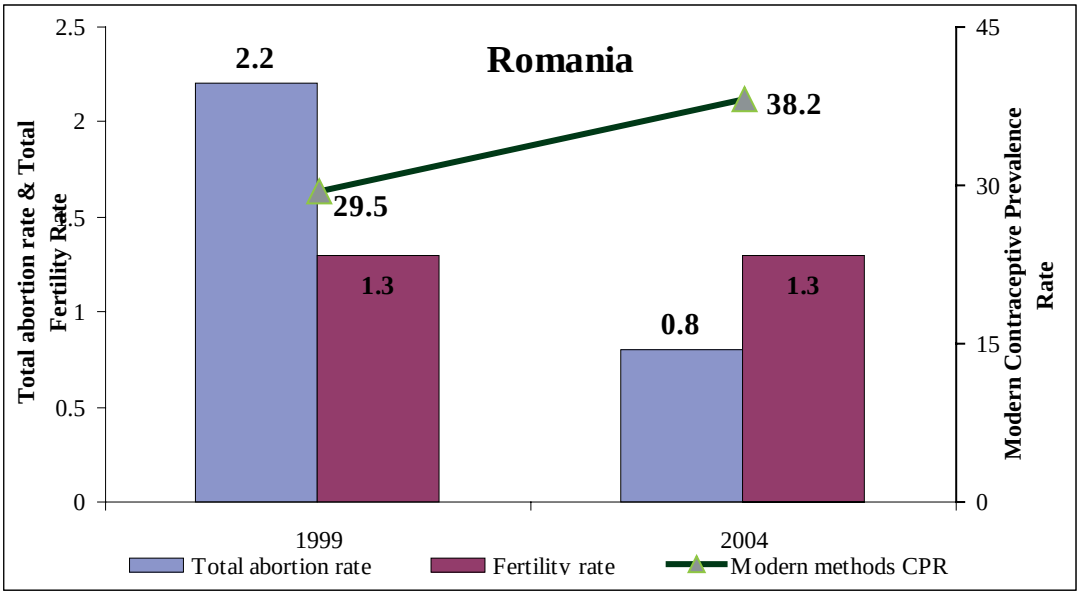


Figure 1-1. Trends in the Abortion Rate, Contraceptive Use and the Fertility Rate in Romania

Family planning and reproductive health in Ukraine are primarily issues of health, human rights and international standards. As Ukraine seeks to lower its abortion rate and improve maternal and child health in accordance with international and European standards, investment in family planning and reproductive health programs are essential. As set forth in the WHO Regional Strategy for Sexual and Reproductive Health, Ukraine has begun and needs to continue to address this issue by increasing the quality of, and access to, reproductive health services (especially for at-risk populations such as youth), improving access to the full range of modern contraceptives at all price levels, improving the population's knowledge of and attitudes toward

[17] Bossert, 24.

[18] World Health Organization, 11.

[19] In 2007, the population growth rate of Ukraine was -0.62% according to the State Statistics Committee of Ukraine. State Statistics Committee of Ukraine. "Population." Statistical Information. 27 Oct 2008. < http://www.ukrstat.gov.ua/>.

[20] Sources: 1) Reproductive Health Survey(s), Romania 1999 and 2004. 2) 2007; Guttmacher Institute, 2007; Willingness and Ability to Pay Survey (WAPS), 2004; Ukraine DHS, 2007. 3) Georgia Reproductive Health Surveys, 1999 and 2005.

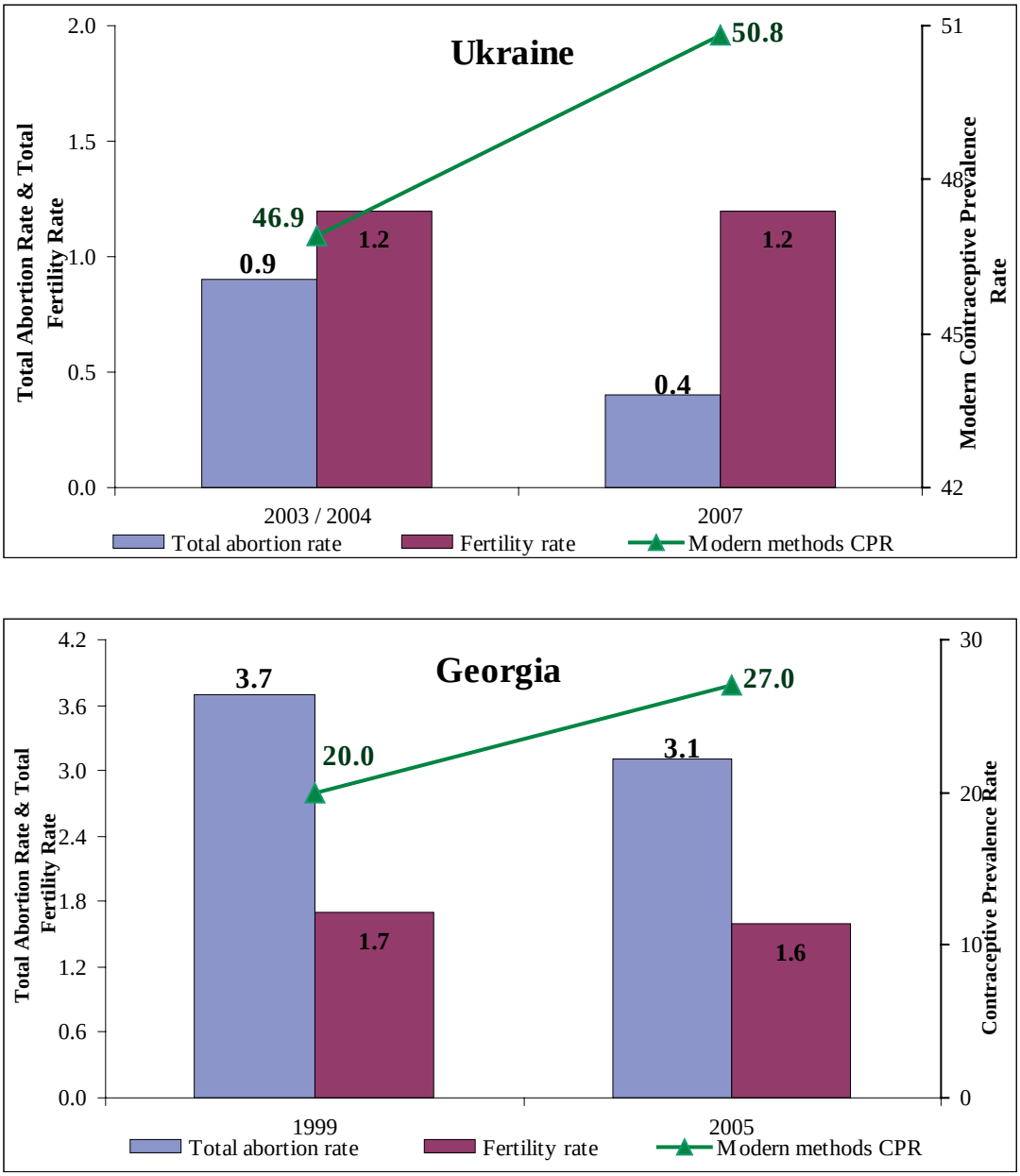


Figure 1-2. Trends in the Abortion Rate, Contraceptive Use and the Fertility Rate in Ukraine, and Georgia

family planning, prevention of STIs and HIV through educational campaigns and ensuring that its health care management system can sustain and continue these innovations.

Reproductive health in Ukraine will not improve, however, unless health care managers, policy makers, medical professionals, and key players in other sectors at all levels continue to make a concerted effort to work toward the betterment of the reproductive health of the nation as a health and human rights priority. Creative and progressive public health management in particular plays a large role in a successful reproductive health program. Reproductive health relies on preventive health measures, such as providing contraception and counseling services, educating the population about how to protect themselves against STIs and HIV, and providing the antenatal care necessary to ensure a safe and healthy birth. This curriculum is designed to aid health care managers—using examples from Ukraine—as they develop and implement programs to improve family planning and reproductive health in Ukraine.

Appendix 1

RESOLUTION OF THE CABINET OF MINISTERS OF UKRAINE

December 27, 2006, No. 1849
Kyiv

On approving the State Program Reproductive Health of the Nation up to 2015.
The Cabinet of Ministers of Ukraine has enacted to:

1. Approve the State Program Reproductive Health of the Nation up to 2015 (hereinafter called the Program)
2. Ministries, other central entities of the executive branch, as well as the Academies of Medical Sciences, Academies of Pedagogical Sciences, the Council of Ministers, Autonomous Republic of Crimea, oblasts, and the Kyiv and Sevastopol City Administrations are responsible for the implementation of the Program. They must submit information regarding the implementation of the Program to the Ministry of Health on an annual basis before February 1st in order for it to be forwarded to the Cabinet of Ministers of Ukraine before the deadline of February 20th.

State Program Reproductive Health of the Nation up to 2015

Context

Under the Constitution of Ukraine, the State highly values each human being, his or her life and personal health. The future of the State depends on political, economic and social issues that influence the country's demographics and the general health of the population. A quantitative and qualitative analysis of the population in the last 10 to 15 years shows that Ukraine is in a serious demographic crisis. It is characterized by depopulation, increased aging and reduced life expectancy. This has had a negative impact on the development of productive capacity, public welfare and the overall economic situation in the country.

Of special concern is the status of reproductive health, which is an integral part of the general health of the nation and is strategically important for the sustainable development of society. Activities implemented in recent years as part of the *National Reproductive Health Program 2001 to 2005* brought about positive changes in the area of reproductive health. Specifically, a system of family planning services has been set up; the population's awareness about healthy lifestyles, safe sexual behavior, responsible parenthood and contraception has increased; and the contraceptive prevalence rate has risen.

The abortion, maternal and infant mortality rates have declined. However, these indicators are still high and exceed European averages. There are problems associated with miscarriage, premature delivery and infertility, which result from unsafe sexual behavior and lead to considerable reproductive losses.

The current situation demands that further action be taken to improve the Ukrainian population's reproductive health.

An Analysis of the Causes of Inadequate RH in Ukraine:

— The social situation of the population, lack of concern about the role of the family, the decline of historical Ukrainian family traditions as well as a failure to preserve cultural relationships within the family, which was once a key underpinning of society;

- Insufficient social and legal protection for labor, a lack of proper enforcement of labor protection standards with safety measures, which results in unsatisfactory health conditions for women and discrimination against women, especially those who work in private companies, who are moved into low-paying jobs or are forced to seek work in the black market or abroad;
- Inadequate legal services;
- Mortality among men of working age exceeds that of women 3.6 times. Irreparable losses among the male population of reproductive age impacts the gender ratio in society and, at the same time, leads to a high number of single women, incomplete families and orphans;
- High maternal and infant mortality rates are tied to the population's lack of information on healthy lifestyles, responsible sexual behavior, family planning and modern standards of prevention, diagnosis and treatment of reproductive tract diseases. In addition, the lack of equipment in health care facilities and of trained specialists leads to reduced quality of care;
- Unsatisfactory care for pregnant women increases complications during delivery, which contribute to high morbidity rates among children under 14 as well as disabilities in children;
- High rates of induced termination of pregnancy (19.1 per 1,000 WRA) also affect fertility as well as subsequent pregnancy and childbirth. Induced termination of pregnancy and its complications kill every 10th woman;
- Pornography, promotion of sexual violence, broad advertisement of harmful habits (smoking, alcohol and drugs) have a negative impact on adolescents' reproductive behavior;
- High levels of infertility in Ukrainian families are related to reproductive losses;
- The spread of cancers of the reproductive tract is considered one of the main causes of death, resulting in many deaths among young women who have not begun to reproduce;
- Insufficient level of equipment and resources in healthcare facilities that provide RH services;
- One of the main factors in reproductive health disorders is STIs. They cause infertility, miscarriage, cancers and intrauterine infections of the fetus, which can result in serious consequences and even defects in future development. Reproductive loss due to miscarriage is 36-40,000 unborn children annually. HIV-positive pregnant women is another issue of importance, because they can potentially increase the number HIV-positive children.

The Goal and Main Objectives of the Program

Improving the reproductive health of the Ukrainian population is an important element of overall health, influences the demographic situation and ensures the socio-economic potential of the country.

The Program's main objectives are:

- Ensure conditions for safe motherhood;
- Shape RH in children and youth;
- Improve the FP system;
- Guarantee the RH of the population;
- Ensure efficient management of Program implementation;

- For effective work on RH problems, the main target groups must be defined:
  - children under 14;
  - adolescents, aged 15-17;
  - young people, aged 18-20;
  - young families under age 35;
  - pregnant women;
  - women and men of reproductive age.

Priority areas for implementation of the Program are as follows:

Socio-economics:

- Improve the regulatory framework for reproductive health care for families;
- Promote family values and ensure social services for young families;
- Protect the health of socially vulnerable groups.

Education:

- Develop and implement cross-sectoral strategies to promote, develop and encourage healthy lifestyles, responsible parenthood and safe motherhood;
- Inform the population about taking responsibility for their own health;
- Carry out information and communication educational activities on health issues that promote healthy lifestyles, family planning, reproductive health, the protection of motherhood and cancer prevention;
- Develop a strategy to reduce harm inflicted by information technologies on the lifestyles of children and adolescents.

Medical care:

- Strengthen preventive reproductive health services for every target group;
- Implement a strategy for general practitioners and family doctors to provide reproductive health services;
- Ensure the quality of medical care in reproductive health and family planning in accordance with protocols;
- Ensure access to reproductive health services for men and women;
- Improve access to health care services for adolescents and rural populations;
- Continue to develop and implement evidence-based medicine technologies and practices in reproductive health;
- Improve logistics for reproductive health facilities;
- Improve and optimize the family planning system in Ukraine;
- Develop a contraceptive security strategy;
- Develop and implement a system of training family physicians and general practitioners on issues of reproductive health and family planning;
- Improve graduate and postgraduate curricula by including reproductive health and family planning issues;
- Raise the level of professional training of health providers;
- Improve the system of management of health facilities.

Science and Research:

- Identify factors and mechanisms that maintain and improve reproductive health;

— Carry out a situational analysis of TB related to reproductive health.

Coordination and Cooperation with the Program:

— Implement monitoring and evaluating programs.

Expected results:

The implementation of the Program will reduce the levels of:

— Maternal mortality by 20%
— Anemia among pregnant women by 45%
— Infant mortality by 20%
— Hemolytic disorders in newborns by 20%
— Abortion rate among adolescents by 20%
— Inflammatory diseases of the reproductive tract among adolescents aged 15-17 by 20%
— Induced termination of pregnancy among adolescents aged 15-17 by 20%
— Induced termination of pregnancy among adult women by 20%
— STIs by 30%
— Gonorrhea incidence among adult men by 10%
— Cervical cancer by 20%
— Breast cancer by 10%
— Infant mortality from respiratory tract disorders by 20%
— Increase the number of babies who are breastfed before 6 months of age by 60%
— Ensure antenatal care for 98 % of pregnant women
— Introduce “Youth-Friendly Clinics” in outpatient polyclinics and pediatric healthcare facilities by 90%
— Increase contraceptive prevalence to prevent unintended pregnancies by 20%.

Financing of the Program:

The Program and its activities are to be funded from the budgets of the MOH and other executive entities, the Autonomous Republic of Crimea, the oblasts, Kyiv and Sevastopol Cities as well as from other sources involved in implementation of the Program.

Funding for the Program will be provided as follows: 455,165,700 UAH from the State budget, 295,135,200 UAH from local budgets, and 10,709,600 UAH from other sources.

Appendix 2

FAMILY PLANNING AND REPRODUCTIVE HEALTH INDICATORS

Although family planning and reproductive health may appear difficult to measure because of the very personal and broad nature of the field, there is an international consensus on a set of indicators to monitor and evaluate family planning/reproductive health status, service provision, resource availability and trends over time. These indicators, in addition to others used by the Ministry of Health (MOH) of Ukraine, are used in the SPRHN and allow managers, policymakers and other partners to establish a picture of reproductive health in the country and monitor its progress. As health care managers in Ukraine continue to develop and implement family planning and reproductive health programs, these indicators will be useful in defining the needs of both the population and the health care system, as well as in monitoring feedback. It is important to note that improved indicators alone are not an indication of success. Changes in indicators must be accompanied by real changes in the health care system and not just different ways of looking at the numbers.

FAMILY PLANNING INDICATORS

- The **contraceptive prevalence rate (CPR)** is defined as the percentage of women of reproductive age (ages 15-49) who are using, or whose partner is using a contraceptive method at any given point in time. This indicator is calculated as follows:

$$\text{CPR (\%)} = \frac{\text{Number of women of reproductive age at risk of pregnancy who are using, or whose partner is using a method of contraception at a given point in time}}{\text{Number of women of reproductive age at risk of pregnancy at that point in time}} \times 100$$

Contraceptive methods include all traditional and modern methods of contraception. **Modern contraceptive methods** include female and male sterilization, intrauterine devices (IUDs), hormonal methods (pills, vaginal ring, patch, injections, implants), male and female condoms, other barrier methods (e.g. diaphragm, cervical cap) and spermicides. **Traditional methods of contraception** include the rhythm or calendar method, withdrawal (coitus interruptus), abstinence and lactation amenorrhea. Women **at risk of pregnancy** refers to women who are sexually active, fertile and not pregnant.

This indicator is used for measuring the use of contraceptive methods in a population. When compared to the number of women who want to use contraception (indicated either by survey data, the abortion rate or the fertility rate, depending on the country and available data), this indicator can show how successfully the health care system is meeting the contraceptive needs of the population.[21]

Internationally, the CPR is most commonly measured using survey data, such as the Demographic and Health Surveys, in order to include women using natural methods or women who

[21] World Health Organization. Reproductive Health Indicators: Guidelines for their generation, interpretation and analysis for global monitoring. Geneva: World Health Organization, 2006, 13.

have obtained their method directly from a pharmacy. The SPRHN, however, uses health facility-based data to calculate the CPR, so the indicator is calculated as follows:

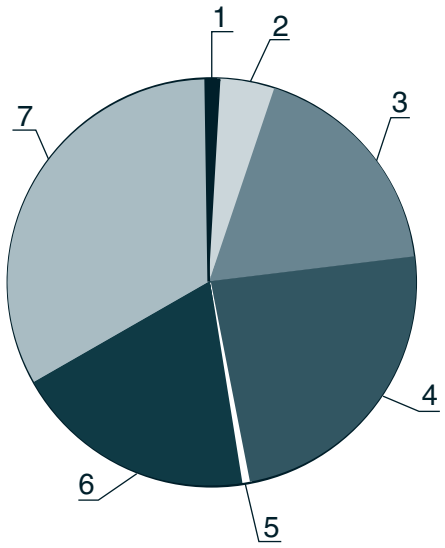
$$CPR_{SPRHN}\ (‰) = \frac{\text{Number of registered IUD and}}{\text{Number of women of reproductive age}} \times 100$$

The SPRHN seeks to increase the contraceptive prevalence rate by 20% by 2015.[22]

- The **contraceptive method mix** is a breakdown of the methods chosen by women using contraception in a given population. This indicator is usually portrayed as a pie chart and the contraceptive methods are sometimes grouped into traditional and modern methods (pic. 2). The percentage using each method can be calculated and displayed as follows:

$$\text{\% women using contraceptive method X} = \frac{\text{Number of women using contraceptive method X}}{\text{Total number of women using contraception}} \times 100$$

The Contraceptive Method Mix in Ukraine, 2007 (%)



1.	Female sterilization;	**0,6%**
2.	Pill;	**4,8%**
3.	IUD;	**17,7%**
4.	Male condom;	**23,9%**
5.	Foam/Jelly;	**0,5%**
6.	Any traditional method;	**19,2%**
7.	Not currently using any method;	**33,3%**

Picture 2. The Contraceptive Method Mix in Ukraine, 2007[23]

The contraceptive method mix is often used as a proxy for measuring method availability or choice. If it is skewed in favor of a particular method, managers may want to explore the reason behind the preference for that method.

[22] Ministry of Health of Ukraine. "National program indicators, targets, and their definition." State Program for the Reproductive Health of the Nation up to 2015. Kyiv, Ukraine: 2006, 2.

[23] Ukrainian Center for Social Reforms. Ukraine Demographic and Health Survey: Preliminary Report. Calverton, Maryland: MEASURE DHS, June 2008, 9.

- The SPRHN aims to lower the **rate of teenage (age 15-17) pregnancy** by 20% by 2015. The indicator for teenage pregnancy in Ukraine is calculated as follows:

$$\text{Teenage pregnancy rate}_{\text{SPRHN}} = \frac{\text{Number of deliveries and abortions to women aged 15-17}}{\text{Total number of women aged 15-17}} \times 100$$

"Pregnancy" is notoriously difficult to measure, since it consists of births + miscarriages + abortions. Women do not know immediately when they become pregnant, and abortions and miscarriages are often not reported. Internationally, the level of pregnancy among teenagers is assessed using a combination of the adolescent fertility rate (for women aged 15-19) and the adolescent abortion rate (the number of abortions to women aged 15-19) per 1,000 women aged 15-19 in a population.[24] In the context of the SPRHN, which relies primarily on facility-based data, pregnancy is defined as delivery of a baby and induced abortion.[25]

FERTILITY INDICATORS

- The **total fertility rate (TFR)** is the number of births a woman would have by the end of her reproductive life if she were to experience the current age-specific fertility rates (ASFR) from age 15 to 49. This indicator is often seen as an approximation of the number of births per woman in a population. The ASFR in any age group is calculated as follows and is usually expressed per 1,000 women:

$$\text{ASFR (women aged X)} = \frac{\text{Births in a year to women aged X}}{\text{Number of women aged X at mid-year}}$$

The ASFR is often calculated for five-year age groups (15-19, 20-24, and so on until 45-49.) Assuming this is the case, and that the ASFR is expressed per 1,000 women, the TFR is calculated as follows:

$$\text{TFR (per woman)} = \frac{\text{Sum of ASFRs} \times 5}{1{,}000}$$

The TFR is used as a general demographic indicator associated with other indicators, such as the contraceptive prevalence rate and the maternal mortality ratio. As mentioned before, in countries with high fertility rates, a decrease in TFR can correlate with an increase in the contraceptive prevalence rate; however, this is not the case in Ukraine or elsewhere where there is a low TFR.[26]

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[24] United Nations Economic and Social Commission for Asia and the Pacific. *Handbook on Reproductive Health Indicators.* New York: United Nations, 2003, 33.

[25] Ministry of Health of Ukraine, 2.

[26] World Health Organization, 9

- According to WHO, the **prevalence of infertility among women** is defined as the percentage of women of reproductive age at risk of becoming pregnant who report trying for a pregnancy for two years or more. It is calculated by:

$$\text{Prevalence of infertility among women (\%)} = \frac{\text{Number of women of reproductive age at risk of becoming pregnant who report trying unsuccessfully for a pregnancy for two years or longer}}{\text{Total number of women of reproductive age at risk of becoming pregnant}} \times 100$$

Health care managers can use this measure as a general indication of sexual and reproductive health in a country, since infertility is sometimes caused by genital tract infections or complications from STIs. [27]

MATERNAL HEALTH INDICATORS

- The **maternal mortality ratio (MMR)** is the number of maternal deaths per 100,000 live births. It is important to note that the indicator generally used to measure maternal mortality is a ratio and not a rate. This is because the denominator is the total number of live births, and not the number of women. The MMR is derived using the following rubric:

$$\text{MMR} = \frac{\text{Number of maternal deaths occurring in a certain period x 100,000}}{\text{Total number of live births occurring in that period}}$$

Maternal death is defined as the death of a woman while pregnant or within 42 days after termination of a pregnancy for any reason related to or aggravated by pregnancy or its management.[28]

- **Live birth** is defined by WHO as "the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born."[29]

This definition differs from that of "live birth" employed by the Soviet Union, which stated that only if an infant is breathing is it considered born alive. The Soviet Union employed the term "live fetus" to refer to infants who were born before 28 weeks of gestation, weighed less than 1,000 grams or measured less than 35 centimeters. These infants were only counted as live births if they survived for seven days.[30] The result of this discrepancy in definitions is that, in many countries of the former Soviet Union, an infant who is not breathing at delivery does not receive neonatal emergency care, even if it meets the WHO and international definitions of a live birth by displaying any sign of life.

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[27] World Health Organization, 49.

[28] Ibid, 16.

[29] Ibid.

[30] UNICEF. *Social Monitor 2003*. UNICEF, 2003, 37

- **Antenatal care coverage** measures the number of women attended by a skilled health professional at least once during their pregnancy for reasons relating to pregnancy. It is derived as follows:

$$\text{Antenatal care coverage} = \frac{\text{Number of women who have been attended by a skilled health professional at least once during their pregnancy for reasons relating to pregnancy}}{\text{Total number of live births during the same period}}$$

Antenatal care coverage shows the proportion of women who using antenatal care services. It is viewed as a proxy measure of progress toward reducing maternal mortality, since epidemiological studies have shown the connection between antenatal care and improved maternal outcome.[31] This indicator is a good way to assess the progress of programs aimed at improving maternal health, such as the SPRHN. In particular, the SPRHN aims to provide antenatal care for 98% of pregnant women by 2015.[32]

- Another indicator that points to the quality of maternal care is the **perinatal mortality rate (PMR)**, which measures the number of perinatal deaths (fetuses weighing at least 500 grams) per 1,000 births. It is measured as:

$$\text{PMR} = \frac{\text{Number of perinatal deaths x 1,000}}{\text{Total number of births}}$$

Perinatal deaths include all fetal and infant deaths beginning at 22 completed weeks of gestation (when birthweight is normally 500 grams) and ending at seven completed days after birth. This indicator is more of a measure of maternal health, rather than infant health, because it measures the outcome of a pregnancy in terms of the infant. In addition, fetal or neonatal mortality is associated with fetal care administered through care of the mother rather than measures provided post-delivery. [33]

- The SPRHN has a goal of reducing the overall infant mortality rate by 20%, an indicator that is tied both to maternal and infant care.[34] Infant mortality is defined as the number of infant deaths under one year of age per 1,000 live births in a given year.[35]

SEXUALLY TRANSMITTED INFECTIONS (STI) INDICATORS

- In Ukraine, the **prevalence of syphilis** in a population is used as a proxy measure for the prevalence of STIs among the population over 18 years of age. While this indicator is internationally recognized as a dependable proxy, its use may be limited in areas where there is low syphilis prevalence.[36] The syphilis prevalence rate is calculated as follows:

$$\text{Syphilis prevalence rate}_{\text{SPRHN}} = \frac{\text{Number of diagnosed cases of syphilis among men and women over 18 years of age}}{\text{100,000 people over the age of 18 [37]}}$$

[31] World Health Organization, 21.
[32] Ministry of Health of Ukraine, 1.
[33] World Health Organization, 32.
[34] Ministry of Health of Ukraine, 1.
[35] Haupt, Arthur, and Thomas T. Kane. *Population Handbook: International Edition*. Washington, D.C.: The Population Reference Bureau, Inc., 1980, 39.
[36] World Health Organization, 39.
[37] Ministry of Health, 3

Internationally, the data for this indicator are collected from health facilities on the number of pregnant women who test positive for syphilis, since most countries conduct syphilis screening for pregnant women as a part of antenatal care.[38] Registration and testing processes in Ukraine, however, mean that data are available for both sexes, so the indicator is calculated as presented above. The SPRHN aims to lower the STI prevalence rate among both men and women by 30% by 2015.[39]

- The **prevalence of HIV among pregnant women** is generally used as a gauge of HIV prevalence in the population at large. This indicator is defined as the percentage of blood samples taken from women aged 15-24 years that test positive for HIV during routine sentinel surveillance at antenatal clinics. It is measured as:

$$\text{HIV prevalence of pregnant women} = \frac{\text{Number of HIV positive blood samples taken from pregnant women aged 15-24 years at selected antenatal clinics x 100}}{\text{The total number of blood samples taken from women aged 15-24 at selected antenatal clinics that were tested for HIV}}$$

This indicator is used as a proxy for HIV incidence in a population, since the age group surveyed (pregnant women ages 15-24) is assumed to represent the age group just beginning sexual activity. Therefore, all infections among this age group can be assumed to be new infections. The prevalence of HIV among pregnant women can be used to monitor the course of the HIV epidemic.[40] This indicator will become increasingly important to health care managers in Ukraine as the HIV epidemic becomes more widespread and moves into the general population, a phenomenon that is already beginning to occur.

OTHER REPRODUCTIVE HEALTH INDICATORS

- Two other important indicators mentioned in the SPRHN are the **incidence rates of cervical and breast cancers**, two diseases that Ukraine is particularly trying to address. The SPRHN plans to lower the incidence rate of cervical cancer by 20% and the incidence rate of breast cancer by 10% by 2015.[41] These indicators are defined as the number of new cases of (cervical or breast) cancer per 100,000 population. They are calculated as follows:

$$\text{Breast cancer incidence rate}_{\text{SPRHN}} = \frac{\text{Number of new cases of breast cancer}}{\text{100,000 members of the population}}$$

$$\text{Breast cancer incidence rate}_{\text{SPRHN}} = \frac{\text{Number of new cases of cervical cancer}}{\text{100,000 members of the population}}$$[42]

[38] World Health Organization, 39.
[39] Ministry of Health, 3.
[40] World Health Organization, 53.
[41] Ministry of Health, 3.
[42] Ministry of Health, 3.

Chapter 2

AN INTRODUCTION TO THE CASE METHOD

By Marc Mitchell and Rachel Criswell

During the past decade, many changes have called for new approaches in the way health care is managed in Ukraine. A shift from centralized planning to local initiatives and the changing patterns of disease, from acute to chronic, require a new way of thinking about health care and how it is delivered. In this context, there is a clear understanding of the need to help managers at all levels of the system learn about public health approaches, which are aimed at improving the health status of the populations they serve, and techniques to better manage their health system and achieve better results, despite limited resources.

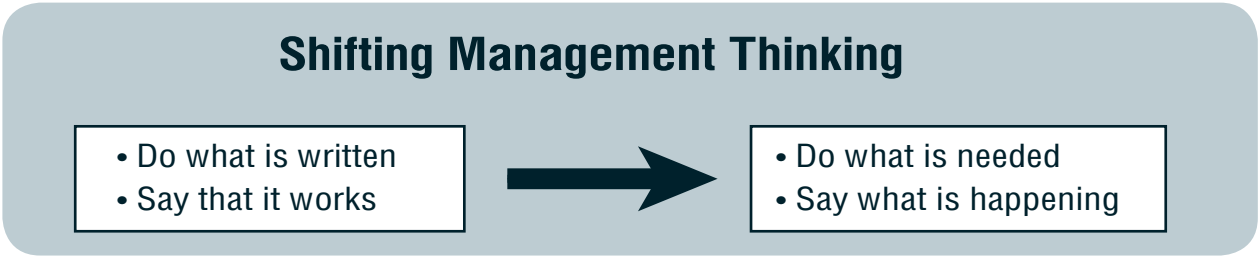
Based on this, a model for management training has been developed, which will increase the ability of managers, as well as the overall health care system, to better meet the needs of the population, particularly when providing family planning and reproductive health services.

The goals of this management training curriculum are to improve the performance of the public health care system and enable it to meet the health care needs of the population using available resources. It pays particular attention to family planning and reproductive health services. In order to achieve these goals, several things are needed:

1. Health managers must understand that their role is to improve health and to align the health care system to deliver quality preventive and curative care that meets the needs and expectations of the population.
2. Managers must adopt a public health approach to planning. This means that initiatives are developed on the basis of their likely impact on the health and welfare of the population rather than the needs of the facilities that deliver the services.
3. Clients perspectives must be known and respected by providers and managers. To achieve this, clients must be given accurate and understandable information as well as be involved in decisions about their own care.
4. Managers must understand the value of accurate information upon which to base decisions and an analytic approach to data analysis, which examines the validity and implications of data, rather than just the source.
5. Prevention and treatment must be based on Evidence-Based Medicine (EBM) to ensure both effectiveness and efficiency. This requires the use of accurate data and avoids the overuse of hospital facilities, tests and pharmaceuticals.
6. Managers must understand that many resources are under their control and that changes can be accomplished if they are willing to take the initiative, rather than continue doing things as they have been done in the past.

This curriculum aims to improve the performance of the public health system by training managers in critical analytic thinking. This means that managers do not simply take things that

they read or are told for granted, but rather consider the source of the material and whether the information seems to fit with their own understanding of how things work in the real world. Critical thinking calls for challenging whether statistics are measuring the right thing and whether the source of the data is credible and accurate. It also requires managers to understand how the recent and profound changes in the health care system in Ukraine can be used to improve the quality and efficiency of the services being offered to better meet the needs of the population. This is not simply the application of specific knowledge to a new set of circumstances but an understanding by managers that their role is to achieve results rather than simply to follow procedures. This is a different approach to management from the old Soviet system, where following rules and procedures was paramount and results were assumed to follow. Furthermore, in the old system, it was important to produce reports that showed things were going well. What is needed today is a shift in management thinking from the old style of following directions to the new approach of greater autonomy. This shift is shown in the following diagram.



The fundamental framework of current management thinking is that planning and implementation must be closely linked to monitoring and feedback so that plans can be constantly altered in response to ongoing testing and measuring whether the desired results are being achieved. In the past, managers in Ukraine were taught to implement what was written (often in the form of a five year plan) and then report that it was done. Noncompliance with either of these dictates could have unpleasant consequences and, over time, managers learned to not deviate from this formula.

We are now asking managers to shift their thinking to a very different paradigm of planning, based on the active observation of a situation's needs and effective monitoring to modify plans on an ongoing basis in order to achieve a certain result. This type of training requires a participatory model of learning, instead of the more traditional, passive model used in lectures, One type of participatory learning, which is most commonly used today in management training, is a case-based training model.

The case method is a system in which students actively put themselves in the place of a protagonist in a management situation drawn from real life and practice making management decisions based on individual analysis, group discussion, and instructor guidance. The case method is well-suited to teaching management, since its interactive nature caters to the adult learning style, it helps students develop interpersonal skills and allows them to practice the attitudes and philosophies necessary for good management.

WHY USE A CASE?

The case method of teaching and learning was developed for teaching management in response to the need to give students an opportunity to perform analysis and make decisions in real management situations. The underlying theory is that management, unlike many other types of study, is highly situational; that is, the needed skills and behaviors of managers are highly influenced by the specific situation rather than by a set of rules or theories that can be universally applied. In this regard, it is more like learning to drive a car than following a cooking recipe. Management is learned by doing, rather than by studying.

The case method began in the late 19th century at Harvard Law School and has since spread to professional schools worldwide for the teaching of medicine, business, management and public health. Christopher Columbus Langdell, a Harvard Law professor and the founder of the case method, believed that practicing law was based on a few core theories and principles and that the best way to learn those principles was to induce them from primary source materials—in this situation, legal cases.[43] The practices of induction and active learning can be applied to a wide range of fields, especially ones in which success depends on employing a style of thinking in combination with specific skills and knowledge. Cases provide an opportunity to practice, discuss and evaluate these styles of thinking in a safe classroom setting. Many compare learning management through the case method to learning how to swim—no one would jump into the deep end of a pool after having only read books about swimming. These skills require active practice; therefore, swimmers swim. Since management students cannot realistically practice by managing a company, the case method provides a practical and effective simulation.[44]

Thus, the classic Harvard Business School case is written in a way that puts the reader in the position of the central management figure of the case, asking him/her to do the analysis necessary to make decisions or take actions that are either implicit or explicit in the materials presented. The focus of this type of case is **the manager**, and the class participants are expected to assume the roles of key players in the case, staging and defending the actions they would take given the circumstances presented.

However, as the case method has developed and been used in a wide variety of settings, other uses of cases have arisen. Another very common use of cases is to give students an opportunity to **learn and apply a new skill** such as cost-benefit analysis or statistical analysis. These cases tend to have complicated data sets that must be manipulated in order to understand the situation. Their emphasis is usually on the use and application of a specific analytic skill.

A third use of cases is to **validate a new concept or method of analysis** that may be foreign to students. Through the presentation of real cases in which the concept or analysis applies, students may be more willing to accept counterintuitive approaches that are presented. The cases may be a way to break through their natural resistance to radically new concepts or analytic tools. This is especially useful when participants are being asked to consider approaches or analytic techniques that lead to conclusions inconsistent with their old ideas. For example, it is not intuitive that public sector spending benefits the rich more than the poor, and so a concrete case illustrating this point helps to validate the method of analysis.

WHAT IS A CASE?

Since the use of cases has specific goals as stated above, the content of cases should contain specific elements that ensure these goals are realized. There are a few elements that appear to be needed in all cases, regardless of their particular rationale or setting.

A case should have a clear **teaching objective**. What will students learn from the case? In general, this will reflect one of the approaches described above but should be quite specific. A teaching objective might be to illustrate how a new skill is applied to a real situation, to introduce or reinforce a new concept or model, or to put the participants into a real management situation where they need to make decisions based on the environment in which the case is set. The learning objective must go beyond simply showing how something was done in another country.

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[43] Garvin, David A. *Making the Case*: Professional Education for the World of Practice. Harvard Magazine, September-October 2008, Volume 106, No. 1. Available online at <http://harvardmagazine.com/2003/09/p-making-the-case.html>.

[44] Hammond, John S. *Learning by the Case Method*. Harvard Business School, Cambridge, MA: 1976, rev. 2002, 3.

From each case, students should learn something new, which will often be how to **apply a new tool or concept** presented in an earlier session. This might be the application of a certain skill or a very broad concept. One of the hallmarks of a good case is that is leads students to a new or better understanding of a complex issue. In general, when new concepts are first presented, they are isolated and simplified so that students can more easily understand them. However, in the real world, because it is full of people rather than textbook situations, problems seldom appear in isolation, and often the most difficult problem in management is understanding where to begin. This is one of the benefits of using a case, which presents a situation with a high degree of complexity and lets students systematically figure out what types of approaches are most likely to be successful.

Because cases are used to facilitate active learning, they must involve some type of **analysis by the students** with the leader as a facilitator rather than a lecturer. The point is for students either to practice a skill or to discover new insights rather than simply to sit back and listen. An excellent case will challenge students across a wide range of skill levels by involving multiple analyses, which will depend on the experience of students and their understanding of the topic being discussed. In order to achieve this, enough information must be presented to enable students to complete the analysis required, while not overwhelming them with pages of interesting but irrelevant information. On the other hand, the key messages of the case will often not jump out at the students but require a careful assessment of needed versus superfluous information for analysis.

The lessons learned from a case study should be **applicable** to other situations and in particular to situations in which students are likely to find themselves in the future. This is the difference between a case used for training purposes and a case example, which simply illustrates one country's experience with a particular approach or tool. The role of the facilitator is to help students understand how the specifics of the case lead to new understandings that can be used in a variety of situations.

The situation described in a case is most often **taken from real life**. This allows students to gain experience working with the complex and often ambiguous situations that face managers on a daily basis. A management case is not a piece of research, an example of a management practice or a glorified problem set. Any theory or external example should be provided by the professor in a lecture, a note or supplemental readings. A case delineates a situation and presents students with a problem to be solved. As in real life, cases are full of conflicting information, ambiguity and difficult decisions. The point of a case is not for students to find an easy answer but to weigh the pros and cons of a solution and eventually decide on what they feel to be the appropriate course of action. In order to simulate reality as much as possible, the narratives of cases often include some background about the protagonist, the company and the situation involved. While some cases may require additional research by the students, they are usually self-contained and include several pieces of evidence that the student (protagonist) can use to analyze the problem.

Finally, a case should be **interesting**. Since students in management courses are adults, it is important to remember that adults learn differently from children, who are easily distracted, have short attention spans and need to be kept from falling asleep. Because most of learning from cases is done individually or in small groups, the case method keeps students engaged. Students tend to stay awake because class sessions that use the case method are interactive.

HOW IS A CASE USED?

There are **four steps** to teaching and learning by the case method. First, the student prepares the case outside of the classroom. This is a process that includes reading the case,

identifying the key issues and relevant considerations, performing the appropriate qualitative or quantitative analysis and developing a set of recommendations supported by this analysis. After this individual analysis, many institutions encourage students to discuss the case in small groups outside of the classroom so that each participant can refine recommendations and hone their ability to articulate and defend a position.

Refining one's argument and honing communications skills are essential, because students fuel **the classroom discussion**. A student will present the basics of the case and then other students will be invited to present opinions, challenging each other. The instructor's role is to facilitate discussion, pose questions, make comparisons with other situations and stimulate critical thinking. It is during this discussion that the most important learning occurs: students have an opportunity to articulate their ideas, critique others and respond to criticism the way one would in a real management situation. At the end of the discussion, the instructor **sums up the general themes of the session** and asks students to summarize the discussion.[45] Ultimately, no case has a "right" answer. Cases are designed to teach an approach. A good case will produce several solutions that can all be defended with the right amount of analysis and expertise.

The case method is not suited to teaching all information, as rules and formulas are best delivered in a lecture; however, it can be very useful in teaching the ideas and attitudes necessary to be a successful manager. While there is no formula for successful management, there is a general set of management skills. The case method allows students to practice applying those skills to specific situations. The case method is beneficial in management training because it helps students develop an idea of what factors influence a certain type of decision-making. It allows for practice using these factors in a safe environment and for the exchange of ideas, which broadens the pool of knowledge. Most importantly, the active learning involved in the case method helps participants to truly absorb what they have learned. If used correctly, the case method can provide students with problem-solving experience to which they can refer when they are in a professional management setting.

TEACHING BY THE CASE METHOD

For many teachers who are used to lectures, teaching by the case method is a challenging and exciting change of pace. Unlike a lecture, where the teacher is the center of attention and does most of the speaking, the case method is more interactive and depends on the students to keep the discussion going. The teacher's role is still important, but much of the work that he/she will perform takes place outside of the classroom or in the form of short but purposeful comments and questions during discussions. The instructor is teaching not just facts but guiding the students in learning the arts of analysis, evaluation and discussion.

Case method learning is made up of **six basic elements**, which include discovery, skilled questioning, continual practice, contrast and comparison, involvement, and motivation. While the students have to carry these elements out by themselves, it is the instructor's job, both in and out of the classroom, to guide them through these processes. An instructor can lead a student to discovery by choosing case material that builds on the student's previous knowledge, allowing him/her to use what he or she already knows to learn new things. **Discovery** also takes place in the classroom, as students encounter each other's differing ideas and perspectives through debate.

During class discussions, both students and the instructor enhance **discovery** through **questioning**. A teacher can guide a student through lines of logic and thought by asking a series of questions that urge him/her to think analytically. Continual use of cases in the classroom provides the student with **practice** in this type of thinking. While a student may remember few

[45] Shapiro, Benson P. *An Introduction to Cases*. Harvard Business School, Cambridge, MA: 1984, rev. 1988, 1.

details of each case, the style of managerial thinking will become habit after repeated exposure. **Contrast and comparison** are key components of learning through induction. As students see more cases, patterns of thinking will emerge, with help and encouragement from the instructor.

Finally, as mentioned above, student **involvement** in discussions is key to successful case learning. While this responsibility lies largely with the student, the instructor can play a role in **motivating** students to get involved by laying out expectations, listening closely, exercising respectful listening when students speak, and encouraging quieter students to participate. Each of these elements requires the commitment of the students; however, the instructor plays an essential role in overseeing and guiding the process. The following suggestions will help an instructor of the case method to best guide students through the learning process.

What is the instructor's role?

Just as important as the students' role in preparing the case and participating in the discussion is the instructor's role in choosing the case and guiding the discussion. While the instructor should rarely speak during the classroom discussion of a case, his/her work prior to the discussion is essential to the case method. The instructor must have enough knowledge of the field to know which skills are necessary and which real life case will best teach those skills. After choosing an appropriate case, the instructor also prepares for class by brainstorming possible solutions and questions for further discussion while keeping in mind that every case has multiple answers.

During the in-class discussion, the instructor's most important role is that of an active listener. While he/she "places the responsibility of learning on the student," he/she recognizes that an open mind, probing questions, and inquiries into reasoning are essential parts of a student's learning process.[46] The instructor may present variations on the scenario at hand in order to push the students to think about the issue from a different perspective. Most importantly, the instructor maintains a willingness to learn from his students; especially in management trainings, where students often have firsthand experience in the professional world. Each member of the class can be a valuable teacher. In the end, the instructor does not help the class come to a consensus but rather summarizes the discussion, points out the key lessons and observations that emerge from the discussion and encourages the students to apply the case to their own situations. [47]

At the start of the course

The instructor sets the tone in any course, but this is especially important in one that employs the case method. Since the case method is based on active discussion and debate, it is essential that every student has knowledge of the case, participates and is respectful when listening. The instructor can outline the basics of the case method and classroom etiquette at the beginning of the course, but it is also important that he/she displays these behaviors him/herself as an equal participant in the class. For example, the instructor must have a solid grasp of the case facts in order to set an example, to spot inaccuracies in the students' knowledge, and to move the discussion from reciting of facts to drawing conclusions from information.

Different students have different levels of comfort when it comes to expressing their opinions in front of a group. Even if a student is not vocal in class, he still may be paying attention and actively listening. An instructor can engage these students and encourage active listening by periodically directing questions at certain students. Ensuring that students are attentive and thinking, even when they are not speaking, will make the class discussion richer.

The instructor can also set the tone of discussion through facilitation. Since the case method involves students learning from each other, the discussion could span a range of topics and

[46] Corey, E. Raymond. *Case Method Teaching*. Harvard Business School, Cambridge, MA: 1980, rev. 1998, 2.

[47] Hammond, John S. *Learning by the Case Method*. Harvard Business School, Cambridge, MA: 1976, rev. 2002, 3.

maybe even jump from one to another. This allows students to express their ideas when they think of them, rather than have them wait for the "right time" to do so. It also allows for a thorough exploration of all of the topics included in the case. If the instructor thinks that a subject has not been explored to the fullest extent, he/she might suggest that the discussion stay focused on that point for a little while longer.

The instructor's most important role when setting the tone of class discussion is to be a respectful participant. If the instructor gives each contribution consideration and offers only constructive criticism, then the rest of the class will be encouraged to do so as well. This will create a safe classroom environment, where students feel they can express their opinions without fear of being derided.

The Class—Preparation

The choice of case is important in determining what students will learn. As mentioned earlier, the case method is based on the principles that students have some knowledge of general management and that the successful application of this knowledge depends on the situation.[48] However, an instructor must know the field well enough to know exactly which skills are important and which case best highlights those skills. As one instructor explains, a case is "the world in a grain of sand." An instructor must know enough about the real world in order to simplify it for a case while still preserving important details.[49] Therefore, the choice of which case to assign to students is important.

Also important is the amount of guidance an instructor wishes to provide students who are preparing a case. Including very specific discussion questions with the case will point students in a particular direction of thinking, while providing broader discussion questions will require students to use a little more initiative in deciding which management issues are most relevant to the case. Readings and supplements can be used to aid students with case analysis, teach a specific skill or provide a broader perspective on a theme.

The Class—The Beginning

Many instructors who use the case method say that the first 10 minutes of class are the most crucial. During this time, the instructor or a student should set up the case by recounting its basic details, relating its subject to important managerial issues or other cases, and posing opening questions. In order to set the tone for student participation, the instructor may ask a student to give a brief presentation on his analysis or some aspect of the case that is especially important to discuss or to answer some general questions. The instructor can decide either to "cold call" the student, meaning that all students need to be adequately prepared to begin class discussion, or he/she can "warm call" the student by giving him/her notice a moment or two before class so that he/she can look over his/her notes.

Since the foundations of the case discussion are laid out at the beginning of class, it is important to use time wisely. While some background information is necessary, the student who begins the discussion should provide not only facts but also analysis in order to spark controversy. The instructor should keep students focused, so they follow a line of thinking through to its end, uncovering the significance of each fact in order to present conclusions. These can eventually lead to recommendations and a plan of action. The opening presentation should define the problem in need of a solution and identify the areas in need of analysis so that the ensuing discussion has a clear purpose.

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[48] Roberts, Michael J. *Developing a Teaching Case (Abridged)*. Harvard Business School: Cambridge, MA, 2001, 1.

[49] Roberts, 2.

The Class—The Middle

After the initial presentation, the instructor should open the floor to comments either by asking for voluntary contributions or specific follow-up questions. At this point, the comments may be random, but they will set a general agenda of ideas to be pursued during the discussion. The instructor can moderate by asking for clarification, analysis or substantiation. He/she can also participate by connecting comments, focusing attention and noting similarities and differences. He/she may also keep track of ideas discussed on a chalkboard, so that no point of the discussion is overlooked.

About halfway through the discussion, the instructor can refocus it by bringing up certain issues that he/she feels have not been adequately explored. These can be issues that the students have already raised but not exhausted, or they can be new concepts. Rather than asking specific questions at this point, the instructor should focus more generally on areas of the discussion. Once an area has been completely discussed, the students should be urged to move on to the next topic in order to avoid stagnation. As previously mentioned, the instructor's attitude is key in ensuring that the discussion remains open and respectful. This can be conveyed through comments, questions and body language.

The Class—The End

At the end of class, students should summarize what they have learned and try to apply those concepts in a more general sense. The instructor can ask a student to summarize the points of discussion or can comment on the discussion, him/herself, emphasizing some of the more important concepts. The most important thing is that the summary is rooted in what the students have said rather than introducing something new. This not only reinforces what the students have already learned but also rewards each individual for his contribution to the class. Alternatively, the instructor could ask the students to review the class once the discussion has been completed, leaving the students to draw their own lessons and conclusions.

The instructor may also take this opportunity to generalize the skills and concepts learned in a given case. This can be done by asking students to apply these concepts to their own management experiences or by citing the experiences of others with similar problems. In order to aid this process, the instructor should keep an ongoing file of clippings about companies in similar situations to that at hand.

After the class has ended, students may be invited to stay for a few minutes if the discussion is particularly interesting. The instructor should make a point to stay a few minutes after class in case students need clarification or would like to speak with him/her personally. It is also advisable to take some notes after class about how the discussion proceeded and what could have made it better, for use in the future.

Evaluations and Exams

Students are evaluated in a case-based course on their class participation and on exam performance. In order to judge students' in-class performance, the instructor may call on them to answer questions. The students can then be graded on their responses. Calling on students is helpful for the quieter students who may be nervous to express their views in front of a large group. It is generally acceptable to call on a student three to four times during a 60-80 minute class period while still leaving room for voluntary comments, which can also be graded. In order to keep consistent records of students' in-class contributions, the instructor should take some notes after class on each student's performance.

Examinations in case-based classes generally involve cases that the students need to read, evaluate and resolve on paper. A good case exam should engage the knowledge covered in the course and not require new skills. It should include some directly stated issues but also a broader issue that is not explicitly stated, that students need to identify as the backdrop of the case. The case should also include some quantitative analysis. This being said, the case needs to be short so that most of the students' time can be spent on the treatment and not on reading the case. It should also be relatively open-ended so there is no single right answer. The students should be graded not only on their recommendations and action plan but also on the thinking that brought them to those answers.

The case method is an engaging and effective way to teach management, in which the instructor is an essential part. He/she can empower students to take responsibility for their own learning and discovery. The best way to do this while teaching by the case method is through example. If the instructor is engaged in the material, actively listens and responds to student ideas, respects the insights of others, and treats the classroom as both a learning and a teaching experience, students will be inspired to do the same. In the best case scenario, both instructor and student leave a case session having learned something new.

Information based on Corey, E. Raymond. *Case Method Teaching*. Harvard Business School: Cambridge, MA, 1980, rev. 1998 unless otherwise noted.

Chapter 3

HOW TO USE THIS CURRICULUM

By Rachel Criswell and Marc Mitchell

Together for Health is a five-year project made possible through USAID that seeks to improve the health of men, women and families in Ukraine by reducing rates of abortion, unintended pregnancy and STIs. The project's goal is to increase the demand for, and supply of, family planning and reproductive health services. It recognizes the need for improving the capacity of the health system to deliver and oversee these services and to be more responsive to the needs of the population, whether through the public sector or the emerging private sector. In order to strengthen these systems, a team of professors, managers and public health experts from the P.L. Shupyk National Medical Academy of Postgraduate Education (NMAPE), Together for Health, and the Harvard School of Public Health (HSPH) have collaborated on the creation of this curriculum based on the experience of Ukrainian public health managers. After several months of research, writing, editing and refining, this curriculum was taught in a pilot training at NMAPE. These cases can serve as tools to show health care managers that a change of attitude and a public health approach is possible and useful.

There are two types of knowledge that students can acquire in the classroom. The first is a set of skills, terms and concepts. They are best acquired through lectures, where the information can be delivered directly. The second type is when students learn how, when and where to apply these skills, terms and concepts. This is best acquired through participatory learning, such as case studies. By practicing the skills and concepts they have learned in lectures, students can go on to use them with confidence in the professional world.

Each module of this curriculum is made up of **three** parts. **The first part** introduces students to new terms and concepts through a traditional teaching method, such as a lecture or reading on the subject. **The second part** gives students the opportunity to exercise these skills and concepts through active participatory learning, specifically the case method. The case should challenge students to explore and get excited about the skills they are learning so they will retain them for later use in the workplace. Cases do not have any "right answers" or clues as to what the teacher is looking for—it is the students' duty to exercise knowledge and come to their own conclusions.

Each case is accompanied by teaching notes. **The third part** of the module directs the instructor in how to lead discussion, which points should be examined and which conclusions students may reach. Again, a case does not have a right answer, but the teaching notes should give the instructor a general idea of what the discussion should encompass. These three components of a module will provide a comprehensive approach to learning and teaching management skills in post-Soviet Ukraine.

During the past decade, many changes have occurred in the way public health is managed in Ukraine. The shift from centralized planning to local initiatives and the changing patterns of disease, from acute to chronic, require a new way of thinking about health care and how it is delivered. In this context, there is a clear understanding of the need to help managers at all levels of the system learn about public health approaches aimed at improving the health status of the

populations they serve. To better manage health care systems, managers must learn and understand techniques that will help them achieve improved outcomes with limited resources.

On this basis, a design for management training has evolved, which develops the capacity of managers and the overall health care system to better meet the needs of the population, particularly in the sphere of family planning and reproductive health. The central focus of this training is to help managers understand how to better cope with the new realities they face in Ukraine. This includes a system where oblast and district managers can have more active control over their resources. The keys are to move from simply doing what is written to doing what is needed and to using information as a management tool rather than simply as material for reports.

Each of the seven modules of this curriculum is aimed at addressing these needs by training Ukrainian health care managers using the case method with Ukrainian cases. In order to achieve the goal of improving the reproductive health, as well as the general health, of the population, health care managers throughout the country will need both a **change of attitude** and a **set of tools** to be effective.

The purpose of this management training program is to show Ukrainian health care managers examples of management situations in which a public health approach can be, and has been, applied to improve health care in a Ukrainian context.

While this curriculum is by no means comprehensive, the topics were determined to be some of the most important in the context of strengthening Ukrainian health care management. The topics addressed can provide a solid foundation for a more public health and patient-centered approach to management. It hopefully can act as a model for future case-based management curricula. These cases can be especially helpful to managers working in family planning and reproductive health care programs, since many of the cases focus on this area.

Because of the fundamental changes occurring in the Ukrainian health care system, there are several different audiences that could benefit from a management training program. Health care managers at the oblast, city and district levels are one group that needs both technical skills and a rethinking of their roles as managers. However, since the opportunity for effective reform is also determined by the regulations put into place, there is a need for other groups to be more informed about aspects of health management. This would include local government councils, oblast, city and district councils and other managers who interact with health care managers. An example of the latter would be local auditors, who are in a position to allow or prevent budgetary changes and other financial activities needed for effective reform.

Training is also needed for hospital managers and senior physicians who may have difficulty accepting changes they do not understand, causing them to slow down the reform process and making it difficult to succeed.

Given the diversity of the audience, it is apparent that both the topics and the depth of this training will differ among the groups. **These seven modules make up a 10-day public health care management training; however, the modules and cases can be used individually to teach any of the topics mentioned.** We hope that, with the combination of a public health focus, the case-method and the innovation and enthusiasm of management teachers, this curriculum will help health care managers in Ukraine take a creative and open-minded approach toward problem-solving in health care management, especially in family planning and reproductive health.

Module 1 provides a general background on public health and how it can be used as a preventive tool in management. Planning in Ukraine should not be an exercise in copying last year's plans and adding in a small percentage for inflation. The keys to planning health care systems today are (1) understand-

ing the population's health problems, (2) identifying how to address these problems, and (3) knowing how to use resources effectively to alleviate these problems. It also includes knowing how to balance prevention with curative care, whether for reproductive health or other types of health services.

Module 2 familiarizes managers with communication and outreach techniques for preventive health campaigns, which promote healthy lifestyles and improve the general health of the population. For most doctors in Ukraine, "public health" means treating diseases in public hospitals or private clinics. They do not see themselves as having the ability to shape public policy around lifestyle issues that have significant impacts on the general health of the population. By helping individuals and communities take a more proactive role in improving health care, doctors will come to see themselves not only as healers but also as promoters of good health.

Module 3 focuses on how to best use information to make decisions and monitor effectiveness when public health approaches are applied in a decentralized health care system. As a result, both mid-level managers and local managers will have more decision making power. In order to reorient managerial thinking, this module explores the basics of monitoring, evaluation and analysis. Managers will develop the skills to use information as a planning tool, which will help them understand the needs of clients more quickly and clearly for accurate assessment.

Module 4 looks at the new role managers play in a more decentralized health care system. For managers to be effective, they need a change of attitude. Instead of simply being administrators, who follow orders, they need to become strong managers, who identify key result areas, strategies and tactics on a day-to-day basis in order to ensure achievement. A health care manager is a leader, strategic planner and spokesperson for the health needs of the population.

Module 5 cites patient-centered care as a primary element of quality health care management, since it is the patient (or client) and not the doctor who determines health. A doctor may prescribe a medication, but a patient may chose not to take it. A doctor can only treat a patient who seeks care. Many patients will self-treat or chose alternative treatments that are cheaper or thought to be equally effective. Only when clients' wishes and needs are known and respected by providers and managers will they be able to influence a patient's behavior and, subsequently, their health. This is particularly important for family planning in Ukraine, where patient-controlled methods rather than doctor-controlled methods are generally more accepted.

Module 6 addresses the needs of those working in the health care system by providing management students with a more proactive and creative approach to optimizing human resources. Under the old system, this element was not under a manager's control; however, in today's workforce, it is a much needed and valuable skill. This module will teach managers to handle human resource issues, such as downsizing staff to match the needs of their facilities and patients as well as reorganizing staff for greater workplace efficiency.

Module 7 explores one of the most significant challenges faced by managers in the Ukrainian health care system: financing. Although new models of revenue generation are being used in Ukraine, including health insurance, partner-

ships with private companies, leasing of space in pharmacies and other medical facilities and charging copayments, these models are not widely used or understood. Under the new model of contracting, oblast, district and hospital managers will have much more flexibility in reallocating resources based on efficiency and need rather than on outdated formulae and itemized budget systems. Thus, health care managers will need to learn how to allocate resources, balance inpatient and outpatient facilities and plan bed and staff numbers for a given population ahead of time. This module will help them link patient care services that are already in place with those that are more preventive and public health oriented.