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# OPTIONS

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**REPRODUCTIVE HEALTH SERVICES EXPANSION PROGRAM (RHSEP):**

**STRATEGY FOR ASSISTANCE**

**for**

**Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan**

**MARCH 1994**

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ABBREVIATIONS

AVSC	Association for Voluntary Surgical Contraception
CAR	Central Asian Republics comprised of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan
CAs	Cooperating Agencies
CT	Contraceptive Technology
DHS	Demographic Health Survey
FH	Family Health
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IEC	Information, Education and Communication
IUD	Intrauterine Device
IPPF	International Planned Parenthood Federation
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/PCS	Johns Hopkins University/Population Communication Services
MCH/FP	Maternal Child Health/Family Planning
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NIS	Newly Independent States
OCs	Oral Contraceptives
OPTIONS	OPTIONS for Population Policy Project of The Futures Group
RHSEP	Reproductive Health Services Expansion Program
SOMARC	Social Marketing for Change Project of The Futures Group
TOT	Training of Trainers
UNFPA	United Nations Fund for Population Assistance
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USIA	United States Information Agency
WHO	World Health Organization

## EXECUTIVE SUMMARY

In 1993 and early 1994, the U.S. Agency for International Development (USAID) sponsored a team composed of cooperating agencies' staff to conduct a general assessment of the Central Asian Republics' (CAR) contraceptive services. The Reproductive Health Services Expansion Program (RHSEP) team included representatives from USAID; Newly Independent States (NIS) Task Force; The Futures Group (TFG) OPTIONS and Social Marketing for Change (SOMARC) Projects; the Johns Hopkins University Program for International Education in Reproductive Health (JHPIEGO); the Johns Hopkins University Population Communication Services (PCS); the Association for Voluntary Surgical Contraception (AVSC); and the Demographic and Health Survey (DHS) Project. The team conducted several visits and traveled to Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan to study family health<sup>1</sup> care systems. The goal of the assessment was to develop a package of activities to assist the Ministries of Health (MOHs) of the CAR in strengthening family health and contraceptive services with the support of USAID and its cooperating agencies (CAs). As a result of the assessment, the team drafted the program presented in this document.

The assessment revealed that a significant demand for fertility regulation exists in the CAR, but this demand is not adequately met. Demand is greatest among urban women of European ethnic origin, who tend to be better educated, belong to higher socio-economic groups, desire smaller families, and who are easier to reach through the existing infrastructure than rural women. Urban Central Asian ethnic women also desire smaller families than their rural counterparts. Rural populations, both of European and Central Asian ethnic origin, desire large families.

Many women -- particularly European ethnic urban women -- rely on abortion as a primary means of fertility regulation. Contraceptive supplies are in demand but not available due to the lack of supply and distribution channels. Available contraceptives are often of low quality. Lack of training in contraceptive delivery, especially in counseling, is another important obstacle to the expansion of contraceptive services.

Substitution of contraceptive use for abortion would have an immediate positive impact on reproductive health in the region. Maternal mortality and secondary infertility are important public health problems that are exacerbated by the high incidence of poorly-performed abortions. Strong government support exists for expanding the availability of high quality reproductive health and family planning services as a means to replace abortion.

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<sup>1</sup> In this program, the term *family health* is interchangeable with the term *family planning*. Due to the negative connotation associated with the word *planning* in post-Communist societies, the governments of Central Asia prefer the use of the term *family health*.

DRAFT DOCUMENT FOR MISSION REVIEW

This document lays out a strategy of technical assistance funded by USAID to be carried out by the CAs who participated in the assessment. These activities are organized into five program areas, including: 1) Creating a Favorable Political Environment; 2) Strengthening MOH's Institutional Capacities to Plan and Delivery FH Services; 3) Diversifying Contraceptives Sources and Broadening the Method Mix; 4) Training Providers and Strengthening the MOHs' Institutional Capacities to Train Family Health Services Workers; and 5) Educating clients.

The following table outlines the activities to be conducted by each of the CAs to strengthen the CAR family health programs.

Table 1

PROJECT SUMMARY

COOPERATING AGENCIES (CAs)	GENERAL MANDATE OF CAs	PROPOSED CAR ACTIVITIES	FUNDING LEVEL	DURATION/ START DATE
<p><b>AVSC</b></p> <p>79 Madison Avenue New York NY 10016 tel: (212) 561-8000</p>	<p>AVSC's work around the world emphasizes high quality service delivery of contraceptive methods that require medical procedures. This includes: female sterilization, vasectomy, implants, IUDs and injectables</p>	<ul style="list-style-type: none"> <li>▪ Shipment of posters</li> <li>▪ Assessment of site needs (including inventory of existing equipment and pricing of equipment, supplies, and contraceptive needs)</li> <li>▪ Procurement and shipping of contraceptives for training purposes and of other related supplies and equipment</li> <li>▪ Two weeks service delivery training program and clinical/counseling</li> <li>▪ Medical overnight</li> <li>▪ Design 1-8 model service/training centers (at least 1 in each republic)</li> <li>▪ Examine and revise national medical guidelines for reproductive health</li> </ul>	<p>\$ 950,000</p>	<p>18 months/ October 1993</p>
<p><b>DHS III</b></p> <p>11785 Beltsville Dr. Suite 300 Calverton MD 20705-3119 tel: (301) 572-0200</p>	<p>DHS III improves the information base for family planning and health program management through conducting demographic and health sample surveys. It also provides limited technical assistance in survey operations and data analysis</p>	<ul style="list-style-type: none"> <li>▪ Development and implementation of one DHS on a national sample of 5000 ever-married women of reproductive age to provide critical baseline data for strategic planning and program evaluation</li> </ul>	<p>\$</p>	<p>24 months/ October 1993</p>
<p><b>JHPIEGO</b></p> <p>Brown's Warf 1615 Thames Street Suite 200 Baltimore MD 21231 tel: (410) 955-4332</p>	<p>JHPIEGO trains physicians, nurses, midwives, and medical administrators in family planning. The agency works closely with medical and nursing schools to incorporate family planning into their basic curricula and to design continuing education activities for clinicians. JHPIEGO develops training of trainers skills</p>	<ul style="list-style-type: none"> <li>▪ Examine and revise national medical guidelines for reproductive health</li> <li>▪ Conduct preliminary training assessment</li> <li>▪ Minilap training tour to the Philippines</li> <li>▪ Minilap training in region</li> <li>▪ Training of trainers skill development course</li> </ul>	<p>\$ 580,000</p>	<p>18 months/ October 1993</p>

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<p><b>TFG/OPTIONS II</b></p> <p>1050 17th Street NW Suite 1000 Washington DC 20036 tel: (202) 775-9680</p>	<p>OPTIONS activities are designed to support the policy development process and help countries formulate comprehensive national family planning policies that endorse and encourage family planning and mobilize resource support.</p>	<ul style="list-style-type: none"> <li>■ Observation study tours to Turkey and USA for key policy makers</li> <li>■ Provider Surveys in each country</li> <li>■ Family Health policy Symposium in each country</li> <li>■ Training in each country on utilization of data for program planning</li> <li>■ Examine and revise national medical guidelines for reproductive health</li> <li>■ Legal and regulatory analyses</li> <li>■ Strategic planning and supporting research</li> </ul>	<p>\$ 1,525,000</p>	<p>36 months/ June 1993</p>
<p><b>PCS</b></p> <p>111 Market Place Baltimore MD 21202 tel: 410-659-6239</p>	<p>PCS provides assistance to identify the communication needs of family planning programs. PCS conducts surveys and qualitative studies to assess consumer needs and desires, it designs and implements mass media campaigns, develops promotional materials and conducts education activities for users of FP services</p>	<ul style="list-style-type: none"> <li>■ Focus group research</li> <li>■ Printed materials development</li> <li>■ Media planning</li> <li>■ Media production/ pretesting</li> <li>■ Launch mass media campaign</li> <li>■ Evaluation of mass media campaign</li> <li>■ Regional communication workshop</li> </ul>	<p>\$ 800,000</p>	<p>24 months October 1993</p>
<p><b>TFG/SOMARC III</b></p> <p>1050 17th Street NW Suite 1000 Washington DC 20036 tel: (202) 775-9680</p>	<p>SOMARC utilizes private sector marketing techniques and resources to increase the availability and use of contraceptives through the development of commercial outlets to sell contraceptives</p>	<ul style="list-style-type: none"> <li>■ Establish regional logistical support and office</li> <li>■ Commodity sourcing with pharmaceutical Companies</li> <li>■ Identify regional advertising agency</li> <li>■ Develop regional market research plan</li> <li>■ Facilitate market research</li> <li>■ Conduct training assessment</li> <li>■ Develop regional training plan</li> <li>■ Conduct training</li> <li>■ Implement regional planning meeting</li> <li>■ Launch products</li> </ul>	<p>\$ 5,254,000</p>	<p>36 months October 1993</p>

The strategy employs USAID's logical framework as its conceptual basis to identify problems through technical analyses, and plans activities to resolve problems. A log frame has been prepared (please refer to Section VI.) that specifies the goal, purposes, outputs, and inputs, as well as indicators, end of project status, means of verification, and assumptions.

In developing the RHSEP, the design team also identified four key issues that can potentially threaten the success of the overall program. The issues are:

- **Sufficient contraceptive commodities need to be made available for the program to take off:** Currently, the RHSEP team does not envision technical assistance in contraceptive supply and logistics even though anecdotal information from the Central Asian MOHs indicates there will be a shortage in contraceptive supplies within the year (1994). Although there will be limited amounts of contraceptive commodities donated by UNFPA, AVSC, SOMARC and USAID, all these sources combined do not meet the need estimated for the next three years and still do not address the overall issues of a consistent and reliable supply of high-quality commodities. The absence of commodities and lack of vision to address contraceptive self-reliance will undermine the RHSEP's efforts.
- **Clarification of mandate to provide assistance in Tajikistan and Turkmenistan and its budgetary implications:** While the mandate of the OPTIONS buy-in clearly states the intention of USAID to include both Tajikistan and Turkmenistan in the program, this mandate is less clear for other CAs. The assessment visit to Kazakhstan, Kyrgyzstan, and Uzbekistan revealed extensive needs in all three countries. The assessment visit to Turkmenistan in early February 1994 also uncovered similar needs. If the CAs are expected to provide a complete and comprehensive package of technical activities in five countries, it is now clear that the budget allocated to the region is not sufficient to ensure impact.
- **Extending the time horizon for RHSEP and other reproductive health initiatives in the region:** The design team expects that technical assistance to the region will begin to show impact within a short period of time due to the existing level of infrastructure and the existing human resources in the CAR. However, the 36 months, including the design phase, accorded to the project may be too short a period to effect lasting changes and demonstrate impact. Some components of the RHSEP take longer than others.
- **Monitoring and evaluating the RHSEP's impact:** In constructing the logical framework, the design team identified key indicators by which to measure project impact and suggested sources of data. Although each CA will generate data that can be used to monitor and track its project components, USAID has not provided funds for an external evaluation of the program. Moreover, the current strategy only plans for one DHS survey in one country and no other data collection or qualitative research is planned to evaluate the RHSEP.

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**In conclusion, each CA participating in this program brings its own expertise and international experience to the program, as well as its in-country experiences and impressions. The CAs are not only professionally committed to improving Central Asian family health, but they are also individually committed to the success of this program. Members of the RHSEP team have been personally touched by the unusual health conditions confronting CAR men, women, and children, and the resolve demonstrated by MOH officials to overcome these problems.**

## I. INTRODUCTION

### A. Overview of Women's Health and Fertility Behavior in the Central Asian Republics

The Central Asian Republics (CAR) included under this strategy for USAID assistance are Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. Each of these countries is in a transitional phase, moving from a centrally-planned to a market-based economy. These changes have led to inevitable economic and social disruption, with many families suffering financial hardships. The most vulnerable groups are women and children, whose health and welfare are negatively affected by social and economic changes that endanger national health systems<sup>2</sup>.

Among the republics of the Newly Independent States (NIS), the CAR have the poorest health indicators. Infant mortality ranges from a high of 58.2 per 1,000 live births in Turkmenistan, to 45.9/000 in Uzbekistan, and 29.4/000 in Kazakhstan. In contrast, infant mortality is 19.4/000 in Russia. Maternal mortality rates are as high as 80 deaths per 100,000 live births in the CAR, compared to 54/00,000 in Russia<sup>3</sup>.

The CAR, in comparison to other republics of the former Soviet Union, have significantly higher fertility<sup>4</sup>. The average number of children born to women during their childbearing years is between 4.0 and 4.6 in Kyrgyzstan, Turkmenistan, and Uzbekistan. Women of Kazakhstan have lower fertility, averaging 3.0 children during their reproductive years. This lower rate is in part attributable to the larger number of persons of European origin, mostly Russians and Ukrainian settlers, who constitute 38 percent of the population of Kazakhstan<sup>5</sup>. These groups tend to live in large urban centers, prefer smaller-sized families, and have a fertility rate of 2.0 children. Ethnic Kazakhs, the majority of whom live in rural areas, have fertility levels similar to those in neighboring CAR (4.0 - 4.6).

Currently, each country is experiencing some level of emigration of ethnic Russians and

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<sup>2</sup> UNICEF. *Rapid Assessment of Kazakhstan, Uzbekistan, and Kyrgyzstan*. November, 1992.

<sup>3</sup> Center for International Health Information/ISTI. *Kazakhstan, Kyrgyzstan, Turkmenistan, Uzbekistan and Russia: USAID Health Profiles*. 1992. Data is from 1987.

<sup>4</sup> Source for data on TFR are: Darsky and Dworak. *Kazakhstan, Kyrgyzstan, and Uzbekistan: Fertility Indicators and Characteristics of the Potential Market for Contraception*. The Futures Group. 1993. and Center for International Health Information/ISTI. *Russia:USAID Health Profiles*. 1992.

<sup>5</sup> Source for data on TFR are: Darsky and Dworak. *Kazakhstan, Kyrgyzstan, and Uzbekistan: Fertility Indicators and Characteristics of the Potential Market for Contraception*. The Futures Group. 1993. and Center for International Health Information/ISTI. *Russia:USAID Health Profiles*. 1992.

Europeans. Their exodus will affect the total fertility rate of each country. It is expected that the total fertility rates will increase in countries experiencing high levels of emigration. Until new censuses or national surveys are conducted, empirical verification of these estimates will be difficult.

Current fertility levels are sustained by many of the same factors that contribute to the region's relatively high rates of maternal and infant mortality and morbidity. First, it is considered normal to have short intervals between births. Indeed, 20 percent of all birth intervals are less than one year, and up to 80 percent are less than two years. Frequent pregnancies place a significant portion of mothers and their children at risk<sup>6</sup>. Second, reports indicate that breastfeeding has been declining in all of the republics during recent years<sup>7</sup>. Women, on average, breastfeed for only four months. This decline impacts negatively both on child survival and birth spacing. Third, contraceptive prevalence is low in all countries. Approximately 20 to 22 percent of married women of child bearing age are estimated to be using modern contraceptives<sup>8</sup>. This may somewhat underestimate actual use because there are anecdotal reports of parallel health care services not documented in national official records.

While fertility rates are well above those in Russia, it is important to recognize that they are significantly lower than those in the adjacent countries of Pakistan, Afghanistan and Iran. In the CAR, contraceptive supplies are available in very limited quantities, and women rely on abortion when faced with unwanted pregnancies. Pregnancy terminations are often performed under poor conditions (nearly 60 percent are done by dilation and curettage with very low or no use of anesthesia) and weak infection control practices. This results in high rates of secondary infertility among women in the region, with reports varying between 6 - 16 percent. Sexual abstinence is another prevalent coping mechanism for those who desire no more children, especially among older couples.

## **B. Key Programmatic Issues in Family Health Services**

Recognizing the need to improve maternal and child health conditions, governments of the CAR have attempted to develop national family health services and to make contraception more readily available. Unfortunately, there are many constraints. The reproductive and

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<sup>6</sup> Center for International Health Information/ISTI. *Kazakhstan, Kyrgyzstan, Turkmenistan, and Uzbekistan: USAID Health Profiles*. 1992.

<sup>7</sup> Welsby, Susan. *Executive Summary of the Review of Documentation on Women's and Children's Health in Five Central Asian Republics*. USAID. 1993.

<sup>8</sup> Seligman, Barbara and Laughrin, Ann. *Current Contraceptive Practice and Its Potential for Expansion in the Central Asian Republics*. Draft Document for USAID/Almaty. November, 1993.

family health situation in the CAR is complex and affected by many significant problems. UNICEF, the World Bank, and USAID have identified several programmatic issues that need to be addressed to strengthen family health services and to improve health conditions in the CAR. They include:

1. *The lack of awareness of the health benefits associated with contraceptive use and the limited support for reproductive and family health*

Currently, the use of modern contraception is not well understood nor fully accepted by many segments of society. Misconceptions and rumors abound among potential clients and health providers, and are fueled by the poor quality of the available contraceptives, such as poorly-made IUDs, or by such outdated contraceptives as high-dose contraceptive pills. The lack of accurate and up-to-date information about contraceptive use contributes to the poor acceptability of several contraceptive methods, in particular hormonal contraception.

MOHs in the region have deployed efforts to overcome the negative image of modern contraception and to communicate to government officials, providers, and the public the ways in which family planning can improve the health of mothers and children. Despite their efforts, it is unclear how widespread the support is among top leadership outside the MOHs and how willing health professionals, at all levels, are to provide family planning services. Although the consensus among health professionals is that there is little resistance to family planning, there is still a sense of caution among religious leaders and ideologists, including some intellectuals, who view any attempt to limit the number of ethnic citizens as weakening the strength or economic potential of the nation.

2. *Limited capacity to manage and sustain family health services*

The nascent MOH family health services managers have limited skills in implementing programs. Historically, all program planning was directed from Moscow with little input from local MOHs. All management functions, including planning, are now the responsibility of local MOHs, yet they have little experience and practically no exposure to international expertise on family planning management.

Program directors are stifled by the lack of timely data and information with which to plan services. Service statistics are reported only once a year. A health surveillance system exists, but it is limited in scope and does not collect data required for reproductive and family health services decision-making. There is also insufficient information on clients' knowledge, attitudes and use of modern contraception, as well as for the potential demand for contraceptive services.

The sustainability of these emerging family health services is threatened by lack of service source options. Financial resources for these programs can barely support the modest, current levels of use, much less the expansion that would accompany safe motherhood and healthy birth-spacing programs. The MOHs are the only providers of modern contraceptives in the CAR, and there are few private health services or product outlets. The privatization of medical services, although currently under discussion, has not yet begun, and there are no non-governmental organizations active in family planning. Yet, MOHs are unable to maintain existing programs because public health/social services budgets have been cut by as much as 50 percent due to the economic crises. The shortage of hard currency impedes the purchase of necessary equipment and commodities for safe and effective family health programs.

### 3. *Chronic shortages in contraceptive supply*

The region is facing two major issues regarding contraceptive supplies. The first is the impending shortage over the next few years. Current inventories, particularly of IUDs, are already depleted or will be soon. No relief is in sight since MOHs have clearly stated that they do not intend to purchase contraceptives, even with funds from international drug-related credit lines. MOHs in the region have already received a small amount of contraceptive commodities from UNFPA, and although additional contraceptives have been pledged, the proposed donations do not match the existing need<sup>9</sup> and will not meet the growing demand expected once the benefits of family health programs are more widely understood. The second issue concerns the need to protect the CAR against importation of low quality contraceptives<sup>10</sup>. Regional MOH decision makers are being solicited by many international companies proposing a variety of contraceptive products. Of particular concern is the lack of experience and technology in the CAR to assess the quality of the proposed contraceptives and to develop procurement requirements.

### 4. *Limited options of high quality contraceptive methods*

Chronic shortages are the principal cause of the narrow range of contraceptive methods available in the CAR. Injectables and Norplant<sup>R</sup> are virtually unknown. Rumors about voluntary surgical contraception are rampant. Oral contraceptive pills (OCs) are routinely rejected by both providers and users because of the side effects associated with high-dose OCs, while low-dose OCs are not available or well known. IUDs are, in effect, the only method available. Not surprisingly, staff at the MOHs estimate that approximately 90 percent of clients using contraception accept IUDs.

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<sup>9</sup> Olson, Clifford. *Contraceptive Cost Projections - Central Asian Republics*. The OPTIONS Project, 1994.

<sup>10</sup> UNFPA. *Basic Recommendations of the Basic Needs Assessment Mission to Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan: October, 1992*. New York.

**5. *Over-reliance on abortion as a means of fertility regulation***

Limited options in contraceptive method choice and source, combined with chronic shortages in supply, have made induced abortion the primary method of fertility control. Some estimates report that 65 to 75 percent of women obtain three or more abortions, while over 30 percent may have five or more during their reproductive life. Numbers as high as 13 are reported to be common in the CAR.

Attitudes toward other contraceptive methods also serve to encourage abortion. Many doctors comment that women are afraid of IUDs and OCs and prefer to risk an unwanted pregnancy and subsequent abortion than to use a modern contraceptive. Moreover, there appears to be a strong provider and client bias favoring abortion. Abortions are offered free of charge to poor women or at a nominal cost (300 roubles or approximately US 30 cents). Also, abortion, when compared with other methods frequently in short supply, may be perceived as a more reliable solution.

**6. *Out-of-date information and lack of training on contraceptive methods***

While many reproductive and family health practitioners are skilled and aware of newer methods, a common belief is that their knowledge is not complete due to limited training and the lack of up-to-date scientific information on contraceptive technology. Doctors and nurses receive only six hours of training on family planning every three to five years, and contraceptive technology is not included in the curriculum for pharmacists. In addition, there are no consistent or current standards of practice (SOP) governing the use of contraception, resulting in non-standardized provision of contraceptive services.

International donor assessments have revealed that existing training systems in the CAR are struggling to generate and maintain a steady stream of qualified service providers and trainers required to sustain high-quality family health services. Indeed, many of the problems found in CAR training institutions recur in training systems worldwide:

- reproductive and family health training does not exist in pre-service training of health staff and pharmacists;
- undergraduate and post-graduate training does not include reproductive and family health (or it is incomplete) in its curricula, and relevant teaching materials are out-of-date, technically inaccurate, or most commonly non-existent;
- training systems do not have a strong or effective clinical skills development component; consequently, graduates lack the clinical skills to deliver quality contraceptive services; and

- existing training does not instruct medical and pharmacology students how to counsel their clients; informed and voluntary choice is an unknown concept to providers.

7. *Limited experience with education and counseling of family planning users*

The UNFPA regional assessment underlined that health education services need significant improvement<sup>11</sup>. Current educational activities and materials are conventional, highly technical, mostly didactic, difficult to understand and not user friendly. Although health sector workers are expected to advise and educate the public on health, interpersonal communication skills are not taught. This deficit is compounded by the paucity of information, education and communication (IEC) materials for service providers, and written materials (leaflets and pamphlets) for clients.

**C. Expanding Reproductive Health and Contraceptive Services: A Sound Development Strategy for the CAR**

A number of factors describing the current situation concerning fertility regulation in the CAR suggests that a supply-side approach, emphasizing expanded access to reproductive health and contraceptive services, would have a significant and short-term pay-off. These factors may be summarized as follows:

- Significant demand for fertility regulation exists in the CAR, but this demand is not adequately met. Demand for fertility regulation is concentrated among women under 30, most of whom will face the risk of unwanted pregnancy many times over the course of the 20 or so reproductive years that lie before them. Demand for both birth spacing and limitation is concentrated in the age intervals 20-29, and among women of parity less than four.
- Treatment of secondary infertility and post-abortion counseling services are virtually non-existent, despite abortion and sterility rates that are among the highest in the world. Abortion, as currently practiced, is known to be a primary source of secondary infertility. Environmental pollution may also contribute to secondary, and perhaps primary, infertility in some regions.
- Strong MOH support exists for expanding the availability of high quality reproductive health and contraceptive services as a means to improve the health of mothers and children. Increasingly, more political and social leaders are concerned about the rising levels of maternal and child mortality and morbidity, primarily attributable to short birth intervals and high abortion rates. Also, a recent study indicated that a

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<sup>11</sup> UNFPA. *Basic Recommendations of the Basis Needs Assessment Mission to Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan: October, 1992*. New York.

majority of couples were troubled by having to resort to abortions to resolve an undesired birth<sup>12</sup>. As a result, key government officials in the CAR acknowledge the importance of high-quality family health and contraceptive services, and recognize the potential positive impact of child spacing on maternal/child health. They express their desire to expand the availability and quality of services and methods offered.

- Activities designed to increase public knowledge of the benefits derived from use of reproductive health services will be enhanced by the multiple communication channels operating and available in the region. Conducting large-scale communications efforts will be effective because of:
  - high literacy among the general population;
  - well-developed communication networks, either through newspapers, radio, or television;
  - local capacity to develop and produce communication materials, and to implement information campaigns; and
  - widespread access among the general population to radio and television.
- The CAR is in a region of the world where focused, short-term technical assistance can achieve dramatic impact. Proposed activities and technical assistance will build on existing, well-established systems of prenatal and perinatal care, and pharmacy systems. In addition, the medical staff are well trained and highly motivated to provide family health services, as evidenced by the success of the Wellstart Almaty Conference, held in January 1993. Technical collaboration, therefore, will only require limited focused activities to strengthen and improve nascent family health services programs.

The following sections describe in detail the proposed package of activities to be funded by USAID and executed by its CAs.<sup>13</sup> The activities have been selected to address the problems identified during the assessment trips. The table below provides an overview of the proposed program and the roles of the CAs.

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<sup>12</sup> Dr. D. M. Asadov. *The Uzbekistan's Population Attitude Towards Some Family and Marriage Relations Problems*. Paper presented at the International Conference on Maternal/Child Health Protection, Almaty, January, 1993.

<sup>13</sup> This strategy is only for Kazakhstan, Kyrgyzstan, Turkmenistan, and Uzbekistan. Tajikistan will be added to the countries included in USAID's technical assistance following OPTIONS' assessment scheduled for May 1994.

Table 2

## OVERVIEW OF RHSEP IN THE CAR

PROBLEM STATEMENT	PROGRAM COMPONENT	TECHNICAL ACTIVITY	CAs
Limited support for FH among top leadership  Lack of awareness of health benefits of FH services	Develop and strengthen policy support for FH	Observe successful FH programs through study tours  Analyze and reform legal and regulatory environment  Raise awareness of health benefits of FH services through seminars for policy-makers & leaders in medical community to garner support	OPTIONS  OPTIONS/ JHU/PCS/ JHPIEGO  OPTIONS/ JHU/PCS/ JHPIEGO/ SOMARC
Limited capacity to plan, manage & sustain FH services	Strengthen MOHs' institutional capabilities to plan and to deliver FH services	Carry out national level strategic planning, address resource allocation issues to finance family health programs.  Train to improve program management & planning skills  Conduct focused research for program planning and management  Develop skills for communication and health education  Develop model service delivery centers	OPTIONS  OPTIONS  DHS/OPTIONS/ SOMARC/ JHU/PCS JHU/PCS  AVSC
Chronic shortages in contraceptive supplies  Limited options for high quality contraceptive methods	Increase contraceptive supply & options  Diversify provision of family health services	Work with international pharmaceutical companies to develop market and sale network for wide range of quality contraceptives on consignment to MOHs  Increase contraceptive sources by developing private physicians and pharmacists networks	SOMARC  SOMARC
Out-of-date information & lack of training in contraceptive methods	Train health providers      Educate clients	Establish model training centers  Conduct clinical training  Strengthen MOH's training systems  Review and update national medical guidelines for reproductive health  Sponsor training tours to develop minileparotomy skills  Develop educational and counseling materials and activities	JHPIEGO/AVSC  AVSC/JHPIEGO  JHPIEGO  JHPIEGO/ AVSC/OPTIONS  JHPIEGO  JHU/PCS SOMARC/AVSC
Over reliance on abortion as a means to regulate fertility	Educate clients & providers	Design & implement communication programs	JHU/PCS/ SOMARC

## **II. GOALS AND OBJECTIVES OF USAID TECHNICAL ASSISTANCE**

### **A. Program Goal**

The goal of USAID technical assistance through the RHSEP is to improve the health of mothers and children in the CAR.

### **B. Program Objectives**

While there are many ways to contribute to achieving this goal, the RHSEP proposes interventions designed to modernize, expand and improve the quality and sustainability of family health services. The overall assistance package has five main objectives. They are:

- to develop a favorable political environment and cultivate supportive leadership in order to expand quality family health services;
- to strengthen each the institutional capability of each MOH so that it promotes and delivers quality family health services that are adequately funded and sustainable;
- to train health care providers and to improve family health training institutions to ensure long-term training capabilities;
- to educate clients and providers about the safety and efficacy of modern contraceptive methods and the health benefits derived from their use, shifting reliance on abortion to demand for modern contraception; and
- to diversify sources for contraceptives by expanding the private sector and broadening the method mix available to consumers.

### **C. Proposed Project Outcomes**

By the end of the program's activities, each country's national family health program and services should have made progress in developing:

- a supportive policy environment for public and private provision of family health services;
- improved planning and management of national family health services;
- development of at least one center of excellence in each country;

- increased public and private resources allocated to family health and contraceptive services;
- more adequately trained health care providers in family health services in the public and private sector; and
- improved family health counseling programs promoting individual choice and dispensing better knowledge of modern contraception.

### III. TECHNICAL COMPONENTS OF THE RHSEP

#### Components of Technical Cooperation

In response to the challenges facing the reproductive and family health providers in the CAR, USAID and its CAs have designed a strategy for assistance in women's reproductive health and family planning entitled the Reproductive Health Services Expansion Program (RHSEP). The interventions proposed reflect the observations and conclusions of a multi-disciplinary team that traveled to the Kazakhstan, Kyrgyzstan, and Uzbekistan in October 1993, and to Turkmenistan in February 1994. The program was elaborated in close coordination with CAR counterparts.

The original scopes of work developed by the NIS Task Force and USAID did not clearly include Tajikistan and Turkmenistan activities, except in the case of the OPTIONS scope. The other CAs are attempting to incorporate activities in Turkmenistan, and are currently working to secure additional resources to do so.

The potential for the CAs to undertake activities in Tajikistan is less clear. OPTIONS has scheduled an assessment in Dushanbe in May 1994. The other CAs however, do not presently have budgets for inclusion of Tajikistan activities. OPTIONS will make every effort to include Tajik representatives in its upcoming activities. In the activities described below, the Tajik additions will be made when possible. Until assessment work is completed, it is difficult to determine the appropriateness of the activities. Therefore, the project will wait to make its recommendations.

The proposed technical activities will be implemented by six CAs and funded through USAID NIS Task Force and RD/POP buy-ins (see Table 1). The CAs include: the Association for Voluntary Surgical Contraception (AVSC); the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO); The Futures Group OPTIONS for Population Policy and Social Marketing for Change (SOMARC) Projects; the Johns Hopkins Population Communications Services (JHU/PCS); and the Demographic and Health Survey Project (DHS). The CAs will continue to work in close collaboration as a follow-up to the joint assessments in the CAR. They will meet on a regular basis to share information and discuss implementation issues, and jointly implement technical activities. The OPTIONS Project, in providing technical assistance to MOHs to develop national strategic plans to expand services, will play a coordinating role for all technical activities. CAs will endeavor to coordinate their work with other health-related interventions in the region funded by USAID and other international organizations.

Components of the RHSEP are intended to be carefully linked to form a synergistic whole program of regional magnitude. The components of RHSEP are presented in the following sections of this document.

**A. Creating a Favorable Political Environment for Family Health**

Policy activities strive to cultivate supportive leadership and create a favorable policy environment to expand quality reproductive and family health services. To this end, technical assistance will support study tours for high level government officials to observe successful family planning programs in other countries, conduct seminars for policy makers and senior providers to raise their awareness of the benefits of family health services, and carry out a review of the legal and regulatory environment to identify policy constraints to the expansion of family health services. The following activities are proposed:

*1. Observing successful family health programs through study tours*

OPTIONS will conduct up to two study tours for delegates from four republics (Uzbekistan, Kazakhstan, Kyrgyzstan, and Turkmenistan). The objective of the study tours will be to increase the awareness of key decision makers of the health benefits of modern contraception and to provide them with a range of perspectives on service delivery options, financing mechanisms, and interventions for family health services. The trips will be organized for high level MOH and Pharmatsia directors. One of them will be conducted in Turkey and the other trip will be conducted in the United States. At the conclusion of the study tours, there will be a wrap-up meeting in the region for all study tour participants to discuss how they can apply lessons learned to improve their own nation's family health program and perhaps to form a cadre of regional officials with mutual interests. After the study tour and wrap-up, a report will be compiled describing the participants' observations and their plans for future action, based on information obtained during the study tours.

*2. Fostering political support for family planning through other awareness raising activities*

In addition to study tours, two other approaches to foster political commitment will be promoted: 1) targeted IEC materials designed specifically for opinion leaders and politicians; and 2) policy seminars to educate top political, religious and medical leaders on the health benefits of family planning and to address key issues related to creating a favorable policy environment for family health and contraceptive services. OPTIONS and JHU/PCS will develop and assemble from other sources translated policy materials to be distributed widely to policy makers. In addition, JHU/PCS will identify and involve key MOH personnel in the design and implementation of IEC programs. This effort will include training in the development and production of appropriate communication materials.

A critical initial element of awareness-raising activities for policy makers and influential leaders in the medical community will be a major symposium on women's and family health in each of the countries. The symposia will be organized and hosted by the OPTIONS Project, with the participation of other CAs. The objectives of the symposia will be to

inform MOH staff of the health benefits of modern contraception, to address the obstacles and opportunities to the expansion of reproductive health services, and to share information on method mix and contraceptive technology. Other themes to be addressed at these symposia will include the use of communication to motivate contraceptive use, service delivery options outside of the public sector, and the concept of informed choice and client counseling. Participants will include policy makers and health providers specializing in obstetrics, gynecology, and pediatrics as well as representatives from all appropriate medical institutions and the pharmaceutical industry. The symposia will lay the groundwork for subsequent policy, training, service delivery and contraceptive social marketing activities. The symposia are scheduled for January 1994 in Uzbekistan, April 1994 in Kazakhstan, June 1994 in Kyrgyzstan, and September 1994 in Turkmenistan.

In addition, a policy workshop will be conducted in Turkmenistan in May 1994. This workshop will have objectives similar to those of the symposia, but will be targeted to a smaller audience consisting mostly of policy makers at the highest level of government. OPTIONS learned during its Turkmenistan assessment that the Turkmen government is presently in the process of defining its national health care system. Key policy makers in the MOH and cabinet of ministers indicated keen interest in a small, policy-oriented workshop where free discussion regarding the international experience and alternate approaches to delivery and financing of health care could be discussed, especially regarding family health.

3. *Analyzing and reforming the legal and regulatory environment to create a favorable policy environment*

The OPTIONS Project will conduct analyses of current policies and regulations in each country to identify the constraints to the promotion and expansion of family health and contraceptive services in the public and private sectors. The policies, regulations, training and medical practices that impede modern contraception will be targeted first for attention. Several areas for possible attention include: 1) restrictions on methods; 2) inappropriate client eligibility requirements; 3) unwarranted contraindications; 4) process hurdles in receiving family health services; 5) restrictions on types of providers and settings for service delivery; 6) provider and institutional bias; 7) inadequate management of contraceptive side effects; and 8) pricing policies.

A second area of analysis will assess the feasibility of the private sector to provide family health services. In collaboration with SOMARC, the OPTIONS Project will also analyze: 1) the evolving policy environment as it relates to privatization of the medical sector within the economy; 2) potential mechanisms for private sector provision of such family health services as employer-based services, private pharmacies, insurance schemes as they develop, and non-government organizations; and 3) consumers' ability and willingness to pay for private family health services.

Finally, with the support of AVSC and the OPTIONS Project, JHPIEGO will spearhead an intensive process of reviewing and updating the official medical guidelines and standard operating procedures for service delivery practices in family health. AVSC and JHPIEGO will follow-up on this activity with training in the new guidelines.

Following any successful policy reform in any of the three areas described above, the OPTIONS Project will assist host country counterparts to disseminate the policy changes to related policy makers, service providers and other appropriate institutions.

**B. Strengthening MOHs' Institutional Capacities to Plan and Deliver Family Health Services**

MOHs in the CAR are experiencing dramatic reductions in their budgets. At the same time the changing socio-political environment requires them to initiate bold and innovative strategies to strengthen family health services. Technical assistance will support the MOHs to better plan and manage the delivery of contraceptive services. It will call attention to all of the resource issues underlying these programs from the cost-benefit of investments, the need to target public sector investments to those who can afford to pay, the need to create private sector partnerships, etc.

Technical assistance to strengthen the MOHs' institutional capabilities will focus on improving their planning and programming skills. In addition, the CAs, under OPTIONS leadership, will collaborate closely to gain a better understanding of the policy environment regarding contraceptive services and to provide missing information on contraceptive practices and family health services. This information will help to identify priority issues, develop training activities, and design strategies to expand family health services.

The proposed activities are as follows:

*1. Strengthening public sector's capacity to plan, manage, and evaluate national family health programs*

The OPTIONS Project will work with MOHs in the five republics to undertake strategic planning exercises that will result in the articulation of national program goals, objectives, and strategies. Strategic planning exercises will help prioritize issues challenging the expansion of a national program; identify strategies to implement national-level family health and contraceptive services; and assess the structural and personpower changes needed in relation to available resources. Integral to the discussion will be the financing of the national programs. Considerations will be made on the expansion of the method mix to meet the clients' reproductive intentions; on the diversification of contraceptive sources; and on the means to ensure a steady supply of contraceptives and other necessary equipment and

products. OPTIONS will assess the public sector service statistics in each country. This effort will illustrate strengths and weaknesses in collecting and using service data to plan their programs and commodity requirements. The SOMARC Project will collaborate with the OPTIONS Project in focusing on the financing and distribution of commodities through both public sector agencies and private sector partners.

OPTIONS will also provide training to facilitate program planning processes. Specific activities will include: 1) the transfer of computers and software packages; and 2) the training of key personnel in basic demographic and program planning concepts, looking at unmet need, method mix forecasting, channel of delivery, and use of data for decision-making.

2. *All of the CAs will sponsor targeted research to support program activities*

The RHSEP is uniquely positioned to coordinate research and increase the effective use of data collected to make decisions. Because little or no data or collective international experience with reproductive and family health conditions exists, all RHSEP research activities will be valuable and useful. The CAs will collaborate closely to coordinate their research by developing a master research agenda and disseminating the results among the CAs and CAR counterparts.

The primary objective of the research agenda will be to create a baseline understanding of the political and social culture, and of attitudes toward and practices of modern contraception in all segments of the CAR populations. The research results will be used to fine tune technical assistance, design strategies for the expansion and improvement of family health services, and to monitor and evaluate the RHSEP's impact. The second objective of the research will be to strengthen the analytic capability of local institutions through collaboration, thereby increasing their ability to conduct similar research linked to the design and evaluation of reproductive and family health services.

The largest research activity will be a Demographic and Health Survey (DHS) in Uzbekistan or Kazakhstan, to be carried out by MACRO International. This survey will provide: 1) critical baseline data for strategic planning, program design and implementation; 2) data on knowledge, preference and method use required to develop appropriate marketing and advertising strategies; 3) data on several aspects of family health, including immunizations, prevalence and treatment of diarrhea, antenatal care, and nutritional characteristics of the target population.

Additional studies will be undertaken in other countries where a comprehensive DHS will not be conducted. These targeted and highly-focused studies will partially provide the same type of information, but in a limited scope. The following studies will be undertaken: 1) the OPTIONS and SOMARC Projects will evaluate attitudes and practices of medical providers and pharmacists toward modern contraception and determine their interest in, and ability to,

provide modern contraceptive and family health services; 2) the SOMARC Project will assess women and men's use of and attitudes toward fertility regulation and modern contraception through a client-based survey; 3) the OPTIONS Project will conduct an analysis of service delivery systems in each country to determine the linkages between family health and other primary health care services; and 4) the OPTIONS Project will explore the incentives, biases, and motivations relating to abortion. These studies will be supplemented with qualitative research, namely focus group research conducted by JHU/PCS, to determine attitudes, social, cultural, and religious values related to contraceptive use and birth-spacing.

### *3. Analyzing public financing and resource allocation issues*

Clearly, an integral part of any technical assistance program is an analysis of public finance and resource allocation issues. Full adoption of safe motherhood and birth spacing programs, eliminating too early, too late, and too closely spaced births, as well as achieving fertility desires of families through modern contraception, might increase usage to levels of 50 percent or beyond as in Egypt and Tunisia. Financing this level of service delivery will require mobilizing public and private resources. The issues surrounding public resource requirements will be addressed by OPTIONS' symposia, policy workshops, and observational study tours. Emphasis will be placed on financing family health and targeting government resources to those who need them. Private sector resources are discussed in section D. 1.

OPTIONS will conduct a small economic study in Kyrgyzstan to analyze the cost of providing family health services in the public sector. The objective of the analysis will be to demonstrate to leaders the policy implications of service expansion, broad method mix, program financing and market segmentation, and savings gained by providing family health services. The data will also provide the MOH with a more accurate estimate of the cost of services to include in their overall budget to be submitted to the Kyrgyz Ministry of Finance.

This agenda represents only the beginning of initiatives to address the critical resource allocation issues. OPTIONS activities should be coordinated with those of the NIS Health Care Financing Project to ensure that adequate technical assistance is available to develop appropriate policies and implementation activities to resolve resource issues.

### *4. Strengthening the public sector's capacity to deliver high quality family health services*

During the country assessments conducted by AVSC and JHPIEGO, several sites were selected to be upgraded to become centers of excellence in the delivery of family health and contraceptive services. The selection criteria included the need for the site to be connected to a training institution or system, as well as to be linked to maternity and/or abortion services. The sites targeted to become centers of excellence are presented in Table 3 on the next page.

TRAINING SITES	
Kazakhstan	<ul style="list-style-type: none"> <li>◆ Perinatal Center, Almaty</li> <li>◆ Maternity House #3, Almaty</li> <li>◆ Human Reproduction Center, Almaty</li> </ul>
Kyrgyzstan	<ul style="list-style-type: none"> <li>◆ Marriage and Family Consultation Center, Bishkek</li> <li>◆ Maternity House #4, Bishkek</li> <li>◆ The Kyrgyz State Medical Institute</li> </ul>
Uzbekistan	<ul style="list-style-type: none"> <li>◆ Maternity House #9, Tashkent</li> <li>◆ Maternity House #4, Samarkand</li> <li>◆ The Samarkand Medical Institute</li> </ul>
Turkmenistan	<ul style="list-style-type: none"> <li>◆ Polyclinic #9, Ashgabad</li> <li>◆ The Research Institute for Maternal and Child Health</li> <li>◆ The Republican Clinical Hospital</li> </ul>

The strengthening of key service delivery sites will serve multiple purposes. The centers of excellence provide a model center where observers from provincial centers can learn to upgrade services. They can also be key in the introduction of new technology and new modes of service delivery. But most importantly, model sites are crucial for the support of training programs, as is described in the training section later in this document.

AVSC will take the leadership in upgrading at least one site per country. Equipment needs will be assessed, and the sites will be upgraded early in the program's schedule of activities. The improvement in service delivery at these model sites is expected to generate high demand for services, thus fulfilling two key objectives: 1) demonstrating that the quality of services has an important impact on increasing the utilization of contraceptive methods; and 2) providing a regular flow of clients for training purposes.

### C. Diversifying Sources for Contraceptives and Broadening the Method Mix

Currently, MOHs in the CAR are the principal, if not the exclusive source for contraceptive services and commodities (they almost exclusively supply IUDs). Some of the key objectives of the RHSEP are to diversify the sources of providers by expanding the private sector and to broaden the method mix available to consumers to include other methods of contraception -- namely low-dose oral pills, high quality IUDs, condoms and injectables.

The diversification of method sources and mix is viewed as an important step toward improving clients' choices and satisfaction, and as a prerequisite to expanding demand for services among those who do not yet manage their fertility. Proposed technical activities will focus on removing obstacles to the development/expansion of the private sector. Efforts will be made to assist interested physicians and pharmacists who wish to offer family health services and sell modern contraceptives in private practices, and to implement a contraceptive social marketing program (CSM). The proposed activities include:

*1. Promoting a conducive policy climate for private provision of family planning*

OPTIONS will support activities that are integral to the development of the SOMARC contraceptive social marketing (CSM) project. The OPTIONS Project will first analyze the legal and regulatory environment governing the privatization of the medical sector to suggest strategies to reform current policies that impede private sector activities. (Public sector analysis and reform were discussed in section C. 3.) At least one country will be reviewed in-depth, including an analysis of the cost of providing family health services in the public sector and an assessment of expected costs in the private sector. OPTIONS will also present international experience to the MOHs on the respective roles of public and private provision of family health services, with the objective of fostering support for policy reforms.

*2. Increasing service provision by private physicians and pharmacists*

Given the absence of a viable private medical sector in the CAR, the OPTIONS and SOMARC Projects will assist in establishing associations of private physicians and pharmacists where appropriate. To date, only physicians in Uzbekistan have formed a non-governmental association: The Association of Uzbekistan Physicians (AUP). OPTIONS-sponsored activities with the AUP will include: 1) development of the AUP institutional management capacity, including a better understanding of its constituency, and strategies to attract new members; 2) seminars for physicians and pharmacists promoting the new association and its family health activities, and for educating members in the health benefits of contraceptive use; 3) equipment and training in computer-based demographic and supply management; and 4) development of criteria and systems for the certification of member qualification. The goal of this activity is to contribute to improving the quality of private sector family health services.

The SOMARC Project will help to create other non-government associations to stimulate the development of the private medical sector and provide training in contraceptive technology, contraceptive logistics, procurement, and marketing.

3. *Contraceptive Social Marketing/SOMARC activities*

SOMARC will support the development of commercial marketing networks for modern contraceptives and the expansion of private sector family planning services. The proposed strategies vary among countries. In Uzbekistan, SOMARC/OPTIONS will work with the AUP as the primary means of establishing reproductive health services within an emerging private medical community. To strengthen the AUP's leadership role in the private provision of health/family planning services, SOMARC will provide technical assistance to:

- train private physicians and pharmacists to provide family health services and modern contraceptives through seminars and symposia on reproductive health for members of the Association; and
- distribute and market contraceptives through the Association's members.

In Kazakhstan and Kyrgyzstan, SOMARC will work with Pharmatsia, the MOH division that manages, procures and distributes drugs and contraceptives. Pharmatsia also operates the network of public sector pharmacies. The goal of this activity will be to develop private sector operations from within the MOH since, at the moment, the country has no private sector to build upon. The Kazakh and Kyrgyz Pharmatsias already have plans to establish at least one pharmacy in each region that will be a semi-private outlet for drugs and contraceptives. Consumers will be provided with selected drugs and will use hard currency to purchase them. In both countries, SOMARC has negotiated with Pharmatsia for guaranteed access to pharmaceutical outlets for the distribution of contraceptive products for sale (most probably through the "private" window located in each pharmacy, but also stand-alone "private" facilities).

In Turkmenistan, social marketing activities may only be possible as and when the government sanctions the sale of drugs in pharmacies. The government is moving slowly to design their health care system. Assuming some pharmacies will be privatized, SOMARC can provide technical assistance throughout the process. The infrastructure exists to develop and implement distribution, conduct market research, and implement marketing communication activities to support a social marketing project.

Another important aspect of the CSM program will be to ensure a reliable contraceptive supply flow to all its projects. SOMARC will work with international pharmaceutical companies to secure agreements to sell commodities on consignment to CAR MOHs at low prices. SOMARC envisions negotiating the supply of contraceptive commodities from sources in Turkey as part of the U.S.-Turkey collaboration program. Other companies in the United States and Europe will also be contacted. In support of the CSM program, SOMARC will also: 1) train pharmacists in contraceptive technology to support consumers in appropriate and effective use; 2) use the JHU/PCS focus group findings on knowledge, attitudes, and behavior regarding reproductive health; 3) build on the motivation campaign to

use modern contraception developed by JHU/PCS by developing brand-specific advertising; and 4) develop promotional materials and distribute them in all pharmacies.

**D. Training Providers and Strengthening the MOHs' Institutional Capacities to Train Family Health Services Workers**

There is resistance to modern contraceptives among health providers due to bad experiences with first-generation and poor-quality contraceptives. JHPIEGO, AVSC, and JHU/PCS through the RHSEP, will: 1) give family health service providers reliable and current information on modern contraceptives and their use; 2) train them in sound clinical practices in the delivery of contraceptive services, including infection control and client counseling. In addition, JHPIEGO and AVSC will strengthen training systems and institutions in the CAR to produce a wide range of qualified health professionals capable of delivering contraceptive services safely, reliably, and with sensitivity. JHPIEGO and AVSC will provide MOHs' with technical assistance to revise medical guidelines and clinical standards of practice (SOP). The following technical activities are planned:

*1. Clinical training to update providers' knowledge of modern contraceptives*

In collaboration with JHPIEGO, AVSC will equip and strengthen at least one model family health service delivery center in each republic. These centers of excellence will also become practical training sites dedicated to strengthening the training capacity of the republics. The main objectives of the training activities are to update public sector providers' knowledge of family planning practices, specifically the use of modern contraceptives and counseling skills of providers; to develop commitment to continuous improvement of the quality of contraceptive service delivery in public sector facilities; and to expand post-partum and post-abortion contraception in facilities operated by the MOHs.

Kazakhstan. AVSC reached agreements with the Perinatal Center, Maternity House #3 and the Human Reproduction Center of Almaty to expand contraceptive services linked to maternity and/or abortion services at the two sites. Medical staff from these institutions, supplemented by doctors from the medical college and from the refresher training program, will participate in a joint two-week training course scheduled for August 1994 in Almaty. The course will include a contraceptive technology update on all methods (250 participants); a module on the concepts of communication and counseling skills training for doctors and nurses (20 participants); and clinical training for reversible and permanent methods of contraception. Fifteen doctors and nurses will receive training in IUDs and injectables; four doctors from the two sites will be trained in permanent contraceptive methods. These courses will be followed by courses to be conducted by JHPIEGO to train the most able trainees as trainers and to develop a curriculum.

Kyrgyzstan. AVSC will work with Maternity House #4, and the Marriage and Family Consultation Center in Bishkek to establish model training sites and expand contraceptive services. Maternity House #4 is the largest maternity hospital in Kyrgyzstan with up to 7,000 deliveries per year. It serves as the clinical training site for medical students and for refresher courses for practicing doctors. The Marriage and Family Consultation Center, closely connected with the MOH, is the country's main center for family planning services and counseling, with outreach by means of regional centers and branches located in polyclinics throughout Kyrgyzstan.

Medical staff from these institutions, supplemented by doctors from the Kyrgyzstan State Medical Institute and the refresher training school, will participate in a two-week training course scheduled for October 1994 in Bek. The course will include a contraceptive technology update on all methods (100 participants); a module on concepts of communication and counseling skills training for doctors and nurses (20 participants); and clinical training for reversible and permanent methods of contraception. Fifteen doctors and nurses will receive training in IUDs and injectables; four doctors from the two sites will be trained in minilaparotomy. These courses will be followed by courses to be conducted by JHPIEGO to train the most able trainees as trainers and to develop a curriculum.

Uzbekistan. The MOH and AVSC selected Maternity House #9, Tashkent, and Maternity House #4, Samarkand (in collaboration with the Medical Institute of Samarkand), as sites for training activities. Medical staff from these institutions, supplemented by doctors from the refresher program at Maternity House #9 and from the Samarkand Medical Institute associated with Maternity House #4, will participate in two-week training courses, scheduled for May 1994 in Tashkent and Samarkand. Medical staff from a site in Andijan will also be invited to participate. The course will include a contraceptive technology update on all methods (100-250 participants); a module on the concepts of communication and counseling skills training for doctors and nurses (20 participants); and clinical training for reversible methods (and permanent methods, on-site in Samarkand only). Fifteen doctors and nurses will receive training in IUD insertion and injectables; four doctors from two sites will be trained in minilaparotomy. These activities will be followed by training of trainer and curriculum development courses to be conducted by JHPIEGO.

Turkmenistan. The MOH and AVSC selected Polyclinic #9 in Ashgabad to become a model contraceptive clinic within its women's consultation center by training its service providers. AVSC reached an agreement with the Republican Clinical Hospital, Polyclinic #9, and the Republican Institute for Maternal and Child Protection to participate in a 10-day training course for contraceptive information, counseling and clinical training in temporary methods, to be provided by AVSC in December 1994 in Ashgabad. The course will be held at two sites: a three-day contraceptive technology update will be at the 240-seat lecture hall of the Republican Clinical Hospital to reach the maximum number of health professionals. Doctors and nurses from the three institutions, MOH officials, and representatives from each

of the five districts of Turkmenistan will participate. The remainder of the training course will be held at the women's consultation center of Polyclinic #9 and will be limited to 20 participants for the counseling training, and 15 participants for clinical training for IUDs and injectables. Three training staff from the Republican Hospital and Republican Research Institute will also participate.

In addition to these activities, AVSC will provide equipment, supplies, contraceptive commodities and education materials (with JHU/PCS) to support the training activities and service provision at all sites. Training-related contraceptives to be supplied will complement an expected UNFPA commodities donation to the CAR. AVSC is requesting technical assistance from USAID's Commodities Procurement and Support Division to evaluate the capability of each MOH to receive and manage distribution of limited commodities. This assistance will direct AVSC's transfer of training-related commodities to the CAR. AVSC will ship 1,000 Russian-language contraceptive posters to Uzbekistan's MOH, 10,000 to Kyrgyzstan's MOH, and 15,750 to Kazakhstan's Human Reproductive Center. Few were sent to Uzbekistan and none to Turkmenistan because they highlight vasectomy, a method both countries do not want to incorporate presently. AVSC will also coordinate the distribution of 30,000 copies of the Russian version of Contraceptive Technology: International Edition to all republics.

2. *Strengthening MOHs' training systems to generate new clinicians qualified in contraceptive technology and client counseling*

JHPIEGO will complement the clinical training undertaken by AVSC in strengthening the MOHs' capacity to train new and qualified health professionals to provide family planning services. JHPIEGO will employ a strategy comprised of four activities, including: 1) study tour to learn minilaparotomy; 2) training of trainers; 3) co-teaching of first clinical skills course; and 4) revision of medical school curricula.

Training Tour to Observe Minilaparotomy. Since women end child-bearing at an early age, interest in long-term methods of contraception is strong. There is growing interest among CAR health providers to provide women with the choice of minilaparotomy, and to develop skills in laparoscopy. JHPIEGO will organize and lead a study tour to teach the minilaparotomy technique and to allow participants to observe how this method is an integral component of reproductive health services.

The tour is tentatively scheduled for April 1994, and participants will visit the Fertility Care Center in Manila, Philippines. Study tour participants will be leading physicians or instructors from the four Central Asian Republics. They will be selected from centers identified by each country's MOH to become the national minilap training center. At the Fertility Care Center, the delegation will participate in a minilap training course. The focus of the course is on developing the skills to perform the medical procedure. A module of the

course emphasizes client counseling for the method. Upon their return to the CAR, participants are expected to begin offering this service to clients, using minilap kits provided by AVSC. The study tour participants will also take part in JHPIEGO's training of trainers (TOT) course to ensure that they become competent trainers. Participants will then continue training others at the designated national training centers established by AVSC/JHPIEGO.

Training of Trainers. In collaboration with AVSC, JHPIEGO will identify potential clinical trainers at the model centers. A two-week TOT and curriculum development course in multiple methods will be conducted by JHPIEGO. A module of the TOT emphasizes development of client counseling skills. Key service providers and instructors who participated in AVSC's training will participate in JHPIEGO's training. JHPIEGO's course will train competent clinicians to become trainers, thus promoting sustainability of the national training system.

JHPIEGO will also provide participants with course handbooks and reference manuals in Russian. In addition, each center will be provided with educational materials and teaching aids, including the "Zoe" pelvic models, slide sets, and audiovisual equipment. All participants will be trained in the use of these materials to promote their effective use in future training courses. The training course will also include development of a curriculum for future training courses in each country.

Co-teaching of First Clinical Skills Course. To reinforce the skills acquired by the physicians during the TOT course, JHPIEGO will assist the trainers in each country to conduct their first multi-method clinical skills training course, thereby ensuring the skills are actually transferred to other national physicians. Additional technical assistance will be provided to the trainers as necessary; development of counseling skills may be a focal point for further assistance.

Revision of Medical School Curricula. In order to address the desires of medical institutes to incorporate family planning into medical school curricula, JHPIEGO will provide technical assistance to the deans and professors of each Republic's medical institutes in curricula development. A one-week workshop will take place to review the OB/GYN curriculum, review a sample family planning curriculum, and incorporate family planning into the current curricula. By incorporating family planning into the 4th, 5th, and 6th-year medical school training program, medical students will receive the necessary theoretical and practical training for the provision of quality family planning services. Medical schools will help to generate and maintain a steady flow of qualified service providers and trainers. The CAR currently lack this influx of qualified new professionals. The directors of Maternal/Child Health Departments in the MOHs will take the lead role in organizing the workshop and selecting participants.

**3. *Reviewing current standards of practice to ensure compliance with international standards***

JHPIEGO will take the lead in ensuring that medical guidelines and SOP for the provision of contraceptive services are updated and comply with international standards of excellence. OPTIONS and AVSC will provide support to this activity. OPTIONS and JHPIEGO will facilitate the review process, as well as disseminate the norms and regulations. AVSC will reinforce the new SOP by using them at the model training centers.

The SOP review process is comprised of several steps, including: 1) the establishment of committees composed of local experts to be responsible for the analysis of existing and international standards of practices; 2) consultations from international experts on contraceptive technology; 3) open discussions among local committee members and family health providers to ensure that SOP reflect local medical knowledge, practice, and attitudes; and 4) dissemination of and training in the revised guidelines.

In addition to the large, comprehensive volume of service guidelines, the MOHs requested the preparation of "pocket guides" for clinicians' daily use. JHPIEGO will collaborate with OPTIONS to develop and disseminate the "pocket guides."

This combined effort will produce broad-based support for the clinical guidelines from the clinical, academic and policy arenas. Emphasis will be placed on integrating the delivery of contraceptive services appropriately in the context of maternal and child health activities.

**E. *Educating Clients***

One of the key components of the RHSEP strategy is client education, information and counseling to affect behavior change. The objective of all communication activities in this project will be to educate clients about the safety and health benefits of modern contraceptives and to promote shifting their reliance on abortion as a fertility regulation method to effective and sustained use of modern contraception. JHU/PCS will lead the technical activities to develop a communication program that will include a mass media campaign; IEC materials for service providers in support of their educational activities; and printed materials (leaflets and pamphlets) for clients. SOMARC and AVSC will also be active partners in client communication, coordinating their marketing campaigns and development of counseling materials with JHU/PCS. The communication strategy will include the following components:

**1. *Consumer research***

JHU/PCS will conduct at least 10 focus group discussions in each of the republics to explore knowledge, attitudes, practices and behaviors of women and men toward family

planning/birth spacing. This information will be used to develop appropriate communication messages and counseling materials. The research will be conducted in several locations in each republic to ensure geographical and ethnic coverage. In Kazakhstan, focus-group research will be conducted in Almaty and nearby rural areas. In Kyrgyzstan, focus-group research will target young women in Bishkek and women in rural areas. JHU/PCS will limit the focus groups to the greater Tashkent area in Uzbekistan and the greater Ashgabad area in Turkmenistan.

Additional focus-group research may be conducted in other regions to provide a more representative view of different population segments as needed. These would be conducted in collaboration with the SOMARC Project.

SOMARC will conduct client surveys in three countries (Kazakhstan, Kyrgyzstan, and Uzbekistan) to explore in-depth client knowledge, attitudes and practices regarding family health.

## *2. Designing communication programs*

JHU/PCS will lead the efforts to develop public communication campaigns that will stimulate demand for modern contraceptives. JHU/PCS will work closely with the MOHs and local media agencies to develop and implement mass media campaigns appropriately adapted for each republic. Some materials will be produced for regional use and some for national or local use. The highlights of each campaign are described below:

Kazakhstan. JHU/PCS will work with a private advertising agency to develop two public awareness spots for television and radio on the health benefits to mothers and their children of child spacing and the regular use of modern contraception. These spots will be aired in Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan.

Kyrgyzstan. JHU/PCS' counterparts in Kyrgyzstan will be the MOH's Family Planning and Marriage Center in Bishkek, and Pyramid TV. Working with the MOH, JHU/PCS will develop and implement two mass media campaigns. The first will focus on preventing unintended pregnancies and on contraceptive use for young women in Bishkek. The campaign will underline the high incidence and negative health effects of repeated abortions. This campaign will be broadcast through the Pyramid radio and television stations whose audience includes mostly the young people in Bishkek.

The second campaign will be targeted to rural women and men. It will be broadcast on the national television channel and will include materials developed for the region but adapted for the rural Kyrgyz audience. The emphasis of the message will be on the health benefits of birth spacing.

Turkmenistan:

The regional campaign developed in Kazakhstan will be broadcast on Turkmen television and radio.

Uzbekistan:

The regional campaign developed in Kazakhstan will be broadcast on Uzbek television and radio. This campaign will be supplemented with two locally-produced spots that address messages identified as important by the research conducted in rural areas.

In addition, SOMARC will complement JHU/PCS' activities in mass media communications. SOMARC will develop extensive educational and motivational communications materials to educate consumers on contraceptive methods and brands. The materials, such as truck panels, billboards, and advertising spots will enforce the messages JHU/PCS sends.

3. *Information, education and counseling materials*

JHU/PCS will work with AVSC, JHPIEGO, and each MOH to develop Russian language information leaflets on contraceptive methods. Also, counseling materials will be prepared to assist providers in providing guidance to clients. Materials will include:

- a leaflet for general method overview (10,000 copies);
- several method-specific leaflets for oral contraceptives, IUDs, injectables, and condoms (10,000 copies each);
- a flipchart and cue cards for doctors to use in counseling sessions with clients (500 sets);
- a waiting room poster; and
- Russian translations of five editions of Population Report, one on low-dose pills, IUDs, injectables and condoms, as well as one on counseling guidelines. Seven-thousand copies of each report will be distributed to service providers.

All of the Russian-language IEC materials for the CAR will be produced in Kazakhstan and distributed to all countries. As necessary and when feasible, JHU/PCS will assist in the adaptation of materials to local ethnic languages and will redesign and produce the materials using local resources. These materials would be distributed in rural areas by both clinics and the patronage nurse social workers.

Materials will be ready for use in the providers' training workshops planned by AVSC and JHPIEGO for Uzbekistan in May 1994; for Kazakhstan mid-August 1994; and for Kyrgyzstan and Turkmenistan in October 1994.

4. *Regional communication workshop*

JHU/PCS will organize a regional workshop on the role of communications and on materials development in reproductive health. The audience of the two to three day conference will be health professionals, local advertising/communication companies, journalists, social research groups and appropriate media representatives. Participants will become familiar with state-of-the-art health communications and materials development. The ultimate goal of the conference will be to establish relationships among the disciplines of communications, family planning, and government. The conference will also provide participants with the skills needed to develop and implement a national communications strategy. This conference is scheduled for October 1994.

F. **Program Coordination and Collaboration**

The RHSEP will be implemented by an informal consortium composed of AVSC, OPTIONS, SOMARC, JHPIEGO, JHU/PCS and DHS. These CAs are not linked through formal contractual relationships. USAID has appointed OPTIONS as the lead CA to maintain coordination among activities and to promote synergy among project interventions. The unity of goal and purpose was initiated by the collaboration of the assessment team and will continue through joint TA trips to the region, exchanging of trip reports and research findings, and jointly sponsored activities in-country and state-side. During project design, linkages among the project components were established to ensure timely fit and to avoid duplication.

The policy symposia have been designed to set the tone for the entire assistance package. While the symposia will be sponsored for the most part under the program's policy development component, the inclusion of other project components will promote the commonality of goal and approaches to the expansion of quality family health services in the region.

As the lead CA, OPTIONS will continue to promote collaboration and will actively contribute to the sharing of information. Whenever possible, OPTIONS will also facilitate the work of other CAs in the region by sharing resources and expertise. The RHSEP CAs will maintain regular contact and meet quarterly. CAs working in the RHSEP project will use some of the same consultants, especially at the local level, thus adding to project unity.

#### IV. ISSUES

The program design team has identified four key issues that can potentially threaten the success of the overall program. Some of these issues have been discussed with USAID during and after the first assessment team visit to the CAR. Although solutions are being discussed, no closure has been reached. The issues are: 1) adequate supply of contraceptives and logistical capacity; 2) programming technical assistance for Tajikistan and Turkmenistan; 3) end-of-project timing; and 4) monitoring and evaluating RHSEP's impact.

*1. Sufficient contraceptive supplies need to be made available for the program to take off*

Currently, the RHSEP team does not envision technical assistance in contraceptive supply and logistics even though anecdotal information from the Central Asian MOHs indicate there will be a shortage in contraceptive supplies within the year (1994). UNFPA has made an initial donation of commodities to the region (about two million dollars worth) and at this time the agency has not yet formulated a follow-up plan to donate more contraceptives to the CAR. USAID has recently pledged about a million dollars worth of contraceptives to initiate the RHSEP program. In addition, SOMARC and AVSC will provide a limited supply of contraceptives related to their project activities. Yet all these sources combined do not meet the need estimated for the next three years and still do not address the overall issue of a consistent and reliable supply of high quality commodities for the public sector programs.

This is a critical sustainability issue that has been identified but has not yet been resolved in the RHSEP assistance package. The issue includes three elements: 1) the provision by donation of essential commodities to support the program in the initial stages, while other sources of commodities are being organized; 2) the more general issue of ensuring that the governments of the CAR include contraceptives in their lists of essential drugs with a high-priority ranking, and allocate funding to support the expanded delivery of contraceptive services; and 3) assessing contraceptive supply needs and evaluating/improving logistical capabilities to disperse and maintain a reliable flow of contraceptive commodities in each country.

If USAID decides that, in the interest of ensuring a successful RHSEP, it is necessary to provide donated contraceptives, there are many policy activities the CAs can undertake during the period from order to delivery of commodities. The dialogue with governments can stress an understanding of mutual roles and responsibilities, and a time-frame to assure that the program is sustainable when USAID phases out. Policy analyses of a wide range of related issues -- cost and benefits of investments in family health, cost and benefits of method mix, forecasting of needs by method, willingness and ability to pay, mechanism to target public suppliers, expansion of usage, and funding requirements for phase over to host government-funded programs -- can supplement the policy dialogue.

The RHSEP should assist the MOHs in the development of procurement and logistical skills to ensure that high-quality commodities are purchased at the best price and are in constant supply. The absence of high quality commodities and lack of vision to address long-term sustainability issues, such as strengthening MOH's logistical capacity, will undermine the RHSEP efforts. The assessment team strongly recommends that USAID provide resources to carry out these activities as well as the temporary contraceptive supplies to ensure the success of the activities in the RHSEP.

2. *Clarification of mandate to provide assistance in Tajikistan and Turkmenistan and its budgetary implications*

While the mandate of the OPTIONS buy-in clearly states the intention of USAID to include both Tajikistan and Turkmenistan in the program, this mandate is less clear for other CAs. The assessment visit to Kazakhstan, Kyrgyzstan and Uzbekistan revealed extensive needs in those three countries. The assessment visit to Turkmenistan in early February 1994 also uncovered needs similar to those in the other countries. Indeed, Turkmenistan is less advanced in developing a private sector for health services than the other countries and will require even higher levels of policy assistance. If the CAs are expected to provide a complete and comprehensive package of technical activities in all five countries, then it is now clear that the budget allocated to the region is not sufficient to ensure impact.

The design team recommends that USAID reassess the budget allocated to the region in view of the pressing needs identified during the assessment visits to four countries. In the meantime, OPTIONS is planning an assessment visit to Tajikistan in late May. And, until this issue is clarified, all the CAs will include Tajik and Turkmen representatives in RHSEP activities whenever possible.

3. *Extending the time horizon for RHSEP and other reproductive health initiative in the region*

The design team expects that technical assistance to the region will begin to show impact within a short period of time due to the existing level of infrastructure and the existing human resources in the CAR. However, the 36 months, including the design phase, accorded to the project may be too short a period to effect lasting changes and demonstrate the full impact. Some components of the RHSEP take longer than others to achieve. For example, improved clinical skills should be realized immediately, while developing private sector channels to distribute commodities will likely take much longer than 36 months. The design team recommends that as the project evolves, the End-of-Project deadline be reassessed in view of the progression of the activities and the obstacles encountered during implementation. It would also be desirable for USAID to develop a more long-term view, perhaps three to five years, of the needs of this region in reproductive health.

4. *Monitoring and evaluating the RHSEP's impact*

In constructing the logical framework, the design team identified key indicators by which to measure program impact, and suggested sources of data. Although each CA will generate data that can be used to monitor and track its project components, USAID has not provided funds for an external evaluation of the program. Moreover, the current strategy plans for only one DHS survey in one country and no other data collection or qualitative evaluation is planned. The design team recommends that USAID plan for an external review and allocate resources to undertake some of the analytical work necessary to conduct the review.

**V. CALENDAR OF ACTIVITIES**

















## **VI. MONITORING AND EVALUATION OF TECHNICAL ASSISTANCE - PROJECT OUTPUTS AND IMPACT**

### **A. Monitoring**

The overall responsibility of the program falls under the charge of the NIS Task Force, with technical support from the Office of Population. Periodically, USAID will assemble the various CAs' CTOs to ensure that project monitoring from USAID's point of view is coordinated, and to ensure the mobilization of support and resources until the job is done. Field oversight is assured by the regional USAID mission in Almaty.

As knowledge of the region expands and activities develop, the suitability of the strategy proposed in this document may need to be reassessed to ensure that it continues to fit the needs of the target countries. Clearly, while the CAR can be viewed as a region with many common characteristics, sensitivity will need to be maintained regarding the emerging differences from country to country. Coordination with other international donors and technical assistance agencies will be critical to the success of the program and in to the optimal utilization of the resources.

### **B. Evaluation**

In an effort to facilitate the monitoring and evaluation of the program, the scope of work has been combined into a Logical Framework, which is presented on the next page. All of the proposed interventions are designed to achieve the common program goal: *improve the health of mothers and children in the Central Asian Republics.*

The Logical Framework suggests suitable indicators by which to measure program impact and indicates possible sources of data. However, it must be clearly stated that the resources included in the program are exclusive of the funds required to conduct the mid-term and final evaluations, and to collect impact-monitoring data. Only one DHS survey is planned for one country under the RHSEP. This data may have some utility as a baseline for the entire region, but this one survey will not support program assessment or impact evaluation at the regional or local level.

LOGICAL FRAMEWORK

<p><b>GOAL:</b></p> <p>To Improve the Health of Mothers and Children in the Central Asian Republics by providing quality family health services in sustainable programs.</p>	<p><b>VERIFYING INDICATORS:</b></p> <ul style="list-style-type: none"> <li>-Increased birth intervals</li> <li>-Decreased abortion rates and related complications</li> <li>-Decreased abortion-related hospital deaths</li> <li>-Decreased reliance on abortion as a fertility regulation means while maintaining current fertility rate levels</li> <li>-Decreased infant mortality</li> <li>-Decreased number of low birthweight babies</li> </ul>	<p><b>MEANS OF VERIFICATION:</b></p> <ul style="list-style-type: none"> <li>-DHS and other health surveys</li> <li>-Hospital and clinic- based service statistics</li> <li>-Census data</li> <li>-Hospital-based studies of maternal perinatal complications and death</li> <li>-Client surveys</li> <li>-Contraceptive use data</li> </ul>	<p><b>ASSUMPTIONS:</b></p> <ul style="list-style-type: none"> <li>-Continued support and collaboration of participating countries</li> <li>-Political stability and continued favorable relationship with the US</li> <li>-Availability of contraceptive commodities</li> </ul>
<p><b>PURPOSE:</b></p> <p>To modernize, to expand and to improve the sustainability of programs that provide family health services and modern contraceptives in the Central Asian Republics</p>	<p><b>END OF PROJECT STATUS:</b></p> <ul style="list-style-type: none"> <li>-Increased contraceptive use</li> <li>-Uninterrupted high quality contraceptive supplies</li> <li>-More diversified method mix</li> <li>-Improved management and planning of family health services</li> <li>-Increased public sector resources allocated to family health and contraceptive services</li> <li>-Increased number of private sector providers</li> <li>-Increased number of service delivery points for contraceptive services</li> <li>-Improved equipment in institutions providing contraception</li> <li>-Increased number of highly trained health care providers in contraceptive services</li> <li>-Improved family health counseling programs</li> <li>-Improved knowledge, attitudes, and practices regarding modern contraception.</li> <li>-Improved knowledge, attitudes and practices of clients and service providers regarding modern contraception</li> </ul>	<p><b>MEANS OF VERIFICATION:</b></p> <ul style="list-style-type: none"> <li>-Exit cables</li> <li>-Trip reports</li> <li>-Periodic program reports</li> <li>-Central Asian Republics' internal evaluation reports and budget allocations</li> <li>-Midterm and end-of-project evaluations</li> <li>-Commitment of CAR governments to fund programs for clients who cannot afford to pay</li> </ul>	<p><b>ASSUMPTIONS:</b></p> <ul style="list-style-type: none"> <li>-Good collaborative relationship with the MOHs in general, and especially with the sections of the MOH responsible for MCH in all four countries</li> <li>-Continued commitment of the CAR governments to privatization efforts</li> </ul>

DRAFT DOCUMENT FOR MISSION REVIEW

OUTPUT CATEGORIES:	QUANTIFIABLE OUTPUTS:	MEANS OF VERIFICATION:	ASSUMPTIONS:
<ul style="list-style-type: none"> <li>-A favorable political environment and supportive leadership to expand quality family health services access</li> <li>-A strengthened and more sustainable MOH capable of promoting and providing high quality family health services</li> <li>-Trained health care providers and strengthened family health training institutions</li> <li>-Educated clients knowledgeable about safety/efficacy of modern contraceptives and about health benefits derived from their use.</li> <li>-Shift from reliance on abortion to modern contraceptives use for fertility management</li> <li>-Diversified contraceptive sources and broader method mix available to consumers with more channels of distribution in the private and public sector</li> <li>-Coordination with other reproductive health initiatives concerned with perinatal care and breastfeeding promotion</li> <li>-More effective use of media in motivating the public for contraceptive use.</li> </ul>	<ul style="list-style-type: none"> <li>-2 observational tours for a total of 30-35 participants</li> <li>-4 symposia on benefit of contraception and quality of care, one in each country (up to 500 trained)</li> <li>-1 policy seminar (up to 50 trained)</li> <li>-Analysis of regulatory and legal environment in 4 countries</li> <li>-2 Management training workshops (up to 40 trained)</li> <li>-System in place to track public sector investments in family health</li> <li>-Sustained present level of financial support to family health, and increase by 20 percent annually over program life</li> <li>-At least 4 and up to 8 model service delivery/ training centers operational (at least one in each country)</li> <li>-3/4 workshops to improve clinical and counseling skills of providers (up to 600 providers updated)</li> <li>-1 training tour overseas for training in minilap (up to 10 trained)</li> <li>-Medical guidelines and standards developed and applied in 4 countries</li> <li>-4 training of trainers workshops (up to 60 trained as trainers)</li> <li>-Printed materials developed and distributed</li> <li>-Mass media campaign developed and implemented in 4 countries</li> <li>-5 Population Reports translated and mass distributed</li> <li>-1 regional communication workshop (up to 50 trained)</li> <li>-Commodity supply system established for private sector</li> <li>-Monthly coordination meetings of CAR CAs</li> </ul>	<ul style="list-style-type: none"> <li>-Activity reports</li> <li>-Exit cables</li> <li>-Trip reports</li> <li>-Periodic program reports</li> <li>-Provider surveys</li> <li>-Client surveys</li> <li>-Coordination meeting agendas and follow-up action memos</li> </ul>	<ul style="list-style-type: none"> <li>-No or few delays in implementation resulting from political disturbances or flexibility with end-of-project</li> </ul>

DRAFT DOCUMENT FOR MISSION REVIEW

INPUTS:	BUDGET BY COLLABORATING INSTITUTION:	MEANS OF VERIFICATION:	ASSUMPTIONS:																
<ul style="list-style-type: none"> <li>-Technical Assistance</li> <li>-Training, training materials, and equipment</li> <li>-Guidelines, treatment standards and medical reference materials</li> <li>-Advertising and communications materials</li> <li>-Commodities to support training programs</li> <li>-Medical equipment</li> <li>-Contraceptives for the commercial sector</li> <li>-Computer training and computers/software transfer</li> <li>-USAID donated commodities</li> <li>-Research</li> <li>-Evaluation</li> </ul>	<table border="0"> <tr> <td>AVSC</td> <td style="text-align: right;">950,000</td> </tr> <tr> <td>JHPIEGO</td> <td style="text-align: right;">580,000</td> </tr> <tr> <td>OPTIONS</td> <td style="text-align: right;">1,525,000</td> </tr> <tr> <td>SOMARC</td> <td style="text-align: right;">5,254,000</td> </tr> <tr> <td>DHS</td> <td></td> </tr> <tr> <td>JHU/PCS</td> <td style="text-align: right;">800,000</td> </tr> <tr> <td>Contraceptives</td> <td style="text-align: right;">1,000,000</td> </tr> <tr> <td><b>TOTAL</b></td> <td></td> </tr> </table>	AVSC	950,000	JHPIEGO	580,000	OPTIONS	1,525,000	SOMARC	5,254,000	DHS		JHU/PCS	800,000	Contraceptives	1,000,000	<b>TOTAL</b>		<p>Periodic financial and program reports</p>	<p>Continued support from USAID for the program and consistent funding flow</p>
AVSC	950,000																		
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## APPENDIX A

## ASSESSMENT OF KEY FAMILY PLANNING INSTITUTIONS BY AVSC

**Kazakhstan**

The parallel structures of Ministry of Health and City of Almaty added a degree of complexity to the AVSC team assessment of city and country reproductive health care needs. Following meetings with Kazakhstan Ministry of Health officials and with Dr. Nina A. Kaiupuva, Director of the Republic Research Center for MCH Protection, the AVSC team was directed to two city institutions that provide contraceptive services within the context of maternity and/or abortion services, and that have links to the medical college and refresher course training systems: the Perinatal Center at Maternity House #3 and the Human Reproduction Center of Almaty. Interest in and suitability and capacity for expansion and strengthening contraceptive services and training were assessed and an inventory made of equipment, supplies, and contraceptives. Linkages to pre- and in-service training were also assessed. A brief description of each facility is given below.

**Perinatal Center, Maternity House #3:** The 340-bed (soon to be 360 beds) Perinatal Center provides perinatal services to normal and high risk pregnant women from Almaty; an additional 30% women are referred from other regions of the country. It offers out-patient and in-patient services. The faculty of over 40 doctors is responsible for approximately 3500 deliveries and 4300 abortions per year. An estimated one-third of the women receive post-abortion IUDs.

The hospital is linked to both the medical colleges and refresher training systems. Faculty from the Medical Institute are based at this center and the hospital provides a clinical site for refresher training for neonatology. Two polyclinics ("women's consultation centers") are connected to the maternity house, including contraceptive services among other routine outpatient services.

After delivery, women remain in-hospital for 3-4 days. They are given information about contraception on an individual basis by both doctors and nurses; only a small percentage receive postpartum IUDs. Contraceptive pills are virtually unavailable on site or off-site at pharmacies. Staff requested information about contraceptives and training on how to give contraceptive information to patients. At staff's request, the site visitors gave an impromptu seminar, meeting with approximately 30 doctors and nurses to answer questions about contraception and the U.S. health care system.

The Perinatal Center is directed by Dr. Olga Alimbaecova, who additionally is the Chief OB/GYN of the City of Almaty. She strongly requested assistance to improve and expand contraceptive services and training and identified training needs to include a contraceptive

technology update and clinical training in temporary and especially permanent methods of female contraception. Equipment, supplies, and contraceptive needs were assessed.

**Human Reproduction Center of Almaty:** This center has been given a mandate by the City of Almaty to implement the municipal family planning program and it is the major provider of family planning services in Kazakhstan. Its services cover 8 districts and include 24 family planning rooms, located in polyclinics throughout Almaty, in addition to substantial services at the headquarters of the Human Reproduction Center. The family planning rooms are under the management of the center which also provides refresher training to the decentralized nursing staff and distributes commodities to the branches.

The center serves as an practical base for providing in-service family planning training for doctors, medical students, and midwives. Nurses are the primary providers of family planning services in the family planning rooms within the polyclinics. Currently doctors insert IUDs, but this fall nurses will be given clinical training and will begin inserting IUDs in the family planning rooms. These progressive advances, decreases in the abortion rate, and increases in contraceptive use are being compromised by reports of severe critical contraceptive shortages.

The center includes an outpatient marriage and family department, medical and genetic counseling, and a 100-bed in-patient clinic (under repair, but reopening in November). The marriage and family department offers infertility treatment, andrology, endocrinology, adolescents, and family planning, including counseling for couples registering for marriage.

The vigorous family planning policies of the City health department require women of reproductive age using the municipal polyclinics to visit the family planning clinic before seeking other services. In 1992, approximately 20,000 abortions were performed within the center's system; abortions are reported to be 40% lower in the first 9 months of 1993 because of the mandatory referrals. To extend access, family planning services are located in drug-treatment clinics. The high incidence of birth defects has led the city to require women to obtain two ultrasounds during pregnancy at the center or at polyclinics. Women having abortions are strongly urged to obtain IUDs or a prescription for pills. At the same time, there were few patient education materials available.

The center's director, Tamara Djusubaliev, M.D., is very eager for assistance to maintain the momentum and quality of the center's program and to strengthen contraceptive services. Contraceptive updates and clinical training for staff, and help in obtaining commodities and supplies are needed. An extensive inventory of equipment, supplies, and commodities was made.

**Conclusions and recommendations:**

1. Perinatal Center, Maternity House #3 and the Human Reproduction Center of Almaty are acceptable sites for collaboration in the improvement and expansion of contraceptive services linked to maternity and/or abortion services. These facilities are both connected with training systems.
2. Staff at these two facilities and linked medical school and refresher training faculty should be offered update training in contraceptive technology, service-centered clinical training in temporary and permanent methods of contraception, with emphasis on principles of choice and counseling women about contraceptive methods.
3. Training, equipment, and supplies should be offered to Perinatal Center, Maternity House #3 and the Human Reproduction Center of Almaty in support of contraceptive services for pills, IUDs, injectables, and female sterilization.
4. Determination should be made as to where contraceptive commodities and supplies should be transported, through the Ministry of Health or directly to the city service sites in support of the recommended training and service expansion activities. Within the context of mandatory referrals for family planning, the availability of a range of contraceptives are essential to give women real choices.
5. Technical assistance should be offered to help staff at these facilities to conduct self-assessments of quality of care.

**Kyrgyzstan**

The goal of AVSC's effort in Kyrgyzstan is to improve maternal and child health through the provision of safe, effective contraceptive methods. The objectives are to establish model service-centered training centers and to expand services for post-partum and post-abortion contraception within Ministry of Health service delivery systems.

The substantially smaller size of the capital city of Bishkek facilitated our work, and, as in Uzbekistan and Kazakhstan, visits were made to facilities that are primarily involved in pre-service and in-service training in women's health and which provide delivery and abortion services: Maternity House #4, Maternity House #5, and the Marriage and Family Consultation Center. Interest in and suitability and capacity for expansion and strengthening of contraceptive services and training were assessed and an inventory was made of equipment, supplies, and contraceptives. Linkages to pre-service and in-service training were also assessed. A brief description of each facility is given below.

**Maternity House #4:** This large 300-bed maternity hospital provides services to residents of Bishkek and also serves as referral center for women from throughout the republic. Approximately 68,000 women are in its immediate catchment area. It offers out-patient and in-patient services. The hospital staff of 560, which includes 119 physicians, assist in 4000-7000 deliveries per year and perform about 2000 gynecologic surgeries per year. There are 130,000 out-patient visits per year. Approximately 1500-2000 early abortions are performed annually.

The 18 exam room outpatient clinic ("women's consultation") is staffed by 23 physicians who work in 2 shifts from 7 a.m. to 7 p.m. Here family planning services are fully integrated with other outpatient services. All staff physicians provide family planning information and services, including IUD insertion. The staff estimates that 20% of the women are IUD users, with 5-6% choosing hormonal methods.

Family planning is essentially limited to IUDs, due to the virtual absence of other methods. Small fees are levied for IUDs and for the consult visit itself. Tubal ligations are performed only in the case of significant medical or social contraindications to further childbearing.

In addition to offering clinical services, Maternity House #4 serves as a training center for two institutions: the Scientific Research Institute of Pediatrics and Obstetrics, and the Dept. of OB/GYN of the Medical Institute. The hospital facilities include a nice lecture hall which can accommodate up to 100 people.

Maternity House #4 is directed by Dr. Gulbary Kachkinmaevna. She is eager for technical assistance in contraceptive methods and in procuring aid to improve and expand contraceptive services and training. This interest is shared by the staff. Specifically, up-date training for staff is desired for IUDs and injectables. Financial help is urgently needed to procure contraceptive commodities. Extraordinary interest is present for adding postpartum, post-abortion, and interval mini-laparotomy sterilization services.

This maternity hospital has exceptional human resources and facilities to accommodate the addition of sterilization services. The physical plant is currently under-utilized. Two floors on one wing of the hospital are not being used. Each floor includes one beautiful operating room, with scrub facilities, one recovery room, one procedure room, and one 7-bed patient room. Equipment is available to equip one operating room. Sufficient staff are available to provide surgeons, nurses, and anesthesiologists for sterilization services on two floors.

**Maternity House #5:** This hospital is much smaller than Maternity House #4. It is primarily an in-patient facility which serves as a referral center. Of 1600 deliveries per year, most are high risk, many with renal or hypertensive diseases of pregnancy. Little outpatient work is done. Approximately 800 abortions are performed yearly. The hospital is staffed by 22 physicians. The facility also services as a site for "refresher" training for

physicians. The director evidenced little interest in outside assistance.

**Marriage and Family Consultation Center:** This facility is the most active center for family planning in the republic. In 1992 approximately 4800 early abortions were performed, almost 1000 hormonal methods dispensed, and about 1000 IUDs inserted. The relatively small numbers for temporary methods reflects an acute shortage of contraceptive supplies. The center also provides services in ultrasound, prenatal care, infertility, urology, endocrinology, general gynecology, and social work.

The center is staffed by 11 physicians and 18 nurses. It has one large procedure room, 1 5-bed patient rooms, and 7 large counseling/examination rooms. The center is well staffed and well equipped, but contraceptive commodities and supplies are in short supply.

There are two free standing centers in the republic, one in Bishkek, the other in Osh, near the Uzbek border in the south. Below the centers, family planning services are offered in about 40 facilities at both the regional and district levels. These services are provided within the women's consultation clinics of maternity houses. Staff from the Bishkek and Osh centers visit these facilities monthly to provide tutorial oversight. Below this level are the rural polyclinics, staffed by physicians, and below this the Feldshers, staffed by nurses.

The center in Bishkek serves as a site for clinical training of physicians and nurses. It conducts week-long refresher courses for family planning service providers, conducts one-day seminars for administrative personnel and clinicians, and provides clinical experience for medical intern and nursing student rotations.

The center director, Dr. Anara Doolotova, is extremely interested in outside assistance to upgrade and expand family planning services. Contraceptive updates and clinical training for staff in all methods, and help in purchasing commodities and supplies are needed. The center has a list of women requesting sterilization in anticipation of the possibility of adding post-abortion and interval minilaparotomy sterilization services. With minor renovation and the addition of equipment and supplies, sterilization services could be offered in the section now devoted to abortion service provision.

#### **Conclusions and recommendations:**

1. **Maternity House #4 and the Marriage and Family Consultation Center are acceptable sites for collaboration in the improvement and expansion of contraceptive services linked to maternity and abortion services. These facilities are also connected with training institutions.**
2. **Staff at these two facilities, as well as a small number of medical school and refresher training faculty, should be offered update training in contraceptive technology,**

counseling, and clinical training.

3. Training, equipment, and supplies should be offered to Maternity House #4 and the Marriage and Family Consultation Center for pills, IUDs, injectables, and the addition of interval, postpartum and post-abortion sterilization services at the hospital, and interval and post-abortion services at the center.
4. Funds for minor remodeling should be offered to the center to allow for scrub facilities. The remodeling involves addition of scrub sinks in the room adjoining the procedure room.
5. Contraceptive commodities and supplies should be offered to the two service sites mentioned above in support of the recommended training and service expansion activities. Securing a supply of commodities is essential for a viable contraceptive program.
6. Technical assistance should be offered to help staff at these facilities strengthen supervisory system by conducting continuous self-assessments of quality of care.

## **Uzbekistan**

The Uzbek Ministry of Health's Healthy Generation policy is based on improving women's health by reducing maternal and infant mortality through contraceptive use. Women's reproductive health requires attention because of historically limited access to contraception and reliance on abortion as a primary method of fertility control.

In each of the three central Asian republics visited, AVSC pursued a "services-based" training strategy that will result in an appropriate, sustainable service and training program at the end of the project period. Medical institutional infrastructures are almost identical from country to country, leading to the development of a prototype training model in support of the goals.

With guidance from the Ministry, visits were made to facilities in Tashkent and Samarkand linked to in-service and pre-service training in women's health and which provide delivery and abortion services: the Research Institute of Obstetrics and Gynecology and Maternity House #9 in Tashkent, and Maternity House #4 in Samarkand. Interest in and suitability and capacity for expansion and strengthening of contraceptive services and training were assessed and an inventory was made of equipment, supplies, and contraceptives. Linkages to in-service and pre-service training were also assessed. A brief description of each facility is given below.

**Research Institute of Obstetrics and Gynecology, Tashkent:** The primary interest of this large WHO collaborative research center, directed by Dr. Damin Asadov, is the conduct of clinical trials of contraceptive methods. The maternity unit has 40 beds which support 2000-3000 deliveries per year. The abortion unit performs about 10 abortions per day. Innovative policies include support for breastfeeding, an end to swaddling newborns, laparoscopic sterilizations (about 1000-2000 per year), and anonymous outpatient abortion services. Its well-stocked Family Health Center, a contraceptive service within the Institute, provides IUDs and pills. A polyclinic building under construction nearby will have a floor dedicated to family planning. The Institute has a fee-for-service policy for all services except deliveries and also charges tuition for its medical trainees.

**Maternity House #9, Tashkent:** This 215 bed maternity hospital (165 for maternity cases, 50 for gynecologic diseases) provides services to local Tashkent residents. It offers outpatient and in-patient services. The hospital is staffed by 37 doctors and 96 midwives who assist in 2000-3000 deliveries and 1300 abortions per year. Both deliveries and abortions have decreased, linked to worsened economic conditions in the country.

Attached to the maternity hospital is a 12-room polyclinic ("women's consultation center"). The 65,000 women in its catchment area make 122,000 visits every year. Each of the 13 doctors staffing the polyclinic provides continuity of care to a caseload of 5000 women. All doctors provide contraceptive services. Stocks include IUDs, oral contraceptives, and some condoms. Staff claim that sufficient contraceptives are available to support demand.

The polyclinic is the primary site for family planning at the hospital. Pregnant women do not receive contraceptive information during the average of 15-17 prenatal visits, although doctors from the polyclinic give family planning lectures on the post-delivery ward. Some contraceptive information is given to women coming for abortions, but few leave with an IUD inserted or a pill prescription.

The hospital is one of three in Tashkent that provides two-month refresher training courses to groups of 18 doctors from all regions of Uzbekistan, 3-4 times per year. Additionally, five refresher course faculty from this maternity house delivery lectures, demonstrate operations, and staff conferences in other regions 2-3 times per year.

Maternity House #9 is directed by Dr. Delia Karimova, who has been appointed to the prestigious Fund for Healthy Mothers by the Ministry of Health. She expressed strong interest in procuring aid to improve and expand contraceptive services and training, as did her staff. Specifically, she requested updated contraceptive information, and training assistance for IUDs, injectables, and postpartum minilaparotomy services. An extensive inventory of equipment, supplies, and contraceptive stocks was made that substantiated the request to remedy basic shortages.

**Maternity House #4, Samarkand:** This maternity hospital serves local residents of Samarkand and also as a referral center for an additional 30% high-risk pregnant women from outside the district. Approximately 46,000 women are in its immediate catchment area. It offers out-patient and in-patient services. The hospital consists of administrative offices and outpatient polyclinic ("women's consultation clinic", gynecologic and obstetrical services. There are about 3000 deliveries per year and approximately 10 abortions per day.

Prenatal visits (average, 14) take place in the consultation clinics, but do not include contraceptive information or services. Contraceptive information is given within the abortion service, but only IUDs are available. 80% of the women receive post-abortion IUDs. Similarly over half the high-risk women have IUDs inserted postpartum. New mothers remain at the hospitals 5 days after delivery and attend lectures on new-born care and IUDs.

Maternity House #4 is directed by Dr. Zuchra Chikmariova. She and her staff asked for technical assistance in support of the expansion of contraceptive services, including supplies, equipment, and urgent needs for a range of contraceptive commodities. She requested a contraceptive update and clinical training for IUDs, injectables, and postpartum minilap.

There are close linkages between Maternity House #4 and the Medical Institute of Samarkand, headed by Dr. Islam Z. Zakirov. Medical students rotate through the maternity hospital polyclinic and obstetric/gynecologic services daily. They receive in-hospital clinical training at the 800-bed Medical Institute.

### **Conclusions and Recommendations**

1. **Maternity House #9, Tashkent, and #4, Samarkand are acceptable sites for collaboration in the improvement and expansion of contraceptive services linked to maternity and abortion services, and also because of connections with refresher course and medical college training.**
2. **Staff at these two facilities, as well as medical school and refresher course faculty, should be offered update training in contraceptive technology, counseling, and clinical training.**
3. **Training, equipment, and supplies should be offered to Maternity House #9 and Maternity House #4 for pills, IUDs, injectables, and postpartum minilaparotomy services, with special attention to remedying the imbalances at the Samarkand site.**
4. **A high priority should be given to providing contraceptive commodities and supplies for distribution to the two service sites mentioned above in support of the recommended training and service expansion activities.**

**DRAFT DOCUMENT FOR MISSION REVIEW**

5. **Technical assistance should be offered to help staff at these facilities to strengthen the supervision system by conducting self-assessments of quality of care.**
6. **Staff from a third site to be determined should be selected from Andizhan, within the populous Fergana Valley in eastern Uzbekistan, for inclusion in training activities as described above, as recommended by the Uzbek Ministry of Health.**

**APPENDIX B**

**ASSESSMENT OF KEY FAMILY PLANNING INSTITUTIONS BY JHPIEGO**

**Kazakhstan**

**MOH Briefing:** There are five million Kazakh women of reproductive age. The country is divided into four regions: North, South, East, West. Unplanned pregnancies are common in all regions. North and East regions have high abortion rates: one abortion per two births. South and West regions have multiparity with little birth spacing. The need for family planning is urgent.

The MCH Research Center has established a family planning division. "Family planning" is a sensitive term both in parliament and in public, because it is synonymous with birth restriction and limitation. The MOH now uses the term "family health" and emphasizes increased birth spacing.

Throughout the country, family planning rooms have been placed in out-patient clinics for family planning consultation. In a family planning room, counseling on contraceptive methods takes place. Some family planning rooms also include an exam table, where doctors can examine clients. Since March 1993, twenty-two family planning rooms have been functioning in eight districts. They are staffed by nurse midwives and physicians who are trained by the Human Reproduction Center in Almaty. By establishing family planning rooms, the MOH hopes to reduce the number of abortions.

In Almaty, the Human Reproduction Center (HRC) also provides family planning services. Dr. Tamara Dzhusubalieva is the director of the Human Reproduction Center (HRC).

Throughout our visits, we continually heard mention of the January MCH conference that was sponsored by USAID. Not only were people thrilled with the information they received, but they have already implemented policies that were discussed at the conference (ie. rooming-in, breastfeeding on demand). The enthusiasm and actions indicate the potential of our work having a large impact on future family planning services.

**Perinatal Center:** (Director:Dr. Olga Alimbaeva) The Perinatal Center is primarily a tertiary-care referral center for women with complicated pregnancies. It currently has 340 beds but will expand to 360 beds after the first of 1994. It currently includes only maternity services, although a women's consultation out-patient clinic will open in January 1994. The Center is comprised of two departments: neonatology and gynecology. There are sixty beds for gynecology, and an additional fifteen beds specifically for adolescents.

In Kazakhstan, women's consultation centers in each district refer women to maternity

houses if they are pregnant, and the women delivers there. If the women is high risk, she is referred to the Perinatal Center. Health services at the Perinatal Center are free, including abortion services. Multiload was the only available IUD.

Approximately ten to fifteen abortions are performed per day under general anesthesia. All are curettage abortions. Mini-abortions, using vacuum aspiration, are performed in other women's consultation clinics up to 22 days gestational age. At the Perinatal Center, approximately 30% of women who obtain abortions request IUD insertion post-abortion. The Perinatal Center relies on women's consultation clinics for counselling. IUDs are inserted five to six days postpartum. Women are asked to return to their district women's consultation center ten days following discharge from the Perinatal Center.

Rooming-in was begun in 1985. Women now stay only three to four days post-delivery, as shorter stays are considered more economical and healthier for the baby. The neonatology unit is equipped with sterile gloves, incubator, and bilirubin light: definitely more modern and better equipped than most centers.

Refresher training in neonatology is conducted at the Perinatal Center under the direction of Dr. Kaufman. Doctors from around the republic come to the Perinatal Center every three years for training. Training courses run continually and include 40-50 physicians per course. The courses are primarily theoretical.

An AVSC consultant, John Fishborn, conducted mini-lap training at this institution.

**Human Reproductive Center:** (Director:Dr. Tamara Dzhusubalieva; Deputy:Dr. Gunara Ascarava) The Human Reproduction Center is comprised of three divisions:

- Marriage and Family out-patient clinic
- Medical-Genetic center
- 100-bed in-patient hospital (area under repair during visit)

The Marriage and Family Center serves all of Almaty, which includes 18,000 women of reproductive age. At the main center, thirty women are seen each day.

The Marriage and Family clinic treats infertile men and women in the city. After the initial exam, the patient is referred to the in-patient facility for treatment. A urologist is on staff at the clinic.

There are five branches of the adolescent and children's GYN center in the city which treat girls younger than fourteen years of age.

Almaty is made up of eight districts, each with a large polyclinic and family planning room. If a woman is seen in a polyclinic for any reason, she must also be seen in the family

planning room before she leaves the polyclinic. These rooms primarily prescribe IUDs, though Tamara asked about mini-lap for mentally handicapped women. In addition to family planning rooms in polyclinics, there are rooms in women's consultation centers, as well as in psychiatric homes and drug rehabilitation centers. These rooms primarily prescribe IUDs, although Tamara asked about mini-lap for mentally handicapped women.

In the past year, the City government, as well as the MOH, has become interested in family planning. As discussed above, twenty-two family planning rooms have been opened in health care facilities throughout Almaty, and there are plans to open more rooms. Of the twenty-two rooms, fourteen are staffed by nurse midwives, and eight are staffed by physicians. A one-week training course was organized in April 1993 for the staff of the family planning rooms. Currently, if a women who is seen by a midwife would like an IUD, she must go to a different location to have the IUD inserted by a doctor. However, Tamara is planning an IUD training course for her senior midwives in November 1993. She is already facing resistance from the physicians.

Due in part to the efforts of the MOH family planning program, the abortion rate has reportedly decreased 40% this year. Doctors who perform abortions are required to discuss and recommend contraception. Doctors are now being encouraged to promote pill use (Tricholar). However, no pills are in stock at the HRC. No injectables are available. When the in-patient hospital reopens, Tamara and her colleagues are interested in beginning interval mini-lap and laparoscopy. In general, the family planning program is in jeopardy due to the lack of commodities.

Refresher training takes place in the family planning rooms, but it is theoretical training only. The staff believes that physicians should ideally receive ten to twelve days of training, and that family planning should be added to the medical school curriculum.

Incidence of syphilis and GC is on the increase because of the lack of pharmaceuticals. The increase of STDs is seen primarily among the alcoholics and drug abusers. There is also an increase in tuberculosis as well. Every newly registered patient is tested for STDs and HIV twice per year. Pap smears are mandatory for every woman with a GYN infection or at least once a year. Colposcopy is available.

There are no service guidelines for the clinics. Drug companies leave literature that is often reproduced and followed.

**Advanced Training Institute:** (Director: Dr. Ivan Pavlich Korkan) The Advanced Training Institute, as far as we could tell, has branches in hospitals and clinics throughout Almaty. At the branch located in the Perinatal Center, doctors receive refresher training in neonatology. At the branch located in Maternity Hospital No. 1, doctors from throughout the republic (including first year doctors) receive refresher training in obstetrics and gynecology. Upon

completion of medical school, doctors must spend one year (their 7th year of training) practicing under the supervision of Advanced Training Institute professors. They complete one to two month rotations at various sites, according to their specialty. Doctors receive one to two month refresher training courses every three to five years. Maternity house No.1, given its location in the outskirts of Almaty, primarily serves a rural population.

Maternity House No.1 has two hundred beds, sixty for gynecology. An average of 3000 babies are delivered each year. An average of ten to twelve abortions are performed daily, including abortions up to 28 weeks gestational age for medical/genetic reasons. Abortions performed after fourteen weeks gestational age are for medical or social reasons (ie. drug abuse, family instability). All women are counselled about contraception post-partum and post-abortion. Approximately 30% of women receive an IUD post-abortion, and others receive pills before leaving the hospital. The staff expressed a great deal of interest in mini-laparotomy (interval and post-partum).

Based on the strong recommendation of John Fishborn, we met with Professor Ivan Pavlich Korkan and colleagues at Maternity Hospital No.1. Anticipating the arrival of Libby Antarsh, Dr. Jibek Karagulova of the WHO Collaborating Center for Primary Care and Nursing also attended our meeting. Everyone spoke highly of the training they had received from Dr. John Fishborn and requested we build on and expand the training. Because they were given no mini-lap kits following the training, they have constructed their own instruments by stretching and bending uterine sounds. They are very much in need of mini-lap kits which AVSC or JHPIEGO needs to provide with some additional clinical training. More training in all methods and any educational materials on all methods was requested. This should include slide sets and written material translated into Russian. In addition, visiting doctors should plan grand rounds at this hospital.

Dr. Korkan has invented his own laparoscopic equipment (minus cautery and/or ring applicator for sterilization) and is performing transvaginal hysterectomy. He would do interval laparoscopic tubal ligations if he had the equipment.

Dr. Korkan emphasized two points: 1) his hospital provides refresher training for doctors from all over the country, so information will be easily disseminated, and 2) training his staff at either the Perinatal Center or the Human Reproduction Center will be difficult, if not impossible. At any one time, Korkan has 37 seventh year medical students and forty doctors receiving refresher training.

A verbal agreement was made with Dr. Korkan to organize a meeting of the Chairs of gynecology from the six medical institutes in the country in February/March to review the family planning curriculum (see description of meeting with Paltusheva below). We hope to discuss what needs to be accomplished versus what is being accomplished. Drs Korkan and Karagulova agreed to help organize a similar session for nurses. Appointments will be made

for discussion in March. Dr. Korkan and Jibek are recent acquaintances but form an energetic team. Dr. Karagulova is also interested in addressing the medical barriers issues.

**State Medical Institute of Almaty:** We met briefly with two of the OB/GYN professors. There are no lectures in family planning. Students receive practical training at the Human Reproduction Center or in maternity houses. All professors work in the maternity house. If a student chooses to specialize in OB/GYN, the 6th and 7th year are practical training, monitored by the Institute. There are approximately seventy medical students in the 6th year, but only thirty-five in the 7th year. In the past, the medical school curriculum was only modified through Moscow. The institute uses drug company literature and has audio visual capabilities. The Chairman of the dept has already been vocal against the pills, making such public remarks as the pills can only be used for a year. She was not present at our meeting. This institute was not ready to take a lead in pre-service education.

**Meeting with Dr. Tamara Paltusheva, Chief OB/GYN for MOH:** We requested a debriefing with Dr. Paltusheva to inform her of our plans, discuss the study tour, and ask a few questions. Dr. Paltusheva was excited about our plans. It was clear at the end of our visit that all future plans should be discussed with her and receive her approval.

We described the study tour and requested she select the two Kazakh participants. We outlined criteria for participation and the location of a future mini-lap training center (center providing services for low-risk women, capable of performing interval and post-partum mini-laps). She agreed to confirm the two names within a month.

We also discussed the review and development of national service guidelines. She would like to see a copy of our guidelines and offered to show us theirs. Once we all have a chance to look over each other's guidelines, we will have a meeting to review them together. She suggested the month of May, once everyone has attended Futures' April seminar.

She was enthusiastic about the meeting with Dr. Korkan to review the medical school curriculum. However, she indicated that he is not in a position to draw conclusions and make decisions on the final curriculum: the MOH must be involved as well. She provided us with the current OB/GYN curriculum and asked us to provide her with a sample curriculum. She will make arrangements in conjunction with Dr. Korkan to schedule the working session.

## **Kyrgyzstan**

**MOH Briefing:** The team met with Deputy MOH Kafan Subanbaev and his colleagues: Dr. Chubakov (Director, Refresher Training Center), Dr. Anara Doolotova (Chief, Marriage and Family Consultation Center), Dr. Ludmila Rybalkaneva (Deputy Director, Institute of Obstetrics and Pediatrics), and Olegbek Buylashov (Deputy Director, Scientific Research Center in OB/GYN).

The population of Kyrgyzstan is 4.5 million. As in other republics, the hospital system is distributed as follows: republic hospitals, district (oblast) hospitals and clinics, regional (rayon) hospitals and clinics, rural hospitals, rural ambulatory clinics, and feldsher posts. All research institutes are at the republican level. In the past five to six years, the MMR and IMR have declined. More recently, however, the IMR has begun to rise as a result of economic difficulties. As many as 24% of Kyrgyz women give birth two times in one year.

The breakup of the USSR has created enormous economic difficulties for the highly dependent Kyrgyzstan. The government currently spends only \$3-\$4 per capita on health care. Dr. Subanbaev is confident that his country will prosper in the not-so-distant future.

According to Dr. Subanbaev, the health system inherited from the USSR "is not a bad system." It provides primary services and treatment to everyone at no charge. However, the emphasis was always on quantity, based on attempts to outnumber the Americans. They certainly lead the U.S. in numbers of doctors and hospital beds. However, the government now believes that quality is more important than quantity, and the MOH is responding accordingly. To date, there has been a 10% cutback in the number of beds, and another 15% cutback will take place in 1994. Whereas hospitals and clinics were formerly funded according to the number of beds, new financing reforms will fund hospitals according to the size of the population they serve. In addition, the number of medical students accepted each year into the medical institute will drop from 900 to 500. Mid-level health workers will be given more responsibilities (and the appropriate training). A new emphasis will be placed on improving the professionalism of health care providers.

The development and implementation of a National Health Program is underway. The program will include two stages: 1993-1995 and 1995-2000. The first stage will address the most urgent and supported concerns. The second stage will address problems that cannot currently be supported/financed by the government. Dr. Subanbaev is unsure where family planning fits in to the program.

A social work program is currently underway. The MOH trained 1,000 women aged 30-35 who have experience in childbirth and motherhood to work with high-risk families (dysfunctional, alcoholic, impoverished, etc). One worker is responsible for thirty families and is paid by the MOH. Their work is evaluated according to the health of the family.

Lack of finances threatens the future of this program (which, by the way, was the topic of Subanbaev's doctoral thesis).

Family planning programs and rooms were also established. Initially, they were strongly denounced by religious and national leaders as programs to decrease the national Kyrgyz population. In response, the MOH brought the opponents together, argued for three and one-half hours, and eventually generated support for their programs. The Muslim and Christian leaders have since published articles supporting family planning efforts.

Based on meetings with the MOH throughout our visit, the MOH appeared very enthusiastic and grateful for our assistance. They hosted a wonderful dinner for all the CAs before our departure. We did not simply identify counterparts in Kyrgyzstan; we found friends.

**Maternity House No.5:** (Chief doctor:Guldana Dyshenbaeva) The maternity house is primarily an observational, in-patient maternity house. There are no out-patient women's consultation services. It serves primarily difficult cases, particularly pregnant women with kidney diseases.

There are seventy-five obstetric beds, twenty-five gynecology surgery beds, fifty beds for newborns, six beds for intensive care, and five beds for abortions. In the first nine months of 1993, 1150 babies were delivered. Approximately 800 abortions are performed each year up to twenty-eight weeks gestational age. Both local and general anesthesia is used. Eight to ten percent of post-abortal women accept an IUD. Sterilization is performed during C-sections for medical reasons, and fifty to seventy sterilizations occur each year. There is a staff of thirty-two, with twenty-two staff members working at one time.

Maternity House No. 5 is the training site for OB/GYN doctors from throughout the republic to receive refresher training. Dr. Chubakov, Director of Refresher Training, accompanied us on our visit. There is another site in the city of Osh. Groups of twenty doctors pass through the one-month training at one time. Five professors from the Refresher Training Institute teach at the maternity house. In addition, the professors conduct follow-up visits to the clinics of the trainees.

The training includes only one lecture on family planning. However, family planning and contraception is integrated into many other topics (STDs, cancer, etc.). The faculty is attempting to establish a self-instructional reading program. Computer assisted instruction (CAI) is too new since the school lacks computers, however the ideas is intriguing for these instructors.

Although the maternity house is one of only two refresher training sites in the country, it has absolutely no equipment or educational materials for training. They use only words and hands to train. The doctors requested slides, models, overheads and projector, and written

materials. They potentially have access to a VCR at the medical institute and to computers at Chubakov's center. There is a lecture room at the maternity house that seats forty people. They said that all 1,000 OB/GYN doctors in the country would like a copy of Contraceptive Technology.

**Maternity House No.2:** Dr. Chubakov accompanied us to the maternity house. The meeting included the chief doctor and her colleagues.

Maternity house No.2 is one of two practical training sites for OB/GYN students at the Kyrgyz State Medical Institute. Three to five Medical Institute faculty teach students at Maternity House No. 2. During the fourth year, students spend twelve hours observing OB/GYN procedures; during the 5th year, four hours which includes IUDs. In the 6th year, after deciding to specialize in OB/GYN, students complete one month of hands-on training. The seventh year of postgraduate training is coordinated with the Refresher Training School. In all training, family planning and contraception is included, although no formal family planning curriculum exists.

A new curriculum that includes family planning is currently being developed for medical and pharmacy students. The first step, the overview, is nearly complete. The second step involves converting the curriculum to the European medical training curriculum. WHO is helping to develop the new curriculum, but Chubakov said they would take assistance from JHPIEGO as well. All doctors present discussed their unique opportunity to select the best training ideas from around the world and incorporate them into the curriculum. They would like to begin the new curriculum in September 1994.

Training guidelines were discussed. They explained they must follow laws that are determined by the MOH. Laws were most recently reviewed and revised in 1991. Chief specialists at the OB/Pediatrics Institute assist the MOH to develop laws.

An interest in mini-laparotomy was expressed. Sterilization is only performed if a woman is over thirty years, has at least two children, and only at the time of C-Section. We will try to include professors from Maternity house No. 2 in any mini-lap training. The maternity house desperately needs teaching aids and educational material. The staff was excited about our visit and enthusiastic to work with us.

**Maternity House No. 4:** (Chief Doctor: Gulbari Kachkintaeva; Director, OB/GYN Medical Training: Makenjan Musuraliev) Dr. Chubakov accompanied us to the maternity house, where we met with the Chief Doctor and the Director of medical training. Both participated in the Futures' study tour to Turkey to examine family planning programs. The staff appeared eager to meet with us and expressed much interest in future training programs.

Maternity house No. 4 is a large, comprehensive maternity house that includes a women's

consultation clinic. It is the only institute with complete in-patient and out-patient services to provide training. It serves 68,000 women and has more than 500 beds, 300 for GYN. The maternity house employs 560 workers, including 190 doctors with fifteen medical faculty. It is a training site for both the Kyrgyz State Medical Institute and the OB/Pediatrics Institute. One hundred students (ten groups of ten students) rotate through the GYN department each year. The GYN chair also trains post-graduates. In addition, the department travels to the local oblasts to deliver grand rounds at least twice a year.

Each year, approximately 4000 babies are delivered, and 2000 GYN operations are performed. 1500-2000 abortions are performed. Vacuum is used up to six weeks then curettage. Both general and local anesthesia is used. There is a real shortage of gloves, aspiration equipment, and commodities. After the Almaty conference, they began rooming-in and breastfeeding on demand. They are interested in allowing the man to attend the delivery, but the women are not quite ready.

Contraception is discussed post-partum, and IUDs are primarily used. There is interest in injectables and Norplant. Leiras came to negotiate Norplant introduction but conducted no follow-up. Approximately twenty to thirty IUDs are inserted each week. IUD acceptors return in ten days post-insertion, at one month, at six months, and are then referred to the district clinic. OC acceptors must return with the first three MPs before referral.

On exams, all students must answer questions about family planning. The practical training begins in the 6th year with specialization. Each student keeps a clinical log of his work. The chairman has outlined lesson plans which include family planning. This OB/GYN chair was the first to show us a family planning curriculum in the CAR. The greatest problem in teaching: too many students.

The Maternity House is in desperate need of educational materials. Despite the fact the house is a training facility for a majority of OB/GYN students, it has no educational materials, an ancient slide projector, no video capabilities, and few written materials.

**Marriage and Family Consultation Center:** At the headquarters in downtown Bishkek, 250-300 patients pass each day. Thirty percent are FP acceptors but only 1.8% are for OCs. There are seven physicians on staff to exam women. In addition, there are four regional centers. Due to economics, these centers are used for follow-up of trainees even though there has been no instruction for follow-up. Physicians train at the HQ at the rate of one to two per week. Primarily, the trainees are attached to one of four preceptors for hands-on skills. There is no curriculum, no schedule, and no checklist. It is really ad hoc. Nurses and midwives train in a similar manner. Once or twice a year the Center arranges for regional continuing education.

Commodities are a problem--no supply. This clinic is a city clinic even though it is supervised by the MOH. Supplies need to be bought from the MOH warehouse.

The Center wants to become a training center for the republic for in-service and pre-service training. Ideally, as a center, they would like train ten to twelve doctors each week, every week. To do this, the center needs to develop a training center and designate a coordinator, and it has asked JHPIEGO and AVSC for assistance. A room is available for training, but it needs to be furnished and equipped with training materials.

## **Uzbekistan**

**Ministry of Health:** The offers of assistance by the Reproductive Health and Technology Program (the new name for the team of USAID CAs) were received with much enthusiasm and interest. The Uzbeks feel strongly that their country needs assistance, but they also truly believe their future is bright. Based on the enthusiasm and devotion of the people, coupled with the country's human and physical resources, there appears to be much hope for Uzbekistan. There is potential for JHPIEGO's programs to have a tremendous impact on future family planning services.

The Cabinet of Ministers signed the National Plan for A Healthy Generation during the visit of the USAID team. Within the plan, the MOH designates the Uzbek women who should have children. Over 5 million women were examined to delineate three categories of women: 1) those for whom pregnancy is a serious threat and thus should not become pregnant, 2) those who have external genital disease and should be treated first and then can become pregnant, 3) those who are normal and can become pregnant as desired. In this delineation, anemia and renal disease are considered external genital diseases requiring treatment first. The best age for pregnancy is specified from 20 to 35 years. Thus, women outside these ages will be educated not to become pregnant. Clearly, only healthy mothers are to have healthy children. This decree for a healthy generation has been adopted.

The most popular contraceptive method is the IUD, principally due to its availability and women's fears of oral contraceptives. The government wants to increase the number of women using Oral Contraceptives (OCs) and Noristerat but neither is in sufficient supply. Schering, Organon and Upjohn are represented in Tashkent. There are an estimated 500,000 IUD acceptors each year. The government is very proud of its decreasing IMR and MMR. For the first time the IMR is less than 30/1000 live births and MMR has dropped from 73 to 48/100,000 live births. Of course the rates are higher in the rural areas. Abortions are common, and women believe they are safer than OCs. Counselling for informed choice and/or motivation to use contraceptive in lieu of repeated abortions is a foreign concept but receiving more attention. Thus, there is great need to address counselling in one of the first activities.

Low acceptability of pills has led to the common remark that Uzbek women are different from other women in the world. While Uzbek doctors accept that contraceptives offer non-contraceptive benefits in Western women, they do not believe that Uzbek women will experience the same non-contraceptive benefits. A prominent physician/MOH official argued that the pill is inappropriate for Uzbek women because the women are anemic. The health care system is controlled by physicians: all health administrators and decision makers are physicians. Many physicians are unemployed, and the role of nurses and midwives is menial at best.

There are nine medical institutes for pre-service training in Uzbekistan, of which three are in Tashkent. JHPIEGO was asked to work with medical institutes in Tashkent, Samarkand and Andizhar. In addition to the medical schools, Uzbekistan has "Refresher Training Institutes" for in-service providers to update their skills. JHPIEGO and AVSC were also asked to conduct courses in clinical and training skills for instructors at the refresher training institutes in these cities.

Throughout the visits, there was frequent mention of the USAID/MCH seminar which was held in Almaty in January. At several sites, we saw the JHPIEGO materials that Ron Magarick had given out and were pleased to see they had been distributed.

**Maternity House No. 9, Tashkent:** Dr. Karimova conducted the discussions and tour of this 165-bed facility which offers delivery, abortion, and women's consultation services. The maternity house covers a pre-established geographical area. In the delivery and abortion service, 37 doctors and 96 midwives rotate. In the out-patient women's consultation clinic, there are thirteen doctors each of whom are responsible for 5000 clients, equalling a total of 65,000 patients. The out-patient area has seven exam rooms covered by two shifts of doctors.

Of the 165 beds in the Maternity House, 50 are designated for gynecology. There are 3000 deliveries per year. 10% of the pregnant patients are toxemic. Women remain at the Maternity House for 5-6 days following delivery, 10 days following a C-Section. The doctors are responsible for teaching women about family planning while they recover in the hospital.

In 1992, at this center, there were a total of 122,000 patient visits, and 1700 IUDs were inserted. Both the CuT and the Russian-made Multi-load are available. IUDs are inserted one month post abortion, and 3 month post delivery. IUD patients return in one week, one month, then every six months. Due to the short supply, only one cycle of pills are given out at a time, requiring a return visit every month. There are no injectables. A complete pelvic exam with cultures and blood tests are done on the first visit. Ironically, B/P is not routinely performed on the monthly visits. Ultra sound and colposcopy services are available.

Vacuum and curettage abortions are conducted under general anesthesia. Women stay one night in the hospital. An IUD is inserted with the procedure if desired by the client, but OCs are rarely prescribed. The physician is responsible for discussing family planning with the woman. Abortions are free of charge.

Exam gloves are in short supply, and disposable gloves are reused after autoclaving. Simms speculums are used for most procedures. Disinfectant is Chloramine which is made up daily. Instruments soak for 30 minutes in the solution before being transferred to the autoclave.

This Maternity House conducts in-service refresher training for regional doctors. Refresher training is required every 5 years. Each course lasts for 2 months; 18 doctors participate in each course. 3-4 different courses are conducted each year. Courses focus on a variety of issues, and the participants know the topic of the course before arriving. Courses include a practicum. Five faculty members conduct these refresher courses.

Due to its large client load and its in-service and pre-service training capabilities, this maternity house was chosen for training and service expansion activities by both JHPIEGO and AVSC.

**Tashkent Medical Institute No. 2:** The Dean of the OB/GYN department, Dr. Tomas Tygalanov, hosted the visit. Within the OB/GYN department there are three departments: two for local students, one for international students. The department uses Maternity House No.12 for practicum training. All medical students complete six years of training before receiving a diploma. The first five years are general training. In the sixth year the student must specialize. Top students may choose to go to the Scientific Research Institute for additional post-doctoral training. Family planning training in the medical school curriculum is limited to thirteen hours.

A potential curriculum meeting of the deans and chairman was discussed. The objective would be to compare the current training with what is needed and then modify the curriculum and training for the school year beginning in September. Although an ambitious task, the Dean felt confident it could be accomplished and suggested June for the meeting. The faculty vacation in July and August. Dr. Tygalanov expressed particular interest in written training materials available from JHPIEGO. Thus, JHPIEGO needs to be ready with a show-and-tell in Russian.

The Dean will assist in the development of national service guidelines, now slated to begin in February 1994 following the contraceptive update. At that time, JHPIEGO's training packages should be made available as a preview to discussions during the curriculum meeting.

There are fourteen clinical faculty members at the Medical Institute, and five work at Maternity House No. 2. At Maternity House No. 12, a special room is designated for IUD insertions. In the first nine months of 1993, 1,099 IUDs have been inserted. Since there was a problem with perforations, sounding of the uterus is highly emphasized. IUDs are inserted 6-7 days post partum, immediate post abortal. There is a real shortage of gloves and reports of operating without gloves. The IUD patient rests at the clinic for two hours before going home. She is instructed to return in one week, monthly for 3 months, and then every 3 months. In addition to gloves, this room needs a light source and speculums. Pills are prescribed, but there are no injectables.

**Maternity House No.4, Samarkand:** JHPIEGO and AVSC met with the Chief Doctor, Zukrah Chikmariova, and her colleagues, including the MOH Chief OB/GYN for Samarkand, Tashtimir Abdyrohimov.

Maternity House No. 4 has eleven exam rooms. Fourteen physicians staff the rooms, and all give information regarding family planning. The doctors are divided into two shifts, and approximately 250 patients are seen per day. The maternity house offers out-patient OB/GYN services, dental services, general practitioner's office, and ultra-sound services.

The Maternity House consists of four buildings: 1) women's consultation and administration, 2) gyn procedures, 3) newborns, 4) pregnancy pathology. Each year, the house delivers 3000 babies, averaging 10 births per day. Approximately ten abortions are performed each day.

Women have 14-17 prenatal visits during pregnancy, but family planning is not discussed at any visits. Following delivery, women are required to attend a 1-2 hour lecture on taking care of newborns and family planning.

IUDs are inserted on the fifth day following delivery. Women receiving IUDs are asked to return to women's consultation in one week, immediately following the first menstrual period, and then once every six months. The staff expressed an interest in prescribing hormonal methods following abortion.

Dr. Islam Zahidovich Zakirov, Chairman of OB/GYN at the Samarkand Medical Institute, joined us at lunch time. He has worked with the Institute for forty years, serving as Chairman for thirty years.

Currently, students receive their practical training at Maternity House No. 4. All fourteen doctors from the house work with students, and 4 maternity house doctors are on the Medical Institute faculty. Medical Institute instructors only conduct theoretical training at Maternity House No.4 to complement the practical training conducted by the Maternity House doctors.

Currently, 6th year students train at Maternity House No.4 in two groups of seven students for fifteen days. In the 4th year, student receive six hours of family planning lectures and observation. In the 5th years, students spend eight hours on family planning. In the 6th year, students spend eighteen hours in clinical training and lectures. There is no family planning curriculum.

Dr. Zakirov clearly recognizes that family planning training is largely insufficient. He claims he is starting a new revolution in teaching that he hopes will bring students to the level of practice of European medical students. Students will increase general training from 6 to 7 years. OB/GYN specialists will be required to train for an additional three years. Dr. Zakirov is eager to include a family planning curriculum and largely increase the number of hours devoted to family planning. June is the best month for him to work on revising the curriculum.

**Ministry of Health:** (Dr. A. Yarkulov) At this meeting, The CAs proposed their plans. Dr. Yarkulov participated in the study tour that Future's conducted to Turkey. He is very enthusiastic about our work and anxious to begin as soon as possible. Dr. Yarkulov agreed to appoint a committee to work with JHPIEGO on the development of national service guidelines. This activity would begin in February as it is essential to quality training and quality of care. However, Dr. Yarkulov requested that the JHPIEGO/AVSC team work not only in Tashkent and Samarkand, as planned, but also in Andizhan. Andizhan is in the far east and represents the most densely populated portion of the FSU. It is also one of the more traditional muslim sectors. The American Embassy, after hearing of the request, said "jump on it!" Zakirov, as well as Zukrah and her colleagues, were and will be an absolute joy to work with. Their enthusiasm, interest, and warm hospitality were remarkable.

## APPENDIX C

### ASSESSMENT OF KEY MEDIA AND COMMUNICATION INSTITUTIONS BY JHU/PCS

#### KAZAKHSTAN

- o The Ministry of Health MCH program is divided across four regions: North, South, East and West (19 provinces). The abortion rate is highest in the North and East (with the ratio of abortions to pregnancy at 1 to 2.) The South and West regions are characterized by multiparity and short birth intervals, focus should be on child spacing and FP is urgently needed.
- o Intellectuals and much of the public have rejected the term "family planning" and communications should use "family health" instead. Emphasis should be put on the use of contraceptives for spacing to save mothers and children's health and lives.
- o The House of Health is the propaganda (IEC) department for the MOH and covers a wide range of health education topics. There are similar centers in all regions of the country, through which activities are coordinated. For example: during the cholera outbreak, they had media programs, newspaper coverage, placards, and hand-out materials to explain the disease to everyone. The hand-outs were distributed to the regional centers.

All work is planned annually following MOH plans. Specific programs are developed after discussions with the MOH, based on their dictated needs. These are tied closely with health situations and cycles (summer intestinal problems versus respiratory infections in winter, etc.) Once topics are decided, the House of Health seeks out medical experts and links the experts with the topics. Typical use of media includes plugging experts into existing "Health" programs on tv and radio.

The House of Health works with producers at the tv and radio stations to produce mass media programs. These programs tend to be presentation/documentary style formats. For the most part, entertainment and PSAs have not been used. Magazines are occasionally used, but they don't reach everybody.

In the past, materials came from Moscow. Now staff must produce materials on their own. One recent example was a nicely illustrated comic book style leaflet, developed with funding from UNICEF.

Mr. Sedumonov, the Deputy Director of the House of Health, suggests the following popular entertainment programs/ popular performers:

- Tamasha (tv entertainment musical program)

- Singers: Rosa Rymbaera - Alibek Dnishev  
Ermek Serkebaev
- Group A-Studio
- Radio Max (radio and tv program)

- o The Almaty City TV Station broadcasts on 2 channels, the local city channel and the Russian channel which reaches throughout the CAR region.

Costs average about \$100 to \$150 per minute for production. Trade (the private sector) pays about 3 times as much.

Almaty TV is the second most popular channel (47% viewership), following Moscow tv (60% viewership.) The State channel is third (13%.)

The most popular programs include the evening news "Akikok Akpar" (Reliable News), Altin Dala (Gold Field) game show and Only Women (variety show.) Also live programs with call-ins are popular.

- o The Deuir Publishing House has complete production facilities including the ability to make color separations, print large size posters, lamination, etc. using modern equipment including an 8 color offset press. Typesetting and design is on Pagemaker/Windows, (using 8 stations with full support and networking capability) with fonts for Russian, Kazakh, English, and other CIS languages including Uzbek and Kyrgyz.

Paper shortages can be a problem since all paper and ink supplies come from Russia. In addition, inflation makes it difficult to estimate costs for future jobs because of the uncertainty of paper costs.

For planning purposes, an estimate in today's paper costs for producing posters and flip charts in full color are as follows:

50,000 Posters (quality paper, 5 color)	\$7,000.00
10,000 Flipcharts (heavy stock, 6pps/chart, 5 color, plastic binding)	\$12,000.00

Turn-around time should be about 2 months for printing, from the camera-ready artwork stage. An additional month is needed if the Printer provides typesetting, design and layout/mechanical production services.

Full payment must be given in advance when the order is placed. Any balances will be reimbursed after the actual costs.

- o The City Center For Human Reproduction expressed a need for IEC materials on contraceptive methods. Dr. Tamara visited England through an IPPF Study Tour and was very impressed with the range and quality of brochures on FP and specific methods. She is very interested in putting together materials in conjunction with the future medical training and for use in the clinics. While she was thinking about translating existing materials and printing copies locally, the Center does not have the funds to design, produce and print the materials in sufficient quantities. Dr. Tamara reports that she could easily use and distribute 1 million copies of method specific FP leaflets to clients through the primary center, 8 district centers, and FP rooms in the numerous polyclinics under the district centers.

At a planning meeting on with Dr. Tamara on October 15, 1993 we agreed to produce the following initial run of support materials:

- Overview of Methods Leaflet (10,000 copies);
- Method Specific Leaflets (10,000 copies each) for the Pill, IUD, Injectable and Condom;
- A flipchart and cue cards for doctors to use in counseling clients (500 sets) and cue cards;
- A waiting room poster; and
- A Russian translation of the Pop Reports on the Pill (500 copies.)

JHU/PCS will send Dr. Tamara samples of existing IEC materials from several countries to provide a model for the Kazakh materials. In addition, JHU/PCS agreed to send samples of materials on breast feeding, sterilization, and sex education for teens, even though there are no plans for developing such materials at this time.

- o The Almaty Polygraphic Enterprise Government printing facility primarily publishes books and has the capability to produce 4-color leaflets, booklets and posters. They share similar problems with limited paper options/supplies and occasional ink shortages as the Kazakhstan Republic printers.

Turn-around is reported to be 2 weeks for printing from camera-ready artwork.

For planning purposes, an estimate in today's paper costs for producing posters, flip charts and leaflets in full color are as follows:

50,000 Posters (quality paper, 5 color)	\$ 7,652.00
10,000 Flipcharts (heavy stock, 6pps/chart, 5 color, no binding) no estimate given because of limitation in lamination and binding capabilities	
100,000 Leaflets (simple, 2 color, 4 panel)	\$ 739.00

- o BRIF is the first private research firm in Kazakhstan. It began as the Republic Opinion Center prior to the break-up of the USSR and went private 2 years ago. BRIF's specialty is conducting public opinion polls on a wide range of topics: political reform, attitudes towards government, national tensions, social programs, and questions about medical services. Work began in Almaty, but BRIF now has the capability to conduct representative studies nationwide.

Research activities are divided into two lines of business: social research (where results are published and openly used) and market research, where results are proprietary.

BRIF conducts interviews and telephone surveys in Almaty (limited phone sampling bias) and is familiar with focus groups and qualitative techniques. (They have not yet conducted FGDs.) They use their own (Russian) statistical analysis package for quantitative work and are familiar with SPSS software.

The organization is currently undertaking a national mass media survey which will quantify media usage. In addition, BRIF is working with USIA.

- o The Kazakhstan Republic Television Station broadcasts throughout Kazakhstan. Each of 19 different regional stations broadcast in their local markets on the State channel, every evening between 7pm - 8pm. The Almaty City Station also broadcasts over the State channel, but with greater frequency and exposure at 2 hours each day and 3 hours (12 noon - 3pm) on Sundays. In addition, the Almaty TV also broadcasts over its own station and its evening programs are picked up by the Russian channel giving it the greatest reach of any of the Kazakh stations. Apparently, the Almaty station is also much more popular than the State TV channel. Station rankings (without available data) are as follows:
  - Moscow Channel
  - Almaty TV
  - Commercial Channel (4 commercial channels)
  - Republic TV Station
  - Bishkek/Kyrgyz TV
  - Uzbekistan TV

Republic TV broadcasts in both Russian and Kazakh. The station has the capability to do full production of programs and advertising, using creative talent that can be brought in

from the outside.

Costs for advertising were quoted at 70 million Rubles, which covers production costs for the ad and air time for spots running 3 times per week for one year. The station expressed limited flexibility in changing the media buy from this set pattern of 3 spots/week. JHU/PCS could not get a clear answer as to the cost breakdowns between actual production costs and media placement costs. The station is not familiar with public service advertising and even the Government must pay for advertising air time.

The station strongly suggested (several times) that any production and creative work be managed and produced using the Almaty TV station. JHU/PCS was told that the City Station had much greater creative and production capability than the Republic station.

- o Mr. Golovinsky at ICSB Studios, has a full service tv/video production and post-production studio including high-end computer graphics, animation, sound, editing, and mixing equipment. Staff has been trained in the US and the quality of their video reel is excellent. The company has worked on ads, features and documentary films.

Production costs are relatively high for the market, but not out of line for the private sector and relatively high level of quality. A typical, simple ad (eg. an ad JHU/PCS reviewed for a cosmetic retailer) can be produced for about \$3,000 to \$5,000. High end animation costs about \$200/second or \$6,000 for a 30 second spot.

**Conclusions and recommendations:** JHU/PCS activities in Kazakhstan are planned as follows:

- o JHU/PCS will provide communication technical assistance to support the training and service delivery components of the Reproductive Health Program. These activities will be on-going in anticipation of the August, 1994 training programs.
- o JHU/PCS will conduct focus group research in Almaty (and nearby rural areas) in collaboration with a local social research agency to identify the knowledge, attitudes and practices of women and men in order to facilitate and identify appropriate communication messages.
- o JHU/PCS will participate in the Family Health Conference planned for April 1994. The input will be the concept of informed choice and counseling and the role of public education/communication in Family Health.
- o Working with the Human Reproductive Center of Almaty and the House of Health, JHU/PCS will produce contraceptive informational leaflets for clients and counseling

materials for the use of the providers with clients. These materials will be ready for use in the providers training planned by AVSC and JHPIEGO for mid August, 1994. A list of these materials include:

- Overview of Methods Leaflet (10,000 copies);
  - Method Specific Leaflets (10,000 copies each) for the Pill, IUD, Injectable and Condom;
  - A flipchart and cue cards for doctors to use in counseling clients (500 sets);
  - A waiting room poster; and
  - A Russian translation of the Pop Reports on the Pill (500 copies.)
- o JHU/PCS will work with a private advertising agency to develop two public awareness ads on the benefits of using contraceptives and child spacing on the health of the mother and children. These ads will be aired both in Kazakhstan as well as in Uzbekistan and Kyrgyzstan.
  - o JHU/PCS will organize a regional conference on the role of communications (and materials development) in Reproductive Health. This 2-3 day conference will be attended by FP health professionals, local advertising/ communications companies, journalists, sociological research groups and other appropriate media representatives. Participants will become familiar with the state of the art in health communications and materials development and will better understand FP issues and IEC opportunities. The ultimate goal will be to establish relationships between the differing disciplines of communications and FP health services and to provide participants with the skills needed to develop and implement a future national communications strategy for the promotion of contraceptive use in Kazakhstan. This communications conference will be scheduled for October, 1994.

To complete the activities outlined above, JHU/PCS anticipates working with the following counterparts:

- o The MOH House of Health and Mr. Sedumonov Sultan Turarovich will participate with JHU/PCS and the other collaborators during all key steps in the development of activities and materials and will be one of the primary recipients of the technology transfer to a more marketing oriented approach to health communications.
- o The City Center for Human Reproduction and Dr. Tamara Djusubalievna will collaborate on the development of counseling and patient education materials and will take the primary role in distributing materials throughout their FP clinic system. The printing of

materials will be bid out to the various polygraphic facilities identified during the visit, and the final decision will be based on turn-around time, paper availability and printing costs.

- o BRIF Research Company and Mr. Vladislav Boubenshtikov will collaborate on the design and implementation of the focus group research.
- o The MOH, House of Health, Center for Human Reproduction, and Almaty Television Station will collaborate on the development, content and design of the media October Communication conference.
- o A private advertising agency will collaborate on the development of the regional tv and radio advertisements.

## KYRGYZSTAN

- o When the FP program activities began, the MOH was accused by religious and political leaders of trying to limit population. Since then the program has worked to build their support and ties FP to health issues. The biggest threat facing the program today is lack of funds. The National program has been divided into two areas: 1. Key programs funded by the Government; and 2. Programs that are key but cannot be funded by the Government. USAID FP activities will cut across both areas.
- o The Health (IEC) Center is staffed by 7 full time staff, consisting of 5 doctors and two editors, one for tv and the other for publications. (The editors and doctors work with photographers, artists, camera-men, etc. at the media production facilities.) The Center is responsible for distributing different methods of propaganda. These include:
  1. Education/Nutrition - preparation of methodological papers for the polyclinics;
  2. Issues/Literature - preparation of issues related posters, brochures, advertisements, flyers, etc.
  3. Media - work with tv and radio stations to make programs and coordinate the work of the 16 Oblasts.

Materials published by the Center must be sold to recover their production costs. MOH funds cover salaries but there's no running budget for purchases. In the past they used an outside printing plant, but now they rely on in-house typing, copying and simple jobs. IEC materials were of relatively limited production values, using typewriter type, grey

layouts, and printing on newsprint paper in both languages, Russian and Kyrgyz. However, many of these leaflets at least had simple illustrations on the front covers, representing an improvement over the materials developed in the other Republic. Posters were better designed, with images and themes demonstrating creativity, and adequate printing. In-house production facilities are inadequate for our needs. Despite the inadequacies, the Center staff were very enthusiastic, inquisitive and interested in the JHU/PCS approach and expressed great interest in working together to produce campaign materials and activities supporting reproductive health.

- o The Family Planning Center sees about 120-150 clients each day. 60% of the mini-abortions are among young women. Eighty percent of the late term pregnancies seeking abortions are among the younger women. This group should be a primary target for education activities and programs. The center also has a separate area for men, which treats a range of sexual problems.

During the FP Center site visit, a mini-focus group/ interviews was conducted among 4-5 randomly selected young women in the waiting area. Findings from this discussion included the following: - The five women ranged in age from 22 to 32. All claimed to be married. Most had heard of the center from tv and/or friends. One was at the Center for fertility services, and the rest for FP services.

- Three of the women had abortions at the Center, including one with two abortions. A universal comment was that using contraceptives was better than having abortions. Many relied on friends and older sisters for information. One learned about contraceptives from her mother.

In a follow-up meeting with Dr. Doolotova on October 20, 1993, Dr. Doolotova requested support from JHU/PCS for counseling materials, posters and patient education leaflets. She agreed that materials could be initially prepared in Russian. In addition, Dr. Doolotova estimates that an initial run of 10,000 copies of the posters and each patient education leaflet would provide an adequate first supply. Finally, Dr. Doolotova requested materials that could be used in schools to help teach sex education to younger girls and boys.

- o The Kyrgyz Republic Television station airs from 6:30pm - 11pm Mondays through Fridays and from 9am - 1pm and 6:30pm - 11pm on Saturdays and Sundays. The station produces 4 hours of original programming each day. While the equipment is not state of the art, staff is intensely proud of their production work.

Viewers have a choice of 4 public and 1 private station as follows:

#### Public Channels

- 2 Russian Channels: Moscow and Russia .
- 1 National (Republic) Channel
- 1 Kazak/Tashkent/Turkey Channel (programs alternate times and days)

**Private Channels**

- Pyramid TV (Commercial station restricted to Bishkek and the Chu Oblast)

In remote places, 62% watch the national channel. However, the national channel is third in popularity, behind the Moscow and Pyramid tv channels (limited to Bishkek viewers).

Time costs for advertising time range from 30 - 40 Coms per minute (\$1 = 7.6 Coms.) The most expensive time is adjacent to the local news. Popular programs for advertising include: the news; a musical program; plus/ minus (a youth program) and folk concert programs on Sundays.

The station anticipates that production costs for a 60 second ad should be about 5 times the airing cost, or approximately 200 Coms for a one minute spot. Securing PSA time is open for negotiation.

- o A planning meeting with Dr. Subanbaev on October 19, 1993 confirmed the following direction for the IEC activities in Kyrgyzstan:
  - Young women are a priority audience in Bishkek and are appropriate for a media-based campaign promoting contraceptive use related to preventing unintended pregnancy and abortion. This program may rely on Pyramid tv and radio as the primary channels for reaching this audience.
  - Additional program activities should focus on using the existing nurse social workers to reach rural audiences with a message on the health benefits of child spacing.
  - Dr. Subanbaev agreed to take a key role in overseeing the media related activities including securing the necessary permissions for public service media support and appropriate clearances and reviews of all critical stages in the program development process.
- o The Republic Center for Public Opinion was organized in 1988 as an affiliate of the old soviet union center. Now it is a self supporting organization, independent from the Government and its regulations and guidelines. The center has conducted over 40 sociological studies on economic, cultural, political and social issues. This includes work for USIA, Eastern Europe, Germany, and most recently the household study for the World Bank, and a qualitative research for Radio Liberty.

- o Pyramid TV has produced many television ads for cars, banks, computers, jewelry, retail stores, etc. Studio equipment is high-end consumer Panasonic SVHS cameras and a Panasonic SVHS editing mixer capable of simple cuts and fade edits. The station also has limited animation capabilities using an Amiga (Commodore) computer and an IBM based system supported by a 3-D animation program.

Pyramid offers the full range of production services including concept development, writing, art direction, filming, editing and final production.

Production costs average from 15 to 80 Coms per second or about \$112 to \$600 for a :60 spot. Airtime ranges from 1.28 to 2 Coms/second or about \$10 to \$15 for a :60. Prime time is before the first feature film.

The tv station broadcasts from 6am-8am in the morning with children's programs, and from 6:15pm-12midnight with movies, and imported entertainment programs.

Pyramid Radio broadcasts everyday from 7am to 7pm. The station produces and sells advertising, but virtually all of the radio ads are prepared as "audio classified ads", featuring straight announcements of apartments for rent, items for sale, etc. Only one doctor has produced "image" ads" similar to the typical radio advertising in the US, to promote his alcohol/substance abuse clinic.

- o Under the Rural Patronage Nurse Social Workers program, each nurse social worker takes care of 30 families, including the children, parents, grandparents etc. The nurse social workers do not provide direct services, but rather act as resource people connecting family needs with available medical and social services.

The nurse social worker training program does not include components on effective communications, inter-personal communications, and/or counseling. In addition, nurse social workers do not have or use any visual aids or informational/ educational materials in their work in counseling families. 11. Ministry of Health - Debriefing

- o Suggestions made by Dr. Subanbaev at the MOH debriefing on October 22, 1993 included the following:
  - Materials targeted to the rural areas should be in Kyrgyz and not Russian;
  - When targeting the rural population, care should be taken to invoke the participation and support of the religious leadership;
  - Nareen, Jallabad and Osh should be included in the programs targeted to rural populations. In addition, both these Oblasts have requested video equipment that will

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allow them to go around and show programs at community meetings (mobile video capability.) JHU/PCS suggested that this would be mentioned to the local UNDP office and UNFPA funding; and

- Work must be targeted to changing the attitudes of the rural populations regarding the use of contraceptives and the value/health benefits of spacing children.o
- o Production capabilities at the Kyrgyz Film Studio include the full range of services from concept and artistic development, scriptwriting, art direction, filming, editing, mixing, etc.

Production costs are very reasonable. For example, a recently completed 10 minute documentary film costs 1,550,000 Rubles or under \$800. A 5-minute animated short costs 2,500,000 Rubles or \$1,000.

**Conclusions and recommendations:** JHU/PCS activities in Kyrgyzstan are planned as follows:

- o JHU/PCS will conduct focus group research on attitudes and practices related to the reproductive health of young girls in Bishkek and rural women in rural areas.
- o JHU/PCS will participate in the Conference on Reproductive Health and contraceptive use scheduled for June 1994. JHU/PCS's input will be on the role of communication in Family Health, the concept of informed choice and counseling.
- o Working with the MOH, Health Center, Family Planning Center and Pyramid TV, JHU/PCS will develop and implement a mass media campaign on preventing unintended pregnancy and contraceptive use for young women in Bishkek, in response to the high incidence and negative health effects of abortions. This will be broadcast through the Pyramid radio and television stations, which are listen to by the young people in Bishkek.
- o Working with MOH, JHU/PCS will implement a birth spacing campaign for rural woman and men using the National television Channel and the materials developed for the regional program activities (and adapted for rural Kyrgyz.) As part of this project, materials developed in Russian will be translated, redesigned (if necessary) and produced in Kyrgyz using local resources.
- o JHU/PCS will produce client education materials for use in the clinics by service providers in counseling clients and as give-aways to clients on contraceptive use. These materials will be developed and published in Russian in Kazakhstan for regional distribution. Specific materials include the following:

- Overview of methods leaflet;
- Method specific leaflet, one each for the Pill, IUD, Injectable, and Condom;
- A flipchart and cue cards for doctors to use in counseling;
- A waiting room poster; and
- A Russian translation of the Pop Reports on the Pill.

These materials could be translated into Kyrgyz language and published locally for distribution in the rural areas by both clinics and the patronage nurse social workers.

- o JHU/PCS will conduct an impact evaluation of the campaigns.

To complete the activities in Kyrgyzstan, JHU/PCS anticipates working with the following counterparts:

- o Dr. Subanbaev will take a key role in overseeing the media related program activities, including securing permissions and public service media time, and reviewing critical steps in the process.
- o Dr. Bektursun Tokubaev and Mrs. Tatiana Tsiganeeva from the Health Center; Dr. Talajbek Burjlashev from the MOH, and Dr. Anara Doolotova from the FP Center will participate with JHU/PCS and the other collaborators during all key steps in the development of activities and will be the primary recipients of the technology transfer to a more marketing oriented approach to health communications.
- o Pyramid TV will assist in the production and placement of the advertising campaign targeted to young women.
- o The Republic Center for Public Opinion and Mr. Vladislav Potolsky will collaborate on the design and implementation of the focus group research. In addition, the Republic Center for Public Opinion may play a role in conducting the impact evaluation.

## UZBEKISTAN

- o The Health Education Center has 2 Republican Health Centers (one for Uzbekistan and one for Karakalpak) followed by Regional Centers (Oblast), and including City Centers and District Health Centers (rayon, which are not very operational). According to a 1991 law, every doctor must work at least 4 hours each month to promote the healthy way of life. The concrete tasks to be carried out and content of talks are issued by the Republican Center.

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- o The Ministry of Information must give 2 hours/month for television and 10 hours/month radio for covering health topics. (TV has a regular program called "Health.") Typically health topics are seasonal with intestinal infections in summer, influenza in winter, etc. There are 7 channels, 2 local in Tashkent (Republic and City), 2 Russian stations from Moscow, and stations coming in from Turkey, Kyrgyz and Tajikistan. Favorite programs on the Republic tv include Yashik (for 18-20 year olds) and Asalom Uzbekistan (a morning variety program.)
- o Each year annual health media program plans are developed in November and finalized in December for the coming calendar year. These plans Polls are conducted using written survey instruments, administered in person and completed by the respondent in an "intercept" style at locations such as tea houses, factories, etc.
- o Recent television viewership data was reviewed. The Tashkent Republic station is reportedly watched by 54%-60% of the public, making it the number 2 choice after the Moscow station. This makes the accessible local stations a viable choice for developing a national advertising campaign.
- o The commercial advertising department is a new independent group within the Republic tv/radio stations that started in April 1993. They represent the only advertising capability in Uzbekistan. They work with many overseas groups including Dae-woo, Apple Computers, cigarette accounts etc. Activities range from placing existing materials (imported spots dubbed in Russian) to creating original advertising.

The commercial advertising department runs seven hours of entertainment programming on Sundays where their ads are placed. In addition, they own four 5-minute advertising blocks in the popular Information Uzbekistan morning program.

Most production is done within the tv/radio station facilities using their equipment. Occasionally, they go outside of Uzbekistan for computer generated graphics, and other specific production techniques. Animation is available using the Tashkent Film Studios.

Production costs vary according to the creative parameters. Typical costs for a 30 second tv spot run from \$15,000 to \$30,000. Radio is considerably less at about \$1,000.

Media costs were quoted significantly higher than those in previous trip reports. A 30 second tv spot averages \$250. Radio ranges from \$75 to \$150. \$150 will buy a spot on Radio Tashkent's early morning "Mashal" program, reportedly reaching 10 million listeners (perhaps an overstatement of audience size.) Regardless, it is likely that MOH will arrange for free public service airtime for its spots. (This was discussed with Dr. Yarkulov during the October 7, 1993 discussion/debriefing meeting).

- o The Tashkent Health (Education) Center carries out similar planning and implementation activities to the Republican Health Center but only within the Tashkent municipality. The Center puts on monthly propaganda programs in all 10 district branches, each with 3-4 people responsible for about 200,000 residents (in each district.) Each district has 20 medical institutions and at least 1 person who organizes propaganda in tea houses (primarily for men) schools, Mahalla (communities), factories, and other outreach locations.

Every three months, staff from the Republican, city and district centers get together to coordinate activities. This past year the emphasis has been on mothers and children's health issues (breast feeding, etc.)

The Center makes posters in their on-site studio. The studio houses 8 designers/production craftsmen who also create much of the signage, displays, and other materials for use in the health centers/clinics/hospitals. The quality of work was outstanding. Under the direction of Dr. Mamlakat, the production staff totally renovated the Tashkent Center building and offices in remarkable style. Posters at the Center are all hand painted. The facility does not have printing capabilities to duplicate/print offset posters. The Center does not have a license for publishing.

The Center also produces two television programs on the Tashkent Channel one on Adult Health Protection and one on Child Health protection as well as a daily program on city radio.

- o State Committee of Publications building houses the Medicine Publication House (in addition to other departmental topic areas such as agriculture, engineering, etc.) which is responsible for producing all text books, publications, booklets etc. within the health and medical community. Specific publications, production runs, and distribution are determined by the MOH. The publications house then sets the type, does the layout, prints, binds and delivers the printed materials.

Most of the work is simple text, without photos/ illustrations and complex layouts. Yet, the publications center reportedly houses a 6-8 color press that can handle web or sheet fed printing, along with cold, hot and photo typesetting and in-house color separations. Materials are created in both Russian and Uzbek languages.

Turn-around time is 2-3 months for layout and printing and about 1 month if they received camera-ready work. The printing equipment can handle color offset posters, but the publications center has not produced many posters in the past. Posters will cost approximately 300 Rubles each when printed in large quantities. The major obstacle is paper procurement. There are no private printing houses in Uzbekistan.

**Conclusions and recommendations:** The final list of activities was developed and approved by Dr. Yarkulov for the 18 month program period. These include the following:

- o Conducting qualitative focus group research on 10 groups of women and men from the Tashkent region to identify knowledge, attitudes and behaviors towards family planning/child spacing. These will be conducted in December, in time to present the findings at the January symposium.

Depending upon final plans, additional focus groups may be conducted in other regional sites to provide a more representative view of different regions within the country. These would be funded by The Futures Group and conducted by JHU/PCS. It is anticipated that these groups would not be conducted prior to the January symposium.

- o Participating in the contraceptive technology symposium through preparing materials and conducting sessions on:
  - Informed choice;
  - Counseling;
  - Examples and uses of mass media in family planning;
  - Findings of the focus group research.

In addition, JHU/PCS will provide coordination for all handouts for the symposium. The symposium is planned for January 1994.

- o In collaboration with AVSC, JHPIEGO and the MOH, design and produce counseling materials for use by doctors/ service providers in counseling clients. In addition, design and produce patient education leaflets for the primary contraceptive methods (IUD, Pill, Injectable and Condom.) This activity is scheduled for completion in time for planned service provider training starting in May 1994.
- o Working closely with local counterparts, develop a mass media/communications strategy plan, based on focus group findings, and including television and radio PSAs and posters. This tactical planning activity is being scheduled for March, 1994 TA visit.
- o Explore the costs and feasibility of a Russian version(s) of POP Reports, with priority on the Health Benefits and Injectables editions.

Details associated with the IEC strategy for Uzbekistan were discussed with Dr. Yarkulov at a meeting on October 8, 1992, and our counterparts were identified as follows:

- o Dr. Yarkulov will take a key role in overseeing the media related program activities. He will assist in securing permissions; establishing partnerships across related Ministries (Information, Culture, etc.); securing free advertising time with the tv/radio stations; and reviewing critical steps in the process.

- o The Republican Health (Education) Center and Dr. Assisov will be the administrative counterpart, helping to set up meetings, gain access to partners, and preparing/ reviewing initial agreement. In addition, Dr. AssisovUD, Pill, Injectable and Condom.) This activity is scheduled for completion in time for planned service provider training starting in May 1994.
- o Working closely with local counterparts, develop a mass media/communications strategy plan, based on focus group findings, and including television and radio PSAs and posters. This tactical planning activity is being scheduled for March, 1994 TA visit.
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- o The Republican Health (Education) Center and Dr. Assisov will be the administrative counterpart, helping to set up meetings, gain access to partners, and preparing/ reviewing initial agreement. In addition, Dr. Assisov will be one of the MOH persons to participate with JHU/PCS in the process of communication material development.
- o The Tashkent Health (Education) Center will participate with JHU/PCS and the other collaborators during all key steps in the process and will be one of the primary recipients of the technology transfer to a more marketing approach to health communications. In addition, the Center artists will be involved in designing and producing the posters.
- o The Advertising Commercial Center will assist in the concept development, creative writing, and all production supporting the development of the local Uzbekistan tv and radio ads.
- o The Expert Sociological Center will carry out the qualitative research and pretesting of materials. The JHU/PCS Senior Research Officer will assist them in developing the research methodology, training moderators, and will participate in conducting the first round of groups scheduled for December.

Appendix D

Exit Cable From Turkmenistan Group Assessment

PROG 02/07/94  
AMB:JSHULINGS  
AID/CA: ANN LAUGHRIN  
P/E:GBCHRISTY  
P/E

AMEMBASSY ASHGABAT  
SECSTATE WASHDC  
INFO AMEMBASSY ALMATY

AIDAC  
DEPT FOR AID/RD/POP/RCD - WILLA PRESSMAN  
INFO TO AID/ENI/NIS/TF/DIHR - PAULA BRYAN  
ALSO FOR S/NIS/C AND EUR/ISCA/ECA  
ALMATY FOR USAID M. SCHMIDT

E.O. 12356: N/A  
TAGS: EAID, TX  
SUBJECT: EXIT CABLE - INITIATION OF WOMEN'S REPRODUCTIVE  
HEALTH AND TECHNOLOGY PROGRAM (RHTP) TECHNICAL ASSISTANCE  
VISIT TO TURKMENISTAN

REF: 93 STATE 388845

1. THIS IS NOT AN ACTION CABLE.
2. SUMMARY: THIS CABLE SUMMARIZES THE TECHNICAL ASSISTANCE VISIT FROM JANUARY 31 - FEBRUARY 7, 1994, FOR THE WOMEN'S REPRODUCTIVE HEALTH AND TECHNOLOGY PROGRAM RHTP WHICH WILL BE IMPLEMENTED IN TURKMENISTAN OVER THE NEXT 18 - 36 MONTHS. THE OBJECTIVES OF THE TECHNICAL ASSISTANCE VISIT WERE: TO IDENTIFY APPROPRIATE COUNTERPARTS WITH WHICH TO WORK; TO DEVELOP A COHESIVE REPRODUCTIVE HEALTH STRATEGY FOR THE PUBLIC AND PRIVATE SECTORS; AND TO INITIATE A

**COORDINATED PLAN OF ACTIVITIES WITH THE IDENTIFIED  
COUNTERPART INSTITUTIONS AND PERSONS. END SUMMARY.**

3. FROM JANUARY 31 - FEBRUARY 7, 1994, A NINE PERSON RHTP TEAM OF FIVE RD/POPULATION COOPERATING AGENCIES VISITED ASHGABAT TO DEVELOP A REPRODUCTIVE HEALTH PROGRAM. MARILYNN SCHMIDT, USAID ALMATY GENERAL DEVELOPMENT OFFICER, AND ZAMIRA KANAPIANOVA, PROJECT MANAGEMENT SPECIALIST ACCOMPANIED THE TEAM COMPRISED OF JANET SMITH AND ANN LAUGHRIN OF THE OPTIONS II PROJECT, DON LEVY AND BELA BABUS OF THE SOMARC III PROJECT, LIBBY ANTARSH AND GEORGE HUGGINS OF AVSC, ANNE ATKINSON OF JHPIEGO, AND BUSHRA JABRE AND IRINA GUSHRIN OF THE JOHNS HOPKINS PCS PROGRAM.

4. THE TEAM MET WITH MOH OFFICIALS: DR. KHANGELDY MAMEDOV, DEPUTY MINISTER OF HEALTH, DR. TATIANA NIKOLAIENKO AND DR. ALEXANDER PETROV, DEPUTY DIRECTOR OF TURKMEN RESEARCH INSTITUTE FOR MATERNAL AND CHILD HEALTH. THE TEAM WAS WARMLY WELCOMED BY THE TURKMEN HEALTH OFFICIALS WHO STRONGLY SUPPORTED THE ACTIVITIES AND PROVIDED EXCELLENT SUPPORT TO THE TEAM IN IDENTIFYING COUNTERPARTS WITH THE CAPACITY TO DEVELOP AND EXPAND WOMEN'S REPRODUCTIVE HEALTH POLICY, SERVICES, COMMUNICATION, AND TRAINING. THE MOH OFFICIALS HELPED TO ARRANGE MEETINGS FOR THE TEAM AS WELL.

AT THE DEBRIEFING MEETING HELD AT THE END OF THE TEAM'S VISIT THE TURKMENISTAN MOH VOICED STRONG SUPPORT FOR THE ACTIVITIES PROPOSED BY EACH COOPERATING AGENCY. MOH OFFICIALS MADE A STRONG PLEA FOR CONTRACEPTIVE SUPPLIES PARTICULARLY DURING THE PERIOD OF ECONOMIC TRANSITION.

5. BACKGROUND. THE WOMEN'S REPRODUCTIVE HEALTH AND TECHNOLOGY PROGRAM WAS DEVELOPED TO RESPOND TO THE HIGH RATES OF MATERNAL MORTALITY, HIGH RATES OF ABORTION, AND LOW LEVELS OF MODERN CONTRACEPTIVE USE IN THE CENTRAL ASIAN REPUBLICS CAR. THE TRANSFORMATION AND MODERNIZATION OF REPRODUCTIVE HEALTH POLICY AND TECHNOLOGY IN THE PUBLIC SECTOR SUPPORT AND COMPLEMENT THE RELATED US-TURKEY PROGRAMMING EFFORTS TO EXPAND SIMILAR SERVICES THROUGH THE PRIVATE SECTOR THROUGH THE ENCOURAGEMENT OF PRIVATIZATION

WITHIN THE MEDICAL AND PHARMACEUTICAL SECTORS. IN BROAD TERMS, THE PROGRAM ACTIVITIES COVER SEVERAL COMPONENTS; IMPROVED POLICY ENVIRONMENT; TRAINING IN CLINICAL SKILLS, TRAINING SKILLS, AND COUNSELING FOR SERVICE PROVIDERS; SUPPORT FOR THE IMPROVEMENT OF QUALITY SERVICES; REPRODUCTIVE HEALTH COMMUNICATION AND EDUCATION FOR THE PUBLIC AND SERVICE PROVIDERS; AND SOCIAL MARKETING OF QUALITY, MODERN CONTRACEPTIVES. IN TURKMENISTAN, THE PROGRAM INTENDS TO ADDRESS BIRTH SPACING TO IMPROVE BIRTH OUTCOMES, NOT THE LIMITATION OF FAMILY SIZE. ALL ACTIVITIES ARE FUNDED BY AID/NIS TASK FORCE BUY-INS TO THE PARTICIPATING COOPERATING AGENCIES.

6. ACCOMPLISHMENTS. THE FOLLOWING SUMMARIZES THE ACCOMPLISHMENTS OF THE VISIT.

#### I. PROGRAM MANAGEMENT

WITH MONITORING ASSISTANCE FROM USAID/ALMATY, THE NIS TASK FORCE AID/ENI/NIS DIHR OFFICE, AND RD POPULATION, EACH COOPERATING AGENCY WILL WORK WITH COUNTERPART INSTITUTIONS TO UNDERTAKE SPECIFICALLY AGREED UPON ACTIVITIES FOR WOMEN'S REPRODUCTIVE HEALTH. TECHNICAL ASSISTANCE WILL BE PROVIDED AT APPROPRIATE TIMES OVER THE LIFE OF THE PROJECT AS AGREED TO BY THE COOPERATING AGENCIES AND COUNTERPART INSTITUTIONS. LOGISTICAL SUPPORT FOR RHTP ACTIVITIES IN TURKMENISTAN WILL BE PROVIDED BY THE FUTURES GROUP/SOMARC REGIONAL OFFICE IN TASHKENT UNTIL A LOCAL ASHGABAT CONTACT CAN BE IDENTIFIED.

#### 7. TECHNICAL ASSISTANCE

A. ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION - AVSC AND JOHNS HOPKINS PROGRAM FOR INTERNATIONAL EDUCATION IN REPRODUCTIVE HEALTH - JHPIEGO

AVSC AND JHPIEGO COLLABORATED CLOSELY TO IDENTIFY COUNTERPARTS AND APPROPRIATE SITES FOR TRAINING ACTIVITIES AND SERVICE DEVELOPMENT. POLYCLINIC NO. 9 WAS SELECTED TO BE THE MODEL SERVICE DELIVERY SITE AND TRAINING SITE FOR MEDICAL STUDENTS IN REVERSIBLE METHODS. THE MCH RESEARCH

INSTITUTE WAS SELECTED AS THE REFRESHER TRAINING SITE FOR DOCTORS FROM AROUND THE REPUBLIC. THE REPUBLICAN CLINICAL HOSPITAL WAS IDENTIFIED AS THE FUTURE SERVICE AND TRAINING SITE FOR MINILAPAROTOMY.

IN DECEMBER 1994, AVSC WILL CONDUCT A TWO WEEK COUNSELING AND CLINICAL SKILLS COURSE. THE COURSE WILL BEGIN WITH A CONTRACEPTIVE UPDATE SEMINAR THAT WILL INCLUDE UP TO 250 PROVIDERS FROM AROUND THE COUNTRY. THE COUNSELING AND CLINICAL TRAINING WILL INCLUDE A SMALL NUMBER OF PROVIDERS FROM THE POLYCLINIC, MCH RESEARCH CENTER, AND REPUBLICAN HOSPITAL. AVSC WILL PROVIDE EQUIPMENT AND SUPPLIES TO SUPPORT THE TRAINING AND SERVICE DELIVERY.

JHPIEGO WILL FOLLOW UP ON AVSC'S TRAINING WITH A TRAINING SKILLS COURSE IN JANUARY 1995. AVSC WILL HELP TO IDENTIFY WHICH DOCTORS WILL PARTICIPATE IN THE COURSE. JHPIEGO WILL PROVIDE EACH TRAINING SITE WITH TRAINING MATERIALS, AUDIOVISUAL EQUIPMENT, AND TRAINING MODELS. THE COURSE WILL BE FOLLOWED BY A SECOND CLINICAL SKILLS COURSE (FEBRUARY/MARCH 1995) WHICH WILL BE CO-TAUGHT BY JHPIEGO AND LOCAL TRAINERS.

PER THE REQUEST OF THE MOH, JHPIEGO WILL INCLUDE 3 DOCTORS FROM TURKMENISTAN IN ITS APRIL TRAINING TOUR TO THE PHILIPPINES FOR TRAINING IN MINILAPAROTOMY. FOLLOWING THE TRAINING, AVSC WILL PROVIDE THE REPUBLICAN CLINICAL HOSPITAL WITH THE INSTRUMENTS AND SUPPLIES TO INITIATE SERVICE DELIVERY. IN FALL, 1994, AVSC WILL MONITOR AND EVALUATE THE SERVICE. ALSO IN FALL, 1994, JHPIEGO WILL CONDUCT A MINILAP TRAINING SKILLS COURSE (TRAINING OF TRAINERS) FOR THE PHILIPPINES STUDY TOUR PARTICIPANTS.

#### **B. JOHNS HOPKINS POPULATION COMMUNICATION SERVICES - PCS**

COMMUNICATION ACTIVITIES IN TURKMENISTAN WOULD INCLUDE THE FOLLOWING: CONDUCTING FOCUS GROUP RESEARCH IN SEVERAL GEOGRAPHICAL AREAS AMONG MEN AND WOMEN IN ORDER TO DEVELOP THE COMMUNICATION STRATEGY FOR TURKMENISTAN; PROVIDING REGIONAL COMMUNICATION STRATEGY FOR TURKMENISTAN; PROVIDING REGIONAL COMMUNICATION PRODUCTS FOR USE IN TURKMENISTAN, NAMELY TV SPOTS TO BE DEVELOPED IN

ALMATY FOR TURKMENISTAN STRESSING THE HEALTH BENEFITS OF BIRTH SPACING FOR THE MOTHER AND CHILD PROMOTING THE BENEFITS OF CONTRACEPTIVE USE; PRINT MATERIALS, NAMELY CUE CARDS ON CONTRACEPTIVE METHODS FOR SERVICE PROVIDERS AND AN ALL-METHOD LEAFLET FOR CLIENTS.

PRELIMINARY FINDINGS FROM DISCUSSION WITH SERVICE PROVIDERS AND CLIENTS HIGHLIGHTED THE NEED TO PROMOTE MALE RESPONSIBILITY IN BIRTH SPACING AND THE NEED TO TARGET YOUNG WOMEN, MAINLY RURAL WOMEN WITH MESSAGES PROMOTING THE HEALTH BENEFITS OF BIRTH SPACING.

#### NEXT STEPS

CONDUCT FOCUS GROUP RESEARCH IN APRIL/MAY.

PROVIDE MASS MEDIA AND PRINT MATERIALS DEVELOPED FOR THE CENTRAL ASIAN REGION TO TURKMENISTAN IN MAY/JUNE.

DEVELOP A COMPLEMENTARY MASS MEDIA PLAN IN JUNE.

THE MOH HAS PROMISED TO NEGOTIATE WITH THE NATIONAL TELEVISION AND RADIO COMPANY FOR THE FREE AND FREQUENT AIRING OF THE DEVELOPED TELEVISION SPOTS. JHU/PCS WILL BE RESPONSIBLE FOR THE PRODUCTION OF THE TELEVISION SPOTS AND THE DEVELOPMENT OF A BROADCASTING STRATEGY. THE MINISTRY WILL BE RESPONSIBLE FOR IMPLEMENTING THE STRATEGY.

#### C. SOMARC III

SOCIAL MARKETING ACTIVITIES MAY ONLY BE POSSIBLE AS AND WHEN THE GOVERNMENT SANCTIONS THE SALE OF DRUGS IN PHARMACIES. INITIAL MEETINGS INDICATED THAT THE GOVERNMENT OF TURKMENISTAN IS MOVING SLOWLY TO DESIGN THE HEALTH CARE SYSTEM FOR THE INDEPENDENT REPUBLIC. DURING THIS DESIGN PROCESS POLICY DECISIONS INCLUDING THAT ON PRIVATIZATION WILL BE MADE. ASSUMING SOME PHARMACIES WILL BE PRIVATIZED, SOMARC CAN PROVIDE TECHNICAL ASSISTANCE IN THE PROCESS. THE INFRASTRUCTURE EXISTS TO DEVELOP AND IMPLEMENT DISTRIBUTION, CONDUCT MARKET RESEARCH, AND IMPLEMENT MARKETING COMMUNICATION ACTIVITIES TO SUPPORT A SOCIAL MARKETING

**PROGRAM.**

A SOCIAL MARKETING PROGRAM IN TURKMENISTAN WILL NOT INITIALLY BE BASED ON COMMERCIAL SALES SINCE THERE IS NOT LIKELY TO BE TRUE PRIVATE MARKET SALES OF CONTRACEPTIVES IN PHARMACIES IN THE FORESEEABLE FUTURE. SOCIAL MARKETING IN THIS CONTEXT WOULD ASSIST IN IMPROVING DISTRIBUTION, CREATING DEMAND, PROVIDING TRAINING TO PHARMACISTS, AND CONDUCTING RESEARCH THAT WOULD INFORM THE IMPROVEMENT AND EXPANSION OF PHARMACY-BASED CONTRACEPTIVE SERVICES. THE OUTPUT WOULD NOT HOWEVER RESULT IN THE DEVELOPMENT OF THE PRIVATE SECTOR, OR A PRIVATE MARKET, BUT IT WOULD MEET THE SOCIAL GOAL OF EXPANDING SERVICE.

**NEXT STEPS**

COLLABORATE WITH OPTIONS TO PROMOTE A POLICY AGENDA THAT WILL, AMONG OTHER THINGS, BE CONDUCTIVE TO SOCIAL MARKETING ACTIVITIES, IN PARTICULAR PRIVATE SECTOR MARKETING OF CONTRACEPTIVES AND THE PRIVATIZATION OF PHARMACIES.

PLAN THE IMPLEMENTATION OF CONSUMER FOCUS GROUPS IN COLLABORATION WITH PCS TO EXPLORE CURRENT KNOWLEDGE, ATTITUDES AND PRACTICE REGARDING CONTRACEPTIVE USAGE.

PLAN THE IMPLEMENTATION OF A QUANTITATIVE BASELINE SURVEY BUILDING ON FOCUS GROUP FINDINGS, WHICH WILL INFORM DECISION MAKING AND THE DEVELOPMENT OF A STRATEGIC PLAN FOR THE IMPLEMENTATION OF MARKETING ACTIVITIES. FOLLOWING A MINISTRY DECISION TO ALLOW THE SALE OF CONTRACEPTIVES, SCHEDULE A RETURN VISIT TO DISCUSS A SOCIAL MARKETING FRAMEWORK WITH THE MINISTRY, AND DEVELOP A WORK PLAN.

**D. OPTIONS II**

THE MINISTRY OF HEALTH'S PROCESS OF PLANNING THE NATIONAL HEALTH CARE SYSTEM PROVIDES A CLEAR CUT OPPORTUNITY FOR TRANSFER OF INTERNATIONAL EXPERIENCE. THE TWO STUDY TOURS CONDUCTED BY THE OPTIONS PROJECT IN CONJUNCTION WITH THE TWO UPCOMING STUDY TOURS TO BE HOSTED BY OTHER CAS (HEALTH CARE FINANCE AND PHARMACEUTICAL INDUSTRY) MEAN THAT KEY

DECISION MAKERS HAVE OR WILL BE EXPOSED TO A VARIETY OF IDEAS AND COUNTRY EXPERIENCE ABOUT THE ORGANIZATION OF HEALTH CARE DELIVERY. THEREFORE IT IS TIMELY TO PROVIDE A STRUCTURED FORUM FOR PROGRAM PLANNERS AND POLICY MAKERS (INCLUDING THE STUDY TOUR PARTICIPANTS AND OTHERS) TO CONVENE, IN ORDER TO DISCUSS NEW INFORMATION AND APPROACHES TO THE DESIGN OF HEALTH CARE SYSTEMS AND TAILOR THE NEW SYSTEM TO TURKMENISTAN'S NEEDS.

#### NEXT STEPS

OPTIONS FIRST ACTIVITY IS TO ORGANIZE AND FACILITATE A POLICY WORKSHOP FOR APPROXIMATELY FORTY PEOPLE TO BE HELD IN MAY. THE POLICY WORKSHOP WOULD COVER ALL ASPECTS OF FAMILY PLANNING SERVICE DELIVERY, INCLUDING; THE POLICY IMPLICATIONS OF EXPANSION OF SERVICES; BROAD METHOD MIX; PROGRAM FINANCING AND MARKET SEGMENTATION; AND POLICY IMPLICATIONS OF COMMUNICATIONS, RELIGION AND CULTURE IN THE PROGRAM. THE PARTICIPANTS WILL BE DRAWN FROM ALL RELEVANT POLICY AND PLANNING AGENCIES OF THE GOVERNMENT.

SECOND, OPTIONS PLANS TO CONDUCT A SURVEY OF FAMILY HEALTH SERVICE PROVIDERS' KNOWLEDGE, ATTITUDES AND PRACTICES - KAP - REGARDING FAMILY HEALTH. THE RESEARCH RESULTS WILL PROVIDE

DIRECTION FOR FUTURE POLICY WORK, COMMUNICATION AND EDUCATIONAL MATERIALS DEVELOPMENT AND TRAINING NEEDS. THE SURVEY IS SCHEDULED TO BE FIELDDED IN APRIL.

OPTIONS PLANS TO HOST A FAMILY HEALTH SYMPOSIUM SOMETIME BETWEEN THE POLICY WORKSHOP AND AVSC'S TRAINING SCHEDULED FOR DECEMBER 1994, POSSIBLY IN EARLY FALL. THE PURPOSE OF THE SYMPOSIUM IS TO KEEP THE ISSUES DEVELOPED DURING THE MAY POLICY WORKSHOP IN THE FOREFRONT OF POLICY MAKERS AND SERVICE PROVIDERS' MINDS. THE AGENDA AND LOGISTICS FOR THE SYMPOSIUM WILL BE DEFINED COLLABORATIVELY WITH THE COUNTERPARTS DURING THE MAY 1994 TDY.

8. AN EXIT BRIEFING WAS PROVIDED TO UNITED STATES AMBASSADOR TO TURKMENISTAN BY TEAM ON FEBRUARY 4, 1994. DURING THIS MEETING THE AMBASSADOR INDICATED HIS STRONG SENSE THAT GIVEN THE POLICY CLIMATE CHARACTERIZED BY DESIRE FOR LARGE

FAMILIES, LACK OF UNDERSTANDING OF THE HEALTH REPERCUSSIONS OF THIS, AND UNFAMILIARITY WITH A BROAD RANGE OF CONTRACEPTIVES, FULL INSTITUTIONALIZATION OF A BIRTH SPACING PROGRAM IN TURKMENISTAN WOULD REQUIRE DONATED CONTRACEPTIVES TO COMPLEMENT TECHNICAL ASSISTANCE EFFORTS.  
HULINGS ##