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# Central Asian Republics

# Reproductive Health Services Expansion Program

## RHSEP

## Final Report
## September 30, 1995

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Central Asian Republics

# REPRODUCTIVE HEALTH SERVICES EXPANSION PROJECT (RHSEP)

Final Report
September 30, 1995

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OPTIONS for Population Policy

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## ABBREVIATIONS

| | |
|---|---|
| AUP | Association of Uzbekistan Physicians |
| AVSC | Access to Safe and Voluntary Contraception |
| CAR | Central Asian Republics (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) |
| CAs | Cooperating agencies |
| CIS | Commonwealth of Independent States |
| CTU | Contraceptive technology update |
| DHS | Demographic Health Survey |
| DMPA | Depo-Provera |
| FP | Family planning |
| ICPD | International Conference on Population and Development |
| IMR | Infant mortality rate |
| IEC | Information, education and communication |
| IUD | Intrauterine device |
| JHPIEGO | Johns Hopkins Program for International Education in Reproductive Health |
| MCH/FP | Maternal child health/family planning |
| MMR | Maternal mortality rate |
| MOH | Ministry of Health |
| NGO | Nongovermental organizations |
| NIS | Newly Independent States |
| OB/GYNs | Obstetrician/Gynecologists |
| OPTIONS | Options for Population Policy Project |
| PCS | Population Communication Services |
| RHSEP | Reproductive Health Services Expansion Program |
| SOMARC | Social Marketing for Change Project |
| TICA | Turkish International Assistance Agency |
| UNFPA | United Nations Fund for Population Assistance |
| USAID | United States Agency for International Development |

# EXECUTIVE SUMMARY

This document provides a record of the accomplishments achieved during the first two years of the Reproductive Health Services Expansion Program (RHSEP) in the five Central Asian Republics (CAR): Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan and Turkmenistan. This work was funded by the U.S. Agency for International Development (USAID) for the period October 1993 - December 1996. The RHSEP was implemented through buy-ins to six cooperating agencies (CAs): AVSC International, The Johns Hopkins Program for International Education in Reproductive Health, The Johns Hopkins University Population Communication Services, Macro International's Demographic and Health Survey, and The Futures Group International's SOMARC III and OPTIONS II projects. As the lead CA, OPTIONS was responsible for coordinating RHSEP activities. This was the first group of CAs to work in the family planning arena in the CAR and much can be learned from the experience and accomplishments of the RHSEP.

The goal of USAID technical assistance through the RHSEP was to improve the health of mothers and children in the CAR. While there are many ways to help achieve this goal, the RHSEP was designed to modernize, expand and improve the quality and sustainability of family health services. The overall assistance package had five main objectives:

- to develop a favorable political environment and cultivate support for the expansion of quality family health services;
- to strengthen 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 in the provision of contraceptive services and to strengthen family health training institutions to ensure long-term supply of competent service providers; and
- to diversify sources for contraceptives by expanding the private sector and broadening the method mix available to consumers.
- to educate clients and providers about the safety, efficacy and health benefits of modern contraceptive methods, shifting reliance on abortion to demand for modern contraception.

Several mechanisms were available to CAs for implementing the activities proposed in the RHSEP strategy. These included: technical assistance; provision of training, training materials and equipment; development of guidelines, treatment standards and medical reference materials; development of advertising and communication materials; provision of commodities to support training programs; provision of medical equipment and supplies;

procurement of contraceptives for the commercial sector; transfer of computer equipment and skills; and research and evaluation.

*Technical Activities*

Technical assistance in the policy area supported: 1) study tours for high-level government officials to observe successful family planning programs in other countries; 2) activities to raise the awareness of the benefits of family health services among policymakers and high-level medical officers; and 3) reviews of the legal and regulatory environment to identify policy constraints to the expansion of family health services.

Technical assistance to strengthen MOH institutional capability focused on improving planning and programming skills. The CAs also worked together to gain a better understanding of the policy environment regarding contraceptive services and to provide needed information on contraceptive practices and family health services. RHSEP also established and equipped demonstration training sites in selected leading maternity hospitals.

The goals of the RHSEP training component were to: 1) train reproductive health care providers in the public and private sectors in the safe delivery of modern contraceptives and to integrate contraceptive counseling and services into maternity services; and 2) develop a contraceptive training capacity in order to generate a steady flow of competent service providers. Altogether, training systems and institutions in the CAR have been strengthened and are now producing a wide range of qualified health professionals capable of delivering contraceptive services safely, reliably and with sensitivity. To date, approximately 1,650 public and private sector providers have received clinical training and over 75 physicians have received supplementary training to ensure their capability to train others. In support of the nascent social marketing programs, over 1,050 pharmacists and 1,000 physicians have received training in contraceptive service delivery from 130 qualified trainers. In support of training activities, medical guidelines for family health service delivery have been updated in Kazakhstan, Kyrgyzstan and Uzbekistan.

The diversification of product sources and the method 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. Technical activities focused on removing obstacles to the development/expansion of the private sector and initiating social marketing programs in three countries. RHSEP also assisted in setting up an association of private physicians in Uzbekistan.

RHSEP communication activities educated clients about the safety and health benefits of modern contraceptives and promoted effective and sustained use of modern contraception. RHSEP supported the development of an integrated communication program, consisting of public service campaigns, advertising, public relations and extensive print materials for service providers, pharmacists and clients.

*Results*

RHSEP resources did not include funds to conduct mid-term or final evaluations or to collect impact-monitoring data. Nonetheless, CAs did make an effort to evaluate the outcomes and impacts of RHSEP activities. Given the short timeframe for implementing activities, the internal evaluation focused on process and output indicators, but stopped short of examining population-based measures of longer-term impacts, which are difficult to assess with accuracy at this time. Each country's national family health program has 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;
- increased public and private resources allocated to family health and contraceptive services;
- model training institutes in each country;
- better trained health care providers in family health services in the public and private sector;
- improved family health counseling programs promoting individual choice and dispensing better knowledge of modern contraception; and
- improved educational materials on contraception for clients and providers.

RHSEP's success would not have been possible if the CAR governments had not recognized the need to improve maternal and child health conditions in their respective countries. Without this receptivity and recognition on the part of policymakers, the numerous constraints to the provision of safe, high quality contraceptive services could not have been overcome by the activities implemented under the RHSEP. Coordination of activities and collaboration among CAs also were important factors in the success of RHSEP. As a result of this cohesive working arrangement, the RHSEP was able to mount activities quickly that proceeded on several fronts at the same time. In addition, there was close collaboration among CAs in a number of activities, including the exchange of trip reports, development of a research agenda, translation of materials, dissemination of research findings and implementation of jointly-sponsored activities. The calibre and receptivity of our counterparts were other critical elements for success.

Considerable results have been achieved to date and most of the first round of buy-in funds to CAs have been expended. The focused, short-term technical assistance offered through RHSEP strengthened and improved the nascent family health services in the region.

# REPRODUCTIVE HEALTH SERVICES EXPANSION PROGRAM

# FINAL REPORT

# REPRODUCTIVE HEALTH SERVICES EXPANSION PROGRAM

## I. INTRODUCTION

This document provides a record of the accomplishments achieved during the first two years of the Reproductive Health Services Expansion Program (RHSEP) in the five Central Asian Republics (CAR): Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan and Turkmenistan. This work was funded by the U.S. Agency for International Development (USAID) for the period October 1993 - December 1996. The RHSEP was implemented through buy-ins to six cooperating agencies (CAs): AVSC International, The Johns Hopkins Program for International Education in Reproductive Health, The Johns Hopkins University Population Communication Services, Macro International's Demographic and Health Surveys program, and The Futures Group International's SOMARC III and OPTIONS II projects. As the lead CA, OPTIONS was responsible for coordinating RHSEP activities. This was the first group of CAs to work in the family planning arena in the CAR and much can be learned from the experience and accomplishments of the RHSEP.

Because RHSEP activities were implemented by the consortium of six CAs, documentation of the completed activities is scattered in the trip reports, and quarterly, semi-annual or other progress reports of the individual CAs. The purpose of this report is to pull together information from the myriad sources into a single document as a record of the comprehensive nature of activities and achievements carried out under RHSEP. Much has been accomplished in a short period of time. It will be important to capitalize on this momentum to build future activities and to benefit from the lessons learned from this experience when planning and undertaking activities in other parts of the Commonwealth of Independent States.

This document begins with a brief overview of the demographic characteristics of the republics to set the context in which the RHSEP originated. Section III describes the origins of the RHSEP and presents the overall goals and objectives of the program. Section IV describes the activities carried out by each of the CAs under the five program components. This is followed by a brief assessment of RHSEP accomplishments with due recognition given to the lack of a formal evaluation mechanism. We conclude by highlighting some of the lessons learned from working in the CAR and by considering some of the factors that enabled the consortium to work so successfully there.

## II. PROFILE OF REGION

In 1990-91, 11 former Soviet republics agreed to form the Commonwealth of Independent States (CIS). Five republics—Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan and Turkmenistan—joined the commonwealth as a unit known as the Central Asian Republics (CAR). This region is characterized in modern history by Soviet colonization. The CAR comprise about 20 percent of the former USSR and share a common Moslem heritage. The USSR legal system and executive powers of the central government provided a common development framework during most of this century. However, the individual republics have unique ethnic, geographic, socioeconomic and demographic characteristics. Figure 1 shows a map of the region.

Figure 1
Map of Region

The most recently available detailed information pertaining to the CAR comes from the Soviet census of 1989 and population estimates of 1991. Within the CIS, each independent state is now responsible for its own statistical system. Vital registration systems are independently maintained at the present time, and there is no longer a single source of information for intercensal population estimates. This situation has been confounded by an unknown amount of undocumented migration between republics, making it difficult to know with precision the size and characteristics of the baseline populations of the CAR at the time the RHSEP began. Table 1 presents basic demographic information available for the period around 1990.

While the CAR maintain comprehensive systems of national statistics, less is known about the reproductive health or family planning status of the respective populations. There is little information available regarding women's and men's knowledge and attitudes about modern contraceptives or on contraceptive use and method mix. Some estimates of prevalence exist, but they can not be corroborated through recent national survey data or service statistics. Abortion appears to be a widely practiced form of fertility control, but there is a lack of accurate information on the exact magnitude or level of abortion that exists in the CAR. Moreover, definitional problems associated with some of the key indicators further complicate the estimation process. Abortion statistics are particularly difficult to analyze due to definitional problems.

The lack of timely, up-to-date and useable information about the reproductive health status of the population of the CAR influenced the RHSEP in two ways: first, a considerable amount of research and information gathering had to be conducted in order to shape program activities; second, the extent to which the impact of activities under RHSEP could be assessed by measuring change in key indicators was hampered by the lack of appropriate baseline information.

Table 1
Demographic Characteristics of the CAR
(circa 1990)

| Characteristic | Kazakhstan | Kyrgyzstan | Uzbekistan | Turkmenistan | Tajikistan |
|---|---|---|---|---|---|
| Capital | Almaty | Bishkek | Tashkent | Ashkabad | Dushanbe |
| Pop. Size | 16.7 | 9.4 | 20.6 | 3.7 | 5.3 |
| % Urban | 57 | 38 | 40 | 45 | 33 |
| Ethnicity % | Kazakh 40<br>Other As. 9<br>Russian 38<br>Other Eur. 14<br>Other 3 | Kyrgyz 52<br>Other As. 13<br>Russian 22<br>Other Eur. 7<br>Other 4 | Uzbek 71<br>Other As. 14<br>Russian 8<br>Other Eur. 3<br>Other 2 | Turkmen<br>Other As.<br>Russian<br>Other Eur.<br>Other | Tajik 62<br>Other As. 25<br>Russian 8<br>Other Eur. 3<br>Other 2 |
| CBR | 22 | 29 | 34 | 34 | 38 |
| CDR | 8 | 7 | 6 | 12 | 6 |
| CRNI | 1.4 | 2.2 | 2.8 | 2.2 | 3.2 |
| IMR | 26 | 34 | 41 | 54 | n/a |
| Life Expect. | M 64<br>F 73 | M 64<br>F 72 | M 66<br>F 73 | M 62<br>F 68 | M n/a<br>F n/a |
| TFR | 2.9 | 3.9 | 4.2 | 4.4 | 5.2 |
| MMR | 53 | 43 | 43 | 55 | 39 |
| Prevalence Rate | 26 | 11 | 6 | 12 | 3 |
| Est. Abortions per woman | 2.3 - 2.9 | 2.3 - 2.7 | 1.2 - 1.6 | 1.1 - 1.3 | 1.1 - 1.4 |

Note: Population size and percent urban are 1991 estimates; crude rates and IMR are for 1990; all other information refers to 1989.

Sources: Darsky and Dworak. 1993. Fertility Indicators and Characteristics of the Potential Market for Contraception (Reports for Kazakhstan, Kyrgyzstan, Uzbekistan, Turkmenistan and Tajikistan prepared by the OPTIONS II Project).

CIHI/ISTI. 1992. USAID Health Profile (reports for Kazakhstan, Kyrgyzstan, Uzbekistan, Turkmenistan and Tajikistan).

## III. ORIGINS AND MANDATE OF RHSEP

### A. Background

In 1993 and early 1994, USAID sponsored a team of cooperating agency (CAs) staff to conduct a general assessment of contraceptive services and training in the CAR. The team included representatives from:

- the USAID Newly Independent States (NIS) Task Force;
- AVSC International (Access to Safe and Voluntary Contraception);
- the Demographic Health Surveys (DHS) Program at Macro International;
- The Johns Hopkins University Program for International Education in Reproductive Health (JHPIEGO);
- The Johns Hopkins University Population Communication Services (PCS); and
- the OPTIONS and Social Marketing for Change (SOMARC) projects at The Futures Group International.

Figure 2
Cooperating Agencies Involved in RHSEP

**RHSEP Cooperating Agencies**

- ✦ OPTIONS II for Population Policy
- ✦ AVSC
- ✦ JHU/Population Communication Services
- ✦ JHU/JHPIEGO
- ✦ DHS II
- ✦ SOMARC III

The team conducted several visits and traveled to Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan to study family health care systems. The goal of the assessment was to develop a package of activities to assist the ministries of health (MOH) of the CAR in strengthening family health and contraceptive services with the support of USAID and its CAs.

The assessment revealed that a significant demand for fertility regulation exists in the CAR and that this demand is not adequately met. Contraceptive supplies are needed but not readily available due to the governments' lack of hard currency with which to purchase them. Distribution channels are nonexistent. Available contraceptives are often of low quality. Lack of training in contraceptive delivery further inhibits the expansion of contraceptive services. Many women—particularly urban women of European descent (Russian, Ukrainian, German)—rely on abortion as a primary means of fertility regulation. Maternal mortality and secondary infertility are important public health problems that are exacerbated by the high incidence of poorly-performed abortions. Despite these problems, some government support exists for expanding the availability of high quality reproductive health and family planning services as a means to replace abortion. Substitution of contraceptive use for abortion would have an immediate positive impact on reproductive health in the region.

In response to the challenges facing reproductive and family health providers in the CAR, USAID and its CAs designed a strategy for assistance in women's reproductive health and family planning, entitled the Reproductive Health Services Expansion Program (RHSEP). Technical activities were funded through the USAID NIS Task Force and G/POP buy-ins and carried out in Kazakhstan, Kyrgyzstan, Uzbekistan, Turkmenistan and Tajikistan[1] by the six CAs that participated in the assessments. Annex 1 lists the CAs participating in the RHSEP and their respective inputs.

The RHSEP was elaborated in close coordination with CAR counterparts. The activities in RHSEP are organized according to its five component areas: 1) creating a favorable policy environment; 2) strengthening MOH institutional capacity to plan and deliver family health services; 3) training providers and strengthening MOH institutional capacity to train reproductive health service providers; 4) diversifying contraceptive sources and broadening the contraceptive method mix; and 5) educating clients.

## B. Goals and Objectives of RHSEP

The goal of USAID technical assistance through the RHSEP is to improve the health of mothers and children in the CAR. While there are many ways to help achieve this goal,

[1] The original scopes of work developed by the NIS Task Force and USAID did not include activities in Tajikistan and Turkmenistan, except in the scope of work for OPTIONS, although a number of activities were subsequently carried out in those countries by other CAs.

the RHSEP is designed to modernize, expand and improve the quality and sustainability of family health services. Thus, the RHSEP mandate is to support the transformation and modernization of reproductive health services and technology in the public sector and to complement public sector programs through the creation of private sector services. The overall assistance package had five main objectives:

- to develop a favorable political environment and cultivate support for the expansion of quality family health services;
- to strengthen 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 in the provision of contraceptive services and to strengthen family health training institutions to ensure long-term supply of competent service providers; and
- to diversify sources for contraceptives by expanding the private sector and broadening the method mix available to consumers.
- to educate clients and providers about the safety, efficacy and health benefits of modern contraceptive methods, shifting reliance on abortion to demand for modern contraception.

## IV. TECHNICAL COMPONENTS OF THE RHSEP

Several mechanisms were available to CAs for implementing the activities proposed in the RHSEP strategy. These included: technical assistance; provision of training, training materials and equipment; development of guidelines, treatment standards and medical reference materials; development of advertising and communication materials; provision of commodities to support training programs; provision of medical equipment and supplies; procurement of contraceptives for the commercial sector; transfer of computer equipment and skills; and research and evaluation.

CAs met regularly to share information and discuss implementation issues. They also jointly carried out many technical activities. OPTIONS, in the context of providing technical assistance to MOHs to develop national strategic plans for service expansion, played a coordinating role for all technical activities. CAs also coordinated their work with other health-related interventions in the region funded by USAID and other international organizations. The following sections describe the package of activities funded by USAID under the RHSEP and implemented by the CAs.

## A. Creating a Favorable Policy 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 supported: 1) study tours for high-level government officials to observe successful family planning programs in other countries; 2) activities to raise the awareness of the benefits of family health services among policymakers and high-level medical officers; and 3) reviews of the legal and regulatory environment to identify policy constraints to the expansion of family health services. The following activities were carried out.

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

OPTIONS organized two study tours for delegates from four republics (Kazakhstan, Kyrgyzstan, Uzbekistan and Turkmenistan) to Turkey and the United States. The study tours increased the awareness of the health benefits of modern contraception among key decision-makers and provided them with a range of perspectives on service delivery options, financing mechanisms and interventions for family health services. In September 1993, 15 participants spent two weeks in Istanbul and Ankara hosted by the Turkish MOH and the Turkish International Assistance Agency (TICA) to observe reproductive health programs in Turkey's public and private sectors. In December 1993, 11 participants spent two weeks in the United States visiting international agencies and health institutions in Washington, D.C., North Carolina, Maryland and New York. Participants observed U.S. health care institutions and became acquainted with international assistance resources in the field of reproductive health.

In early September 1994, OPTIONS and SOMARC jointly sponsored delegations (8 participants total) from each CAR to attend the International Conference on Population and Development in Cairo and contribute to the official conference process.

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

In addition to study tours, four other approaches fostered political commitment: a) 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; b) the compilation and translation of a wide variety of policy materials; c) the design of IEC materials specifically targeted to opinion leaders and politicians; and d) the development of senior-level advisory boards to guide family planning policy.

*a) Policy seminars*

In three of the countries, a critical initial element of RHSEP's awareness-raising activities for policymakers and influential leaders in the medical community was a major symposium on women's and family health. With support from the other RHSEP CAs, OPTIONS conducted symposia in January, April and June 1994 in Uzbекistan, Kazakhstan and Kyrgyzstan, respectively. The symposia provided information on the health benefits of contraceptive use to 150-200 leading MOH physicians and decision-makers in each country and allowed discussion of the various components of a dynamic family planning program. The key themes of the symposia were: health benefits of contraceptive use; maximizing access and quality of care; contraceptive technology update; communications; and social marketing. The symposia laid the groundwork for subsequent policy, training, service delivery and contraceptive social marketing activities. Figure 3 displays a poster announcing the June seminar in Kyrgyzstan, which depicts the theme of "healthy families, healthy society."

Figure 3
Poster Announcing Policy Seminar in Kyrgyzstan

Alumni of the earlier study tours assembled for the "Women's and Family Health" symposium in their respective countries to further explore key policy issues regarding the expansion of reproductive health services in their country. In Kazakhstan, the group prepared an oral declaration in support of the expansion of family health services, which they read during a plenary session of the symposium. In Kyrgyzstan, the group drafted a similar declaration, which was printed and distributed to symposium participants after it was read and approved by acclamation by the symposium audience.

In September 1994, OPTIONS conducted a policy workshop in Turkmenistan for approximately 35 participants representing several ministries and agencies as a means of providing assistance to policymakers working to redefine the national health care system. The workshop provided a structured forum for multisectoral program planners and policymakers to convene in order to: 1) discuss the importance of investing in family health and family planning, concentrating on the health benefits associated with the use of contraception; 2) identify important policy issues, including the role of culture and communications, and explore the existing barriers to private sector involvement in improving Turkmenistan's National Reproductive/Family Health Program; and 3) begin planning specific "next steps" in program development. SOMARC also developed a presentation on the role of the private sector in the provision of family planning services, which discussed the potential of social marketing in Turkmenistan. Overall, the workshop was a great success and participants became interested in pursuing the development of a policy and social marketing program. Unfortunately, government changes have placed follow-up activities on hold.

In July 1995, OPTIONS conducted a policy workshop in Tajikistan. The workshop's objectives, format, and results were similar to the workshop conducted in Turkmenistan. Participants issued a declaration during the workshop stating their common will to expand contraceptive services and provide women with an alternative to abortion.

*b) Materials translated and disseminated*

Because of the overall lack of up-to-date knowledge pertaining to contraceptive methods and family planning policy issues, the CAs compiled and translated into Russian a wide variety of materials for distribution to CAR policymakers. Many of these materials were distributed at the policy symposia and workshops. For example, the Russian version of the book *Contraceptive Technology: International Edition* was distributed to nearly 500 health professionals in the region. Drawing from other sources, OPTIONS and PCS developed and assembled policy materials that were translated and widely distributed to policymakers. (A list of all materials assembled, translated and distributed to CAR counterparts is included in Annex 5.)

*c) IEC targeted to policymakers*

SOMARC and PCS identified and involved key MOH personnel in the design and implementation of IEC programs. SOMARC's efforts included media training of senior-level government representatives to help foster political support for family planning initiatives. In Kazakhstan and Uzbekistan, SOMARC trained senior government officials to serve as spokespersons for social marketing activities. The media training provided these representatives with correct information on the family planning and maternal child health scenarios in their country to ensure that they were: 1) well-informed about the specific methods being included in the social marketing project; 2) ready to respond to negative criticism or misinformation; and 3) prepared to speak about all components of the project. The process helped to develop strong advocates for the program who were willing to publicly support the project and committed to defending it in the face of opposition. In both countries, SOMARC's media training activities have resulted in very senior officials publicly supporting family planning initiatives overall as well as in the context of social marketing activities.

PCS' efforts included training and orientation in using health communication to reach broad audiences and to effect behavior change. Another focus was explaining the importance of counseling to increase family planning acceptance and continued and correct use.

*d) Advisory boards*

SOMARC's development of advisory boards in Kazakhstan and Uzbekistan has also helped to foster overall political support for family planning. The two advisory boards are composed of senior government officials as well as leading private sector representatives, including representatives from the Cabinet of Ministers, ministries of health, State TV and Radio Committees, leading NGOs and women's organizations, and the pharmaceutical sector. The advisory board in each country was established to review the overall strategies and workplan of the social marketing project, to monitor the achievements of the social marketing activities, to promote and advocate the goals of the project, and to provide advice, assistance and guidance in any way. The advisory boards have strengthened the public sector's recognition of the strong potential role that the private sector can play in family health services and have served as a forum for other CAs needing to address key policy issues related to family planning.

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

OPTIONS conducted analyses of current policies and regulations in Kazakhstan and Kyrgyzstan to identify constraints to the promotion and expansion of family health and contraceptive services. The policies, regulations, training and medical practices that impede modern contraceptive use were targeted for attention. Following the analysis, OPTIONS

conducted workshops in Kazakhstan in November 1994 to discuss the legal and regulatory issues in the region with a special focus on non-legislative mechanisms to promote the expansion of contraceptive services. Thirty-five participants from Kazakhstan, Kyrgyzstan and Turkmenistan attended.

Another emphasis was to assess the ability of the private sector to provide family health services. In collaboration with SOMARC, OPTIONS examined the evolving policy environment as it relates to privatization of the medical sector and suggested strategies to reform current policies that were impeding private sector activities.

## B. Strengthening MOH Institutional Capacity 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 supported the MOHs to better plan and manage the delivery of high-quality reproductive health services that are adequately funded and sustainable. It focused attention on such resource issues underlying public sector programs as the costs and benefits of investments, the need to target public sector investments to those who can afford to pay, and the need to create private sector partnerships.

Technical assistance to strengthen MOH institutional capability focused on improving their planning and programming skills. Under OPTIONS leadership, the CAs also worked together to gain a better understanding of the policy environment regarding contraceptive services and to provide needed information on contraceptive practices and family health services. This information helped to identify priority issues, design training activities and develop strategies to expand family health services. The activities carried out included:

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

OPTIONS assisted the MOHs in Kazakhstan and Kyrgyzstan to undertake strategic planning exercises that resulted in the articulation of national program goals, objectives and strategies to expand contraceptive services. Strategic planning exercises identified priority issues challenging the expansion of a national program; strategies to implement national-level family health and contraceptive services; and the structural and personnel changes needed given available resources. Integral to the discussion was the financing of the national programs. Consideration was given to the expansion of the method mix to meet clients' reproductive intentions; the diversification of contraceptive sources; and the means to ensure a steady supply of contraceptives and other necessary equipment and products. OPTIONS provided training to facilitate program planning processes in Kazakhstan and Kyrgyzstan during two workshops in each country. The first series of workshops addressed

the need for strategic planning, types of strategic planning, and the strategic planning process. The second series of workshops provided participants with training in the use of the Target-Cost Model. Expanding on model projections for a target method mix and source mix, participants reviewed their country needs for training, financing, demand generation, IEC and advocacy.

OPTIONS assessed public sector service statistics in each country. This effort illustrated the weaknesses of service data pertaining to family planning and the lack of its use in planning family planning programs and estimating commodity requirements. These observations led to discussions during the strategic planning workshops on the data needs for planning.

OPTIONS also provided equipment, software and training to facilitate the program planning process. This included: 1) the transfer of computers and software packages (in conjunction with SOMARC) to Kazakhstan, Kyrgyzstan and Uzbekistan; and 2) training of key personnel in basic demographic and program planning concepts, estimation of contraceptive needs and use of data for decision-making.

2. Targeted research to support program activities

Because there was little available data or familiarity with international reproductive and family health conditions, RHSEP research activities placed a strong emphasis on research and dissemination. The CAs created a research task force to coordinate their research activities and developed a master research agenda and dissemination plan for sharing the results with the CAs and CAR counterparts.

The research agenda was intended to provide a baseline understanding of the political and social culture and of attitudes and practices regarding modern contraception in all segments of the CAR populations. Based on RHSEP's goals and objectives, the research strategy focused on provider research, consumer research and policy environment research. Research results were used to inform programmatic decisions of the MOHs, assist CAs in designing better interventions for the expansion and improvement of family health services, and provide some baseline information by which to evaluate RHSEP impact. A secondary objective of the research was to strengthen the analytic capability of local institutions by providing analysis tools and training in their use, thereby increasing counterparts' ability to conduct similar research linked to the design and evaluation of reproductive and family health services. A list of the research reports generated through the RHSEP is included as Annex 4.

The largest research activity was the Demographic and Health Survey (DHS) in Kazakhstan carried out by MACRO International. The survey was initially envisioned to take place in Uzbekistan, but after negotiations the survey was finally conducted in Kazakhstan. Preliminary data from the DHS are now available and 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. Complete survey results are expected in late 1995.

Due to the delayed start of the DHS, additional studies were undertaken to fill the immediate need for information to guide program design. OPTIONS conducted provider surveys in Kazakhstan, Kyrgyzstan and Uzbekistan. The surveys evaluated attitudes and practices of medical providers and pharmacists regarding modern contraception and examined their interest in, as well as their ability to provide, modern contraceptive and family health services. The surveys included 100 physicians and 50 pharmacists in each country and were conducted in collaboration with a Turkish research firm (SIAR). Three reports of the findings have been prepared, translated into Russian and distributed to the MOH of the respective countries.

SOMARC implemented a consumer survey of 1,001 women in the cities of Almaty, Oskamen and Karaganda (the pilot markets of the social marketing initiative in Kazakhstan). The survey was conducted to establish a baseline for monitoring and evaluating the RHSEP's communication activities (of both PCS and SOMARC) in Kazakhstan and to provide data for planning and monitoring other USAID-sponsored activities. The survey helped to identify several key programmatic issues that should influence the design of all future child-spacing initiatives in Kazakhstan. For example, ever-use of contraceptives is actually quite high and increases with age. Sixty-eight percent of women in union reported using some type of contraceptive method. The survey also suggests, however, that contraceptive failure rates are quite high—21 percent of completed pregnancies during the last three years were due to contraceptive failure. Indeed, many abortions may be a result of contraceptive failure. Survey results show that one-third of the last induced abortions were preceded by contraceptive failure. The report of this survey is complete and has been provided to the Kazakh MOH. The tracking phase of the survey is scheduled to be fielded in early 1996.

Using the Target-Cost Model, an OPTIONS consultant assessed contraceptive needs in Kazakhstan, Kyrgyzstan and Uzbekistan in the spring of 1994. The resulting projections were used to demonstrate to USAID the need to allocate contraceptives to initiate the RHSEP. This work resulted in the allocation of US $1 million dollars worth of commodities in support of the program and its training activities. OPTIONS also analyzed data from the record keeping and health information systems for contraceptive services in Kyrgyzstan. It was hoped that some of the data could be used to provide insight into contraceptive use, continuation rates and patterns of method continuation. However, the assessment indicated that the data could not be used in its current state for this purpose. In addition, OPTIONS provided technical assistance for the design of a study to identify the cost elements of abortion care in Aktiubinsk Oblast in Kazakhstan and to estimate the cost of a standard abortion in order to identify the cost-effectiveness of contraception.

These studies were supplemented with qualitative research, especially focus group research conducted by PCS and SOMARC. PCS' study was designed to determine attitudes and social, cultural and religious values related to contraceptive use and birth spacing in Kazakhstan, Kyrgyzstan, Uzbekistan and Turkmenistan. PCS worked with a private research company in Uzbekistan, which in turn supervised subcontracts with other private research companies to conduct research in Kazakhstan and Kyrgyzstan. The Uzbek company conducted research in Uzbekistan and trained MOH officials to carry out research in Turkmenistan. Thus, over 30 focus group moderators were trained to conduct the focus group research. A total of 92 focus groups, covering approximately 1,000 men and women, were conducted in these republics. In Kazakhstan, focus group research was conducted in Almaty and nearby rural areas; in Kyrgyzstan, focus group research targeted young women in Bishkek and women in rural areas. Focus group discussions were limited to the greater Tashkent area in Uzbekistan and the greater Ashgabad area in Turkmenistan. The information gained was used to develop appropriate communication messages and counseling materials. In addition, communication materials were pretested with the intended audience. Results of the focus group research are summarized in several reports published by PCS.

SOMARC's qualitative research in Kazakhstan and Uzbekistan focused on attitudes and beliefs regarding specific methods of contraception, primarily condoms, oral contraceptives and injectables. This qualitative research was instrumental in the design of all communication materials and helped to identify special cultural concerns related to these methods. In addition, the final communication materials were all pretested among representatives of SOMARC's target audience.

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. Fully adopting safe motherhood and birth-spacing programs, eliminating high-risk births and achieving fertility desires of families through modern contraception might increase usage. Financing increased levels of service delivery will require mobilizing public and private resources. The issues surrounding public resource requirements were addressed by the policy symposia and workshops and by the observational study tours for CAR decision-makers, which emphasized (among other things) financing of family health services and targeting government resources to those who need them most. Private sector resources are discussed in section D.

RHSEP activities represent only the beginning of initiatives to address critical resource allocation issues. RHSEP has coordinated its activities with those of Abt's Zdarov Reform 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, AVSC and JHPIEGO selected several sites to become demonstration clinics for the introduction of new technologies and new modes of family health and contraceptive service delivery. In order to be selected, the site needed to offer a full range of maternity and contraceptive services. In addition, it was necessary for the site to be a clinical training site for pre-service and in-service training institutions. In each country, AVSC established demonstration service delivery sites in selected leading maternity hospitals. The sites have been furnished with essential equipment and supplies, including a one-year supply of contraceptives donated by USAID, and personnel have been trained to deliver contraceptive services. The improvement in service delivery at these sites has already begun 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. The sites targeted to become demonstration service delivery centers are presented in Table 2.

## C. *Training Providers* and Strengthening MOH Institutional Capacity to Train Reproductive Health Service Providers

The goals of the RHSEP training component are to: 1) train reproductive health care providers in the public and private sectors in the safe delivery of modern contraceptives and to integrate contraceptive counseling and services into maternity services; and 2) develop a contraceptive training capacity in order to generate a steady flow of competent service providers. In this context, AVSC, JHPIEGO, SOMARC and PCS updated the knowledge of family health service providers regarding modern contraceptive use and trained service providers in the safe delivery of contraceptive services, emphasizing counseling and infection prevention. (See Annex 5 for a complete list of technical materials compiled and translated into Russian for use in training sessions.) In addition, JHPIEGO and SOMARC strengthened training systems by preparing and equipping service providers to train additional doctors and students in the safe delivery of contraceptive services. SOMARC developed training-of-trainer courses for private sector physicians and pharmacists who then conducted multiple contraceptive technology training sessions throughout the region. In support of these activities, JHPIEGO and OPTIONS provided technical assistance to MOHs to develop and revise service delivery guidelines for reproductive health services in Kazakhstan, Kyrgyzstan and Uzbekistan.

Table 2
Training Sites

| | | | |
|---|---|---|---|
| Kazakhstan | JHPIEGO, AVSC | ● | Perinatal Center (Maternity House #3), Almaty |
| | JHPIEGO, AVSC | ● | Human Reproduction Center, Almaty |
| Kyrgyzstan | JHPIEGO, AVSC | ● | Marriage and Family Consultation Center, Bishkek |
| | JHPIEGO, AVSC | ● | Maternity House #4, Bishkek |
| | JHPIEGO | ● | The Kyrgyz State Medical Institute |
| Uzbekistan | JHPIEGO, AVSC | ◆ | Maternity House #9, Tashkent |
| | JHPIEGO, AVSC | ● | Regional Center for MCH (formerly Maternity House #4), Samarkand |
| | JHPIEGO | ● | The Samarkand Medical Institute |
| | JHPIEGO, AVSC | ◆ | Maternity House #3, Andizhan |
| Tajikistan | JHPIEGO, AVSC | ● | Leninabad Regional Maternity House, Khojand (Oblast Maternity House) |
| | JHPIEGO | ◆ | Scientific Research Institute of Obstetrics, Gynecology and Pediatrics, Dushanbe |
| Turkmenistan | JHPIEGO, AVSC | ● | Polyclinic #9, Ashgabad |
| | JHPIEGO, AVSC | ● | Central Clinic/Red Cross Hospital |

Altogether, training systems and institutions in the CAR have been strengthened and are now producing a wide range of qualified health professionals capable of delivering contraceptive services safely, reliably and with sensitivity. To date, approximately 1,650 public and private sector providers have received clinical training and over 75 physicians have received supplementary training to ensure their capability to train others. In support of the nascent social marketing programs, over 1,050 pharmacists and 1,000 physicians will be trained in contraceptive service delivery by 130 qualified trainers. Annex 3 presents a complete list of training activities that have taken place in the five CAR.

1. Clinical training to update providers' knowledge and skills in the delivery of contraceptive services

The main objectives of the clinical training activities are to: a) update public sector providers' knowledge of family planning practices, specifically the use of modern contraceptives and counseling skills of providers; b) develop commitment to continuous

improvement of contraceptive service delivery in public sector facilities; and c) expand postpartum and post-abortion contraceptive services in facilities operated by the MOHs.

*a) Minilap training tour*

Interest in long-term contraceptive methods is strong in the CAR. There is growing interest among CAR health providers in developing laparoscopy skills and in making minilaparotomy available to women. JHPIEGO organized and led a training tour to the Philippines for nine participants in April 1994 to teach the minilaparotomy technique and to allow participants to observe how this method is an integral component of reproductive health services. At the Fertility Care Center in Manila, the nine-person delegation (from Kazakhstan, Kyrgyzstan, Uzbekistan and Turkmenistan) participated in a training course that focused on developing the skills to perform the minilap procedure. A module of the course emphasized client counseling on the method. Upon return to the CAR, participants began offering this service to clients, using minilap kits provided by AVSC. The training tour participants later took part in JHPIEGO's clinical training skills course to ensure that they became competent trainers (see section C.2). Participants in some countries are currently training others at the designated national training centers established by AVSC and JHPIEGO.

*b) Contraceptive technology update (CTU) training*

As described in section B.4, AVSC and JHPIEGO equipped and strengthened demonstration family health service delivery centers in all five CAR (see Table 2). These demonstration sites became practical training sites dedicated to improving the training capacity of the republics. Extensive clinical training of service providers in contraceptive technology took place in these centers in each of the five republics. AVSC and JHPIEGO will continue this work through 1996.

AVSC took the lead in conducting clinical training in the provision of modern contraceptive methods. The centerpiece of AVSC's training activities consisted of a 10-day contraceptive technology training course. The AVSC 10-day course consisted of three days for a contraceptive technology update; two days of counseling training; four days of IUD, Depo Provera and group counseling training; and one day of infection prevention training. AVSC conducted six of these courses in the five CAR; three additional courses consisted of only the contraceptive technology update. In Kyrgyzstan and Uzbekistan, AVSC also conducted a five-day clinical training course on minilaparotomy. Altogether, approximately 1600 OB/GYNs, physicians and other service providers received training in AVSC's courses. (See Annex 3 for a complete list of all training venues and the numbers of participants trained.)

In response to a strong need to update infection prevention practices, JHPIEGO conducted clinical infection prevention training courses in Turkmenistan and Tajikistan in December 1994 for 30 participants. Participants included service providers from the sites,

as well as representatives of the "Sanitary-Epidemiology Stations" (policymakers) in each oblast. Participants and the sites received infection prevention reference manuals, posters, slides and videos translated into Russian by JHPIEGO and AVSC.

In addition to these activities, AVSC provided medical equipment and supplies to cover a one-year period and education materials (with PCS) to support training activities and service provision in seven of the sites. Contraceptives used in the training activities were donated by USAID and complemented the commodities donated to the CAR by UNFPA. AVSC shipped 1,000 Russian-language contraceptive posters to the Uzbek MOH, 10,000 to the Kyrgyz MOH, and 15,750 to the Kazakh Human Reproductive Center. Few were sent to Uzbekistan and none to Turkmenistan because the posters highlighted vasectomy, a method neither country presently wants to incorporate into its method mix. AVSC also coordinated the distribution of 30,000 copies of the Russian version of *Contraceptive Technology: International Edition* to all republics.

2. Strengthening MOH training systems to generate new clinicians competent to deliver contraceptive and counseling services

Among the major constraints to strengthening and expanding high-quality services in Central Asia is the lack of a training system for contraception. Early assessments in the CAR indicated that contraceptive training is not included in pre-service and in-service curricula and that the majority of reproductive health training is theoretical and observational.

In order for CAR countries to continue to generate a sufficient number of competent family health service providers, JHPIEGO worked to develop a training capacity for the provision of contraceptive services. Following AVSC's work to strengthen contraceptive service delivery, JHPIEGO conducted several activities to integrate clinical contraceptive training into pre-service and in-service training curricula. At each demonstration site in the CAR, JHPIEGO collaborated with AVSC to identify potential clinical trainers. Seven two-week training skills courses were conducted in 1994 and 1995, resulting in the training of over 75 trainers. The objectives of the courses were to prepare trainers to teach contraceptive courses using participatory, humanistic and competency-based training techniques. A practicum during the second week of the course enabled the new CAR trainers to practice their training skills while they trained additional service providers in the use of reversible contraceptive methods. In addition, a three-week minilap training skills course was conducted in November 1994 for the nine service providers who were trained in the Philippines.

To increase provider knowledge of contraceptive technology and to support training activities, PCS translated *Population Reports* on lower-dose pills, condoms and counseling. PCS also developed and translated method-specific cue cards on condoms, IUDs, injectables and lower-dose pills to enhance family planning counseling. These materials were distributed to providers during seminars. In support of future training activities,

JHPIEGO provided each demonstration site with a wide variety of reference materials, anatomic models, audiovisual equipment and supplies, comprehensive slide sets and videos. See Annex 5 for a complete list.

Following clinical and training skills training by AVSC and JHPIEGO, the next stage in the development of a training capacity is the revision of pre-service and in-service curricula to integrate clinical contraceptive training into existing curricula. Currently, JHPIEGO is providing technical assistance to the chairpersons and teaching staff at the demonstration sites to revise and/or develop a contraceptive component of the curricula. Through workshops, contraceptive curricula are reviewed and revised, and the working groups come to consensus on course schedules and content. Training materials are also reviewed and possible adaptations are discussed. In addition, the working groups discuss next steps and plans for implementation of the contraceptive course on a regular basis.

3. Contraceptive technology training for private physicians and pharmacists collaborating with social marketing activities

SOMARC designed and implemented two new training programs to support its social marketing activities under RHSEP. The first training program, a two-day CTU for pharmacists, reviewed basic knowledge and information on all contraceptives, with a special emphasis on social marketing products (i.e., condoms, oral contraceptives and injectables). The second training program was a two-day CTU with particular emphasis on the administration of Depo-Provera (DMPA). SOMARC was asked specifically by USAID/Almaty to develop the DMPA training program due to the large quantities of UNFPA-donated DMPA that were being widely distributed and used throughout the region without proper training. SOMARC's training initiative represents the largest-scale training of service providers and pharmacists to date in Central Asia.

Kazakhstan. SOMARC's ongoing two-day pharmacist training began in September 1994. In total, SOMARC has conducted over 19 sessions and trained approximately 450 pharmacists. These sessions were conducted by 25 trainers who were selected from five prestigious institutions: the Ministry of Health, the Maternal Child Health Center, Medical Training Institute, Pharmatsia and Kazmed. The physician training focusing on DMPA utilizes 21 trainers who have conducted over 20 sessions in Almaty, Karaganda and Oskamen, training more than 400 OB/GYNs from these areas.

Kyrgyzstan. SOMARC's pharmacist training program in Kyrgyzstan will train over 250 pharmacists from all regions of the country. The pharmacist training program has trained 20 trainers who are now conducting approximately 10 separate sessions. The physician training program for DMPA also includes 20 trainers who will subsequently train over 300 physicians from all regions of the country.

Uzbekistan. SOMARC has trained 25 trainers from all regions of Uzbekistan to implement the pharmacist training. SOMARC will train over 350 pharmacists in Tashkent

and Samarkand—the project's two pilot areas. For DMPA training, SOMARC has trained 18 trainers from all regions who will subsequently train over 300 physicians from Tashkent and Samarkand. The trainers came from seven prestigious institutions in Uzbekistan: the Ministry of Health, Pharmatsia, Maternal Child Health Center, Medical Training Institute, OB/GYN Institute, the Healthy Generation Fund and the Scientific Research Institute.

4. Review of current standards of practice to ensure compliance with international standards

JHPIEGO and OPTIONS jointly led an intensive process of reviewing and updating the official medical guidelines and standard operating procedures for service delivery practices in family health in Kazakhstan, Kyrgyzstan and Uzbekistan. JHPIEGO and OPTIONS assembled teams of eminent researchers and physicians in each country and sponsored workshops to discuss the content of the guidelines, the process for revision, and the production of the revised guidelines. Each MOH team received a high-performance computer and relevant training in its use. JHPIEGO also provided a translated version of their reference manual on diskette for use in revising the guidelines. During 1995, the newly-developed service guidelines were completed in Kazakhstan and Kyrgyzstan.

Kazakhstan received further support from OPTIONS to publish its guidelines chapter by chapter in the national journal of public health. JHPIEGO is assisting with the final production of the guidelines in Kazakhstan and Kyrgyzstan and with the dissemination of approximately 5,000 copies to existing service facilities. Uzbekistan is still completing its revision of service delivery guidelines. Medical guidelines were not reviewed in Turkmenistan and Tajikistan. Instead, JHPIEGO will provide the Russian translation of its *Pocket Guide for Family Planning Service Providers* to those countries.

AVSC and JHPIEGO reinforced the new standards of practice by using them in their training sites. SOMARC immediately made use of the new guidelines in the development of method-specific brochures on oral contraceptives and injectables targeted to consumers. SOMARC also spent considerable time in Kazakhstan and Uzbekistan ensuring that all communication materials were consistent with the newly-developed guidelines. This combined effort produced broad-based support for the clinical guidelines from the clinical, academic and policy communities.

## D. Diversifying Contraceptive Sources and Broadening the Method Mix

MOHs have been the principal, if not the exclusive source for contraceptive services and commodities in the CAR (they almost exclusively supply IUDs). A key RHSEP objective is to diversify the contraceptive sources by expanding private sector outlets and to broaden the method mix to include a range of quality methods (i.e., low-dose pills, IUDs, condoms, injectables and voluntary sterilization).

The diversification of product sources and the method 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. Technical activities focused on removing obstacles to the development/expansion of the private sector and initiating social marketing programs in three countries. RHSEP assisted physicians and pharmacists interested in offering family health services, selling modern contraceptives in private practices, and implementing contraceptive social marketing programs. SOMARC made great strides in establishing and implementing contraceptive social marketing projects in Kazakhstan and Uzbekistan and is exploring the feasibility of extending activities to Kyrgyzstan. SOMARC also assisted OPTIONS in setting up an association of private physicians in Uzbekistan.

1. Contraceptive social marketing activities

In Kazakhstan and Uzbekistan, SOMARC has launched a social marketing program that is designed to increase the availability of quality, affordable contraceptives in the private sector. The social marketing projects in both countries include condoms, oral contraceptives and injectables. The products used in these programs are currently sourced directly through the commercial sector, diversifying commodity sourcing for the respective governments and eliminating any long-term dependence on USAID for donated commodities. In addition, in a region where maternal and child health programs have historically focused on the IUD, the social marketing projects are helping to broaden the overall method mix in these countries.

SOMARC's efforts to identify commercial sourcing alternatives for the projects were difficult because international manufacturers initially perceived Central Asia as an unviable commercial market. This problem was exacerbated by the fact that manufacturers had experienced difficulty obtaining payment from local governments for pharmaceutical supplies. To establish commercial sourcing of products, SOMARC identified private sector distributors that were willing and able to enter the contraceptive market. To be considered by SOMARC, these distributors needed to provide up-front commodity costs, place orders and be solely responsible for payment, clear products through customs and distribute products to as many outlets as possible. After much discussion and negotiation, SOMARC identified a number of private distributors in both countries. Since these truly "private" distributors are just beginning to develop and expand their distribution infrastructures, SOMARC is also working with the former Pharmatsia pharmacies (government-run pharmacies that also have commercial windows). SOMARC facilitated the contacts between the international contraceptive manufacturers and local distributors—including helping to negotiate terms of credit and product pricing levels. Currently, four international manufacturers are providing product to the social marketing initiatives: Gideon Richter, Schering, Upjohn and Organon.

SOMARC's pilot program also includes comprehensive training and IEC components. The training effort is designed to ensure that service providers, both OB/GYNs and pharmacists,

are knowledgeable about specific contraceptive methods and that they are committed to providing high-quality service. (SOMARC's training activities are described fully in section C.) SOMARC's IEC component is designed to stimulate demand for available contraceptives by providing correct information and directly addressing fears and misconceptions about the products. (SOMARC's IEC activities are described in detail in section E.)

The development of a social marketing initiative in these countries has also required a substantial amount of technical assistance to local private sector agencies. All SOMARC's activities have been implemented in conjunction with local advertising, public relations and market research agencies. SOMARC has provided hands-on technical assistance to the advertising agencies in teaching them to use market research to support the development of communication messages, to improve production quality for television and radio, and to develop media purchasing plans. The public relations agencies have been assisted with their overall public relations strategies. SOMARC has taught them to conduct media training, develop a video news release, monitor and evaluate press coverage, and respond to crisis situations. The market research agencies have received extensive technical assistance in quantitative and qualitative research. The result of this extensive technology transfer and technical assistance is that these organizations are now better able to provide these services to other commercial entities as well as other family planning groups.

In Kyrgyzstan, SOMARC conducted an assessment to determine if the overall economic situation would support a commercially-based social marketing initiative. The assessment concluded that a commercial program is viable; hence, SOMARC proposed to USAID/Almaty to expand social marketing activities in the region to include Kyrgyzstan, where SOMARC has already conducted provider and pharmacist training. Additional funds for Kyrgyzstan have become available, and SOMARC is currently designing a national social marketing project there.

To date, there have been no social marketing activities implemented in Turkmenistan due to basic policy issues inhibiting privatization of the pharmaceutical sector. SOMARC's activities in the Central Asian region will continue under its current buy-in through December 1996.

2. Increasing service provision by private physicians and pharmacists

Given the absence of a viable private medical sector prior to RHSEP's activities in the CAR, OPTIONS and SOMARC provided assistance for the establishment of the Association of Uzbekistan Physicians (AUP). OPTIONS provided funding and technical assistance to the AUP to get organized, initiate a newsletter and conduct a survey of its membership on their attitudes toward private practice. Much of this work was facilitated with technical assistance from SOMARC's in-country manager. The AUP also received a microcomputer and training in its use. After completing its bylaws and conducting the membership survey, the AUP conducted two seminars for members. One of the seminars

focused on how to get a private practice organized; the other focused on the provision of reproductive health services. AUP activities contributed to improving the quality of private sector family health services in Uzbekistan.

## E. Educating Clients

The objective of communication activities in RHSEP was to educate clients about the safety and health benefits of modern contraceptives and to promote effective and sustained use of modern contraception. PCS and SOMARC developed an integrated communication program, consisting of public service campaigns, advertising, public relations and extensive print materials for service providers, pharmacists and clients. SOMARC and AVSC were active partners in client communication and coordinated marketing campaigns and the development of counseling materials with PCS. The components of the communication strategy are described below.

### 1. Designing communication programs

PCS developed public service communication campaigns in Kazakhstan, Kyrgyzstan and Uzbekistan to increase support for child-spacing concepts and conducted focus group research to determine knowledge, attitudes, and behavior regarding reproductive health to shape the campaigns. PCS worked closely with the MOHs and local private media agencies to prepare public service mass media campaigns for television and radio and to design posters and brochures developed specifically for each republic. SOMARC built on PCS' initial activities and research in mass media communication by developing extensive educational and motivational communication materials to educate consumers on specific contraceptive methods and brands. The materials developed included advertising spots, video news releases, television and radio interview programs, newspaper columns and interviews. The highlights of each campaign are described below.

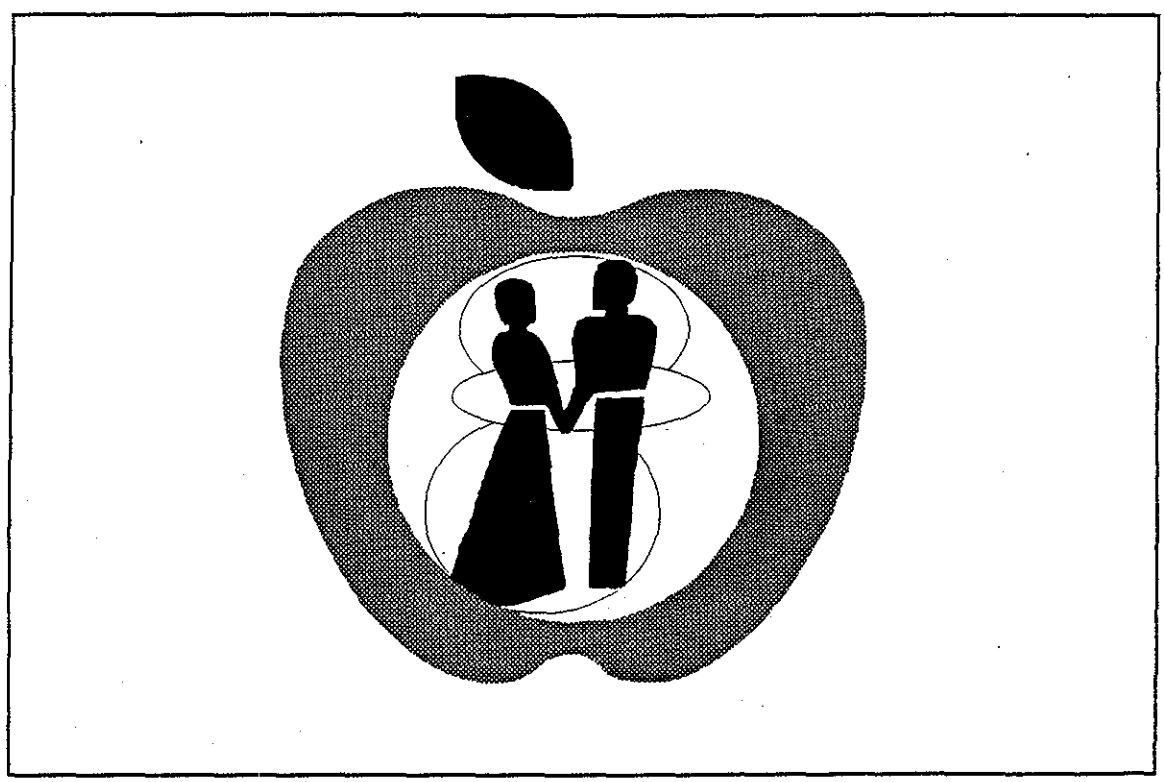
Kazakhstan. PCS worked with a private production firm to develop two public awareness spots for television and radio. One of the TV and radio spots focused on presenting the health benefits of modern contraceptives for spacing births to women of reproductive age. The other spots targeted adolescents to increase their awareness of the safety of modern contraception for avoiding unplanned pregnancies. The TV and radio spots are currently used in closed circuit. Accompanying print materials were distributed to schools and clinics.

SOMARC developed an advertising campaign with the local agency, DANK VIDEO, featuring a "Red Apple" identifying logo and method-specific product advertising for television and radio; a radio spot to promote method-specific brochures at point-of-sale; "slice of life" television spots on low-dose pills and the injectable; and 12 radio spots addressing information and misconceptions about hormonal contraceptives, low-dose pills and the injectable. Consumer brochures, point-of-sale posters and in-store logo decals were

also developed. The "Red Apple" campaign was designed to position the participating social marketing brands as high-quality contraceptives and to address women's specific health concerns related to the method. (See Figure 4 for an illustration of the red apple logo that identifies the social marketing products.) To launch the program in Kazakhstan, a press conference was held and program spokespersons were "media-trained" to be able to speak about the program to public and media audiences.

In addition to advertising efforts, public relations efforts are ongoing. These include weekly television programming, radio interview shows in Russian and Kazakh, newspaper articles and columns, and periodic media training and briefings. Special programming has been developed for Depo-Provera, and physician and media seminars in contraceptive technology are planned. SOMARC and DANK VIDEO also developed an innovative pilot soap opera that introduces modern contraceptives in an entertaining way. SOMARC's Red Apple advertising and communication campaign has been running in Kazakhstan continually since November 1994.

Figure 4
Red Apple Logo Identifying Social Marketing Products



Uzbekistan. PCS's campaign is directed toward married couples of reproductive age to promote awareness of the benefits of modern contraceptives in family planning. Campaign materials include a radio and a TV spot, as well as posters and brochures united by a common theme. The regional campaign developed in Kazakhstan by SOMARC was intended for broadcast on Uzbek television and radio. The advertising campaign was revised based on research results from Uzbek pretesting focus groups to simplify some of the messages. While the Red Apple logo and the basic advertising messages were well received, the spots were reproduced in Uzbekistan using Uzbek actors to ensure greater political and cultural acceptance in the Uzbek market. The "Red Apple" program in Uzbekistan was launched in September 1995.

Kyrgyzstan. Working with the MOH and a private production company, PCS developed and implemented two mass media campaigns. The first campaign focused on preventing unintended pregnancies and on contraceptive use for young women in Bishkek. The campaign has been broadcast on Pyramid radio and television stations, whose audience includes young people in Bishkek and surrounding areas. The campaign ran for six consecutive weeks. The second campaign is targeted to rural couples and has been broadcast on Pyramid radio and TV. The emphasis of the message is on the health benefits of birth spacing. MOH has thus far been unsuccessful in negotiating air time on the Kyrgyz national television channel. SOMARC's communication activities in Kyrgyzstan are just now getting underway. It is examining the feasibility of adapting and pretesting materials developed for Kazakhstan in Kyrgyzstan.

2. Education and promotional materials produced

PCS, SOMARC, AVSC and JHPIEGO worked with each MOH to develop Russian-language information leaflets on contraceptive methods to be distributed to health centers and clients. PCS produced brochures, cue cards, poster, radio and video spots in Russian (and other languages as noted) for use in Kazakhstan, Kyrgyzstan and Uzbekistan. PCS also prepared counseling materials on contraceptive methods to assist providers in giving guidance to clients. Print materials for women and adolescents were distributed primarily to clinics and schools. Video and radio spots were broadcast on local television and radio or shown in closed circuit. *Population Reports* and counseling cue cards were distributed to providers to increase their knowledge of modern contraceptive methods and to improve their family planning counseling skills.

AVSC translated a flipchart it had developed for doctors to use in counseling sessions with clients and distributed 500 copies. SOMARC produced a range of advertising and promotional materials in support of social marketing activities in Kazakhstan, Kyrgyzstan and Uzbekistan. These included: a pharmacists guidebook, method-specific brochures, and pharmacy logos, displays and decals.

## V. EVALUATION AND OUTCOMES OF RHSEP

Due to the high level of infrastructure and existing human resources in the CAR, technical assistance to the region should begin to show impact within a short period of time. However, the 36-month project duration is too short to effect measurable changes and demonstrate full impact. Some components of RHSEP take longer to achieve. For example, improved clinical skills should be realized immediately, while developing private sector channels to distribute commodities will take longer.

RHSEP resources did not include funds to conduct mid-term or final evaluations or to collect impact-monitoring data. Available resources did not allow us to gather needed baseline and follow-up data for the target population. A DHS has been conducted in only one republic, from which preliminary data are just now becoming available. Therefore, any measurement of changes in contraceptive practice, abortion use or fertility patterns is not possible. Additionally, it would not be possible to isolate the long-term impact of RHSEP activities at the population level in the context of the tremendous economic, political and social changes that are occurring in the region. Nonetheless, CAs did make an effort to evaluate the outcomes and impacts of RHSEP activities.

Due to the available resources and timeframe for the completion of activities, OPTIONS spearheaded efforts for an internal evaluation of RHSEP activities that emphasized short and medium-term qualitative results that could be closely linked to program interventions. Each CA considered feasible evaluation indicators for individual CA programs given its current evaluation resources. Several CAs also conducted more detailed internal evaluations of their own activities.[2] Some of the evaluation indicators considered included changes in the policy environment; expansion of service delivery sites in the private sector; increased availability of modern contraceptive methods; changes in levels of training and client and provider attitudes; and availability of family planning materials and information at the demonstration sites.

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[2] AVSC International evaluated its work in April 1995. The evaluation examined the status of contraceptive services in the demonstration sites, service delivery and management issues, and outcomes of the program in terms of changes in attitudes and knowledge and improved access to quality family planning services at demonstration sites. AVSC interviewed administrators, providers and clients; collected training and service statistics; inventoried supplies and equipment; and observed counseling sessions and clinical services.

SOMARC has designed a research plan and indicators to enhance the design of their marketing strategy and to assess the impact of the social marketing initiative. The plan included the design of a reporting system for tracking and monitoring contraceptive distribution and sales in the private sector; a mystery shopper study to evaluate the impact of training activities on the provision of quality services by providers; and quantitative baseline survey to evaluate the impact of communication activities. SOMARC is now in the process of developing the tracking survey to assess change in consumer knowledge, attitudes and practice as a result of the social marketing intervention in Kazakhstan.

Other CAs are considering the following possibilities: 1) PCS may conduct a series of exit interviews with clients to assess IEC activity; and 2) JHPIEGO plans to conduct periodic monitoring visits at the demonstration sites; these may include provider and client interviews to assess quality of training and services.

Given the short timeframe for implementing activities, the internal evaluation focused on process and output indicators, but stopped short of examining population-based measures of longer-term impacts, such as increases in contraceptive prevalence, reduction in the number of abortions performed or decreases in fertility, which are difficult to assess with accuracy at this time. However, in demonstration service sites, there is evidence of a broader method mix (minilap, IUDs and oral contraceptives are available) and reports of decreasing abortion rates. With the proliferation of private pharmacies under the social marketing programs in Kazakhstan and Uzbekistan (and soon to be in Kyrgyzstan) and the establishment of the UAP in Uzbekistan, there is also some evidence of diversified contraceptive sources.

Thus, each country's national family health program has 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;
- increased public and private resources allocated to family health and contraceptive services;
- model training institutes in each country;
- better trained health care providers in family health services in the public and private sector;
- improved family health counseling programs promoting individual choice and dispensing better knowledge of modern contraception; and
- improved educational materials on contraception for clients and providers.

The RHSEP internal evaluation made use of a logical framework that draws on the evaluation framework developed by The EVALUATION Project. The logical framework presents inputs and outputs for the RHSEP. Inputs refer to the financial resources, materials and equipment, technical assistance and other human resources provided through the program, which were described earlier in this document. Process indicators refer to activities carried out during the program that are aimed at achieving program objectives. Outputs are divided into two types. Functional outputs refer to the establishment of capability to effectively carry out specified activities. An assessment of the functional outputs of RHSEP activities are presented in Table 3. Service outputs address the parameters of access, quality and image/acceptability. Effects/outcomes are reflected in changes at the population level, such as increased contraceptive prevalence (intermediate outcome) or lowered fertility rates (long-term outcome).

Table 3
Functional Outputs of RHSEP Activities

| | |
|---|---|
| Policy Environment | • Achieved consensus that universal access to contraceptive services is key to diminishing use of abortion for fertility regulation<br>• Developed consensus that expanded access to contraception will occur in partnership with private sector<br>• Enhanced knowledge that contraception is safe and that use often improves the health of mothers and children<br>• Enhanced national commitment to providing and funding a broad range of contraceptive options<br>• Helped MOHs become more active in advocacy to gain support for family health programs |
| Institution Building | • MOHs rethinking data collection and information systems and exploring new ways of planning<br>• Baseline data available for the region to inform MOH programmatic decisions<br>• Model training sites established and furnished with materials and supplies<br>• Increased capacity for IEC program management |
| Training | • Service providers trained<br>• Improved knowledge, attitudes and practice of service providers regarding contraception<br>• Contraceptive counseling improved and linked to services within maternity centers at model sites<br>• Training sites established with capacity to continue training<br>• Contraceptive training curricula integrated into medical school programs and in-service continuing education institutions<br>• Locally-organized CTUs held<br>• Second-generation training of providers taking place |
| Broadened Method Mix | • Established commercial market for contraceptives<br>• Increased availability and usage of modern contraceptives through public and private sector outlets<br>• Expanded contraceptive services in the private sector |
| Education of Users | • Enhanced interest in contraceptive services*<br>• Increased demand for contraception*<br>• Enhanced desire for more knowledge on contraceptive use*<br>• Increased availability of state-of-the-art information on contraceptives available in service delivery outlets and for clients |

* Cannot be measured without additional funding and evaluation research

Table 4 presents service outputs and other impacts believed to have occurred as a result of RHSEP activities, although for the reasons described above, we were not able to definitively measure these impacts.

Table 4
Service Outputs and Other Outcomes of RHSEP Activities

| | |
|---|---|
| Access | • Increased number of trained public and private sector providers<br>• Diversified contraceptive sources and broader method mix available to consumers (pharmacies expanded, availability of minilap at demo sites, hormonal methods on the rise)<br>• Increased number of service sites<br>• Increased availability of family planning information in media<br>• Increased availability of family planning information in clinics |
| Quality | • Standardized service guidelines in use in three republics<br>• Improved clinical practice (infection prevention procedures)<br>• Improved family health counseling programs<br>• More diversified method mix |
| Image/ Acceptability | • Increased public awareness and use of sterilization*<br>• Increased public awareness of benefits of modern contraceptive methods*<br>• Increased positive public attitudes toward modern methods*<br>• Increased public knowledge of methods* |
| Service Utilization/ Contraceptive Practice | • Increased use of sterilization at demo sites<br>• Increased contraceptive use at demo sites<br>• Increased requests for FP information and methods at demo sites<br>• Increased referrals resulting from IEC interventions*<br>• Decreased reliance on abortion for fertility regulation* |
| Fertility Change | |
| Institutionalization/ Sustainability | • Favorable policy environment* (service guidelines approved and in use)<br>• Training in reproductive health institutionalized (new curricula in medical schools)<br>• Increased capacity of private organizations to conduct advertising, public relations, and qualitative and quantitative research<br>• Strengthened MOH capable of planning for and providing high-quality FP services<br>• Strengthened training institutions<br>• Increased coordination between public and private sector organizations for IEC activities |

* Cannot be measured without additional funding and evaluation research

## VI. CONCLUSION

In the following sections, we summarize some of the lessons learned from our experience in the CAR as a way of guiding future activities in the region. We also present some of the factors underlying the success of RHSEP activities and some of the challenges that lie ahead.

### A. Lessons Learned

Considerable results have been achieved to date and most of the first round of buy-in funds to CAs have been expended. The wisdom accumulated from working in the region and the lessons learned influenced activities at later stages of the program. Some of the key lessons learned from the RHSEP are detailed below.

- The challenges of working in the region have, in many ways, increased.

When the assessment team arrived in the CAR in 1993, a little over a year after the formation of the CIS, the individual countries comprising the CAR were not very differentiated. Under the Soviet system, they shared the same laws and regulations, legal, monetary, and educational systems, and the same health structures. Initially, there was very good communication between CAR capitals, but this became more difficult as countries developed their own state-level systems. Border control was established where movement between republics previously was not restricted. Professionals in the different countries lost track of one another. Air travel between areas became more inconvenient as frequent and direct routes between capital cities became less frequent. Each country has now adopted its own currency and is developing its own laws, regulations and systems of government.

- It was important to maintain a degree of flexibility in the strategy to allow activities to be tailored to individual countries.

Initially, the RHSEP team designed an ambitious set of activities to be carried out in the CAR. However, there was not enough time or money to implement common activities in all countries. As differences among countries began to emerge, each republic was interested in different types of activities and requested a tailored approach. Work plans were adjusted to reflect these needs. Some of the activities originally envisioned were ultimately not carried out in every country. However, the RHSEP team kept abreast of the changes taking place and worked with great flexibility to plan and adapt activities to individual country needs.

- The rapid influx of external funds from many different sources made it difficult to focus on coherent longer-term strategies.

As a result of the deteriorating economic climate and a show of support from the international community, the CAR receive many forms of external assistance. While RHSEP was trying to build a foundation on which family planning services could be improved over the long term, many of our counterparts were trying to learn the intricacies of humanitarian assistance. Clearly, donor coordination is necessary.

- It was necessary to lay a foundation on which subsequent activities could be based.

The consortium of CAs implementing the RHSEP was the first group to introduce population/family planning assistance to the region. A great deal of foundation-building, team-building and skill-building was required before the program could really move forward. Counterparts were not accustomed to working with donor organizations or the Western world and needed time to absorb the concept of participation in the planning and implementation of jointly-determined activities. There was also little understanding of and appreciation for the role of effective information, education and communication interventions to bring about attitude and behavior change. Thus, CAs had to take the time to develop the appropriate climate in which RHSEP activities could take place.

There was an enormous thirst for information and relevant experience from the outside world, but the lack of a conceptual framework for privatization, counterparts in the policy arena, and skills and capabilities made accomplishments more difficult to achieve. At the same time, because of the high level of education and calibre of CAR personnel, counterparts (once identified) learned very quickly.

- Research was critical for amassing quantitative and qualitative information with which to design assistance strategies.

SOMARC was instrumental in developing an atmosphere of trust and congeniality between the public and private sectors in Kazakhstan and Uzbekistan, thereby positively influencing the environment for private sector participation in family planning service delivery. The social marketing program established the private sector as a credible conduit for family planning services, demonstrated the cost-effectiveness and sustainability of private sector family planning services and provided an alternate resource for services. As a consequence, these governments are more confident of the positive impact of a private health infrastructure.

*Foundation for subsequent activities*

Background information and research pertaining to family planning and reproductive health in the CAR did not exist in a useable format. Some decline in health status and economic well-being is believed to have occurred since independence. Abortion, which is legal in the CIS, may have increased due to economic uncertainties, for example. There was little reliable information available on fertility preferences, reproductive intentions or contraceptive knowledge and use. There was not a history of incorporating data into the planning and decision-making processes in the republics. Thus, the research agenda of RHSEP was critical in guiding the implementation of activities and in establishing baseline information for future activities.

Investments in qualitative research and in the development of capabilities to conduct research and incorporate the results into the decision-making process, while difficult, paid dividends. For example, focus group research enabled subsequent survey work to focus on the right issues. Despite RHSEP's success in collecting and analyzing data to guide program activities, the lack of comprehensive baseline information (together with the short timeframe) will affect its ability to assess the impact of its activities on the improvement of reproductive health in the CAR.

- There was a need for a more relevant model for family planning.

Most of the family planning experience of the CAs was based on developing-country experience. It would have been helpful at the outset to have been more familiar with European experience with socialized health systems and selective roles for private sector providers that could have served as a suitable model for the CIS.

- Policy activities were difficult to mount at the beginning.

Because policy benefits are somewhat abstract, it is more difficult to stimulate policy activities than to obtain support for activities involving more tangible outputs, such as equipment transfer, supplies, commodities or international trips.

All policy work had to deal with the unfamiliarity of counterparts with the policy process. They came from a background where participation in the policy formulation process was not encouraged. The policy systems in the CAR are undergoing a transition, with officials taking on more responsibility and becoming accountable for their actions to varying degrees. External policy dialogue is also occurring. Thus, the policy environment is in a state of flux as each country negotiates its own solutions. Yet, counterparts absorbed lessons quickly, internalized and adapted models and materials, took the initiative to move forward, replicated training and expanded the outcomes.

More work in policy/advocacy would have been desirable, but there was limited recognition among leaders and counterparts of how policy works and what their role should be in shaping and implementing it. In the first stage, counterparts wanted to be exposed to options; now they are ready to choose. Participation in decision-making, policymaking and the planning process is beginning to take place. The challenge now is to continue policy work in conjunction with technical training. Continued support will be necessary to build on this foundation.

- The private sector was even more nascent than envisioned.

The private sector proved to be even more nascent than was originally envisioned. Because of the literal absence of a private sector in many of the countries, some activities were not carried out at all. In others, much developmental work was necessary to build the beginnings of a private sector and to serve as a foundation on which other activities could be built. This slowed down some of RHSEP's accomplishments.

In Kazakhstan, SOMARC's launch of a multi-method social marketing initiative assisted in formalizing the infrastructure for pharmaceutical distribution among private sector entities. Prior to the social marketing program, there were relatively few private distributors consistently providing products to private pharmacies. With SOMARC's assistance, these distributors are gradually expanding their distribution networks and increasing the total number of outlets they reach. To support their improved distribution activities, SOMARC is providing the sales teams with formal training in product detailing and sales skills.

Building the private sector

- A medium-term strategy is needed in order to achieve impact.

Eighteen months is too short a time in which to achieve measurable impact. Initially, a lot of time was spent educating counterparts about international donor organizations, the role of CAs, bilateral agreements and the vocabulary of the assistance process. Now that counterparts understand the process, it is easier to address family planning issues. It also took time to identify counterparts, build trust and stimulate thinking about activities. The program is now in a position to reap the rewards of these initial investments.

- Investments in institutional development greatly facilitated activities at later stages.

It is very expensive to work in the CAR. Start-up costs in five countries, including equipment, personnel, translation and travel, combined with rapid inflation, quickly depleted available resources. Investments in institutional development, however, greatly

facilitated activities at later stages. The resulting cadre of translators, organizations that assisted with logistics and travel, and training institutions has expedited the transfer of technology.

- Continued training is essential to build sustainability.

The first cadre of leaders has been trained through RHSEP. RHSEP had the advantage of being able to offer a variety of training mechanisms: observational tours (to Turkey, the United States, Cairo for the ICPD, and the Philippines) and in-country classroom and clinical training. As would be expected in an emerging democracy, political changes and rapid turnover of personnel are occurring. It is vital to continue training to build sustainability, both at national and subnational levels. Trainees of any type (policy, service provision, etc.) need peers.

> As second-generation training of providers takes place, larger groups should be encouraged to attend CTU training sessions to avoid single-provider isolation and to increase the potential for change by developing trained providers within many organizations. Holding contraceptive updates on site at the clinic not only minimizes disruption to services but fosters teamwork in providing family planning services.

Trainees need peers

- Consensus building and advocacy remain important activities.

As governments evolve, women's reproductive health will increasingly compete for scarce resources in the post-Soviet environment. There are many pressing social and economic problems. In these countries, there is a need to combat two issues: those associated with Soviet-style care (e.g., abortion) and Islamic/nationalistic views on family size and family planning. It will be increasingly important to sustain advocacy for keeping women's reproductive health a priority.

## B. Factors Important to Success

Through participation in RHSEP activities, senior government officials gained a better appreciation of decentralized management and strengthened their management skills in the context of the changing form of governance taking place in the CAR. Under the new system of govenment, MOH leaders had to learn to take responsibility and be accountable for their own programs. RHSEP provided assistance in planning and management of programs that focused on the needs of the end user. MOH officials were thus provided with the tools and processes by which to become accountable not only to the highest levels of government, but to the citizenry as well.

RHSEP's success would not have been possible if the CAR governments had not recognized the need to improve maternal and child health conditions in their respective countries. Indeed, in the post-independence period in which RHSEP originated, there was strong MOH support for expanding the availability of high quality reproductive health and contraceptive services as a means of improving the health of mothers and children. There was also significant demand for fertility regulation and a desire for alternatives to abortion. Without this receptivity and recognition on the part of policymakers, the numerous constraints to the provision of safe, high quality contraceptive services could not have been overcome by the activities implemented under the RHSEP.

Coordination of activities and collaboration among CAs also were important factors in the success of RHSEP. As a result of this cohesive working arrangement, the RHSEP was able to mount activities quickly that proceeded on several fronts at the same time. OPTIONS coordinated the activities of other CAs involved in RHSEP to promote synergy among project interventions. This included keeping in close contact with the CAs, other agencies with programs in Central Asia and the CIS, USAID and other donors. OPTIONS provided briefings for the assessment team and new staff and consultants to the region. OPTIONS and SOMARC also facilitated the preparation of invitation letters, visa processes, translators, transport, hotel booking and other logistical needs of the CAs. In addition, OPTIONS conducted regular coordination meetings to exchange information and look for opportunities to leverage resources and share technical results. USAID used OPTIONS to disseminate information to other agencies working in the region and to channel requests for reports and briefing materials to relevant agencies.

In addition, there was close collaboration among CAs in a number of activities, including the exchange of trip reports, development of a research agenda, translation of materials, dissemination of research findings and implementation of jointly-sponsored activities. Linkages among projects were established at project design to ensure a timely fit of activities, avoid duplication of efforts, and leverage available resources to the maximum extent possible.

The calibre and receptivity of counterparts were other critical elements for success. Moreover, activities and technical assistance built on existing, well-established systems of prenatal and perinatal care. State-run pharmacies were widely available. Medical staff were well-trained and highly motivated to provide family health services. In addition, the high level of literacy of the population and the existence of well-developed communication networks through multiple channels enhanced the success of communication activities

> The RHSEP introduced counterparts to exciting new methods of collaboration—brainstorming, group work, participation and sharing of expertise across disciplines. Our counterparts felt both intellectually stretched and elated with this new team approach to problem-solving and learning. They even gave it a special name, "brain attack."

New methods of collaboration introduced

designed to increase public knowledge of the benefits of reproductive health services. Thus, the focused, short-term technical assistance offered through RHSEP strengthened and improved the nascent family health services in the region.

## C. Challenges to the Program

In order to extend the gains of program advances, the CAR will need to address a number of longer-term challenges to ensure continued expansion of reproductive and family health services in the region. Some of the challenges that need to be addressed are presented below.

- How to resolve long-term contraceptive commodities needs
- How to deal with unstable currencies and inflation
- Need to balance usage of commodity-based methods by introducing sterilization, lactational amenorrhea methods, and natural family planning to the method mix
- How to quickly train sufficient numbers of providers to meet immediate contraceptive demands, given economic difficulties
- Need to build local expertise in IEC program design and implementation
- Need to adjust for unexpected slow development of privatization and democratization initiatives
- Need to construct data base that can be used for program planning
- Need to build monitoring and evaluation systems that will allow CAR decision-makers to assess the impact of program activities on key outcomes

## D. Next Steps

Almost all the activities proposed under the first round of RHSEP buy-ins have been completed; remaining activities will be completed during FY96. A number of important next steps can be taken to maintain the momentum and impact achieved under the RHSEP, some of which are listed below.

- Expand the successes experienced in selected urban centers to build a nationwide program and ensure widespread, long-lasting national impact

- Increase attention devoted to leadership development (policy/advocacy/consensus building)
- Develop an understanding of advocacy and increase skills in its use to empower women to become the engine of future change
- Expand strategic management to selected oblasts, extending planning skills beyond urban centers
- Improve MOH capacity to project contraceptive needs using Target-Cost model
- Continue to support development of a diversified contraceptive market
- Work with MOH to develop national reproductive health IEC strategies, combining mass media and interpersonal communication approaches
- Monitor the progression of the legal and regulatory environment as new laws are passed and assess their effect on reproductive health
- Train potential private physicians and pharmacists in management of private/group practices
- Continue to support and further strengthen institutions involved in the first round of RHSEP—there is still much room for improvement and development

# ANNEX 1

## LIST OF BUY-INS
## AND SUMMARY DESCRIPTIONS

Updated 9/30/95

## RHSEP BUY-IN SUMMARY BY CA

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

| COOPERATING AGENCIES | GENERAL MANDATE OF CAs | CAR ACTIVITIES | FUNDING LEVEL | DURATION/ START DATE |
|---|---|---|---|---|
| **AVSC International**<br><br>79 Madison Avenue<br>New York<br>NY 10016<br>tel: (212) 561-8000 | AVSC International's work around the world emphasizes access to high quality FP services provided in hospitals and clinics. AVSC is committed to the principle of free and informed choice and to ensuring FP services are safe, voluntary and responsive to the needs of the women they serve. | ▪ Shipment of posters<br>▪ Assessment of site needs (including inventory of existing equipment and pricing of equipment, supplies, and contraceptive needs)<br>▪ Procurement and shipping of medical supplies and equipment for training purposes and in support of services<br>▪ Two-week service delivery training programs, including clinical and counseling sessions<br>▪ Medical oversight<br>▪ Design model service/training centers (at least 1 in each republic | $ 950,000 | 18 months/ October 1993 |
| **DHS III**<br><br>11785 Beltsville Dr. Suite 300<br>Calverton<br>MD 20705-3119<br>tel: (301) 572-0200 | 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. | ▪ 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 | $ | 24 months/ October 1993 |
| **JHPIEGO**<br><br>Brown's Wharf<br>1615 Thames Street<br>Suite 200<br>Baltimore<br>MD 21231<br>tel: (410) 955-4332 | 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. | ▪ Examine and revise national medical guidelines for reproductive health<br>▪ Conduct preliminary training assessment<br>▪ Minilap training tour to the Philippines<br>▪ Minilap training in region<br>▪ Training of trainers skill development courses<br>▪ Provision of training materials and equipment<br>▪ Extensive translation of materials<br>▪ Infection prevention workshops | $ 580,000<br>$ 331,000 (to expand into Tajikistan) | 24 months/ October 1993 |



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| | | | | |
|---|---|---|---|---|
| **TFG/OPTIONS II**<br><br>1050 17th Street NW Suite 1000<br>Washington<br>DC 20036<br>tel: (202) 775-9680 | 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. | ▪ Observation study tours to Turkey and USA for key policy makers<br>▪ Provider surveys in each country<br>▪ Family health policy symposium in each country<br>▪ Training on utilization of data for program planning<br>▪ Examine and revise national medical guidelines for reproductive health<br>▪ Legal and regulatory analyses<br>▪ Strategic planning and supporting research<br>▪ Support for private sector professional associations<br>▪ Coordination of CAs | $ 1,525,000 | 27 months/<br>June 1993 |
| **PCS**<br><br>111 Market Place<br>Baltimore<br>MD 21202<br>tel: 410-659-6239 | PCS provides assistance to identify the communication needs of family planning programs. PCS conducts surveys and qualitative studies to assess consumer needs and desires; designs and implements mass media campaigns; develops promotional materials; and conducts education activities for users of FP services. | ▪ Focus group research<br>▪ Printed materials development<br>▪ Media planning<br>▪ Media production/ pretesting<br>▪ Launch mass media campaign<br>▪ Evaluation of mass media campaign | $ 800,000 | 24 months<br>October 1993 |
| **TFG/SOMARC III**<br><br>1050 17th Street NW Suite 1000<br>Washington<br>DC 20036<br>tel: (202) 775-9680 | 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. | ▪ Establish regional logistical support and office<br>▪ Commodity sourcing with pharmaceutical companies<br>▪ Identify regional advertising agency<br>▪ Develop regional market research plan<br>▪ Facilitate market research<br>▪ Develop regional training plan<br>▪ Conduct training<br>▪ Implement regional planning meeting<br>▪ Launch products | $ 5,254,000 | 36 months<br>October 1993 |

# ANNEX 2

# RHSEP ACTIVITIES BY COUNTRY

Updated 9/30/95

# RHSEP FOCUS ON KAZAKHSTAN

## POLICY AGENDA

1. Three decision-makers participated in observation tour to Turkey (9/93)

2. 130 OB/GYNs participated in a policy symposium on reproductive health services expansion (4/94)

3. National task force created to update medical guidelines for reproductive health services (4/94)

4. Medical guidelines revised, produced and disseminated (1995)

5. Two government officials sponsored to represent Kazakhstan at the ICPD (9/94)

6. Nine MOH staff planned (11/94) and 12 participated in strategic planning workshop (3/95)

7. 16 MOH/MCH staff participated in workshop in Kazakhstan to review legal and regulatory environment for provision of reproductive health services (11/94)

## INSTITUTIONAL DEVELOPMENT

1. Microcomputer hardware and software transferred to MOH (1994)

2. Office established for the social marketing program (1/94)

3. Two demonstration FP service delivery centers equipped and received contraceptives for an entire year (1994)

4. Two training sites developed and provided with educational materials and teaching aids (1994)

5. Extensive technical assistance provided to BRIF in qualitative market research techniques (1994)

## TRAINING OF SERVICE PROVIDERS

1. Over 200 family health providers and pharmacists with increased knowledge of contraception (8/94)



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2. Over 200 nurses trained in family planning (8/94)

3. 25 clinicians trained to insert IUDs (8/94, 11/94)
   30 clinicians trained in infection prevention (8/94)
   23 family health providers with better understanding of client counseling (8/94)

4. Seven family health providers with improved clinical skills and able to train others in delivering quality contraceptive services (10/94)

5. 11 OB/GYNs with surgical skills able to perform female sterilization, at least one capable to train others (4/94, 8/94, 11/94)

6. Numerous OB/GYNs received copies of *Contraceptive Technology* book and reports, manuals, articles and papers, translated into Russian

7. 400 OB/GYNs trained for the safe delivery of DMPA (1995)
   21 trainers trained

8. 463 pharmacists trained in Contraceptive Technology and QCS (3/95)
   25 trainers trained

**SOCIAL MARKETING**

1. Established reproductive health advisory board to the social marketing program (1-3/95)

2. Social marketing officially launched (11/94)

3. Red apple logo and brochures developed (8/95)

4. Distribution of contraceptives through about 100 outlets (current)

5. Media training conducted for senior public and private officials

**RESEARCH**

1. Demographic analysis conducted using the 1989 Soviet census (1993)

2. Provider survey conducted (12/93)

3. Contraceptive needs analysis completed (5/94)

4. Study design prepared for cost of abortion services (1994)

5. Analysis of legal and regulatory environment for family planning service delivery (7/94)

6. Focus group research analyzed women's and men's attitudes and practice of family planning (8/94)

7. Baseline knowledge, attitudes and practice survey completed (11/94)

8. Demographic and Health Survey underway (1995)

**IEC**

1. Reproductive health communication campaign developed and launched

2. Two radio and two TV spots produced for teens and women on the benefits of modern contraception shown on closed circuit

3. 50,000 posters and 10,000 brochures developed for teens and women and distributed in clinics; materials for teens also distributed through schools

4. Social marketing materials produced:
   17,500 brochures (each) on oral contraceptives, injectables, and all methods
   7,500 pharmacist oral contraceptive screeners
   3,000 pharmacists guides
   1,000 pharmacy posters
   500 brochure dispensers
   2,500 mobiles
   35,000 instructional inserts for oral contraceptives

# RHSEP FOCUS ON KYRGYZSTAN

## POLICY AGENDA

1. Six decision-makers participated in two observation tours to Turkey (9/93) and the USA (12/93)

2. 160 OB/GYNs participated in a policy symposium on reproductive health services expansion (6/94)

3. National task force created to update medical guidelines for reproductive health services (4/94)

4. Medical guidelines revised, produced and disseminated (6/95)

5. Three government officials sponsored to represent Kyrgyzstan at the ICPD (9/94)

6. Eight MOH staff planned (11/94) and 14 participated in strategic planning workshop (3/95)

7. 15 MOH/MCH staff participated in workshop in Kazakhstan to review legal and regulatory environment for provision of reproductive health services (11/94)

## INSTITUTIONAL DEVELOPMENT

1. Microcomputer hardware and software transferred to MOH (1994)

2. Two demonstration FP service delivery centers equipped and received contraceptives for an entire year (1994)

3. Three training sites developed and provided with educational materials and teaching aids (1994)

## TRAINING OF SERVICE PROVIDERS

1. Over 170 family health providers and pharmacists with increased knowledge of contraception (6/94, 10/94)

2. Six OB/GYNs with surgical skills able to perform female sterilization, at least two of them capable to train others (4/94, 10/94)

3. 30-60 OB/GYNs trained in the use and delivery of Depo-Provera (10/94)

4. 18 clinicians trained to insert IUDs (10/94)
   30 clinicians trained in infection prevention (10/94)
   23 family health providers with better understanding of clients' counseling (10/94)

5. Nine family health providers with improved clinical skills and able to train others in delivering quality contraceptive services (12/94)

6. Numerous OB/GYNs received copies of *Contraceptive Technology* book and reports, manuals, articles and papers, translated into Russian

7. 300 physicians trained in the safe delivery of DMPA
   20 trainers trained

8. 250 pharmacists trained in Contraceptive Technology and QCS (3/95)
   20 trainers trained

**RESEARCH**

1. Demographic analysis conducted using the 1989 Soviet census (1993)

2. Provider survey conducted (12/93)

3. Contraceptive needs analysis completed (5/94)

4. Analysis of record keeping system and HIS for contraceptive services (1994)

5. Analysis of legal and regulatory environment for family planning service delivery (7/94)

6. Focus group research analyzed women's and men's knowledge, attitudes and practice of family planning (8/94)

**IEC**

1. Reproductive health communication campaign developed and launched

2. Two TV spots and two radio spots produced for urban teens and rural couples broadcast on private TV and radio

3. 50,000 posters and 10,000 brochures developed for teens and women and distributed in clinics; materials for teens also distributed through schools

# RHSEP FOCUS ON UZBEKISTAN

## POLICY AGENDA

1. Seven decision-makers participated in two observation tours to Turkey (9/93) and the USA (12/93), including the Deputy Minister of Health

2. 150 OB/GYNs participated in a policy symposium on reproductive health services expansion (1/94)

3. National task force created to update medical guidelines for reproductive health services (4/94); medical guidelines revised

4. One government official sponsored to represent Uzbekistan at the ICPD (9/94)

## INSTITUTIONAL DEVELOPMENT

1. The association of private physicians of Uzbekistan organized (1994); membership survey conducted (1995); first newsletter produced (1995)

2. Office established for the social marketing program (1/94)

3. Four demonstration FP service delivery centers equipped and received contraceptives for an entire year (1994)

4. Four training sites developed and provided with educational materials and teaching aids (1994)

5. Microcomputer hardware and software transferred to UAP (1994)

6. Extensive technical assistance to SIAR in qualitative market research techniques (1994)

## TRAINING OF SERVICE PROVIDERS

1. 450 family health providers and pharmacists with increased knowledge of contraception (5/94, 4/95)

2. 53 clinicians trained to insert IUDs (5/94, 4/95)
   60 clinicians trained in infection prevention (5/94)
   62 family health providers with better understanding of client counseling (5/94, 4/95)

3. 47 family health providers with improved clinical skills and able to train others in delivering quality contraceptive services (5/94)

4. 11 OB/GYNs with surgical skills able to perform female sterilization, at least two capable to train others (4/94, 6/94, 11/94)

5. Numerous OB/GYNs received copies of *Contraceptive Technology* book and reports, manuals, articles and papers, translated into Russian

6. 300 OB/GYNs trained in the safe delivery of DMPA (1995)
   29 trainers trained (1995)

7. 350 pharmacists trained in Contraceptive Technology and QCS (1995)
   18 trainers trained (1995)

**SOCIAL MARKETING**

1. Established reproductive health advisory board to the social marketing program (1-3/95)

2. Red apple logo tested (2/95)

3. Advertising materials developed and tested (4/95)

4. Communication campaign developed (5/95)

5. Negotiations to establish a regular supply of contraceptive products completed. This included mediating extensive negotiations to resolve currency conversion issues between distributors and the government (11/94 - 5/95)

6. Media training conducted for senior public and private officials (1995)

**RESEARCH**

1. Demographic analysis conducted using the 1989 Soviet census (1993)

2. Provider survey conducted (12/93)

3. Focus group research analyzed women's and men's knowledge, attitudes and practice of family planning (1/94 and 8/94)

4. Negotiations with the government to plan a DHS (1994)

5. Contraceptive needs analysis completed (5/94)

6. Focus group research explored consumer attitudes toward specific methods (10/94)

**IEC**

1. Development of one TV spot and one radio spot for married couples of reproductive age

2. 50,000 posters and 10,000 brochures developed for married couples of reproductive age

3. Written agreement reached with MOH and State TV/Radio for the distribution and broadcast of IEC materials

4. Social marketing materials produced:
   17,500 brochures (each) on oral contraceptives, injectables, and all methods
   7,500 pharmacist oral contraceptive screeners
   3,000 pharmacists guides
   1,000 pharmacy posters
   500 brochure dispensers
   2,500 mobiles
   35,000 instructional inserts for oral contraceptives

# RHSEP FOCUS ON TURKMENISTAN

## POLICY AGENDA

1. Seven decision-makers participated in two observation tours to Turkey (9/93) and the USA (12/93)

2. 30 senior multisectoral ministry officials participated in a policy workshop on family health services, private sector development and program sustainability (9/94)

3. Two government officials sponsored to represent Turkmenistan at the ICPD (9/94)

4. Two MOH/MCH representatives participated in legal and regulatory assessment workshop (11/94)

## INSTITUTIONAL DEVELOPMENT

1. Two demonstration FP service delivery centers equipped and received contraceptives for an entire year (1994-95)

2. Three training sites developed and provided with educational materials and teaching aids (1994)

## TRAINING OF SERVICE PROVIDERS

1. Over 200 family health providers and pharmacists with increased knowledge of contraception (12/94)

2. 23 clinicians trained to insert IUDs (12/94, 2/95)
   28 clinicians trained in infection control (12/94, 5/95)
   25 family health providers with better understanding of clients' counseling (12/94)

3. 30 OB/GYNs trained in the use and delivery of Depo (12/94)

4. Three OB/GYNs with surgical skills able to perform female sterilization, at least one capable to train others (4/94)

5. 11 OB/GYNs with improved clinical skills and able to train others in delivering quality contraceptive services (2/95)

6. Numerous OB/GYNs received copies of *Contraceptive Technology* book and reports, manuals, articles and papers, translated into Russian

**RESEARCH**

1. Demographic analysis conducted using the 1989 Soviet census (1993)

2. Focus group research analyzed women's and men's knowledge, attitudes and practice of family planning (12/94)

# RHSEP FOCUS ON TAJIKISTAN

## POLICY AGENDA

1. One OB/GYN observed at regional medical guidelines workshop in Kazakhstan (11/94)

2. One government official sponsored to represent Tajikistan at the ICPD (9/94)

3. 38 multisectoral ministry representatives participated in policy workshop to frame policy agenda to expand reproductive health/family planning services (7/95)

## INSTITUTIONAL DEVELOPMENT

1. Two training sites developed and provided with educational materials and teaching aids (1994-95)

## TRAINING OF SERVICE PROVIDERS

1. 206 health practitioners with improved knowledge of contraception (4/95, 6/95)

2. 25 clinicians trained to insert IUDs (6/95)
   17 family planning providers trained in infection prevention procedures
   45 OB/GYNs and nurses with better understanding of client counseling (4/95, 6/95)

3. 25 family planning providers with improved clinical skills and able to train others in delivering quality contraceptive services (3/95)

4. Numerous OB/GYNs received copies of *Contraceptive Technology* book and reports, manuals, articles and papers, translated into Russian

## RESEARCH

1. Demographic analysis conducted using the 1989 Soviet census (1993)

# ANNEX 3

# TRAINING ACTIVITIES BY COUNTRY

Updated 9/30/95



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# KAZAKHSTAN

| Type of Training | Skill | Organization | Region | Topic | # & Profession of participants | Time Frame (# days) |
|---|---|---|---|---|---|---|
| SERVICE PROVIDERS | Clinical | JHPIEGO | (held in Phil.) | minilap | 2 OB/GYN | April 1994<br>2-week course |
| | | AVSC | Almaty | IUD | 14 physicians & OB/GYN | August 1994<br>10-days* |
| | | AVSC | Almaty | minilap | 1 OB/GYN | August 1994<br>5 days |
| | | JHPIEGO | Almaty | IUD | 11 OB/GYN | October 1994<br>5 days |
| | | SOMARC | Almaty, Oskamen, Karaganda | Depo | 400 OB/GYN/FP | April - June 1995<br>20 sessions |
| | Counseling | AVSC | Almaty | | 23 OB/GYN & nurses | August 1994<br>10 days* |
| | CT Updates | OPTIONS, JHPIEGO | Almaty | medical guidelines | 12 MOH reps | April 1994<br>4 days |
| | | AVSC | Almaty | all methods | 204 service providers | August 1994<br>10 days* |
| | | JHPIEGO, OPTIONS | (held in Bishkek) | medical guidelines | 5 MOH reps | November 1994<br>4 days |
| | | SOMARC | Almaty, Oskamen, Karaganda | all methods, QCS | 463 pharmacists | [dates?]<br>19 sessions |
| | Infection Prevention | AVSC | Almaty | | 30 OB/GYN | August 1994<br>10 days* |
| TRAINERS | Trainers | JHPIEGO | Almaty | clinical training skills | 11 OB/GYN | October 1994<br>10 days |
| | | JHPIEGO | (held in Samarkand) | clinical training skills for minilap | 3 OB/GYN | November 1994<br>15 days |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | SOMARC | Almaty | TOT for DMPA | 21 trainers | [date?]<br>1 session |
| | | SOMARC | Almaty | TOT for CT, QCS | 25 trainers | [date?]<br>1 session |
| POLICY | Population Policy | OPTIONS, JHPIEGO, PCS | Almaty | policy symposium | 150-200 physicians, policymakers | April 1994<br>3 days |
| | | OPTIONS | Almaty | legal and regulatory | 15 MOH reps | November 1994<br>2 days |
| | Decision Making | OPTIONS | Almaty | strategic planning prep. | 9 MOH reps | November 1994<br>1 day |
| | | OPTIONS | Almaty | strategic planning/Target-Cost | 12 MOH reps | March 1995<br>5 days |
| RESEARCH | Tools | OPTIONS | Almaty | computer training | 3 MOH reps | Spring 1994 |
| | Methodology | PCS | Almaty | focus group methods | 10 moderators | March 1994 |

* AVSC 10-day course consists of 3 days for contraceptive technology update, 2 days of counseling training, 4 days of IUD, Depo-Provera and group counseling training, and 1 day of infection prevention training.

# KYRGYZSTAN

| Type of Training | Skill | Organization | Region | Topic | # & Profession of participants | Time Frame (# days) |
|---|---|---|---|---|---|---|
| SERVICE PROVIDERS | Clinical | JHPIEGO | (held in Phil.) | minilap | 2 OB/GYN | April 1994<br>2-week course |
| | | AVSC | Bishkek | IUD | 18 physicians & OB/GYN | October 1994<br>10 days* |
| | | AVSC | Bishkek | minilap | 2 OB/GYN | October 1994<br>5 days |
| | | JHPIEGO | Bishkek | IUD | 10 OB/GYN | December 1994<br>5 days |
| | | SOMARC | all regions | Depo | 300 OB/GYN | August - Sept. 1995<br>15 Sessions |
| | Counseling | AVSC | Bishkek | communication and counseling skills | 23 OB/GYN & nurses | October 1994<br>10 days* |
| | CT Updates | JHPIEGO, OPTIONS | Bishkek | medical guidelines | 9 MOH reps | June 1994<br>3 days |
| | | AVSC | Bishkek | all methods | 107 service providers | October 1994<br>10 days* |
| | | AVSC | Osh | all methods, Depo | 64 service providers | October 1994<br>2 days |
| | | JHPIEGO, OPTIONS | Bishkek | medical guidelines | 9 MOH reps | November 1994<br>4 days |
| | | SOMARC | all regions | all methods, QCS | 250 pharmacists | February - April 1995<br>10 sessions |
| | Infection Prevention | AVSC | Bishkek | | 30 OB/GYN | October 1994<br>10 days* |

| | | | | | | |
|---|---|---|---|---|---|---|
| TRAINERS | Trainers | JHPIEGO | Bishkek | clinical training skills | 9 OB/GYN | December 1994<br>10 days |
| | | JHPIEGO | (held in Samarkand) | clinical training skills for minilap | 2 OB/GYN | November 1994<br>15 days |
| | | SOMARC | all regions | TOT for Depo | 20 trainers | July 1995<br>1 session |
| | | SOMARC | all regions | TOT for CT, QCS | 20 trainers | 1 session |
| POLICY | Population Policy | OPTIONS, JHPIEGO, PCS | Bishkek | all methods | 150-200 physicians, policymakers | June 1994<br>3 days |
| | | OPTIONS | (held in Almaty) | legal and regulatory | 15 MOH reps | November 1994<br>2 days |
| | *Decision Making* | OPTIONS | (held in Almaty) | strategic planning prep. | 8 MOH reps | November 1994<br>1 day |
| | | OPTIONS | Bishkek | strategic planning/ Target-Cost | 14 MOH reps | March 1995<br>5 days |
| RESEARCH | Tools | OPTIONS | Bishkek | DOS/Windows/Word/ EpiInfo/Targ-Cost | | |
| | Methodology | | | | | |

* AVSC 10-day course consists of 3 days for contraceptive technology update, 2 days of counseling training, 4 days of IUD, Depo-Provera and group counseling training, and 1 day of infection prevention training.

Training Matrix
As of Sept. 30, 1995

## UZBEKISTAN

| Type of Training | Skill | Organization | Region | Topic | # & Profession of participants | Time Frame (# days) |
|---|---|---|---|---|---|---|
| SERVICE PROVIDERS | Clinical | JHPIEGO | (held in Phil.) | minilap | 2 OB/GYN | April 1994<br>10 days |
| | | AVSC | Tashkent, Samarkand | IUD | 33 OB/GYN | May 1994<br>2 10-day courses* |
| | | JHPIEGO | Tashkent | IUD | 10 OB/GYN | June 1994<br>5 days |
| | | AVSC | Tashkent | minilap | 3 OB/GYN | July 1994<br>5 days |
| | | AVSC | Andizhan | IUD | 20 OB/GYN | April 1995<br>10 days* |
| | | AVSC | Andizhan | minilap | 2 OB/GYN | April 1995<br>5 days |
| | | JHPIEGO | Andizhan | IUD | 10 OB/GYN | May 1995<br>5 days |
| | | SOMARC | Tashkent, Samarkand | Depo, QCS | 300 OB/GYN | July - September 1995<br>12 sessions |
| | Counseling | AVSC | Tashkent, Samarkand | communication and counseling skills | 42 service providers | May 1994<br>2 10-day courses* |
| | | AVSC | Andizhan | communication and counseling skills | 20 service providers | April 1995<br>10 days* |
| | CT Updates | AVSC | Tashkent, Samarkand | all methods | 300 service providers | May 1994<br>2 10-day courses* |
| | | JHPIEGO | Tashkent | medical guidelines | 12 MOH reps | June 1994<br>4 days |
| | | JHPIEGO, OPTIONS | (held in Bishkek) | medical guidelines | 4 MOH reps | November 1994<br>4 days |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | AVSC | Andizhan | all methods | 145 service providers | April 1995<br>10 days* |
| | | SOMARC | Tashkent, Samarkand | all methods, QCS | 350 physicians/<br>pharmacists | March - May 1995<br>(14 sessions) |
| | Infection Prevention | AVSC | Tashkent, Samarkand | | | May 1994<br>10 days* |
| TRAINERS | Trainers | JHPIEGO | Tashkent, Samarkand | clinical training skills | 11 OB/GYN | June 1994<br>10 days |
| | | JHPIEGO | Samarkand (regional training) | clinical training skills for minilap | 2 OB/GYN | November 1994<br>15 days |
| | | JHPIEGO | Andizhan | clinical training skills | 10-12 OB/GYN | May 1995<br>10 days |
| | | SOMARC | all regions | TOT for Depo | 18 trainers | May 1995 |
| | | SOMARC | all regions | TOT for CT, QCS | 29 trainers | |
| POLICY | Population Policy | OPTIONS, AVSC, JHPIEGO, PCS, SOMARC | Tashkent | all methods | 180 service providers | January 1994<br>3 days |
| | | OPTIONS | Tashkent | private sector dev. and FP | 100 members of AUP and govt. | June 1995<br>2 days |
| | | OPTIONS | Tashkent | private sector dev. and FP | 100 members of AUP and govt. | September 1995<br>2 days |
| | TOOLS | OPTIONS | Tashkent | computer training** | 2-3 AUP staff | 1995 Spring |
| RESEARCH | Methodology | PCS | Tashkent | focus group research | 4 moderators | December 1993 |

* AVSC 10-day course consists of 3 days for contraceptive technology update, 2 days of counseling training, 4 days of IUD, Depo-Provera and group counseling training, and 1 day of infection prevention training.

** computer literacy, word processing, powerpoint

Training Matrix
As of Sept. 30, 1995

# TURKMENISTAN

| Type of Training | Skill | Organization | Region | Topic | # & Profession of participants | Time Frame (# days) |
|---|---|---|---|---|---|---|
| SERVICE PROVIDERS | Clinical | JHPIEGO | (held in Phil.) | minilap | 3 OB/GYN | April 1994<br>10 days |
| | | AVSC | Ashgabad | IUD | 25 OB/GYN | December 1994<br>10 days* |
| | | JHPIEGO | Ashgabad | IUD | 8 OB/GYN | Feb - March 1995<br>4 days |
| | Counseling | AVSC | Ashgabad | communication and counseling skills | 25 OB/GYN & nurses | December 1994<br>10 days* |
| | CT Updates | AVSC | Ashgabad | all methods | 136 service providers | December 1994<br>10 days* |
| | | AVSC | Charzho | all methods, Depo | 68 service providers | December 1994<br>2 days |
| | Infection Prevention | AVSC | Ashgabad | | 17 OB/GYN | December 1994<br>10 days* |
| | | JHPIEGO | Ashgabad | | 17 OB/GYN | May 1995<br>5 days |
| TRAINERS | Trainers | JHPIEGO | (held in Samarkand) | clinical training skills for minilap | 1 OB/GYN | November 1994<br>15 days |
| | | JHPIEGO | Ashgabad | clinical training skills | 11 OB/GYN | February 1995<br>10 days |
| POLICY | Population Policy | OPTIONS | Ashgabad | policy workshop | 30 senior officials | September 1994<br>2 days |
| | | OPTIONS | (held in Almaty) | legal and regulatory | 2 MOH reps | November 1994<br>4 days |
| RESEARCH | Methodology | PCS | Ashgabad | focus group research | 6 moderators | December 1994 |

* AVSC 10-day course consists of 3 days for contraceptive technology update, 2 days of counseling training, 4 days of IUD, Depo-Provera and group counseling training, and 1 day of infection prevention training.

# TAJIKISTAN

| Type of Training | Skill | Organization | Region | Topic | # & Profession of participants | Time Frame (# days) |
|---|---|---|---|---|---|---|
| SERVICE PROVIDERS | Clinical | AVSC | Khojand | IUD | 25 OB/GYN | June 1995<br>10 days* |
| | | AVSC | Khojand | minilap | 2 OB/GYN | June 1995<br>5 days |
| | Counseling | AVSC | Khojand | communication and counseling skills | 25 OB/GYN | June 1995<br>10 days* |
| | CT updates | JHPIEGO, OPTIONS | (held in Bishkek) | medical guidelines | 2 MOH reps | June 1994<br>4 days |
| | | JHPIEGO, OPTIONS | (held in Bishkek) | medical guidelines | 2 MOH reps | November 1994<br>4 days |
| | | AVSC | Dushanbe | all methods | 87 service providers | April 1995<br>3 days |
| | | AVSC | Khojand | all methods | 119 service providers | June 1995<br>10 days* |
| | Infection Prevention | JHPIEGO | Khojand, Dushanbe | | 17 OB/GYN, MOH & SES officials | May 1995<br>5 days |
| TRAINERS | Trainers | JHPIEGO | Dushanbe | clinical training skills | 15 OB/GYN | March 1995<br>4 days |
| POLICY | Population Policy | OPTIONS | (held in Bishkek) | policy symposium | 2 MOH reps | June 1994<br>3 days |
| | | *JHPIEGO, OPTIONS* | *(held in Bishkek)* | *medical guidelines* | 1 OB/GYN | November 1994<br>4 days |
| | | OPTIONS | Dushanbe | policy workshop | 38 senior officials | June 1995<br>2 days |

* AVSC 10-day course consists of 3 days for contraceptive technology update, 2 days of counseling training, 4 days of IUD, Depo-Provera and group counseling training, and 1 day of infection prevention training.

Training Matrix
As of Sept. 30, 1995

# ANNEX 4

# PUBLICATIONS/REPORTS EMANATING FROM RHSEP ACTIVITIES

Updated 9/30/95



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## Publications/Reports Emanating from RHSEP Activities
(English language)

### Policy Research: Demographic Secondary Analysis (core funds from OPTIONS)

*Kazakhstan: Fertility Indicators and Characteristics of the Potential Market for Contraception*
*Kyrgyzstan: Fertility Indicators and Characteristics of the Potential Market for Contraception*
*Uzbekistan: Fertility Indicators and Characteristics of the Potential Market for Contraception*
*Tajikistan: Fertility Indicators and Characteristics of the Potential Market for Contraception*
*Turkmenistan: Fertility Indicators and Characteristics of the Potential Market for Contraception*

### Research on Providers: Survey of Providers (OPTIONS)

*Survey of Health Providers' Knowledge, Attitudes and Practices of Contraceptive Services: Kazakhstan*
*Survey of Health Providers' Knowledge, Attitudes and Practices of Contraceptive Services: Kyrgyzstan*
*Survey of Health Providers' Knowledge, Attitudes and Practices of Contraceptive Services: Uzbekistan*

### Research on Clients: Focus Group Discussions (PCS)

*Clients' Perspectives on Contraceptive Technology and Practices in the Tashkent Region of Uzbekistan: A Report of Focus Group Research Findings*
*Clients' Perspectives on Contraceptive Technology and Practices in three Central Asian Republics: A Preliminary Report of Focus Group Research Findings*
*Clients' Perspectives on Contraceptive Technology and Practices: A Report of Focus Group Research Discussions* (separate reports prepared for Kazakhstan, Kyrgyzstan, Uzbekistan and Turkmenistan)

### Research on Consumers: Baseline Survey (SOMARC)

*Family Planning Knowledge, Attitudes and Practices among Urban Women in Kazakhstan*

### Policy Research: Legal and Regulatory Environment to Contraceptive Delivery (OPTIONS)

*Assessing Legal and Regulatory Enviroment for Contraceptive Service Delivery: Kazakhstan* (draft)



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*Assessing Legal and Regulatory Enviroment for Contraceptive Service Delivery: Kyrgyzstan* (draft)

**Demographic and Health Survey (DHS) Report (forthcoming)**

**Evaluation Reports**

*Evaluation of AVSC-supported Programs in Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan*

**Project Documents**

*Reproductive Health Services Expansion Program for Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, 1994* (strategy document)

*Reproductive Health Services Expansion Program: Final Report*

# ANNEX 5

# RUSSIAN LANGUAGE MATERIALS ADAPTED BY THE CAS

Updated 9/30/95

**Russian-language Materials Translated by the CAs**

## AVSC

*Handouts*

1. Basic Learning Guide for IUD Counseling Skills. Adapted from JHPIEGO materials 1994.

2. How to Use Condom. AVSC International, 1994.

3. Postabortion Women. Adapted from A Manual for Counseling and Medical Screening for Family Planning, The Zhordania Institute of Human Reproduction, 1993.

4. Sterile Package for IUD Copper T380A. Adapted from JHPIEGO materials, 1989.

5. Contraceptive Methods for Postabortion use. Adapted from IPAS material, 1991.

6. Medical Screening. Adapted from A Manual for Counseling and Medical Screening for Family Planning, The Zhordania Institute of Human Reproduction, 1993.

7. Introduction to Family Planning Counseling. Adapted from Module 19, Minilaparotomy under Local Anaesthesia, A Curriculum for Doctors and Nurses, AVSC, 1993.

8. Sounding the Uterus. IUD Insertion. Adapted from JHPIEGO materials, 1993.

9. Injectables: Side Effects and Complications. Adapted from Family Planning Reference Manual, JHPIEGO.

10. Medical Barriers to Access to Family Planning. James D. Shelton et al. The Lancet. Volume 340, November 28, 1992, pp. 1334-1335.

11. Injectables: Patient Instructions. Adapted from Family Planning Reference Manual, JHPIEGO.

12. Injectables: Indications for Use, Adapted from Family Planning Reference Manual, JHPIEGO.

13. IUD: Clinical Features of Specific IUDS. Adapted from Family Planning Reference Manual, JHPIEGO.

14. IUD: Indications for Use. Adapted from Family Planning Reference Manual, JHPIEGO.

15. IUD: Patient Instructions. Adapted from Family Planning Reference Manual, JHPIEGO.

16. IUD: Management of Side Effects. Adapted from Family Planning Reference Manual, JHPIEGO.



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17. Oral Contraceptives: Side Effects and Complications. Adapted from Family Planning Reference Manual, JHPIEGO.

18. Oral Contraceptives: Combined Oral Contraceptives. Adapted from Family Planning Reference Manual, JHPIEGO.

19. Postabortion Contraception. Adapted from IPAS materials.

20. Lactational Amenorrhea Method. Adapted from IRH materials.

21. Sterilization Using Local and General Anaesthesia. Adapted from A Manual for Counseling and Medical Screening for Family Planning, The Zhordania Institute of Human Reproduction, 1993.

22. Patient Evaluation. Adapted from Family Planning Reference Manual, JHPIEGO.

23. Birth Control Pills. Patient Education material. PCS, 1994.

24. Hormonal Injectable Contraceptives. Patient Education material. PCS, 1994.

25. IUD. Patient Education material. PCS, 1994.

26. Birth Interval. Patient Education Material. PCS, 1994.

27. Infection Prevention. Poster. AVSC International, 1994.

28. Female Sterilization. Patient Education materials. AVSC International, 1994.

## AVSC

*Slides*

1. Norplant. Adapted from JHPIEGO materials.
2. IUD. Adapted from JHPIEGO materials.
3. IUDs: Service Delivery Guidelines. Adapted from JHPIEGO materials.
4. Postpartum IUDS. Adapted from JHPIEGO materials.
5. Oral Contraceptives. Adapted from AVSC International materials.
6. Oral Contraceptives: Service Delivery Guidelines. Adapted from JHPIEGO materials.
7. Injectables. Adapted from JHPIEGO materials.
8. Injectables: Service Delivery Guidelines. Adapted from JHPIEGO materials.
9. Injectables: Side Effects. Adapted from JHPIEGO materials
10. Infection Prevention Guidelines for Administration of Injectable Contraceptives. Adapted from JHPIEGO materials.
11. Infection Prevention: Overview. Adapted from JHPIEGO materials.
12. LAM. Adapted from IRH materials.
13. Condoms. Adapted from AVSC International materials.
14. Female Sterilization. Adapted from AVSC International materials.
15. Male Sterilization. Adapted from AVSC International materials.
16. Sterilization: Service Delivery Guidelines. Adapted from AVSC International materials.
17. Postabortion Contraception. Adapted from IPAS materials.
18. Postpartum Contraception. Adapted from FHI materials.

## JHPIEGO

1. JHPIEGO Approach to Training
2. JHPIEGO: Overview
3. Clinical Training Skills for Reproductive Health Professionals
4. International Family Planning Service Delivery Guidelines
5. Pocket Guide for Family Planning Service Providers
6. Clinical Training Skills: A Problem Solving Reference Manual
7. IUD Guidelines for Family Planning Service Programs (Course book)
8. IUD Trainer's Notebook
9. Norplant: Implants to Prevent Pregnancy (Procedure booklet & one page summary flyer)
10. Norplant: Guidelines for Family Planning Service Programs
11. Infection Prevention for Family Planning Service Programs
12. Infection Prevention: Participant's Handbook
13. Contraceptive Technology and Safety (M.F. Fathalla - WHO, Geneva)

*Slide Sets and Transparencies*

1. Norplant (58 slides)
2. The Copper-T IUD Insertion and Removal Slide Set (53 slides)
3. IUDs (34 slides)
4. Oral Contraceptives (24 slides)
5. Low-dose Combined Oral Contraceptives (15 slides)
6. DMPA (20 slides)
7. Benefits of Family Planning (24 slides)
8. The Toll of STDs (18 slides)

9. Voluntary Sterilization (20 slides)

10. Emerging Contraception (8 slides)

11. Post-abortion Care (20 slides)

12. Maximizing Access and Quality (MAQ) (25 slides)

13. Clinical Training Skills (98 transparencies)

## OPTIONS/SOMARC


1. "Policy Approaches to the Removal of Medical Barriers: Improving Quality of Care and Access to Family Planning Services." November 1992. OPTIONS.

2. Obermyer, Carla Makhlouf. 1994. "Reproductive Choice in Islam: Gender and State in Iran and Tunisia." *Studies in Family Planning* 25(1): 41-51.

3. Cisek, Cindi R. and Sheila Maher. "Maximizing Self-Sufficiency in CSM Project Design: Fourth Generation Social Marketing." Washington D.C.: The Futures Group, SOMARC Occasional Paper # 17, October 1992.

4. "A History of the United Nations Population Conferences." Executive Summary, Population Resource Center.

5. "Regional Recommendations: ICPD." Executive Summary, Population Resource Center.

6. "Women's Status and Empowerment." Executive Summary, Population Resource Center.

7. "Health and Mortality." Executive Summary, Population Resource Center.

8. "The Family: Its Role and Composition." Executive Summary, Population Resource Center.

9. "Reproductive Health, Reproductive Rights, and Family Planning." Executive Summary, Population Resource Center.

10. Medical Barriers (reference material for interpreters). Prepared for the 1994 Symposium on Women's and Family Health, Tashkent, Uzbekistan.

11. "Legal and Regulatory Checklist & Summary of Regulations and Policy Issues" (Tables 1 and 2, Genevieve M. Kenney, *Assessing Legal and Regulatory Reform in Family Planning. Manual on Legal and Regulatory Reform*. January 1993. OPTIONS Policy Paper Series.)

12. Strategic Planning Checklist (Appendix 1, Thomas W. Merrick, *Strategic Planning for the Expansion of Family Planning*. February 1993. OPTIONS Policy Paper Series.)

13. "OPTIONS for Population Policy" (OPTIONS project brochure)

14. "SOMARC: Social Marketing For Change" (SOMARC project brochure)

15. Contraceptive Safety and Technology. Pharmacist Two-day Training Module. SOMARC.

16. Pharmacist Guide (overview of all contraceptive methods). SOMARC.

17. Consumer Brochures (for oral contraceptives, injectables and all-methods). SOMARC.

**Materials translated from Russian into English**

Bishkek Declaration: Healthy Family, Healthy Society. Declaration adopted at the RHSEP-sponsored Symposium on Family Health held June 20-22, 1994 in Bishkek.

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2. Population Report J36. "Lower-Dose Pills." Baltimore, Maryland: Population Communications Services. November 1988.

3. Population Report H8. "Condoms - More Now than Ever." Baltimore, Maryland: Population Communications Services. 1991.

4. Cue-cards on condoms, IUDs, oral contraceptives and injectables).

5. Birth Spacing (brochure).

6. P-Process (leaflet).

7. "Entertainment Educates." (video).

8. Fact Sheets: Promoting Providers; Enter-Educate; POPLINE Access