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**The Europe and Eurasia Regional
Family Planning Activity**

Central Asian Republics: Final Technical Report



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Planning Activity**

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EUROPE AND EURASIA REGIONAL FAMILY PLANNING ACTIVITY is a three-year initiative funded by the U.S. Agency for International Development through contract GHS-I-05-03-00026-00. The Regional Activity is a regional effort to leverage best practices in family planning in order to accelerate program implementation across the region to increase modern contraceptive use and decrease abortion rates.

John Snow, Inc. implements the Europe and Eurasia Regional Family Planning Activity.

The views expressed in this document do not necessarily reflect those of USAID.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CAR	Central Asian Republics
CPG	Clinical Practice Guidelines
DMPA	Depot Medroxyprogesterone Acetate
FP	Family Planning
GTZ	German Technical Cooperation, or <i>Deutsche Gesellschaft für Technische Zusammenarbeit</i>
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
M&E	Measure and Evaluation
MOH	Ministry of Health
PP	Post-Partum
RH	Reproductive Health
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

Executive Summary

In 2008, the USAID's Europe and Eurasia Regional Family Planning Activity (Regional Activity) implemented by John Snow, Inc carried out activities to improve local capacity for providing long-term and permanent methods in Tajikistan and the Kyrgyz Republic. This report provides summary of activities, findings, and recommendations for continuing to develop local capacity to provide long-term and permanent methods over the near and long term.

In 2008, the Regional Activity:

- Undertook a rapid assessment of long-term and permanent methods needs in Tajikistan in May.
- Held "Contraceptive Technology Update: Evidence-based Facts" meetings in Dushanbe, Tajikistan and Bishkek, Kyrgyz Republic in June. With ZdravPlusII support, the Regional Activity staff replicated these workshops in Almaty, Kazakhstan and Tashkent, Uzbekistan.
- Conducted a Training of Trainers workshop on immediate postpartum and postabortion IUD insertion in Jalalabat, Kyrgyz Republic for Tajik and Kyrgyz family planning service providers and professors in August.
- Conducted training on obtaining informed consent and performing Voluntary Surgical Contraception (minilaparotomy) in Dushanbe, Tajikistan for Tajik obstetrician-gynecologists in September.
- Completed a working group meeting to develop evidence-based IUD Clinical Practice Guidelines and Service Provision Protocols with Tajik and Kyrgyz participants in Hodja-Obigarm, Tajikistan in September.
- Conducted two interval IUD insertion and removal trainings for 20 midwives in primary care settings in Khujandt City (Sughd Oblast) and Kurgan-Tube (Khatlon Oblast), Tajikistan in October.
- Procured 100 IUD kits for Tajikistan, which also included long, curved forceps for immediate postpartum insertions, which were delivered in December.
December.

These activities were undertaken in collaboration with UNFPA, the ZdravPlusII Project, and the Tajik and Kyrgyz Ministries of Health. The interval IUD trainings were also undertaken in collaboration with the Tajik National Center for Reproductive Health. Leveraging funds from other organizations allowed the Regional Activity to include Kyrgyzstan in additional activities, which was very much needed. Furthermore, the project developed local capacity with their activities by investing in local trainers to help update their materials, skills, and abilities to provide quality family planning services.

Based on project activities, evaluations, and working with providers, Ministry staff, and other stakeholders, there is a need to support dedicated improvements in quality of long-term and permanent method service provision in these countries.

Current practices are not in line with World Health Organization (WHO) recommendations for safe and effective provision of contraceptives. Key areas where improvements are needed are in infection prevention, and developing policies, procedures, and guidelines that operationalize the Medical Eligibility Criteria, so that contraception can be demedicalized and unnecessary tests and examinations creating barriers to use are removed.

Furthermore, there is a need to build local capacity to teach and implement up-to-date, evidence-based practices, as well as eliminate provider bias against certain contraceptive methods. In CAR where women complete their families at early ages, quality provision of long-term and permanent methods will go a long way toward helping women achieve their reproductive goals.

Tajikistan Activities

Previous Activities

As reported in *Contraceptive Needs Assessment and Contraceptive Technology Conference: Summary of Activities and Findings: Tajikistan and Kyrgyzstan*, July 2008, the Regional Activity began efforts to improve capacity in CAR to provide quality FP services by updating providers' knowledge about the latest developments in contraceptive technology. During this first trip to the region, the project also assessed the situation with long-term and permanent family planning methods in Tajikistan. The findings of this rapid assessment and the contacts developed during this initial trip helped set the stage for the work that followed under the Regional Activity.

I. Training on Obtaining Informed Consent and Performing Voluntary Surgical Contraception (Minilaparotomy)

Dr. Kelly O'Hanley, consultant to the Regional Activity, and Ms. Vera Zlidar, Family Planning Advisor, traveled to Dushanbe, Tajikistan for training on Voluntary Surgical Contraception (VSC) from Sept 1-10, 2008. This training was led by two local trainers, Drs. Saodathon Muhamadeva and Ergashoi Khushvatova (consultants to the Regional Activity). Dr. O'Hanley provided technical and clinical oversight during the training.

The use of VSC is quite low in Tajikistan—in 2005, only 0.4 % of married women of reproductive age reported using female sterilization and 0.4% of married men reported using vasectomy¹. Despite biases against VSC, the Regional Activity worked with a group of motivated local trainers who are convinced that demand would be higher if providers could shed their own biases, and openly and honestly counsel women about this method. The local trainers—and trainees—believe that VSC is a good fit in countries where women begin and complete childbearing at an early age, particularly when many women have multiple pregnancies and live births.

Current situation in Tajikistan. One of the contributing factors to the low levels of VSC in Tajikistan is the provider bias against this method (see *Contraceptive Needs Assessment and Contraceptive Technology Conference: Summary of Activities and Findings: Tajikistan and Kyrgyzstan*). Furthermore, few providers have been trained to provide this method in the country, and many facilities lack the proper surgical equipment for the procedure. Lastly, because of lack of adequate financing in the clinics and hospitals, clients are required to pay for anesthesia and the cost of consumables related to the procedure. Thus the costs of the procedure are often out of reach for the women who need it the most.

¹ 2005 Tajikistan Multi-Indicator Cluster Survey (Preliminary Report).
http://www.childinfo.org/mics/mics3/docs/countryreports/MICS3_Tajikistan_PreliminaryReport_2006_eng.pdf

Training Activity and Outcomes

The objectives of this training were to increase participants' knowledge about safe minilaparotomy provision and develop the clinical skills to do this procedure at their home maternity. This training focused on:

- Providing an overview of the method
- Teaching participants the WHO Medical Eligibility Criteria for minilaparotomy
- Providing opportunities for participants to develop competency in:
 - Counseling
 - Obtaining informed consent
 - Surgical technique
 - Follow-up

Participants. Eight senior obstetrician-gynecologists with years of experience attended the training. Each was from a city, district, or regional maternity from the Khatlon and Soghd Oblasts. Six of the participants came as teams of two people from one maternity, so that they could support one another in their home maternity. During the training, all trainees were punctual, attentive, and participatory. They appeared to be kind, responsible physicians.

Training schedule. The eight-day training included:

- Overview of the reproductive and demographic situation in Tajikistan
- Role plays and actual client counseling about minilaparotomy and obtaining proper informed consent
- Theoretical components of VSC
- Small group work on medical eligibility criteria
- Learning proper documentation of the procedure in patient records
- Becoming familiar with the instruments used for minilaps, how to arrange them for use during the procedure
- Infection prevention
- Watching slide shows and videos of procedures, discussing techniques, critiquing what they saw
- Demonstrations and practice of the procedure on clinical models
- Observing, assisting, and leading minilaparotomies

Informed consent. Informed consent was taken very seriously during the training, with the local trainers placing a lot of emphasis on this component. They discussed the counseling process, and the need to discuss various scenarios with women where they may imagine wanting to have another child in the future. The skills of the trainers were very strong in this crucial element of providing minilaparotomies.



Dr. O'Hanley's suturing technique is viewed with keen interest by the trainees. Tajik providers use older, less sophisticated surgical techniques than the ones used in the US.

The trainers also taught the trainees how to properly fill out the Tajikistan national consent form that legally needs to be signed by the patient and her husband. The national consent form does not specify the risks of the procedure—rare but real surgical complications such as bleeding, injury to bowels, injury to bladder, and infection. Furthermore, the form does not mention the risk of failure with the method, which can lead to pregnancy. This information needs to be included in the consent form as well as the counseling process (see recommendations, below).

The Regional Activity distributed a number of materials prepared for the participants to keep, including Medical Eligibility Criteria, procedure checklists, client after-care instructions, and national consent forms. The trainees also copied down examples of how the procedure is documented in patients' charts. These materials can all be used in the trainee's home facility. During the training, participants developed a job aid for use in obtaining a complete medical history and thus ensure proper screening of the Medical Eligibility Criteria. The Regional Activity also provided copies of *Family Planning: A Global Handbook for Providers* for each participant, with instructions and information about minilaparotomies.

The Regional Activity distributed a number of materials prepared for the

Minilaparotomies. Eight procedures were successfully completed during the training. Each trainee assisted in one procedure and was the lead surgeon in one procedure. The trainers participated in each procedure to guide the trainees, answer questions, correct technique—generally help the trainees learn how to do the procedure safely and properly. Each procedure was reviewed in detail after the surgery: Those performing the procedure talked about what they did, how it felt, what they learned; then observers made comments; and finally the trainers provided feedback on the procedure.

While this was excellent experience, it is desirable to undertake several procedures under supervision so as to have sufficient competency in providing minilaps in their home institutions. Furthermore, it is desirable to have an entire surgical team trained in providing and supporting minilap provision, and a system for referral, informed consent, and follow up developing within an institution to help support provision of this method. Nonetheless, trainees report feeling sufficiently prepared to provide the procedure in their course evaluations (see Training Course Evaluation, below).

Changes in Knowledge. A 19-question, true/false pre-test was given to assess trainee's knowledge of minilaparotomy. This included questions on medical eligibility criteria for VSC, basic principles of the procedure, infection prevention, and proper follow up and management of any problems. This same questionnaire was given at the end of the

training to measure whether provider knowledge about minilaparotomy changed as a result of the training.

The average score for the pretest was 77.0% (range 73.7% to 89.5%), and for the post-test was 93.4% (range 89.5% to 100.0%). A paired student's T-test confirmed that this 16.4 percentage point increase in the correct answers was statistically significant at the $p=.001$ level. At the pre-test, the questions where a majority of the trainees answered incorrectly related to medical eligibility—that is, who safely can and cannot use the method, the timing of the procedure, and infection prevention. These are all key components to quality service provision and increasing access by reducing unnecessary medical barriers to use of the method.

Based on JSI's work in the Newly Independent States, the Regional Activity expected problems with infection prevention. In the pre-test, not one participant was able to correctly answer the question on high-level disinfection during the pre-test, and only one participant responded correctly on what the proper procedure is to sterilize the surgical instruments. At the post-test, all participants correctly answered the question on high-level disinfection, and all but one participant correctly answered the question about proper instrument sterilization. Similarly, at the pre-test, most respondents said diabetes was a contraindication to the procedure, and that the procedure could not be undertaken any time during the menstrual cycle. At the post-test, every trainee was able to respond correctly to these two questions. The training was obviously successful in helping change provider knowledge on who can use the procedure, and when the procedure can take place.

Training Course Evaluation.

Participants were clearly pleased with the course. Much of this was because the course met their expectations: They learned about a new method of contraception and got practical experience with the counseling, surgical, and follow-up components of VSC. Some expressed happiness that they can go back and provide a valuable service to clients. Others were excited with the prospect of being able to bring VSC back to their facility and implement a VSC program in their site.

The course evaluation included closed-ended questions about course content, length, types of exercises, and fulfillment of



Trainees gain hands-on experience excising and ligating the fallopian tubes during the VSC training. Each provider at the training was able to assist at least one procedure and lead one.

expectations. Open-ended questions about what they would like to see changed about the training were also included. All participants agreed or strongly agreed felt that the role plays, models, and practical aspects of the course were very useful. Most importantly, 100% of the trainees indicated that they felt prepared to perform a minilaparotomy as a result of the training—87.5% strongly agreed with this statement and 12.5% (1 participant) agreed with this statement.

Trainee comments clearly indicated that the participants were very pleased at the hands-on nature of this training. They had hoped that they would be able to participate in one surgery, and each participant was able to participate in two. They also liked how most of them were trained as a team, so that they could work together in their facility and support one another as they tried to get a VSC program off the ground in their facility.

Next Steps. To help increase the availability of this method, these newly-trained providers will start counseling clients about this contraceptive option in their maternities, and begin obtaining informed consent.

Training Impact. Follow up of the eight trainees in January found that these providers have consistently begun including VSC as a contraceptive option for their clients. They report counsel women about the availability of this method along with other methods of contraception as well as VSC method provision. This shows that the training successfully was able to overcome some of the traditional provider biases against this method.

**VSC from the Client's Perspective: Addressing Unmet Need
for Limiting Family Size**

Many women in Tajikistan have many pregnancies and fairly large families. This is a result of the confluence of cultural factors: marrying early, pressure to demonstrate their fertility, son preference, and a lack of power/women's status, particularly for younger women. As a result, women often complete their families at an early age, which requires the use of an effective method of contraception for many years, until menopause when the risk of pregnancy ends.

The reproductive history of the women who consented to sterilization during the training clearly illustrates this long pattern of early family completion. The average age of these clients was 35, with the youngest client age 30, and the oldest, 41 years old. Except for one client with four pregnancies, the other clients all had had six or seven pregnancies:

Client's Age	# of Pregnancies	# of Births	# of Living Children	# of Abortions
35	4	4	4	0
30	7	4	4	3
36	7	5	3	2
31	6	5	5	1
41	7	6	6	1
31	6	5	5	1
39	7	6	6	1
36	6	5	5	1
Average	34.9	6.3	5.0	1.3

The youngest client who had the sterilization procedure was 30 years old. She had had 7 pregnancies, 3 abortions, and 4 births. When asked why she had wanted the procedure, she said "I do not want to ever have to worry about contraception again. I have all of the children I want—girls and boys."

The discussion with another client underscored the appeal that a one-time, permanent procedure has for women when their families are completed. "Why not pills?" she was asked. "Too expensive. I have to take them every day, and I just don't want to be bothered," she replied. "What about DMPA?" "I don't want to have to come back every three months for another shot." "You don't have to come back for an IUD, why didn't you want an IUD?" "I had heavy bleeding with the IUD. It was not a good method for me. With this sterilization, I don't have to worry about pregnancies any more."

LTPMs are a good fit for such women. Yet there is very low capacity of providing VSC in Tajikistan. Investing in developing local capacity for VSC has the potential to help many Tajik women no longer have to worry about pregnancy once they have completed their families.



A former client stops by the training to discuss her experience with VSC.

Future Needs

There is a need to tap into and fulfill what is likely considerable latent demand for VSC in Tajikistan (and other countries in CAR). In order to do so, provider bias against this method must be overcome, and a cadre of competent providers that can obtain informed consent and perform the procedure safely and correctly must be developed. Activities that can help cultivate the growth of this nascent but much-needed method include:

- Provide follow-up mentoring visits to the newly-trained minilaparotomy providers to assess their skills, provide follow-on technical assistance, help train a surgical team in the facility, and support development of a VSC program in their facilities.
- Work with UNFPA to help procure and distribute minilaparotomy kits to more facilities.
- Work with the National Center for Reproductive Health and other FP/RH programs to include VSC as one of the methods of contraception that women learn about during contraceptive counseling.
- Establish a referral system for women who want minilaps to the facilities that have trained providers in this method.
- Help develop expanded, up-to-date training materials in Russian.
- Work with medical schools to include VSC as a component of the obstetrics/gynecology residency program, ensuring that their teaching and training materials are evidence-based and consistent with WHO recommendations
- Work with in-service training/accreditation organizations to ensure that their teaching and training materials are evidence-based and consistent with WHO recommendations.
- Develop a mechanism for making the costs of the procedure more affordable to clients than it is currently.
- Update the Tajikistan national informed consent form to include risks of the procedure and risk of failure of the procedure, including pregnancy.
- Help develop local capacity to support a VSC program by investing in the local trainers to update and improve their surgical techniques. The trainers were very willing to incorporate suggestions made by Dr. O'Hanley during the classroom and operating room sessions, and would welcome investment in updating and improving their skills. For example, after being coached by Dr. O'Hanley about better ways of identifying and delivering the fallopian tubes for ligation, sterile technique, placement of the incision, correct exposure of the tissue layers of the incision, and closure of the incision, the trainers agreed that these techniques were superior to those that they had been using, and working with the trainees using these methods. Additional activities that can help improve local trainers' skills:



Providers practice laying out minilap instruments in the order they will need them prior to performing mock tubal ligations on a Zoe model. Using models is one way to help trainees develop competency in performing a new procedure prior to undertaking the procedure on a client.

- Use combined local anesthesia and Ketamine anesthesia. (All the procedures were performed under general anesthesia using intravenous Ketamine. By adding local anesthesia, the dose of Ketamine can be reduced and the safety of the anesthesia improved.)
- Modify use of prophylactic antibiotics. (The trainers overused antibiotics and did not time the administration of antibiotics according to the latest evidence-based recommendations. Dr. O’Hanley shared the latest research to help update their knowledge about prophylactic antibiotic use.)
- Not over-medicalizing the procedure. Many clients received pre-operative tests such as an ultrasound and vaginal smear that are not necessary, according to WHO recommendations. These procedures, however, are mandated by the current national clinical practice guidelines for minilaparotomies. (It should be noted, however, that the last minilap client did not undergo the unnecessary tests due to timing issues. The trainers used this as an opportunity to say that the current Tajik guidelines are more conservative than WHO’s, and that minilaps can still be safely performed without them.)
- None of the procedures were performed as an out-patient procedure. Every client stayed overnight after her surgery. There were several motivations on the part of the trainers for this, including easy follow up of the patients to show the trainees that complications are rare.

Such activities would go a long way toward helping further develop local capacity to support, teach, and sustain a VSC program in Tajikistan.

II. Develop Evidence-based IUD Clinical Practice Guidelines and Service Delivery Protocols

This activity was identified as a need from service providers, trainers, and professors in Tajikistan during the Regional Activity's rapid assessment and the Contraceptive Technology Update in May/June 2008 (see *Contraceptive Needs Assessment and Contraceptive Technology Conference: Summary of Activities and Findings: Tajikistan and Kyrgyzstan*). Dr. Tatiana Buzdugan (consultant to the Regional Activity) and Ms. Vera Zlidar facilitated a meeting in Hojda-Obigarm, Tajikistan from September 15-17, 2008, to help develop evidence-based IUD clinical practice guidelines (CPGs) to submit to the Ministry of Health (MOH) for consideration and signing into law.

Current Environment. The guidelines in use today are outdated, requiring unnecessary tests and examinations prior to IUD insertion. These guidelines increase the cost of providing IUDs to the medical system and the client, include unnecessary treatments, and multiple return visits for a client before she can obtain her IUD. At the same time, the MOH, USAID, UNFPA, and WHO encourage the use and adoption of WHO's evidence-based Medical Eligibility Criteria and the Selected Practice Recommendations for Contraceptive Use. Providers expressed frustration at this situation—they want to practice according to evidence-based medicine, but can be fined if they do not adhere to the existing CPGs.

Key personnel from medical schools and teaching institutes, the National Center for Reproductive Health, and Ministry of Health departments (Maternal, Child Health and Family Planning, Dermavenerology, Sanitation and Epidemiology, and HIV/AIDS), formed a working group that drafted a set of CPGs and service delivery protocols for interval IUD insertion. This meeting was geared toward addressing the key medical barriers that currently existing for IUD service provision.

The meeting opened with discussing the goals for the meeting, and followed with a presentation and discussion of the process of undertaking CPG development. Experiences and lessons learned about the process were presented from Moldova.

Participants were then given an overview of the different classification systems that can be used to distinguish the level of evidence available for a recommendation, and the group decided which scheme they were going to use.



A break-out group discusses what information is crucial to include in their country's clinical practice guidelines for managing any problems or complications related to IUD insertion or use.

After this, participants then were broken up into small working groups:

- Screening, testing, and medical eligibility: What is necessary and appropriate?
- Infection prevention: Standards for high-level disinfection, sterilization, and safe IUD insertion.
- Managing problems and complications during insertion and at follow up.

Relevant IUD reference documents, research articles, WHO documents were on hand for this small group work. The participants were also given examples of IUD CPGs developed in the US, the United Kingdom, Georgia, and Kazakhstan. Each group drafted a section of the CPGs on their assigned topic. Once completed, each group presented their draft to the plenary session. The full group debated and discussed the draft guidance presented by the small groups, and came to consensus on any necessary changes. The same process followed for the step-by-step IUD clinical protocols, and a draft version of them was also completed.

The Dermavenerology and Sanitation/Epidemiology department representatives were concerned about consistency with their existing guidelines for infection prevention and STI screening and testing. This was the primary reason for including these services to the CPG development meeting—the Regional Activity wanted to ensure the endorsement and buy-in of related Ministry department.



Working group participants ensure consistency among guidance coming from different departments at the Ministry of Health.

The group members worded the recommendations for STI screening in a way that would eliminate unnecessary barriers to IUD use. Furthermore, since group members had been involved in the development of other CPGs for Tajikistan and know what protocols and recommendations had been problematic in developing, they made certain to reference the proper existing Tajik national decrees (“prikaz”) containing clinical practice standards so that it was clear that this CPG did not contradict existing guidelines in infection prevention, STI and HIV testing, etc.

The Regional Activity has carefully reviewed the draft guidelines and suggested revisions have been sent back to a sub-group of participants to finalize. The Regional Activity is sponsoring a meeting at the MOH in Dushanbe in March 2009 to review these guidelines and set the stage for signing them into law, and will help in developing a strategy for widespread dissemination of these guidelines.

III. Interval IUD Insertion Training for Primary-level Providers in Tajikistan

With support from Regional Activity, local trainers, Drs. Muazzom Radjapova, Guljahon Tumanova, Gulnora Ahmedjanova and Manzura Mirsaidova, conducted two interval IUD training. Drs. Radjapova, Tumanova, and Ahmedjanova work for the National Center for Reproductive Health. Dr. Mirsaidova was a consultant at the time of the training (formerly with UNFPA, now with GTZ).

The training in Kujandt took place from October 16-24, 2008 and the one in Kurgan-Tube from October 16-25, 2008. To help increase access to long-term contraception among those with the least access to these services, the Regional Activity targeted this training specifically to midwives working at the primary care level in Medical Houses in rural areas. Midwives can legally provide IUDs in Tajikistan if they have undergone training and certification. However, the National Center for Reproductive Health does not have funding for such training, and few midwives have been able to provide IUDs.

Participants. A total of 20 midwives were trained in interval IUD insertion. In Khujandt, 10 midwives participated in the training—nine were from Medical Houses, and one was from the medical-sanitary department. In Kurgan-Tube, eight of the 10 midwives were from Medical Houses, with the remaining two working in a local Center for Reproductive Health. Generally the participants served women who have between 5 and 6 children. Some midwives reported serving clients in three or four other villages in addition to their own village due to the lack of medical personnel in these remote areas. They worked in difficult conditions—lack of clean running water, lack of electricity in the winter, lack of medical equipment such as autoclaves in their facility.

Of the 10 participants in Khujandt, five of the midwives originally had only trained as nurses. Later, as a result of a lack of trained midwives in their region, they were asked to attend a three-month program that would re-train them and re-qualify them as midwives. (Interestingly, the trainers noted that they had to spend extra time after class with these participants to review anatomy and physiology of the women’s reproductive tract.)

Training Schedule. An eight-day clinical training course was held to:

- Influence in a positive way the attitudes of the participant toward the benefits and appropriate use of IUDs
- Provide the latest technical information on IUDs, including the most up-to-date WHO medical eligibility criteria
- Provide the participants with information on general family planning counseling, as well as training in method-specific counseling for IUDs
- Provide the participants with the knowledge and skills necessary to use the appropriate infection prevention practices when providing IUD services

- Provide the participants with the knowledge and skills necessary to conduct an assessment of potential IUD users
- Provide the participants with the knowledge and skills needed for IUD insertion and removal
- Provide the participant with the knowledge and skills needed to provide routine follow-up care, and manage side effects and potential problems related to IUD use
- Provide the participant with the knowledge and skills needed to organize and manage quality IUD services

The training used various learning techniques, including:

- Illustrated lectures and group discussions
- Individual and group exercises
- Role plays
- Simulated practice with anatomic (pelvic) models
- Guided clinical activities (counseling and IUD insertion and removal)

Changes in Knowledge. A 23-question, true/false pre-test was given to assess trainee's knowledge of the IUD. This included general information about the method, questions on medical eligibility criteria, infection prevention, proper follow up and management of any problems, and counseling about the IUD. This same questionnaire was given at the end of the training to measure whether provider knowledge about IUDs changed as a result of the training.

The average pretest score in Khujandt was 69.1% (range 43.5% to 95.7%), with the average post-test score increasing 21 percentage points to 90.4% (range 73.9% to 100.0%). In Kurgan-Tube, the average pre-test score was 43.9% (range 26.1% to 56.5%), also increasing 21 percentage points to 64.8% (range 47.8² to 82.6%). Using a two-sided Student's T-test, these differences were statistically significant at the $p = .002$ level.

Interestingly, the areas where participants knew the least were very different in the two trainings. In Khujandt, participants gained the most knowledge in counseling—including acknowledging that the client was most capable of deciding what method was best for her, not subjecting the client to unnecessary tests and examinations prior to IUD insertion, who can and cannot use, and infection prevention. In Kurgan-Tube, the greatest increases in knowledge centered around medical eligibility criteria, how long the IUD lasts, when to provide the IUD, and how removal is not always necessary for managing any problems related to the IUD. These improvements in knowledge relate to quality service provision.

² This participant missed answering five questions, which dropped her score down considerably.

Next Steps. The National Center for Reproductive Health was pleased at the support that they received from the Regional Activity for this training, and would welcome support for additional trainings. Staff from these centers have provided data on the family planning needs of people in some of the most remote villages of Sughd and Khatlon oblasts, indicating that an IUD training for midwives of these areas would be welcome. Unfortunately, the Regional Activity does not have any additional funding to support training of more midwives.

The National Center for Reproductive Health, however, now has up-to-date training materials, reference documents, and slides that they can use in future trainings as their funding permits. These materials have also been made available to ZdravPlus and UNFPA, so that their trainers and trainings can make use of the most up-to-date, medically accurate recommendations. The National Center for Reproductive Health will be pursuing donors in-country for funding to continue training primary care providers in interval IUD insertion, since this is a core part of their strategy to increase access to IUD services in rural Tajikistan where doctors are scarce.

The strategy focuses on first reaching the midwives with the largest client bases and catchment areas, since these providers area likely to have the highest demand.

Training Impact. Follow-up assessment of the Khujandt training found demand in these areas is indeed high. In the three-month period after the training, 144 IUDs have been inserted by the 10 midwives who learned this new skill. Clearly, there is an unmet demand for long-term methods in these rural areas that are traditionally underserved.

IV. IUD Kit Procurement

The Regional Activity procured 100 IUD kits for Tajikistan which were delivered in December. The National Center for Reproductive Health and the ZdravPlusII Project will distribute these kits to primary-level facilities and facilities that have a high number of clients.

Each IUD kit included the following surgical-grade, stainless steel items:

- Instrument tray and cover
- Iodine cups
- Kelly uterine forceps
- Emesis pans
- Rochester-Pean forceps
- Bozeman forceps
- Uterine tenaculum
- Sponge-holding forceps
- Uterine sound
- Vaginal speculum (small)
- Vaginal speculum (medium)

- Vaginal speculum (large)

All 20 midwives who underwent the interval IUD trainings will receive an IUD kit for their facility.

Kyrgyz Republic Activities

Previous Activities

As reported in *Contraceptive Needs Assessment and Contraceptive Technology Conference: Summary of Activities and Findings: Tajikistan and Kyrgyzstan*, the Regional Activity began their support of improving capacity in CAR to provide quality FP services by updating providers' knowledge about the latest developments in contraceptive technology. The workshop, "Contraceptive Technology: Evidence-based Facts", took place in Bishkek on June 2-3, 2008.

I. Training of Trainers Workshop on Postpartum and Postabortion IUD Insertion

The WHO recommendations for timing of IUD insertion indicate that postpartum insertion up to 48 hours after delivery and immediate postabortion insertion are safe³. Furthermore, these are ideal times to provide a woman with contraception: Women who have just delivered a child generally want to wait before their next pregnancy, and woman undergoing an elective abortion generally want to avoid pregnancy. In addition to being convenient for the client, there are significant time and cost savings to the health system as well as to clients with immediate postpartum and postabortion contraception.

Current IUD insertion practices. IUD use is widespread in Tajikistan and Kyrgyzstan, with many obstetrician-gynecologists skilled at interval insertion. The Regional Activity planned this activity because of barriers to postpartum and post-abortion IUD use.

Postpartum. Most providers in Kyrgyzstan and Tajikistan have been taught that the best time for postpartum IUD insertion is three to five days after delivery. This practice was taught previously. The rationale for waiting this period after delivery is to minimize the risk of infection with insertion. The providers and medical faculty who attended the training confirmed that they indeed teach and insert IUDs three to five days after delivery. This practice is unsafe, according to the medical literature. Research indicates that the safest time to insert IUDs postpartum is within 48 hours after delivery of the placenta. After 48 hours, the cervix has closed enough to require the use of an inserter for IUD placement. The postpartum uterus, however, is soft in the first few weeks after delivery, and using an inserter risks uterine perforation. Thus, WHO recommends that postpartum IUD insertion occur either within the first 48 hours after delivery, or 4 weeks or more after delivery.

Postabortion. Due to outdated clinical practice guidelines for IUD insertion, providers must subject abortion clients who want an IUD to a number of unnecessary tests and

³ Family Planning: A Global Handbook for Providers, JHUCCP and WHO, 2008
http://www.infoforhealth.org/globalhandbook/book/fph_chapter9/index.shtml

examinations prior to being able to provide the IUD (see *Contraceptive Needs Assessment and Contraceptive Technology Conference: Summary of Activities and Findings: Tajikistan and Kyrgyzstan*). Because of unfounded fears about infection risks and national guidelines that require hemoglobin and sexually transmitted infection testing, many abortion clients are denied IUDs immediately postabortion. They must return after a period of time, which risks losing clients.

Training Activity and Outcomes

Drs. Kelly O’Hanley and Larisa Agababyan, consultants to the Regional Activity and Ms. Vera Zlidar, the Regional Activity’s Family Planning Advisor, traveled to Jalalabat, Kyrgyzstan August 28-30 to hold a Training of Trainers workshop on postpartum and postabortion IUD insertion.

This training of trainers focused on:

- Presenting the evidence base for timing and safety of IUD insertion practices
- Dispelling commonly-held myths about postpartum and postabortion risks, based on the Regional Activity’s knowledge of IUD insertion practices in the region
- Learning counseling points specific to postpartum IUDs that are crucial to obtaining informed consent, including postpartum expulsion rates (which are higher than expulsion rates for interval IUD insertion)
- Providing opportunities to develop competency in postpartum IUD counseling and insertion through use of models, counseling clients, and inserting IUDs in clients who requested and consented to the method

The Regional Activity used the postpartum IUD manual recently developed by EngenderHealth. They are grateful to EngenderHealth providing them an advance copy of the manual so that it could be translated into Russian in time for the training, and has made the Russian language version available to EngenderHealth to make more widely available. The Regional Activity has developed slides to go with the training manual, which they provided to EngenderHealth for their use. The Regional Activity has also widely distributed the Russian version throughout the Commonwealth of Independent States.

Participants. Eighteen participants from Kyrgyzstan and Tajikistan—midwives, obstetrician/ gynecologists, professors, and family medicine doctors attended the Training of Trainers, including those involved in pre-service, in-service and postgraduate accreditation organizations. These participants were selected because they had the ability to disseminate the new guidance, information, and insertion skills to their own facilities/ programs/departments. Furthermore, they were all experienced IUD providers.

Training schedule. The objectives of this training were to increase participants' knowledge about safe postpartum and postabortion IUD insertion, and develop the

clinical skills to do and teach others to do such insertions. The three-day training of trainers included:

- Theoretical/research components: Postpartum anatomy, research articles with evidence on the timing of insertion, data on expulsion rates, etc)
- Practice on models
- Counseling postpartum and postabortion women about family planning options after delivery and abortion, including obtaining informed consent for IUD insertion
- Inserting and/or observing insertions on clients



Training participants discuss what was most valuable to them at the end of the PP IUD training.

Six postpartum insertions were attempted and all six were successful. These insertions were all immediate PP instrumental insertions (that is, within the first 48 hours after delivery). No post-placental insertions were attempted, since none of the clients in the pathology ward who had been counseled about this option delivered while the training was taking place.

When the trainees were discussing family planning options with women who had recently delivered a child, two other women wanted an IUD. More than 48 hours had passed since delivery, however, and so they were ineligible to receive it. Thus these women were counseled to request an IUD at their first postpartum visit. Interestingly enough, the obstetricians at the maternity who helped these women deliver were upset that their clients were “denied” an IUD. This was another valuable teaching moment—with trainees explaining the rationale for delaying insertion to the local providers who were practicing differently. This situation generated much discussion among the providers in the Jalalabat Oblast Maternity where the training was taking place, with many of the providers wishing they could participate in the training. This clearly underscored the need for educating IUD providers in the region about safe postpartum insertion guidelines. It also appeared to have made an impact on postpartum IUD insertions in the maternity (see Figure 1, p. 21).

Postpartum and Post-abortion IUD Insertion: Helping Clients Obtain Complementary Services during One Visit

Imagine a woman with eight pregnancies by the time she is 30 years old, with six children to care for. She wants no more children. Yet in the village where she lives, no providers are trained and qualified to give her an IUD. This was the case with one client who obtained an IUD during the Regional Activity's postpartum/postabortion IUD training.

This was the client's second trip—and second abortion—to the clinic in Jalalabat in seven months. She came to the clinic with her daughter in tow. When she received counseling her about her family planning options prior to the procedure, this woman was thrilled at the long-term nature of the IUD, repeating after the provider "You mean I don't have to worry about becoming pregnant for *twelve years???*" Clearly this client had an unmet need for a long-term or permanent method of contraception. She was fortunate enough to come to Jalalabat when this training was taking place, and the contraceptive supplies that she wanted—and needed—were available to her free of charge.

Unfortunately, this one woman's experience in Jalalabat is common throughout Kyrgyzstan and much of rural Central Asia. When the trainees who performed this woman's counseling and insertion discussed their experience with the rest of the group, the participants, sadly, were all too familiar with such a history. They agreed that similar situations were common in Kyrgyzstan, having seen many such women during their practice. Because family planning services—specifically, long-term and permanent methods—are not widely available in rural areas, women either resort to abortion, or have more children than they intended. Furthermore, the linkages between complementary reproductive health services and family planning are not strong, resulting in lost opportunities for these women who want and need contraception.



This young client delivered her daughter at home, alone. No one was home to take her to the maternity when she went into labor. This is her second child in two years, and she said she wants to take a break from having babies.

The trainees felt that they performed this client an invaluable service that day. They also saw how important it was to make FP methods available to women when they were seeking related reproductive health services. This experience underscored the importance of their work, the need for this training, and helped to increase the sense of urgency and commitment to helping bring complementary family planning services to their programs.

The clients tolerated the insertions very well. The most uncomfortable part of the procedure was not the insertion, but rather the vulvar preparation, due to the disinfectant containing some alcohol⁴. In fact, some clients were talking during the insertion. Some of the providers were surprised at how comfortable the clients were feeling during the insertion, and how easy the initial insertion steps were, since the cervix was so open. The trainers took this as an opportunity to review the difference between postpartum anatomy and anatomy during interval IUD insertions.

Changes in Knowledge. A pre-test with true/false questions was given to assess trainee's knowledge of proper postpartum and postabortion IUD practices. The main categories for the 25 questions were:

- Postpartum anatomy and physiology
- Counseling and informed choice
- Medical eligibility criteria
- Infection prevention
- Insertion technique
- Follow-up
- Managing any problems

The average score for the pretest was 73.7%, ranging from 56.0% to 96.0%. The same questions were given to participants after the training as a post-test. The average score was 88.7% (range, 80.0% to 96.0%). Using a two-sided Student's T-test to assess whether the 15 percentage point increase was significant found that this increase was indeed significant at the $p = .001$ level.

The questions with the largest increases in knowledge were about postpartum reproductive anatomy and how that affects IUD insertion, timing of postpartum IUD counseling, and likelihood of post-placental expulsion versus immediate postpartum insertion. These concepts are crucial to quality service provision, including obtaining proper informed consent. Interestingly, even after the training, the providers still considered marital status as an essential part of the client history. It may be that they use marital history as a proxy for assessing a client's risk of sexually transmitted infections, some of which are a contraindication to IUD use.

⁴ This situation also shows just how difficult it is to change some entrenched practices. The day before the training, the trainers met with the maternity managers to discuss what materials and supplies should be prepared for the training, including chlorhexidine—a water-based antiseptic. During this discussion, the local staff questioned not using alcohol, since this is routinely used for antiseptic purposes. The trainers assured them that we indeed did not need alcohol—it is painful to the client, and dries out the mucosa. Yet when the facility prepared the materials, they had evidently added alcohol to the chlorhexidine.

Trainee Comments. During and after the training, some of the comments made by the trainees highlighted what a good fit this activity was for the region:

- When I was invited to the training, I thought to myself “What are they going to teach me about postpartum IUD insertion? I already know about it.” Now I realize just how much I *didn't* know about postpartum IUDs.”
- It's such a big difference between watching and actually doing. It looks easy when someone else is doing it, but it's a lot harder when you are actually doing it! I am so pleased I had the opportunity to do an insertion.
- Using the Kelly forceps made the insertions so easy! The forceps were heavy and nice and dull, easy to use without worrying about nicking the cervix, as with the sharper forceps I generally use. (The Regional Activity provided these forceps for the training, and gave each participant one pair of forceps to take back to their institutions to help encourage immediate postpartum IUD insertions.)
- Postpartum insertion is very different from interval or post-abortion insertion in several ways:
 - You have to insert with the curve of the postpartum uterus
 - You need to exert slight pressure to move past the upper uterine segment
 - You must rotate the forceps 90 degrees prior to withdrawing them to leave the IUD in place.
 - Traction of the cervix will bring the uterus down, which makes insertion easier.



A trainee shows the client the IUD she is about to insert. Under the watchful eye of a master trainer, participants learned the special technique required for immediate postpartum IUD insertion.

Training Impact: Changes in Immediate Postpartum IUD Provision

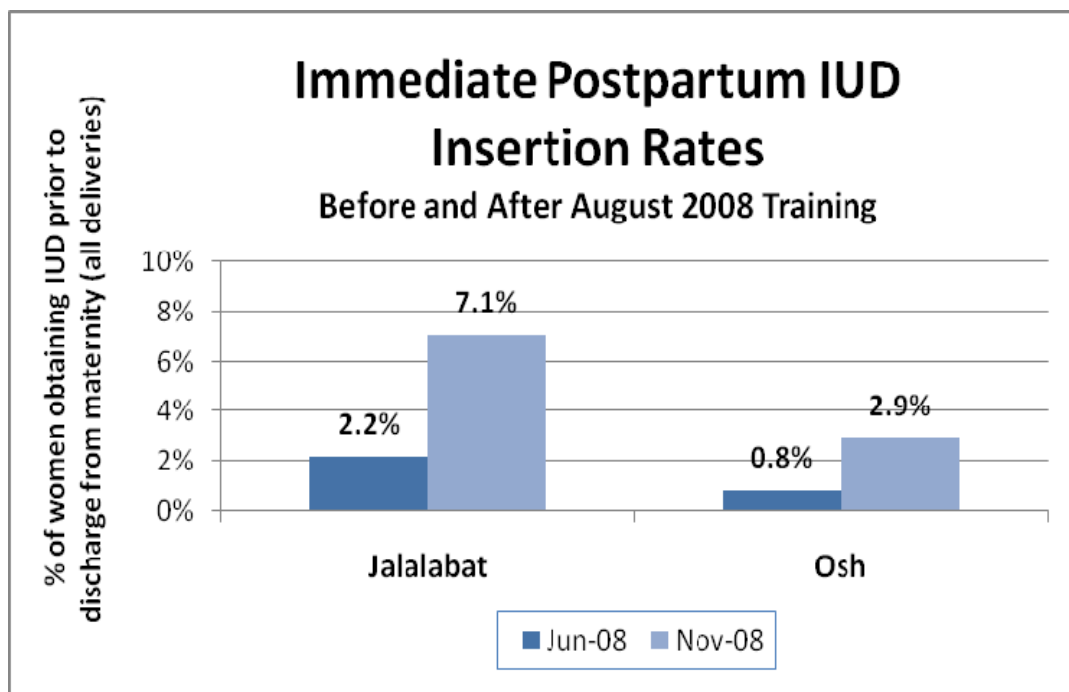
To assess whether the training had an impact on the way providers practice, the Regional Activity conducted follow-up and obtained delivery and IUD data from two maternities in Kyrgyzstan. Two providers attended the training from Jalalabat Oblast Maternity Hospital, where the training was held. Two other participants came from Osh Maternity Hospital.

Data from June 2008 and November 2008 show that there was a strong upward trend in postpartum IUD insertion prior to discharge in selected maternities where providers had attended the postpartum IUD training (see Figure 1).

Postpartum IUD insertion increased 2.5 times in Jalalabat Oblast Maternity Hospital and 3.5 times in Osh Oblast Hospital maternity ward in five months.

With sustained support—that is, ensuring that IUDs, long, curved, forceps to help with immediate PP insertion, program development, supportive supervision and any necessary refresher training are available to these facilities—it is likely that IUD uptake would continue to increase. Women’s reproductive histories in the region suggest considerable latent demand for limiting children, and for many rural women, obtaining an IUD in the maternity after delivery is their only chance at obtaining contraception before they return home.

Figure 1. Increase in Immediate Postpartum IUD Insertions after Training Activity



Next Steps. A discussion on the final day of the training was about how the participants will to use the information and techniques learned during the training. Participant responses varied depending on where they worked and what position they held within that organization. Responses included:

- Report on the new techniques and information to their health care facility when providing an update on what took place during the training
- Incorporate information from the slides and manual into medical school, in-service, and post-graduate IUD curricula
- Incorporate this training activity into the institute for postgraduate education for obstetrician/gynecologists and general practitioners
- Consider how postpartum and postabortion IUD insertion can be measured and incorporate monitoring and evaluation of such insertions into their work

- Work with antenatal care providers to ensure postpartum contraception is part of the care received during pregnancy
 - Develop standards and checklists for antenatal care counseling to including counseling on family planning
 - Have women's choice of postpartum family planning method to be documented in the woman's antenatal card so that the maternity can provide the woman with her method of choice
- Replicate the training in their own facilities. The participants were open about how acceptance of postpartum IUD insertion in particular will vary:
 - Some said that their colleagues will feel as if postpartum IUD insertion is nothing new (despite the fact, they noted, that they are doing the insertions when the risk of uterine perforation is increased)
 - Others talked about how postpartum insertion is something that is not done in their facility, and how such an activity will be interesting and exciting for their colleagues.

Future Needs

Postpartum and post-abortion IUD insertions are not routinely done in Kyrgyzstan and Tajikistan. When such insertions are done, they are characterized by unnecessary and/or unsafe procedures. Future activities that can help improve the quality of postpartum and postabortion IUD insertion include:

- Incorporate postpartum IUD insertion as part of undergraduate, post-graduate, and continuing medical education training programs for obstetrician-gynecologists and midwives
- Develop linkages between antenatal care family planning counseling and women's contraceptive choices, so that decisions about family planning made during pregnancy can be acted on in the maternity after delivery and before discharge
- Procure IUD kits and long, curved forceps for maternities practicing immediate postpartum IUD insertion
- Ensure adequate IUD supply in maternities and facilities where abortions are performed



A midwife from the Dushanbe Reproductive Health Center prepares to insert an IUD on a woman the day after she has given birth. In addition to learning about postpartum IUD insertion, the training focused on improving participants' infection prevention practices.

- Include post-placental and immediate postpartum IUD insertion as a component of Making Pregnancy Safer activities, including training providers on such insertions during essential perinatal care trainings

Monitoring and Evaluation

Monitoring and Evaluation (M&E) are key aspects of the continued success of the Regional Activity. M&E are fully integrated into all aspects of the Activity and not seen as stand-alone activities. The purpose of the M&E activities is to keep track of the progress of the project in achieving its goals and to assist with the overall project management.

The Regional Activity has developed a M&E Plan that follows the U.S. Agency for International Development (USAID) guidance on Performance Monitoring Plans* and JSI's own Basic Management Package which was developed to assure quality to JSI's clients. The Plan details the Activity's approach to M&E, data sources, data collection methods, and indicators of performance and effectiveness. Through performance M&E, the Regional Activity measures, analyzes, interprets and reports on activities and outcomes to ensure effective program implementation and achievement of results. Based on the Tajikistan and the Kyrgyz Republic work plans and timelines, specific indicators were developed to track the progress of the efforts in each of these countries.

Activity performance indicators measure the direct outputs of one or more activities, and are designed primarily to inform management decisions and ensure that activities are on track. We use specific indicators for each Activity component. For the Tajikistan and the Kyrgyz Republic activities, one such indicator is, "Number of meetings with senior health authorities held in Dushanbe." *Effectiveness indicators* measure the direct effects that should stem from completion of program tasks, and are indicators of the desired results for the Activity. "Increased knowledge of proper postpartum and post-abortion IUD practices" is an example of one effectiveness indicator. For the Tajikistan and the Kyrgyz Republic component, progress on these indicators is available from program records as the activities whose progress they measure are completed.

An internal monitoring system has been put in place that enables project staff to track inputs, processes, and outputs for each activity. The table in Appendix 1 shows the status of all the Tajikistan and the Kyrgyz Republic indicators. From this table, we can see that the project is on target and has completed the majority of its activities. The one remaining activity is to submit IUD Clinical Practice Guidelines and Protocols to the MOH, which is scheduled to happen in March 2009.

It is clear that the work conducted in these two countries has been effective, as reflected in the changes in knowledge amongst participants in the trainings described in detail in this report. For example, the changes in participants' knowledge from pre- to post-training for all of the training activities ranged from +15% to +21.4%.

* Pricewaterhouse Coopers (2001). *The Performance Monitoring Toolkit for USAID*, under the Integrated Managing for Results Contract.

These numbers reflect significant increases in participants' knowledge of minilaparotomy, the IUD, and proper postpartum and post-abortion IUD insertion.

As an initial indication of the long-term effects of the activities in these countries, we can see from Figure 1 that the uptake in IUD use has increased in both Jalalabat and Osh after the trainings in the Kyrgyz Republic. In addition, counseling on the availability of minilaparotomy has become ingrained among the eight providers in Tajikistan who have undergone VSC training. Future increases in the uptake of these methods can be directly attributable to the combined efforts of the Regional Activity to improve the family planning environment in each of these countries.

Conclusions

The Regional Activity had a modest budget for their activities in Central Asia, yet made strong contributions to improving the quality of service provision for long-term and permanent contraceptive methods in the region. This was done by selecting the activities that would have the most impact. The project responded to local needs and requests by modifying its work plan to address needs and gaps identified by in-country counterparts. The Regional Activity leveraged the resources and activities of existing projects by partnering with UNFPA, the National Center for Reproductive Health, Project Hope, and the ZdravPlus Project.

The last comprehensive family planning quality improvement efforts in CAR were held in the early 1990s. These trainings were highly regarded and very desperately needed—providers speak to this day about the tremendous changes that were needed in family planning service provision when those investments took place.

While some strides have been taken, many family planning needs are evident throughout the region. Such needs include:

- Provide evidence-based, up-to-date information on safe and effective provision of family planning services. The low scores on many Regional Activity pre-tests indicate that knowledge of proper family planning practices/evidence-based facts about contraceptive technology in Central Asia is low.
- Strengthen local capacity to identify evidence-based family planning materials, recommendations, and guidance and incorporate them into their pre-service and in-service teaching and training materials.
- Update national guidelines and protocols for providing all FP methods, so that unnecessary tests and examinations are no longer mandated by law, and barriers to access are eliminated.
- Develop competency and certify all nurse-midwives in IUD insertion, particularly in the most remote, mountainous regions of CAR. After this level of provider has been trained, general practitioners should undergo the same training, competency, and certification in IUD provision.
- Strengthen linkages between family planning service provision where abortion services and maternity/delivery services are provided.

- Overcome provider bias against permanent methods, so that women who have completed their childbearing—usually at an early age—can have a choice of methods for contraception, rather than just the IUD and thus, increasing the capacity for providing VSC.

Currently no USAID-funded projects in Kyrgyzstan or Tajikistan focus solely on improving the quality of care of family planning services. This component is a secondary or tertiary piece of other projects focusing on social marketing or health sector reform. Yet as can be seen in the points above, significant needs in the family planning arena exist in the region. Meeting these family planning service provision needs would help these countries achieve their Millennium Development Goals as they relate to maternal and child health, well-being, and survival. Investing in improving family planning services in CAR has the potential to provide many benefits to the health of women and children in the region, and should be given priority consideration when developing future activities.

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