



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

ISA 83462

MATERNAL AND CHILD HEALTH, FAMILY PLANNING AND BREASTFEEDING

NEEDS ASSESSMENT

IN CENTRAL ASIA

November 2-23, 1992

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ABBREVIATIONS

ACNM	American College of Nurse Midwives
AFP	Alpha Feto Protein
CMV	Cytomegalovirus Infection
CBC	Complete Blood Count
FP	Family Planning
GC	Gonorrhea
GYN	Gynecology
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
IEC	Information, Education and Communication
IUD	Intrauterine Device
LBW	Low Birth Weight
MCH	Maternal Child Health
MOH	Ministry of Health
NIS	Newly Independent States
OB/GYN	Obstetrician/Gynecologist
PKU	Phenylketonuria
RH	Rhesus Factor
STD	Sexually Transmitted Diseases
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The purpose of this trip was to conduct a needs assessment to plan a seminar for maternal child health, family planning and breastfeeding for representatives from the five Central Asian countries of Kazakhstan, Kyrgyzstan, Uzbekistan, Turkmenistan and Tajikistan. (Due to civil war in Tajikistan, the team was unable to visit Tajikistan.)

Members of the assessment team were Mary Ann Anderson, USAID Office of Health, Roy Jacobstein, USAID Office of Population, Mary Ellen Stanton, MotherCare/American College of Nurse Midwives (ACNM) Representative, and Susan Welsby, Wellstart/Expanded Promotion of Breastfeeding Program consultant stationed in Alma Ata in charge of coordinating the conference. Pamela Pearson of the AID/Washington Newly Independent States (NIS) Task Force also accompanied the team during portions of the planning visit. The team traveled to Kazakhstan, Kyrgyzstan, Uzbekistan, and Turkmenistan from November 2 - November 23, 1992; Mary Ellen Stanton and Roy Jacobstein left the team on November 16 as Mary Ann Anderson and Pamela Pearson continued on to Turkmenistan and back to Alma Ata to finalize seminar plans with Ann Van Dusen, Director of the Office of Health, AID/Washington, Jack LeSar, Regional Medical Advisor for the NIS based at USAID/Moscow and Paula Feeney, USAID/Alma Ata, General Development Officer.

The needs and concerns identified are as follows:

1. Imminent transition in health care financing resulting in decrease or withdrawal of some state support.
2. High abortion rate, low contraceptive usage and limited variety of family planning methods.
3. Inconsistent adherence to standard worldwide definitions for vital statistics.
4. Ineffective breast feeding practices.
5. High prevalence of iron deficiency anemia in women of childbearing age.
6. High maternal mortality ratio for a developed country.
7. Need for currency in women's health care especially treatment of vaginitis, sexually transmitted diseases (STDs) and infertility.
8. Need for client and family-centered approach to care which allows for client autonomy and choice rather than rigid adherence to routines which are not scientifically based.

The recommendation for the initial response to most of these needs is to proceed with plans for a seminar on maternal and child health, family planning and breastfeeding for representatives from the five Central Asian countries to be held January 11-15, 1993, in Alma Ata, Kazakhstan.

Other possible responses for USAID or other donors are detailed in the report.

I PURPOSE OF THE TRIP

The purpose of this trip was to conduct a needs assessment to plan a seminar for maternal child health, family planning and breast feeding for representatives from the five Central Asian Republics of Kazakhstan, Kyrgyzstan, Uzbekistan, Turkmenistan and Tajikistan. (Due to civil war in Tajikistan, the team was unable to visit Tajikistan.)

II BACKGROUND

As a result of preliminary assessments of health needs in Central Asia, the USAID Newly Independent States (NIS) Task Force proposed a series of technical exchange seminars to be held by USAID in the Central Asian Republics as a lead-in to longer term initiatives. Three seminars were proposed for: 1) Maternal Child Health, 2) Environmental Health and 3) Health Care Financing. A needs assessment team was assembled to travel to Central Asia in November, 1992, to plan for the first seminar in the series, the one on Maternal Child Health, Family Planning and Breastfeeding to be held in Alma Ata in January, 1993. Seminars for Environmental Health and Health Care Financing are proposed to be held later in 1993.

III ACTIVITIES

Members of the assessment team were Mary Ann Anderson, USAID Office of Health, Roy Jacobstein, USAID Office of Population, Mary Ellen Stanton, ACNM/MotherCare Representative, and Susan Welsby, Wellstart consultant stationed in Alma Ata in charge of coordinating the conference. Pamela Pearson of the AID/Washington NIS Task Force accompanied the team during portions of the planning visit. The team traveled to Kazakhstan, Kyrgyzstan, Uzbekistan, and Turkmenistan from November 2 - November 23, 1992; Mary Ellen Stanton and Roy Jacobstein left the team on November 16 as Mary Ann Anderson and Pamela Pearson continued on to Turkmenistan and back to Alma Ata to finalize seminar plans with Ann Van Dusen, Director of the Office of Health, AID/Washington, Jack LeSar, Regional Medical Advisor for the NIS based at USAID/Moscow and Paula Feeney, USAID/Alma Ata, General Development Officer.

In each state, the team briefed and debriefed with U.S. Embassy personnel and interviewed key people in the Ministry of Health, the scientific research institutes for MCH, the training institutions for middle level health providers, service institutions and health IEC programs (Appendix A). In each country the interviews and observations were carried out in the capital cities and in Kazakhstan, the team visited a rural rayon (district) Talgar, just outside Alma Ata.

IV FINDINGS

Overall, the impression of the health care system was one of a system which is highly developed in that it provides universal coverage for all members of the society. It is a system which is uneven in that it has sophisticated equipment and surveillance for certain diseases (such as PKU) while it has inadequate treatment for common diseases responsible for a significant amount of morbidity (such as anemia). In general, procedures and protocols appeared to be several decades behind the U.S. (such as policies regarding maternal care and breastfeeding).

The team heard consistently that the two major problems adversely affecting health in the Central Asian countries are poor nutrition and shortage of drugs.

There has been a reported decrease in meat consumption of about 40%. Meat is available in the stores but people cannot afford to buy it. There is normally a very high consumption of meat and dairy products in the diet so that the decrease is certainly significant in terms of individuals' cutback in foods they prefer. The extent to which the cutback represents a significant nutritional deprivation is unknown, particularly since there was no opportunity to visit rural areas. Of the many patients seen in hospitals and clinics, none seemed overtly malnourished.

The lack of drugs was regularly verified at the hospitals and clinics visited. Certain regimes reflect inadequate supplies. For example, iron supplementation is never prescribed for prevention of anemia in fertile or pregnant women and when it is prescribed for treatment of diagnosed anemia, it is often prescribed in such small amounts as to be useless. General overprescription of medications, which has been reported, could not be systematically verified. There were anecdotal reports of antibiotics given to reduce fever and unnecessary and inappropriate combinations of antibiotics for relatively minor diseases.

A. HEALTH CARE STRUCTURE

From the point of view of the client and from the community up, the health care system as depicted in Appendix D is as follows:

Feldsher/Acucher (Obstetrician) Post (FAP)--The feldsher unit is the lowest level community health post. Each unit serves 600-900 people and is staffed by a feldsher or a midwife, who are midlevel personnel trained in primary health care. These are small units with a waiting area, consultation room and small pharmacy. Immunizations and prenatal care are provided. This is the first point of care for people in the rural areas.

Ambulatory Outpatient Clinic (mobile visits by doctors) or polyclinic (doctors present)--serves 7,000-8,000 people and is staffed/visited by dentists, general practitioners, obstetricians and pediatricians. These clinics have consultation rooms and a laboratory. At this level, there are also Women's Consulting Clinics which provide outpatient reproductive health care, including prenatal check-ups, family planning and abortion services.

Sub-District Cottage (Utchastok) Hospital--wherever there is a population greater than 10,000. This facility has 25-100 beds and a maternity department with surgical capability.

Central District Hospital--has 150-200 beds and includes a maternal "house" (hospital, where surgery can be performed). In the Alma Ata region of Kazakhstan, which extends far outside the city limits, 5% of cases are referred from this level to a higher level of care. In rural areas, mobile units from the district hospital visit the ambulatory clinics regularly to provide more advanced care by a staff of Obstetricians, Pediatricians, General Practitioners and Laboratory technicians.

Regional or Provincial (Oblast) Hospital--accepts high risk clients including maternity cases in the region from the district level.

National (Republican) Research Institute for Maternal and Child Health (Kazakhstan)--is the tertiary referral level for high risk obstetrical or gynecological clients from all regions or districts. Ambulances, airplanes and helicopters are used to transport obstetric emergency cases from rural areas as needed. Persons interviewed stated that there normally is transportation available when needed. Fewer than 2,000 of the annual 340,000 deliveries in Kazakhstan occur at the Institute. The equivalent institutes in the other countries are known as: the Research Institute of Obstetrics and Pediatrics (Kyrgyzstan); the Research Institute of Obstetrics and Gynecology (Uzbekistan); and the Research Institute of Maternal and Child Health (Turkmenistan).

The team was consistently brought to the highest levels of care and, when the team was brought to a district level hospital and feldsher unit in Kazakhstan, staff mentioned that these were model units. From all appearances, the system is working well as described. Clients are referred as necessary and the facilities have space and staff to accommodate referrals. It was impossible to determine how the system works in the rural areas since the "rural" area the team was shown was actually suburban. The team did see clients in the MCH center who had come in by plane for hospitalization at the MCH Institute.

The team did not have the opportunity to view rural health facilities in Uzbekistan, Kryrgyzstan or Turkmenistan. However, each country still followed the former Soviet model without any major deviation.

B. HEALTH CARE FINANCING

Although not the focus of this needs assessment, changes in health care financing are likely to have a most dramatic effect upon the provision of health care services in the next few years.

In Kazakhstan, the Minister of Health stated that the allocation of funds from the state budget to health care has been decreasing lately. This decrease in funding along with decreased labor productivity, decreased ties to the former Soviet Union and inflation, has caused a deterioration in health care services. Parliament is trying to stabilize the situation and to continue supporting to the socially vulnerable groups (elderly and children). The world community has been helping with credits from other countries and humanitarian assistance from the Red Cross, but this cannot go on indefinitely. The Minister stated that there will be a transition from centralized to decentralized planning and that health insurance will be introduced in early 1993. The Minister hoped that a decree mandating these changes would be endorsed in December, 1992, but acknowledged that it will take time to put these changes into effect.

In Kyrgyzstan, the Vice Minister stated that they had been advised by the World Bank to close nine sanitoriums and all polyclinics and to reduce the number of hospital beds by 50%. He is not certain that this advice will be followed because he believes the death rate will rise since there are no roads or transportation that will permit clients to travel to more distant urban facilities if rural facilities are closed. The Minister said that they will have to postpone a move to medical insurance for the time being. Apparently, a decree regarding health care financing was endorsed by the Parliament in July, 1992, but will not go into effect until 1993.

C. CLINICAL SERVICES AND STATISTICS

1. MATERNAL MORTALITY

Statistics on maternal mortality are presented in Appendix B. Throughout the Central Asian countries visited, the maternal mortality ratios are high for developed countries but low for developing countries. The range is from 53 (Uzbekistan) to 134 (Turkmenistan)/100,000 live births in the first nine months of 1992, compared to a maternal mortality ratio of 8 in the U.S. In the three countries for which the team obtained trend data, the ratios have risen

by 10% in Kazakhstan, by 32% in Tajikistan and by 34% in Turkmenistan since 1987. Ministry of Health officials see these maternal mortality ratios as too high and, alarmed by the rising ratios, wish to plan measures to improve maternal survival.

Data collection appears to be very good. All those interviewed stated that almost all births occur in district hospitals (also called maternal houses) or referral sites. When deaths occur at home (often after a criminal abortion), at least some of these data are recorded as well. Officials stated that deaths due to abortion are systematically included in the maternal mortality statistics.

Reports with the case history for each maternal death are sent up the health system from the district to the region to the Ministry of Health and national research institute level for tabulation and for review and determination of whether anything more could have been done to prevent the death. The results are sent back to the responsible doctor, who may be punished in case of malpractice. It is a very impressive system in which the Ministry of Health can report on the causes, location, socio-demographic characteristics, etc. for every maternal death.

In Kazakhstan, the team had the opportunity to review several of the mortality reports which are forwarded to the Ministry of Health. These reports (which included name, region, age, place and date of hospitalization, place and date of delivery, place and date of death, clinical diagnosis, annotated diagnosis and cause of death) are quite detailed about the immediate causes of death and the history of interventions and complications immediately preceding the death. In the few reports seen, no mention was made of contributing causes of death such as problems with transport, lack of supplies, etc. When questioned, officials routinely said that the referral and transport systems were working well despite the downturn in the economy.

The major causes of maternal mortality are:

- obstetric hemorrhage,
- toxemia (often included in the general category of extragenital diseases which includes cardiovascular, lung and kidney disease),
- sepsis,

- extragenital disease (sometimes translated as "gestosis" or "toxycosis"), and
- abortion.

The extent to which each of these causes contributes to maternal mortality varies from one country to another, but obstetric hemorrhage was consistently mentioned as the most common direct cause of maternal death. Obstructed labor, as such, was not mentioned as the immediate cause of maternal death but presumably contributes to hemorrhage and/or sepsis.

2. PRENATAL CARE

Prenatal care in the cities of Central Asia appears to be very similar to that in the United States. Women are encouraged to register earlier in the pregnancy and are seen monthly until the last two months when they are seen every week or ten days. Screening procedures include CBC, blood group and RH, urinalysis, HIV, GC, syphilis, AFP and ultrasound twice (at 16 and 26-28 weeks). A detailed risk assessment tool is used and referrals made according to risk. Mother's classes are offered through the health education department.

Fifty to eighty percent of women are said to be anemic. No preventive iron therapy is given to pregnant or reproductive age women. Curative therapy is given when iron tablets or parenteral iron preparations are available. Often iron supplements are in such short supply that only a 7-10 day course of therapeutic oral iron supplementation is prescribed.

Women at risk of spontaneous abortion are given electromagnetic therapy through the abdomen, or electromagnetic therapy with an external magnesium solution. It was also stated that women are given progesterone therapy to protect the pregnancy.

Alcoholism in pregnant women was not considered to be significant problem among those interviewed. Some felt that smoking among pregnant women is fairly common. There is overriding concern about the content of the mother's diets because of decreased intake of protein. In addition, there is great concern about health problems caused by nuclear radiation and pesticides which are claimed to permeate the air, ground, food and water sources in some areas.

Women are regularly referred to higher levels in the system for diagnosis and therapy. These systems of referral seem to be very well

defined.

Immunization with tetanus toxoid is not done in pregnancy for fear it is dangerous to do so. Instead, DPT immunization in childhood and tetanus booster doses in adulthood are relied on to prevent tetanus.

3. LABOR AND DELIVERY

By law, all women deliver in hospitals at the district (rayon) level or higher (except in cases of rapid labor when women deliver at home or en route to the hospital). Hospitals are equipped and staffed to carry out surgery, if necessary. All delivery facilities viewed were clean. Most equipment was old. When admitted to the hospital, all women receive a perineal shave and an enema. The women were seen laboring flat in bed, although staff stated that women could walk around if they wished. Liquids are permitted. Fetal monitors seem to be scarce; the one seen was very old. Deliveries are in delivery rooms. All tables have stirrups; some allow for the women to be propped up rather than lying flat. Women do not have any family members or friends in attendance in labor or at delivery. Partographs are not used. When labor is induced with pitocin, no flow sheet is used to record the increments in the infusion of the medication or the status of the mother, the fetus and the labor. Episiotomies are common but not universal. Staff consistently verified the lack of a regular supply of important drugs for treating hemorrhage and toxemia. Oxytocin is normally given postnatally only for treatment of hemorrhage rather than prophylactically.

Cesarean section rates ranged from 5% at district hospitals to 17% at the MCH Institute in Alma Ata which has a large number of referrals. Indications mentioned were almost entirely maternal.

Hospitals have several operating theaters for deliveries and they rotate their use for hygiene purposes by closing one room down for several days and thoroughly cleaning it while they deliver babies in the other room.

4. POSTPARTUM

Women normally stay in the hospital for five days after a normal delivery, and two to three weeks if there has been surgery or complications. In Turkmenistan they have shortened the stay to 3-4 days by cutting off the infant's umbilical cord stump rather than waiting for it to dry and fall off naturally. Previously mothers were not

released from the hospital until the cord stump had fallen off. All postpartum mothers were seen lying in bed. Due to fear of infection, no family members are allowed to visit and flowers are forbidden. In most places, midwives attend to mothers postpartum and separate nurses attend to the babies who are kept in separate nurseries. This redundancy of staff and separation of mothers and babies is inefficient and counterproductive, especially for successfully establishing breastfeeding.

5. NEWBORN

The Silverman scale is used to determine gestational age. APGAR scores are routinely calculated for newborns. After birth, newborns are washed and tightly swaddled and kept lying on their backs in individual beds in separate nurseries. They are given to mothers for breastfeeding about two hours after birth unless there has been a complication, which could delay breastfeeding for several days. Their breastfeeds are on a fixed schedule every three hours (local pediatricians referred to these scheduled feeds as "the Moscow regime" mandated throughout the former Soviet Union) and are routinely alternated with glucose water or sterile water fed in bottles with nipples. Mothers are taught to do this even after they leave the hospital because of what is considered the extreme climate of Central Asia.

Premature or small-for-dates (low birth weight) infants are often kept from nursing. They receive donated breast milk which is mixed from multiple sources. Low birth weight infants born at normal maternity hospitals may be referred to higher level tertiary care children's hospitals when stabilized 3-4 days postpartum. Frequently babies will be transferred first from the facility where they were born and their mothers transferred several days later. That separation makes breastfeeding impossible. Low birth weight babies are discharged from the hospital after they weigh 2000 grams. There was no familiarity with the "Kangaroo Mother Method" of skin-to-skin contact of mother and baby and breastfeeding on demand for low birth weight babies able to suck. At most hospitals visited requests were made for additional incubators.

The infant mortality rate for the first nine months of 1992 ranges from 26 (Kazakhstan) to 44 (Turkmenistan)/1,000 live births (Appendix B). The incidence of low birth weight (LBW) babies is about 5-7% which is about the same incidence as in the U.S.; likewise, as in the U.S. approximately two thirds of these are due to prematurity (< 37 weeks gestational age) and one third due to full-term intrauterine growth

retardation. The infant mortality and LBW statistics exclude those infants who weigh less than 500 gms. (in one case 950 gms.) or die before seven days of life. This results in rates which should not be compared with international norms because the rates appear better than the situation actually is. (The team was told informally that small dead infants were sometimes frozen before being weighed so that the weight would be as low as possible, to get under the 500 gm. limit.) Infant deaths are attributed to asphyxia, respiratory disease, heart disease, birth trauma, and congenital anomalies. One problem mentioned was the difficulty in determining whether a newborn was dead or alive due to lack of equipment to detect the heartbeat. A practice was described in which an infant suspected to be dead is submerged in water. If the infant floats to the top it is alive, and if it sinks it is dead.

In Kazakhstan, there is routine testing of infants for PKU. A computer is reserved for keeping track of the results (while much of other disease surveillance is done by hand). There have been only two cases found in the last 100,000 infants tested.

Due to shortage of medication, there is no routine prophylactic treatment of all newborns' eyes with silver nitrate drops or tetracycline ointment to prevent ophthalmia neonatorum due to maternal genitourinary tract infection with gonorrhea or chlamydia. Instead only those infants born of women known to be infected receive eye treatment.

6. BREASTFEEDING

With rare exception, the WHO/UNICEF "Ten Steps to Successful Breastfeeding" in maternity services, the prerequisites of "baby-friendly hospitals", are not being followed (see Appendix E). Instead of initiating breastfeeding within a half-hour after birth, a two-hour wait is observed. Rooming-in is not practiced with the exception of the following institutions visited: in Alma Ata, Kazakhstan, at the Research Institute of Pediatrics, Maternity Hospital 1 and Children's Hospital 1; and in Ashgabat, Turkmenistan, at the Research Institute for Maternal and Child Health. All infants are frequently bottle-fed glucose water on demand in between scheduled (3-hourly) breastfeeds.

In the premature/low birth weight ward of the Kazakhstan Pediatric Institute mothers and babies were "rooming-in" together, but, instead of breastmilk, infants (all able to suck) were being bottle-fed a thick fermented milk beverage known as "Baldergan" formulated by the nutrition institute.

In Kazakhstan, 70-90% of infants were reported by the pediatric institute to be anemic per WHO hemoglobin, serum ferritin and transferrin saturation criteria. It is being addressed by iron supplements in syrup form and by recommending breastfeeding or iron-fortified infant formula, juice at 1 month of age, and solid foods at 4-5 months of age. Some of the anemia may be due to giving infants cow's milk which has not been heat-treated or modified which causes intestinal bleeding and thus iron losses. The suboptimal breastfeeding practices and use of breastmilk substitutes no doubt also contribute because up to 70% of the iron in breastmilk is absorbed compared with 30% in cow's milk and only 10% in breastmilk substitutes. To compensate, large amounts of supplemental iron have to be added to breastmilk substitutes which favors the development of pathogenic gut bacteria.

Although the team was not able to see actual data on breastfeeding practices we were told that in Kazakhstan 72% of infants breastfeed to four months of age and only 18% to six months of age. Most mothers stop breastfeeding at 3-4 months postpartum. The team conducted a mini-survey of ten mothers of infants in an Ashgabat polyclinic and found that among the five less than five months of age none were exclusively breastfed, three were predominantly breastfed (breastmilk plus juice and water), one was partially breastfed (breastmilk plus fermented cow's milk (Biolac), juice, water and apples) and one was totally bottle-fed donated Similac from the American Red Cross. Of the five infants over six months of age, three were partially breastfed and two were not breastfed.

Breastfeeding rates have been declining in Central Asia in contrast to the U.S. and Europe where they have been increasing. This is in part the result of ready availability and promotion of free or heavily subsidized breastmilk substitutes within health facilities and at milk kitchens for many years. The decline does not appear to be due to maternal employment, as paid maternity leave from the 32nd week of pregnancy to one and a half years postpartum, and job protection with reduced payments up to six years postpartum, is a routine benefit availed of by most mothers.

Most health professionals stated that Central Asian mothers are too undernourished to produce enough breastmilk of adequate nutrient composition to nourish their babies. They do not understand the golden rule of breastmilk production, namely that the more the mother nurses, the more breastmilk she produces; nor that breastmilk volume and composition and growth of exclusively breastfed infants in the first four

months of life is normal and effected very little, if at all, by maternal undernutrition, based on a number of studies in severely underweight and anemic women in Bangladesh, India and elsewhere in the developing world. The nutritional status of Central Asian mothers is apparently much better than that of Bangladeshi or Indian women, as witnessed by the very low rates of low birth weight (a clear marker of maternal undernutrition). Thus, poor breastfeeding practices, especially infrequent, scheduled breastfeeds and supplementation, are reducing infant demand and, ultimately, maternal breastmilk production rather than maternal undernutrition. Furthermore, health professionals in Central Asia are not aware that if maternal undernutrition is a problem, that it has been found to be much more cost-effective and beneficial to the mother's health and to the infant's health and survival to supplement the mother's diet and promote breastfeeding versus directly giving breastmilk substitutes to the infant.

There is also widespread fear but little scientific data on potential contamination of breastmilk with pesticides, nitrates and nitrites, and other environmental pollutants and consequent health risks to the infant. The health risk or benefit to the baby of breastmilk versus breastmilk substitutes (which may also be environmentally contaminated if produced from local cow's milk or reconstituted with local water) needs to be carefully analyzed. In preparation for the MCH seminar, the Wellstart Expanded Promotion of Breastfeeding Program with funding from RD/Health is preparing a literature review on what is known about this topic. The Pediatric Institute in Uzbekistan expressed interest in occupational health procedures for exposed women or other means for preventing contamination of breastmilk.

Camel's milk and mare's milk are used as breastmilk substitutes for those allergic to cow's milk. Many health providers cited the need for nutritionally balanced breastmilk substitutes for infants unable to breastfeed, as the Central Asian countries have been cut-off from their former supplies of imported infant formula and do not manufacture any locally. However, care should be taken to calculate and provide the least amount required only for those infants truly unable to breastfeed, with equal effort placed on more actively promoting and supporting breastfeeding in new cohorts of newborn infants. Breastmilk substitutes should be sold at true market cost and not be distributed free or heavily subsidized, because they may easily displace breastfeeding and lead to dependency and poor child health when donated infant formula is gone and infant feeding practices cannot be sustained. The increased diarrhea and acute respiratory infection risks with bottlefeeding and increased fertility should also be stressed in the Central Asian

environment where all three are major problems. The former Soviet Union had endorsed the WHO international code of marketing of breastmilk substitutes and the Central Asian countries queried said they intend to continue to follow the code. Thus, any marketing or distribution of infant formula should be done in a manner consistent with the code.

It was disturbing to see in Turkmenistan that the American Red Cross had donated 1483 tons of powdered U.S. infant formula (SMA, Similac, Gerber) worth \$6,480,710, which had been distributed free to mothers through milk kitchens all over the country. It is estimated that this is enough to totally feed one third of all the infants (38,000 infants) in Turkmenistan free for one year, and obviously far more than was truly required based on actual inability to breastfeed. With 53% of homes in Turkmenistan having no indoor plumbing, running water or central heat, water-borne diseases are a critical problem for child health. In such an environment, it is easy to imagine the diarrhea in infants that could result from unhygienically prepared breastmilk substitutes. In fact among the former republics of the Soviet Union in 1990, Turkmenistan had the highest infant mortality and was second highest only to Moldova in age-standardized mortality from gastrointestinal diseases. It is in these unclean environments that infants most need the protection that breastfeeding uniquely provides.

7. FAMILY PLANNING

Abortion is the most common method of family planning in all the Central Asian countries visited, with the rate per woman being highest in Kazakhstan and lowest in Turkmenistan. Abortions are legal and done after a 20 day delay in the menstrual period. Abortions can now be legally done up to 26 weeks of pregnancy in Kyrgyzstan. Previously, abortions could only be done up to 12 weeks of pregnancy. The result was a large number of criminal abortions (outside the modern health care system). In some places up to 1/3 of the abortions are done outside the official system. While it has been reported for Russia that for every birth 1- 1 1/2 abortions are performed, actual numbers noted in Central Asia were less (Appendix B). By all accounts, abortions are gradually decreasing. Mini-abortions are performed up to 3 weeks of pregnancy.

After abortion, IUDs are the major form of family planning. Uzbekistan has been promoting IUDs aggressively and officials report that more than one million have been inserted in the last year. Available IUDs were a copper T made in Leningrad and sold for 20

rubles which lasts 3 years, a multiload made in Switzerland which costs 16 rubles and lasts 5 years, and the Lippes Loop.

Oral contraceptives are unpopular, apparently because they received high dose (estrogen) pills from Hungary previously and women were bothered by side effects. Now triphasics are available but they are not widely used. Injectables seem to be almost unknown. Norplant was tested in Uzbekistan but not well received.

It is reported that rural people still desire large families but that the urban population are more likely to use modern contraceptives. Kazakhstan also reported that they only have enough contraceptives to be able to fill 17% of the demand.

8. MATERNAL ANEMIA

A prevalence of maternal anemia of 70-80% (per World Health Organization criteria of hemoglobin less than 11 grams per deciliter in pregnancy) was reported in each of the Central Asian countries visited. Iron deficiency anemia impairs work capacity, mental performance and resistance to infection, and greatly increases the likelihood that postpartum hemorrhage will be fatal. Effects of maternal iron deficiency anemia on newborn health are lower birth weight and poor health. Clear data on the causes of the anemia in women were not provided but it is attributed to dietary iron deficiency (as prices have risen there have been documented reductions in meat consumption and increases in cereal consumption), inhibitors in the diet (most notably the high consumption of tea), frequent pregnancies and abortions, use of IUDs for contraception which increases menstrual blood loss, and environmental contamination with nitrates in the food and water supply which impair hemoglobin. There is a real shortage of iron tablets in each of the Central Asian countries visited. The Ministry of Health in Uzbekistan reported that in 1991 it received only 69% of the supply of iron tablets it ordered from Moscow and in 1992 only 28%. In the past, tablets were imported from Poland and Japan. Due to the shortage of iron/folic acid tablets, there has never been a program of routinely supplementing all pregnant women to prevent anemia as is common in most other countries in the world. Instead, iron supplements are only used therapeutically and the team observed that the treatment doses being given were too low to be effective, again due to shortages.

There is no provision for fortification of any food with iron in Central Asia. Some of the salt from the Aral sea is iodized opening up the

possibility of double fortification with iron as is being done in India. Pregnant women with anemia get special food supplements (meat, milk, butter) through a program run by the municipal government, the Ministry of Health and the Ministry of Agriculture. In Turkmenistan, a specially formulated high protein and iron food made from cow's blood, milk and sugar known as "N-Peet" is distributed to pregnant women.

9. GYNECOLOGY

Although not a major focus of this needs assessment, many aspects of gynecologic care for women were observed. The practices currently in use necessarily have a major impact on women's reproductive health.

In the area of vaginitis, sexually transmitted diseases, and postnatal infections, diagnosis and treatment are quite different from that available in the U.S. Referral hospitals devote a significant portion of their facilities to treating these problems. Nonspecific vaginitis is often treated with herbal preparations in the vagina which are pushed inside with an ultrasound probe. A course of this treatment may be given before an abortion is carried out. Postpartum reproductive tract infections are treated by putting a woman up in stirrups and turning on an ultraviolet light in the room. It is not clear the extent to which these diseases are diagnosed by organism or treated with antibiotics and other medications.

When there are infertility problems, external laser treatment is used to treat adhesions. Additionally, psychological problems related to or thought to be causing infertility are treated with extended hospital stays, hydrotherapy and mudbaths. Some of the clinics are performing artificial insemination.

In Uzbekistan, there is a new effort to place all fertile women into one of three categories: essentially normal, those having extragenital disease and those having chronic disease. Theoretically, one can be rehabilitated from either of the two disease categories. Once a woman is declared normal she can get pregnant whenever she wants to, with the recommendation that she maintain a spacing of at least three years. It is not entirely clear how one becomes rehabilitated from the disease categories since some require medicines which are not available. Authorities maintained that these categories are to help women become healthy and that there is no coercion in their decisions about whether to use contraception or to abort a pregnancy.

D. PERSONNEL AND TRAINING

Midwives and OB/GYNs are the two categories of health care providers who care for pregnant women. OB/GYNs are trained to do Caesarean sections but obstetrics is not considered a surgical specialty, as such. Their level of training is low and the title "OB/GYN" is in no way consistent with the level of training expected in North America. There appears to be a sufficient number of OB/GYNs at all the district hospitals.

Midwives are part of a large category of midlevel personnel which also includes nurses and feldshers (who are trained in the prevention and cure of the most prevalent diseases). Some feldshers go on to specialize in midwifery.

1. PRESERVICE TRAINING FOR MIDWIVES

See Appendix F for a chart which summarizes the present system of medical education for paramedics (nurses, midwives, feldshers) and physicians in Central Asia based on the former Soviet system. Midwives receive 2 1/2 years of training after they have completed their ten years of basic education (equivalent to a high school graduate though the education system is a continuum of 8 plus 2 years and not divided into elementary (or primary) and high school (or secondary) as it is in other countries). If they have not completed their basic education, then they must study for an additional year (3 1/2 years of midwife training). For nurses, the duration of training is less: 2 years (for graduates) and 3 years for others. Nurses can take an additional specialized 2 month midwifery course and then practice midwifery. Students enter residential training and are housed in dormitories. Approximately 1/3 of the time is spent in class and 2/3 of the time in clinical assignments. The instructors are usually OB/GYNs. Those midwives who are involved as faculty in the training school have qualified as OB/GYNs (which means starting over in medical school).

The team was told by an interpreter after an interview in one of the schools that training is often interrupted by need for the students to take part in agricultural activities and that students may miss as much as two months training per year for these activities.

A new type of midlevel medical education has been launched at the Alma Ata Nurse Training College. This College has just started a three year program for high school graduates which will train feldshers, midwives and nurses at the Bachelor's level. The curriculum is common in the first two years and specialization occurs in the third year. The faculty describe this program as unique in all the former

Soviet Union.

2. POSTBASIC TRAINING

All health care personnel are required to have refresher training every five years in order to get promoted. This training takes from two weeks to two months. The institutes which do this refresher training are separate from those that do the basic preservice training. The postbasic training is normally residential training provided by the government. However, one postbasic training school visited had just started training commercial students who paid for the training.

It is not clear whether this is usually the case, but in one school visited, nurses, feldshers and midwives were jointly receiving their refresher training. Because of provision of facilities and trainers for residential training as well as the expectation that such refresher training occurs regularly for all practitioners, this system should provide an excellent resource for bringing the medical practitioners to currency in practice.

3. CURRICULA, PROTOCOLS, TRAINING RESOURCES

In neither the preservice nor postbasic programs was a standard curriculum seen. What was seen were a variety of leaflets, booklets and books which are used as resources. Government printed booklets essentially included the textbook narrative and protocols for various problems. Some dated back into the '70s but most were dated in the '80s. Some clinical algorithms were available but needed updating. Many models for teaching were available. Although quite old, many are still quite usable. No modern audiovisual equipment was seen in the schools visited.

E. SUPPLIES AND LOGISTICS

Drugs do appear to be in short supply. Drugs and IUDs are supplied from a variety of places from inside the former Soviet Union and outside. Commercial ties with countries of the former Soviet Union have been disrupted. The result is that they are dependent upon irregular supply of varying brands and types of medication. Hospitals, clinics and feldsher posts keep a small supply of drugs but this is usually insufficient for needs. Often clients are given prescriptions and they need to find the drugs at pharmacies. In the case of parenteral medications, these drugs then need to be brought back to the health care facility for administration to the client.

Since the team saw only one feldsher unit and this was close to Alma Ata, it was not possible to ascertain the regularity and sufficiency of delivery of the scarce supply of drugs to the rural areas. However, since the supply of food is irregular in the markets and restaurants, it is logical to assume that there are similar problems in the delivery of the drugs.

F. HEALTH EDUCATION

Each country visited had a national health education center or "house of health". These centers conduct mass media health education campaigns using radio, television, film shorts in movie theaters, magazines, etc. Most families have a radio and television in their home. However, it is hard to get air time for health education. The health education centers also prepare printed educational brochures on various health topics for distribution at health clinics. The health education centers decide on relevant topics and technical content in consultation with the various health research institutes. While quantitative surveys of knowledge, attitudes and practices are done to guide the design of materials there appears to be little familiarity or use of qualitative research techniques such as focus groups and in-depth (open-ended) interviews.

G. HEALTH STATISTICS

There are a number of definitions of key indicators of maternal and infant health that are at variance with those used internationally. Thus, there is an important need to get the Central Asian countries to adopt the definitions in standard use internationally, which can be found in the WHO International Classification of Diseases document. For example, the Kazakhstan Pediatrics Institute defines low birth weight as any infant born from 22 weeks gestation onwards with a weight between 500-2500 grams that survived up to 7 days. Previously, infants born before 28 weeks gestation were considered miscarriages. In contrast internationally there is no lower weight limit nor survival to 7 days. Elsewhere, we were told that the lower limit was 950 g or 1000 g. Prematurity is defined as birth less than 38 weeks gestation, which is consistent with international use. There is also deliberate underreporting/overreporting depending on which event is seen as more negative or likely to be viewed as having been preventable, i.e. some perinatal deaths are recorded as abortions. Likewise, deaths from abortion may be left out of maternal mortality statistics, because, in part, illegal abortions are not supposed to occur, thus deaths from them are not supposed to occur.

H. PROFESSIONAL ORGANIZATIONS

The countries visited are in a very early stage of organizing professional societies and associations to respond to professional needs in their own

countries and to participate with their counterparts in international associations.

In Kazakhstan, Mrs. Maya Ababkova, Chief Specialist for Middle Level Personnel of the City Department of Health in Alma Ata, has recently been appointed to the Coordinating Council of the Middle Level Medical Personnel which includes nurses, midwives and feldshers. Mrs. Ababkova is trained as a midwife-feldsher. Also in Kazakhstan, meetings were held with Mrs. Bakhyt B. Munaidova, who is the Chief Expert of the Nurses' Service in the Ministry of Health. She has been appointed to the Council, as well.

The Council has been in existence for one year and its purposes include:

- set criteria for education,
- address legal problems,
- serve as an advocate for the rights of this group (salaries, working conditions, etc.), and
- set up contacts with foreign counterparts.

Currently, the council consists of the Chair, a Board of Specialists, and a Unit of Nurses, Unit of Midwives and Unit of Feldshers. In January, there will be a meeting to set their terms of office and to expand the organization from what had just been serving the City of Alma Ata to become a republican (country wide) organization. The work of the council will not focus only upon MCH and primary care, but also will address issues for the elderly.

In Kazakhstan there is also a Republican Association of Doctors and Pharmacists. There is no specialty society for OB/GYNs, but there is a pediatric society headed by Nina Bar with branches at national, regional and municipal levels.

In Kyrgyzstan, they are in the very early stages of forming professional societies. Mrs. Jumoeva Svetlana was identified as the head of the Midwife Society, and Professor Musuraliev as the head of the Obstetrics and Gynecology Society.

In Uzbekistan, there is no formal society for midwives or midlevel providers. Dr. Tamara Leshneva, trained as both a midwife and an OB/GYN, is the chief midwife in the country. Mr. Bakhtyar Kadyrov is the President of the Republican Society of Pediatrics. Apparently, this society is in the process of changing into an association. As an association, they will be able to make a profit from general commercial ventures. That money will be used to send their members to other countries for professional training.

The names of the chief midwives in Kazakhstan, Kyrgyzstan, and Uzbekistan have been forwarded to the International Confederation of Midwives (ICM) to assist them in the process of admission to the ICM.

In Turkmenistan, there is no formal society of midwives or midlevel health providers. However, there is a society of Obstetricians and Gynecologists headed by Dr. Victor E. Radzinsky (who is also the head of the MCH research institute and chair of the obstetrics and gynecology faculty at the medical institute). This society is already a member of the International Federation of Obstetrics and Gynecology (FIGO) and the European Federation of Obstetrics and Gynecology. Dr. Radzinsky attended the FIGO conference in Singapore in 1991 and the European conference in Helsinki, Finland.

I. WOMEN'S AUTONOMY AND ROLE IN THEIR OWN HEALTH CARE

This visit to Central Asia did not allow for any substantive conversation with women about the health care system. The delegation was regularly scheduled for appointments with official personnel. Arrangements for visits to health care delivery points were made in advance and visits were quite formal. Mothers were observed in the labor units and the postpartum rooms. It was impossible to get direct information about their perceptions of the care that they were receiving, although requests were made to the translators to arrange informal meetings with women.

It is hard to eliminate one's own biases when imagining what the care seems like to the women who experience it. From an American woman's point of view, the care seems rigidly routinized and, therefore, there is little or no chance for women to make individual choices. Without exception, rooms were devoid of the women's personal belongings and women wore hospital clothing. No books, flowers, religious objects, cards or toilet articles were seen. Husbands drop women off at the hospital in labor and pick them up five days after the birth, if it has been without complication. Fathers come to the hospital windows and try to get attention so they can be shown their babies. The team was laughingly told that sometimes the nurse holds up just any baby who is around to appease the father so that he will go home. When asked in one place if the mothers couldn't see the fathers, the doctor in charge said "Of course, they may go downstairs to talk to the fathers on the telephone." From an American's point of view, this is a description of a prison.

On one occasion, when the team was enjoying a banquet in a district hospital, screaming was heard in the hallway. The director of the hospital excused himself and, when he returned, stated that this was just a grandmother who was reacting when told that her grandson would need to be hospitalized for a week for treatment of an infection. Apparently, there was no question of not

hospitalizing the child because of the family member's wishes.

When asked about how voluntary family planning is, it was stated that this is the woman's choice and that when there is a disagreement between the husband and the wife, they will follow the wishes of the wife.

In Uzbekistan, there is now a program to examine all women of fertile age and to place them in one of three categories. One category is healthy women and these women can get pregnant whenever they want although three years of spacing is recommended. The other categories are sick categories and the plan is to rehabilitate the women in these categories so they can be healthy enough to have children. It is not clear that there is any punitive measure if a woman does get pregnant if she is in one of the sick categories. However, one can speculate that there is a psychological force when one is categorized as "sick" or "diseased," even if it is done with the honest intention of rehabilitating the women so they can become healthy enough to have children.

The most unsettling part of the visit was the occasional comment by an interpreter after the team got out of the hospital and back in the car. After seeing one hospital, an interpreter stated that what we had seen and had been told in the hospital was different than what he had heard from women--that the hospitals were dirty and that the care was unsatisfactory. One interpreter was more blunt. She stated that she "was treated worse than a nigger in the field" and that the personnel were "cruel." Another stated that she found it ironic that the maternity hospital had not allowed her to have flowers in her room for fear of infection when there were rats in the room at night.

The above comments and observations are anecdotal but do lead to serious concerns about women's ability to choose and participate in their own health care to make it humane and satisfying.

V. NEEDS AND CONCERNS IDENTIFIED

- A. Imminent transition in health care financing resulting in decrease or withdrawal of some state support.**
- B. High abortion rate, low contraceptive usage and limited variety of family planning methods.**
- C. Inconsistent adherence to standard worldwide definitions for vital statistics.**
- D. Suboptimal breastfeeding practices.**
- E. High prevalence of iron deficiency anemia in women of childbearing age.**

- F. High maternal mortality ratio for a developed country
 - excessive resources devoted to screening of rare problems at the expense of prevention of major public health problems, and
 - out of date protocols for practice.
- G. Need for currency in women's health care, especially treatment of vaginitis, STDs and infertility.
- H. Need for client and family-centered approach to care which allows for client autonomy and choice rather than rigid adherence to routines which are not scientifically based.

VI. POSSIBLE RESPONSES THROUGH A MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PROGRAM

The following possible responses to the identified problems are offered to provide information for both USAID and other donors. The team determined that an expansive summary of possible responses was preferable at this point. Prioritizing of responses can be done at a later date after information about the availability of funds and further input from the Central Asians is known. Many more ideas for practical ways USAID could assist will undoubtedly emerge from the seminar on maternal and child health to be held in Alma Ata, January 11-15, 1993.

There are common needs across the three areas of maternal/neonatal health, breastfeeding and family planning and widespread interest among Central Asian MCH officials in receiving the following kinds of assistance to address them.

A. TRAINING

The first priority would be training to update the knowledge and improve the skills of the plentiful health staff that have been isolated from advances made in the west during the past 20 years. There is a need to revise curricula for basic preservice training of pediatricians, obstetricians/gynecologists, and midwives. There is also the need to update knowledge through refresher training. An outstanding feature of the former Soviet Union approach to medical education, which is being continued, is the provision for mandatory (for promotion) refresher training and recertification for all health staff every five years. Thus, a ready infrastructure exists for refresher training.

The training needs can best be met by a combination of training senior trainers in the U.S. or in Central Asia followed in turn by their training health staff in-

country; study tours to the U.S. and other countries; sponsorship of senior health policy makers to attend international professional meetings, particularly of international medical associations of pediatricians, obstetricians and gynecologists, and midwives; and design and provision of training materials. Some courses could easily be held regionally. The biggest hurdle for USAID is the Russian language barrier.

B. INFORMATION, EDUCATION AND COMMUNICATION

There is an excellent infrastructure for health education of the general public and families through the national health education center or house of health in each country. However, propaganda available for distribution by television, radio, film shorts, and print material is out of date. Furthermore, materials and messages have not been developed through qualitative research to determine existing knowledge and behavior and motivation and resistance factors, nor cultural differences between ethnic groups within each country. There is a real need to solicit the clients' point of view on existing services and how they could be improved. Thus, technical assistance could be provided for conducting qualitative research and designing new educational materials.

C. HEALTH INFORMATION SYSTEMS

The types of maternal and child health and family planning statistics being monitored are impressive, but ability to analyze and interpret the data and use health statistics for planning purposes is weak. Definitions of some indicators also are at odds with those in international use, making standard comparisons impossible (e.g. excluding deaths during the first 7 days of life from infant mortality rates). Furthermore, the existing information systems are totally manual and need to be computerized. Technical assistance could be provided for designing a computerized health information data base following international definitions and for training decision makers in analytical skills for planning purposes. Material support of computers and supplies would also be very useful.

D. NATIONALLY REPRESENTATIVE DEMOGRAPHIC AND HEALTH SURVEYS

All data presented to the team by health ministries were derived from routine reporting of service statistics by health providers. There is a need to conduct nationally representative household surveys, like the Demographic and Health Surveys (DHS) AID has supported in many other countries, to validate existing statistics; fill information gaps in certain areas for which data are not available, such as breastfeeding practices and prevalence of anemia; and have

an accurate baseline from which to gauge progress. If such surveys are done, it would be useful to collect data on anthropometry and hemoglobin of women of reproductive age.

E. DRUGS, SUPPLIES AND EQUIPMENT

There are also acute needs for pharmaceuticals, contraceptives, medical supplies and equipment, but how to address these needs in a sustainable manner needs to be determined. Priority drug needs identified by the team were oxytocin for preventing postpartum hemorrhage (a major cause of maternal mortality in Central Asia), antibiotics for treating maternal and neonatal sepsis, and iron (ferrous sulfate) and iron plus folic acid tablets for prevention and treatment of widespread nutritional anemia in women of reproductive age, especially pregnant women. Existing supplies of oxytocin and iron are insufficient even for adequate treatment of cases, and, therefore, are never given prophylactically, in contrast to currently recommended procedures for managing hemorrhage and anemia. For family planning, there is a need for all contraceptives including oral contraceptives, Norplant, Depoprovera, IUDs, and minilap kits. UNFPA will reportedly supply 60,000-80,000 IUDs per country during the next year.

F. MATERNAL HEALTH

Maternal mortality ratios in the Central Asian countries are elevated over those expected in developed countries and, even more alarming, appear to have risen during the past five years. Yet maternity care, including prenatal care and institutional delivery by trained personnel, is near universal. What is critically needed is better quality of care and assurance of supply of essential drugs.

One possible response is training on state of the art maternal care to prepare the way for policy and practice changes. This could be done by arranging study tours for key research institute, training school and Ministry of Health personnel to view MCH/family planning care in the U.S. with particular attention to:

- client education and choice;
- elimination of unnecessary interventions;
- provision of full range of family planning services;
- state of the art care of maternal complications especially obstetric hemorrhage, toxemia, and sepsis (including use of the partograph for monitoring the progress of labor and prophylactic use of oxytocin in the third stage of labor); and
- current practice protocols based upon outcomes of research.

These study tours might be effectively arranged in New Haven, New York, Philadelphia or Washington, D.C., where there are midwifery as well as physician training programs at major universities and a variety of service institutions.

The next step would be to assist with refresher workshops (including curriculum and materials development) for midwives and OB/GYNs based upon desired changes stimulated by ideas from the MCH seminar to be held in Alma Ata, January, 1993, and from the study tours. These workshops would focus upon clinical practices with specific emphasis on life saving skills which address major causes of maternal mortality. The workshops could be held at the postbasic training schools normally used for refresher training, where there are dormitories, classrooms, clinical site affiliations and faculty. Consideration could also be given to sponsoring graduate study in the United States for key faculty in OB/GYN, midwifery and public health.

Another important step for improving the quality of maternity care would be to assist with the development of "model" maternal and child care institutions in each country. This would involve work with the national research institutes for obstetrics and gynecology or maternal and child health in each Central Asian country, which are in many senses model institutions but which need further updating, as well as service sites to be used for primary clinical practice during refresher and specialty training. Part of establishing the model institutions would be to provide technical assistance for review and revision of relevant protocols for the major causes of maternal mortality, followed by formal review, publication and wide distribution. The libraries in the institutes and training schools should be provided with key texts and journals with translation into Russian of key articles and texts. The team was specifically asked for copies of the 1989 compendium on Effective Care in Pregnancy and

Childbirth by Chalmers, Enkin and Kierse (editors), Oxford University Press, which would be put to very good use by the research institutes. Central Asian MCH/family planning researchers and clinicians should be encouraged to contribute articles to international newsletters and journals.

Reforms in Central Asian maternity care toward a client and family centered approach which allows for client autonomy and choice rather than rigid adherence to routines which are not scientifically-based, is a high priority. This could be addressed by providing opportunities for women's groups (consumers) to visit the U.S. They should have the opportunity to visit women's health care services including outpatient clinics, hospitals and birth centers, and to speak with women in consumer and childbirth education organizations such as the Boston Women's Health Collective, International Childbirth Education Association, etc.

Qualitative research should be conducted on women's attitudes, concerns and desires about their health care. This should include differentiating the attitudes of different ethnic groups. The results of these studies should then be integrated into the training of all levels of health care personnel.

G. WOMEN'S HEALTH

Once responses are underway to address the major causes of maternal mortality, similar training activities could be carried out to promote state of the art care for improving women's health with emphasis on sexually transmitted diseases. It would be worthwhile to hold an international forum/seminar to exchange results of scientific studies related to treatment of sexually transmitted diseases and infertility.

H. PROFESSIONAL MEDICAL ASSOCIATIONS

Another need is to assist in establishing formal relationships between the Central Asian national professional medical associations of pediatricians, obstetricians/gynecologists and midwives and international professional societies (International Congress of Midwives (ICM), International Federation of Obstetricians and Gynecologists (FIGO) and the International Society for Pediatricians). In the case of midwife societies, it would be worthwhile to send one or two midwives (chair of the coordinating council, society or association and the chief specialist in the MOH for middle level personnel, if she is a midwife) from each Central Asian country to the next triennial International Congress of Midwives to be held in Vancouver, May 9-14, 1983. Midwives who hold these key positions have been identified from Kazakhstan, Kyrgyzstan and Uzbekistan. This trip could profitably be combined with a study tour.

I. MATERNAL ANEMIA

The prevalence of anemia in women of reproductive age is very high. Yet, due to shortage of iron/folic acid tablets, there has never been a program of routinely supplementing all pregnant women to prevent anemia, as is common in most other countries in the world. Nor is there any supplementation of women of reproductive age who are not pregnant, nor fortification of food with iron. It would be very cost-effective to shift Central Asian health ministries to a preventive approach to anemia if sufficient iron tablets could be produced in one of the countries, procured abroad or donated. This would include provision of iron supplements to all women of reproductive age (1 tablet per day with 60 mg of elemental iron or 300 mg hydrated ferrous sulfate) and to all pregnant women (2 tablets per day, each containing 60 mg elemental iron and 250 micrograms of folic acid). UNICEF is considering supplying some iron/folic acid tablets to some of the Central Asia countries as part of the assistance program it is currently designing, but the total needs will be far from met. USAID should also consider whether it can supply some of the needs on a declining scale, while alternatives are being worked out. The 1991 cost of iron/folic acid tablets from UNIPAC/Copenhagen was \$1.56 per 1000 tablets.

Technical assistance could also be provided to explore the feasibility of food fortification with iron. A technique of dual fortification of salt with iodine and iron has been successfully employed in India and could be relevant in Central Asia, where iodine deficiency is also a problem. Funds for research plus technical assistance, could be provided to elucidate the etiology of the iron deficiency and, as mentioned above, nationally representative hemoglobin data could be collected as part of a DHS household survey. Serious consideration should be given to using some of the special micronutrient funds Congress has allocated to AID for pursuing some of these ideas.

The team noted during the visit to Bishkek, Kyrgyzstan, that AID has sponsored a partnership between the University of Kansas Medical Center and the Kyrgyzstan national Research Institute on Pediatrics and Obstetrics and Gynecology. Furthermore the head of the Kyrgyzstan Institute, Dr. Dusne K. Kudjarov, is a hematologist, and Kansas Medical Center's Dr. James Cook heads a world-renowned research center on nutritional anemia which has been receiving support from RD/Nutrition for a number of years to provide technical assistance on anemia research to developing countries. However, the partnership does not include work on anemia so Dr. James Cook has not been involved. The possibility of including a collaborative study on the etiology of nutritional anemia in women and children in Kyrgyzstan as part of the partnership should be explored, if at all feasible. If not feasible, then other ways of accessing the technical assistance of Dr. Cook should be investigated.

Of course, the need is regional and not unique to Kyrgyzstan.

J. FAMILY PLANNING

Contraceptive prevalence rates are low and abortion rates are high. There is a great need for updating knowledge and skills of health professionals and changing their negative attitudes toward oral contraceptives and voluntary surgical contraception (sterilization) and a great dearth of up-to-date scientific information and training materials and ability.

One priority response would be the provision of method-specific information in Russian, e.g. translation, printing and distribution of key issues of Population Reports and the book entitled Contraceptive Technology. In-country or regional training of trainers in counseling, clinical skills (e.g. Minilap with local anesthesia for female sterilization), and contraceptive technology updates who then train others will have a cost-effective multiplier effect. In addition, assistance should be provided to revise curricula in medical and nursing schools. In conjunction with provision of contraceptive commodities as noted above, contraceptive social marketing would assist vis-a-vis moving to a market economy, pressures to decrease government spending, etc. Management assistance to develop strategic planning skills from a public health perspective in key leaders would be useful. Assistance could also be provided for conducting mass media educational campaigns. Study tours of Uzbekistan officials to Indonesia to view the national family planning program were reportedly very effective and should be repeated for a number of senior health officials.

K. BREASTFEEDING

Breastfeeding practices were found to be very poor, with exclusive breastfeeding rare and few mothers continuing to breastfeed beyond 6 months postpartum. None of the maternities visited were following the WHO/UNICEF recommended ten steps for protecting, promoting and supporting breastfeeding, the prerequisites of "Baby-Friendly Hospitals".

The first priority for improving breastfeeding practices will be re-orienting the thinking of pediatricians, obstetricians, nurses and midwives and thus reforming hospital practices. The most effective way to accomplish this would be to send a team of 4 senior MCH policy makers and clinicians from each of the 5 Central Asian countries to the one month lactation management education program at Wellstart, in San Diego, California. Wellstart has a window of time held open for doing such a tailored course in Russian for Central Asian participants in May-June, 1993. The complete cost for 20 people including travel would be approximately \$260,000. Wellstart will need to know

immediately if this is desired as they have demands for training from other parts of the world for that same time. Part of a trip to Wellstart could include a study tour to see Baby -Friendly hospitals in Turkey and in the Philippines. The Wellstart trained team would be expected to conduct training for other health staff upon their return. Thought could also be given to setting up a regional lactation management training center within one of the Central Asian countries that could provide training to the others.

Other needs are a mass media campaign to educate the public on the benefits of breastfeeding and to overcome women's fears about insufficient breastmilk. Mother-to-mother support groups like the La Leche League movement in the U.S. need to be established. It would be particularly useful to translate the popular La Leche League book entitled The Womanly Art of Breastfeeding into Russian and distribute it for sale in book stores.

VII. PROPOSED SEMINAR PLANS

The regional maternal and child health seminar is planned to be held by USAID/Alma Ata in Alma Ata, January 11-15, 1993 at the National Academy of Sciences. The objectives of the seminar are to: a) present and exchange current knowledge in maternal and neonatal health, breastfeeding and family planning between U.S. and Central Asian participants, and b) review and compare definitions of key maternal and infant health indicators in Central Asian countries with internationally used (World Health Organization) definitions and determine if any revisions are needed in Central Asian indicators for international comparability. Participants will be invited from Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. Opportunity will be given for representatives from each of these countries to present a situation analysis on maternal and child health and family planning in their countries. Details of plans for the seminar developed by the team can be found in the team's reporting cable (Alma Ata 002195) in Appendix J including: the agenda, proposed speakers, Central Asian participants, donor involvement, funding arrangements, and travel and accommodation arrangements.

APPENDIX A

Persons Contacted

APPENDIX A

Persons Contacted

1. Kazakhstan

U.S. Embassy

William Courtney, U.S. Ambassador
Jackson Mc Donald, Deputy Principal Officer

USAID Regional Office for Kazakhstan and Central Asia

Herb Miller, Acting Mission Director
Paula Feeney, General Development Officer
Michael Curtis, Executive Officer
Zamira K. Kanapianova, Project Specialist

Ministry of Health

Vasilii N. Deviatko, Minister
Aman Duisekeev, Deputy Minister for MCH
Tamara Paltusheva, Chief, MCH Department
Bakhyt Munaidarova, Chief Specialist for Midwifery/Nursing

Edil Dadanbayev, Chief Pediatrician

Republican Health Education Center

Durumbetov Erkin Ermekovitch, Chief Physician

WHO Collaborating Center on Primary Health Care and Nursing

Jibek Karagulova, Deputy Head of Center

Scientific Center on Regional Nutrition Problems

Turegeldy Sharmanovich Sharmanov, Director
Shamil Tazhibayev, Deputy Director
Tsoi Igor, Deputy Director
Mussa Aidjanov, Chief of Laboratory
Gulnara Semenova, Researcher

Republican Scientific Research Institute of Pediatrics

Mashkeev Auken, Director
Kulyan Omarovna Omarova, Deputy Director, Hematology

Republican Scientific Research Center on Maternal and Child Health

Nina Kayupova, Director
Tamara Chuvakova, Deputy Director on Science, Neonatology
Magrifa Sahrifkanova, Deputy Director on Clinics

Republican Medical School for Nurses and Midwives
Sara Erezhepova, Deputy Director

Children's Hospital #1, Alma Ata
Aman Rymbayevich Matakbayev, Chief Physician

Faculty of Pediatrics, Medical Institute, Alma Ata
Kasen Kozhakhonov, Dean
Bulat Khabizhanov, Chief, Chair of Pediatrics Batyr

Municipal Health Department, Alma Ata
Gulshara Urmurzina, Head
Maya Ababkova, Chief Midwife
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Alma Ata Oblast Department of Health
Kulyash Nadirova, Deputy Head

Polyclinics on Medical-Social Assistance to the Family
Tamara Dzhusabalieva, Head

Republican Postbasic Training Center for Nurses/Midwives
Zoya Murzagulova, Director

Alma Ata Medical College
Galina Beisenova, Deputy Director

Talgar Rayon District Hospital
Bulat Sadykov, Chief Physician
Valentina Makarenko, Chief Maternity Department

UNICEF
Alexandre V. Zouev, Research Officer Programme Division, NY
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2. Kyrgyzstan

U.S. Embassy
Ed Hurwitz, U.S. Ambassador
Tom Hutson, Deputy Principal Officer

Ministry of Health
Kafan A. Subanbayev, Deputy Minister for MCH
Sasyrbek Orozaliev, Chief, Department of Economics and

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**Yevgeniya Doskeyeva, Chief MCH Department
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Apisa Khushbakeeva, Chief Pediatrician**

**Republican Scientific Research Institute of Obstetrics, Gynecology and
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Medical College for Nurse/Midwife Training

Karjan Kenenbai, Director

3. Tajikistan

U.S. Embassy (met while on evacuation status in Tashkent)

Ed Mc Williams, Deputy Principal Officer

4. Turkmenistan

U.S. Embassy

**Joseph S. Hulings, III, U.S. Ambassador
Gene B. Christy, Deputy Principal Officer
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Ministry of Health

**Gurbangeldy Kurbanovitch Kadamov, First Deputy Minister
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5. Uzbekistan

U.S. Embassy

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Ministry of Health

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Anvar Nurmohamedov, Chief MCH Section, Family Planning
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Tamara Leshniva, Chief Specialist for Nursing/Midwifery
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Republican Research Institute of Obstetrics and Gynecology

Damin Abdurakhimovich Asadov, Director
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Republican Research Institute of Pediatrics

Orchan S. Machmudov, Director
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18. Mr. Shamil Tazhibayev
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19. Mr. Tsoi Igor
Deputy Director

20. Mr. Mussa Aidjanov,
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21. Ms. Gulnara Semencva,
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22. Mr. Batyr Tastanbekov,
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24. Mr. Bulat Khabizhanov,
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30. Ms. Tuigin Zikirova,
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37. Dr. Alma Turkaeva,
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38. Dr. Gulnara Assimova,
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39. Dr. Larissa Tsoi,
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40. Dr. Murat Usataev,
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APPENDIX B

Statistics

APPENDIX B

Statistics

Kazakhstan

Population: 16.7 million 1991

MMR: 67.0/100,000 live births (actual 230/352,000) first 9 months of 1992

73.3/100,000 1990

76.9/100,000 1989

60.4/100,000 1988

61.6/100,000 1987

LBW: (< 2500 Gms, >500 Gms., >7 days) including premies 5-7%

C/S rate: Range 5-17%

Abortions: 97/1000 births 1990

85/1000 women of childbearing age 1990

99/1000 women of childbearing age 1980

Births: 352,000/yr

Birth rate: 21.7/1000 1991

23.0/1000 1989

Total Fertility rate: 2.3 (urban) 1990

3.6 (rural)

IMR: 26.0/1,000 live births, first 9 months of 1992

26.4/1000 1990

Perinatal mortality rate: 19.3/1000 births 1990

18.4/1000 1988

Kyrgyzstan

Population: 4.3 million 1991

MMR: 75.3/100,000 1992

65.5/100,000 1989

80.0/100,000 1980

LBW: (<2500 g) 5.5% 1990

C/S rate: 10% in one referral institution

IMR: 31.8/1,000 1992

27.0/1,000 1991

29.9/1000 1990

Perinatal mortality rate: 15.7/1,000 1992

16.4/1,000 1991

Abortions: 67-70,000/yr previously
54,000/yr 1991
60 per 100 births 1990
76 per 1000 women of childbearing age 1990
76 per 1000 women of childbearing age 1980
Births: 152,000/yr
Birth rate: 29.3/1000 1991
30.3/1000 1989
Total Fertility rate: 2.6 (urban) 1990
4.7 (rural)
Pregnant women with diseases: 86%
Pregnant women with anemia: 80%

Tajikistan

Population: 5.3 million 1991
MMR: 99.6/100,000 live births 1991
97.7/100,000 1990
74.9/100,000 1989
76.3/100,000 1987
135.9/100,000 1980
LBW: (<2500 g) 6.4%
IMR: 40.8/1000 1990
46.8/1000 1985
58.1/1000 1980
45.1/1000 1970
Abortions: 25 per 100 births 1990
44.3 per 1000 women of childbearing age
Births: 203,771 1991
Birth rate: 38.8/1000 1991
38.6/1000 1989
Total Fertility rate: 3.4 (urban) 1990
6.1 (rural)
Breastfeeding 0-4 mos.: 85.6% 1990
0-6 mos.: 67.5% 1991

Turkmenistan

Population: 3.7 million 1991
MMR: 134.0/100,000 live births first nine months of 1992
106.0/100,000 1991
113.4/100,000 1990
125.0/100,000 1989
112.5/100,000 1988
99.7/100,000 1987
102.6/100,000 1986

LBW: (<2500 g) 4.8% 1990
IMR: 44.2/1000 live births first 10 months of 1992
46.3/1000 1991
45.3/1000 1990
54.3/1000 1989
53.3/1000 1988
56.4/1000 1987
58.2/1000 1986
Perinatal Mortality Rate: 22.2/1000 births 1991
Abortions: 28 per 100 births 1990
40.4 per 1000 women of childbearing age
Birth rate: 34.2/1000 1991
33.2/1000 1990
Births:
Total Fertility rate: 3.7 (urban) 1990
4.8 (rural)
Contraceptive Prevalence (IUD): 15.1% 1991

Uzbekistan

Population: 20.6 million 1991
MMR: 55.0/100,000 live births first 9 months of 1992
65.0/100,000 1991
72.6/100,000 1990
78.9/100,000 1989
LBW: (<2500 g) 5.1%
IMR: 37.5/1,000 live births first 9 months of 1992
35.5/1000 1991
35.2/1000 1990
37.7/1000 1989
42.8/1000 1982
Abortions: 31 per 100 births 1990
44.7 per 1000 women of childbearing age 1990
43.8 per 1000 women of childbearing age 1980
188,995 total number 1991
Births: 700-725,000/yr
Birth rate: 33.7/1000 1991
Total Fertility rate: 3.0 (urban) 1990
4.8 (rural)
Pregnant women with anemia: 80%

KAZAKSTAN STATISTICS

MATERNAL HEALTH (/1000 WOMEN)

Extragenital Diseases

1990	Anemia Prevalence	248.5%	
	Kidney Disease Prevalence	76.0%	
	Cardiovascular Disease Prevalence	45.5%	
	Gyn Disease	83.3% of women	21.7% adenetis 61.6% erosions, endocervicitis

ABORTION RATE 60%

DISEASES OF THE NEWBORN

Ashphyxia	48.8%
Resp. Dsyfunction Syndrome	14.0%
Congenital Diseases	13.1%
Birth Traumas	11.9%

CONTRIBUTION TO NEWBORN MORBIDITY

Extragenital Diseases

Cardiovascular	26.6%
Anemias	20.3%
Diabetes	20.0%
Respiratory Diseases	13.0 %

Pregnancy Complications

Toxemia	26.6%
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CAUSES OF MATERNAL DEATH

General-especially extragenital	32.7%
Abortions	26.7% - some die at home
Hemorrhage	19.2%

PERINATAL MORTALITY

1990	19.3%?
1988	18.4%
1989	

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MATERNAL DEATHS IN KAZAKHSTAN - 1990

		NO.	%
LOCATION	Rural	166	62.4%
	Urban	100	37.6%
PARITY	Primigravida	99	37.2%
	Multigravida	167	62.8%
OCCUPATION	Blue Collar	86	32.0%
	Workers	66	24.8%
	Farmers	31	11.7%
	Housewives	57	21.9%
	Students		1.5%
	Invalids		1.5%
	Prisoners		0.4%
	No data	17	6.4%
EDUCATION	Primary	3	1.1%
	Vocational	187	70.3%
	Specialized Vocational	28	10.5%
	Higher Education	31	11.7%
ETHNIC BACKGROUND	Kazakh	165	62.0%
	Russians	63	23.7%
	Other	38	14.3%
MARITAL STATUS	Married	218	82.0%
	Singles	28	10.5%
	Lived Together		
	Not Registered	20	7.5%
PLACE OF DEATH	City Clinics	175	65.8%
	MCH	3	1.7%
	Rural Clinics	91	34.2%
CAUSES	Abortion		26.7%
	OB Hemorrhage		19.2%
	All Other Not Connected with pregnancies		24.3%?
	Toxemia		13.9%
	Other Connected with pregnancies including-	Sepsis	4.1%
	Ectopic	3.4%	

APPENDIX C

Institutional Profiles

APPENDIX C

Institutional Profiles

1. Kazakhstan

The Ministry of Health

The Ministry of Health in Kazakhstan is headed by the Minister of Health, V. N. Deviatko. He is grateful for outside help and stated that he cannot expect it for long. The concern of highest priority is health care financing. Mr. Aman Duisekeev is the Deputy Minister of Health. He is not acquainted with the specifics of many health care policies and problems but directed the team to others who could be of help. He was designated by the Minister as the point of contact for specific plans for the MCH/FP seminar and he will direct this work with the help of the heads of the institutes. Ms. Tamara Paltusheva is the Chief of the Department of Maternal and Child Health of the MOH. She is very knowledgeable and helpful about the specifics of the problems in MCH. She arranged to find the key papers with the infant and maternal mortality statistics which could not be obtained through anyone else. Ms. Bakhit Munaidarova, Chief Specialist for Nursing for the MOH, did not get much chance to speak because she was joined at her interview by someone else who monopolized the conversation. However, Ms. Munaidarova appeared to be knowledgeable and is in a key position at the Ministry to influence policy for the middle level providers. She is currently connected with the Republican Council of Nurses and Midwives.

The government health infrastructure of Kazakhstan is as follows: There are 19 regions (oblast) each with a regional hospital. In regional capital cities, marriage and family clinics have also been recently established for provision of family planning services. There are 250 districts (rayon), each with a central district hospital serving 70,000-100,000 population. At the district level there are also 220 maternity hospitals and 686 women's consulting centers. There are 5,785 feldsher units.

Research Institutes

Republican Scientific Research Center on Maternal and Child Health

The MCH Institute is headed by Dr. Nina Kajupova who is knowledgeable and well traveled (U.S., Western Europe). She obviously is very strong politically since she managed to have a former VIP facility turned over to the MCH Institute three years ago. While she accepts referrals from the entire country, her focus is upon the level of care in the institute and the referral system. She was not particularly helpful in describing or even speculating about different conditions in the outlying regions of the country. She was helpful in providing some papers and is necessarily a key player in any MCH effort. Several other doctors attended the meeting with Dr. Kajupova but their expertise and authority could not be determined.

The Institute is a magnificent facility on the outskirts of town. A former VIP facility, it is spacious, well kept and well equipped. There is high tech equipment from all over the world. All appears to be well maintained and underutilized. The institute combines the function of a tertiary referral center and a sanatorium for extended stays with hydrotherapy and mud baths for psychological rehabilitation.

The Institute accepts high risk referrals from all over the country. Among the departments and work of the Institute are a family planning lab for clinical testing of IUDs and oral contraceptives, as well as studying contraceptive requirements and reasons for abortions. There are departments for general OB/GYN (2), high risk pregnancy, surgery, GYN problems in children, infants, recovery, physiotherapy, functional diagnosis, prenatal care, and a polyclinic for outpatient care including departments for artificial insemination, dentistry, biochemistry, immunology, cytology, pathomorphology and genetics. There is also a large auditorium. Many have defended their PhDs at the Institute. The Institute provides training for doctors and medical students as well as seminars for students of vocational medical schools, especially midwives.

Republican Scientific Research Institute of Pediatrics

Dr. Mashkeev Auken is director of the pediatrics institute. It is one of 12 health research institutes of the Ministry of Health of Kazakhstan. He is a graduate of Alma Ata medical school and did his internship and post-graduate work at the Institute of Pediatrics in Moscow. The institute serves as the highest level referral point for pediatric cases from all over the country and provides laboratory and diagnostic services for the children's hospitals.

There is a 40 bed department for premature and low birth weight babies. This ward is innovative in that it has "rooming-in" in which mothers and their babies share the same room.

A 30 bed hematology department headed by Professor Kulyan Omarova was set up in 1989 because of the increase in children with leukemia. She studied hematology at the Moscow institute of pediatrics. The 40 bed cardiovascular department is headed by Dr. Habi Janov and specializes in rheumatic arthritis and heart disease, especially as it relates to ecologically unbalanced areas like the Aral Sea region. This work is funded by the Children of Aral Movement of the Ministry of Health.

There are also departments for malnutrition/malabsorption, gastroenterology, respiratory infections, nephrology/urology. There are facilities for microbiology, laboratory, radiology, angiography, colonoscopy, bronchoscopy, etc. The scientific statistics department monitors infant mortality and its causes from all over the country to compile the national rates for the Ministry of Health.

The director said he would like to learn more about the latest techniques for screening newborns for inborn errors of metabolism, phenylketonuria (PKU), cystic fibrosis,

and diagnostic tests of heart function to determine if the baby is a live birth or still birth (per WHO). He needs equipment for the latter and also 12 more incubators.

Scientific Research Center on Regional Nutrition Problems. WHO Collaborating
Center on Nutrition

This institute works under the auspices of the National Research Institute for Pediatrics (Kazakhstan) and serves the whole of Central Asia. The director is Dr. Turegeldy Sharmanovich Sharmanov. He has a son who is an immunologist in Birmingham, Alabama. The institute has branches in most of the Central Asian countries and also in Mongolia, from where a number of professionals have come to the institute for training in nutrition. The institute became a WHO collaborating center in 1979. It has close contacts with Finland and Bulgaria and also WHO/EURO in Copenhagen and WHO headquarters in Geneva. As part of the inter-health program of WHO, the institute held an international conference in 1991 on cancer and infectious diseases which was transmitted by teleconference throughout the region.

The nutrition institute also has close ties with the University of Texas School of Public Health for a joint research program on food habits and ethnic background. Two researchers from Texas will be assigned to the nutrition institute for two years from December, 1992, and two Kazakhstani institute staff will go to Texas. The key U.S. contact for this partnership is Alfred MacAlister. As part of the agreement, the institute and the University of Texas will publish a joint health magazine by the end of 1992.

With help from the People to People International Citizen Ambassador Program in the U.S., the institute held a conference on important issues in modern nutritional sciences in 1990, which was attended by 28 U.S. collaborators. The published proceedings of this conference were left with USAID/Alma Ata.

With technical assistance from Elisabet Helsing of the Nutrition Division of WHO/EURO, the nutrition institute has been carrying out a rapid nutrition assessment along with the other three former Soviet Union nutrition institutes (Kiev, Ukraine and Moscow, Russia -- Nutrition Institute and Preventive Medicine Institute). The survey entails a dietary survey (2 repeat 24-hour recalls several days apart) and height and weight in a random sample of 10 year old and 15 year old school children. The results will be available by mid-December.

The institute formulates and invents breastmilk substitutes and others which are clinically tested in infants in the pediatric institute's hospital. We were able to sample the fermented cow's milk formula at the pediatric institute. Although complete details on the formula's composition were not made available to us, it did not seem to be an adequately formulated breastmilk substitute in terms of macro and micronutrient composition. The institute is very interested in a joint venture for commercializing the production and sale of these baby foods which are being produced by the institute

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at a mini-plant in Alma Ata (Shipagare). The products are milk-based and use imported skim milk powder or fresh local cow's milk. The production is 1 ton per day, down from 2 tons per day before the break-up of the Soviet Union. Dr. Sharmanov met with the Bristol-Myers representative in Alma Ata who promised to send him some free samples of breastmilk substitutes but so far he has received nothing.

The Infant Nutrition Kazakh Fund was founded as a public charity organization by the institute in May, 1992, in order to raise funds to launch a children's nutrition industry in Kazakhstan. However, this presents a conflict of interest if continued to be run by the institute as proposed, since the institute should maintain scientific objectivity about the risks and benefits of breastfeeding and breastmilk substitutes and needs to carry out an independent, regulatory food safety function. With profits at stake this objectivity could easily be compromised. Indeed, the nutrition institute is already spending much more time on devising breastmilk substitutes than on research for promoting, protecting and supporting breastfeeding.

The nutrition institute has not formulated any cereal-based weaning foods for which there is a real need throughout Central Asia. It would be beneficial to assist or encourage the institute to do research in this direction.

Training Centers

WHO Collaborating Center on Primary Health Care and Nursing

The team met with Dr. Jibek Karagulova, Deputy Director, and her staff. In 1980, two years after the WHO global conference on Health for All by the Year 2000 was held in Alma Ata, this center was established as a WHO collaborating center for primary health care. In 1990, it also became a WHO collaborating center for nursing. The center has a semi-autonomous relationship with the Ministry of Health and there is currently some animosity in the relationship because the MOH is trying to evict the center from its building. The functions of the center are research, training, information dissemination and international collaboration. The center has translation facilities for converting documents from English to Russian and reproducing them. In fact, they had taken the ISTI Health Profile for Kazakhstan and translated it into Russian.

The collaborating center focuses only on nursing and not on midwifery. In September, 1993, they will host a WHO/EURO regional conference on nursing in Alma Ata. A current research interest is community participation in primary health care. They think the most urgent primary health care needs in Central Asia are: health education, essential drugs, nutrition, adequate and safe drinking water (free of pathogens and environmental pollutants), maternal and child health and family planning. They do not think immunization and infectious diseases need as much attention.

The director was offered an eight month fellowship in nursing at George Mason University in 1992 by Amelia McLucas and Rita Carty, but she wasn't able to go. Dr. Karagulova is also active in the Nevada-Semi Palatinsk anti-nuclear movement.

Faculty of Pediatrics, Medical Institute

The view of the dean (Dr. Kasen Kozhakhonov), chair (Dr. Bulat Khabizhanov), and deputy director (Mr. Batyr Tastanbekov) of the faculty of pediatrics of the medical institute was that the 6 years of medical education, after ten years of basic education, to become a pediatrician was too short. There is no difference in the courses taken by pediatricians versus internists. They think the program should be revised to 5 years general medical training plus 3-4 years of specialization. The existing program includes 200 hours on neonatology. There is only one week of courses on lactation management and another week on bottle-feeding for which they use a manual on children's nutrition prepared by Tatiana Imanhaeva. There is a separate post-graduate institute for refresher training of pediatricians and re-certification every five years.

Republican Medical (Vocational) School for Nurses, Alma Ata

The team met briefly with Ms. Sara Erezhepova, Deputy Director of the School. This school is one of the oldest and was set up in 1937 as a school to train rural midwives. It has grown and is now the biggest school with 2,700 students. Currently they are training dentists, orthodontists, pharmacists, medical nurses, feldshers, lab technicians and sanitary feldshers. They have not trained midwives since 1987, since there has been no demand.

Post Basic Training School for Nurses, Alma Ata

This school is headed by Ms. Zoya Muzzagulova who is very interested in foreign involvement. Ms. Roza Sandybekovna is the midwife tutor. The school is responsible for the one month refresher training (which might vary in time from two weeks to two months) which is carried out every five years for all feldshers, midwives and nurses. Until recently, they used a curriculum set for the entire USSR and are now in the process of revising the curriculum. This school also provides advanced training for nurses in a two year program (not available for midwifery specialization). In addition, they have just added commercial training for which students pay. Teaching aids were old and training materials out of date (some dated as far back as 1977, others 1984 and 1988.) This school does provide an excellent working mechanism for workshops for middle level personnel.

Alma Ata Nurse Training College, Alma Ata

This College was opened in September, 1992 with a brand new curriculum and approach. The team met with Ms. Galina Beisenova, Vice Director, who is energetic, knowledgeable and proud of this new endeavor. Ms. Turgin Zikirova is the Deputy Director, Ms. Nurmisa Mirsakhmetova is Chief of the Midwifery

Department and Ms. Sholpan Takyezhanova is Chief of the Education Department. This institution actually started in 1981 but has expanded and changed in the past year. The school offers four courses:

- Direct Nursing Care to Patients,
- General Nursing,
- Bachelors of Medicine with specialization in Midwifery, Therapeutics (Feldsher) or Nursing, and
- Higher Education for Nurses.

There was nothing like this in the former Soviet Union. There is no one in the midwifery specialization yet since that doesn't occur until the third year. Nurses, midwives and feldshers study a common curriculum for the first two years. The curriculum, which is not yet set for the midwifery portion, does not include FP. The entering class included 250 students. This appeared to be the most dynamic group of individuals involved in middle level training. The team did not have a complete tour of the facility, but what the team saw appeared to be better than the other two training institutions visited in Kazakhstan.

Information, Education and Communication (IEC) for Health, Family Planning and Nutrition

House of Health

Dr. Durumbetov Erkin Ermekovitch is the director and chief physician at the republican (national) House of Health for health education. They prepare mass media health education campaigns for Kazakhstan. They have offices in all regions (oblasts). In Alma Ata, at the headquarters, there are 44 staff, of whom 16 are physicians and the rest are writers, artists, photographers, secretaries, etc. They have a small publishing house in which they can print in black and white. Fifty percent of the print materials are done in Russian and 50% in Kazakh.

They have set-up mother's schools in maternity houses for educating new mothers but most mothers don't have time to attend. The classes are 1 hour theoretical and 30 minutes practical and cover pregnancy nutrition, physical exercise, breast preparation, care of the newborn, babies clothes and supplies, and infant feeding. The classes are easier to organize in urban than in rural areas. There are also classes for fathers.

2. Kyrgyzstan

Ministry of Health

The Ministry of Health of Kyrgyzstan has a similar organizational structure for maternal and child health as that described for Kazakhstan. Names of officers we met in key positions are found in Appendix A. We experienced considerable good will at the Ministry, which we attribute to the fact that several of the people who we met had recently had a very good trip to the U.S. to launch their health partnership with the

University of Kansas. We had first met in the U.S. and then were able to solidify the relationship by meeting again in Kyrgyzstan: Deputy Minister Subanbayev, Pediatric Institute Director Dr. Kudajrov, and Family Planning specialist Buylashev.

Research Institutes

Republican Research Institute for Obstetrics, Gynecology and Pediatrics

The team met with Dr. Dusne K. Kudajrov, Director, Dr. Ludmila D. Rybalkina, Scientific Assistant Director, and Dr. Talaybek S. Buylashev, Chief of the Medical and Social Investigation Department and Family Planning Advisor. Dr. Kudajrov is a hematologist and Dr. Rybalkina is an obstetrician. The Institute was founded in 1961. More than seven hundred persons work at the Institute including 290 scientists. There are clinical facilities (400 beds) at the Institute only for pediatric cases. The research interests of the institute include creating new products for infant feeding, especially fermented milk products, intrauterine infections (toxoplasmosis, CMV, hepatitis), effects of altitude on health and broncho-pulmonary diseases in childhood.

Training Centers

School for Training Midlevel (Paramedical) Personnel, Bishkek

The team met with Mr. Kapan Kenebai, Director of the School. The school has programs for Nurses, Pharmacists, Midwives, Laboratory Technicians, Sanitary Doctors Assistants, Dentists and Feldsher-Midwives. There are 10 such schools in the country. All other such training schools accept students from 14 years of age. This school, which has 1600 students, only accepts students who are 18 years of age. There has been some liaison between this school and the Alma Ata Nurse Training College. The Director does not anticipate that they will have a similar program and granting of Bachelor's Degrees due to lack of funds. Facilities and teaching resources seen at the school are old.

Post Basic Training School for Midlevel Personnel, Bishkek

This large facility directly across from the pre-service training school and dormitories was not visited.

3. Turkmenistan

The Ministry of Health

The Ministry of Health of Turkmenistan has a similar organizational structure for maternal and child health as that described for Kazakhstan. Due to a concurrent visit of a 17-member UNICEF delegation, we did not get the attention of the MOH that we had expected; although the U.S. Embassy had previously scheduled an appointment with the Minister of Health, this was cancelled at the last minute by the Ministry

because of the UNICEF delegation. Names of officers we met in key positions are found in Appendix A.

Research Institutes

Republican Research Institute for Mother's and Child's Protection

The team met with Dr. Victor E. Radzinsky who is both the director of the institute and the chair of obstetrics and gynecology at the Turkmen State Medical Institute. He is also the President of the Turkmenistan Society of Obstetricians and Gynecologists, which is a member of FIGO and the European OB/GYN society. Last year he attended the FIGO conference in Singapore and the European OB/GYN conference in Helsinki.

Dr. Radzinsky is very interested in and supportive of family planning. In particular he would like Turkmenistan to have access to Depoprovera and Norplant, as he feels these methods can be discretely controlled by women to overcome male resistance. He said that there is also quite a problem with infertility and requested supplies of ovulation stimulant drugs named Pergonal or Neo-pergonal from the Leroma Company.

Several years ago the institute received technical assistance from Professor Warren Isson of the University of Ohio, who helped standardize the definitions of vital statistics like infant mortality to make them comparable to WHO definitions. Rooming-in is practiced at the institute's hospital, but Dr. Radzinsky is a strong supporter of free infant formula for all who want it in Turkmenistan, and he attributes reduction in infant mortality in recent years to Turkmenistan's ability to distribute 2300 tons of free infant formula in 1991 versus only 400 tons in 1985. He also is a fan of fermented milk products for infants.

4. Uzbekistan

Ministry of Health

The Ministry of Health of Uzbekistan has a similar organizational structure for maternal and child health as that described for Kazakhstan. The Deputy Minister for MCH died recently so Dr. Sultanov, the First Deputy Minister, was acting in his stead. Names of officers we met in key positions are found in Appendix A.

Research Institutes

Scientific Research Institute of Pediatrics

The team met with Orchan S. Machmudov, Director of the Institute and Mischmon N. Achmedov. Dr. Machmudov is President of the Friendship Society with Foreign

Countries and has traveled extensively in the United States (Boston, New York, Los Angeles) and Canada on government of Uzbekistan funds. He visited the U.S. at the invitation of Dr. Lawrence, a famous cardiologist who is President of the Society for Preventing Nuclear War. He is a gracious man and powerful, but is not, himself, up to date on some of the questions brought up by the team. Mr. Achmedov was very quiet during the meeting. The Director told the team that this Institute and the one in St. Petersburg are the two pediatric institutes on the highest level. The Institute does research exclusively and all 460 beds and the outpatient clinic are devoted to this effort. Their areas of research interest are nutrition, hepatitis and gastrointestinal diseases. The Institute has departments of virology, microbiology, hematology, gastroenterology and a lab with experimental animals. There is a ward with 30 beds for premature babies. The Institute is a training institution. Doctors come from the countryside for one month of refresher training. The institute also trains lab nurses and ICU personnel.

Dr. Machmudov was very interested in the Wellstart lactation management training and said he would like to do a similar regional course at his institute. He asked for curriculum and training materials so that he could pursue this idea.

Republican Research Institute for Obstetrics and Gynecology

The team met with Damir Adburakhimovich Asadov, Director. He speaks English and appears to be in good command of the scientific aspects of the Institute. He traveled to Indonesia for a Family Planning Conference on Uzbekistan government funds after the President of Uzbekistan had visited the Indonesia family planning program and returned very impressed. The Institute is responsible for OB services throughout the republic. They have 380 beds, including 80 newborn beds and an outpatient department for general consultation, prenatal diagnosis, medical and genetics services and a department for artificial insemination. The institute has 60 research staff and 25 clinical staff. Each year there are approximately 9,000 outpatient visits and 5,000 deliveries. The OB department cares for 85% complicated and 15% normal cases. The Cesarean section rate is 8-9%. Approximately 50% of women with previous Cesarean sections deliver vaginally. The facility is exceptionally well kept and clean.

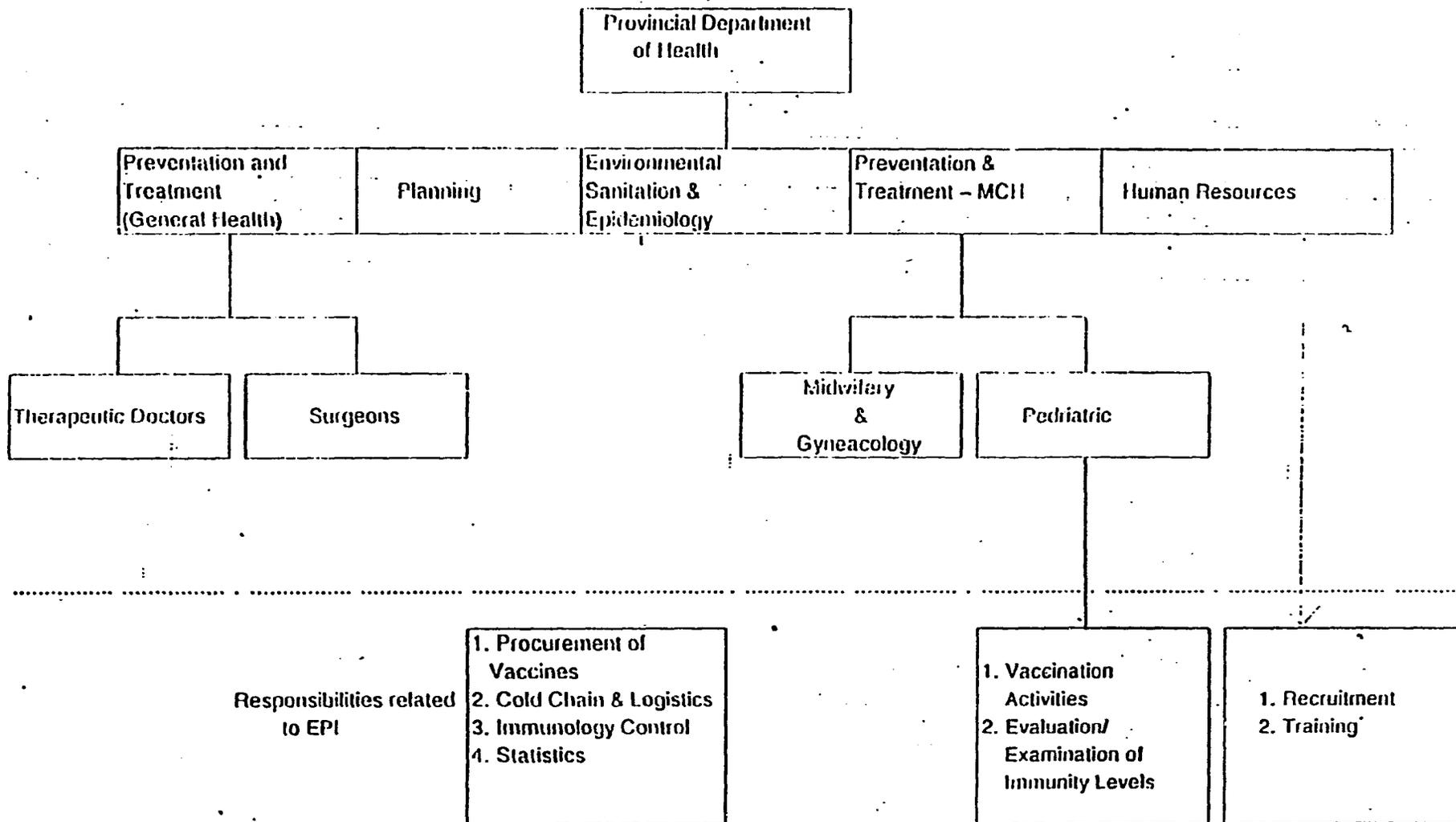
The Institute has done a great deal of work on FP and was involved in the Norplant studies. It is a collaborating center for WHO's Human Reproduction Program. The director is seeking scholarship funding for two of his staff to go abroad to study family planning for six months but so far there have been no donors. This Institute keeps track of maternal mortality and FP statistics. It was the only place where we saw computers being used to track maternal deaths.

Current research at the Institute includes the areas of OB hemorrhage, intrauterine growth retardation and congenital diseases. They are training foreign students from Syria and Afghanistan.

APPENDIX D
Health Structure

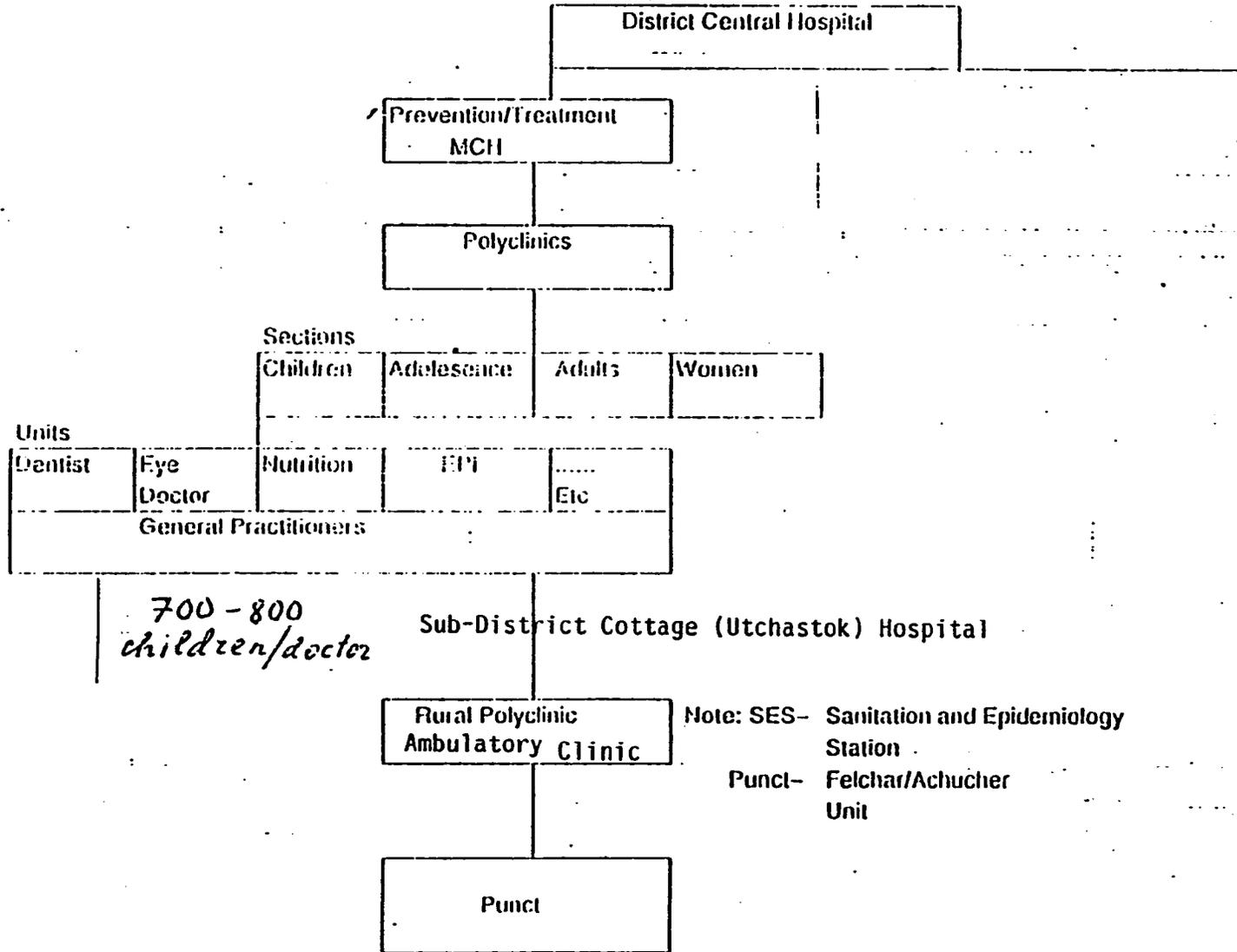
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PROVINCIAL HEALTH STRUCTURE (Regional- Oblast)



Annex D

DISTRICT LEVEL (Rayon)



APPENDIX E

Ten Steps to Successful Breastfeeding

Ten steps to successful breast-feeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast-feeding.
4. Help mothers initiate breast-feeding within a half-hour of birth.
5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
7. Practise rooming-in — allow mothers and infants to remain together — 24 hours a day.
8. Encourage breast-feeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breast-feeding infants.
10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

Source: Protecting, Promoting and Supporting Breastfeeding. A Joint WHO/UNICEF Statement: Geneva, World Health Organization, 1989.

APPENDIX F
Medical Education System

The present structure :

				Specialty
	8. years + 2 years +	2 years +	2 years +	2 years
		Nurse		
Primary	Basic	Midwife		
	Science	Technician		
School		Sanitarian		
				Internist
			Doctor	Surgeon
	Basic	*PRE-Med	Dentist	Pediatrics
	Science	(Felsher)	Pharma-	OB-Gyn
			cist	

* At the conclusion of the two year PRE-Med program, an exam is taken. Approximately the top half of the class proceeds to complete the next two years of Medical School. The students who end in the lower half complete their education at this point and become Felshers, who are physician assistants in the rural areas.

Source: Winkler, W. 1992

APPENDIX G
Materials Collected

APPENDIX G

Materials Collected

Maternal and Perinatal Mortality in Kazakhstan

Analysis of Maternal Mortality (in Kazakhstan)

Program of Mortality Control in Pregnant, Puerpera and Women in Childbirth, Alma Ata, 1990

Organization Chart of Ministry of Health Protection

2012 & 2014
in Kazakhstan
(current state, tendencies, prognosis)

About 8 million 524 thousand women live in Kaz, that is 52%. Of all women 52,2% are of age of ~~no~~ working ability, 33,7% - ~~younger~~ ^{below}, and 11,1% - ~~older~~ above the age of working ability.

Percentage of women among the population with high school education is 62,2%;
~~Among~~ 196,3 thousand of mothers in Kaz have 4 and more children (1989), among the - with 7 and more children - 33,2%.

I. Obstetric & gynecology service: material & technical provision

The basis of the service includes 1950 ps. of med. institutions, among them 52 delivery houses, 239 delivery departments in regional & municipal hospitals.

Recently 14 delivery houses for 1200 beds, 8 women's dispensaries for 2450 visits per shift were built also, 14 specialized departments for newborn in ~~the~~

profile were newly organized. In regional ~~countries~~ cities consultations, named "Family & Wedding" ~~were~~ ~~are~~ ~~opened~~, In A.A. - polyclinic rendering medical & social aid to the family - are opened. Provision with obstetric beds increased and reached 53.4 (to 1000 ~~per~~ newborn, dead & alive) in 1990 versus 44.4 in the year 1985.

Further improvement in material support of the service lead to increase of the rate of pathological pregnancy beds to 28% in 1990, ~~instead of~~ ~~24.5~~ in 1985, compared with

At Provision with general gynecological bed increased slightly - from 6.4 per 10.000 population in 1990 to 6.1 in 1985.

Provision with doctors ~~of~~ (obstetric - gynecology) in the Rep. is 10.6 per 1000 births or 2.2 per 10.000 population, provision with paramedical personnel - 42.5 (per 1000 births) or 10.1 per 10000 population.

The following needs to be done for further development of the material basis:

- 1) to attract foreign companies to build & reconstruct centers in + of

(compared 35,6 thousand in 1987), including 18,900 of premature babies and 3,6 dead fetus births.

In the break-down of the gynaecological disease, by the prevalence rate, first place is occupied by inflammatory diseases of genitals (83,3%), among which ~~and~~ adnexites prevale - 21,7% and cervical disease - 61,6 (erosions, endocervicitis) - prevale., then - sterility - 7,4%, and menstrual cycle disturbances - 4,9%.

Abortions rate per 1000 women of fertile age is 60,7 per 100 alive ~~&~~ and 71,9 per 100 dead child births.

Morbidity ~~of~~ among the newborn during 10 year period increased from 84,0 to 131,1 ~~&~~ per 1000. This rate is ~~as~~ regularly ~~higher~~ exceeds the mean republic one in Kustanay, Semipalatinsk, Chitubent regions.

~~R. &~~ Child morbidity ~~a~~ decreased a little in Karaganda & Almaty regions during the last 3 years, but it increased in A. Sta, East-Kaz and Pavlodar regions.

The increase of general morbidity ~~of~~ among the newborn in those regions and ~~is~~

due to immature babies: during 10 year period. morbidity rate among them increased from 87% to 79%.

Among the diseases of the newborn, the following are leading:

1) asphyxia 2) respiratory system abnormality dysfunction syndrome, 3) congenital diseases and 4) birth traumas.

Asphyxia, intrauterine hypoxia, as causes of morbidity of newborns, occupy the 1 place as a rule, and comprise 48.8%, the passing decade shows an increase of respiratory system dysfunction syndromes, which comprises 14%, congenital diseases also have trend to increase, and give 13.1%.

Birth traumas decreased during last 10 years from 16.1 to 11.9%.

The morbidity among the newborns in the Republic is determined by pre- as well as by intra-natal causes.

To perinatal losses, mothers' extra-genital diseases also contributed: cardio-vascular diseases - 26.6%, anaemias - 20.3%, diabetes 20%, respiratory system diseases - 13%, of complications of pregnancy - gestoses - 21.7%

- ~~Active~~ Active.
- Kyrgyz Ordā
- Ust-Danunovsk
- Akmoła

2) to improve the qualification of doctors:

- prebation courses ~~for~~ in big clinics abroad.
- education of medical geneticists, neonatologists.
- cooperation with foreign clinics in the area of human reproduction.
- joint ~~scientific~~ symposia on the gestoses, obstetric hemorrhages, & modern methods of contraception.

II . Maternal & child health.

In the Rep, women's health rate is 80%, in some regions - about 20%. Of 337 thousand of pregnant, attended at women's ~~dispensaries~~ consultations in 1990, prevalence of anaemias was 2485 per 1000 of pregnant, kidney disease - 76.0, cardiovascular disease - 45.5.

Compared with the year 1985, in ~~the~~ pregnancy ~~per case~~ anaemias increased 2,2 times, kidney disease - 2, cardiovascular disease - 1,9, 1,2 +

(7).

BEST AVAILABLE COPY

At present, every other pregnant woman in Kaz, suffers from anemia, every twenty'th ~~is~~ ^{is having} multiparous. (there are 126.3 thousand mothers ~~with~~ ^{having} many children in Kaz)

Morbidity rate among ^{in the pregnancy & newborn} ~~among~~ the pregnant & newborn is high in the South of the Rep. in Dzhambul region - kidney diseases: 122.2 per 1000 pregnant, in Chirchikent region - anemias: 340.4 per 1000 pregnant.

Women's health is also affected by the unfavourable ecological situation. E.g., in semi-desert region there is the highest in the Rep. rate of c/v diseases (205.8 per 1000 pregnant), high morbidity (154.4) and mortality rates in newborn.

The East Kaz region is characterized by the highest in the Rep. morbidity rate in newborn (171.4 per 1000), Aral and Subaral region - by high ~~of~~ ^{of} maternal anemias - 323.4, kidney diseases - 85.1, gestoses - 118.5 (all - per 1000/pregnant).

In general, in the Rep, 50% of women of child bearing age have extragenital diseases. As a result of, in 1980, 43.1 thousand

IV. Regional characteristics of maternal and perinatal mortality in the Republic.

The maternal mortality rate in the Rep. in 1990. was 73.3 per 100.000 of child births, and in 1988-1989, resp, 60.4 and 76.1.

In different regions this index is different. Long term follow-up allows to distinguish between 4 groups ^{of regions} regarding mortality rate, quality of medical aid, ecology and social & economic development.

Group I: Low mortality.

Kyzyl Orda, Ural.

Group II: Medium, with ~~tends~~ ^{tendency} to ~~lower~~ decrease.

Aktubinsk, E-Kaz, Dzherkarghai, Kustanay, Pavlodar.

Group III: Above medium. Unstable. ~~tends~~ ^{tendency} to decrease.

Atyrau, Dzhambul, Karaganda, N-Kaz, T-Burgan, Akmolg.

Group IV: High. Unstable ~~trend~~ ^{tendency} to decrease, no decrease, or an increase of mortality rate.

Alma-Ata, Kokchetav, Semipalatinsk, cit.

In the structure of ^{causes of} maternal deaths, the general causes have ^{first place} ~~max. majority~~ - 32.7%, with prevalence of extragenital diseases, ~~the~~ ~~see~~ the second place - abortions 26.7%, the third - obstetric hemorrhages - 19.2%.

In regions with medium level of maternal ~~mortality~~ ~~disease~~ (40-55 per 100,000 ~~population~~ of alive child births), among the causes, general ones occupy the first place, hemorrhages - second, the third - gestoses; in regions with high level of maternal mortality (more than 55 per 100,000 of alive child births first place is occupied by obstetric hemorrhages, second - abortions, the third - ~~general~~ other causes.

Perinatal mortality (PM) is another ~~an~~ important index of obstetric aid.

This index remained in the Rep. on a high level. In 1990 it showed 19.3‰, 1988, 1989 - 18.4‰.

~~There is~~ The index differs in different regions: ~~the~~ stable high indices are in northern (Kustanay - 22.3‰, Turgay 20.5‰) southern (Chimkent 20.1‰, eq. Ita 20.1‰)

① Mangystau region: 24.2‰

Dead ~~child~~ births' rates during last 3 years remained ~~about~~ about 10.4‰, and ~~that~~ those of early neonatal - 9‰. Specific antenatal mortality ~~within~~ rate ~~in~~ in the ~~within general~~ whole perinatal mortality ~~in the~~ is 30.5‰, in the whole intranatal 22.9‰, and in the early neonatal mortality - 46.6‰

Main cause of mortality among neonates in the Rep are: asphyxia, respiratory dysfunction syndrome, congenital disease and birth traumas. High ^{asphyxia} mortality rate ~~for~~ ~~asphyxia~~ is: in Chimkent 2.0‰, A.A. - 1.9, Akmoln 1.6‰, North Kaz 2.52, Rep. Karaganda 2.02 (mean republic rate is 1.37); respiratory dysfunction syndrome mortality rate is high in Pavlodar: - 5.8‰, Taldy-Kurgan 15.6‰, Chimkent 5.1, Guryev 4.8.

Congenital diseases mortality rate in East Kaz and Dzhenkashan reaches 1.9‰, in A.A. city - 2.2‰

IV. Perspectives of improvement of Mothers & Children's Health.

Main tendencies of obstetric & gynecology service development in Kaz, with resp. to regional peculiarities, shall have 3 phases:

I phase: ~~1990~~ for the year 1992.

Provision of 30 hospitals of obstetric & gynecology profile with:

1. medicines
2. Contraceptives 30.000.
3. Dry milk ~~for~~ mixtures 150 tons
4. ~~Use and - throw~~
Single use linens. 30.000.000
5. Sutural materials
6. Surgical instruments
7. ~~Incubators for~~ 800
Incubators 50.
8. Fetal monitors 60.

II phase. 1993-1995.

Equipment:

1. US apparatus 30
2. Surgical laparoscope 10
3. Diagnostic laparoscope 10.

5. respiratory devices for newborns 90

6. Immunoenzyme analysers 5.

7. Diagnostic equipment for homeostatic measurements in mothers & children.

Education of specialists, jointly ~~conduct~~ held symposia.

III phase. For the following period

- ~~start~~ establishment of perinatal centres.
- education of specialists.
- scientific cooperation.
- IV ~~part~~ produce contraceptives etc.

3 Analysis of the maternal mortality - 1990.

Maternal mortality in the year 1990 was 73.3 per 100000 against 76.4 in the year 1989

In Akitubinsk oblast. there is an increase of maternal ^{mortality} rate from 40.2 to 55.5) in Alma-Ata (110.6 to 123.0), Eastern-Kazakhstan (53.2 to 67.2), Karaganda (49.3 to 73.6), Kokchetav (41.9 to 90.9), Northern-Kazakhstan (63.4 to 71.6), ² in Alma-Ata 123.5 to 127.3

We don't know the age of the following 3 ladies - 2 pages
Chernenko - died at home (Kokchetav), Omerova - abortion & death at home (Semyalatinsk), Kolbenova - abortion & death at home (Alma-Ata)

The majority of women who died were from the rural areas. This year there were 166 (62.4%) women from the urban areas - 100 (37.6%).

39.37.2% were unigravida, 12 of them were of older age gravida (67 - 62.8%)

Among those who died - 86 (32.0%) were blue collar workers, 26 - 24.8% were workers, 31 (11.7%) farmers, housewives - 57, 21 students 1 (1.5%), invalids - 7 (1.5%), prisoner 1 - 0.9%. In the 17 of them we don't have any data (6.4%)

Educational background of the dead women.
primary education - 3 - 1.1%
vocational - 18 - 20.3%
specialized vocational - 28 - 10.5%
higher education - 31 - 11.7%

ethnic background - Kazakh - 165 - 62.0%, Russians - 63 - 23.7%
 other nationalities - 38 - 11.3%

218 (82.0%) were married, single - 28 (10.5%), lived to-
 gether, but were not registered - 20 (7.5%)

75 (65.8%) died in the city clinics, among them - 72 (14%
 in the city maternity hospitals, gynecological department
 of the city clinics - 9 (5.1%), in the Central city hospitals
 34 (17.7%), MCH - 3 (1.7%), other clinics - 6 (3.4%)

Rural clinics - 91 (34.2%), Central Republican clinic - 24 (32.0%)

3 page maternal

Causes of ~~de~~ mortality

1) abortion (26.7%) Every 3 abortions (36.6%) is criminal.
 This figure is 1.5 times higher in Eastern - Kazakh, Gorniy,
 Samoil, Karaganda regions, twice that number in Dzhezkazgan,
 Kostanai, North - Kazakh & Semipalatinsk.

2) obstetric bleedings 19.2% It's common among
 women of Mangyshlak (50%), Taldy Kurgan (40%), Turgai
 (37.5%), Irtyshsk (28.6%), Tselinograd (23.9%)

3) all the other causes, that are not connected with
 pregnancy, labor & postnatal period - they account

for 14.3%. It's above the republican rate in A-liaq
 oblast (17.4%), Dzhezkazgan (15.0%), Kokshetau & Kostanai
 (25%), Mangyshlak (50%)

4) toxemia - 13.9%

5) Other reasons, - that are connected with pregnancy
 labor, post-natal.

Last year the number of those who died of sepsis
 dropped from 6.7% to 4.1%, in the republic, except for
 Semipalatinsk, Turgai, Tselinograd oblast

Maternal mortality because of extrauterine pregnancy
 increased from 2.8% to 3.4%. It's typical of Gorniy,
 Karaganda, Taldy-Kurgan & Alma-Ata oblast

Obstetrical bleedings
old - the 2 place. The level of maternal mortality is the highest in Kzyl-Orda (33.3%), Mangyshlak (50.0%), Taldy Kurgan (40.0%), Turgai (37.5%), Aktyubinsk (28.6%) among those who died of bleeding - women from previous years make up 70.2%, paratell (57.5%), among them multi-para (26.6%), pregnant woman, women in child birth over 35 years make up 36%

79% who died of 1st 2nd 3rd trimester died of bleeding were from the high risk groups, having extra genital diseases (anemia 25%, cardio-vascular diseases - 30.2%, kidney diseases - 21.1%) in 20.2% obstetrical history was:

77.8% - pregnancy with complications
% high risk women in child birth were admitted to a hospital during the 1 period (stage) of labor, 32% had to be urgently hospitalized, 2% of them died at home, medical services haven't be provided in the oblast.

60.4% hemotransfusion hasn't been done in a clinical way in 16% cases they know stopping the bleeding during pregnancy was done in 13.7% cases, in 3% cases uterine extirpation was done.

The amount of pathologic blood loss is shown in 46.6%, in 28.7% blood loss has been replaced.

late toxemia - pre-eclampsia & eclampsia were the main causes of death of 37 women compared to the year 1989 its maternal mortality rate increased from 10.7 to 13.9%, mostly in Aktubinsk (20%), Alma-Ata (17%), Irbayevskaya (18.2%), Dzambul (20.7%), Dzizkazgan (25%), Kzyl-Orda (33%), Kouchetar (25%), Chonken (17.7%) oblast

Analysis shows that at the women's consulting centres, attention was not paid to the prevention & early detection of pathology. Not a single blood analysis had been done in 10% of cases, examination of urine has been done in 14% & 45% were not weighed.

Only 18% pregnant women with toxemia were hospitalized beforehand, 70% of those who died were from the high risk group.

Almost half (44%) in the 3 periods preferred not to use women's consulting centres, as a result 35.3% of women were hospitalized. With the diagnosis eclampsia common. In the clinic in 100% of cases long-term non-efficient therapy happened, in 30% inadequate anesthesia, hysterectomy was done (Alma-Ata, Dzhalgiz, Kzyl-Orda, Turgai region).

Sepsis

Postnatal purulent septic diseases are the main cause of maternal mortality in 11 cases, which makes up - 4.1%.

Among the causes of death sepsis in Aktubinsk accounts for 1/10 Karaganda region - 6.25%, Semipalatinsk - 7.14%, Turgai 2.5%, Tselinograd - 7.7%, Chumkent - 8.7%, Alma-Ata 5%. 4 cesarean sections led to sepsis (36.4%).

In 3 cases chronic pyelonephritis led to sepsis (Tselinograd, Chumkent, Aktubinsk), 1 case - 2. Alb. TB - 1 (Aktubinsk oblast), Splenitis - Alma-Ata. With toxemia as a background - sepsis developed in 6 cases (Tselinograd, Turgai, Chumkent oblast). With overweight as a background sepsis developed in 11. Uterine extirpation - 5 times, once - uterine amputation. In 5 case patients were not operated. In 1 case 18...

ralatinsk) the pregnant women died
All these deaths would have been avoided with the
right diagnosis & treatment
prevent hospitalization of the high risk pregnant
women.

Uterine rupture

14 (5.3%) of the pregnant women died because of that,
there is a 20% increase of uterine rupture deaths in Altai
oblast - (3 cases), Eastern Kazakh - 18.2% - 2 cases,
Tuvier (20% - 2 cases) in Altai - 8.7% - 2 cases.
Among them - 4 - multipara, 6 -
- big fetus) Attention should have paid to preventive
hospitalization, late diagnosis of uterine rupture, wrong medical
therapy, blood loss has been replaced
- all causes connected with pregnancy, labor, postna-
-l period

30 women (11.3%) died in the year 1990 because of
that. The biggest N gives us North-Kazakh (37.5%)
Iktimbursk (30%), Tselinograd 30, 6% Ural 14.2%
oblast 2.1% set down in Karaganda, Kost-Orda,
Kustanay, Chirchik oblast.

Causes of death
- 12 shock, 12, including anaphylactic shock - 9,
hemolytic reaction, allergic reaction - 3, complication of
emotions - 3, resuscitation - 3, surgical
twining, 2, intestinal obstruction

Examination of these cases shows that in 50% of cases
death wouldn't have happened if preventive measures
were taken: attention should be paid to allergic reactions,
thrombotic reactions, anesthesia, resuscitation introduction.

In the year 1990 - 10 (32.2%) died of anaphylactic shock
Every 3 women that died). Reaction to albumin in treated blood
freshly frozen plasma (Kokchetav), Suezkarn (Kustanai),
Lampyrat, combination of drugs - 2 (Alma-Ata), D. S. S. P.
(Dzambul).

Antistock treatment is not done properly -
12 of the pregnant women & women in child bed
died of incompatible blood transfusion - 2 of them in the
Maternity Hospital of Almaty - which shows that per-
sonnel is not well qualified for the blood of
recipient serum, there were ... in determination of
grouping & thesis blood factor.

Other causes, that are not connected with pregnancy,
delivery & post-natal period

38 women died in the republic in 1990 as a result of
extragenital diseases; 5 of them of cardiac-vascular diseases
(Alma-Ata, Dzambul, Karaganda, Semipalatinsk, Pavlodar),
6 of pneumonia (3 - in Chirchik, 1 in Kustanai, 1 - Kokchetav,
1 - in Karaganda regions), 3 of kidney disease (1 in Pavlodar,
1 - in Kokchetav, 1 - Alma-Ata oblast), liver disease - 4
(3 - in Chirchik, 1 - Tselinograd), 4 - viral hepatitis
(1 - in Chirchik, Tselinograd, Kustanai, Semipalatinsk); 6 - tumours
(A-A, Ybuv, Dzambul, Suezkarn, Kustanai, Chirchik,
anemia (Mangistau), TB. (Mangistau),
nose furunculosis (Taldyk-Kurgan), intestinal obstruction, (A-A),
meningitis (Chirchik), appendicitis (Kokchetav), diabetes (Pavlodar).
Among the extragenital diseases - in the 1 place - lymphomas
- 7 (18.4%), in the 2 - oncologic - 6 (15.7%), in the 3 - cardiac-vascular
- 5 (13.2%), in the 4 - viral hepatitis - 4 (10.5%), liver disease - 4 (10.5%).

One of the main causes of the high mortality rate in women with extra-genital diseases - difficulty in detecting them (9 per cent) 35% of the dead women were examined by the 78% - were examined at a later stage (abort after 13 weeks of pregnancy) - abortion couldn't be done at this stage pregnancy wouldn't be recommended to 75% of these women.

Indications of women (as recommended information on complications should be made available) It is also a failure in the work of the therapist - with extra-genital diseases of the 30% of the women haven't been detected at an earlier stage. Among the high risk pregnant 38% - recover, 28% get hospitalized in advance.

Abortion

Mortality rate with 28 weeks of pregnancy is in the place accounts for 26.6% of cases. It is common in Semipalatinsk, Northern Kazan - 11, Kostanai, Dzhezkazgan, Abai - 10%, La Gorn - 40%, Karaganda - 37.5%, Eastern Kazan - 36.4%, Kzylsk - 28.6%. The overwhelming majority out of 71 women - (36.6%) died of criminal abortions, in Aktubinsk, Pavlodar - 100%, Northern Kazan - 75%, in A. A. 66.7%, 50% - this rate is typical of Eastern Kazan, Dzhezkazgan, Kostanai, Kzylsk regions. Extra-genital diseases are causes of death in 28.2% in 21.2 cases - pregnancy complications. 5 cases - artificial abortion done before the 12 weeks pregnancy (2 cases - 2 deaths, 3 deaths - as a result of justifiable abortion, socially indicated) - 2 cases.

Death of the women
in weeks of pregnancy - 17%
from 13 to 20 weeks of pregnancy - 36.6%
from 21 to 28 weeks of pregnancy - 14.6%

The majority of the dead women were gravida II (50.7%)
multipara - 31.4%, primipara - 17.9%
multipara - 17.9%

Analysis shows: that women with extra-uterine disease
even under gynec prophylactic medical examination,
syndrom has + been identified, sepsis has been
noticed

To decrease the mortality rate - prevention of undesirable
pregnancy has to be done, contraceptives should be used
alongside with the timely hospitalization

Extra-uterine pregnancy

as the cause of 9 deaths (Alma-Ata oblast - 2 Eastern
Kaz - 1, Guryev - 1, Karaganda - 1, Taldy-Kurgan - 1,
Kokshetau - 1, Alma-Ata - 1)

4 of them had - tubal pregnancy

2 cases - there were operated, 2 - died before operation
(Karaganda, Taldy-Kurgan)

2) 1 case the patient has been hospitalized a place
in a Central Republican hospital. Diagnosis: ischemic heart disease
paroxysmal tachycardia. She died & autopsy showed that
she had - tubal pregnancy

2 case - Partovatt Javri admitted to a hospital with
head-poining diagnosis. With the wrong diagnosis she
died of hemorrhagic shock

Summary

Maternal mortality is decreasing in the republic
from 7.64% per 10000 in the year 1989
to 7.33% — 11 — " — 1990

At the same time there is an increase of maternal mortality
in Aktyubinsk, Alma-Ata, Eastern-Kaz-17, Karaganda,
Kochetav, Southern-Kaz-17 & Alma-Ata

Causes of death

- 1 - abortions
- 2 - obstetrical bleedings (19.2%)
- 3 - causes, that are not connected with pregnancy, delivery, postnatal period (11.3%)
 - 1. - uterine rupture (5.3%)
 - 5 sepsis - 4.1%
 - extra-uterine pregnancy - 2.4%

70% of cases of maternal ~~mortality~~ ^{death} could have been prevented - High risk pregnant women should have been identified at an earlier stage

Contacts between obstetricians - gynecologists, their joint activities should be closer, their attention should be paid to family planning, so that to prevent unjustifiable pregnancies. Medical care should be organized on a stage by stage basis, education of people, rehabilitation of women with acute genital diagnosis of those, who difficult pregnancy & labor; training of doctors, updating them.

suggestions

To implement everywhere the Project (Programme) on decreasing mortality rate among pregnant women, women in childbirth. The high risk pregnant women should be monitored according to this programme.

All the maternity hospitals should be provided with this programme by the Chief obstetrician's - gynaecologist of municipal health care centres & District health care centres.

At the hospital treatment of pregnant women & monitoring them should be done in accordance with existing recommendations.

Obstetricians gynaecologist of the women consulting centres should provide maternity hospitals with the Programme on decreasing mortality rate among pregnant women in childbirth.

Family planning issues should be the focus of these works with the idea of preventing undesirable pregnancies, use of contraceptives should become common.

In the hospital - optimal management of labor should be introduced.

Women working at the med-industrial enterprises should be provided with better medical services, proper organization of the work of district gynaecology department attached to the enterprise, obstetricians, measures of occupational rehabilitation.

Women with after abortion complications should be referred to specialized clinics in a due time or other medical establishments where a highly qualified assistance would be rendered.

- Due attention should be given to women in labor with extra-uterine diseases, those who suffered of miscarriage complications during the pregnancy. Physical therapy & physiotherapy should be provided.

Ministry of Public Health of the Republic of Kazakhstan
Republic Scientific - Research Center
for Maternity & Child Care

Program
of mortality control in pregnant,
puerpera and women in childbirth.

Alma - Ata, 1990

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Risk group is based on the following main stages:

Stage I - Women's dispensaries.

1. Diagnosis of a risk - group pregnancy with evaluation of degree of the risk at 12, 28-32, 33 weeks of pregnancy and dispensarisation (preventive medical examination). (Annex.I)
2. Evaluation of the health status jointly with other specialists to see whether full - term pregnancy is possible.
3. Compiling the individual plan of handling of the pregnancy with considerations to the risk degree.
4. Estimation of the date and the place of advanced admittance with regard to degree of the risk.

Stage II - Obstetric hospital.

1. Specification of the degree of risk and prognosis of obstetric complications.

These are the main risk factors of:

- obstetric haemorrhages: anemias, multiple birth, abortions, late toxicosis of pregnancy,
- septic complications: acute & chronic infections, non-timely cesarion sections,
- hysterorhexis: multiple birth, giant fetus, uterine scars,
- late toxicoses of pregnancy: extragenital diseases, esp, of kidneys, history of previous toxicoses.

2. Complex measures of preventive therapy.
3. Treatment of extragenital or obstetric diseases in a specialized department according to the Methodological recommendations.

4. Advanced admittance of the pregnant with different degrees of risk to the obstetric hospital rendering a highly qualified aid. High risk pregnancy women shall be hospitalized to the IV-V stage obstetric hospitals. (According to the Decree of Ministry of Health of the USSR, N1059, of October 27, 1982, the stages of medical institutions, as follows:

- I. Feldshers & Obsteric Station, Rural Delivery House, Rural Ambulance.
- II. "Utchastok" (medical area) hospitals, district hospitals.
- III. Central District hospital.
- IV. Regional Delivery House, Municipal Delivery House.
- V. Clinical Delivery House, Institute of Obstetrics & Gynecology.)

5. Thorough examination of the pregnant at the modern level, more accurate diagnosis of current obstetric & extragenital pathology, choosing the proper management of the pregnancy as well as of the optimal method of delivery.

6. Conduction of pathogenetically sound preventive treatment.

Antenatal pretreatment in risk group pregnancy:

Oleous solutions of folliculine and Dipropionate of Estraadiole 20000IU once/two times a day, nospanum (antispastic) tablets 0,04 BID or 2,0 ml of 2% solution 1m BID, glucose 40% solution, 20,0 ml,

with sigetine, 1% sol, 2,0 ml i/v, ascorbic acid 5% sol 3,0ml i/v, vitamine B6 5% sol 1.0ml i/m ascoruthine tablets 0,5 TID, cocarboxylasum (thiaminediphosphate) 0,05 or ATP (adenosine triphosphate) solution 1,0 ml i/m once a day, calcium chloride, 10% sol, 10,0 ml with glucose 40% sol 20,0 i/v, oxigene-therapy: inhalation of water saturated oxygene-air (60% V/V) mixture - 30-60 min BID, folic acid, 0,002xTID, glutaminic acid 1,0xTID or methionine, 0,25xTID, galascorbine, 0,3xTID, ferroplex tablets, 1tabxTID, trental 0,2xTID or 0,1 i/v in 250-500,0 ml of 5% glucose solution, partusysten 0,5 ml i/v in 250-500,0 ml of 5% glucose solution, theonicole, 0,15xTID or 2,0 ml once or three times a day i/v, euphylline 2,4%-5,0 ml in 40% glucose solution, i/v, once a week, fresh plasma 150 ml i/v (if the blood total proteins show below 6 mg%), prevetion of respiratory disfunction syndrome with corticoids (dexamethazone, 16 mg, 2 days).

7. Principles of treatment (acc. to Methodological recomendations)

- in obstetric hemorrhages:

blood loss of 1200,0 and still lasting-execute surgical method, i.e. uterine extirpation and ligation of the internal iliac arteries.

- in late toxicosis of pregnancy:

treterm abortion if the treatment of I-II stage nephropathy during 1-2 weeks, or if the intensive treatment of III st. nephropathy & preeclamply during 1-2 days are ineffective. Eclampsy is an absolute indication for Cesarean seccion.

- septic peritonitis is an indication for uterus extirpation with peritoneal drainage.

- uterine scars: regarding to scars conditions delivery through planned operation of cesarean section, before 38-39 week of pregnancy.

Stage III.

1). Rehabilitation jointly with other specialists of the postparta with extragenital pathology and with a history of obstetric complications during pregnancy and delivery.

2). Contraception.

- sick women with contrindications to full- term pregnancy.

- women with a history of many childbirth in order to make interbirth intervals longer.

Stage IV.

Organizing & clinical aspects of analysis methodology of causes of death in pregnant & periparta (Annex 3)

Risk factors	Points
I. Social & biological factors	
1. Age	
up to 19	0,2
20-29	0,1
30-34	0,2
35-39	0,3
-40	0,7
2. Body weight	
normal (Brock)	0,1
subnormal (-10-15kg)	0,4
overweight (+20kg)	0,2
3. Attendance at the women's dispansaries	
irregular	0,3
II. Obstetrical-gynecological history	
4. Late menarche	0,1
5. Menstrual cycle disturbances	-
6. History of inflammation diseases of genitals	0,1
7. Infertility	0,5
8. Myoma uteri	1,0
9. Pregnancy	
1	0,2
2-4	0,1
5-7	0,2
8	0,4
10. Child birth	
1	0,2
2-4	0,1
5-7	0,2
8	0,5
11. Birth intervals	
up to 1 year	0,3
3	0,1
more than 3	0,2
12. Medical abortions	0,1
13. Spontaneous abortions	0,2
14. Uteral scars	1,6
15. Premature birth	0,2
16. Late toxicosis of pregnancy	0,5
17. Anemia gravidarum	0,1
18. Uterine inertia	0,2
19. Obstetric hemorrhages	0,3
20. Surgical intervention during II & III periods of labors	0,1
21. Postpartal diseases	0,2

III. Extragenital diseases		
22. Diseases of cardio-vascular system:		
vitia cordis, without heart failure		0,3
vitia cordis, H.F I.		1,0
same, H.F II		2,0
heart surgery		1,0
heart muscle pathologies		0,5
hypotony		0,1
hypertonic disease, I st		0,5
- " - II-III st		1,0
23. Endocrine pathology		0,1
24. Kidney diseases		0,2
25. Respiratory diseases		0,1
26. Chronic specific diseases		0,2
IV. Current pregnancy		
27. Acute infections		0,1
28. Late toxicosis		
up to 26 weeks		2,0
27-31 weeks		1,0
32-36 weeks		0,5
37 and more		0,3
Duration up to 2 week		0,1
3-4		0,4
5		1,0
Severity (Witlinger)		
up to 6 points		0,2
8-12		0,5
14		2,0
29. Anemia		0,1
30. Jeopardizing abortion		0,2
31. Pelvic presentation		0,1
32. Preterm delivery		0,3
33. Prolonged pregnancy		0,1
34. Placental pathology		2,0
V. Delivery & postpartal periods.		
35. Un-timely effusion of amniotic waters		0,1
36. Uterine inertia		0,4
37. Uterine hyperactivity		0,2
38. Contracted pelvis (clinically)		0,2
39. Abnormal cranial inclination		0,2
40. Cesarean seccion		1,5
41. Surgical intervention during II period		0,3
42. Obstetric hemorrhages		2,0
43. Surgical interventions during III period		0,2
44. Traumas of soft tissues		0,1
45. Post-partal diseases		1,0

Total: _____

Low risk group: pregnant with total estimates of 0,8 points and less, medium risk group: over 0,8 and less than 2 points, high risk: 2 point and more.

Compiled by: assist.of a professor N. Kayupova, junior researcher G. Lekerova.

Indications to artificial abortions (pursuant to the Recommendations of the USSR Ministry of Health).

Trimester I.

1. Rheumatic endo-myocarditis
2. Subacute septic endocarditis
3. Acute myocarditis (infectious, infectious & allergic)
4. Circulation (heart) failure of any stage during first trimester, in different heart diseases
5. Mythral valvular diseases with pulmonal hypertension
6. Aortal valvular diseases, with a history of decompensation
7. Multivalvular diseases, in partucular, combinations of mythral stenosis and tricuspud insufficiency
8. Post-comissuratomic patients, minor effectiveness of operation, restenosis, pulmonar hypertension, heart failure or rheumatic attack
9. Patients with heart valvular prostesis
10. Ciliary arrhythmias
11. Congenital heart & vessels defects of "blue" type
12. Congenital heart vitia with symptoms of pulmonary hypertension
13. Aortal coarctation, complicated with aneurhism
14. Hypertonic disease, IIB-III stages, perniciousse hypertention
15. Hypertonic disease, II stage with frequent crisis or/and anginal attacks
16. Renovascular hypertension
17. Pulmonary diseases, accompanied with heart-pulmonary decompensation, hemoptysis, amyloidosis of parenchymatous organs
18. Asthmatic status, uncontrollable during several days
19. Exsudative pleuritis
20. Pyelonephritis, either with renal failure or systemic hypertension, or pyelonephritis of a single kidney
21. Glomerulonephritis: hypertensive and combined types of chronic G, acute G and acumination of a chronic G, hyperazotemia, irrespective of it's cause
22. Congenital hydronephrosis, or secondary H, acquired before pregnancy, if it is bilateral; H of a single kidney
23. Pyonephrosis
24. Single kidney, with either, hyperazotemia, and/or pyelonephritis, hypertension, renal failure
25. Hyperplastic or aplastic anemia
26. Acute & chronic leucosis
27. Lymphogranulomatosis
28. Verlhoff's disease, (thrombocytopoenic purpura), severe cases, or with frequent acuminations
29. Schonlein-Genoch's disease (capillarotoxicisis), severe cases, or with frequent acuminations
30. Systemic erythomatous lupus

31. Systemic sclerodermia
32. Nodouse periarteriitis
33. Duodenal & gastric ulcer, with bleeding and/or sthenosis
34. Acute viral hepatitis
35. Chronic hepatitis, active phase
36. Chronic calculous cholecystitis with frequent attacks, cholangitis
37. Liver diseases with pronounced hepatic failure
38. Liver cyrrhosis
39. Acute pancreatitis
40. Severe cases of diabetis mellitus (i.e. with acidosis, renal complications, retinopathy)
41. Diabetes in both parents (high risk for the child)
42. Insulin-resistant diabetes, high risk of miscarriage
43. Moderate and severe cases of thyreotoxycosis if ectomy is rejected
44. Pheochromocytoma
45. Cushings syndrome, active phase, and with pronounced residual manifestations after treatment
46. Chronic cortical failure, resistant to steroid therapy

Trimester II

1. Severe heart failure, resistant to intensive therapy
2. Acute heart (left ventricle) failure pulmonary edema, esp, repeated cases; pulmonar edema in mythral stenosis patients when comissurotomy is impossible
3. Aorthic coarctation, complicated with aneurisemas
4. Hypertonic disease, III st, pernicious hyptension
5. Renovascular hypertension
6. Severe asthmatic cases
7. Pyelonephritis with renal failures or/and of a single kidney
8. Acute glomerulonephritis, chronic glomerulonephritis with renal failure
9. Single kidney with renal failure or with hydronephrosis
10. Hypoplastic & aplastic anemia
11. Acute & chronic leucosis
12. Lymphogranulomatosis
13. Acute pancreatitis
14. Tyreotoxycosis, moderate or severe, not ectimized during I trimester
15. Pheochromacytoma
16. Chronic cortical failure, resistant to steroid therapy

Organizational & clinical aspects of analysis of main causes of death in pregnant, and postparta.

I. Generals

1. Total member of dead:
 - municipal
 - rural
2. Died in hospitals:
 - regional
 - municipal
 - "utchastok"
 - feldsher & obstetric station
 - at home
3. Break-down of causes

N	Causes	Abs. figures	**
---	--------	--------------	----

- I. Related to pregnancy, labors and postpartal period
 1. Obstetric hemorrhages
 2. Sepsis
 3. Late toxicosis
 4. Uterine disruptions
 5. Embolism with amniotic waters
 6. Others (thromboembolism, air-bubble), shock (anaphylatic, posttransfusional)
- II. Non-related to pregnancy, labors, and to postpartal period
 1. Cardio-vascular diseases
 2. Other

4. Break-down by age

Age	Abs. figures	**
up to 20		
20-24		
25-29		
30-34		
35-39		
40-44		
45		

5. Obstetric history
 - First labors.
 - Non first pregnancy, but first labors.
 - Repeated labors incl. multiple
6. Died during periods of: pregnancy, in labor, post - partal
7. Medical documentation: approved forms (individual chart N111, exchange-chart of the pregnant, N___, case records - form N96).
8. Characteristics of attending doctors.

Stage-category (years)	Doctors	
	municipal	rural
up to 5		
5-14		
15-19		
20-24		
25-29		
30 and more		
II category		
I category		
supreme		

9. Time-table of obstetricians-gynecologists
10. Doctors qualification improvements (conferences, seminars, postgraduate courses etc.)
11. Analysis of maternal deaths (expert board, maternity-child committees, doctors conferences, invitation of adjacent areas specialists)

II. Women's dispensaries.

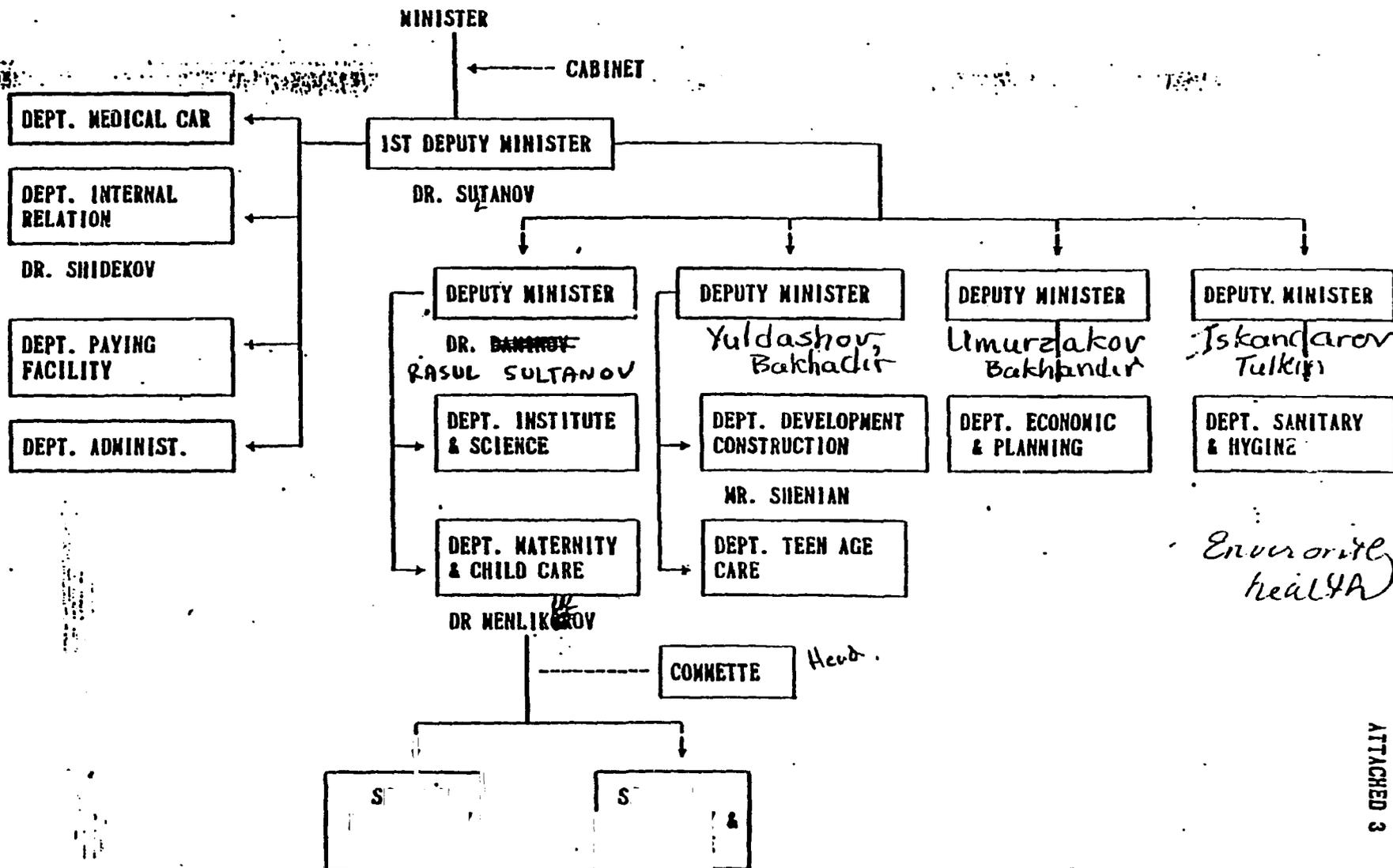
1. Capacity (number of "utchastoks", equipment, completeness, associations)
2. Relationship with general polyclinic
 - doctors consultations and examinations
 - list of women with serious extragenital pathology (should be at therapist's and gynecologist's)
3. Local relations with medical & sanitarian departments and medical stations at the industrial enterprises
4. Laboratory examination: choice of methods
5. Patronage (active attendance, Red Cross activity etc.)
6. Prophylactic examinations on regular basis (early stages, after 28 weeks, didn't visit at all, no information)
7. Regularity of visits to see a doctor
8. Examinations by specialists (terms of pregnancy, DS)
9. Indications for abortion
10. Attendance by a doctor, by an accouchee
11. Attendance by a visiting medical team member
12. Nutrition schedule
13. Psycho-prophylactic preparation of the pregnant to labors
14. Evaluation of risk factors, calculated in points

III. Hospital.

1. Number of beds for pathological pregnancy
2. Sanation of the pregnant (up to 28 weeks) in relevant departments of the hospital
3. Timely admittance to the hospital of the pregnant with obstetric & extragenital pathology
4. Timely admittance to the hospital with preventive purposes
5. Refuse from admittance
6. Availability of a medical specialists of different profile
7. Laboratory & diagnostic capacities
8. Organization of syndromal therapy in urgent cases
9. Anesthesiology & reanimatology services
10. Organization of blood service
11. Medical aviation (quantity & quality of calls)
12. Plan & prognosis of labors
13. Consultations by the head of the department, deputy doctor-in-chief, assistants to professors
14. Timely decision on abortion
15. Labor conducted by a doctor, by a midwife
16. Timely doctors calls in complicated labors
17. Concern for indications and contra-indications for changing hospital
18. Timely conducted operations: cesarean section, supravaginal amputation of uterus, uterine extirpation.
19. Readiness of a hospital for urgent surgeries
20. Timely control of shock, anemia, blood transfusion
21. Correctness and accuracy of labors records (duration, operations, blood transfusion protocols etc.)
22. Autopsy:
 - diagnosis of the disease
 - correspondence of the clinical DS to patho-anatomical one

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ORGANIZATION CHART MINISTRY OF HEALTH PROTECTION



APPENDIX H

Materials to be Translated for the Seminar for Maternal Health

"Effective Care in Pregnancy and Childbirth: A Synopsis for Guiding Practice and Research" by Chalmers, Enkin and Kierse from Effective Care in Pregnancy and Childbirth

Excerpts from Making Motherhood Safe by Tinker, et al.

Excerpts from WHO material on the Partograph (from WHO)

Excerpts from WHO booklet on Obstetric Hemorrhage (from WHO)

Pregnant Woman's Bill of Rights

APPENDIX I

Materials to be Provided at the Seminar for Maternal Health

Safe Motherhood Newsletter (from WHO)

MotherCare Matters (from MotherCare)

"Effective Care in Pregnancy and Childbirth: A Synopsis for Guiding Practice and Research" by Chalmers, Enkin and Kierse from Effective Care in Pregnancy and Childbirth (Provide one copy of the entire book to each MCH Institute)

Excerpts from Making Motherhood Safe by Tinker, et al. (being translated in Alma Ata)

WHO material on the Partograph (from WHO)

WHO booklet on Obstetric Hemorrhage (from WHO)

Article(s) about the safety of letting families into the hospital and protective clothing and procedures in the nurseries (Speaker will need to find this)

WHO book on hypertensive disorders of pregnancy (Speaker needs to look at it this to see if it is appropriate)

Pregnant Woman's Bill of Rights (Speaker or ACNM can provide)

Videos which show family centered care (for showing during the seminar)

APPENDIX J

USAID/Alma Ata Cable with MCH Seminar Plans

OR INTL DEV. TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A 02195 01 OF 09 230704Z 5957 040013 AID3133
ACTION GISA-02

ALMA A 02195 01 OF 09 230704Z 5957 040013 AID3133

ACTION OFFICE NONE-00
INFO NIS-03 RDA-01 STN-01 NEAL-04 POP-06 STAG-02 NDM-03
VER-02 NENA-03 NPAC-03 NFA-03 NPSI-03
/234 A4 TR 23/2125Z

INFO LOG-00 AGRE-00 AID-00 AMAD-01 CIAE-00 C-01 DODE-00
EUR-00 HNS-06 INRE-00 INR-01 IO-10 ADS-00 NSAE-00
OES-00 OIC-02 P-01 TRSE-00 /044W
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OFFICIALS RESPONSIBLE FOR MATERNAL AND CHILD HEALTH AND FAMILY PLANNING INCLUDING SENIOR POLICY MAKERS AT RESEARCH INSTITUTES, MEDICAL AND MIDWIFERY FACULTIES, AND CLINICIANS DURING VISIT NOVEMBER 2-23, 1992 TO IDENTIFY PRIORITY TOPICS, PARTICIPANTS AND SPEAKERS FOR THE SEMINAR. PAMELA PEARSON OF THE NIS TASK FORCE ALSO ACCOMPANIED THE TEAM DURING PORTIONS OF THE PLANNING VISIT. ANN VAN DUSEN, DIRECTOR RD/H AND JACK LESAR, REGIONAL MEDICAL ADVISOR FOR THE NIS BASED AT USAID/MOSCOW, JOINED USAID/ALMA ATA GDD AND TEAM FOR DEBRIEFING IN ALMA ATA DURING FINAL WEEK.

P 230705Z NOV 92
FM AMEMBASSY ALMA ATA
TO SECSTATE WASHDC PRIORITY 1610
INFO USMISSION USUM NEW YORK
USMISSION GENEVA
AMEMBASSY TASHKENT
AMEMBASSY BISHKEK
AMEMBASSY MOSCOW
CDC ATLANTA GA
AMEMBASSY ASHGABAT

UNCLAS SECTION 01 OF 09 ALMA ATA 002195

FOR NIS/TF/DINHR, RG/HEALTH, RD/POPULATION,
RD/NUTRITION
STATE FOR D/CISA, IO/T AND IO/D
CDC FOR IMPO (DAVIS)
GENEVA FOR AID REP PRESSLEY
MOSCOW FOR A. I. D. (LESAR)
STATE PLEASE PASS TO OHNS FOR OIM (BELMONT AND VOGEL)

E.O. 12356: N/A
TAGS: EAID, WHO, K2, KG, T1, TX, UZ

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON
MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA
ATA

REFS: (A) STATE 351371 (B) ALMA ATA 1662

1. THIS IS AN ACTION CABLE. SEE PARAS 11-13, 16-19,
22.

SUMMARY

2. AID'S PLANS FOR A REGIONAL MATERNAL AND CHILD HEALTH (MCH) SEMINAR FOR CENTRAL ASIA TO BE HELD IN ALMA ATA, KAZAKHSTAN JANUARY 11-15, 1993 HAVE BEEN FORMULATED DURING THE LAST THREE YEARS. IN ORDER TO EXPEDITE VISA PROCESS, MINISTRY OF HEALTH, KAZAKHSTAN WILL SPONSOR THE CONFERENCE AND ISSUE AN INVITATION LETTER FOR FOREIGN PARTICIPANTS. SEMINAR PLANNING TEAM COMPRISED OF MARY ANN ANDERSON, RD/H, ROY JACOBSTEIN, RD/POP, MARY ELLEN STANTON, MOTHERCARE/AMERICAN COLLEGE OF NURSE MIDWIVES, AND SUSAN WELSBY, WELLSTART/EXPANDED PROMOTION OF BREASTFEEDING (EPB) PROGRAM VISITED KAZAKHSTAN, KYRGYZSTAN, UZBEKISTAN AND TURKMENISTAN. THE TEAM WAS UNABLE TO VISIT TAJIKISTAN, BUT MET ED MCWILLIAMS, DEPUTY CHIEF OF MISSION, US EMBASSY DUSHANBE IN TASHKENT TO DISCUSS SEMINAR. MCWILLIAMS URGED THAT PARTICIPANTS FROM TAJIKISTAN BE INVITED AND INDICATED THAT HE WOULD FOLLOW-UP WITH HIS STAFF TO IDENTIFY APPROPRIATE MINISTRY OF HEALTH PARTICIPANTS AND TO

WORK OUT LOGISTICAL ARRANGEMENTS FOR ISSUING INVITATIONS AND TRAVEL. TEAM MET WITH USAID/ALMA ATA, US EMBASSY STAFF AND NUMEROUS MINISTRY OF HEALTH

3. THERE WAS WIDESPREAD ENTHUSIASM FOR THE SEMINAR AMONG CENTRAL ASIAN HEALTH OFFICIALS BUT CONCERN WAS EXPRESSED BY SOME THAT MORE IMPORTANTLY THE SEMINAR SHOULD BE FOLLOWED-UP BY CONCRETE FINANCIAL ASSISTANCE FROM A. I. D. TO ADDRESS SOME OF THE NEEDS DISCUSSED. WITHIN THE BROAD TOPIC OF MATERNAL AND CHILD HEALTH THERE WAS FURTHER AGREEMENT TO FOCUS ON MATERNAL AND NEONATAL HEALTH, BREASTFEEDING, AND FAMILY PLANNING NEEDS AS IDENTIFIED IN TEAM'S VISIT TO A NUMBER OF POLYCLINICS, MATERNITY HOSPITALS, WOMEN'S CONSULTATION AND FAMILY PLANNING CLINICS. NEXT STEPS ARE: A) TO ISSUE INVITATION LETTERS TO CENTRAL ASIA PARTICIPANTS THE TEXT OF WHICH WILL BE SENT BY USAID/ALMA ATA IN SEPTELS TO CENTRAL ASIA EMBASSIES FOR TRANSMISSION TO MINISTRY OF HEALTH UNDER U.S. AMBASSADOR'S SIGNATURE; B) TO ISSUE INVITATION LETTERS TO DONORS (USAID/ALMA

ATA ACTION); AND C) TO CONFIRM OUTSIDE SPEAKERS AND FUNDING ARRANGEMENTS (RD/H, RD/POP, RD/N AND ACTION).
END SUMMARY.

OBJECTIVES OF MCH SEMINAR

4. A) PRESENT AND EXCHANGE CURRENT KNOWLEDGE IN MATERNAL AND NEONATAL HEALTH, BREASTFEEDING AND FAMILY PLANNING BETWEEN U.S. AND CENTRAL ASIAN PARTICIPANTS; B) REVIEW AND COMPARE DEFINITIONS OF KEY MATERNAL AND INFANT HEALTH INDICATORS IN CENTRAL ASIAN COUNTRIES WITH INTERNATIONALLY USED (WORLD HEALTH ORGANIZATION- WHO) DEFINITIONS AND DETERMINE IF ANY REVISIONS ARE NEEDED IN CENTRAL ASIAN INDICATORS FOR INTERNATIONAL COMPARABILITY.

5. MCH SE
MINAR AGENDA AND PROPOSED SPEAKERS
(INTERNATIONAL SPEAKERS NEED TO BE CONFIRMED BY AID/W

UNCLASSIFIED

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AGENCY FOR INT'L DEV. TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A #2195 #2 OF 09 230704Z 6340 040023 AID3210
ACTION CISA-02

ACTION OFFICE NONE-00
INFO NIS-03 RDA-01 STN-01 HEAL-04 POP-06 STAG-02 MDIN-03
NER-02 NEHA-03 NPAC-03 NFA-03 NPSI-03
/034 A4 TR 23/2141Z

INFO LOG-00 AGRE-00 AID-00 AMAD-01 CIAE-00 C-01 DODE-00
EUR-00 HMS-06 INRE-00 INR-01 IO-19 ADS-00 NSAE-00
OES-00 OIC-02 P-01 TRSE-00 /044W
-----709613 230844Z /22

P 230705Z NOV 92
FM AMEMBASSY ALMA ATA
TO SECSTATE WASHDC PRIORITY 1611
INFO USMISSION USUN NEW YORK
USMISSION GENEVA
AMEMBASSY TASHKENT
AMEMBASSY BISHKEK
AMEMBASSY MOSCOW
CDC ATLANTA GA
AMEMBASSY ASHGABAT

UNCLAS SECTION 02 OF 09 ALMA ATA #02195

FOR NIS/TF/DINHR, RD/HEALTH, RD/POPULATION,
RD/NUTRITION
STATE FOR D/CISA, IO/T AND IO/D
CDC FOR IHPO (DAVIS)
GENEVA FOR AID REP PRESSLEY
MOSCOW FOR A. I. D. (LESAR)
STATE PLEASE PASS TO DHNS FOR OIM (BELMONT AND VOGEL)

E.O. 12356: N/A
TAGS: EAID, WHO, KI, KG, TI, TX, UZ

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON
MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA
ATA

AND CENTRAL ASIA SPEAKERS BY USAID/ALMA ATA):

MONDAY, JANUARY 11

08:00-09:00 REGISTRATION

09:00-09:30 WELCOME AND INTRODUCTIONS BY CHAIRPERSON
- US AMBASSADOR, WILLIAM COURTNEY
- USAID DIRECTOR, CRAIG BUCK
- MINISTER OF HEALTH, KAZAKHSTAN,
VASILII N. DEVIATKO

09:30-09:50 KEYNOTE ADDRESS

BARBARA TURNER, AID/WASHINGTON, NIS TASK
FORCE

09:50-10:00 INTRODUCTORY REMARKS BY CHAIRPERSON

10:00 COUNTRY PRESENTATIONS ON MATERNAL AND
CHILD HEALTH AND FAMILY PLANNING

10:00-10:15 KAZAKHSTAN
10:15-10:30 DISCUSSION
10:30-11:00 BREAK
11:00-11:15 KYRGYZSTAN
11:15-11:30 DISCUSSION

11:30-11:45 TAJIKISTAN
11:45-12:00 DISCUSSION
12:00-12:15 TURKMENISTAN

ALMA A #2195 #2 OF 09 230704Z 6340 040023 AID32

12:15-12:30 DISCUSSION
12:30-12:45 UZBEKISTAN
12:45-1:00 DISCUSSION
1:00-2:00 LUNCH AND EXHIBITS
2:00-2:30 REDUCING MATERNAL MORTALITY: THE SAFE
MOTHERHOOD INITIATIVE

JUDITH ROOKS (CONSULTANT)

2:30-2:45 DEFINITIONS OF MATERNAL AND INFANT HEALTH
INDICATORS

MARK BELSEY, WORLD HEALTH ORGANIZATION

2:45-3:00 DISCUSSION

3:00-3:30 EFFECTIVE CARE IN PREGNANCY & CHILDBIRTH
BASED ON OUTCOMES RESEARCH

TIM JOHNSON, JOHNS HOPKINS UNIVERSITY

3:30-4:00 BREAK

4:00-4:15 EFFECTIVE CARE IN PREGNANCY AND
CHILDBIRTH (CONTINUED)

4:15-4:30 DISCUSSION

4:15-5:30 DISCUSSION GROUPS ON DEFINITIONS OF MCM
INDICATORS AND EFFECTIVE PREGNANCY AND
CHILDBIRTH CARE (4 GROUPS)

TUESDAY, JANUARY 12

09:00 PREPREGNANCY AND PRENATAL CARE
09:00-09:30 - CONTENT JUDITH ROOKS (CONSULTANT)

09:30-09:50 - RISK ASSESSMENT TIM JOHNSON, JOHNS
HOPKINS UNIVERSITY

09:50-10:10 - RISK ASSESSMENT IN CENTRAL ASIA
NINA KAYUPOVA, REPUBLICAN SCIENTIFIC
RESEARCH INSTITUTE ON MATERNAL AND
CHILD HEALTH, KAZAKHSTAN

10:10-10:30 DISCUSSION

UNCLASSIFIED

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TELEGRAM

AGENCY FOR INT'L DEV.
TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A 02195 03 OF 09 230705Z 5059 040014 AID3134
ACTION CISA-02

2:45-3:00

ALMA A 02195 03 OF 09 230705Z 5059 040014 AID3134
DISCUSSION

ACTION OFFICE NONE-00
INFO HIS-03 ROAA-01 STM-01 HEAL-04 POP-06 STAG-02 NDM-03
NER-02 NENA-03 NPAC-03 NFA-03 MPSI-03
/034 A4 TR 23/2126Z

3:00-3:30

INFECTION CONTROL AND FAMILY
INVOLVEMENT IN MATERNITY SERVICES

JUDITH ROOKS (CONSULTANT)

INFO LOG-00 AGRE-00 AID-00 AMAD-01 CIAE-00 C-01 DODE-00
EUR-00 HNS-06 INRE-00 INR-01 10-10 ADS-00 NSAE-00
OES-00 OIC-02 P-01 TRSE-00 /044M

3:30-4:00

BREAK

4:00-5:30

DISCUSSION GROUPS ON STRATEGIES FOR
REDUCTION OF MATERNAL MORBIDITY
(INCLUDING ANEMIA) AND MORTALITY (4
GROUPS)

P 230705Z NOV 92
FM AMEMBASSY ALMA ATA
TO SECSTATE WASHDC PRIORITY 1612
INFO USMISSION USUN NEW YORK
USMISSION GENEVA
AMEMBASSY TASHKENT
AMEMBASSY BISHKEK
AMEMBASSY MOSCOW
CDC ATLANTA GA
AMEMBASSY ASHGABAT

WEDNESDAY, JANUARY 13

UNCLAS SECTION 03 OF 09 ALMA ATA 002195

FOR HIS/TF/DINHR, RD/HEALTH, RD/POPULATION,
RD/NUTRITION
STATE FOR D/CISA, IO/Y AND IO/D
CDC FOR IMPO (DAVIS)
GENEVA FOR AID REP PRESSLEY
MOSCOW FOR A. I. O. (LESAR)
STATE PLEASE PASS TO DHNS FOR DIM (BELMONT AND VOGEL)

9:00-10:00

CARE OF THE NEWBORN
- THERMAL CONTROL
- ASPHYXIA
- PREMATURITY/LOW BIRTH WEIGHT
- RESPIRATORY INFECTIONS, SEPSIS,
MENINGITIS
- OPHTHALMIA NEONATORUM

10:00-10:30

MARK BELSEY, WORLD HEALTH ORGANIZATION
DISCUSSION

10:30-11:00

BREAK

11:00-12:00

HEALTH AND ECONOMIC BENEFITS OF

BREASTFEEDING AND GLOBAL PATTERNS IN
BREASTFEEDING PRACTICES

TICES

CHLOE O'GARA, WELLSTART

E. O. 12356: N/A
TAGS: EAID, WMO, NZ, NG, TI, TX, UZ

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON
MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA
ATA

12:00-12:15

DISCUSSION

12:15-12:30

MATERNAL NUTRITION, BREASTFEEDING
PRACTICES AND LACTATION PERFORMANCE

10:30-11:00 BREAK

11:00-11:30 MATERNITY CARE: PRIORITIZATION OF
COMPONENTS BASED ON COST-
EFFECTIVENESS AND PREVALENCE OF
NEGATIVE OUTCOMES

12:30-12:45

MATERNAL NUTRITION, BREASTFEEDING
PRACTICES AND LACTATION PERFORMANCE
IN CENTRAL ASIA

TIM JOHNSON, JOHNS HOPKINS UNIVERSITY

GULNARA MAKAROVNA SEMENOVA, SCIENTIFIC

11:30-11:45 DISCUSSION

11:45-12:15 MATERNAL NUTRITION: PREVENTION AND
TREATMENT OF ANEMIA IN WOMEN OF
REPRODUCTIVE AGE

MARY ANN ANDERSON, AID/WASHINGTON,
OFFICE OF HEALTH

12:15-12:30 DISCUSSION

12:30-1:00 INTRAPARTUM CARE: THE PARTOGRAPH AS A
TOOL FOR MONITORING PROGRESS OF LABOR

JUDITH ROOKS (CONSULTANT)

1:00-2:00 LUNCH AND EXHIBITS

2:00-2:15 DISCUSSION

2:15-2:45 POSTPARTUM CARE: PREVENTION AND

TREATMENT OF HEMORRHAGE

TIM JOHNSON, JOHNS HOPKINS UNIVERSITY

UNCLASSIFIED

TELEGRAM

AGENCY FOR INT'L DEV. TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A 02195 #4 OF 09 230705Z 5962 040015 A103135 ACTION C15A-02

ALMA A 02195 #4 OF 09 230705Z 5962 040015 A103135 AUDREY HAYLOR, WELLSTART

ACTION OFFICE NONE-00 INFO NIS-03 ADAA-01 STN-01 NEAL-04 POP-06 STAG-02 NDIM-03 NER-02 NEMA-03 NPAC-03 NFA-03 NPS1-03 /034 A4 TR 23/2127Z

4:45-5:15 - POLICY CHANGE, MOTHER-TO-MOTHER SUPPORT GROUPS AND EDUCATION OF FAMILIES

INFO LOG-00 AGRE-00 AID-00 AMAD-01 CIAE-00 C-01 DODE-00 EUR-00 HNS-06 INRE-00 INR-01 IO-19 ADS-00 NSAE-00 QES-00 OIC-02 P-01 TRSE-00 /044V

CHLOE O'GARA, WELLSTART

5:15-5:30 DISCUSSION

P 230705Z NOV 92 FM AMEMBASCY ALMA ATA TO SECSTATE WASHDC PRIORITY 1613 INFO USMISSION USUH NEW YORK USMISSION GENEVA AMEMBASSY TASHKENT AMEMBASSY BISHKEK AMEMBASSY MOSCOW CDC ATLANTA GA AMEMBASSY ASHGABAT

THURSDAY, JANUARY 14 9:00 ROOMING-IN AT MATERNITY HOSPITALS AND BREASTFEEDING PROMOTION

UNCLAS SECTION 04 OF 09 ALMA ATA 002195

9:00-9:15 - TURKMENISTAN VICTOR E. RADZINSKY, REPUBLICAN SCIENTIFIC RESEARCH INSTITUTE ON MOTHER'S AND CHILD'S HEALTH PROTECTION

FOR NIS/TF/DINHR, RD/HEALTH, RD/POPULATION, RD/NUTRITION STATE FOR D/CISA, IO/T AND IO/D CDC FOR INPO (DRAVIS) GENEVA FOR AID REP PRESSLEY MOSCOW FOR A. I. D. (LESAR) STATE PLEASE PASS TO DUNS FOR DIN (BELMONT AND VOGEL)

9:15-9:30 - KAZAKHSTAN MASHKEEV AUKEN, REPUBLICAN SCIENTIFIC RESEARCH INSTITUTE ON PEDIATRICS

E.O. 12356: N/A TAGS: EAID, WHO, NZ, KG, TI, TX, UZ

9:30-10:00 BREASTFEEDING PROMOTION IN POLAND KRYSZYNA MIKIEL-KOSTRYA, MATERNAL AND CHILD HEALTH INSTITUTE, POLAND

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA ATA

10:00-10:30 DISCUSSION

CENTER ON REGIONAL NUTRITION PROBLEMS

10:30-11:00 BREAK

12:45-1:00 DISCUSSION

11:00-12:00 DISCUSSION GROUPS ON BREASTFEEDING PROMOTION (4 GROUPS)

1:00-2:00 LUNCH

12:00-12:45 IMPACT AND BENEFITS OF FAMILY PLANNING ON HEALTH

2:00-2:45 ENVIRONMENTAL CONTAMINATION OF BREASTMILK

ALLEN MARGOLIS, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

AUDREY HAYLOR, WELLSTART

12:45-1:00 DISCUSSION

2:45-3:00 ENVIRONMENTAL CONTAMINATION OF BREASTMILK IN UZBEKISTAN

ORCHAN HACHMUDOV, REPUBLICAN SCIENTIFIC RESEARCH INSTITUTE OF PEDIATRICS, UZBEKISTAN

3:00-3:30 DISCUSSION

3:30-4:00 BREAK

4:00 EFFECTIVE BREASTFEEDING PROMOTION PROGRAMS

4:00-4:45 - CHANGING LACTATION MANAGEMENT

PRACTICES IN MATERNITY SERVICES AND TRAINING OF HEALTH STAFF

UNCLASSIFIED

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AGENCY FOR INT'L DEV. TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A 02195 05 OF 09 230705Z 5864 040016 A103136
ACTION CISA-02

ALMA A 02195 05 OF 09 230705Z 5864 040016 A103136
PLANNING AND CONTRACEPTIVE SOCIAL
MARKETING IN TURKEY

ACTION OFFICE NONE-00
INFO NIS-03 RDA-01 STN-01 HEAL-01 POP-06 STAG-02 MDH-03
NER-02 NEHA-03 NPAC-03 NFA-03 NPSI-03
/034 A4 TR 23/2127Z

PAULA BRYAN, AID/WASHINGTON, NIS TASK
FORCE

INFO LOG-00 AGRE-00 AID-00 AMAD-01 C.AE-00 C-01 OODE-00
EUR-00 HNS-06 INRE-00 INR-01 IO-10 ADS-00 NSAE-00
OES-00 OIC-02 P-01 TRSE-00 /004M

12:15-12:30 DISCUSSION

12:30-12:45 UZBEKISTAN FAMILY PLANNING PROGRAM

DR. NORNOMHEDOV, MINISTRY OF HEALTH,
UZBEKISTAN

P 230705Z NOV 02
FM AMEMBASSY ALMA ATA
TO SECSTATE WASHDC PRIORITY 1614
INFO USMISSION USUN NEW YORK
USMISSION GENEVA
AMEMBASSY TASHKENT
AMEMBASSY BISHKEK
AMEMBASSY MOSCOW
CDC ATLANTA (C)
AMEMBASSY ASHGABAT

12:45-1:00 DISCUSSION

1:00-2:00 LUNCH

2:00-2:15 KYRGYZSTAN FAMILY PLANNING PROGRAM
TALAYBEK S. BUYLASHEV, REPUBLICAN
SCIENTIFIC RESEARCH INSTITUTE OF
OBSTETRICS AND GYNECOLOGY,
KYRGYZSTAN

UNCLAS SECTION 05 OF 09 ALMA ATA 002195

2:15-3:30 DISCUSSION GROUPS ON FAM
ILY PLANNING
(4 GROUPS)

FOR NIS/TF/DIHR, RD/HEALTH, RD/POPULATION,
RD/NUTRITION
STATE FOR D/CISA, IO/T AND IO/D
CDC FOR IHPO (DAVIS)
GENEVA FOR AID REP PRESSLEY
MOSCOW FOR A. I. D. LESAR
STATE PLEASE PASS TO DMNS FOR OIM (BELMONT AND VOGEL)

3:30-4:00 BREAK

4:00-4:30 CONFERENCE SUMMARY
JOHN W. LESAR, USAID/MOSCOW

E. D. 12356: N/A
TAGS: EAID, WHO, KZ, KG, TJ, TX, UZ

4:30-5:00 CLOSING REMARKS, APPRECIATION AND
FAREWELL

- MINISTER OF HEALTH, KAZAKHSTAN, VASILII
N. DEVIATKO
- USAID/ALMA ATA, PAULA FEENEY

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON
MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA
ATA

5:00-5:30 PRESS AVAILABILITY

CENTRAL ASIA GOVERNMENT PARTICIPANTS AND INVITATION
PROCESS

1:00-2:00 LUNCH AND EXHIBITS
2:00-3:00 WORLDWIDE EXPERIENCE & TRENDS WITH
CONTRACEPTIVES
JAMES SHELTON, AID/WASHINGTON, OFFICE
OF POPULATION

6. TEAM IDENTIFIED A LIST OF NAMES OF 12-14 SENIOR
MATERNAL AND CHILD HEALTH AND FAMILY PLANNING POLICY
MAKERS FROM THE MINISTRY OF HEALTH (MCH) AND THE
SUPREME SOVIET HEALTH COMMITTEE IN EACH COUNTRY.
THESE INCLUDE:

3:00-3:30 DISCUSSION
3:30-4:00 BREAK
4:00-5:15 NEW FAMILY PLANNING METHODS (SURGICAL
METHODS AND INTRAUTERINE DEVICES)
ALLEN MARGOLIS, UNIVERSITY OF
CALIFORNIA, SAN FRANCISCO

DEPUTY MINISTER OF HEALTH FOR MATERNAL AND CHILD
HEALTH (MCH)

5:15-5:30 DISCUSSION
7:00-8:30 RECEPTION AT U.S. EMBASSY
FRIDAY, JANUARY 15
9:00-10:30 NEW FAMILY PLANNING METHODS (HORMONAL)
JAMES SHELTON, AID/WASHINGTON, OFFICE
OF POPULATION

10:30-11:00 BREAK

11:00-11:15 DISCUSSION

11:15-12:15 EDUCATING FAMILIES ABOUT FAMILY

UNCLASSIFIED

TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A 02195 06 OF 09 230706Z 1967 040017 A103137
ACTION CISA-02

ALMA A 02195 06 OF 09 230706Z 1967 040017 A103137

ACTION OFFICE NONE-00
INFO NIS-03 RDAA-01 STN-01 HEAL-04 POP-06 STAG-02 HOIN-03
NER-02 NEHA-03 NPAC-03 MFA-03 NPSI-03
/034 44 TR 23/2120Z

INFO LOG-00 AGRE-00 AID-00 AHAD-01 CIAE-00 C-01 DODE-00
EUR-00 HNS-06 INRE-00 INR-01 IG-19 ADS-00 NSAE-00
OES-00 DIC-02 P-01 TRSE-00 /044V
-----708F15 230706Z /30

P 230705Z NOV 92
FM AMEMBASSY ALMA ATA
TO SECSTATE WASHDC PRIORITY 1615
INFO USMISSION USUN NEW YORK
USMISSION GENEVA
AMEMBASSY TASHKENT
AMEMBASSY BISHKEK
AMEMBASSY MOSCOW
CDC ATLANTA GA
AMEMBASSY ASHGABAT

UNCLAS SECTION 06 OF 09 ALMA ATA 002195

FOR NIS/TF/DINHR, RD/HEALTH, RD/POPULATION,
RD/NUTRITION
STATE FOR D/CISA, 10/7 AND 10/D
CDC FOR INPO (DAVIS)
GENEVA FOR AID REP PRESSLEY
MOSCOW FOR A. I. D. (LESAR)
STATE PLEASE PASS TO OHNS FOR OIH (BELMONT AND VOGEL)

E.O. 12356: N/A
TAGS: EAID, WHO, MZ, KG, TI, TX, UZ

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON
MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA
ATA

CHIEF OF MCH DEPARTMENT, MCH
CHIEF ADVISOR ON PEDIATRICS, MCH
CHIEF ADVISOR ON OBSTETRICS AND GYNECOLOGY, MCH
CHIEF ADVISOR ON FAMILY PLANNING, MCH
CHIEF ADVISOR ON NURSING/MIDWIFERY, MCH
DIRECTOR OF NATIONAL RESEARCH INSTITUTE ON MCH
DIRECTOR OF NATIONAL RESEARCH INSTITUTE ON PEDIATRICS
DIRECTOR OF REGIONAL RESEARCH INSTITUTE ON NUTRITION
(IN ALMA ATA AND BRANCH OFFICES IN BISHKEK, DUSHANBE
AND ASHGABAT)
DIRECTOR OF NATIONAL RESEARCH INSTITUTE ON OBSTETRICS
AND GYNECOLOGY
DIRECTOR OF NATIONAL HEALTH EDUCATION CENTER (OFTEN
KNOWN AS HOUSE OF HEALTH),

SENIOR CHAIR OF FACULTY OF PEDIATRICS
SENIOR CHAIR OF FACULTY OF OBSTETRICS AND GYNECOLOGY
SENIOR CHAIR OF FACULTY OF MIDWIFERY

SUPREME SOVIET HEALTH COMMITTEE CHAIRMAN.

7. TEXT OF ONE INVITATION LETTER BY COUNTRY WITH
NAMES OF ALL PARTICIPANTS TO BE INVITED WILL BE SENT
BY SEPTELS TO INVOLVED EMBASSIES TO TRANSLATE INTO
RUSSIAN AND SEND TO MINISTRY OF HEALTH UNDER US
AMBASSADOR'S SIGNATURE.

FOR BISHKEK: KYRGYZSTAN HAS REQUESTED THAT
INVITATION LETTER BE SENT TO DEPUTY MINISTER OF
HEALTH, KAFAR A. SUBANBAYEV.

FOR TASHKENT: UZBEKISTAN HAS REQUESTED LETTER
ADDRESSED TO FIRST DEPUTY MINISTER OF HEALTH, RAYSHAN
TULYAGANOVICH SULTANOV.

FOR ASHGABAT: TURKMENISTAN HAS REQUESTED LETTER
ADDRESSED TO MINISTER OF HEALTH AKSOLTAN TOREEVNA
ATAEVA.

FOR DUSHANBE C/O TASHKENT: SUSAN WELSBY, A. I. D.
HEALTH CONSULTANT, WILL BE IN TASHKENT NOVEMBER 23-25
AND WILL ATTEMPT TO CONTACT ED MCWILLIAMS AT U.S.
EMBASSY TO DELIVER INVITATION LETTER AND FINALIZE
ARRANGEMENTS.

8. EACH COUNTRY WILL BE REQUESTED TO MAKE A
PRESENTATION ON THE OPENING DAY OF THE SEMINAR
REGARDING ITS MATERNAL AND CHILD HEALTH AND FAMILY
PLANNING SITUATION AS INDICATED IN THE AGENDA. IN
ADDITION THE AGENDA SHOWS OTHER PRESENTATIONS WHICH
WILL BE REQUESTED OF SPECIFIC COUNTRY OFFICIALS BY
SUSAN WELSBY WHO WILL FOLLOW-UP WITH THE RELEVANT
SPEAKERS TO GUIDE THE CONTENT OF THE PRESENTATIONS.

DONOR INVOLVEMENT AND INVITATION PROCESS

9. INVITATIONS WILL BE EXTENDED BY USAID/ALMA ATA TO
UNICEF, WHO, UNFPA, EBRD, EC, RED CROSS, WORLD BANK AS
OBSERVERS TO SEMINAR. TEAM HAS RECOMMENDED TECHNICAL
INVOLVEMENT AND PARTICIPATION BY JANE SELVAGE,
MIDWIFERY SPECIALIST AND ELISABET HELSING, NUTRITION
SPECIALIST OF WHO/EURO, COPENHAGEN AND MARK BELSEY OF
MCH/FAMILY PLANNING DIVISION OF WHO/GENEVA (ALSO
PROPOSED SPEAKER) AND WILL BE CONTACTING THEM DIRECTLY
TO EXTEND AN INVITATION. DONORS WILL BE EXPECTED TO
FUND THEIR OWN TRAVEL AND MAKE THEIR OWN ARRANGEMENTS
FOR VISAS AND LOCAL LOGISTICAL SUPPORT IN ALMA ATA
INCLUDING AIRPORT TRANSPORT. USAID/ALMA ATA WILL
REQUEST MINISTRY OF HEALTH TO INCLUDE DONORS' NAMES IN
OFFICIAL SEMINAR INVITATION LETTER TO EXPEDITE VISA
PROCESS IF NAMES RECEIVED FROM DONORS IN TIME. ROOMS
HAVE BEEN RESERVED FOR DONOR PARTICIPANTS AT HOTEL
KAZAKHSTAN IN ALMA ATA AND USAID/ALMA ATA WILL REQUEST
DONORS TO CONFIRM HOTEL ROOMS ACTUALLY NEEDED. SINCE
BELSEY WILL BE REQUESTED AS A SPEAKER, RD/M
(WELLSTART/EPB) IS PREPARED TO FUND HIS TRAVEL IF

UNCLASSIFIED

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AGENCY FOR INT'L DEV. TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A 02195 07 OF 09 230706Z 0970 040010 A103130
ACTION CISA-02

ALMA A 02195 07 OF 09 230706Z 0970 040010 A103130

ACTION OFFICE NONE-00

INFO NIS-03 RDAA-01 STN-01 HEAL-01 POP-06 STAG-02 MDIH-03
NER-02 NENA-03 NPAC-03 NFA-03 NPSI-03
/034 A4 TR 23/2129Z

INFO LOG-00 AGRE-00 AID-00 AMAD-01 CIAE-00 C-01 CODE-00
EUR-00 HNS-06 INRE-00 INR-01 IO-10 ADS-01 N31E-00
OES-00 DIC-02 P-01 TRSE-00 /044W

-----700F10 230706Z /30

P 230705Z NOV 92
FM AMEMBASSY ALMA ATA
TO SECSTATE WASHDC PRIORITY 1616
INFO USMISSION USUN NEW YORK
USMISSION GENEVA
AMEMBASSY TASHKENT
AMEMBASSY BISHKEK
AMEMBASSY MOSCOW
CDC ATLANTA GA
AMEMBASSY ASHGABAT

UNCLAS SECTION 07 OF 09 ALMA ATA 002195

FOR NIS/TF/DINHR, RD/HEALTH, RD/POPULATION,
RD/NUTRITION
STATE FOR D/CISA, IO/T AND IO/D
CDC FOR INPO (OAVIS)
GENEVA FOR AID REP PRESSLEY
MOSCOW FOR A. I. D. (LESAR)
STATE PLEASE PASS TO DHHS FOR OIH (BELMONT AND VOGEL)

E.O. 12356: N/A
TAGS: EAID, WHO, XZ, NG, TI, TX, UZ

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON
MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA
ATA

NECESSAR
Y.

FUNDING ARRANGEMENTS

10. THE ESTIMATED TOTAL COST FOR THE SEMINAR WHICH IS
EXPECTED TO HAVE 110 PARTICIPANTS (80 FROM CENTRAL ASIA
AND 30 FROM ABROAD INCLUDING DONORS) IS U.S. DOLS.
175,000. RD/HEALTH HAS AGREED DURING VAN DUSEN AND
ANDERSON TDY TO CENTRALLY FUND A PART OF THE SEMINAR
COSTS UNDER PROJECT 936-1986 AGREEMENTS WITH
WELLSTART/EPB AND MOTHERCARE (JOHN SNOW INC.).
WELLSTART/EPB WILL FUND ALL LOCAL COSTS OF CENTRAL
ASIAN PARTICIPANTS' TRAVEL AND PER DIEM, CONFERENCE
HALL RENTAL, VEHICLE AND AUDIO-VISUAL EQUIPMENT
RENTAL, INTERPRETERS, REPRODUCTION AND TRANSLATION OF
DOCUMENTS, ETC. WELLSTART WILL ALSO FUND SALARY,
TRAVEL AND PER DIEM FOR WELSBY AND MIKIEL-KOSTYRA
(CONSULTANTS) AND O'GARA (STAFF), TRAVEL OF BELSEY (IF
NEEDED) AND U.S. PROCURED STATIONERY, SUPPLIES,
BREASTFEEDING BOOKS, DOCUMENTS, AUDIO-VISUALS AND
TRANSLATION FOR THE CONFERENCE. WELLSTART/EPB HAS
COMMISSIONED AND IS FUNDING A U.S.-BASED REVIEW PAPER
ON ENVIRONMENTAL CONTAMINATION AND TOXINS IN
BREASTMILK FOR THE CONFERENCE BY CONSULTANTS SALLY
LEDERMAN AND WILLIAM WICKHAM. TOTAL WELLSTART BUDGET

ESTIMATED AT U.S. DOLS. 60,461. MOTHERCARE SUPPORTED
TRAVEL BY MARY ELLEN STANTON FOR PLANNING VISIT AND
WILL FUND SALARY, TRAVEL AND PER DIEM FOR ROOKS AND

JOHNSON (CONSULTANTS) AND KOBLINSKY (STAFF) AS WELL AS
U.S. PROCURED MATERNAL AND NEONATAL HEALTH BOOKS,
DOCUMENTS, AUDIO-VISUALS AND TRANSLATION FOR THE
SEMINAR AT AN ESTIMATED TOTAL COST OF U.S. DOLS.
47,367. RD/M SUPPORTED ANDERSON TRAVEL FOR PLANNING
VISIT AND WILL ALSO SUPPORT HER RETURN TRAVEL FOR
SEMINAR AT AN ESTIMATED COST OF U.S. DOLS. 13,436.

11. USAID/ALMA ATA REQUESTS RD/POP CENTRAL FUNDING
FOR SALARIES, TRAVEL AND PER DIEM OF MARGOLIS
(CONSULTANT) AND SHELTON (STAFF) AS WELL AS U.S.
PROCURED FAMILY PLANNING BOOKS, DOCUMENTS, AUDIO-
VISUALS AND TRANSLATION FOR THE SEMINAR. ESTIMATED
COST FOR MARGOLIS U.S. DOLS. 15,355, SHELTON U.S.
DOLS. 6,000, AND FOR PLANNING TRIPS ALREADY MADE BY
JACOBSTEIN U.S. DOLS. 6,120 AND VAN DUSEN U.S. DOLS.
6,000.

12. MISSION REQUESTS RD/M CENTRAL FUNDING FOR SALARY,
TRAVEL AND PER DIEM OF NAYLOR AS KEY SPEAKER FOR
SEMINAR UNDER LACTATION MANAGEMENT EDUCATION
COOPERATIVE AGREEMENT. TRAVEL AND PER DIEM ESTIMATED
AT U.S. DOLS. 6,073.

13. USAID/ALMA ATA ALSO REQUESTS HIS TASK FORCE FUND
TRAVEL BY TURNER AND BRYAN AT AN ESTIMATED COST OF
U.S. DOLS. 12,146 AND USAID/MOSCOW SUPPORT LESAR
TRAVEL AT U.S. DOLS. 1,399.

14. ALL SPEAKERS/CONSULTANTS WILL BE EXPECTED TO BE
PRESENT FOR ENTIRE SEMINAR JANUARY 11-15 AND WILL NOT
BE APPROVED FOR SHORTER STAYS. SPEAKERS WILL ALSO BE
EXPECTED TO FACILITATE DISCUSSION GROUP SESSIONS IN
ADDITION TO THEIR PRESENTATIONS AND THIS TASK SHOULD
BE INCLUDED IN THEIR SCOPES OF WORK.

CENTRAL ASIAN PARTICIPANTS' TRAVEL, PER DIEM AND
ACCOMMODATION ARRANGEMENTS

15. TRAVEL ARRANGEMENTS FOR CENTRAL ASIA PARTICIPANTS
FROM OUTSIDE KAZAKHSTAN BY COUNTRY FOLLOW. FOR
TASHKENT: PARTICIPANTS WILL BE PROVIDED TICKETS BY
LOCAL STATISTICA STAFF WITH FUNDS FROM SUSAN WELSBY,
WELLSTART. FOR ASHGABAT: PARTICIPANTS WILL BE
REQUESTED TO PURCHASE THEIR OWN AIR TICKETS FOR WHICH
THEY WILL BE REIMBURSED UPON ARRIVAL IN ALMA ATA. FOR

UNCLAS

TELEGRAM

AGENCY FOR INT'L DEV. TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A 02195 08 OF 09 230706Z 5072 040819 AID3139 ACTION CISA-02

ALMA A 02195 08 OF 09 230706Z 5072 040819 AID3139

ACTION OFFICE NONE-00 INFO NIS-03 ROAA-01 STM-01 NEAL-04 POP-06 STAG-02 HDIM-03 NER-02 NEHA-03 NPAR-03 NFA-03 NPSI-03 /034 A4 TR 23/2129Z

INFO LOG-00 AGRE-00 AID-00 AMAO-01 CIAE-00 C-01 DODE-00 EUR-00 NNS-06 INRE-00 INR-01 IO-10 AOS-00 NSAE-00 OES-09 OIC-02 P-01 TRSE-00 /044W -----J08F20 230706Z /30

P 230705Z NOV 92 FM AMEMBASSY ALMA ATA TO SECSTATE WASHDC PRIORITY 1617 INFO USMISSION USUN NEW YORK USMISSION GENEVA AMEMBASSY TASHKENT AMEMBASSY BISHKEK AMEMBASSY MOSCOW CDC ATLANTA GA AMEMBASSY ASHGABAT

UNCLAS SECTION 08 OF 09 ALMA ATA 070295

FOR NIS/TF/DINHR, RD/HEALTH, RD/POPULATION, RD/NUTRITION STATE FOR D/CISA, 10/T AND 10/D CDC FOR IMPO (DAVIS) GENEVA FOR AID REP PRESSLEY MOSCOW FOR A. I. D. (LESAR) STATE PLEASE PASS TO DHHS FOR DIH (BELMONT AND VOGEL)

E. O. 12356: N/A TAGS: EAID, WND, K2, KG, T1, TX, UZ

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA ATA

DUSHANBE: PARTICIPANTS WILL BE REQUESTED TO PURCHASE THEIR OWN AIR TICKETS FOR WHICH THEY WILL BE REIMBURSED UPON ARRIVAL IN ALMA ATA. FOR BISHKEK: SUSAN WELSBY, WELSTART, WILL HIRE A BUS FOR TRANSPORT OF PARTICIPANTS. ALL PARTICIPANTS SHOULD ARRIVE ON JANUARY 10 AND DEPART ON JANUARY 16. STATISTICA STAFF OF USAID/ALMA ATA WILL PROVIDE TRANSPORT TO AND FROM ALMA ATA AIRPORT FOR TRAVELERS. RESERVATIONS HAVE BEEN MADE FOR ALL PARTICIPANTS AT THE HOTEL KAZAKHSTAN. THE HOTEL BILL FOR ALL CENTRAL ASIAN PARTICIPANTS AT THE LOCAL RUBLE RATE WILL BE PAID BY WELSTART (SUSAN WELSBY) IN ONE BILL RATHER THAN DISBURSING THIS AMOUNT AS PART OF PER DIEM AND PAYING INDIVIDUALLY. THE MEANS AND INCIDENTALS PORTION OF THE PER DIEM FOR CENTRAL ASIAN PARTICIPANTS WILL FOLLOW THEIR OWN GOVERNMENT RATES OF 100 RUBLES PER DAY. HOWEVER, IN ADDITION LUNCH WILL BE PROVIDED DAILY AT THE SEMINAR SITE.

TRAVEL, VISA AND ACCOMMODATION ARRANGEMENTS FOR AID/W STAFF AND EXPATRIATE SPEAKERS/CONSULTANTS

16. RESERVATIONS HAVE BEEN MADE AT HOTEL KAZAKHSTAN FOR ALL ANTICIPATED AID/W PARTICIPANTS AND CONSULTANTS. EXPATRIATES WILL BE EXPECTED TO PAY THEIR OWN HOTEL BILL IN RUBLES AT CURRENT EXCHANGE RATE EQUIVALENT OF

APPROXIMATELY \$33 PER DAY FROM THEIR PER DIEM. RATES WILL UNDOUBTEDLY INCREASE WITH HYPERINFLATION BY THE TIME OF THE SEMINAR. TRAVELERS SHOULD BRING U.S.

DOLLARS CASH AS CREDIT CARDS AND TRAVELERS CHECKS ARE NOT ACCEPTED. TRAVELERS SHOULD PLAN TO ARRIVE JANUARY 10 AND DEPART JANUARY 16. CONSIDERABLE INTERNATIONAL AIRFARE SAVINGS CAN BE REALIZED BY ROUTING TRAVELERS THROUGH MOSCOW INSTEAD OF FRANKFURT. THEREFORE THIS ROUTING IS RECOMMENDED. STAFF OF STATISTICA UNDER THEIR AGREEMENT WITH USAID MOSCOW SHOULD BE ABLE TO EXPEDITE THE TRANSIT PROCESS IN MOSCOW IF NOTIFIED SUFFICIENTLY IN ADVANCE. STATISTICA STAFF OF USAID/ALMA ATA WILL PROVIDE AIRPORT PICK-UP OF TRAVELERS IN ALMA ATA. UPON RECEIPT FROM AID/W OF A CONFIRMED LIST OF ALL AID/W PARTICIPANTS AND EXPATRIATE SPEAKERS/CONSULTANTS, USAID/ALMA ATA WILL REQUEST MINISTRY OF HEALTH, KAZAKHSTAN TO ISSUE AN INVITATION LETTER WITH ALL OF THE NAMES WHICH WE WILL FAX TO AID/W FOR PROVISION TO INDIVIDUAL TRAVELERS TO EXPEDITE THE VISA PROCESS. ALONG WITH THE NAMES WE WILL NEED TO KNOW PASSPORT NUMBER AND TYPE, DATE AND PLACE OF ISSUE AND EXPIRATION DATE FOR EACH TRAVELER ASAP.

VENUE, AUDIO-VISUAL AND INTERPRETATION SERVICES

17. THE SEMINAR WILL BE HELD AT THE ACADEMY OF SCIENCES CONFERENCE FACILITY IN ALMA ATA. IT IS EQUIPPED FOR SIMULTANEOUS INTERPRETATION WHICH WILL BE USED THROUGHOUT THE SEMINAR. THE OFFICIAL LANGUAGES

OF THE SEMINAR WILL BE RUSSIAN AND ENGLISH. SLIDE AND OVERHEAD PROJECTORS AND VIDEO CASSETTE PLAYERS WILL BE AVAILABLE. NOTE THAT THE LATTER USES THE PAL-SECAM SYSTEM. PLEASE ADVISE OF ANY OTHER REQUIREMENTS.

TRANSLATION REQUIREMENTS

18. ALL SPEAKERS ARE REQUESTED TO PREPARE WRITTEN PAPERS FOR THEIR LECTURES AND TO SUBMIT TWO COPIES OF THE PAPER ALONG WITH TWO COPIES OF ALL HANDOUTS WHICH REQUIRE TRANSLATION TO MARY ANN ANDERSON, RO/W BY DECEMBER 15 FOR ONWARD TRANSMISSION TO ALMA ATA FOR ADVANCE TRANSLATION INTO RUSSIAN. FURTHERMORE ALL VISUALS WITH TEXT SHOULD HAVE RUSSIAN SUBTITLES AND BE BROUGHT AS HARD (PAPER) COPIES TO DISTRIBUTE TO EACH PARTICIPANT. SUFFICIENT COPIES FOR 100 PEOPLE SHOULD BE BROUGHT BY SPEAKERS OR POUCHED OR SENT BY DHL BY DECEMBER 15 TO USAID/ALMA ATA. LOCAL

UNCLASSIFIED

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TELEGRAM

AGENCY FOR INT'L DEV.
TELECOMMUNICATIONS CENTER

PAGE 01 ALMA A #2195 09 OF 09 230707Z 5973 040021 A103140
ACTION CISA-SZ

ALMA A #2195 09 OF 09 230707Z 5973 040021 A103140
OR 639486 AND FAX 011-7-3272-632518 OR 011-073-151-
5439. USE LATTER FAX NUMBER ONLY IN CASE OF FAILURE
OF OTHER NUMBER AS IT IS CONSIDERABLY MORE EXPENSIVE
SATELLITE LINE. HOME TELEPHONE FOR WELSBY UNTIL MID-
DECEMBER IS 7-3272-619011.

ACTION OFFICE HOME-00
INFO HIS-03 RDRA-01 STM-01 HEAL-04 POP-06 STAG-02 NDIH-03
NER-02 NCHA-03 NPAC-03 NFA-02 NPSI-03
/034 A4 TR 23/2330Z

POUCH ADDRESS:
PAULA FEENEY
USAID/ALMA ATA
C/O AMERICAN EMBASSY
WASHINGTON, DC 20521-3830

INFO LOG-00 AGRE-00 AID-00 AMRD-01 CIAE-00 C-01 DODE-00
EUR-00 HNS-06 IMRC-00 INR-01 IO-19 ADS-00 NSAE-00
DES-00 DIC-02 P-01 TRSE-00 /044V
-----700F23 230707Z /30

P 230705Z NOV 92
FM AMEMBASSY ALMA ATA
TO SECSTATE WASHDC PRIORITY 1618
INFO USMISSION USUN NEW YORK
USMISSION GENEVA
AMEMBASSY TASHMENT
AMEMBASSY BISHKEK
AMEMBASSY MOSCOW
CDC ATLANTA GA
AMEMBASSY ASHGABAT

DHL ADDRESS:
SUSAN WELSBY
USAID REGIONAL MISSION FOR CENTRAL ASIA
97A, FURMANOV STREET
ALMA-ATA, KAZAKHSTAN

ACTIONS REQUESTED

UNCLAS SECTION 09 OF 09 ALMA ATA 002195

FOR HIS/TF/DINHR, RD/HEALTH, RD/POPULATION,
RD/NUTRITION
STATE FOR D/CISA, IO/T AND IO/D
CDC FOR IMPO (DAVIS)
GENEVA FOR AID REP PRESSLEY
MOSCOV FOR A. I. D. (LESAR)
STATE PLEASE PASS TO DKMS FOR OIM (BELMONT AND VOGEL)

22. PLEASE CONFIRM RD/H, RD/POP, RD/H AND HIS/TF
FUNDING OF CONSULTANTS AND STAFF TRAVEL. CABLE NAMES
AND PASSPORT DATA FOR ALL OUTSIDE PARTICIPANTS, POUCH
OR OML WRITTEN SPEECHES, HANDOUTS, PRESS KIT MATERIALS
BY DECEMBER 15. ADVISE ON ANY SPECIAL AUDIO-VISUAL
REQUIREMENTS.
23. USAID/ALMA ATA WISHES TO EXPRESS ITS DEEPEST

E.O. 12356: N/A
TAGS: EAID, WHO, KZ, KG, TI, TX, UZ

SUBJECT: HEALTH: CENTRAL ASIA REGIONAL SEMINAR ON
MATERNAL AND CHILD HEALTH, JANUARY 11-15, 1993, ALMA
ATA

APPRECIATION FOR RD/H LEADERSHIP AND FINANCIAL SUPPORT
IN ORGANIZING THE SEMINAR, PARTICULARLY MARY ANN
ANDERSON. USAID WISHES TO THANK PAMELA PEARSON OF THE
HIS/TF FOR HER VALUABLE INPUT DURING THE TEAM'S FIELD
WORK. ALSO USAID IS GRATEFUL FOR RD/POP'S CONTINUED
INVOLVEMENT, INCLUDING THE PARTICIPATION OF ROY
JACOBSTEIN AND THE FUNDING FOR ANN VAN DUSEN FOR THE
PLANNING VISIT. THE MISSION COMMENDS THE
COLLABORATION OF RD/HEALTH, RD/POP, RD/NUTRITION AND
THE HIS/TF/DINHR IN THIS IMPORTANT INITIATIVE. WE
LOOK FORWARD TO A SUCCESSFUL SEMINAR.
COURTNEY

REPRODUCTION SERVICES ARE LIMITED AND PAPER SHORTAGES
ACUTE SO SHOULD NOT BE RELIED UPON. REQUIREMENT WILL
BE FOR 80 COPIES IN RUSSIAN AND 30 COPIES IN ENGLISH.

PRESS KIT

18. RD/H, POP AND N ARE REQUESTED TO ASK THEIR
COOPERATING AGENCIES TO CONTRIBUTE BRIEF STATEMENTS ON
THE TECHNICAL AREAS TO BE DISCUSSED AT THE SEMINAR FOR
A PRESS KIT. USAID/ALMA ATA WOULD APPRECIATE
WELLSTART/EPB TAKING THE LEAD ON PULLING THE
INDIVIDUAL SUBMISSIONS TOGETHER INTO ONE KIT THAT
SHOULD BE POUCHED OR SENT BY DHL TO USAID BY DECEMBER
15 FOR TRANSLATION.

CONTACT NUMBERS AT USAID/ALMA ATA

20. SUSAN WELSBY, M.D., MPH, IS RESIDENT IN ALMA ATA
AND HAS BEEN EMPLOYED BY WELLSTART TO OVERSEE LOCAL
SEMINAR ARRANGEMENTS AND FOLLOW-UP NOVEMBER 2, 1992-
FEBRUARY 26, 1993. SHE IS AVAILABLE FOR RETURN VISITS
TO OTHER CENTRAL ASIA COUNTRIES FOR CONFERENCE SEMINAR
PREPARATION AND FOLLOW-UP AS NEEDED.

21. SUSAN WELSBY OR ALTERNATE PAULA FEENEY,

USAID/ALMA ATA GDO, TELEPHONE NUMBERS (S1 HOURS AHEAD
OF WASHINGTON) AT USAI
D OFFICE ARE 011-7-3272-638267

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