

REPORTS ON THE PROJECT

Improving Reproductive Health Services and Access to Family Planning in Turkmenistan

(Project Number: TUK/96/ P02)



UNFPA
Asia and Pacific Division



WHO
Regional Office for Europe
Women's and Reproductive Health Programme

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EUROPEAN HEALTH21 TARGET 3

HEALTHY START IN LIFE

By the year 2020, all newborn babies, infants and pre-school children in the Region should have better health, ensuring a healthy start in life

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

Keywords

FAMILY PLANNING
CONTRACEPTION
HEALTH SERVICES NEEDS AND DEMAND
HEALTH SERVICES ACCESSIBILITY
TURKMENISTAN

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Preface

The project 'Improving Reproductive Health Services and Access to Family Planning in Turkmenistan' (Project Number: TUK/96/ P02) has been jointly executed by UNFPA and WHO since 1998. At national level, it has been carried out by a very competent and motivational professional team.

This document represents a summary of activities carried out during project implementation and includes recommendations for further improving reproductive health and family planning in Turkmenistan. We hope this report will be useful to national institutions and international agencies working in the field.

We would like to thank all consultants who have been put their efforts into successful implementation of the project, in particular, Dr Babill Stray-Pederson, Dr Evert Ketting, Dr Balthasar Schaap, Dr Michel Duprat, Mrs. Julia Kostenko, Dr Gayane Dolian and Dr Tarek Mahmud Hussain.

We would also like to thank the Danish Family Planning Association for hosting and organising a study tour for colleagues from Turkmenistan. We would also like to thank the national UNFPA team, UNFPA Country Office in Tashkent and Regional Division for Asia and Pacific, UNFPA, New York and the CST Kathmandu, Nepal for their continued cooperation in this project.

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PART ONE

A follow-up report regarding:

A UNFPA executed reproductive health program in Turkmenistan

Report of a mission by Balthasar Schaap, temporary WHO consultant
from 6 September – 16 September 1999.

As commissioned by WHO, Regional office, Copenhagen.

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Acknowledgement

This report is the result of a joint effort of all people met during the visit to Turkmenistan. Without their frank contribution and discussion this report would not be the same. Transport was organized wherever I had to go and all doors opened at the will of the national project coordinator, Ms. Gozel Khodjaeva.

The resident representative of the UN, Mr. Jens Wandel asked critical questions and discussed the executive summary in depth.

The executive colleagues in their clinics gave me their precious time and discussed frankly the merits and drawbacks in the execution of the project.

The trainers and trainees accepted my presence in the training sessions and provided a clear point of view on the training.

The Ministry of Health colleagues were good sparring partners in discussing topics of mutual concern. Lilya did her utmost best to translate the most intimate and difficult questions and provided me with much information.

My colleague and friend, UNFPA national program coordinator, Eziz Khelinov was an excellent host.

Thanks for the support received.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
COC	Combined Oral Contraceptives
EUG	Extra Uterine Gravity
gyn/obs	gynecologist/obstetrician
HIV	Human Immune deficiency Virus
IEC	Information Education and Communication
IUD	Intra Uterine Device
JHPIEGO	Johns Hopkins Program for International Education in reproductive health
LAM	Lactational Amenorrhea Method
MCH	Mother and Child Health
MoH	Ministry of Health
NGO	Non Governmental Organization
PAP	Classification of cervical smears on deviations at cellular level according to Papanicolau
PID	Pelvic Inflammatory Disease
RH	Reproductive Health
STD	Sexually Transmitted Disease
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Fund
WHO	World Health Organization

Preface

The consultancy was carried out between 6 and 16 September 1999. It was scheduled as WHO support to the UNFPA executed reproductive health program in Turkmenistan. Formerly the Project was supported by WHO headquarters in Geneva and is now connected with the regional office in Copenhagen.

The Copenhagen WHO office provided the following terms of reference for the mission:

1. To prepare medical protocol on all contraceptives
 - ♥ Different types of IUD
 - ♥ Oral pills (Regividon, Micronor, Triregol, Triquilar, Microlut, Marvalon, Exluton, etc.)
 - ♥ Injectables (Depo-provera, Noristerat)
 - ♥ Condoms (Male, Female)
 - ♥ Spermicides
2. To participate in training courses on reproductive health held in Ashgabat
 - ♥ For family physicians, 11 day duration, 18 participants
 - ♥ For midwives, 6 day duration, 18 participants
3. To evaluate training programs and improvement of curriculum materials designed for conducting training courses for family planning and midwives.
4. To make recommendations on action to be taken.

Limitations

The demanded medical protocols are not ready for the reasons mentioned hereinafter. The preparation of national protocols on the mentioned topics is not a short time job for a temporary consultant. Standard of clinical practice is the common name for a technical protocol in medicine and this expression is used in this report. Standards have to be developed and implemented by local colleagues because they are the results of a lengthy working process and a national affair.

As a consultant, I have discussed the importance of standards with colleagues from the Ministry of Health (MoH) and the national Mother and Child Health (MCH) institute, the main government and program advisers on reproductive health issues.

Some draft standards have been developed. Others are suggested to be developed by experts from the MCH institute, with the advantage of drafting in Russian directly. This facilitates all interested local parties to give feedback on the drafts before the MoH can approve the accepted standards.

It was not possible to attend both training courses from beginning to end. Observations are based attending the courses for some hours, on a review of the current curriculum and discussions with trainers and trainees.

Due to mastering neither the Russian nor the Turkmen language I had to rely on an interpreter.

Executive summary of the main findings and recommendations

Standards of clinical practice regarding reproductive health

No standards are available and development of standards for the family doctors is hampered by the lack of an approved job description.

It is recommended that UNFPA will hire a local consultant to draft standards according to the examples presented in the annexes. Some topics for standards are suggested in Chapter 1.

The MoH is to be stimulated to come out soon with agreed tasks for the family doctors.

Training courses in reproductive health

The training courses organized for gyn/obs, family doctors and midwives are of good quality and well appreciated by the participants, however it is recommended to introduce more topics in the curriculum. This can transform the course in training in reproductive health as designed two years ago, instead of only covering contraceptive technology.

It is recommended to train all gyn/obs, family doctors and midwives in reproductive health in the coming three years.

Contraceptive choice and procurement

Enthusiast, well-informed and trained gyn/obs, manned all visited reproductive health centers. They had a good supply of contraceptives.

Some contraceptives in the program do not seem essential for an appropriate contraceptive choice.

It is recommended to set up a permanent committee or working group to select essential contraceptives to be taken up by the program according to the guidelines of the WHO essential drug program. The committee members need training in the selection of essential contraceptives according to the guidelines of the WHO essential drug program.

A pharmacist is proposed to be trained in procurement including international tendering, clearance, storage, and distribution of essential drugs/contraceptives.

Support

The World Health Organization can be asked for support to execute the mentioned activities.

Chapter I

Standards of clinical practice

Introduction

The organization of publicly sponsored reproductive health programs rests on a variety of rationales. In Turkmenistan one of the main concerns is maternal and child mortality. In order to contribute to a reduction of these health parameters a child spacing policy is accepted. Success or failure of the program should be judged in terms of quality of services they provide and the extent to which they are successful in helping individuals achieve their reproductive objectives. It is individuals in the middle range whose behavior is most likely to be influenced by a program's quality and access.

Judith Bruce produced a simple framework with fundamental elements of the quality of care in 1990, which is still very valuable¹.

<i>Program Effort</i>	<i>Elements of the Service received</i>	<i>Impacts</i>
Policy/political support	Choice of methods	Client Knowledge
Resources allocated	Information given to clients	Client satisfaction
Program management and structure	Technical competence	Client health
	Interpersonal relations	Contraceptive use:
	Follow-up/continuity mechanisms	-acceptance
	Appropriate constellation of service	-continuation

Technical competence is one of the main factors in providing quality care.

This means, providers have to be properly trained in order to be competent providers.

In Turkmenistan training of providers of reproductive health care services has started in 1997. Many gyn/obs, family doctors and this year also midwives have followed training courses on the subject. Not only the capital city but all vilayats have several trainers and are conducting courses according to set quality levels.

In order to maintain and enhance quality, a need was felt to develop national standards for clinical practice.

Standards are dynamic by nature and aimed at a particular group of health personnel, for example family doctors, gyn/obs or midwives.

The few concepts proposed are aimed at family doctors who are supposed to be the primary health care workers. They work already in some places and will be working all over the country in the near future.

In order to ensure all these doctors who live and work miles apart to follow the same high quality procedures in carrying out their duties, standards of clinical practice are indispensable and should ideally cover all their assigned duties.

¹ Managing quality of care in population programs by Anruth K.Jain, Kumarian Press, ISBN 1-56549-013-4

The Reproductive Health unit has subscribed the importance of the development of standards of clinical practice. I hope the standards which are being developed for reproductive health activities will soon be followed by a set of clinical standards for the other tasks allotted.

Organization of standards of clinical practice

Experts on the subject and family doctors who have experience and a keen interest in the subject are able to develop the standards on the different subjects together. Standards from other countries can be used as an example. Medical literature and research should provide a scientific reference cadre for the standard. The expert knowledge of local leading doctors in their specialty and social-cultural knowledge of the family doctor are both indispensable for national guidelines.

Once a committee or working group of family doctors and experts have decided on the standard, it has to be pre tested by family doctors and in this case gyn/obs in the field. They are to be encouraged to send their observations to the committee.

After some time the agreed standard can be presented to the MoH and might receive endorsement in the form of an order.

Family doctors should be continuously encouraged to give feed-back on the standards by giving them prestamped, addressed envelopes and report forms.

This to enable the committee to regularly update and improve the standards.

The family doctors can be given a filing map to file the standards they receive.

If a doctor does not follow the standard, he must have a very well motivated reason and put it in writing in the personal file of the client. Feed back to the committee of standards might be appreciated.

For the time being some draft standards of clinical practice have been developed by the consultant, Ms. Irena Ereshova and Ms. Olga Nazarliyeva both gyn/obs specialists from the national MCH institute, based on:

- The standards for family doctors in The Netherlands
- The essentials of contraceptive technology, a handbook for clinic staff, published by the population information program, center for communication programs of the John Hopkins University School of Public Health
- Our own experience

Draft standards can be developed along the same lines for other subjects once some local professionals get the hang of it. Irena and Olga have shown to be very capable of preparing more draft standards. I can give feed-back when they send me an English version by E-mail. See annex II, III and IV for some draft standards on IUD insertion for family doctors.

Limitations

Many health professionals do not yet understand the use and importance of clinical standards of practice. They are not used to work according to standards and might feel limited in their professional authority.

Doctors in Turkmenistan are insecure about their future. Once they had a life guarantee on employment. With the reforms ahead they feel that some doctors might get unemployed. This makes them feel uneasy about any change and might create a resistance against change.

The gyn/obs specialists seem to resist the handing over of tasks to family doctors. It is said that the family doctors are not trained in gynecological examination and have no experience at all. Most of the family doctors were pediatricians and therapists with little knowledge even of the physiology of the menstrual cycle. In the rural areas they have hardly been exposed to any further training since their graduation. This makes the gyn/obs feel uneasy to hand over tasks. The family doctor seems likewise uncertain of his capacity to take over some tasks that were formerly assigned to gyn/obs only. The MoH claims that enough gyn/obs are available at all levels. Training of others in for example IUD insertion is not a priority.

However family doctors are working in some places despite their tasks still being under debate in the health reform unit.

Only a proposed set of tasks was available from the health reform unit.

When drafting standards we have taken the proposed duties from the draft tasks in the future as a point of departure. Field-testing is extremely difficult since the MoH does not approve the tasks yet.

Recommendations

UNFPA is recommended to support a local consultant to draft standards of clinical practice aimed at the family doctor on the following subjects along the same lines as the draft standards presented in the annex. It is an advantage to have a local consultant. This person can draft in Russian and get immediate feedback by colleagues to be included in the standards. The local consultant needs to be provided with a translator to explore English literature. He also needs time to do the job and secretarial assistance with computer facilities to draft some standards.

Some proposed topics for standards are:

- Selection of a contraceptive
- Low-Dose Combined Oral Contraceptive
- Progestin-Only Oral Contraceptives
- Injectable contraceptives
- Barrier methods
- Intra Uterine devices
- Lactational Amenorrhea Method
- Natural family planning methods
- Counseling on unwanted pregnancy
- Counseling on Infertility

Other topics can be covered according to the need and requirement of the family doctors and the MoH.

UNFPA/WHO are recommended to support a national workshop on standards of clinical practice to be organized by the MoH. In the workshop, recommendations can be made on the set-up of an organization responsible for the development and follow-up of standards of clinical practice for family doctors. It will familiarize the participants with standards and hopefully gain support for the development of more national standards.

The MoH should consider appointing a committee on standards of clinical practice for family doctors. UNFPA and/or WHO could support the initial start of this committee.

An association of family doctors should be promoted to act as a party in the discussions.

The committee could be composed of experts in the field of reproductive health for these standards, a trainer of family doctors, and one or two interested active family doctors. The MoH can add a representative to anticipate the approval.

The committee should have a chairperson, secretary, and treasurer.

An executive director is needed to organize the work and present the results to the committee. The director should have a budget to involve scientists, buy literature, and consult other organizations. He needs secretarial support, a computer, E-mail and an internet connection to perform his work.

Chapter II

Training of family doctors and midwives

Some observations based on participation in the training courses and discussion with participants and trainers.

A change in teaching attitude, less lecturing at, and more active participation of the students has been realized. The students get actively involved in role-plays, observations, and discussions and seem to appreciate this approach.

Another method to involve the participants is questions and answers.

This is a traditional learning technique that supposes only one answer to be the correct one. At the start of the course and at the end, questions are asked to the students. With this method the trainer can evaluate the progress in mastering the topic. Every student's progress is carefully monitored.

At the end of the course questions are asked to evaluate the outcome, progress made in the course. Some teachers repeat the key points of the last day, the morning they start a session and evaluate the accumulated knowledge by written questions.

A start has been made to base the training on the common knowledge of the participants, to evaluate their progress regularly and to evaluate the course on contents and satisfaction after the course.

Contraceptive technologies as LAM , natural methods, IUD, barrier methods and others are freely discussed. There seems to be no taboo on these subjects, at least not among health workers.

Midwives and family doctors are not trained in IUD insertion. The MoH does not yet recognize them as safe IUD handlers.

Midwives use their knowledge on contraceptive technology to counsel the patients, also during their pregnancy, and to make sure, the method chosen and used by the couple is correctly applied.

Consultation technique, counseling on contraceptive methods and choice, has an important place in the curriculum of the family doctors. The right of the patient to have a free choice is very much emphasized.

The participants in the family doctors course receive textbooks on the topics covered in the course and a workbook. These books are very much appreciated and are told to be very understandable and at great satisfaction.

The trainers have a MoH approved curriculum and use a training manual.

They themselves have been trained as a trainer.

The trainers are enthusiastic and respond well to the questions asked by the participants. The participants are often asked to come out with questions when a topic is covered. The participants seem to feel free to ask questions.

Most of the training materials as slides, overhead projector, and dummy are available.

Although participatory methods of training as role play and questions and answers are used, still lecturing at students who take notes despite the course books and workbook is prevailing. It is told that the students are used to take notes and continue to do so even when a course book with the taught information is available.

Once the training over the trained professionals might lose interest in reproductive health when not kept informed about their performance or the latest developments in this field.

Suggestions for improvement

A special training manual for midwives has to be developed as well as a workbook and course content book.

A special course on IUD insertion should be considered, in particular for midwives and family doctors in the rural areas where gyn/obs are not available. After a training course in reproductive health, an IUD insertion course for family doctors could be organized using a three days curriculum. After this course and having inserted 20 IUDs under supervision correctly, they could be allowed to insert IUDs in their place of work.

To ease the decision making on contraceptives by clients, the trainees could be provided with a pouch/kit containing at least one sample of each method, clear drawings, flyers for distribution and a hand held uterus for IUD demonstration.

For condom demonstration a wooden stick, the size of an average penis, mounted on a console could serve the purpose. Bananas can also serve the purpose when available.

Yearly refresher courses are needed for all medical personnel in particular in this time of transition. Quality and access to services are the key issues to be addressed.

The books provided to the participants are produced by JHPIEGO according to their well tested material. Even the training curriculum has been modified to fit their course books. The course content has been reduced to a training course in contraceptive technology. In the initial curriculum proposal more topics were included to cover the field of reproductive health. Some of these topics were already mentioned to be missing from the curriculum by previous consultants as well as some local trainers.

From some topics it is said that they are covered but they do not figure in the curriculum.

Other topics are said to be mentioned but need more emphasis and practical exercises.

It is recommended to add the following topics to the training curriculum.

- A discussion on the role of the midwife, family doctor and gyn/obs specialist in the reproductive health programs.
- Counseling on medical termination of pregnancy, including post abortion contraceptives.
- The preparation and development of IEC material by the course participants.
- The organization of an awareness campaign among the community on the services offered.

- Counseling skills for a difficult interview need more attention.

In particular counseling on unwanted pregnancy, induced abortion, STD`s, sexual difficulties, sexual dysfunction, sexual variation and abuse should be included in the curriculum for doctors.

Counseling on sexual abuse of women and girls, can be used as an example to train in a difficult interview. The subject could be introduced using a video, on which a woman or girl

tells her story to a well trained counselor who knows to get to the roots of the problem while the patient comes in with vague symptoms of discomfort.

This seems a touchy subject with many taboos. Counseling on these issues is traditionally carried out by psychotherapists. Psychotherapists could be involved in the design of a training session on the topic. Censorship is feared. A seminar might be needed to bring the subject in the open.

The skills could be trained by using actors as patients.

- The management of reproductive health services should be part of the training program. This includes monitoring, administration, stock keeping, calculation of coverage figures for the area and production of graphs on achievements.

Trainers should be encouraged to have a more participatory approach in training. Inter collegial commenting on performance by the trainers themselves might be a method to improve the teaching.

For training in counseling, a video camera and play back of the registered counseling session often gives a good feedback to the counselors on their own performance.

A newsletter on current reproductive health issues, even when produced as a quarterly. It will keep the trained professionals informed and enthusiastic. Results of the program can be discussed. Feed back on the figures produced thanks to their efforts can be given. It might satisfy the information hunger on new technologies and prospects.

Chapter III

Observations and recommendations for action to be taken in the organization of reproductive health services with an emphasis on the improvement of access and quality.

Observations

1 In the organization of services, in particular for IUD, the most accepted method of fertility control the client in the rural areas is dependent on the visit of a gyn/obs specialist who is said to visit the rural centers every 2 weeks. The client could also go to the nearest rural hospital. This might be a problem with a family to leave behind and transport not being always available. IUD insertion ideally takes place at the last day of the menstruation and this might not coincidence with the visit of the specialist. A method of contraception should be offered instantly when a client asks for it, preferably the method of choice.

2 Pregnancy testing is very important when a patient comes for a consultation on fertility control. Rapid urine tests are not available in the rural centers.

3 Contraceptives with almost the same indication are available from the program. This might confuse the doctor and patient. More products with the same indication of prescription might lead to ruptures of stock in the future. Although the service providers stress the importance of free choice of the client, I think offering more of the same only leads to confusion. It is for example of no use having several Sub 50 Combined Oral Contraceptives in different colors or packages.

The three phases COC has little advantage over the mono phase Sub 50 COC. It is more expensive and less reliable.

Tri-regol and Triquilar have exactly the same composition. No scientific, rational reason was found to include both in the assortment.

Similar, the two IUDs provided have no special features to make a rational choice for one or the other.

Although one of the reports by a previous consultant supports the vision that two different injectables should be available, circumstantial evidence suggests that injectables are little used and their use is in decline. A research study at the national MCH institute, although not representative, indicates that Depot-provera has fewer side effects and is better accepted than Noristerat. These facts make it difficult to defend the statement that a second injectable contraceptive is needed.

The newly proposed combined oral contraceptive to be ordered by the program, Diana, seems not a very appropriate choice (see annex I).

It was pointed out that the decision on which contraceptive to be included in the order list was formerly made by the MoH and now by the national institute of MCH with approval of the MoH.

The advisers are very much influenced in their choice by the information available in Russian because none of them is able to read English. Most of the scientific research articles in Russian are provided by pharmaceutical industries and might be biased.

The pharmaceutical companies also sponsor leading specialists to attend seminars abroad, which might create a loyalty problem.

The selection of contraceptives to be included in the program is thus based on biased information available to professionals who are not trained in the selection and procurement of essential drugs/contraceptives. The market economy is a new phenomenon to them and making rational choices is not an easy job when confronted with purchases in a free market.

4 Mini abortion or suction is available at main centers only and the equipment is outdated. In a survey on maternal death in Turkmenistan it was mentioned that 10% was post abortion. It was not mentioned which technique of abortion was the cause.

5 Oral contraceptives are usually prescribed for a 3 months period. It was said that supply for a longer period was debatable. A supply for 3 months might hamper access when a consultation fee is charged each time. Although the contraceptives are free of charge, the fee might influence access to services in particular in the rural areas where the market economy and possession of money is not always prevalent.

6 Once the client has accepted a method of contraception and takes it home she might not remember the facts regarding the method told to her by the doctor. She might doubt about side effects and other information given. She might like to discuss some feelings with her husband who has no information.

7 Although training courses are conducted in all vilayats for gyn/obs, family doctors and midwives, most of them working at the peripheral level have not received training and have no RH material.

8 In order to conduct a training course, ministerial approval is needed. The approval comes down at the executive level as an order. This procedure is elaborate and takes much time. The MoH fears that the work will suffer when employees go for training. On the other hand they claim to have an army of gyn/obs.

9 The distribution of RH material in Ashgabat city from the main RH unit in house of health number 12 to the other RH units is assured by the husband of the coordinator in his own car.

10 No discussion is taking place on other spacing contraceptives that are available in the world like implants.

11 The family doctors participating in the training on reproductive health are very keen to extend their skills and knowledge to be able to live up to the expectations of their new function. They feel a need for more training on new tasks like prenatal perinatal and postnatal care.

12 Family doctors are assigned many tasks. They are afraid not to be able to spend enough time on reproductive health because of the many tasks and administrative duties.

13 Consultation facilities in the houses of health visited are clean, have much space, and are well provided with contraceptives, leaflets, and posters regarding contraceptive issues. Privacy for a difficult interview seems hard to guarantee. In the tradition and former system there might not have been a need for privacy.

14 The executive abilities of the UNFPA program staff are beyond expectation. A good collaboration with other executive agencies in particular on related fields of action is noted. The national staff could benefit from regular follow-up of activities by consultants, knowing the project, who are also ready to help finding solutions for immediate problems or can continue to act as consultant by being available by electronic mail.

Recommendations

1 It is recommended to train family doctors and midwives of the rural clinics, where no gyn/obs specialist is available, in IUD insertion. A special course and practical training under supervision can be organized in order to improve access to services. In most countries midwives and family doctors are inserting IUDs as part of their duties and this practice is not seen as a task for specialists in gyn/obs.

2 It is recommended to make rapid pregnancy tests available for all health facilities in order to allow the doctor to discuss a correct contraceptive on the basis of the outcome of the test. Counseling on unwanted pregnancy, in an early stage, might also benefit from the testing facility.

3 The number of different contraceptives should be kept as minimal as possible to prevent confusion and rupture of stock. An expert committee should decide upon a core assortment of essential contraceptives based on experience and literature research. It is recommended to set-up a committee of selection and procurement of contraceptives, consisting of professionals from the MoH, MCH institute, and a pharmacist. They should work following clear, transparent, rational and scientific procedures for decision making. The WHO guidelines for essential drug choice and procurement can be of great help. A training course on choice, procurement and cost efficiency of essential drugs/contraceptives can stimulate rational choices in the future. A pharmacist can be entrusted procurement, clearing, storekeeping, and distribution after a course in this matter.

4 Special training on mini abortion technique for specialists should be provided with clinical standards of practice to be developed and applied. Disposable, sterile flexible plastic suction tips should be provided to the centers that provide these services. All health centers with a gyn/obs specialist are recommended to be provided with material for mini abortion.

5 Contraceptives should be supplied for the time specified by the client at her convenience once it has proved to be reliable, well accepted, and correctly used by the client. Provision for a longer period saves consultation fees. Important preventive medical services that serve the total population should be free of charge in order to avoid thresholds to access.

6 Leaflets could be developed, with simple Turkmen text explaining the main features of the contraceptive method that has been chosen by the client. One could develop a box with patient information leaflets on each method and give the patient the concerned leaflet. Pictograms can make messages easier to understand. Triquilar ED Fe boxes have examples of clear instructions for use in Russian and some times English.

7 A training plan for each vilayat could be made, aiming at training all gyn/obs, family doctors and midwives. One could at first make sure that every etrap can deliver the required services and in a second instance that all health facilities can deliver RH services. In the town

of Ashgabat, training can be organized in each health house for example every month a course in a different health house. The training could be held in the morning or afternoon to avoid the health personnel to be absent from duty for a long period.

8 It is recommended to set up a frame of teaching activities that has to be executed in the course of a year and get the approval of the ministry. This allows better planning at the executive level without waiting for orders and permission to come down from the MoH.

9 Vilayats need a transport medium for supervision, collection of data and distribution of material.

10 A scientific committee could be formed that could advise on the contraceptives that are recommended to be included in the core RH material and that follows the trends in contraception in the world. It should avoid offering more of the same and try to diversify the choice.

11 The family doctor needs a lot more training to be able to carry out the assigned tasks. In particular antenatal, perinatal and postnatal care may be combined in a safe motherhood package and offered at a later stage. This will require a cooperation from UNICEF, WHO and UNFPA. In Turkmenistan all three organizations are in the same building and cooperation has proved to be fruitful in the past. In particular UNFPA has a lot of credibility at the executive level and WHO has much esteem in medical circles.

12 A committee of family doctors should study the tasks assigned and come out with suggestions for a suitable working schedule for execution that is efficient and feasible.

13 A small consultation room with guaranteed privacy for difficult interviews could stimulate access to services. Women should be offered a private consultation without a chance of being overheard by others, in particular in the rural setting where everybody knows everyone.

14 It is recommended to support the national UNFPA staff with regular consultancy services by consultants who know the program. Much feed-back and advise can be given by E-mail once the program and the national staff is familiar to the consultant and vice versa. Backstopping facilities for project staff will enhance the quality of work.

Annex I

Contraceptives available through the program, some details and remarks

Only the contraceptives that are used frequently are mentioned. Private pharmacies sell more types of contraceptives, most of them too expensive for use by the common people. A private pharmacy visited in “house of health” number 12 in Ashgabat only had some spermicides at an excessive price. The pharmacist explained it was no use to offer more variety while the institute offered all contraceptives free of charge.

Hormonal contraceptives

Exluton, 0.5 mg lynestrenol
Micronor, 0.350 mg norethisterone
Microlut, 0.03 mg levonorgestrel

Depo-provera 150 mg medroxyprogesterone per ml for injection
Noristerat, 200 mg norethisterone enanthate per ml for injection

Marvelon 28, 0.15 mg desogestrel and 0.03 mg ethinylestradiol
Rigevidon, 0.15 mg levonorgestrel and 0.03 mg ethinylestradiol
Ovidon, 0.25 mg D-norgestrel and 0.05 mg ethinylestradiol
Tri-regol, 6 tablets 0.05 mg levonorgestrel and 0.03 mg ethinylestradiol
5 tablets 0.075 mg levonorgestrel and 0.04 mg ethinylestradiol
10 tablets 0.125 mg levonorgestrel and 0.03 mg ethinylestradiol
Triquilar ED Fe, same composition as tri-regol only some iron tablets are added.
Diana, 2 mg cyproteron acetate and 0.035 mg ethinylestradiol

Microlut is said to have many undesired side effects like spotting and is not much in demand. Ovidon is said not to be supplied anymore. It was mainly used for emergency contraception and in cases of metrorrhagia and polymenorrhoea.

Marvelon is told to have a positive effect on hirsutismus and acne.

It is claimed to provoke less spotting than a 3 phase COC.

It is available through the aid project as a 28-pill package with 7 days iron and a 21-tablet version in the commercial pharmacy.

The commercial version has the advantage that the weekdays are mentioned in Russian, while the gifted version has only arrows and weekdays in French and English. It is considered the method of first choice.

The Dutch central medical pharmaceutical committee notes that a third generation pill like Marvalon, containing desogesrel as a prostagen has not proven:

- ♥ to be better accepted,
 - ♥ having less side effects and
 - ♥ being more effective than the second generation pills like Rigevidon.
- They also are more expensive.

Three phases COC are seen as very adapted to young women, having fewer side effects like nausea and vomiting.

The Dutch central medical pharmaceutical committee notes that three phase pills are less reliable than mono phase COC because it requires accurate, regular taking of tablets. Patient failure to do so is a risk to be taken into account. The three phase pills are more expensive than mono phase pills.

Diana is ordered for the next allotment. It is claimed to have a positive effect on hirsutism that seems to be a prevalent beauty problem in Ashgabat.

Cyproteron, one of the components, is a strong prostatic and has a strong anti-androgen effect.

In the Netherlands, Diana it is not considered a contraceptive and only used for climacteric complaints. It has contraceptive properties but is too expensive (not reimbursed by the social security system) to be used as a contraceptive.

Injectables are said to be less appreciated now oral pills are better available.

They seem more popular in the periphery because they can be prescribed by trained family doctors and regularly injected by nurses on repeat once the doctor has approved.

According to the WHO essential drugs list (see annex VII) only Rigevidon is seen as essential.

Other drugs mentioned in the list for use in exceptional circumstances and having limited indications are: Microlut, Depo-provera and Noristerat.

Ovidon can also be considered for use in exceptional circumstances.

Condoms

The male condom is gaining more popularity, in particular among adolescents.

The female condom is hardly used and there is little interest in this barrier method.

In the rural areas it is not valued at all. The AIDS program is currently studying the use of the female condom among professional sex workers.

Spermicides

The aid programs supply Neo Sampoo

Some providers mentioned spermicides to be popular among women with a dry vagina.

Others claim it to be popular among adolescents.

Intra Uterine Devices

The 380 A is widely available and supplied by the aid projects

Multiload Cu 375 is available from aid programs and the pharmacy. Costs about 25000 manat, equal to one and a half US dollar.

Some clients prefer the multiload because the treats are soft and seem to be less irritant for the client and her partner.

Sterilization

Female sterilization is acceptable but it seems very little in demand.

The women do not like the idea of irreversibility.

Some indications mentioned were:

- The desire of the client

- Extra genital pathology

- Life threatening danger at a next pregnancy

- Status after various lower abdominal operations

Male sterilization is not practiced for cultural reasons.

Medical termination of pregnancy

Mini abortion although not seen as a contraceptive method but as an emergency fertility regulation method is still much practiced.

Till about 12 weeks of pregnancy this method can be used, using different sizes of suction tips.

Annex II

Intra Uterine Device, standard of clinical practice for the family doctor as used by the Dutch family doctors.

General

- How has the choice for an IUD been made ?
- Discuss, when needed, other methods of contraception
- Answer questions if any queries arise

Information to be given

- Show an IUD
- Talk about the action in influencing conception and nidation
- Reliability, immediately after placement until removal effective, when no coitus in the week before removal. Pearl index 0.8-0.9
- Infections: risk of an ascending infection while insertion. No protection against PID and STD. More chance for PID when a STD occurs.
- Menses are often heavier, of longer duration and more painful, in particular in the first 3 months
- Reliability for 5-10 years
- Check-up after the first menstrual period.
- Self check-up monthly after menses

Anamnesis

- Cycle: first day of last menstruation, regularity, duration menses, amount of blood loss, pains, intermensuels blood loss
- Use of IUD in the past and experience
- Vaginal discharge
- Known cervix pathology
- Possible risk on STDs
- Lower abdominal operations, treatment for PID or STD
- Maybe talk about attitude when pregnancy arises despite IUD

Examination

- Speculum: when suspicion take material for laboratory investigation. When the anamnesis gives rise to suspicion on Chlamidia, gonococcus or trichomonas, take a smear to the laboratory. In those cases await laboratory result before insertion of an IUD.
- Vaginal examination, bimanual: place, seize, consistence of the uterus. Are the adnexae enlarged and/or painful?

Contra-indications

Absolute:

- Pregnancy
- Active salpingitis, cervicitis, puerperal sepsis unexplained vaginal blood loss
- Birth giving less than 4 weeks ago
- At risk to develop STDs or known cancer of the cervix, endometrium or ovarium

Relative:

- Dysmenorrhoea and/or menorrhagia
- Known congenital deformation of the uterus
- Anaemia
- intermenstrual blood loss without known origin
- cervical smear PAP IIIa or more
- Pathology of the tubae (PID, EUG, operation)
- Story of expulsion of previous IUD or pregnancy using an IUD
- Unexplained lower pelvic complains
- Use of cytostatics of corticosteroids.

No contra-indication

- Age less than 25 years
- Nulliparity
- Promiscuity
- Uterus Myomatosis without complains
- Cardiac problems which needs continuos prophylactic antibiotics
- Use of anti coagulants

Type of IUD

The 2 available IUDs are equally reliable. The guaranteed life span differs.

When at uterine sounding the cavum length is less than 6 cm a short model could be considered.

Insertion

- Explain about the insertion procedure and possible painful moments
- Vaginal examination, be aware of possible abnormalities and pregnancy
- Speculum: when suspicious for infection, take samples and stop procedure. When the cervix is not normal, refer to a gynecologist.
- Clean the cervix with a antiseptic and remove when in situ the old IUD; grasp the portio and use a uterine sound when the uterine position is not clear or when doubts arise about the permeability of the ostium internum
- Put the IUD in place according to the “no touch” 10 steps safe procedure
- Take of the instruments and tailor the treats to about 5 cm. If blood loss occurs apply a cotton and wait for the stopping of blood loss. Take of the speculum.
- Apply a sanitary pad and keep the patient on the chair for another few minutes to recover.
- Ibuprofen may be given 30 minutes before insertion to reduce cramping

Aftercare

- Make an appointment for check-up
- Give information about self control
- Reasons to report earlier like abnormal vaginal discharge, continuous lower abdominal pain, fever, and delay of period

Complications and/or failure

- Do not force to introduce the IUD to pass it through the ostium; refer to a specialist
- When perforation occurs, the fundus can not be felt, sometimes pain and blood loss
- When suspicion for perforation refer to a specialist
- Common reactions are: abdominal pain during insertion, mostly for a short period, no reason to stop the procedure. Fainting, sometimes with tonic and clonic cramps; stop procedure, put the patient on a couch and check pulse. One could after a while have another try possible after giving a small dose of diazepam(5 mg) orally or intramuscular half an hour before insertion

Check-up

- The first check-up, after the first menses
- Speculum inspection and bimanual examination: is the IUD at the correct site, check for partial expulsion.
- Can the patient carry out her own check?
- Come back after 5-10 years for change of IUD
- The need for periodic check-up by a doctor has not been confirmed

Miscellaneous

Some statements on:

- PID, Pelvic Inflammatory Diseases
- Pregnancy
- Replacement
- Expulsion
- IUD as an emergency contraceptive.

Annex III

IUD, standard of clinical practice for the family doctor, based on “The essentials of contraceptive technology”²

General

- Are other methods of contraception discussed?
- If appropriate discuss other methods
- Answer questions

Information giving

- Show an IUD and its position using a hand held uterine model
- Explain the working.
- Talk about effectiveness, Pearl index about 0.8
- Mention advantages and disadvantages
- Mention common side-effects that might occur particularly in the first 3 months like:
 - Longer and heavier menstrual periods
 - Bleeding or spotting between the periods
 - More cramps or pain during the periods

Anamneses, questions to be asked

- Do you think you are pregnant ?
- Did you have unusual vaginal bleeding in the last 3 month, in particularly between the periods or after sex ?
- Did you give birth more than 48 hours ago but less than 4 weeks ago ?
- Do you have an infection following childbirth ?
- Have you had an STD or PID in the last 3 months ?
- Are you infected with HIV or do you have AIDS ?
- Do you think you might get an STD in future or do you or your partner have more than one sex partner ?
- Do you have any cancer in the female organs or pelvic tuberculosis ?

Insertion

- Insertion can take place anytime during the menstrual cycle if it is reasonably sure the patient is not pregnant and has a healthy uterus.
- After childbirth it is recommended to wait for 6 weeks and rely on other methods for the time being.
- When an unexpected deformation of the uterus is detected during bimanual examination or a suspect discharge or cervical abnormality is detected during speculum examination, stop the procedure and refer to a specialist.

² A book published by the Johns Hopkins Population Information Program, ISBN: 1-885960-01-8, second printing, 1998.

- When by palpitation and inspection no abnormalities are found, insert the IUD using the “No-touch” technique.
- Ibuprofen may be given 30 minutes before insertion to reduce cramping and pain.
- The cervix and vagina should be carefully cleaned with an aseptic solution.
- After insertion, the provider should suggest the client to lie down for a few minutes when she does not feel conformable.
- Always provide a sanitary towel after insertion.

Removing the IUD

- When the patient requests
- Unwanted side effects
- Pregnancy, Acute inflammatory disease (endometrioses or salpingitis), perforation of the uterus, IUD has come out of place, abnormal very heavy blood loss.
- When the lifespan of the IUD has passed. It can be replaced immediately.
- When the woman has reached menopause, at least one year after the last menstrual period.
- Removing can be done at any time. Infection prevention procedures to be followed
- If removal is not easy or the threads can not be found, refer to a specialist.

Patient instructions

- Explain some cramping in the first few days. She can take aspirin, paracetamol or ibuprofen to relief the discomfort.
- Some vaginal discharge for a few weeks is normal
- Heavier menstrual periods and possible spotting during the first few months is a common side effect.
- Explain her to check the IUD once a week during the first month and there after every time after her period is over.
- Teach her how to check the IUD
- Ask her to come back when she has serious side effects, any doubts, or queries.
- Explain reasons when she should see a doctor and hand out a patient information leaflet.

Following up

- A routine follow up visit is planned 3-6 weeks after insertion.
- Pelvic examination is done, bimanual examination and speculum inspection.
- Discuss questions and side effects.
- Recommend remedies for side effects, refer to a specialist when you are not sure, or remove the IUD, prescribing another contraceptive when the client is not satisfied.

Annex IV

Intra Uterine Device, proposed standard of clinical practice for the family doctor prepared by two Turkmen colleagues

General

- ♥ What are the reproductive plans ?
- ♥ How many children do you want ?
- ♥ What birth interval do you wish ?
- ♥ When do you plan to have a baby ?

Anamnesis

- ♥ Age, family status, number of pregnancies, deliveries, life children
- ♥ What method has been used and is used at this moment ?
- ♥ Is the patient pregnant, at risk for STD ?
- ♥ Does she have a history of PID, EUG or heavy periods ?
- ♥ Check on anemia and genital cancer.

Information to be given

- ♥ Efficiency, reliability
- ♥ Period of protection
- ♥ Mechanism of working of the IUD
- ♥ Side effects like heavy bleeding during periods, discharge in the intermenstrual period, increased risk on PID and possible expulsion with blood loss.

Referral

- ♥ Explain the procedure of IUD insertion
- ♥ Tell about the check after every period to be done by the patient to verify the IUD is still in place.
- ♥ Explain the possibility of IUD removal without much discomfort at any moment
- ♥ Make an appointment for a visiting gyn/obs specialist or refer to the nearest reproductive health unit with a referral letter.

Follow-up

Ask the patient to see a doctor when she has the following symptoms

- ♥ Delay in period (pregnancy)
- ♥ Abnormal discharges or heavy bleeding
- ♥ Abdominal pain or bleeding during sexual intercourse
- ♥ Fever and lower abdominal pain
- ♥ The IUD threads are absent, shorter or longer than normal

Annex V

Some remarks on hormonal contraceptives and how to make a choice

Subdivision on estrogen component

- 1 *Sub 30 pill*: contains less than 30 mcg ethinylestradiol (20 mcg) per tablet
- 2 *Sub 50 pill*: contains less than 50 mcg ethinylestradiol (30-37.5 mcg) per tablet.
- 3 *50 pill*: contains 50 mcg ethinylestradiol per tablet.

Subdivision on phases in the pill strip

- 1 *Mono phase pills*, all tablets have the same composition
- 2 *Two phase pills*,
sequential pills; first phase only estrogen and later a dose of progesterone added
step-up pills; the first few tablets have a lower dose of progesterone than the last pills.
- 3 *Three phase pills*, combination of estrogen en progesterone with a changing composition of the components in three phases depending on the phase of the menstrual cycle.

Subdivision on chronology of development.

- 1 *First generation*: 50 mcg ethinylestradiol and the same progestagens as the second generation.
- 2 *Second generation*: less than 50 mcg ethinylestradiol and levonorgestrel, lynestrenol or norethisteron as a progestagen
- 3 *Third generation*: less than 50 mcg ethinylestradiol and desogestrel, gestodeen or norgestimaat as a progestogen.

How to make a choice ?

A Sub 50 mono phase pill is the oral contraceptive of first choice.
The second generation pills are the most reliable to start with.
The most efficient, reliable and less expensive mono phase sub 50 pills contain ethinylestradiol combined with levonorgestrel, norethisteron or lynestrenol.
Among the sub-50 pills the mono phase pills are preferred because of reliability.

If the patient uses fenytoine, fenobarbital, carbamazepine, primidon or refampicine one should consider 50 mcg ethinylestradiol tablets.

The third generation pills have so far not proved to be better and are more expensive.

The three phase pills have the disadvantage that delay of menstruation by using the tablets some more days is not possible. The user has to be very reliable in taking the tablets.

The mini pill also requires a very reliable user who is sure to take the tablets every day at the same hour. A three hours difference in intake already influences the reliability of this pill. For

practical reasons this is not the first choice. When breastfeeding it is a reliable pill that does not effect the milk production.

The injectables are reliable. It should be used only when oral intake is not an option for several reasons. After the last injection it takes an average of 9 months before fertility is restored.

See annex VII for the essential drug list of WHO regarding contraceptives.

Annex VI

Mission Program of Balthasar Schaap in Ashgabat from 6-16 September 1999, mentioning the persons met.

7.09.1999

Morning Meeting in the office with the National Coordinator PO2, Ms. Gozel Khodjaeva. Discussion on the Terms of Reference.

Afternoon Participation at the training course for family doctors and midwives on RH in Ashgabat (Polylinic 9)
Meeting with the local RH coordinator for Ashgabat Ms. Alasheeva Margarita and trainers Ms. Rozieva Guldjan and Amanova Maya
Work in the office and collection of documentation and figures.

8.09.1999

Morning Visits to rural RH units of Akhal velayat with Dr. Gulruh Nazarova, chief of the RH Unit of Gyaurtz etrap.

Afternoon Attend the family doctors training

Meeting with the UNFPA Representative Mr. Jens Wandel.
Visit to the MoH, meeting with Chary Mamed Kuliew, Chief of the health reform unit.

9.09. 1999

Morning Visits to the MCH Institute. Meeting with MCH Director Mr. Nazarov Chary
Discussion with the RH department staff as well as with Ms Irena Ereshova to discuss the development of medical standards, protocols

Afternoon Meeting with the national program officer, Mr. Eziz Khellinov.
Meeting at the MoH with Ms. Tatiana Mamedova, chief specialist and Guljamal Ezizova, head of the department of medical treatment and prevention.

10.09. 1999

Morning Preparation of material for discussion on the standards.
Visit to Urban Center N 1, Ms. Rouzanna Amiyantz, in charge of the reproductive health unit.

Afternoon Preparation of an example standard on IUD.
Preparation of comments on the sub-program document

11.09.1999

Morning Visit to the Urban Center N 12.

Afternoon Attendance of the family doctors training course

Working on the report

13.09.1999

Morning

Preparation of standards for discussion at the national MCH institute and discussion with Ms Gozel Khodjaeva, National project officer

Afternoon

Discussion at the national MCH institute about standards with Irena Ereshova and Olga Nazarliyeva, both trainers in reproductive health.
Working out details and translations at the UN office.

14.09.1999

Morning

Discussion on standards at the national MCH institute.

Afternoon

Attendance at the presentation of sub project with the regional representatives at the MoH

15.09.1999

Morning

Writing a comprehensive draft of the mission report.

Afternoon

Debriefing at the MoH
Debriefing at the resident representative's office.

Annex VII

WHO's tenth Model list of Essential Drugs.

Only the chapter on contraceptives is reproduced.

18.3 Contraceptives

18.3.1 Hormonal contraceptives

- *ethinylestradiol + *levonorgestrel tablets 30 micrograms + 150 micrograms.
- *ethinylestradiol + *norethisterone tablets, 35 micrograms + 1.0 mg.
- *ethinylestradiol + *levonorgestrel(C) 50 micrograms + 250 micrograms (pack of four)
- *levonorgestrel(B) tablets, 30 micrograms
- *medroxyprogesterone acetate (B) (7, 8) depot injection, 150 mg/ml in 1-ml vial.
- *norethisterone enantate (B) (7, 8) oily solution, 200 mg/ml in 1-ml ampoule.

18.3.2 Intrauterine devices

Copper-containing device

18.3.3 Barrier methods

Condoms with or without spermicide (nonoxinol)
Diaphragms with spermicide (nonoxinol)

Explanation of the remarks made clear by the following codes:

- B When the drug in the main list cannot be made available
- C For use in rare disorders or in exceptional circumstances
- 7 Adverse effect diminish benefit/risk ratio
- 8 Limited indications or narrow spectrum of activity

PART TWO

PROJECT EVALUATION REPORT

Improving Reproductive Health Services and Access to Family Planning in Turkmenistan

Project Number: TUK/96/PO2

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Mission Dates: 24 November - 9 December 1999

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EXECUTIVE SUMMARY

Project TUK/96/PO2 on 'Improving Reproductive Health and Access to Family Planning in Turkmenistan' is one of 3 related projects, the other two dealing with delivery of contraceptive supplies and equipment (PO1), and with IEC (PO3). This evaluation focuses on PO2, with side-steps to the other two, and on the role of WHO, being one of three executing agencies, besides UNFPA and the MOH of Turkmenistan. An evaluation mission was carried out 24 November - 9 December 1999.

After initial delays, implementation started mid-1997, and continued for the past 2½ years. The design of the project has been adequate as far as access to family planning is concerned; objectives in the areas of HIV/STD and MCH were only marginally translated into activities and as a result only some minor progress has been made there. These areas should preferably become a major focus of attention in the next programme cycle.

In terms of increasing access to good quality contraceptive services, the project has been very successful. A large number of health professionals (more than was planned) have received adequate training on this; RH centres (almost double the number planned) have been established and equipped in each province (Velayat); and similarly RH cabinets are now available in every district (Etrap) of the country. Within a period of about 2 years, this is a major achievement. This result could be achieved because the project has been more than adequately managed, because collaboration between the 3 executing agencies is effective, and because there has been positive and active collaboration with the field, throughout the country.

As a result, the CPR has increased by about 10%, and the choice of contraceptive methods has improved; the extreme dominance of the IUD has become less. For as yet unknown reasons, the increase in CPR has stagnated during the past year. These reasons need to be carefully looked at. There seems to be a stronger preference to use contraceptives for limiting than for spacing births. The latter being one of the main objectives, more information, including the possible backgrounds of this, should be made available.

A major problem is the lack of valid and reliable data on core indicators of RH. In the future, investments have to be made to improve the quality of such data. The MMR, the IMR and the induced abortion rate have probably gone down, but to what extent is unknown.

The need for expert assistance in doing and using research has been under-estimated; the quality of the results is not yet acceptable and more assistance is needed in the future.

Similarly, there is a need to give more support, in terms of expert advice and equipment, to collecting, collating and analysing monitoring data.

There is a need to increase efforts to further integrate STD/HIV (prevention) services in the now established RH services. Women have played a crucial role, at every level, in the success of the PO2 project, but much more attention should be given to the role and responsibilities of men, which has been a largely neglected area until now.

Very impressive progress has been made, given the prevailing cultural conditions, in raising awareness and increasing knowledge and skills of adolescents on RH issues (mainly through IEC; i.e. PO3 project). Initiatives to also make services accessible for this target group need to be encouraged.

The executing role of WHO has been relatively difficult due to the long distance between EURO and the country. Therefore, ways to guarantee a more direct contact with project implementation should be sought and used in the coming programme cycle.

Major recommendations are as follows:

- Collaboration with other international agencies, in order to cover all the major components of Reproductive Health and Family Planning including STD/HIV, should be sought or strengthened.
- The process of integrating family planning, MCH, and STD/HIV services and IEC activities, that has been started at some points, should be given much more emphasis in the next stage of the programme
- Based on proper knowledge and understanding of factors that lead to short birth intervals, targeted activities should be developed aiming at wider adoption of family planning for birth spacing.
- In the future, the choice of available contraceptive methods should be widened.
- In order to get more systematic insight in the Quality of Care of contraceptive and directly related services, it could be considered to implement an independent review at this point, using the so-called 'Situation Analysis' approach in a representative sample of service points.
- Refresher courses should be developed and implemented for those health professional who have already been trained, in order to keep their level of knowledge and skills up to date. Such refresher courses should preferably be given every 5 years.

- In the next programme cycle the emphasis in training should be shifted from ob/gyn's to family physicians and midwives, in order to reach more couples in remoter areas.
- It should be seriously considered to include a full fledged 'male involvement' component in the next programme cycle, for a wide variety of reasons
- As in many other countries, it is to be expected that focus on adolescent health will given in the near future.
- The know-how regarding the planning, conducting, analysing and reporting of surveys urgently needs to be improved.
- Data collected for monitoring service performance should be systematically fed back to those who have originally collected them.

1. INTRODUCTION

Project TUK/96/PO2 is one of three closely inter-linked projects in Turkmenistan, that are funded and partly executed by UNFPA. Besides this project, PO1 deals with procurement of equipment and contraceptives, and PO3 with IEC for reproductive health. The close inter-relatedness of the three projects means that project PO2 cannot be evaluated in a completely isolated way. In this report, therefore, progress in the other two related projects is briefly referred to, if necessary.

This evaluation deals in particular with the role of WHO, the agency that has commissioned this evaluation. WHO is one of three executing agencies, besides the Ministry of Health of Turkmenistan, and UNFPA. The role of WHO focuses on technical assistance in training of health personnel, technical support in conducting research activities, and, to some extent, on monitoring and evaluation. The Terms of Reference (see Appendix 1) of this evaluation are broader than the role of WHO in the project. This is justifiable, because only the combined effort of the three executing agencies can be expected to lead to reaching the stated objectives. In the ultimate impact evaluation, it is virtually impossible to evaluate one of these three in isolation. Therefore, the focus in this evaluation is on the contributing role of WHO, but with several side-steps to the role of the other two agencies. In this way, this evaluation is probably most beneficial to all three parties concerned.

The methodology of this evaluation has been the following. To start with, available documents on the project have been studied before the mission started. Besides the original PROJECT AGREEMENT, these were mainly mission reports by experts that have rendered technical assistance for WHO. Based on these, a preliminary schedule of agencies and individuals to be met was made and shared with the local project staff, before the start of the mission. After arrival in Ashgabat, this schedule was further refined and adapted. During the mission, this schedule was continuously adapted, as deemed feasible while the evaluation proceeded. Many other documents, available at the project implementation site, were added to those originally received, and studied during the mission. Most of these were very valuable for the evaluation. Where possible, advantage was taken of activities taking place in the framework of the project, during the mission, by participating in them. These were extremely valuable in getting first hand impressions of how the project is perceived and supported in the country.

During the mission, on 2-4 December, a national RH conference took place (the third of its kind), organised by the project office, to review and discuss progress made over the past year. Participation in this meeting was particularly useful, because the most recent data on project performance in the entire country were presented and discussed, and because it included an opportunity to meet with all key project staff, working at the Velayat level. Information was obtained from many of them.

During the mission, a large number of people have been met in a variety of institutions and agencies, that play a role in, or are otherwise relevant for the evaluation of the project (see Appendix 2).

This report is based on documentation of the project and project performance by the project staff and visiting consultants, interviews with a variety of persons that play a role in the implementation of the project, or are crucial external observers of it, and observations made during the mission.

In this report, the Terms Of Reference (TOR) are systematically followed. Only in cases where it was felt feasible to change the order of the TOR or add paragraphs, in order to facilitate a proper understanding of project performance and its impact, some changes were made.

2. OBJECTIVES OF THE PROJECT

1. Long range objectives

To have improved reproductive health conditions, including maternal and child health, and to have ensured that pregnancy occurs by choice and under circumstances of the lowest risk, within the framework of the Government of Turkmenistan's programme "Road to Welfare", through UNFPA national programme support.

2. Immediate objectives

By the end of the project period:

- 2.1. To have strengthened the national capacity for formulation of reproductive health policies and strategies, and implementation, supervision, monitoring and evaluation of reproductive health programmes, including HIV/STD prevention;
- 2.2. To have increased birth intervals in Turkmenistan from 1.5 years to more than 2.0 years among 20% of the pregnancies by the year 2000 through improving people's access to birth spacing information, supplies and high quality services with provision of a broad range of methods;
- 2.3. To have further improved performance and skills of health personnel through institutionalising their continuing education in reproductive health including HIV/STD prevention and family planning; to have developed the capacity of one local training institution and provided training in reproductive health to 300 health professionals including physicians, midwives, nurses, doctor's assistants; and

2.4. To have further strengthened the existing reproductive health services including those for maternal and child care, through technical support for identification of programme priorities, adoption of appropriate strategies and improvement of reproductive health facilities; and to have contributed to the reduction of infant and maternal mortality by 10%, and of anemia among pregnant women by 20%.

3. GENERAL COUNTRY CONTEXT

It is important to mention some general features of the context in which project PO2 has been implemented. Turkmenistan is a new independent country, formerly being part of the Soviet Union. A UN office was established in the country only shortly before the formulation of the project, and the UNFPA projects under review here were the first to be started. So, they did not build on previous local experience.

The structure of health care stills has several characteristics of the former Soviet Union, including over-emphasis on curative care, shortage of knowledge and experience in disease prevention and health promotion, a sheer lack of private initiatives, and, according to international standards, far too many professionals working in the health sector: about one quarter of the work force.

The Government is aware of these imbalances. In 1995, the ‘Presidential State Programme of Turkmenistan “Health”’ was launched, which aims, among other things, to reduce the dependency on curative care, strengthen primary health care, diminish the capacity of hospitals, and reduce the number of health professionals. An important element is also the creation of the new function of family physician. Redundant former specialised doctors are being retrained for this new function, or plans are made for this. The Government is very much involved in the process of implementing health care reform along these lines.

The mere idea of non-governmental initiatives to improve health is still almost unknown. There are hardly any NGOs that aim to improve the health of the population, although some scattered initiatives in this direction have recently started. Some of these now get support from the UN Office.

The cultural conditions and traditions make it difficult to publicly address certain RH issues. For example, words like “condom”, “abortion”, “sexuality”, etc. can not be used in public meetings or in the mass media. In a book for women on breast feeding, that has recently been translated into Turkmen language, the drawings showing the breast had to be deleted. These conditions put quite serious limitations to preventive work.

4. BRIEF PROJECT HISTORY

The project was formulated before, and submitted on 24 June 1996, at the request of the Government of Turkmenistan. The original document mentions 1 April 1996 as the planned starting date. Actually, project implementation started in May 1997, at the initiative of the previous UN Resident Representative (also UNFPA country director). The reasons for the delay seem to have been partly connected to some initial hurdles in establishing the UN office in Turkmenistan, and partly in delays at WHO in organising the needed expert support. The

project document was signed by the Ministry of Health and UNFPA in November 1997, and by WHO in January 1998. Originally, the Geneva office took charge of execution, but in 1998 the responsibility was shifted to the European office in Copenhagen. A national project officer, Mr Eziz Khellenov, was appointed in June 1997. He became National Programme Officer about one year later, when Mrs Gozel Khodjaeva was appointed in his previous position. During the second half of 1998 and 1999 the staff for the entire programme (PO1, 2, and 3) rapidly expanded, and by the end of 1999 included 8 plus 2 drivers.

From the start on the project has been a national one, covering the entire country, and it still is.

The project duration is at first sight somewhat confusing. The project document states “1996-1997”, but it has always been understood, by all concerned, that the project would last for about 2.5 years, through 1998. Because of the delayed actual start, during the 1998 TPR, the Government requested extension of the project period for one more year, which was then decided, without changes in the overall budget. This evaluation therefore took place during the final month of the project, at a point in time when the entire staff was very busy organising and conducting the “National Conference”, and preparing for the TPR one week after the mission.

The Work Plan of PO2 was only finalised in November 1997, during a visit of the Regional Representative of UNFPA. A rather remarkable feature of that original work plan has been that WHO is hardly mentioned as a responsible implementing partner (only mentioned in relation to organisation of an international study tour and in relation to “WHO’s rapid evaluation method”).

The Work Plan indicates three major areas of activity: training, research and monitoring and evaluation. Preparation of the training activities started in September 1997 with orientation of training needs, development of training curricula and training packages (WHO mission, B. Schaap), and, later on, selection of so-called “master trainers”. During the same period, under execution of WHO, two preparatory activities abroad were undertaken. A group of four policy makers/specialists plus an interpreter went to Indonesia for three weeks to learn from its FP/RH programme, and 6 ob/gyn’s, being the chiefs of the 5 Velayat and Ashgabat, were sent for a one month training to Hungary. These latter professionals would later on become master trainers, together with several others. A first TOT for these future master trainers was organised in February 1998, after which 17 master trainers were certified to be trainers in their respective Velayat (some did not pass the final exam).

Actual training of ob/gyn’s (12 days) at the Velayat level started shortly after, and by the time of the first TPR (tri-partite review) in October 1998 twelve training courses had already been conducted (average number of participants:18). At the TPR it was decided to conduct a second TOT, which took place in December 1998, where another 17 master trainers were certified, adding up to a total of 34 master trainers. All were active trainers in 1999, some of them also as supervisors of performance in service delivery in the entire country. As a result, by November 1999, 334 ob/gyn’s (out of about 1000) had been trained.

In March 1999, a 3-day workshop was organised for the master trainers, to adapt the training programme for family physicians (FPs) and for midwives. The first would be given an 11-day training, and the second a 6-day one. The one day difference for the family physicians (many of them being gynaecologists, by the way) is only that they are not taught IUD insertion, as they are not entitled to do this. The midwife training is more geared to just informing clients. Training of these two categories started in the course of 1999. By the end of the year, 108 FPs

and also 108 midwives had been trained (many more are planned for in the coming project cycle). In September 1999, the WHO consultant who had initially prepared the curricula, evaluated these training courses, by participating in them, and gave many recommendations for their improvement.

Three national surveys were initially planned, one KAP, one on RTI, and one on environmental factors affecting reproductive health. The last one was cancelled in 1998, for two reasons. The national capacity to carry out this study was insufficient, and the issue would be included in another project. Funds allocated for this project were transferred to strengthen the other two research projects. These two were planned and prepared in some more detail during a WHO mission in May 1998. The KAP survey was carried out, analysed and reported in the remainder of 1998, but the results were hardly used afterwards. The RTI study, involving 5 different groups of women, was started shortly after the KAP, and the first results were reported by the responsible WHO consultant (Mrs Stray-Pedersen) at a meeting in May 1999. Plans were subsequently made to publish the results in international medical journal, but these plans had not yet materialised in November 1999. One of the reasons appears to be that the question whether the largest group (pregnant women) is representative for Ashgabat and surrounding area is as yet unresolved.

Several other studies have been initiated, but all of them not under PO2, but under other programme titles. These include a study on breast feeding as a method of contraception (UNICEF), one on prevention and treatment of anaemia (UNICEF), two on adolescent RH (anamnestic assessment), and on knowledge, attitudes and behaviour regarding sexual and reproductive health. All of these studies were reported on at the RH national conference 2-4 December 1999. Furthermore, there is mention in some documents of a large “provider study”, but details about this could not be obtained. Also, an initiative had recently been started to conduct a national study on “integrated management of childhood diseases”, to be supervised and executed by UNICEF and WHO, but this one was still pending, awaiting WHO funding. Finally, an agreement has been reached by all parties concerned to implement a DHS study (MACRO International) in the year 2000. In all the studies mentioned, the research department of the Mother and Child Health Institute (MCHI) plays a central role.

A wide range of activities have been initiated to create suitable systems of monitoring and evaluation, as well as supervision, for PO2 (and PO1) project elements. Several consultants (some UNFPA/CST, some WHO) have carried out missions to properly organise and support these activities. The objectives of these missions cover the areas of contraceptive logistics, client registration, organisation and formats for reporting, and supervision. Basically, all of these systems were properly in place by the time of this mission, although several improvements were still needed.

Under project PO1, the entire country is being supplied by all contraceptives needed in the programme, and some other supplies and equipment have been delivered. This provides a firm basis for most activities carried out under PO2.

Finally, mention has to be made of a rather impressive and wide range of activities started under PO3 (IEC). These activities supplement, support, and often have direct links with those under PO2.

All in all, the three related projects PO1, 2, and 3 now constitute a multi-faceted programme, executed, implemented and supported by a range of organisations and agencies, but at the same time pretty well co-ordinated.

5. MAIN FINDINGS

1. Relevance of Project Design

The initial project formulation has suffered from a lack of accurate data on RH, and, as it seems, limited knowledge of social and cultural conditions relevant to RH. Because of the crucial relevance of the shortage of reliable basic data for this evaluation, a brief overview of these shortcomings is presented first.

The project document mentions a total fertility rate (TFR) of 4.6 (no year indicated), but the TFR was already substantially lower at the time of project formulation. Data obtained from the Institute of Statistics and Forecasting (ISF) give a TFR of 3.4 for 1995. This later declined further to 2.5 in 1998. Also, the difference between rural and urban areas was less than suggested (“wide variation”) at the project start. In 1995 the rural and urban TFR was 3.95 and 2.73 respectively, and declined to 2.86 and 2.07 in 1998. It is possible that ISF data are incomplete, but it is unlikely that this would be substantial.

The Infant Mortality Rate (IMR) originally mentioned (46/1000) could have been close to the truth. Current data from ISF for 1995 indicate 41.1, but some underestimation is likely, according to one expert.

The Maternal Mortality Rate was originally estimated at 100/100,000. The reliability of this indicator is very difficult to estimate. The MOH still uses this rate for 1996; in the two years after that the rate is said to have declined via 71 in 1997 to 64/100,000 in 1998. However, the ISF uses data that are more than 50% lower (50, 44, and 22 for 1996-98). As long as reasonably reliable data on this crucial indicator are not available, it is difficult to assess project impact at this point.

The abortion ratio (mistakenly called “rate”) at the start of the project was estimated at 330 per 1,000 live births (the 100,000 mentioned in the project document has probably been a typing error). This would have meant an abortion rate of approximately 30-35/1000 women of fertile age.

Data on contraceptive use in the project document are likely to have been incorrect. It mentions 80% of modern contraceptive users having an IUD, but this is more likely to have been over 95% (see: Impact; Contraceptive use; below). Oral contraception, injectables and condoms were hardly used before the start of the project. This can be inferred from the clinical trend data that have been systematically gathered as part of the project, during the past two years. It would therefore not be wise anymore to use the older data as a baseline. Finally, the trend in breast feeding is somewhat confusing. The project document mentions a substantial decline in its use. According to the national expert on this subject, the more precise trend has been a substantial decline during the Soviet period due to free of charge distribution of artificial formula. After independence, this practice has been stopped, which has probably caused an increase in breast feeding during the past years.

Knowledge about the structure of the health care system and about the knowledge and skills of health professionals has been much more accurate. This knowledge, in combination with a rough assessment of the RH needs of the population, has been more important for the original design of the project.

In retrospect, the design of the project has been adequate in many respects, in spite of shortage of reliable baseline information. The many positive results will be dealt with later. At this point, a few shortcomings in the design are mentioned.

Objective 2.2.2. is “to have increased the birth intervals from 1.5 to more than 2.0 years among 20% of the pregnancies by the year 2000”. However, as one international consultant recently found out after analysing 850 patient record, in actual practice the subjective need among the population is more for limiting than for spacing births. As a result most of the contraceptives and contraceptive services are used for the first purpose. The socio-cultural pressures to have two or three children shortly after marriage seem to have been underestimated in the original design. In this design, more emphasis should have been given to understanding these pressures, through qualitative socio-cultural research, and more IEC activities should subsequently have been planned to educate the population on the importance of longer intervals for health reasons, in order to achieve this objective.

It should be noted here that preliminary data from one Velayat (Lebab), that could not be verified, seem to indicate that at least in that region birth intervals are getting longer (45% of births occurring more than 3 years after the previous one; N.B. the basis for this percentage was *all births, including first births, that of course have no interval*).

A conclusion about changes in the length of birth intervals as a result of the project can hardly be drawn, because the period between start of project implementation and latest available data on birth intervals is too short.

In Objectives 2.2.1. and 2.2.3. reproductive health programmes *including HIV/STD* (Italics EK), are mentioned. In spite of the fact that the PO2 project document repeatedly mentions integration of HIV/STD prevention and management, no separate project component was formulated aiming at such integration. Because (primary) prevention of STDs has traditionally been a largely underdeveloped area in former Soviet countries, and because management of STDs is institutionally separated from family planning and MCH services, much more attention should have been paid in the design of the project to this major issue. (It should be added here that in practice \$25,000.- from the PO1 budget has been used to supply HIV tests; and under the PO2 project condom distribution has taken place.)

Objective 2.2.4. is “to have further strengthened the existing reproductive health services *including maternal and child care*” (Italics EK). Here, the same remarks have to be made as in the previous paragraph. Planned PO2 project activities have not been *substantially* directed at improving maternal and child care. Instead these activities have, up till now, more been focused on creating a new network of family planning, or birth spacing services, with limited direct relevance for maternal and child care (other than through prevention of high risk pregnancies and longer birth intervals).

In conclusion, in terms of guaranteeing provision of adequate contraceptive services, the design of PO2 has been more than satisfactory (as is shown later), but in terms of providing an adequate framework for working substantially on other aspects of RH, the design has been too narrow.

The planned activities were not sufficient to achieve the broader RH objectives. This does not mean that substantial progress in some of these areas would not have been made, but that progress can only to some extent be attributed to PO2.

2. Progress-performance

After the initial delays mentioned earlier, and taking into consideration the limitations described in the previous paragraph, progress-performance has nevertheless been very substantial and impressive! Implementation at the service delivery level only started about 1½ year ago, but several results were already visible during this evaluation. Evaluation of the impact in the general population is hardly or not possible after such a short period; this takes at least three year from the start. But in terms of creating the needed positive conditions for project implementation, and of actually starting planned activities, the project has rapidly moved forward. In fact, in several respects, more has been accomplished than was planned. One important reason for this overall impression is the competency of project management. The UNFPA National Programme Officer, Mr Eziz Khellenov, has a clear sense of direction, dedication to the project's (and programme's) objectives, and good management skills. Generally, there is a positive atmosphere among the staff, a willingness to collaborate, and a strong intention to make progress.

The working relationships with other project partners vary from good to excellent. Collaboration with the Ministry of Health (MOH) is intensive and effective. Until recently, implementation of project activities by the UNFPA project staff required authorisation by the MOH, which caused some bureaucratic burdens on the MOH, and led to delays in some project activities. These procedures have now been changed for the better, thus increasing the efficiency of the implementation process.

Collaboration with the MCHI, a major partner in almost all project activities, is close and more than satisfactory. The director of the institute, Mr Chary Nazarov, is particularly satisfied with the fact that the institute can collaborate directly, and on an equal level, with UNFPA. As could be very well observed during the National Reproductive Health Conference, the collaboration with the RH centres in the Velayat is intensive and highly appreciated from both sides. Suggestions and advises are mutually taken seriously, and where possible followed up.

A general feature deserving to be mentioned is the willingness of the project management to listen carefully to suggestions and recommendations for improvement of project performance, to take them serious, and act on them where possible. This also holds true for recommendations given by visiting consultants.

Achievements on most of the immediate objectives are described in some detail in the chapter on Impact. At this point, only those achievements that are not directly related to impact on the general population are dealt with.

Objective 2.1.

The national capacity for formulation of RH policies and strategies, and implementation, supervision, monitoring and evaluation of reproductive health programmes, including HIV/STD prevention (Immediate Objective 1), has clearly been strengthened. This finding does apply to the national, as well as to the Velayat level. Project activities are adequately and realistically planned and implemented. A centralised system of supervision, implemented by MCHI, has been developed and is now well functioning. Suggestions from visiting

consultants to make this system more support than control oriented have been taken serious and have been followed up. The supervisors, one for each Velayat (all working at MCHI), gave a clear impression of knowing about the conditions and developments in 'their' Velayat, and had generally good contact with their counterparts there. In the recent past, several improvements have been made in the system of monitoring and evaluation. Data collection for monitoring has been standardised, and overviews of these data are sent to MCHI on a monthly basis. However, questions remain about the accuracy and completeness of some of those data (see Impact). The system does hardly include data on quality of care. To review this quality, periodic in depth assessments would be needed. Data on STD incidence are not regularly collected as part of the project.

Objective 2.2

People's access to birth spacing information and services, and the range of contraceptive methods have been greatly improved. One RH Centre per Velayat was originally planned, but there are now already two of these centres in each Velayat. RH cabinets have been created and equipped in each of the 47 Etrap. Serious problems in supplying these centres with a range of different contraceptives were not be observed. The centres are also supplied with information and education materials through the PO3 project. For example, during the evaluation the IPPF poster on "Rights of the Client" were being distributed (it was actually hanging on the wall in one of the three centres visited). Written information on proper use of the client's method of choice had been made available, and Turkmen language versions of these leaflets became available at the time of the mission.

Objective 2.3

The performance and skills of health professionals has been greatly improved, first through the series of courses that have been developed and implemented. By December 1999, altogether 334 ob/gyns had been trained in 12 day courses, and so were 108 family physicians (11 days), and 108 midwives (6 days). Taken together, this is almost double the number that was planned in the project (300 health professionals)! The quality of these courses has been judged satisfactory and effective by visiting experts in this field. All trainees had received a full training pack. Performance of these professionals is further improved through regular supervision visits, short workshops, and through three national conferences that have been organised (the last one during this mission). In the courses, STD/HIV prevention and management is discussed in one day, which is rather short. By order of the MOH, in each of the by now 12 RH centres a part time venerologist and a part time psychologist should be working (besides an ob/gyn and a midwife). In practice, this is only the case in two Velayat (Lebab and Mary). In the other, the lack of sufficiently trained specialists is the main problem. There is still a need for more extensive training in STD prevention and management.

Training of RH specialists has not yet been institutionalised, in the sense that this would be fully integrated in regular curricula for the training of relevant health professionals. It is still a separate programme of additional training and retraining, fully dependent on UNFPA support, and co-ordinated by MCHI. This does not mean that there would be no training in RH at the Medical Faculty of the University (The Medical Institute). At this Medical Institute a RH module, developed and implemented by JHPIEGO, is part of the training of obgyns and family physicians. The module is shorter than the PO2 one; it only includes contraception; and seems to focus less on patient education, interaction and counselling.

Objective 2.4

The existing RH services have not only been strengthened, but new ones have been created in addition to them. As mentioned before, 12 RH centres (2 in each Velayat) have been set up and equipped; their personnel has been trained; and they receive regular contraceptive supplies. Furthermore, 47 RH cabinets at the Etrap level have been established. Originally, the focus had been entirely on these centres and cabinets, but later on it has been recognised that other types of services should be included in the activities of the project. Currently, maternity hospitals and gynaecological departments of general hospitals are also supplied with contraceptive supplies and information materials on contraception and birth spacing. Substantive additional activities to improve maternal and child care have not yet been started. The life of the project has simply been too short for this. These activities are now being planned within the coming programme cycle (2000-2004).

Self-reliance of the Government has been achieved up to the point that the Government fully supports the project, and fulfils its role as one of the three executing and implementing agencies. In a meeting with him, Mr B. Sopiyeu, Deputy Minister of Health, expressed his appreciation for the collaboration with UNFPA and WHO. He hoped for continuation of this form of collaboration in the coming years without major changes in the role of each of the partners. No indications were given that the Government itself would intend to procure contraceptive supplies in the near future.

3. Effectiveness

As mentioned earlier, more activities have been implemented than were planned, within the limits of the available budget. The implementation of training courses has been effectively decentralised: trainers are available in each Velayat, and they have successfully conducted a large number of courses. Decentralisation is important because of the large size of country. It was not possible to assess to what extent there has been a cascade effect of this training at the local service delivery level, but some examples of this were given by trained service providers in talks with them, and some visiting consultants have observed such an effect.

Technical assistance provided by WHO in developing the training courses and training materials, and in implementing the first TOT has been adequate. The trained trainers were subsequently sufficiently competent to conduct the courses independently in a satisfactory manner. The second TOT could thereafter successfully be conducted without additional assistance.

Technical assistance provided by WHO to the conducting of surveys in the general population should have been more intensive. Three surveys were initially planned, of which one was cancelled for legitimate reasons. Available funds for this survey (on environmental conditions) have subsequently been transferred to the other two surveys, in order to strengthen them.

However, the final result of the KAP survey (3,000 respondents) has not been adequate. The report, which has remained largely unused for more than one year now, demonstrates many deficiencies, including a general inaccessibility, lack of a clear reporting structure, absence of crucially relevant tables or figures, summary, conclusions and recommendations. This seems to result from a lack of experience in conducting, analysing and adequately reporting a survey. The report would benefit from a restructuring and editing process in addition to some more core analysis. Also, the suggested time schedule for the development of this survey, conducting the field work, and analysing and reporting the results has been far too tight (6

months from preparation to final report), particularly for a staff with very limited experience in conducting surveys. One of the main problems, that have not been sufficiently recognised is the lack of experience in conducting problem- and solution oriented surveys. Finally, more assistance should also have been given to the process of “translating” results to practice and subsequently feeding these results back in order to improve practice.

A complete evaluation of the assistance given to the RTI survey cannot be given, because of shortage of information on this project. The design of it seems to have been adequate. A final report was not yet available in English (only a text in Russian was seen, and a report on some of its outcomes was given at the National RH Conference). There was a difference of view between the responsible assisting WHO consultant, Mrs Stray-Pedersen, and the responsible researcher at MCHI, Mrs Y. Partsalis, on the question whether the important group of pregnant women in the survey would be representative for (a larger group in) Ashgabat.. On the other hand, it must be mentioned that some results from the survey had effectively led to new activities in service delivery (on prevention of miscarriage), with positive results.

Technical assistance given to improve the MIS has been largely adequate. Recently given recommendations had been effectively followed up. At the same time, it had to be concluded that data collection was sometimes incomplete, or at least delayed. The officer responsible for collating the data at the national level (MCHI) was seriously handicapped, because she did not have access to a computer. All tables were hand written, and a small pocket calculator was her only tool for making calculations. She should be better equipped in the near future.

4. Role of women

The overwhelming majority of clients in the project are women. A vast majority of personnel working in the project is female. And the majority of the persons in project management positions are also women, although the most crucial management positions tend to be occupied by men.

But men are scarce!

The project gives the impression of being strongly “feminised”; it is women working in the interest of other women. This characteristic is one of the main strengths and one of the main weaknesses as well. The strength is that all this female personnel often tends to identify strongly with the needs of the women they serve, which increases their motivation and dedication. At the same time, the almost complete absence of male involvement (there are some exceptions) tends to cause a focus on the immediate, practical needs of women, and to some neglect of their more strategic needs. For example, if an STD is diagnosed the *woman* is usually referred to a venerologist for treatment, placing the burden of seeking this treatment on her. Whether her husband, who might well have infected her, will also be treated, again will depend to a large extent on her initiative. Similarly, only the *woman* will usually be informed that she should preferably have a longer interval between births, but it is subsequently on her to convince her husband of this need. Service providers tended to ascertain that they try to inform women that it would be preferable to bring their husband for counselling, but nevertheless the impression was that in most cases it is still only the woman who receives counselling.

In the PO3 project men are addressed as well, and some good examples of it were seen in a stage performance and in a puppet show performed by a new NGO that is now involved in the project. These kinds of activities should be strengthened and supported, in order to create a clear image of RH being an issue that is relevant to both women and men, and for which men feel they share responsibility.

5. Role of executing agencies

The role and responsibilities of the three executing agencies are clear and mutually understood. The UNFPA project staff, located in the UN building, usually initiates implementation of project activities. UNFPA gives support to the staff through UNFPA/CST in Nepal, the Regional Office in Almaty, Kazakhstan, and headquarters in New York. Because of these multiple direct ties, the staff has a natural tendency to identify themselves first with UNFPA. The role of the Government is strong and co-operative. Almost every activity is implemented by the Government or a Government agency, particularly MCHI. In the past year, the MOH has somewhat lessened its direct control over the implementation of project activities, passing some more implementing authority to UNFPA and MCHI. The project has benefited from this gradual change, leading to more efficiency, less delays, and lessening of the administrative burden on the MOH.

WHO has the disadvantage of not having a physical presence in the country, and in the UN building. It therefore has no natural, informal day to day contact with the project. This creates a risk of insufficient fine-tuning of WHO execution with local conditions and progress of the project. Given this risk, the actual role WHO has played in the project has been reasonably successful. It could be further improved in at least two ways. Visiting consultants should preferably be those who already have familiarised themselves with the local conditions through previous visits. Such knowledgeable experts can sometimes also render support without actually visiting the project. Secondly, the potential of using the WHO liaison officer in the MOH for getting a more intensive contact with the project seems to be under-utilised. The issue of intensifying the direct link between WHO and implementing project staff should be given ample attention with a view on the continuation of project activities.

6. Impact

Use of contraceptives

For this indicator there are two sources of data: the KAP survey and the system of monitoring service delivery, implemented by MCHI. Some scattered information is also provided in mission reports of visiting consultants. The CPR in 1997 was estimated at "about 15.5" (mentioned in KAP report; source not mentioned).

The results of the KAP survey (fieldwork October 1998) still need to be recalculated. In the report, the percentage of women in union using contraception is not mentioned. I have given detailed advise on how to calculate this, but during the mission, there was not enough time to produce the needed tables.

Data obtained from the MCHI were extremely useful. This system of reporting is based on client records. The data are transcribed on overview tables that are subsequently sent to MCHI. Apart from surveys, this is the only source of data on contraceptive use in the country. The system has been reviewed in some detail, and the most recent data were obtained.

In his mission report of October 1999, P.M. Brandt, using the same MCHI data, mentions a CPR of 27% in December 1998, 28% in June 1999, but then a drop to 25% in August. The latter, Mr Brandt reported, may be due to incompleteness. However, data for October 1999 also indicate a CPR of 25.2%. This means that, unless reporting has become increasingly incomplete, the CPR has stabilised at around 25% during 1999. Because of the quite crucial significance of this finding, there is an urgent need to first try to clarify the background of this levelling off.

Data on new acceptors of contraception possibly shed some additional light on this question. Data on new acceptors of the IUD and oral contraception were obtained. These show the following trends (absolute numbers of new acceptors):

	1994	1995	1996	1997	1998
IUD	44,168	56,092	53,769	52,215	43,593
OC	2,655	26,531	33,146	33,092	37,533

After 1995 the strong dominance of the IUD in choice of method has diminished, and adoption of OCs has strongly increased. If these data are compared to the calculated actual numbers of current users, the following picture emerges. In October 1999 there were 254,186 IUD users (23% of women of fertile age). This number about equals the number of insertions during the past 5 years, which does not seem to be unreasonable. But the number of OC users in October 1999 was only 16,887. This is extremely low in comparison to with the annual numbers of new acceptors! It would mean that out of the nearly 133,000 new OC users during the period 1994-1998, only 13% are still using the method. This calculation should be handled with extreme caution, for example because several women get their first supply somewhere else than the following ones and are then registered twice as new acceptors. It is even possible that women are registered as new acceptors every time they ask for a new supply, because of inconsistencies in the recording system. But the conclusion that there is a high drop-out rate of OC users is nevertheless likely. This conclusion has also been drawn by other visiting experts.

Some progress is nevertheless made in the contraceptive method mix. According to P.M. Brandt (October 1999), the share of IUDs dropped from 97 to 98% in 1995 to 88% in mid-1999, while the share of hormonal methods increased to 10-12%. Use of condoms, however, remained insignificant at less than 1%. Data for October 1999 indicate a mix of 91% IUD, 6% OC and 3% injectables.

In conclusion: available data indicate an increase in CPR up till the end of 1998, followed by a stabilisation. The same data also show stagnation of the previously observed trend toward a more varied method mix.

There is a need to review the system of collecting and reporting these data, with special emphasis on accuracy, completeness and method of calculation. Also, there is a need to study the magnitude and causes of drop out after adoption of OCs (and possibly also injectables).

Use of abortion

This indicator is difficult to assess, because of discrepancies between data obtained, that could not be explained. The ISF has calculated the following rates per 1,000 women of fertile age for 1995-98:

		1995	1996	1997	1998
All abortions*	33.8	31.9	33.8	33.0	
Of which mini-abortions	4.0	4.4	5.5	5.9	

* includes spontaneous and "unknown"

However, the MCHI, that relies on the same reporting system and actually collects these data, shows a different picture for 1998. The discrepancy could not be explained. MCHI shows a sharp decline in the number of abortions reported in 1998 to 22 (instead of 33), and that sharp decline continues in the first 10 months of 1999. This last decline is said to be partly due to delays in reporting, particularly on 'artificial abortions'. People working in the field give mainly two reasons for this decline. First, the introduction of a fee for abortion (about \$3.30 for 'artificial abortion' and half the amount for mini-abortion). These fees are a very heavy financial burden on most of the women concerned. And second, the increase in modern contraceptive use is given as a reason.

Unfortunately, both explanations cause some puzzles. If the number of abortions drops because women cannot afford them anymore, there would, by necessity, be an increase in the number of births. But the birth rate continued to decline in 1998. And, if the data are correct, increased contraceptive use can also not be the cause, because since December 1998 the CPR has stabilised at 25%, and the number of abortions continued to decline sharply over 1999. Reports presented by Velayat officials during the National RH Conference (December 1999) also mentioned significant declines in numbers of abortions, recently. They also mention a gradual shift toward mini-abortions. The latter is not really confirmed by MCHI data. There was indeed a shift toward mini-abortions until 1997, but in 1998 the number of mini-abortions declined suddenly by 37%, while the number of all other abortions (including spontaneous) declined by 14% only.

In conclusion: in spite of conflicting evidence, it seems that there has been a decline in abortion rate, particularly during the past two years. But the actual rate, the magnitude of the decline and the causes of it are unclear.

Maternal and Infant Mortality

As stated earlier, given the problems in defining, reporting, and correcting initial reporting on maternal deaths, it is at this stage not possible to mention reliable data at this point. However, it is very likely that there has recently been a substantial decline in MMR. In private discussions with experts on maternal mortality at the Velayat level, during the National RH Conference, sufficiently detailed information could be obtained to convince me of this declining trend. The reasons for this are more difficult to grasp. RH service providers tend to attribute this mainly to better prevention of high risk pregnancies, but this explanation seems insufficient for the sharp drops shown at Velayat level (in some cases a reduction by some 75% in 3 years).

On infant mortality little information could be obtained. ISF data show a drop from 41.1 per 1000 new borns in 1995 to 31.7 in 1998. Also some impressionistic information makes it reasonable to assume that some decline has indeed occurred, but the magnitude of it is not clear.

Information available to young people on Sexual and Reproductive Health

Impact on this indicator has to be attributed almost completely to PO3 (IEC). For completeness, some essential information is nevertheless given.

The term 'sexual health' is not used in Turkmenistan, because it is felt to be culturally inappropriate. In terms of informing young people on RH issues, remarkable progress has been made recently. In close collaboration with the Ministry of Education and the MCHI, a 34 hours curriculum has been developed for the 9th grade (15-16 year olds). This has been tested, and implementation was started in 1999. Impressions of the first experiences were given during the National RH Conference. The achievement is remarkable, given the rather strict cultural limitations. Furthermore, collaboration with, and support to some newly established NGOs (mainly women and youth organisations) has generated additional activities (most at the local level) to informing young people about RH. Also these activities are rather courageous and remarkable within the prevailing cultural context. The personal initiatives of the UN ResRep, Mr Jens Wandel, should also be mentioned here. Among other things, he has recently addressed an audience of 22,000 young people on RH, in the national stadium. The meeting was co-organised by the National Youth Organisation. During this mission, he also addressed a meeting of this organisation, at the occasion of World AIDS Day (organised by the national UNAIDS representative).

A variety of IEC materials for young people have been developed under PO3, and are now being distributed.

The contribution of PO2 at this point is necessarily limited, because it concentrates on services, that are scarcely attended by young people. However, it should be noted that some Velayat level RH Centres have taken the initiative to establish confidential RH (information) services for young people, and some outreach work to schools or disco's has been initiated privately by staff members of such centres. These initiatives are extremely encouraging, because they demonstrate personal dedication.

The results of a representative survey among boys (14-19) and girls (15-19) -3000 respondents together- should be mentioned here. These results, brand new at the time of the mission, indicate a low level of information (on relevant indicators about a quarter to a third of respondents have a satisfactory score). They also indicate quite a strong wish to be informed about reproductive health. 15% of girls and 39% of boys feel that sex before marriage should be possible. Girls were not asked about sexual behaviour, but boys were: at age 18, 50% of them (!) said they had experience with sexual intercourse. Some doubts may be cast on the validity of the last finding, but it seems clear that among current youth in Turkmenistan sexuality is an area of great interest.

In conclusion, information on RH given to young people is a new phenomenon that is developing rapidly, and there is quite some synergy between PO3 and PO2, as well as other initiatives that are spontaneously being developed in the country. The need for such information in the country is huge.

Information available to the public on RH

Like the previous one, this is also primarily within the realm of PO3. Under this project a variety of IEC activities has recently been started, using television, radio, newspapers (a women's newspaper has been established with project funding), theatre, information leaflets and brochures, etc. The impact of these activities cannot be assessed at this point (a national survey would be needed for this purpose).

The impact of PO2 is largely limited to reaching the clients that attend the RH services. During counselling they are given some oral information, but several international consultants, that have recently visited RH centres and cabinets throughout the country, have

expressed their doubts about the width and depth of this information given. The quality of this process can only be assessed by doing a Situation Analysis (SA), as developed by The Population Council, in a representative sample of service delivery points. It should be mentioned that clients adopting a method of contraception now do get some written information about this method, on top of the information given orally (the quality of this could not be checked). At the National RH Conference, Turkmen translations of these leaflets were distributed to be photocopied and distributed by the Velayat RH Centres.

It should be emphasised here that very little has been done till now to inform men on RH. Some service providers have stressed that they try to encourage women to bring their partners, but is unknown to what extent this is successful. The RH school education programme started under PO3 is highly relevant in this respect because it is implemented in mixed classes (with mixed feelings as well, as became clear during the discussion on this at the National RH Conference). In this field, there is still much that remains to be done in the next programme cycle!

Snowball effect of the project to other regions

It must be emphasised that the entire programme (PO1, 2, and 3) is a national one, which makes it unique in the region. Training of health professionals has been effectively transferred to all the 5 Velayat and the capital of Ashgabat. In each of them there are now 4-5 'master trainers' who implement the standard training courses in their own region. These activities are being supervised by national level supervisors at the MCHI. Snowball effects can only be looked for at the level of individual RH service delivery sites (maternity hospitals, gynaecological departments). Some initiatives at this level were heard of in individual talks with people that have been trained, but the extent of this cannot be assessed. It is useful, nevertheless, to repeat here that many more medical professionals have been trained than was planned under PO2 (almost double the number).

Data collection on abortion

The ICD classification system for abortion is now being used, at the initiation of MCHI. These include so-called mini-abortions. Data for the past three years have been obtained (up to October 1999). Data for the last few months on so-called artificial abortions (=induced abortion excluding mini-abortion) are said to be under-reported due to delays in delivering the data to MCHI.

Mini-abortions are officially performed up to 6 weeks amenorrhea, but in discussions with some service providers it was found out that in practice this may go up to 8 weeks. The same service providers are rather surprised that mini-abortion (vacuum aspiration) is usually performed up to 12 or 13 weeks in western countries. There is a need for more information, and possibly training at this point.

At service sites visited, attempts were made to find out about possible under-reporting for reasons of confidentiality or other reasons, but no such indications were found. This does not exclude, however, this possibility. The very rapid decrease in abortion incidence in 1999 (also mini-abortions) can hardly be explained by the suggested causes.

As a note of caution, it should be mentioned at this point that among visiting experts there is usually little or no awareness of the fact that 'all abortions' include 'spontaneous abortions'. The latter account for 30-40% (depending on the year) of the total! This means that the 'induced abortion rate' is substantially lower than is often suggested. The rate calculated on

the basis of 'all abortions' cannot be compared to the rates published in international induced abortion overviews.

Clinical record cards on contraceptive use

Contraceptive use at the primary care level is documented in a small 'client booklet'. This system needs to be reviewed, improved, standardised, and in the future computerised in the larger centres. External expertise is probably useful for this purpose.

Networking of the project with other reproductive health services

Considerable progress has been made at this point. Initially, the idea was to render all contraceptive services through the RH centres (in Velayat capitals) and RH cabinets (in capitals and in etraps). In the past year, it was recognised that in this way not all women in need of these services would be reached. Consequently, it was decided to include maternity hospitals and gynaecological departments in the programme. These are now being supplied with contraceptives and with information materials. Reassurance was given by project supervisors that also women having 'artificial' abortions are now (supposed to be?) given contraceptive counselling and contraceptive supplies. Similarly, in maternity hospitals all women, immediately after giving birth, are now informed on all available methods of contraception (or at least supposed to be).

In terms of networking with institutions responsible for STD prevention and management not much seems to have been changed. Women diagnosed or suspected STDs are still referred to those institutions, as in the past. Perhaps a good indicator for the lack of progress at this difficult point is the absence of the STD sector at the recent National RH Conference.

Number of professionals trained under the project in country and abroad

Four RH policy makers/key specialists have participated in a 3-week orientation mission to Indonesia.

Six RH specialists attended a one month technical course on contraception (and some related issues) in Hungary. Both took place in the autumn of 1997. Those who were trained in Hungary have all become master trainers and some also supervisors. This training has been a good investment. Some doubts were, however, expressed on the usefulness of the mission to Indonesia. It was felt that the level of development of RH services in Indonesia was not sufficient to be a relevant model for Turkmenistan.

During 1998/99, 334 ob/gyn's have successfully completed the 12 days RH training course; 108 family physicians have completed the 11 days course; and 108 midwives/nurses have completed the 6 days course designed for them. Taken together, this is almost double the number that had initially been planned (300). By the end of 1999, there were trained professionals in all 12 Velayat RH centres and in all 47 Etrap level RH cabinets.

Mention should also be made here of several short seminars and workshops on varying topics that have been organised in addition to the formal RH training courses.

Cost effectiveness of project strategies

Only some general remarks can be made at this point. The overall project budget has remained unchanged, but nevertheless more activities have been developed and more outputs have been produced than were planned. Within the limits of the budget more training courses have been conducted than planned, and more health professionals have been trained.

Similarly, instead of one RH centre per Velayat (6 in total), two have now been established (12 in total) and fully equipped. Instead of one national conference that was planned, three have been organised. And in addition to what was planned, several short seminars and workshops have been conducted.

An important aspect is that in discussions with local project staff and during site visits, a clear sense of local ownership was often observed. This sense of ownership translated into spontaneous initiatives taken by local staff to improve or extend their services, without getting financial incentives for it. Several examples of this could be given.

Some visiting consultants have reported on the problem of contraceptives in stock passing their expiry date. This problem has been seriously worked on. Centres now include in their monthly reports the numbers of contraceptives in stock and the numbers that near the expiry date. It is too early to judge whether these recently taken measures will solve the problem of waste of contraceptives.

Investments in research (KAP and RTI) have as yet not been sufficiently cost effective (see before), and some doubts have been expressed about the cost effectiveness of the study tour to Indonesia.

In conclusion, for the most part project implementation seems to have been very cost effective, but some specific components have not been sufficiently cost effective.

Birth spacing (not as such mentioned in TOR)

To have longer intervals between births in order to improve mother and child health is one of the most important rationales of the project. Detailed data showing a trend over time on this issue were not available. However, the examination of 850 client records recently carried out by Mr Brandt is useful in this respect. His sample showed that 65% of users of modern contraception were aged 30 or more, and that their average age was 32.5. Based on these findings, his conclusion that modern contraception is primarily used for limiting instead of spacing is acceptable.

The outcome of the national KAP study (fall 1998) was that 2% of subsequent births occur within 12 months of the previous one, 64% within 24 months, and only 34% after 25 months or more. Although these data are now more than one year old, since they were collected, i.e. only half-way project implementation, this finding is also not encouraging in terms of achieving the objective of longer birth intervals. A more detailed qualitative investigation into the reasons behind and beyond these short intervals would be very useful for planning future actions at this point.

Anaemia among pregnant women (not as such mentioned in TOR)

Immediate objective 2.4 includes a reduction of anaemia among pregnant women by 20 %. Data on the prevalence are collected in a standard manner among all pregnant women. The responsible officer at MCHI that receives these data from the health facilities was pertinent that this system is still operative, and that the measurement criteria were not changed in the past years. The data she showed did not indicate a decline, but a continuous increase in the prevalence of anaemia, from 41% in 1995, via 47% in 1996, and 49% in 1997, to 51% in 1998. Other informants tended to deny the reliability or validity of these data. A conclusion is therefore difficult to draw. At the same time, it seems to be highly unlikely that the objective

of 20% reduction would have been achieved. Clear activities in PO2 aiming at this objective could not be identified.

6. CONCLUSIONS

I. Project Design and Implementation.

1. The design of project PO2 has been adequate in terms of proper provision of contraceptive services, training of providers in this field, supervision of service performance and monitoring and evaluation of contraceptive service delivery. However, the design has been too narrow to have a substantial impact on other aspects RH, in particular the integration of STD/HIV prevention and management in RH services and improvement of maternal and child health.
2. Quantitative evaluation of progress made in improving RH is seriously handicapped by lack of reliable data on almost all relevant indicators. Although improvements have recently been made at this point, there is still an urgent need for assistance in improving their quality (relevance and reliability).
3. PO2 project objectives have, where they mention prevention of HIV/STD and improvement of MCH, until now only marginally been translated into concrete activities. Sizeable results on these indicators could therefore not yet be expected, even though some activities have been started under the two related projects.
4. In general, project performance has been more than satisfactory. Planned activities have been implemented rapidly and with enthusiasm, and in addition, several other needed activities have been undertaken. Basic features of the practice of the project are good management, intensive collaboration between the three executing agencies, and good reception and support of the project's activities in the field.
5. The national and regional capacity to formulate and implement RH policies, strategies and activities have been substantially strengthened.
6. People's access to birth spacing information and services have been largely improved. This process of improvement is still being continued. An impressive national network of 12 fully equipped RH centres with trained service providers and likewise 47 RH cabinets has been established to guarantee such access.
7. Knowledge and skills of health professionals in delivering RH services has been substantially enhanced. This applies to many more professionals that was initially planned.
8. There is still a need to invest in improving knowledge and skills of health professionals in the areas of HIV/STD prevention and MCH. Also, there is a need to start preparing refresher courses for those trained in the past. And thirdly, the project's experience in training health professionals still has to be transferred and integrated in the regular training programmes of future health professionals.
9. WHO assistance in developing and conducting training courses for health professionals has been adequate and successful. Its assistance in conducting surveys has not been sufficiently adequate, because the existing local experience and skills have been over-estimated. Its assistance in creating and operating monitoring and evaluation systems has been satisfactory, but additional assistance is still needed.
10. In the project, women play a dominant role in almost any respect. This is both a strength and a weakness. The success of the project in terms of improving RH of the population would have benefited from inclusion of a clear strategy aiming at involving men as well.

11. The roles of the three executing agencies are generally clear, and collaboration between them is quite effective. It is important that their collaboration as equal partners, which is now well functioning, is maintained. WHO's physical absence in the country is a relative disadvantage, for which proper remedies should be found.

II. Project Impact.

1. Available data indicate a rapid increase in CPR during 1998, from about 15.5% to 25 or 28%. This substantial increase seems to have been followed by a stabilisation during 1999, that could have been caused by deficiencies in the reporting system. Data also show a stagnation of the previously observed trend toward a more varied method mix.
2. There is some evidence that contraceptives are more often used for limiting than for spacing purposes, but the project is still too young to measure its impact in terms of average length of birth intervals.
3. In spite of conflicting evidence, it seems that there has been a decline in abortion rate, particularly during the past two years. But the actual rate, the magnitude of the decline and the causes of it are unclear.
4. The combination of a CPR of about 25%, a total fertility rate (TFR) of 2.5, and a total abortion rate (TAR) somewhere between 0.5 and 1.0, which are more or less the current values of these indicators, is unrealistic. Either the actual CPR is much higher, or the abortion rate is substantially higher, because a total pregnancy rate (TPR) of 3 - 3.5 ($TPR = TFR + TAR$) cannot be reached with a CPR of 25%. Even with some pregnancy prevention through LAM, a CPR of around 50% is usually needed to achieve a TPR of 3 - 3.5.
5. It is not possible to find sufficiently reliable national data on maternal and child mortality trends. However, reports from different Velayat make it very likely that there has recently been a substantial decline in MMR. It is also reasonable to assume that some decline in the IMR has occurred.
6. A variety of IEC materials for young people have been developed under the PO3 project, which are currently being distributed. The same project has successfully developed an educational programme for schools, in close collaboration with the Ministry of Education. This programme is currently being introduced in schools. Very recent data from a national KAP survey among adolescents indicate that there is a vast need for such IEC activities among this target group.
7. Also under PO2 a variety of IEC activities have recently been started, using television, radio, newspapers, theatre, information leaflets and brochures, etc. Newly emerging NGOs play an increasingly important role in this respect. The impact of these activities cannot be assessed yet.
8. A conclusion on changes in the prevalence of anaemia among pregnant women is difficult to draw, because expressed doubts about the reliability of data at this point. It seems highly unlikely that the objective of 20% reduction would have been achieved. Clear activities in PO2 aiming at this objective could not be identified.

7. RECOMMENDATIONS

- The PO2 project has, in combination with related projects PO1 and PO3, primarily focused on family planning for birth spacing. In the next stage of the programme, objectives and activities should be broadened to cover other major components of

Reproductive Health, including STD/HIV and MCH. In doing so, collaboration with other agencies working in these areas, in particular UNICEF and UNAIDS, should be sought or strengthened.

- The process of integrating family planning, MCH, and STD/HIV services and IEC activities, that has been started at some points, should be given much more emphasis in the next stage of the programme. Particularly the still existing divide between contraceptive services and STD/HIV prevention and management is inefficient because it causes an extra barrier for clients to seek information and treatment, in addition to the psychological barrier resulting from the cultural sensitivity of the issue. The presumably high prevalence of RTI/STD, as suggested by recent research, should be an additional reason to give a high priority to this issue.
- Based on proper knowledge and understanding of factors that lead to short birth intervals, targeted activities should be developed aiming at wider adoption of family planning for birth spacing. For this purpose qualitative socio-cultural research, that looks into the pressures on young couples to get more than one child immediately after marriage, would be useful. Such research should be carried out by a trained sociologist or cultural anthropologist.
- Available data indicate that, after a previous sharp rise, the use of modern contraception seems to have stabilised at around 25% CPR during the past year (which is still a very low level). An investigation should be made of the possible causes of this stagnation. Attention should first of all be paid to the question whether this stagnation is real, or caused by increasing incompleteness in reporting. It would be useful to compare trends in contraceptive distribution to health facilities with reported data on levels of use.
- In the future, the choice of available contraceptive methods should be widened. Implants, particularly the new one-rod implant (Implanon), that seems to be much easier to handle than its predecessor (Norplant), could be an important addition to the range of contraceptive choices. Also, contraceptive sterilisation, although definitely not acceptable yet, is nevertheless a viable option in a country like Turkmenistan, where couples increasingly tend to consider their families to be complete at the age of about 30 years. Finally, information and education on emergency contraception should be continued, particularly as a method to prevent (mini-) abortion.
- The system of producing data on core Reproductive Health indicators (like MMR, IMR, birth intervals, induced abortion rate, and CPR) should be reviewed and subsequently improved. Activities to be developed for this purpose should aim at adoption and subsequent use of internationally accepted definitions, at increasing the reliability and completeness of data collected, and at proper and efficient processing of those data. The officer at MCHI who is responsible for reviewing and collating national data should at least have access to a computer. Assistance of an international expert is needed to make the needed improvements.
- In order to get more systematic insight in the Quality of Care of contraceptive and directly related services, it could be considered to implement an independent review at this point, using the so-called 'Situation Analysis' approach in a representative sample of service points.

- The training curricula and packages that have been developed and used under PO2 should gradually be adopted by the regular medical higher education institution in the country (The Medical Institute) to become part of the regular educational curricula, as an extension and improvement of the JHPIEGO curricula that are currently used. The possibility of using some of the PO2 ‘master trainers’ in this process should be seriously considered. In addition to this, refresher courses should be developed and implemented for those health professional who have already been trained, in order to keep their level of knowledge and skills up to date. Such refresher courses should preferably be given every 5 years.
- In the next programme cycle the emphasis in training should be shifted from ob/gyn’s to family physicians and midwives, in order to reach more couples in remoter areas. The question whether it is efficient and sufficiently cost-effective to train more ob/gyn’s than the current 340 should be seriously considered. As has been remarked by previous visiting experts, it should be strongly advised to authorise family physicians to insert IUDs, and train them for it. In a country like Sweden, even midwives are authorised and trained to do this. Training courses for (future) family physicians should be organised by their original training background (ob/gyn’s, pediatricians, venerologists, etc.) because their starting position is very different.
- It should be seriously considered to include a full fledged ‘male involvement’ component in the next programme cycle, for a wide variety of reasons. First, because they share responsibility for RH. Second, because their co-operation is probably badly needed to achieve the objective of sufficient birth spacing. Third, they need to be educated on STD/HIV prevention, possibly even more than their spouses. And fourth because, as very recent research indicates, a substantial percentage of young men is sexually active before marriage. For these reasons, men should be targeted both in IEC and in service delivery. The current high degree of ‘feminisation’ of RH issues is a serious obstacle to RH promotion.
- The scattered initiatives to create confidential services for young people, that have been observed, or heard of (often resulting from private initiatives of concerned service providers, and others) deserve to be supported and stimulated. The results of a very recent survey among adolescent boys and girls demonstrate that there is a large need for such services (as well as for information and education). As in many other countries, it is to be expected that this need will grow in the near future.
- The know-how regarding the planning, conducting, analysing and reporting of surveys urgently needs to be improved. A research tradition of doing problem- and solution-oriented research is largely absent, and therefore it is unreasonable to expect that such know-how would be available instantly and without external assistance. It is essential that this research capacity is gradually built up in the country. The willingness to learn doing survey research, the manpower, and the infrastructure are in principle all available, but sufficient experience is not.
- Related to the previous point, there is a need for much wider use of the results of research. Investments in research thus far have hardly paid off, because the results tend to remain available only to a few insiders. These results should first be put in a compact format, in a way that makes them understandable and digestible for the targeted audience, and clear conclusions and recommendations should be added to them. Subsequently, this should be

distributed in sufficient quantity among those who could act upon the results (policy makers, service providers, educators, and sometimes even clients). Thirdly, these results, particularly the recommendations, should be discussed with those could help implementing the recommendations. The suggestion given by another consultant to publish results in international journals should only be given second priority, because this makes these results not more accessible to those working in practice.

- Similarly, data collected for monitoring service performance should be systematically fed back to those who have originally collected them. The steps described in the previous point should also be used for these data. The supervisors can play a crucial role in this process. Apart from being very useful as a starting point for initiatives to improve service delivery, and public education, such a procedure has the important additional value of greatly increasing the motivation of service providers to produce accurate and complete data. This is because, when they get systematic, understandable, and useful feedback on their data collection, their sense of ownership is greatly increased. Without this sense of ownership it is very difficult to get good data.

ACKNOWLEDGEMENTS

I am grateful to all people I had the pleasure to meet in Turkmenistan, for the way they have received me and for their willingness to share information and opinions with me. But I am even more grateful to some persons in particular.

First of all, Lilia Babayeva, thank you for your tireless translation work, your continuous care for my well-being, even after office hours, and for your pleasant company during my stay.

Andrey Muratov, it was a pleasure to have you to drive me around, and to share with you our favourites in music.

Dear Eziz Khellenov, after our working together this summer in Cambridge, I had no doubt you would make my stay in your country useful and pleasant; you did!

Gozel, thanks for the hours you shared with me and the sometimes tough discussions we had.

Lola, I appreciated your continuous support, and I hope that some day I can do something for you in return.

Annex I

TERMS OF REFERENCE FOR PROJECT EVALUATION

TUK/96/PO2

DR EVERT KETTING

TURKMENISTAN, NOVEMBER 1999

The evaluation mission is to analyse and assess the UNFPA-funded project TUK/96/PO2, started in 1997 and terminating in December 1999. In particular, the consultant is to evaluate the following:

Relevance: Adequacy of the design of the project in light of the circumstances and existing information at the time of project formulation, i.e. the extent to which the objectives were derived from an accurate assessment of needs, the activities conducted would have allowed the achievement of the objectives and the planned inputs were consistent with the scope of the activities to be conducted. To comment on the degree of institution building and human resource development achieved. To provide a comprehensive global picture and assessment of the project.

Progress-performance: The degree of achievement of the immediate objectives as adjusted over time and progress made towards the long-range objectives, identifying reasons for this progress and/or for any differences between plans and achievements. To what extent are the objectives including Government self-reliance being achieved?

Effectiveness: Implementation of the activities, in quality and quantity and in terms of planned and unplanned results to the extent possible, the impact of project activities on the target audiences. To comment on the quality and adequacy of the technical assistance provided in the programme and whether there has been appropriate transfer of expertise. To identify the key factors, facilitating and limiting, affecting the pace and extent of implementation.

Role of women: Extent to which the role and concerns of women have been taken into account and the extent to which women have benefited from and have participated in all stages of project formulation and implementation. To comment on the degree women have participated in, and benefited from the programme as a whole.

Role of executing agencies: WHO-EURO, Government, UNFPA

Impact:

Impact of the project on the use of contraceptives and abortion and on maternal and infant health indicators in Turkmenistan

Impact of the project on the information available to young people on sexual and RH

Impact of the project on information available to the public on reproductive health

Snowball effect of the project to other regions of the country

Data collection on abortion conducted by the project

Clinical record cards on contraceptive use

Networking of the project with other reproductive health services in the country

Number of professionals trained under the project in country and abroad

Cost effectiveness of project strategies and implementation by implementing centres

The mission is to identify the discrepancies, if any, between what was planned and what was achieved, to identify factors facilitating or hindering achievement of project objectives, and to identify options for improving achievement of objectives in the future, if necessary. It is expected to provide information, judgement and recommendations on the project being evaluated.

Annex II

List of persons met

UNFPA staff

Mr Jens Wandel, UNFPA & UNDP Res. Rep. & Res. Coordinator
Mr Constantin Sokoloff, UNFPA Rep. KATTUK (visiting)
Mr Eziz Khellenov, National Programme Officer
Mr Eziz Redjepov, NCO for PO3
Mrs Gozel Khodjaeva, NCO for PO2
Mrs Akjemal Magtymova, Programme Assistant
Mrs Lola Babakulieva, Project Assistant for PO2
Mrs Gulshat Amandurdieva, Project Assistant for PO3
Mrs Ainabat Annamukhamedova, Local Expert
Mrs Bairamgul Garabaeva, Local Expert for PO3
Mr Andrey Muratov, Driver PO2
Mr Victor Rassochoa, Driver PO3

Ministry of Health

Mr Byashim Sopiev, Deputy Minister
Mrs Tatyana Mamedova, Chief Specialist MCH
Mr Batyr Berdyklychev, WHO Liaison Officer

Mother and Child Health Institute (MCHI)

Mr Chary Nazarov, Director
Mrs Roza Akmuradova, Deputy Director
Mrs Tatyana Lihachova, Chief Scientific and Clinical Centre
Mrs Olga Nazarliyeva, supervisor PO2
Mrs Irene Ereshova, supervisor PO2 & MIS officer
Mrs Shyrin Turayeva, research officer
Mrs Yelena Partsalis, research officer
Mrs Olga Dasjoguz
Mrs A. Hayitova, Chief Genetic Counselling Department
Mrs T. Taghirova, research officer
Mrs Jorayeva Gulya Rasylorina, Chief Breast Feeding Department

RH Centre or Cabinet

Mrs Maya Japparova, Chief Mary Velayat RH Centre
Mr Juma Nurberdiyev, Chief Doctor Bacharden Etrap Central Hospital
Mrs Jeren Bairamgheldiyeva, Chief Bacharden Etrap RH cabinet
Mrs Guljan Roziyeva, Chief Ashgabat City RH Centre

Other

Mrs Gulja Khanamova, Chief ObGyn, The Medical Institute
Mrs Liudmile Amanyzova, Institute of Statistics and Forecasting
Mrs Khumarah Baghirova, teacher secondary school (RH education)
Mrs Guljahan Kurbanova, The World Bank, Liaison Officer
Mrs Amangul Bekieva, USAID The Policy Project
Mr Philip Schrefer, USAID The Policy Project

Mr Anatoly Abramov, UNICEF
Mrs Galina, UNAIDS

N.B. Short conversations were held with several other people at different meetings.

Annex III

Overview of consultancy missions related to PO2

July 1997:	Mrs Jane Schuler-Repp, UNFPA/CST Bangkok
August 1997:	Mrs Babill Stray Pedersen, WHO Geneva
September 1997:	Mr Balthasar Schaap, WHO Geneva
January 1998:	Mr P.M. (Jesse) Brandt, UNFPA/CST Kathmandu
February 1998:	Mrs Babill Stray-Pederson, WHO Copenhagen
April 1998:	Mrs Jean Robson, UNFPA/CST, Kathmandu
May 1998:	Mrs Gayane Dolian, WHO Copenhagen
September 1998:	Mr Carlos Huevo (IPPF), WHO Copenhagen
December 1998:	Mrs Babill Stray-Pederson, WHO Copenhagen
Feb/March 1999:	Mr Tarek Hussain, (Almaty) WHO Copenhagen
April 1999:	Mrs Jean Robson, UNFPA/CST, Kathmandu
April/May 1999:	Mrs Babill Stray-Pederson, WHO Copenhagen
August 1999 (?):	Mrs Patrina Lee & Mrs Aral Arazniazova, (?)
September 1999:	Mr Balthasar Schaap, WHO Copenhagen
October 1999:	Mr P.M. (Jesse) Brandt, WHO Copenhagen (?)
October 1999:	Mrs Julia Kostenko, WHO Copenhagen
Nov/December 1999:	Mr Evert Ketting, WHO Copenhagen

Annex IV

Diary of activities

24 November

Travel from Holland to Ashgabat with some delays because of fog in Frankfurt. Reading of mission reports on the way. Final arrival in Nissa hotel at 03.00 hours on 25 November, after the UNFPA driver, Mr Andrey Muratov, had been waiting for more than two hours. Luggage was left behind in Frankfurt.

25 November

Morning: meeting with Lilia Babayeva, interpreter, Dr Gozel Khodjaeva, National coordinator of PO2, and Dr Olga Dasjoguz, Maternal and Child Health Institute. Visit with them to the Baharden Etrap Central Hospital, in the Akhal Velayat. Talks with the Chief Doctor, Nurberdiyev Juma and several of his staff, and with the Chief of the Reproductive Health Unit, Dr Bairamgheldiyeva Jeren. Observation of the RH unit, equipment and supplies. Afternoon: UNFPA office; meeting Eziz Redjepov, coordinator of PO3 project. Collection of some missing mission reports, with kind assistance of Gozel Khodjaeva. Reading of mission reports.

26 November

Morning: UNFPA office. Collection of missing consultancy reports, assisted by Dr Gozel Khodjaeva, for further reading. Introduction to other staff members of UNFPA. Maternal and Child Health Institute: meeting with Tatyana Likhachova, chief of Scientific and Clinical Centre of RH. Information on the role of MCHI in the project. Afternoon: discussion with Olga Nazarliyeva and Irene Ereshova, two “supervisors” (and master trainers) in the project, also responsible for contraceptive logistics and MIS. Discussion with an andrologist, about STD prevalence and prevention, and male involvement in RH. Afterwards, studying documents in hotel.

27 November

Morning: Health House 12 in Ashgabat. Interview with Guljan Roziyeva, chief of City Reproductive Health Centre, and midwife working with her. Brief talks with other obgyns in the Health House. Afternoon: visit to another Health House in the city. Brief look around the facility. Further reading of documents. Evening: reception at the UN Building: informal talks with Mrs Imelda Henkin, Director UNFPA Asia and the Pacific, and with Mr Constantin Sokoloff, country director KATTUK, UNFPA.

28 November

Free day. Finishing reading remainder of documents collected thus far. Preparation for coming visits.

29 November

Morning: work in UNFPA office, followed by meeting with Mr B. Sopiev, Deputy Minister of Health, and with Mrs Tatyana Mamedova: monitoring and supervision of RH programme. Afternoon: meeting with Mr Philip Schrefer, and Mrs Amangul Bekieva, USAID “The Policy Project”. Work in office.

30 November

Morning: work in office, followed by meeting with Mrs Liudmila Amaniyazova at the Institute of Statistics and Forecasting: request for essential statistical information. Meeting with Mr Anatoly Abramov, UNICEF: collaboration and essential statistical information. Afternoon: meeting with Mrs Roza Akmuradova, Deputy Director MCHI, Mrs Shyrin Turayeva and Mrs Yelena Partsalis, researchers: several scientific studies on RH (adolescents, RTIs, KAP survey, breast feeding). Meeting with Ms Guljahan Kurbanova, Liaison Officer, the World Bank. Meeting with Mr Jens Wandel, UNDP Resident Coordinator & Resident Representative, and with Galina ..., UNAIDS. Brief talks with Constantin Sokoloff and Eziz Khellenov.

1 December

Morning: work in office. 10.00 Attending meeting of National Association of Youth on the occasion of World Aids Day, together with Mr Jens Wandel, UNDP ResRep. Discussions with Eziz Khellenov on implementation of the project. Work on project report in hotel.

2 - 4 December

Three days participation in the National Reproductive Health Conference. Discussions with several participants. Collection a wealth of information.

5 December

Writing of evaluation report.

6 December

All day: meeting with Mr Chary Nazarov, director MCHI; discussion on collaboration with UNFPA and MOH. Meeting with Tatyana Lichachova and Irene Ereshova; collecting missing empirical data (abortion, CPR, anaemia). Work in UNFPA office.

7 December

Morning: meeting with Mr Batyr Berdyklychev, WHO Liaison Officer at MOH. Afternoon/evening: finalising of draft recommendations.

8 December

Discussion on draft recommendations with Eziz Khellenov and Gozel Khodjaeva. Debriefing session with Mr Jens Wandel, UNDP/UNFPA Res. Rep. Short sightseeing tour in and around Ashgabat, with Lilia Babayeva and Andrey Muratov.

9 December

Travel back to The Netherlands without delays or loss of luggage.

Annex V

List of acronyms

CST: (UNFPA) Country Support Team
IEC: Information, Education and Communication
IMR: Infant Mortality Rate
ISF: Institute of Statistics and Forecasting
KAP: (survey on) Knowledge, Attitudes and Practice
KATTUK: Kazachstan, Azerbaijan, Tadjikistan, Turkmenistan, Uzbekistan and Kyrgistan
LAM: Lactational Amenorrhea Method
MCHI: Maternal and Child Health Institute
MMR: Maternal Mortality Rate
MOH: Ministry of Health
NCO: (UNFPA) National Coordinating Officer
NGO: Non-Governmental Organisation
NPO: (UNFPA) National Programme Officer
RH: Reproductive Health
RTI: Reproductive Tract Infection
STD: Sexually Transmitted Disease
TAR: Total Abortion Rate
TFR: Total Fertility Rate
TOR: Terms of Reference