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# KYRGYZSTAN

## FAMILY PLANNING SITUATION ANALYSIS 2007



The Europe and Eurasia Regional  
Family Planning Activity

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## ACRONYMS

ADB	Additional outpatient drug benefit
CHW	Community health worker
CME	Continuing medical education
COC	Combined oral contraceptive
CS	Contraceptive security
DMPA	Depo Provera
E&E	Europe and Eurasia
EDL	Essential drug list
FAP	<i>feldsher akusher</i> (midwife) point
FD	Family doctor
FGP	Family group practice
FMC	Family medicine center
FP	Family planning
GDP	Gross domestic product
IUD	Intrauterine (contraceptive) device
JSI	John Snow, Inc.
LAM	Lactational amenorrhea
LMIS	Logistics management information system
MHI	Mandatory health insurance
MOH	Ministry of Health
ob/gyn	Obstetrician/gynecologist
OC	Oral contraceptive
PHC	Primary health care
PSI	Population Services International
RH/FP	Reproductive health/family planning
RHIC	Republican Health Information Center
SDC	Swiss Agency for Development and Cooperation
SS	Supportive Supervision
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VFS	Voluntary female sterilization
WHO	World Health Organization

## SUMMARY

Kyrgyzstan has faced considerable economic decline and hyperinflation since its independence in 1991. About 65 percent of the population currently lives below the national poverty line, with a gross domestic product (GDP) per capita of \$1,620 in 2005. Government spending on health has decreased from 4 percent of GDP in 1995 to 1.8 percent in 2003, leading to deterioration of the health infrastructure and declining quality of services. However, the authorities have implemented broad health care reform measures, including strengthening family medicine-based primary health care (PHC), rationalizing the hospital sector, and introducing mandatory health insurance (MHI) covering more than 85 percent of the population.

### TEN BEST FAMILY PLANNING PRACTICES IN THE EE/EA REGION

To better understand the situation in Kyrgyzstan, the Activity reviewed progress against ten regional best family planning policy and program practices. This list is based on the 2005 Senlet and Kantner report, “An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region,” a recent literature review on global best family planning practices and programs, and field interviews in selected countries participating in USAID’s Europe and Eurasia Regional Family Planning Activity program. These best practices include:

1. **Liberalized provision of FP services.** National health regulations require that family planning counseling and services are readily available through a range of health professionals, including not only obstetricians and gynecologists, but also family doctors, general practitioners, pediatricians and nurse/midwives.
2. **Family planning counseling, services and contraceptives are part of the Basic Health Benefit Package.** At the primary health care level contraceptives are provided to all women, regardless of ability-to-pay. A mix of different types of contraceptives are part of the country’s Essential Drug List.
3. **Up-to-date and evidence-based policies, regulations, guidelines, standards and supportive supervision systems are in place to ensure the quality of family planning services at all levels of health care:**
  - a) **Service providers** – A competency-based national qualification system is in place that allows health professionals to provide quality family planning counseling and services;
  - b) **Up-to-date national regulations set minimum standards** for health facilities, equipment, commodities and infection prevention;
  - c) **National guidelines and protocols for family planning counseling and service delivery** are evidence-based, widely available and updated regularly;
  - d) **Effective quality assurance and supportive supervision systems** are in place to ensure the quality of family planning services and strengthen provider performance and support, especially at the primary health care level;
  - e) **National health protocols** require that postpartum and post-abortion women are offered family planning counseling, methods and services;
  - f) **Breastfeeding and the Lactational Amenorrhea Method (LAM)** are promoted as family planning methods.

4. **A broad range of family planning methods are available, accessible, affordable, and acceptable** in both rural and urban areas.
5. **Special programs are in place that are designed to meet the needs of vulnerable target groups**, such as adolescents, internally displaced persons (IDPs), new urban migrants, prostitutes, and the very poor.
6. **Family Planning is part of pre- and in-service training programs for health care providers.** This includes the pre-service training programs in medical universities and technical schools for nurses, as well as in-service training for continuing medical education for doctors and in-service training for re-licensing health professionals, including midwives and nurses.
7. **Contraceptive security is ensured through adequate planning within the government**, guided by a well-functioning Logistics Management Information System (LMIS) that enables targeting of subsidized contraceptives and efficient supply chain management of all contraceptive commodities throughout the country.
8. **Adoption of a “culture” that promotes family planning counseling**, where providers and clients engage in frank and regular conversation about sensitive reproductive health issues and family planning and appropriate services are offered.
9. **Family planning is actively promoted through social marketing and behavior change/social mobilization efforts**, including wide distribution of quality informational materials for clients and “job aids” for providers.
10. **A well-functioning national health management information system collects, analyses and uses FP data** to monitor progress and evaluate and improve program effectiveness.

Kyrgyzstan can serve as a model best practice country in the region for its regulatory environment and its support for the provision of FP services, including IUD services, by family doctors (FDs), nurses, midwives, and *feldshers*. It also can share its success in the structure and operation of its contraceptive commodity logistics management information system (LMIS). At the same time, there is room for further improvement. The following table describes Kyrgyzstan’s progress against the ten family planning best practices described above.

**Summary Table of the Kyrgyzstan Situation Analysis**

<b>Best Practices</b>	<b>Existing Situation</b>	<b>Needs Improvement</b>
#1: Liberalized provision of FP services	<ul style="list-style-type: none"> <li>• FP services provided by FDs, midwives, nurses and feldshers making most FP methods available at PHCs</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable</li> </ul>
#2: Family planning counseling, services and contraceptives are part of the Basic Health Benefit Package	<ul style="list-style-type: none"> <li>• Contraceptives included in the national EDL</li> <li>• State-subsidized contraceptives available for insured; donated FP methods available for uninsured</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable</li> </ul>

#3: Up-to-date and evidence-based policies, regulations, standards, guidelines and supportive supervision are in place	<ul style="list-style-type: none"> <li>• WHO Eligibility criteria in use in pilot regions</li> <li>• National evidence-based guidelines to be available in 2008</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of supportive supervision</li> <li>• Health facility criteria for FP service provision need updating</li> </ul>
#4: A broad range of FP methods are available, accessible, affordable, and acceptable in both rural and urban areas	<ul style="list-style-type: none"> <li>• Wide range of FP methods both affordable and available</li> <li>• LAM promoted as a FP method</li> <li>• Health regulations require postpartum/abortion patients to receive FP counseling</li> </ul>	<ul style="list-style-type: none"> <li>• Permanent methods of contraception are not widely available or used</li> </ul>
#5: Special programs are in place designed to meet the needs of vulnerable target groups	<ul style="list-style-type: none"> <li>• Some youth friendly services available</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable</li> </ul>
#6: Family planning is part of pre - and in-service training for health care providers	<ul style="list-style-type: none"> <li>• Pre-service medical curriculum and in-service training courses for family doctors have been updated with WHO Medical Eligibility Criteria for Contraceptive Use</li> <li>• Nursing/Midwifery post-graduate course in RH/FP available</li> <li>• CME requires postgraduate FP training</li> <li>• In-service training for nurses and midwives in IUD provision conducted and sponsored by USAID and UNFPA</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of pre-service training in FP in nursing education</li> </ul>
#7: Contraceptive security is ensured through adequate planning within the government	<ul style="list-style-type: none"> <li>• National LMIS ensures donated commodities are distributed where and when needed</li> </ul>	<ul style="list-style-type: none"> <li>• Reliance on donated commodities</li> <li>• No national contraceptive security plan</li> </ul>
#8: Adoption of a “culture” that promotes family planning counseling	<ul style="list-style-type: none"> <li>• Government supports promotion of FP counseling and services.</li> </ul>	<ul style="list-style-type: none"> <li>• Provider bias against hormonal methods prevalent.</li> <li>• Providers, especially FDs lack of confidence in IUD insertion skills restricts IUD availability in rural areas</li> </ul>
#9: FP is actively	<ul style="list-style-type: none"> <li>• Unknown</li> </ul>	<ul style="list-style-type: none"> <li>• Limited social marketing</li> </ul>

promoted through social marketing and behavior change/social mobilization efforts		activities due to legal restrictions on advertising <ul style="list-style-type: none"> <li>• Lack of demand in commercial sector for commodities</li> </ul>
#10: A well-functioning national health management information system collects, analyzes and uses FP data.	<ul style="list-style-type: none"> <li>• FP logistics reporting and analysis provides best example of health information use in the region.</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable</li> </ul>

## I. PURPOSE AND METHODOLOGY

### PURPOSE

This review of the FP situation in Kyrgyzstan was conducted as part of USAID’s Europe and Eurasia (E&E) Regional Family Planning Activity. The Activity is a regional effort with the goal to leverage best practices in family planning to accelerate program implementation across the region and, ultimately, to increase modern contraceptive use and decrease abortion rates.

This desk review is designed to:

- Assess factors that affect family planning service delivery in Kyrgyzstan;
- Identify and document supportive policies and best practices in family planning program implementation; and
- Propose recommendations for scaling up best family planning practices and new interventions to improve program effectiveness and increase utilization of modern contraception.

This Kyrgyzstan review is one of a series of situation analyses in the E&E region of the FP environment in priority countries chosen for their interest in participating in this regional program. Each review provides a country background, with a special focus on describing the health care system and the status of reproductive health; describes each of ten best practices as they relate to the particular country context; and provides recommendations for focusing further interventions and resources.

### METHODOLOGY

In order to systematically assess the family planning situation in each of the priority countries, the Europe and Eurasia Regional Family Planning Activity team began by reviewing Senlet and Kantner (2005), “An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region.” Reviewers then developed a questionnaire for in-depth interviews with key informants. Persons interviewed in Kyrgyzstan are included in Annex III.

The team identified a list of ten family planning policy and program best practices based on the Senlet and Kantner assessment report, a literature review on global best family planning practices and programs, and field interviews. The team conducted a review of available documents and an Internet search to obtain additional information on country background, policies, and programs in family planning.

This review is a summary of the generally available literature with qualitative input from key stakeholders in country. The review's intention is to serve as a basis for discussion of country and regional priorities for family planning program improvement, based on the best available information. It is not intended as a comprehensive analysis of the country situation, but rather as a brief "snapshot" of this particular point of program development to guide future programming. Data included in this report are valid through the first quarter of 2007. Due to rapidly changing circumstances in the country, some information may have already changed.

## II. BACKGROUND

### COUNTRY CONTEXT

Since its independence in 1991, the Kyrgyz Republic has faced considerable economic decline and hyperinflation, mainly due to disruption in almost 98 percent of its export markets in the former Soviet countries. About 65 percent of the population currently lives below the national poverty line. With a GDP per capita of \$ 1,620 purchasing power parity in 2005, Kyrgyzstan is the second poorest country in the region after Tajikistan. High unemployment (17.7 percent in 2006), insufficient housing, unequal distribution of income, and labor migration are key poverty indicators. The government has implemented broad systemic reforms to create the foundation for a market economy. These have helped maintain an average annual GDP growth of 5 percent since 1996. However, political turbulence in recent years had a negative impact on the economy, reducing real GDP growth rate from 6.7 percent in 2003 to 2.7 percent in 2006<sup>1</sup>. Agriculture accounted for about 35 percent of GDP and almost half of employment in 2006.

Kyrgyzstan is divided into seven administrative provinces (*oblasts*) and forty districts. Over 93 percent of the country is mountainous, with 40 percent of this rugged terrain higher than 3,000 meters. Of the almost five million Kyrgyz people, 65.7 percent are ethnic Kyrgyz, 13.9 percent are Uzbek, and 11.7 percent Russian.<sup>2</sup>

### HEALTH CARE SYSTEM

Government spending on health has decreased from 4 percent of GDP in 1995 to 1.8 percent in 2003, leading to deterioration of the health infrastructure and declining quality of services. The government has adopted a comprehensive framework to halve poverty in the period 2001–2010 by improving social and health services, ensuring good governance, and preventing the spread of HIV/AIDS. Implementation of Manas Taalimi Health Care Reform (2006–2010) will build on previous health reform efforts that have already resulted in strengthened family medicine-based PHC and rationalization of the hospital sector. In order to pool more resources for health and address high household informal payments, in 1997, the government introduced mandatory health insurance (MHI), which covers more than 85 percent of the population. In addition,

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<sup>1</sup><http://www.state.gov/r/pa/ei/bgn/5755.htm>

<sup>2</sup>UNDP in Kyrgyzstan: <http://www.un.org.kg/english/country.phtml>

formal co-payments for services and drug subsidies in the form of an additional outpatient drug benefit (ADB) package were introduced in 2003.

## **REPRODUCTIVE HEALTH**

Kyrgyzstan has recently adopted an official RH strategy and in general has achieved notable improvements in the delivery of RH/FP services over the past several years. The government eliminated women's outpatient clinics ("women's consultations") and integrated RH/FP counseling and services into PHC services and maternity hospitals. Contraceptives are included in the national essential drug list (EDL) and, as an ADB benefit, clients who have MHI can purchase four different types of combined oral contraceptives (COCs) and one injectable (DMPA) at pharmacies at government-subsidized prices. In addition, contraceptives (OCs, condoms, IUDs, and injectables) donated by USAID, UNFPA, and the Global Fund are widely provided free of charge at health facilities where family planning services are offered. Each of the seven provinces in the country has a Family Planning Center with a designated person in charge of coordinating and reporting to the Ministry of Health (MOH) on family planning services and commodities.

Almost 50 percent of married women of reproductive age use modern contraceptive methods. The introduction of modern contraceptives has resulted in more than a 50 percent decrease in the abortion rate. The infant mortality rate declined from 65 to 58 deaths per 1,000 live births between 1990 and 2005, although this rate remains one of the highest in the E&E region. With the deterioration of the health infrastructure, the frequency of unattended births is increasing and the maternal mortality ratio remains very high at 110 deaths per 100,000 live births. Indeed, a recent survey performed by UNICEF and UNFPA suggests that maternal and infant mortality would be three times higher if international reporting standards were used<sup>3</sup>.

## **III. TEN BEST PRACTICES IN FAMILY PLANNING: KYRGYZSTAN**

The following describes the situation in Kyrgyzstan regarding each of the 10 best practices:

### ***BEST PRACTICE #1 – LIBERALIZED PROVISION OF FP SERVICES***

FP counseling and services, including IUD services, are fully integrated into PHC and provided by FDs, midwives, and nurses at the family medicine centers (FMC), independent family group practices (FGP), and *feldsher akusher*/medic-midwife points (FAP). USAID-, UNFPA-, and Global Fund-donated contraceptives (OCs, condoms, IUDs, and injectables) are provided to all clients free of charge at PHC facilities. This integration was made possible by donor and government efforts to plan and implement health care reforms, including changes in infrastructure, health financing, and service delivery.

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<sup>3</sup> <http://www.unfpa.org/profile/kyrgyzstan.cfm?Section=1>

## POTENTIAL FOCUS AREAS

- **The regulation and provision of family planning services, including IUD services, by FDs, nurses, midwives, and *feldshers* in Kyrgyzstan is a success and best practice and could be proposed for replication in other countries in the region.**

### ***BEST PRACTICE #2 – FAMILY PLANNING COUNSELING, SERVICES, AND CONTRACEPTIVES ARE PART OF THE BASIC HEALTH BENEFIT PACKAGE***

The State Health Benefit Package provides family planning as part of PHC services offered free of charge to all clients who have MHI. Insured clients with a prescription from the FMC and/or FGP can purchase four brands of oral pills and one injectable (DMPA) at state-subsidized prices at pharmacies. These specific contraceptives are included in the national EDL. Still, an estimated 450,000 uninsured are deprived of free services at PHC facilities and do not have access to ADB. Nevertheless, both insured and uninsured clients are eligible to receive donated contraceptives.

## POTENTIAL FOCUS AREAS

- **Work with the MOH to extend provision of affordable family planning services to those not covered in the mandatory health insurance scheme.**
- **Conduct awareness-raising campaigns to inform the uninsured of where they can receive donated contraceptives.**

### ***BEST PRACTICE #3 – UP-TO-DATE AND EVIDENCE-BASED POLICIES, REGULATIONS, STANDARDS, GUIDELINES AND SUPPORTIVE SUPERVISION SYSTEM ARE IN PLACE TO ENSURE QUALITY OF FAMILY PLANNING SERVICES AT ALL LEVELS OF HEALTH CARE***

The USAID-funded *ZdravPlus* project, in collaboration with WHO and UNFPA, has adapted the WHO guidelines on *Medical Eligibility Criteria for Contraceptive Use* and introduced them in several pilot regions. The MOH has adopted a number of clinical protocols for FDs on family planning service delivery and aims to have evidence-based, unified national guidelines and protocols for family planning and RH by the end of 2008. The MOH has requested assistance from international donors to fulfill this plan.

There are several old Soviet regulations governing standards and norms for how family planning services may be provided at all three health facility levels. For example, in order for a facility to be certified to provide family planning services, it has to offer at least three types of FP methods. The MOH has decided to revise existing standards and norms for health facilities and update them based on WHO recommendations and contemporary medical evidence.

The confidence of service providers at the PHC level in their family planning skills varies. Providers trained as gynecologists are the most confident, while others often feel uncomfortable providing family planning methods, especially IUDs, and seek trained gynecologists' advice or refer clients to them. On-the-job training and a supportive supervision (SS) system for service

providers are fragmented or absent in most places. To our knowledge, no programs are implemented to address this problem.

## POTENTIAL FOCUS AREAS

- **Continue collaboration with UNFPA and WHO to assist the MOH in the development, adoption, and institutionalization of unified national family planning service clinical guidelines, protocols, standards, and norms for health facilities where FP/RH services are offered.**
- **Provide on-the-job refresher training in family planning counseling and contraceptive technology, including IUD insertion and removal, for service providers at the PHC level in USAID pilot areas. Advocate for scaling up such trainings at the national level.**
- **Design a framework for a supportive supervision system and tailor it to ongoing health reform and existing PHC quality assurance mechanisms. Develop curricula, training materials, and tools for Supportive supervision training.**
- **Work with the MOH to integrate supportive supervision for family planning services into the PHC service quality improvement framework.**

### ***BEST PRACTICE #4 – A BROAD RANGE OF FAMILY PLANNING METHODS ARE AVAILABLE, ACCESSIBLE, AFFORDABLE AND ACCEPTABLE IN BOTH RURAL AND URBAN AREAS***

Twenty-six contraceptive methods are authorized for use in Kyrgyzstan, including OCs, injectables, IUDs, condoms, spermicides, and implants. Of these, six types of contraceptives (male and female condoms, injectables, COCs, progestin-only pills, and IUDs) donated by UNFPA, USAID, and the Global Fund are widely distributed through the public PHC service delivery system. Results of a survey conducted in 2004 by the Health Insurance Fund and UNFPA indicate that more than 95 percent of respondents believe that contraceptives are accessible and affordable, and about 60 percent believe they had sufficient information on methods.<sup>4</sup>

Ob/gyns at maternity hospitals promote exclusive breastfeeding on demand, both for infant nutrition and as LAM/postpartum contraception. Breastfeeding is popular and widely practiced in both rural and urban areas. According to the MOH Statistics Department, postpartum breastfeeding is 79.9 percent at three months and 70.5 percent at six months.

MOH regulations require that all post abortion and postpartum women receive family planning counseling and services. The *ZdravPlus* project provided training for service providers on postpartum and post abortion service provision in pilot areas. This training could provide a useful base for expansion of services to postpartum and post abortion women.

UNFPA supported training in VFS for ob/gyns from ten maternity departments in provincial territorial hospitals. Despite the fact that most women of reproductive age complete their

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<sup>4</sup> *Contraceptive Security in the Central Asian Republics: Kazakhstan, Kyrgyzstan, and Tajikistan*. Fall 2006. Washington: USAID/DELIVER and PSP-One projects, p 57.

childbearing intentions in their mid 20s, less than 1 percent of them use permanent methods of contraception.

#### **POTENTIAL FOCUS AREAS**

- **Intensify promotion of LAM in pilot districts and advocate for its nationwide implementation.**
- **Based on the experience of the ZdravPlus project, assess and address barriers for postpartum and post abortion women to family planning service delivery in pilot areas.**
- **Study reasons for low utilization of VFS services and develop a plan to eliminate barriers to services.**
- **Coordinate with UNFPA to use its qualified specialists to provide training in VFS in pilot regions and provide appropriate equipment and medical commodities to enhance VFS service provision.**
- **Collaborate with UNFPA on its male involvement program to help generate demand for use of male methods, including no-scalpel vasectomy.**

#### ***BEST PRACTICE #5 – SPECIAL PROGRAMS ARE IN PLACE DESIGNED TO MEET THE NEEDS OF VULNERABLE TARGET GROUPS***

UNFPA supported the establishment of Y-PEER—participation in a regional youth peer education network—that brings together all partners working in the field of youth sexual and reproductive health and provides resources for peer education activities. The program also works with service providers to introduce methodologies and guidelines for youth-friendly FP/RH services. Additional information on programs for other vulnerable groups was not available for our review.

#### **POTENTIAL FOCUS AREAS**

- **Consider development of a training program for pharmacists and other providers in youth-friendly family planning service delivery in pilot areas.**
- **Collaborate with UNFPA and promote the Y-PEER network in USAID program pilot areas.**
- **Advocate with the MOH and local and international organizations to design and implement FP programs that meet the needs of vulnerable groups such as street youth, prostitutes, and new urban migrants.**

#### ***BEST PRACTICE #6 – FAMILY PLANNING IS PART OF PRE- AND IN-SERVICE TRAINING FOR HEALTH CARE PROVIDERS***

The MOH's commitment to improving service provider education is seen in its establishment of the Evidence-Based Medicine Institute in 2006 and adoption of a post-graduate training curriculum on reproductive health and family planning for nurses and midwives. Both the pre- and in-service training curricula in FP for FDs have been updated, based on WHO recommendations and other state-of-the-art evidence. The Kyrgyz State Medical Institute, which

has branches in all seven provinces, provides in-service training of FDs. Existing regulations on medical licensing require that every provider receive in-service training in family planning through a continuing medical education program (CME) and take a licensing exam every five years. USAID's *ZdravPlus* project and UNFPA sponsored trainings for midwives and nurses in IUD service provision in their respective pilot sites. Still, many service providers at the PHC level lack information regarding the effectiveness and safety of contraceptives, especially hormonal methods.

#### POTENTIAL FOCUS AREAS

- **Provide on-the-job refresher training in contraceptive technology for service providers in the pilot areas where USAID-donated contraceptives are distributed. Advocate for scaling up such trainings to the national level.**
- **Work with the MOH and the State Medical Institute to evaluate and strengthen the family planning component of the CME program.**
- **Coordinate with UNFPA and work with the MOH to develop and introduce a pre-service family planning training curriculum in nursing education.**

#### ***BEST PRACTICE #7 – CONTRACEPTIVE SECURITY IS ENSURED THROUGH ADEQUATE PLANNING WITHIN THE GOVERNMENT***

UNFPA, the Global Fund, and USAID will supply quantities of contraceptives that should suffice for the next three years. This cushion may partially explain the MOH's reluctance to begin setting up contraceptive procurement structures and procedures. This could result in a situation where there will be no national or local procurement plans in place when donations end. The national RH strategy does not mention contraceptive security (CS) as a fundamental element for assuring sustainable availability of FP methods.

UNFPA provided technical assistance to the MOH to establish its LMIS. At the central level, the LMIS, or Country Commodity Management System, is located within the Republican Health Information Center (RHIC). All rural health facilities routinely submit quarterly reports to *rayon* FMCs, which are further consolidated at Oblast Health Information Centers and then electronically transmitted to the RHIC. This information is used at the national and *oblast* levels to develop contraceptive distribution plans. Currently, only donated contraceptives are distributed.

The four points in the system at which contraceptives are stored and distributed are the *central*, *oblast*, *rayon*, and *rural* health facility levels.

#### POTENTIAL FOCUS AREAS

- **Work with the MOH to incorporate contraceptive security in the Reproductive Health Strategy and develop contraceptive security transition and sustainability plans that reflect a move away from donor dependence.**

## ***BEST PRACTICE #8 – ADOPTION OF A “CULTURE” THAT PROMOTES FAMILY PLANNING COUNSELING***

The Government of Kyrgyzstan recently adopted a Reproductive Health Strategy that emphasizes promotion of family planning and the availability of services at all appropriate health facilities. Family planning counseling is well established in PHC settings: urban and rural family medicine centers, FGPs, and rural FAPs routinely offer counseling and various contraception methods. However, while all FDs working in the FMCs and FGPs are supposed to provide IUD services, typically only those trained as gynecologists feel confident to provide IUDs. Although this practice may not seriously affect the availability of IUD services in larger urban areas where gynecologists are abundant in the public sector, it could continue to restrict access to this traditionally most popular method of contraception in rural and remote areas. Providers' own preferences about contraception and biases toward or against certain methods is evident. They restrict use of certain methods because of misconceptions. The bias against hormonal contraceptives is particularly evident.

### **POTENTIAL FOCUS AREAS**

- **Consider competency-based training in IUD insertion and removal for family doctors at FGPs. Prioritize remote and rural areas in USAID pilot areas. Training should address provider bias and misconceptions about specific methods.**

## ***BEST PRACTICE #9 – FAMILY PLANNING IS ACTIVELY PROMOTED THROUGH SOCIAL MARKETING AND BEHAVIOR CHANGE/SOCIAL MOBILIZATION EFFORTS***

Low demand for contraceptives in pharmacies and legal restrictions on advertising contribute to limited commercial contraceptive activity in the country. In collaboration with JSI's CAPACITY Program, which emphasizes HIV prevention, Population Services International (PSI) manages social marketing of condoms, with a focus on high-risk groups including injecting drug users, prostitutes, and their clients. In late 2006, UNFPA initiated a pilot project on the integration of social marketing into RH and FP programs in four pilot regions in the north and south of the country. The project manages a competitive grants process that supports local nongovernmental organizations to build their capacity to conduct social marketing activities as well as increase utilization of RH services and modern methods of contraception in rural areas.

### **POTENTIAL FOCUS AREAS**

- **Kyrgyzstan could greatly benefit from an expanded social marketing program to increase the use of modern FP methods. Such a program could be combined with a partnership with a low-cost generic supplier such as Gedeon Richter or Jenapharm.**

## ***BEST PRACTICE #10 – WELL FUNCTIONING NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM COLLECTS, ANALYZES AND USES FAMILY PLANNING DATA***

The RHIC operates a computerized system that provides accurate quarterly information on the number of consumers receiving different methods of contraceptives. The RHIC also operates a well functioning contraceptive LMIS. An evaluation team from the DELIVER and PSP-One projects indicates in its 2006 report that “every decision-maker the team met at national and oblast levels was able to produce the most recent quarterly report”.<sup>5</sup> Additional data on the functioning of other national health information systems was not available for our review.

### **POTENTIAL FOCUS AREAS**

- **The structure and operation of the Kyrgyz contraceptive commodity LMIS could be proposed as a success and best practice for replication in other countries in the region.**

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<sup>5</sup> *Contraceptive Security in the Central Asian Republics: Kazakhstan, Kyrgyzstan, and Tajikistan*. Fall 2006. Washington: USAID/DELIVER and PSP-One projects, p. 65.

# ANNEX I

## FAMILY PLANNING PROGRAMS FUNDED BY USAID AND OTHER DONORS

### USAID

#### The CAPACITY Project (2004–2009)

Under the JSI-led CAPACITY project, PSI plans to implement social marketing of FP services in Kyrgyzstan. The planned intervention has two main components:

- 1) **Improving access** to contraceptives through:
  - The introduction of affordable OCs, injectables, IUDs, and emergency contraception
  - Promotion of and referral to existing points of contraceptive supply and services
  - Training of providers and supply of contraceptives through FAPs
- 2) **Increasing informed demand** for contraceptives through intensive interpersonal communications to:
  - Raise awareness of the benefits of contraceptives
  - Dispel misconceptions about their side effects
  - Provide information on available methods

#### ZdravPlus Project (2004–2009)

The ZdravPlus project contributes to FP service promotion and quality assurance through:

- Sponsored service provider training in postpartum and post abortion family planning counseling and services
- Sponsored training for midwives in IUD counseling, insertion, and removal in pilot sites, in collaboration with UNFPA, and
- The adaptation and introduction in several pilot regions—in collaboration with WHO and UNFPA—of WHO’s “*Medical Eligibility Criteria for Contraceptive Use*”

#### Project HOPE (2004–2007)

Under its maternal and child health program, Project HOPE has sponsored FP counseling training for FDs, nurses, and midwives in two districts of Batken oblast and has distributed injectable (DMPA) and oral contraceptives (Lofeminal) at no charge to clients.

## **UNFPA**

In 2007, UNFPA continues its efforts to improve the supply and distribution of RH commodities to poor and vulnerable groups and plans to:

- Strengthen the LMIS capacity of regional and district FP institutions
- Supply and advocate for key RH commodities and equipment
- Strengthen national capacity in the standardization of contraceptive distribution and monitoring of contraceptive supply quality
- Support the MOH in the establishment of mechanisms to target the poor
- Provide technical support in harmonization of data definition and collection standards, in conjunction with Medico-information Centers and the National Statistics Committee
- Strengthen national capacity to provide high-quality FP services and information through development and introduction of provider training programs, supply of medical and training equipment, and the development of training and information materials on FP based on WHO standards and evidence medicine.

## **THE SWISS AGENCY FOR DEVELOPMENT AND COOPERATION (SDC)**

With SDC funding, Project HOPE has conducted training for community health workers (CHW) in all three districts of Batken oblast on the standard days method. In turn, CHWs provide information and educate communities on this method of contraception as well as distribute free condoms as a back-up measure.

## ANNEX II

### DEMOGRAPHIC AND REPRODUCTIVE HEALTH INDICATORS: KYRGYZSAN

Indicator	Parameter
Total population	5.2 million
Population growth rate	1.4 %
Women of reproductive age (15–49 years)	1.4 million
Total fertility rate (UNFPA, 2005)	2.64
Contraceptive prevalence rate, all methods (UNFPA, 2005)	59.5 %
➤ Traditional methods (all) (PRB, 2006)	10.7 %
- Withdrawal (PRB, 2006)	6.0 %
- Rhythm (PRB, 2006)	3.2 %
➤ Modern methods (all) (UNFPA, 2005)	48.9 %
- IUD (CS CAR, 2006)	31.9 %
- Condom (CS CAR, 2006)	5.9 %
- Pill (CS CAR, 2006)	4.8 %
- Female sterilization (CS CAR, 2006)	0.9 %
Factors for not using modern methods among married women	
- Fear of side effects%	†
- Lack of knowledge %	†
- Cost %	†
- Lack of access %	†
- Religion %	†
- Partner opposes %	†
Unmet need for modern contraception (UNFPA, 2005)	11.6 %
Number of induced abortions per 1,000 live birth (MOH 2006)	8.1
Receipt of post abortion FP counseling	†
- Received a contraceptive method or prescription	†
Maternal morbidity rate attributable to abortion	†
Receipt of postpartum FP counseling	†
Infant mortality per 1,000 live births (UNICEF, 2005)	58
Maternal mortality per 100,000 live births (UNFPA, 2005)	110
Incidence of sexually transmitted infection (per 100,000)	
- Syphilis	32.7
- Gonorrhea	22.8
- Chlamydia	70.36
- Trichomoniasis	135
HIV prevalence (UNAIDS 2006)	0.1
- Number of verified HIV cases by 2004	651

† Unfortunately, this information is not available at this time.

Sources:

**CS CAR** – Contraceptive Security Study: Kazakhstan, Kyrgyzstan, and Tajikistan. PSP-*One* and DELIVER project

**PRB** – Population Reference Bureau, <http://www.prb.org/DataFind/prbdata/wcprbdata7.asp?DW=DR&SL=&SA=1>, accessed 15 03 07

**WDI** – World Development Indicators/World Bank,

<http://devdata.worldbank.org/external/CPProfile.asp?PTYPE=CP&CCODE=KGZ>, accessed 14 03 07.

**UNICEF** – <http://www.unicef.org/infobycountry/index.html>, accessed 12 03 07.

**UNFPA** – <http://www.unfpa.org/profile/compare.cfm>, accessed 15 03 07.

**UNAIDS** - <http://www.unaids.org/en/Regions/Countries/Countries/Kyrgyzstan.asp>, accessed 15 03 07

## ANNEX III

### KEY INFORMANTS INTERVIEWED

#### The CAPACITY PROJECT

Audrey Seger Sprain	Regional Operations Director JSI Research & Training Institute, Inc.
Aisuloo Kasymbekova	Finance and Administrative Manager JSI Research & Training Institute, Inc.
Leila Koushenova	Project Coordinator Population Services International

#### Project HOPE

Sarah E. Porter, MPH	Project Director/COP Healthy Family Project (Tashkent, Uzbekistan)
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#### UNFPA

Doina Bologa	Deputy Representative in Uzbekistan Deputy Country Director for Kazakhstan, Kyrgyzstan, Tajikistan, and Turkmenistan
Cholpon Asambaeva	National Programme Officer, Reproductive Health

#### ZdravPlus Project

Gita Pillai, PhD, MPH	Regional Deputy Director, ZdravPlusII Project Regional Director, Maternal and Child Health JSI Research & Training Institute, Inc.
Vera M. Zlidar	Program Associate ZdravPlusII Project

## ANNEX IV

### LIST OF DOCUMENTS CONSULTED

*Contraceptive Security in the Central Asian Republics: Kazakhstan, Kyrgyzstan, and Tajikistan.* Fall 2006. Washington: USAID/DELIVER and PSP-One projects.

*HiT Summary Kyrgyzstan.* 2005. European Observatory on Health Systems and Policies.

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*Operationalizing the Millennium Development Goals for Health: A Case Study of the Kyrgyz Republic.* 2005. Washington D.C.: World Bank.

*Order of the Minister of Health Of Kyrgyzstan to Approve a Clinical Curriculum on RH Protection and FP for Midwives, Feldshers, and Nurses in FAPs and FGPs.* March 16, 2005. Bishkek: MOH.

*Reproductive Health Trends in Eastern Europe and Eurasia.* 2003. Washington: Population Reference Bureau, MEASURE Communication project.

Senlet, P., and A. Kantner. February 2005. *An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasia Region.* Washington: USAID/POPTECH.

Westoff, C. *Recent Trends in Abortion and Contraception in 12 countries.* February 12, 2004. Princeton, USA: Office of Population Research, Princeton University.

Improving Health in Kyrgyzstan. <http://kyrgyzstan.unfpa.org/rh.htm> accessed 17 Mar 07

<https://www.cia.gov/cia/publications/factbook/print/kz.html>, accessed 5 Mar 07.

<http://www.unicef-icdc.org/research/transmonee.html>, accessed 14 Mar 07.

[http://www.nationmaster.com/graph/eco\\_pop\\_bel\\_pov\\_lin-economy-population-below-poverty-line](http://www.nationmaster.com/graph/eco_pop_bel_pov_lin-economy-population-below-poverty-line), accessed 15 Mar 07.

<http://devdata.worldbank.org/hnpstats/thematicRpt.asp>, accessed 15 Mar 07.

<http://www.prb.org/DataFind/prbdata/wcprbdata7.asp?DW=DR&SL=&SA=1>, accessed 15 Mar 07.

The ZdravPlus Project <http://zplus.kz/default.asp>.

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