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KYRGYZSTAN RHSEP RESEARCH SUMMARY: PROVIDERS KAP

Executive Summary

In 1993 the U.S. Agency for International Development (USAID) sponsored a team composed of cooperating agency (CA) staff to conduct a general assessment of contraceptive services in the Central Asian Republics (CAR). The countries visited were Kazakhstan, Kyrgyzstan, and Uzbekistan. The team included representatives from USAID, the Newly Independent States (NIS) Task Force, The Futures Group International, Inc. OPTIONS II and Social Marketing for Change (SOMARC III) projects, the Johns Hopkins University Programs for International Education in Reproductive Health (JHPIEGO) and Population Communication Services (PCS), the Association for Voluntary and Safe Contraception (AVSC), and the Demographic and Health Survey Project (DHS). The goal of the assessment was to develop a package of assistance to help Central Asian ministries of health strengthen their family health programs.

The result of the assessment was the formation of an umbrella program called the Reproductive Health Services Expansion Program (RHSEP). The six CAs supply complementary components of the assistance package. The primary components are: 1) policy; 2) institution-building; 3) training; 4) IEC; 5) research; and 6) private-sector development. The Program's activities were launched in late 1993 and the assistance is scheduled to continue through late 1995.

One of the first RHSEP activities, developed in collaboration with CAR ministries of health, was a study to assess the knowledge, attitudes and practices of the principal providers of reproductive health services in the capital cities of Kazakhstan, Kyrgyzstan, and Uzbekistan. The countries of Central Asia have poorly developed systems of family planning service delivery. Families have typically relied on abortion for fertility regulation (the estimated total abortion rate for Kyrgyzstan women is 1.6¹) and the ministries of health have avowed the need to provide family planning services to reduce abortion usage. Therefore it is vital to develop information about how to meet the needs of abortion users.

The purpose of this study is to characterize the knowledge, attitudes and practices of providers as regards family planning and reproductive health. These data will help decision makers to plan for the strengthening of family planning service delivery systems to provide quality, accessible family planning services and to accelerate the transition from abortion to family planning usage. Although the study is small in scope and is the first research effort of this nature in the region, OPTIONS is optimistic that results will be highly useful in identifying future reproductive health technical assistance and training needs.

A questionnaire was developed by OPTIONS in collaboration with SIAR Research International, a Turkish research company subcontracted to carry out the research, and their Kyrgyzstan colleagues at Expert International Research (to be referred to as SIAR-

¹ Darsky L., and Dworak, N. 1993. Kyrgyzstan - Fertility Indicators and Characteristics of the Potential Market for Contraception. The Futures Group International, Washington D.C.

Expert). The sample was designed to include providers from every geographical district in the city. Bishkek is divided into four districts (raions), each of which has a range of service delivery facilities that includes hospitals, research institutes, obstetric and gynecological clinics, polyclinics, and health stations.

The present paper focuses on the findings from the Kyrgyzstan research. It provides a descriptive profile of the sampled family health service providers' attitudes and knowledge regarding contraception and abortion, as well as their practices. In summary, the study has revealed the following information:

- Providers believe their patients prefer an alternative to abortion. Providers feel contraceptive counseling should accompany abortion, and most feel it is their responsibility to provide it.
- Abortion is not recommended by providers for fertility regulation, though the majority does provide the procedure.
- Providers are comfortable with IUDs and liberally recommend them to their patients. However, their information is somewhat antiquated.
- Providers are somewhat familiar with oral contraceptives, though again their information is antiquated. Providers reported that they are recommending oral contraceptives to their patients.
- Though providers do not know much about injectables and implants, they indicated a desire to learn more and a propensity to recommend the methods if they were made available in Kyrgyzstan.
- Voluntary surgical contraception is not popular in Kyrgyzstan and is subject to many misperceptions. About half of the respondents indicated a desire for training in VSC.
- Contraceptive technology updates and service delivery training are wanted and needed. In order, providers desire training in injectables and implants first, and in vasectomy and tubal ligation second.
- Few respondents declare private sector activities. It appears that those who are providing private services do not have a full understanding of what private practice entails.

From these findings five major policy directives emerge:

- Develop a reliable supply of quality contraceptive services to the region, with hopes of shifting abortion users to contraception.

- Accelerate and expand state-of-the-art training for providers in all aspects of reproductive health.
- Investigate the knowledge, attitudes and practices of abortion users.
- Educate clients and providers regarding the full range of reproductive health issues.
- Promote development of the private sector through on-going and additional policy and training activities.

Until quality contraceptive supplies and services are readily available in Kyrgyzstan it will be difficult to know if patients are ignoring their physician's advice regarding contraception, or simply cannot follow the recommendations due to lack of supplies and services. The creation of a reliable contraceptive supply must be complemented with client education on a wide-scale. Should use remain low even after a reliable supply of contraceptive services becomes available, technical assistance can facilitate the creation of demand for modern, safe contraception. Once the supplies and services are available, a closer look at abortion, particularly from the users' perspective, is imperative for a full understanding of abortion and contraception practices in the CAR. As the use of modern contraceptives increases, and replaces dependence on abortion for fertility regulation, maternal mortality and morbidity should decrease.

Encouraging the development of private sector family planning services in Kazakhstan is a viable activity -- requiring a long-term investment. The private sector is unlikely to develop quickly. The ongoing effort to train public health providers is a worthwhile investment and the spinoff is that a trained subset will ultimately move into the private sector.

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Chapter 1: Background and Purpose

A. Background

The Central Asian Republics (CAR) include the following independent countries: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. These countries are located in the southernmost region of the former Soviet Union, directly at the heart of the ancient Silk Road -- once a major center of world trade. The region's peoples are a mix of Ethnic Turkic, Ethnic Europeans (mostly Russians and Ukrainians), and Asians. Recognizing the need to improve maternal and child health², the governments of Central Asia are developing quality national family health³ care initiatives that emphasize making contraception more readily available in the hopes of reducing reliance on abortion as a means of fertility regulation. Each country's initiative underscores the health benefits received from birth spacing and de-emphasizes any aspect of population control.

In 1993 the U.S. Agency for International Development (USAID) sponsored a team composed of cooperating agency (CA) staff to conduct a general assessment of contraceptive services in the CAR. The team, which visited Kazakhstan, Kyrgyzstan, and Uzbekistan, included representatives from USAID, the Newly Independent States (NIS) Task Force, The Futures Group International, Inc. OPTIONS II and Social Marketing for Change (SOMARC III) Projects, the Johns Hopkins University Programs for International Education in Reproductive Health (JHPIEGO) and Population Communication Services (PCS), the Association for Voluntary and Safe Contraception (AVSC), and the Demographic and Health Survey Project (DHS). The goal of the assessment was to develop a package of assistance to help the Central Asian ministries of health strengthen their family health programs.

The result of the assessment was the formation of an umbrella program called the Reproductive Health Services Expansion Program (RHSEP). The six CAs supply complementary components of the assistance package. The primary components are: 1) policy; 2) institution-building; 3) training; 4) IEC; 5) research; and 6) private-sector development. The Program's activities were launched in late 1993 and the assistance is scheduled to continue through late 1995.

² See appendix A for a demographic summary of maternal and child health indicators for Central Asia.

³ In this program, the term *family health* is interchangeable with the term *family planning*. Due to the negative connotation associated with the word *planning* in post-communist societies, the government of Kyrgyzstan prefers the use of the term family health.

B. Purpose

One of the first RHSEP activities, developed in collaboration with CAR ministries of health, was a study to assess the knowledge, attitudes and practices of the principal providers of reproductive health services in the capital cities of Kazakhstan, Kyrgyzstan, and Uzbekistan. Although the study is small in scope and is the first research effort of this nature in the region, OPTIONS is optimistic that results will be highly useful in identifying future reproductive health technical assistance and training needs.

This paper focuses on the findings from the Kyrgyzstan research. It provides a descriptive profile of the sampled family health service providers' attitudes and knowledge regarding contraception and abortion, as well as their practices.

Chapter 2: Research Methodology

A. The Survey Population

The subjects of the survey were family health service providers practicing in Bishkek. All providers interviewed were employed by the Kyrgyzstan Ministry of Health (MOH). At the time of the research, there were no private physicians providing services in Bishkek. The service providers were defined as certified, practicing physicians, akin to obstetricians and/or gynecologists in the United States.

B. Sampling Methodology

The sample was designed to include providers from every geographical district in the city. Bishkek is divided into four districts (raions), each of which has a range of service delivery facilities that includes hospitals, research institutes, obstetric and gynecological clinics, polyclinics, and health stations. A list was constructed of all the facilities providing family health services. Eleven facilities were selected from the list based on facility type and number of facilities located in each district (see Appendix B for list of facilities). The sample was comprised of 150 providers who were randomly selected from employment lists of the selected sites.

C. Study Design

A questionnaire was developed by OPTIONS in collaboration with SIAR Research International, a Turkish research company subcontracted to carry out the research, and

their Kyrgyzstan colleagues at Expert International Research (to be referred to as SIAR-Expert). The questionnaire was also reviewed by RHSEP CAs (see Appendix C for a copy of the questionnaire). Interviewers were selected and trained by SIAR-Expert in Bishkek, with technical assistance from OPTIONS. The data were collected through personal interviews conducted March 10 - 30, 1994.

D. Data Analysis

Completed questionnaires were coded in Istanbul by SIAR Research International. The data were entered into SIAR's corporate software program for initial analysis. SIAR-Expert provided OPTIONS with frequency distributions and a report. OPTIONS obtained hard copies of the questionnaires and ASCII files of the data, which were verified by the OPTIONS staff. A 10 percent sample of the questionnaires was selected by taking the first questionnaire and every tenth questionnaire thereafter. This resulted in a sample of 14 cases. Open-ended questions were not checked. The mean for errors was 2.5 per case or 2.1 percent errors. OPTIONS omitted consistently problematic variables from their analysis. All data were read into SPSS and frequencies and cross-tabulations were run. The following results are derived from the SPSS runs.

Chapter 3: Summary of Findings

A. Profile of Respondents

In Kyrgyzstan, those conducting the survey obtained 149 family health service provider interviews. Eighty-eight percent of the respondents were female and all of them (100%) were gynecologists. It is not surprising that most of the respondents were women since men are typically involved only in family health administration, not in service delivery. Almost one half (45%) considered themselves to belong to their country's ethnic title group -- Ethnic Kyrgyz. The remaining 55 percent belonged to Russian, European, or other Asian groups. This sample ethnicity mix is very similar to the country's overall ethnic mix. The sample's mean age was 40 years (see Table 3.0). The mean number of years in practice was 14.

Table 3.0
Profile of Surveyed Providers

Characteristic	Kyrgyzstan
Total N	149 respondents
Average Age	40 years
Avg. Yrs. in Practice	14 years
% Female	88%
% Ethnic Title Group (Kyrgyz)	45%

The respondents were asked to report the most common reasons for their patient visits (see Table 3.1). Routine gynecological exams were the most cited reason, followed by gynecological pathologies and obstetric pathology. Contraception ranked sixth, after abortion, illustrating the reliance on abortion for fertility regulation.

Table 3.1
Most Common Reasons Patients Visit Providers -- A Ranking

<u>Kyrgyzstan (N=149)</u>
1. Routine gynecological exam
2. Gynecological pathology
3. Obstetric pathology
4. Abortion
5. Child Delivery
6. Contraception
7. Prenatal care

B. Providers' Knowledge, Attitudes and Practices Regarding Fertility Regulation

Introduction

Respondents were asked which contraceptive methods they recommend. The following table clearly illustrates that providers are recommending effective contraceptives. Despite their recommendations, Kyrgyzstan reports a total fertility rate (TFR) of four and a

contraceptive prevalence rate (CPR) of 22 percent⁴. How can Kyrgyzstan have simultaneous low fertility (relatively) and low contraceptive use? Though the TFR is above replacement-level, it is substantially lower than in countries where CPRs are much higher. For example, in the Philippines the recent Demographic and Health Survey results indicate a TFR of four and a CPR of approximately 40 percent.

There are several reasons why Kyrgyzstan's TFR and CPR may be incongruent. It is possible that the MOH is underestimating either the TFR or CPR (but not both). It is also possible that the total abortion rate (1.3 - 1.6)⁵ is underestimated. Other factors that may contribute to the conflicting figures are high levels of effective use of unreported methods (traditional or herbal), or low sexual activity of Kyrgyzstan's population. There is also a large group of divorced and single-parent households. The RHSEP team has heard anecdotal reports that some women prefer to discontinue sexual relations at an early age rather than risk unwanted children.

Table 3.2
Methods Recommended by Physicians

	IUDs	Pills
Kyrgyzstan (N=149)	93%	86%

Contraceptive prevalence in Kyrgyzstan is low. Possible explanations for the low CPR are: 1) there is a severe lack of modern, safe contraceptive supplies and services; 2) the quality of the contraceptives that are sporadically available is very poor; 3) the traditional Central Asian cultures value large families; and 4) there has been a dearth of structured information, education and communication regarding contraception in the region in both the public and private sectors.

The respondents were asked to name methods they never recommend to their patients for fertility regulation. Respondents named abortion and female and male sterilization as the methods they never recommend to their patients for fertility regulation (see Table 3.3). The fact that female and male sterilization are not recommended is not surprising as the Soviet system did not promote this method. That abortion is not

⁴ Contraceptive method mix in Kyrgyzstan at time of research includes condoms, IUDs, oral contraceptives, and traditional methods (though not clearly stated which), MOH 1993.

⁵ Darsky, L. and Dworak, N. 1993. Kyrgyzstan -- Fertility Indicators and Characteristics of the potential Market for Contraception. The Futures Group.

recommended by more than half of the providers is somewhat surprising since it is so readily available. The perception that abortion is considered to be the providers' preferred method of fertility regulation is challenged by these findings. The results point toward a general provider discomfort with abortion as a method of fertility regulation, thereby suggesting that providers, given adequate training and access to safe and modern contraception, may strongly advocate for contraception with their clients.

Table 3.3
Methods Never Recommended by Physicians for Fertility Regulation

	Abortion	Voluntary Sterilization Female	Voluntary Sterilization Male
Kyrgyzstan (N=149)	54%	24%	31%

In Kyrgyzstan, abortion is available on request during the first 12 weeks of gestation. Thereafter, induced abortion is available during the next 16 weeks on judicial, genetic, broad medical and social grounds, as well as on demand with special authorization of a commission of local physicians⁶. In all cases, the abortion procedure requires the consent of the pregnant woman and is considered to be official if performed by a licensed physician in a hospital or other recognized medical institution. Seventy-five respondents (50%) perform abortions.

Seventy-six percent of all surveyed indicated that they strongly believe their patients desire an alternative to abortion and 66 percent strongly disagreed with the statement that their patients prefer abortion. Ninety-one percent of the respondents indicated that they strongly believe abortion services should be accompanied with contraceptive counseling. Only five percent of the respondents strongly believe that it is not their responsibility to counsel a woman about contraception. Despite a severe shortage of contraceptives, 93 percent of the providers did not cite this as a reason for not speaking to their clients about contraceptives.

Of the 88 physicians who provide abortion, less than half of the respondents (40%) had inserted an IUD immediately post-abortion. Because abortion remains such a prevalent means of fertility regulation, it is possible that counseling and post-abortion IUD insertion is an appropriate service to offer Kyrgyzstan's women.

⁶ United Nations, 1993.

B.1 IUD

The IUD is the most widely used method of fertility regulation in Central Asia, as well as in the former Soviet Union. Kyrgyzstan providers are very familiar with this method, which is recommended to patients by 93 percent of the respondents. Eighty-three percent of the respondents indicated that they are currently inserting IUDs. However, 32 percent of the respondents indicated that they had never received formal training in IUD insertion. Of those who had received training, 17 percent had received it within the last calendar year and 27 percent between one and five years. These figures suggest that the cadre of providers inserting IUDs may not be well-trained, or may be just recently trained. The respondents were presented with a battery of attitudinal and knowledge statements about IUDs and asked to indicate whether they strongly disagree, disagree a little, agree a little, strongly agree, or do not know (see Table 3.5).

Table 3.5
IUD - Kyrgyzstan Provider Statements

Statement (N=149)	Strongly disagree	Disagree a little	Agree a little	Strongly agree	Don't know	Total
IUDs are easy to insert.	4.0%	8.1%	22.1%	63.8%	2%	100%
IUDs can easily come out of womb.	4.7%	4.7%	38.9%	49.7%	2%	100%
IUDs make it difficult to get pregnant after removed.	10.7%	6.0%	31.5%	49.7%	2%	100%
IUD requires no further attention after insertion.	60.4%	16.8%	14.8%	6.7%	1.3%	100%
IUDs, in some cases, may cause pelvic infection.	6%	2%	32.2%	58.4%	1.3%	100%
IUDs, in some cases, may cause heavy bleeding.	4%	3.4%	27.5%	61.7%	3.4%	100%
IUD reduces some types of cancer.	46.3%	8.1%	12.8%	10.1%	22.8%	100%
IUD can be inserted by a midwife.	60.4%	4%	16.8%	12.8%	6%	100%
IUD is good for women desiring no more children.	8.7%	10.7%	30.9%	47%	2.7%	100%

Though providers have not received much training, they reported that IUDs are easy to insert. Despite this opinion, 64 percent did not agree that midwives can insert IUDs. Also, half believed IUDs can easily come out of the womb. This may be attributed to poor insertion technique. Only 34 percent have inserted an IUD immediately postpartum. Half also strongly believed that following the removal of an IUD, it is difficult to get pregnant. Providers may believe they are familiar with IUDs, but it appears they are lacking important basic technical information about IUD use and require updates on this method.

B.3 Oral Contraceptives

Under Soviet rule, oral contraceptives were not promoted. In fact, in 1974 the Soviet Ministry of Health published a document called "On the Side-effects and Complications of Oral Contraceptives" (United Nations, 1993), in which the mass use of oral contraceptives was de facto prohibited. However, a high-dose oral contraceptive was produced in the Soviet Union and was relatively wide-known, though its side-effects were considered quite negative. Supply of oral contraceptives in Central Asia has been sporadic and available products have often been of low quality or high-dosage. Providers do not have ready access to oral contraceptives, though they are recommended to patients by 86 percent of the respondents. Twenty-five percent dispense oral contraceptives from their office. Providers were not asked by interviewers to produce a physical sample of the pills they dispense, but it is unlikely that providers have reliable supplies. Respondents were presented with a battery of attitudinal and knowledge statements about oral contraceptives and asked to indicate whether they strongly disagree, disagree a little, agree a little, strongly agree, or do not know (see Table 3.6).

Table 3.6
Oral Contraceptives - Kyrgyzstan Provider Statements

Statement (N=149)	Strongly disagree	Disagree a little	Agree a little	Strongly agree	Don't know	Total
OCs have positive health benefits.	11.4%	15.4%	51%	17.4%	4.7%	100%
OCs in some cases may cause breast cancer.	41.6%	12.1%	23.5%	7.4%	15.4%	100%
OCs in some cases may cause cervical cancer.	50.3%	9.4%	20.8%	2.7%	16.8%	100%
OCs regulates menstruation.	9.4%	2.7%	20.1%	65.8%	2%	100%
OCs are easy to take.	28.2%	16.8%	30.9%	19.5%	4.7%	100%
After taking OCs, it is difficult to get pregnant.	20.8%	14.8%	30.2%	25.5%	8.7%	100%
OCs cause deformed children.	57.7%	7.4%	13.4%	6%	15.4%	100%
OCs lessen the chances of some cancers.	8.7%	3.4%	26.8%	38.9%	22.1%	100%
OCs should not be taken by women over 35 who smoke.	7.4%	6.7%	15.4%	53.7%	16.8%	100%
OCs are difficult for women to remember to take.	22.5%	10.1%	41.6%	21.5%	5.4%	100%
OCs cause infertility.	48.3%	17.4%	13.4%	11.4%	9.4%	100%
OCs should not be prescribed to breast feeding women unless it is a progesterone-only pill	11.4%	2%	10.1%	63.8%	12.8%	100%
Side effects of OCs go away after a few months of use.	7.4%	8.1%	28.9%	29.7%	6%	100%

There are reasons to believe that providers lack information regarding oral contraceptives. The responses to this battery of statements evidence lack of uniform knowledge about oral contraceptives among providers. More than one-fourth are unsure that there are health benefits derived from use of oral contraceptives and suspect that they may cause breast and/or cervical cancer. Fifty-six percent believed that it is difficult for women to become pregnant after taking oral contraceptives and 15 percent did not know if oral contraceptives cause deformed children. Seventeen percent did not know if women who are 35 or older and smoke should be given oral contraceptives. It is possible that the quality of the oral contraceptive available to them has been very low, causing the providers to have negative experiences with their patients and oral contraceptives. Nevertheless, their knowledge of hormonal contraception seems to be less than state-of-the-art.

B.3 Injectables

Injectable contraceptives are quite new to Central Asia. The method is not well known in Kyrgyzstan, which is reflected in the following findings. Only 3 percent of the respondents felt they were very familiar with the method, while 34 percent felt they were "somewhat familiar" with it. The remaining respondents (63%) indicated that they were unfamiliar with the method. After explaining to the respondents that the injectable contraceptive sometimes causes amenorrhea in some users, they were asked if they felt this side-effect would be acceptable to their patients. The majority (81%) indicated that amenorrhea would not be a problem for their patients. It was then explained that the injectable contraceptive sometimes causes irregular bleeding or spotting in some women. Respondents were subsequently asked if they felt this side-effect would be acceptable to their patients. Over half (61%) felt irregular bleeding would not be a problem, though 21 percent felt it would. Despite their unfamiliarity with the method and their awareness of the major side-effects, 70 percent of the respondents felt they would recommend the method if it were available in Kyrgyzstan. Seventeen percent were undecided.

B.4 Voluntary Surgical Contraception

Voluntary surgical contraception (VSC) -- particularly vasectomy -- is not a widely used method. Less than half (34%) of the respondents indicated that they perform tubal ligations. None perform vasectomies and only 8 percent had performed more than 10 tubal ligations during the past five years. The respondents were presented with a battery of attitudinal and knowledge statements about VSC and asked to indicate whether they strongly disagree, disagree a little, agree a little, strongly agree, or do not know (see table 3.7).

Table 3.7
Voluntary Surgical Contraception - Kyrgyzstan Provider Statements

Statement (N=149)	Strongly disagree	Disagree a little	Agree a little	Strongly agree	Don't know	Total
Tubal ligation and vasectomy are temporary methods.	81.9%	2.7%	8.1%	3.4%	4%	100%
A man cannot do heavy work after he has a vasectomy.	45%	15.4%	15.4%	6%	18.1%	100%
After a vasectomy a man cannot have as much sex as before.	45%	6.7%	11.4%	7.5%	29.5%	100%
After voluntary surgical contraception there is no harm to a woman's health.	16.1%	9.4%	8.7%	60.4%	5.4%	100%
Tubal ligation and vasectomy decrease a person's sexual drive.	57%	4.7%	7.4%	4.7%	26.2%	100%
After the operation, voluntary surgical contraception has the least side-effects.	12.8%	10.1%	22.8%	46.3%	8.1%	100%
Vasectomy is similar to castration.	56.4%	5.4%	10.7%	12.8%	14.8%	100%
Many people fear the method because of the operation.	4%	2%	16.1%	71.8%	6%	100%

Providers appear to be lacking knowledge regarding VSC -- though the majority knew that it is a permanent method. Common misperceptions prevail in Kyrgyzstan (e.g.) "a man cannot do heavy work following a vasectomy"; "a man cannot have sex as much as before". In fact, 26 percent did not know if VSC affects a person's sexual drive. Twenty-four percent either strongly agreed or agreed a little with the statement that vasectomy is similar to castration, and 15 percent did not know. The majority (72%) indicated that people fear VSC because of the operation required. It is possible that the patients' fears are not unreasonable given providers' poor knowledge about the method and lack of adequate surgical supplies.

B.5 Implants

The providers were very unfamiliar with the contraceptive implant -- 71 percent were completely unfamiliar and 27 percent were only somewhat familiar. Each respondent was read a description of the method (see questionnaire in Appendix C) and then asked if she/he would recommend the method to his/her patients if it were available in Kyrgyzstan. Despite the providers' unfamiliarity with the product, 71 percent indicated that they would recommend it and 22 percent were undecided.

C. Training

Because a large portion of the RHSEP deals with training, the respondents were asked to indicate whether they had received some formal training at sometime during their professional careers or pre-service education. Seventy-two percent of the respondents indicated that they had received some type of formal training in family health care provision, though only 27 percent indicated having received that training within the past five years. Twenty-eight percent indicated that they had never received formal training. When asked if they would like to have training or additional training (see Table 3.8), respondents expressed eagerness to have training in the implant and injectable contraceptives. Over half indicated a desire for training in vasectomy and almost half for tubal ligation training.

Table 3.8
Training -- Kyrgyzstan

Subject Area (N=149)	Has some training	Want training
Family Health Counseling	72%	33%
Oral Contraceptives	84%	34%
IUDs	89%	18%
Tubal Ligation	54%	46%
Vasectomy	9%	52%
Condoms	78%	9%
Female Barrier Methods	68%	21%
Injections	21%	74%
Implants	13%	76%
Lactational Amenorrhea Method	62%	15%
Natural Family Planning	76%	16%

D. Private Sector

OPTIONS wanted to learn if the respondents were delivering any of their services privately, either formally or informally. Only nine of the respondents admitted that they see patients privately. For a provider to see a patient privately, they usually must make use of their home or their patient's home. Though anecdotal reports of private practice circulate in Kyrgyzstan, the respondents of this survey either are not active in private provision of services or are unwilling to discuss their activities.

Of the nine respondents who see patients privately, four indicated that they were providing abortions privately. Eight indicated that they provide other family planning services for their private patients. When asked about the terms of payment for private services, four providers indicated that they are paid "at the time of visit, three did not charge for "private services," and one said "as the patient wishes," suggesting that providers are confusing personal favors with private service. "Private service" is not fully understood by the respondents. It also appears that the respondents are hesitant to discuss the issue. The Project's in-country experience indicates that until the laws regarding private services are better articulated and disseminated, the physicians will not be likely to discuss their attempts at private service delivery.

E. Major Findings

In summary, the study has revealed the following information:

- Providers believe their patients prefer an alternative to abortion. Providers feel contraceptive counseling should accompany abortion, and most feel it is their responsibility to provide it.
- Abortion is not recommended by providers for fertility regulation, though the majority does provide the procedure.
- Providers are comfortable with IUDs and liberally recommend them to their patients. However, their information is somewhat antiquated.
- Providers are somewhat familiar with oral contraceptives, though again their information is antiquated. Providers reported that they are recommending oral contraceptives to their patients.
- Though providers do not know much about injectables and implants, they indicated a desire to learn more and a propensity to recommend the methods if they were made available in Kyrgyzstan.
- Voluntary surgical contraception is not popular in Kyrgyzstan and is

subject to many misperceptions. About half of the respondents indicated a desire for training in VSC.

- Contraceptive technology updates and service delivery training are wanted and needed. In order, providers desire training in injectables and implants first, and in vasectomy and tubal ligation second.
- Few respondents declare private sector activities. It appears that those who are providing private services do not have a full understanding of what private practice entails.

From these findings five major policy directives emerge:

- Develop a reliable supply of quality contraceptive services to the region, with hopes of shifting abortion users to contraception.
- Accelerate and expand state-of-the-art training for providers in all aspects of reproductive health.
- Investigate the knowledge, attitudes and practices of abortion users.
- Educate clients and providers regarding the full range of reproductive health issues.
- Promote development of the private sector through on-going and additional policy and training activities.

Until quality contraceptive supplies and services are readily available in Kyrgyzstan it will be difficult to know if patients are ignoring their physician's advice regarding contraception, or simply cannot follow the recommendations due to lack of supplies and services. The creation of a reliable contraceptive supply must be complemented with client education on a wide-scale. Should use remain low even after a reliable supply of contraceptive services becomes available, technical assistance can facilitate the creation of demand for modern, safe contraception. Once the supplies and services are available, a closer look at abortion, particularly from the users' perspective, is imperative for a full understanding of abortion and contraception practices in the CAR. As the use of modern contraceptives increases, and replaces dependence on abortion for fertility regulation, maternal mortality and morbidity should decrease.

Encouraging the development of private sector family planning services in Kazakhstan is

a viable activity -- requiring a long-term investment. The private sector is unlikely to develop quickly. The ongoing effort to train public health providers is a worthwhile investment and the spinoff is that a trained subset will ultimately move into the private sector.

Appendix A

Demographic Indicators in Kazakhstan, Kyrgyzstan, and Uzbekistan⁷

The three republics are a mixture of cultural and religious groups. As a whole, they have higher fertility than other republics of the former Soviet Union. On average, the total number of children born alive to a woman during her lifetime, assuming she passes through her childbearing years conforming to the age-specific fertility rates of a given year are: Kazakhstan -- 3.0, Kyrgyzstan -- 4.0, and Uzbekistan -- 4.4. These numbers are higher than those found elsewhere in the former Soviet Union, but lower than those in the adjacent countries of Pakistan, Afghanistan and Iran (6.2, 6.9, 6.0 respectively). There are marked differences in fertility between the Russian population and the Ethnic Asian populations of these countries (Darsky and Dworak, 1993). For example, in Kazakhstan the Russian total fertility rate (TFR) is estimated to be 2.2, while the Ethnic Asian TFR is 3.6. In Kyrgyzstan the estimated Russian TFR is 2.1 and the Ethnic Asian TFR is 4.8. In Uzbekistan the estimated Russian TFR is 1.9 and the Ethnic Asian TFR is 4.7.

Total Fertility Rates -- Various Countries 1990-1995

	Afghanistan	Pakistan	Iran	Kazakhstan*	Kyrgyzstan*	Uzbekistan*	Turkey	United States
TFR	6.9	6.2	6.0	3.0	4.0	4.4	3.5	2.1

Source: United Nations, World Abortion Policies, 1994.

*1985-1990 total fertility rates.

Infant mortality rates (IMR) are indicators of a country's socioeconomic status and health care system. The countries of Central Asia are the poorest of the former Soviet Union although their infant mortality rates are comparable to more developed countries and are well below those of neighboring Pakistan, Afghanistan and Iran. Consequently, the RHSEP members, along with other international agencies and scholars are carefully regarding these reported figures. It is possible that CAR ministries of health are using a different definition of what is considered an infant death. In an effort to determine the reliability of these data, the RHSEP is currently investigating the CAR definition of infant mortality, as well as the data collection process.

⁷ Laughrin, Ann and West, Sydney. 1994. The Futures Group International, Washington D.C.

Infant Mortality Rates per 1,000 Live Births, 1985-1990 -- Various Countries

	Afghanistan	Iran	Pakistan	Kazakhstan*	Kyrgyzstan*	Uzbekistan*	Turkey	United States
IMR	172	52	109	26.4	30.0	34.6	68	10

Source: World Population Prospects, 1992 United Nations

* Source: Tabulation of Goscomstat of Russia, 1990 data.

Maternal mortality rates reported by the ministries of health are also very low, relatively speaking. Again, the RHSEP is investigating the definition of maternal mortality and the data collection process. Under-reporting or poor communication mechanisms in rural areas may greatly contribute to possible underestimates.

Maternal Mortality Rates per 100,000 Women -- Various Countries

	Afghanistan ¹	Iran ¹	Pakistan ²	Kazakhstan ³	Kyrgyzstan ⁴	Uzbekistan ⁴	Turkey ⁴	United States ⁵
MMR	640	120	400	48	56	33	146	8

¹1985 data, ²1987 data, ³1988 data, ⁴1989 data, ⁵1991 data

Source: World Abortion Policies, United Nations, 1994.

Under Soviet rule, the region experienced steady declines in infant and maternal mortality rates. Since independence the region's rates have remained constant or worsened, most likely due to the economic strains of independence and its impact on health care delivery and quality.

Abortion Statistics in Kazakhstan, Kyrgyzstan and Uzbekistan⁸

The rates of induced abortion in the CAR are among the highest in the world. The absolute abortion numbers reported in 1991 for each country were: Kazakhstan -- 358,000, Kyrgyzstan -- 49,000, and Uzbekistan -- 189,000. The data were collected by the Goscomstat of Russia. This translates into general abortion rates per 1,000 women aged 15-49 years of: Kazakhstan -- 86.4, Kyrgyzstan -- 47.5, and Uzbekistan -- 39.2. These general abortion rates are much higher than the 1991 U.S. general abortion rate (per 1,000 women aged 15-44) of 26.0, but significantly lower than the Russian Federation's general abortion rate of 119.6/1,000 women (15-44 years) (United Nations, 1994). Put another way, women in Kazakhstan will average between 2.5 and 3 abortions during their lifetimes, women in Kyrgyzstan will average between 1.3 and 1.6, and women in Uzbekistan will average between 1.0 and 1.4 abortions. One possible reason for high abortion rates is the lack or perceived lack of alternatives to abortion on the parts of the users. The second possible reason is that users may prefer abortion as a means of fertility regulation. Both possible reasons need further investigation.

Reported Induced Abortions for Kazakhstan, Kyrgyzstan and Uzbekistan, 1991

Country	Total Number of Abortions	General Abortion Rate (per 1,000 women 15-49)	# Of Lifetime Abortions per Woman
Kazakhstan	358,000	86.4	2.5 - 3.0
Kyrgyzstan	49,000	47.5	1.3 - 1.6
Uzbekistan	189,000	39.2	1.0 - 1.4

Source: World Abortion Policies, United Nations, 1994.

There are numerous factors that affect the reliability of the published abortion estimates. Of particular concern are abortions that occur outside of health care facilities. These unofficial, unreported abortions are not captured in the published estimates and it appears that no effort is made by the ministries of health to factor them into the total abortion estimates.

Obtaining accurate data on unofficial abortion prevalence is extremely difficult. The RHSEP team has heard numerous anecdotal reports of professional, educated women who regularly visit a "friend," usually in her home, to undergo an abortion. It did not appear uncommon that the provider of the abortion would be a massage therapist, a psychologist, or a physical therapist. Most important, these providers did not receive training in abortion provision and it can be assumed that maintaining aseptic conditions and equipment, as well as a supply of anesthesia and antibiotics, would be extremely difficult.

⁸ Laughrin, Ann and West, Sydney. 1994. The Futures Group International, Washington D.C.

Another factor certainly affecting the published abortion rates is the prevalence of menstrual regulation or MR. This procedure is being provided in many, but not necessarily all clinics. OPTIONS staff observed in one Central Asian clinic that every Thursday afternoon was designated as "MR Afternoon." It was reported that many women attend every Thursday as a precautionary measure. It is not clear if these MRs are counted as abortions by the health ministries, which could lead to underestimates in the total number of annual abortions.

Future abortion rates must also be carefully monitored for two additional reasons. One, the level of out-migration by mostly Russians and Europeans, who typically tend to be more frequent abortion users, will create an initial decrease in abortion rates, a fact that may be incorrectly attributed to MOH interventions. Two, the age structure of the region is about to change drastically. Currently, almost 40 percent of the CAR population is under the age of 15. As this very large group of people enters the 15-19 year age category, it is expected that we may see a surge in the abortion rate, which may be incorrectly attributed to lack of MOH interventions.

**Appendix B
Sample Sites**

Institute	Raion
Maternity House #2	Leninsky
Women's Advice Bureau #3	Leninsky
Maternity House #1	Sverdlovsky
Women's Advice Bureau #1	Sverdlovsky
Women's Advice Bureau #5	Sverdlovsky
Maternity House #3	Pervomaysky
Women's Advice Bureau #2	Pervomaysky
Maternity House #4	Okyabirsky
Maternity House #5	Okyabirsky
Women's Advice Bureau #4	Okyabirsky
Gynecological Research Institute	Centre

Appendix C
Questionnaire - Providers

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