

ABORTION AND CONTRACEPTION IN GEORGIA AND KAZAKHSTAN

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EXECUTIVE SUMMARY

The 1999 “Reproductive Health Survey, Georgia” indicates that Georgia has a very high rate of legal abortion and low use of modern contraception. (A second survey will be conducted in 2005.) To explore contributing causes and factors and to develop critical recommendations for the Government of Georgia and health and population donor organizations, the Open Society Institute’s Network Public Health Programs sponsored, in collaboration with the Open Society Georgia Foundation, a report on *Abortion and Contraception in Georgia and Kazakhstan* in 2004.

Key Findings

While half of all Georgian women consider abortion a health risk, nearly 80 percent feel women should have the right to decide about her pregnancy, including the option of abortion. Some reasons for the high abortion rate in Georgia are:

- A long reliance on abortion as birth control in the Soviet Union due to isolation from the development of modern, safe, and effective contraception elsewhere in the world;
- An inadequate supply of government funded contraceptives due to high costs;
- Attitudes and practices of the medical profession that favor abortion;
- A health-care system that favors curative, high-level institutional care and procedures over a preventive health approach that includes family planning at the primary care level.
- Inadequate attention given to providing accessible, affordable contraception through public and private sector points of service and in remote communities;
- A lack of scientifically accurate public information and discussion of modern methods of contraception; and
- A lack of reproductive health counseling and contraceptive methods at primary care levels.

Sixty percent of women interviewed reported that their last pregnancy was mistimed or unwanted, and only 46 percent of women aged 15 to 44 knew where to obtain oral contraceptives.

Rates of method failure and discontinuation of use, as a result of reported side effects, are very high; the desire to get pregnant accounted for a small fraction of the discontinuation rate.

Most unmet need for contraception is for limiting rather than spacing births; only 12 percent of married women with two children said they wanted another child.

Primary care physicians and nurses receive no training in family planning and are not permitted to provide information, counseling, or contraceptives about the subject; pharmacists and clerks, who are allowed to sell contraceptives, are also untrained. At the same time, the opportunities to derive unregulated income from performing abortions reduce the likelihood that obstetricians/gynecologists (OB/GYNs) at higher-level facilities will provide modern contraception or report requests for family planning or abortion correctly.

Recommendations

Family planning information, counseling, and services should be made available nationwide at the primary care level in urban neighborhood clinics, rural ambulatories, and via mobile teams that can reach remote areas.

Legal, regulatory, or professional licensing or certification restrictions that currently prevent primary care physicians, nurses, and midwives from providing modern contraceptive services should be removed or rationalized, according to World Health Organization guidelines and common international practice.

Standards and guidelines for family planning practice at the primary care level, for basic medical and nursing education, and for in-service training should be developed based on international standards and incorporated into nationwide training programs that are supported jointly by the government and donors.

Contraceptives should be stocked in primary care facilities, and national requirements for contraceptives should be estimated by health-care facilities and pharmacies based on the projected expansion of family planning at the primary care level.

The government should take responsibility for centralizing the procurement and distribution of contraceptives, and consult with potential donors about the need for additional resources.

Reimbursement to health-care facilities for family planning counseling and contraceptive services should be incorporated into a basic package of free essential health care under the national health insurance scheme. However, the advantages and disadvantages of the free distribution of contraceptives via all health facilities, issues of affordability, and access at the primary care level need to be studied.

A nationwide education campaign to inform and educate women, men, and couples about modern methods of contraception should be initiated. Brochures and materials about family planning should be reproduced and distributed via local leaders, non-governmental organizations (NGOs), pharmacies, ambulatories, urban neighborhood clinics, and health facilities throughout Georgia. All public and private media—including radio and television call-in shows, advertisements, telephone hotlines, and community-based entertainment—should be utilized to highlight:

- Family planning as a health benefit for both the mother and child and as a factor in family welfare;
- Where to go for family planning services in the public and private sectors;
- The types of contraception that are available at different health facilities and pharmacies;
- Scientifically-accurate information to correct misunderstandings about the benefits and risks of each method of modern and traditional contraception;
- How to manage side effects of each method, without discontinuing use, and how to change from one method to another;
- What clients should ask if physicians or health providers do not cover certain information;
- The types of family planning services available at no cost at different facilities.

Drawing on how other countries have desensitized reproductive health and HIV/AIDS prevention programs, a course about healthy living, responsible marriage, and parenthood—that includes a reproductive health component—should be introduced in schools. NGOs should implement similar courses for young people and for newly married couples.

To meet the needs of couples that want to limit family size rather than space births, IUD services should be strengthened and voluntary surgical sterilization services should be introduced.

To ensure access to safe, voluntary, and affordable abortion services, basic training and periodic refresher courses in manual vacuum aspiration for OB/GYNs should be developed and supported.

INTRODUCTION

According to the “Reproductive Health Survey, Georgia,” Georgia has a very high rate of abortion—possibly the highest in the world—and a low prevalence of modern methods of contraception. Does this indicate a low demand for family planning, an insufficient supply of contraceptives, or a combination of both? (For purposes of this study, supply of family planning includes labor, professional training, facilities, public information, education, communication, services, and commodities, as well as the policies and practices required to ensure that family planning are known and available to those who do not wish to become pregnant.)

The authors of this report believe that the high rate of abortion in Georgia and the low prevalence of family planning were caused primarily by a failure of the supply side. To explore this concept, data from the “Reproductive Health Survey, Georgia” and other surveys were analyzed, interviews were conducted with those knowledgeable about the Georgian reproductive health program, and relevant documents were reviewed.

For comparison, select information from Kazakhstan for the same time period was obtained and analyzed to further elucidate the insufficiency of the supply side in Georgia. Though a visit was made to Georgia to collect information, it was not possible for the authors to visit Kazakhstan. Data and conclusions are based on personal interviews with those involved in reproductive health programs since 1995 and a review of research, donor, and project documents.

GEORGIA

Recent History

The decade of the 1990s that began with the political independence of the country in 1991 has witnessed major socio-economic changes including civil war, forced migrations, a deterioration of health, and serious economic crises. According to the “Reproductive Health Survey, Georgia,” maternal and infant health has fared especially poorly, despite increased mass media exposure: “changes in the status of women are lagging far behind other countries in the region.” Although Georgian women are relatively well educated, 83 percent have completed at least secondary school, most are not part of the paid labor force.

The economy of Georgia has suffered severe dislocations since the early 1990s. In 1999, the GNI per capita (Purchasing Power Parity in U.S. dollars) was \$2,540. The World Bank classifies the country as “low income,” according to the World Bank Report/WDI, 2001. The average poverty rate increased from 43 percent in 1997 to 59 percent in 1999, according to the Second Country Cooperative Framework for Georgia, 2001-2003, UNDP, UNFPA.

According to the 2000 census, the population of Georgia is 4.4 million. The population has decreased since 1990, and the country has one of the lowest fertility rates in the world (1.7 births per woman from 1997 to 1999, estimated to have fallen to 1.1 by 2003), and the rate of natural increase has fallen below zero. Experts project that the population will decline to about half its current size by 2050.

“Reproductive Health Survey, Georgia” Results

Georgia’s low fertility rate has been reached without significant levels of modern contraceptive use or postponement of marriage. In 1999, only 20 percent of married women age 15 to 44 were using a modern method, mostly the IUD, with an additional 21 percent relying on traditional methods, withdrawal or rhythm. These statistics are much lower than in other countries in the region. The high abortion rate—3.7 abortions per woman and 5.5 for married women, probably the highest in the region if not in the world—has been a major factor in the decline of the fertility rate.

Traditional Values

According to sources consulted, Georgian women are conservative in their attitudes about marriage and family planning. For example, there is very little premarital sex reported. Young people begin having sex when they get married, at the average age of 21. Once married, Georgian women desire a child. There is no demand for contraception, or abortion, until after the birth of the first child, and three-quarters of women do not use contraception before their first pregnancy. However, women’s attitudes about fertility are inconsistent with the low rate of fertility. Fifty-one percent believe that women should have “the number of children that God gives them.” Women under the age of 30 consider 2.7 to be the ideal number of children.

Gender role attitudes are also very conservative: 88 percent believe that childcare is a woman’s job, 85 percent believe that a woman should be a virgin at marriage, and 84 percent think that all

people should marry. Nearly 80 percent of women are affiliated with the Georgian Orthodox Church.

Abortion

Georgian women continue to rely on abortion as a method of contraception even though modern contraceptive supplies are available through pharmacies and some government health system facilities. Nearly two-thirds of all pregnancies are aborted; two-thirds of married women have had an abortion, and 78 percent of those women have had more than one; and there are 2.2 abortions for every live birth.

There are many factors that contribute to the high abortion rate including the long history of reliance on the method in the Soviet Union, due to the relative isolation from Western medical developments; the cost of imported modern contraception; attitudes within the medical profession; and “relative ignorance and fatalistic attitudes toward health issues, a medical system that promoted curative rather than preventive care, compounded by a widespread availability of abortion services, and high tolerance of pregnancy termination.”

Abortion is widely considered acceptable; nearly 80 percent of those surveyed feel that women “should always have the right to decide about her pregnancy, including resorting to abortion.” Only two percent feel that abortion is not acceptable on any grounds. Among those who do not feel that abortion is always acceptable, there is strong support for abortion—70 to 80 percent, if the child might be deformed or if the mother’s health is endangered. There is less support if the pregnancy resulted from rape (40 percent), if the woman cannot afford the child (23 percent), or if the woman is not married (22 percent). About two-thirds of those surveyed felt that a woman who became unintentionally pregnant should have an abortion while 28 percent said that she should keep the baby.

Similar to other countries in this region, abortions of first pregnancies are rare (two percent). The use of abortion increases with subsequent pregnancies; most third and later pregnancies are aborted.

It is notable that the abortion rate is so high in a country where more than half of the procedures are performed without any anesthesia. Though 40 percent of abortions are mini-abortions, nearly half of the women having a dilation and curettage (D&C) procedure were not given anesthesia. By contrast, in Ukraine—where the abortion rate was 1.6 from 1999 to 2001 and is estimated to be 1.1 now—the proportion of abortions performed without anesthesia is only 13 percent. The post-operative complications in the two countries are about the same (around 10 percent).

In 1999, only 15 percent of women reported contraceptive counseling before or after an abortion; only three percent were offered contraception and only one percent of women were given a prescription.

Contraceptive Prevalence

Contraceptive use is very low in Georgia. Only 25 percent of all women age 15 to 44 and 41 percent of married women are currently using any method. Half use a modern method, mainly

the IUD or condom, and half a traditional method, such as withdrawal or rhythm. The use of modern methods of contraception has increased, though very slowly, between 1994 and 1999.

In Georgia, the failure rates for contraceptives are quite high. The annual failure rate for all methods is 0.186, 0.122 for modern methods and 0.248 for traditional methods. Moreover, the failure rates for every method except the IUD (0.018) increased in the five to six years prior to the 1999 survey. During this time, the failure rate for the pill increased from 0.065 to 0.297, from 0.149 to 0.270 for the condom, from 0.078 to 0.222 for withdrawal, and from 0.148 to 0.275 for the rhythm method.

Though the increased failure rates partly explain why the abortion rate did not decline during this period (the proportion of unintended pregnancies increased from 58 percent to 65 percent), the reason for the increased failure rates remains unclear. New users may be part of the explanation, but the declining number of children desired is probably the main cause for the increase. This is consistent with the fact that the proportion of contraceptive failures that were aborted increased from 18 percent to 30 percent. One-third of all abortions stem from contraceptive failures, 22 percent from traditional method failures and 10 percent from modern method failures. If users of traditional methods used modern methods instead, with their lower failure rates, the abortion rate would decline by 11 percent.

There are also significant discontinuation rates. Forty-one percent of contraceptive users discontinued use within one year. The rate is particularly high for users of the pill (73 percent), due to side effects. Discontinuation of the rhythm method and withdrawal is due to method failure; discontinuation of the condom is due to neglect. A desire to get pregnant accounts for only a small fraction of the discontinuation rate. With a heavy reliance on withdrawal and the rhythm method, many abortions are a result of women “neglect[ing] to use the method.” About 15 percent of abortions fall into this category.

Unmet Need for Family Planning

In Georgia, 15 percent of all women and 24 percent of married women who are at the risk of unintended pregnancy are not using any method of contraception. These numbers are the highest among 12 countries in the region. Because the women in these categories compose 54 percent of all abortions, the greatest potential for reducing the abortion rate lies in providing women in the unmet need category with modern methods of contraception. Such a shift would reduce the abortion rate by an estimated 41 percent. If users of traditional methods shifted to modern methods also, the abortion rate would decrease by 52 percent.

Estimates of unmet need are useful for identifying particular areas and groups that should receive programmatic attention. For example, unmet need in Georgia is somewhat higher in rural than in urban areas, in the Northeast and the South, and in lower socioeconomic segments of the population. Three-quarters of the unmet need for contraception is for limiting rather than for spacing births; only 12 percent of married women with two children say that they want another child. If one expands the measure of unmet need to include a need for modern methods, 50 percent of women with two or more children fall into this category. This suggests a potential demand for contraceptive sterilization, a method currently used by only 1.6 percent of married women.

Intentions to Use Contraception

A large fraction of women who are exposed to the risk of an unintended pregnancy (44 percent) say that they do not intend to use any method of contraception in the future; an additional 30 percent say they are unsure about future use. The reasons that women are currently not using contraception, as stated in the survey, include: they do not think about it (38 percent), do not believe they can get pregnant (19 percent), do not want to use contraception (10 percent), or fear side effects (9 percent). Users of traditional methods say that they do not use a modern method because they fear side effects (87 percent), possess little knowledge of modern methods (70 percent), or they are too expensive (67 percent).

Sources of Contraceptive Supplies

Women currently using a modern method of contraception report the public medical sector as the primary source of supplies, mainly for the IUD, and commercial pharmacies as the secondary source (37 percent). Condoms and pills are usually supplied by pharmacies. There is a clear need for increased resources for the national family planning program to help women successfully plan their births and reduce the risk of unintended pregnancies and subsequent abortions.

Contraceptive Knowledge

On the superficial level of name recognition, the women of Georgia are well informed about modern methods of contraception. Ninety-five percent have heard of at least one modern method, and, on average, women have heard of 3.2 modern methods. The IUD is recognized by 93 percent of women, the condom by 89 percent, and the pill by two thirds.

There is, however, a gap between having heard of a method and knowing how to use it. Only two-thirds of women who have heard of the IUD or the condom say that they know how to use the method. Less than half know how to use the pill.

Most married women know where to obtain an IUD (76 percent) and condoms (70 percent), but only half know where to get the pill. Friends and peer groups are the main source of information about contraception. One-sixth report seeing TV messages about contraception, and 6 percent report hearing about contraception on the radio. (Only 46 percent of women watch TV daily, and only 30 percent listen to the radio.) A very small percentage of women are aware of family planning clinics.

About half of all women, and 66 percent of women age 20 to 29, say that they would like more information about contraceptive methods. Among women not currently using any method of contraception, 51 percent say they would like more information.

High Risk of Abortion

In Georgia, 20 percent of all married women, age 15 to 44, are at very high risk for abortion. These are women who do not want additional children (58 percent) and who are not using a modern method of contraception (34 percent) and who are at risk of an unwanted pregnancy (28 percent) and who aborted their last pregnancy (20 percent). These women in particular could be candidates for surgical sterilization. Though about half of these women say they have heard of the procedure (14 percent have heard of vasectomy), only 7 percent say they would be interested

in having an operation to prevent having any more children. The leading reason that women offered for not being interested in the procedure is that they do not know enough about it.

The Family Planning Supply Side: 1995 to 1999

Since reliable data are not available for most of the supply side categories from 1995 to 1999, strong reliance is placed on anecdotal data as well as on inferences about conditions based on data gathered about the supply side from 2000 to 2003. Information on relatively minor supply side inputs by non-governmental organizations (NGOs) and private and bilateral donors may not be included in this report. The reproductive health inputs by the United Nations High Commission for Refugees (UNHCR) for Internationally Displaced Persons from 1996 to 1999 are also excluded.

National Policies and Government Financing

During this period, Georgia did not have a population policy. The Law on Health Care acknowledged the right to decide the number and spacing of children, and permitted the production, import, and dissemination of contraceptives. It also included sections on voluntary sterilization and artificial termination of pregnancy though sterilization was only available to individuals who were 35 years old and had two children.

Abortion is legal in Georgia. It is performed on demand up to 12 weeks; after which there are some restrictions. Mini-abortions—abortions during the first seven weeks—can be performed in state-licensed outpatient facilities, usually Women’s Consultations Centers or private clinics. Other abortions must be performed by obstetricians/gynecologists in hospitals. However, Georgia has a unique policy for licensing those who can provide family planning and other reproductive health services. (See *Providers* section below.) In brief, its impact is to significantly constrain the provision of family planning services.

The government is silent on reproductive health policies for youth. The World Bank Project for Health, implemented in 1997, indicated that the government would begin sex education in the schools. Though a sex education curriculum was developed in 1999, it was considered inappropriate after initial testing and abandoned.

One goal of the World Bank Project was to privatize the government’s health system. The major role of the government is to license privately managed facilities, including those that perform abortions and offer family planning services, and reimburse them for approved services. After four years of health care reform, private out-of-pocket expenses account for approximately 83 percent of the national health expenditures, greatly compromising the government’s ability to reimburse these facilities. In 1996, the government expenditure on health was \$0.40 per capita. “In general, the cost of medical services and pharmaceuticals has been repeatedly cited by Georgians as the key barrier to seeking care,” states a January 2002 World Bank Project Implementation Document for a new Health Sector Loan.

Through the World Bank Project (and before, since 1993, through the United Nations Fund for Population Activities (UNFPA)), the government has provided family planning supplies to clients in the health system free of charge; prenatal care, delivery, and childcare were also

provided. Clients, however, paid for family planning counseling, physician examinations, and postnatal care.

Clients also paid for induced abortions. The “Reproductive Health Survey, Georgia” reported that clients paid an average rate of 20 laris, approximately \$10, for an abortion in 1999. According to interviews with a Ministry of Health (MOH) official, spontaneous abortions were free to clients from 1995 to 1996. The government reimbursed physicians on a per case basis, until the government learned that doctors were charging the government for voluntary induced abortions reported as spontaneous abortions.

During this period, the UNFPA donated pills, IUDs, Norplant, Depo-Provera, and condoms to the government. According to the UNFPA, the supplies of contraceptives were sufficient to meet the demand in government facilities. Though there are no data available to determine if supplies were available in all approved facilities at all times, anecdotal information suggests that supplies were not always free, not always available, were sometimes rationed, or found their way into the market. It is unknown how supplies were tracked and distributed to facilities, but apparently the distribution system differed by region.

Prepay health insurance schemes were not and are not currently available for family planning services, abortions, or supplies.

Conclusions

The liberal abortion policy, and past practice, has facilitated the use of abortion as a tool for family planning. Family planning services have been constrained by the policy that limits the professionals who can provide family planning; the restrictive voluntary sterilization policy; and the requirement that clients pay for family planning examinations and counseling.

Providers

Georgia has one of the highest, if not the highest, physician per capita ratio in the world. According to the World Bank Project Report in 1996, Georgia had 1 physician per 197 inhabitants, while the Office of Economic Cooperation and Development (OECD) average was 1 per 435 inhabitants. Further, the report stated that 2,500 students were currently in medical school—10 times the requirement of the country. The excess of physicians and the poor economic condition of the country, which results in low salaries for most physicians, affects the delivery of family planning services.

A formal family planning curriculum was not available in up to 50 medical schools, with the exception of the State Medical University. The government limits the number of OB/GYNs who can provide family planning services and other reproductive health services within the government health system. The government offers two specialties within this profession—reproductologists and licensed family planning gynecologists—with accreditation implemented by the Academy of Medicine. In 1993, the Zhordania Institute for Reproductive Health initiated the training for these specialists with UNFPA funding. Only reproductologists—OB/GYNs with a year of training in endocrinology, infertility, voluntary sterilization, etc.—can provide a full range of reproductive health services. Reproductologists were not trained to work at outpatient facilities, and the numbers trained are unknown.

The training of OB/GYNs as licensed family planning gynecologists was funded by UNFPA from 1996 through 1999 (and beyond). Licensed family planning gynecologists can provide counseling for IUDs, pills, injectables, and condoms, and they can insert IUDs, provide injectables, and distribute pills and condoms in public and private facilities. They were trained to work in reproductive health cabinets. There were approximately 2,000 OB/GYNs at this time; UNFPA reports that it funded training for 400 OB/GYNs and midwives.

There were far fewer licensed family planning gynecologists available to provide family planning services than general OB/GYNs who could provide mini-abortions. Though it was assumed that neither the licensed family planning gynecologists nor the reproductologists would perform abortions, a survey and anecdotal evidence indicates that the majority did.

Conclusions

Georgia has many more providers of abortions than family planning services. Physicians and midwives performing abortions number in the thousands while professionals providing family planning services number in the hundreds.

The policy of limiting the provision of family planning services to licensed family planning gynecologists and reproductologists has seriously constrained the delivery of these services.

Government Health System Service Facilities

A representative of a donor stated that the MOH does not know the exact number of facilities in its system. Though there is no law that requires reporting, facilities that do not report do not receive reimbursement for services.

Government health system facilities are organized through a system of care at primary, secondary, and tertiary levels. Several types of ambulatories were represented at the primary level—Feldsher Ambulatory Posts and Doctor Ambulatory Centers in rural and high mountain areas, and public polyclinics and Women’s Consultation Centers in urban areas. Often, a Women’s Consultations Center is in the same facility as a maternity hospital.

The Feldsher Ambulatory Posts and ambulatories serving rural and high mountain areas did not officially provide family planning services; contraceptives were not available in these facilities. However, many provided free pediatric services for a long period of time after birth. A prominent pediatrician suggested that pediatricians and pediatric nurses could have provided family planning counseling to mothers when they brought their children for appointments, but they were not licensed to provide such services.

Family planning services and contraceptives were provided officially only in maternity hospitals with a licensed family planning gynecologist and in Women’s Consultations Centers with a Reproductive Health Consultation. UNFPA established these consultations in some Women’s Consultations Centers in 1999. By 2000, 16 according to a UNICEF report (or 40 according to the “Reproductive Health Survey, Georgia”) were operating. These facilities provided family planning counseling, examinations, and IUD insertion with a charge to the client. If available, IUDs, pills, and condoms were provided free of charge. The survey showed that of married

women who are using modern methods, only 21 percent received their supplies from a Women's Consultation Center. Abortions were available at the maternity hospitals, and mini-abortions were available at some Reproductive Health Consultations.

The secondary level consists of rural, central district, and municipal hospitals. Family planning was not officially available unless the hospital had a Reproductive Health Consultation. Abortions were performed in hospitals licensed to provide them. However, doctors performed legal abortions in licensed settings and illegal abortions in unlicensed settings. The "Reproductive Health Survey, Georgia" reported that over 96 percent of abortions were provided through the government health system or licensed private clinics and only four percent through other unlicensed facilities. This is probably an overestimate.

The tertiary level includes health care delivered by specialized municipal and republic level hospitals, polyclinics, and research institutes. For example, the Zhordania Institute for Reproductive Health, a research and training institute, has provided a full range of services—including injectables, Norplant, abortions and mini-abortions, voluntary sterilization, and infertility services—since 1995 (and before). Some other hospitals at this level provided family planning counseling and services and abortions through licensed family planning gynecologists and reproductologists. Voluntary sterilization was available at facilities where a reproductologist was available.

Conclusions

Government-supported family planning service facilities did not officially offer family planning services in the high mountain areas and distant rural areas.

Significantly more facilities in the government health system provided abortion than officially provided family planning services.

Despite establishing Reproductive Health Consultations staffed with trained providers, use of these facilities was low (according to the Johns Hopkins University report) and the number inadequate.

Private Facilities

Pharmacies are scarce in rural and high mountain areas but plentiful in urban areas. During this period, they sold several brands of pills and condoms, and in some instances IUDs, without prescription. According to the "Reproductive Health Survey, Georgia," pharmacies were the principal providers of pills and condoms, supplying more than 75 percent of those used. No data are available on the prices, variety of products, or sales during this period.

A few NGOs provided family planning services. The International Planned Parenthood Federation (IPPF) affiliate, the only NGO exclusively providing reproductive health services, established a family planning cabinet within a primary health center for Internationally Displaced Persons in July 1998 that provided free family planning counseling, examinations, and supplies. Residents of Tbilisi also had access to these services. The cabinet served 1,500 clients in one year; the total budget from 1997 to 1999 was \$211,000 plus free contraceptives. CARE, working through the West Georgia Community Mobilization Initiative beginning in 1998, began a

community-health education and community-health financing project in 114 communities. Family planning was not a priority. The American International Health Alliance began a Women's Wellness Center in Tbilisi in the late 1990s. Family planning services were offered. A number of NGOs provided health services through a polyclinic model, but the number that offered family planning services is unknown.

Physicians and midwives provided family planning services and abortions in rural areas through private clinics or in clients' homes.

Conclusions

Pharmacies did offer pills, condoms, and IUDs, but they were scarce in the same areas where government facilities did not offer family planning services. Pharmacists were not trained to provide necessary information about the pros and cons of using pills, condoms, and IUDs. However, pharmacies were the major supplier of pills and condoms.

Near the end of this time period, a few NGOs offered family planning. They served limited populations and, except for the IPPF affiliate program, family planning was not a priority.

Public Information, Education, and Communication Activities

Practically all professionals who were interviewed believed that the public needed more and improved information on the benefits and availability of family planning. Most thought that doctors informed women, in cases that the doctor provided any information on family planning, that pills and IUDs were harmful to the woman's health. According to the "Reproductive Health Survey, Georgia," physicians were cited as a source of information about contraceptives by only one in ten women.

While the survey found that women had heard of 3.2 modern methods on average, 60 percent reported that their last pregnancy was either mistimed or unwanted. Most telling, only 46 percent of women age 15 to 44 knew where to get pills, according to the survey.

During this time frame, no significant public information, education, or communication intervention about the benefits or availability of family planning by either the government or private organizations was implemented. UNFPA printed booklets on reproductive health and provided material for newspaper and magazine articles and TV and radio programs. A World Health Organization (WHO) representative stated that a Russian TV station broadcast family planning messages during this time period. The IPPF project also conducted outreach through the media, workshops, and seminars; the project produced and distributed educational materials and actively engaged youth. There was little community-based family planning outreach during this period. In 1999, an effort to implement sex education in schools was launched and quickly cancelled because the materials were considered inappropriate.

Conclusions

Women knew where to obtain safe abortions, using this as a method of birth control, at a rate that could be the highest in the world.

Women did not have enough information to demand the family planning services and contraceptive methods that would suit them.

Only a small percentage of women were counseled or provided with family planning methods after an abortion.

Contraceptive Supplies

UNFPA provided the government with two types of oral contraceptives (Ovidon and Rigevidon), one type of condom, and the Copper T-380 to be distributed for free. The UNFPA also provided Norplant (only to the Zhordania Institute) and Depo-Provera.

Free supplies were not always available in the few public facilities that offered contraceptives, and a large percentage of women purchased pills from a pharmacy or kiosk.

Interviews indicated that the cost of one month's supply of oral pills equals one month's disposable income for the poor in Georgia. According to the "Reproductive Health Survey, Georgia," 67 percent of women using traditional methods stated that the cost of modern methods was a major reason for not using modern methods.

Conclusions

From the factors stated above, one can assume that contraceptive supplies were not readily available to most Georgians.

Because a large percentage of women purchased pills from pharmacies or kiosks, women may not have visited the government health facilities that provided family planning examinations and counseling.

While pharmacies were a major supplier of family planning, pharmacists had little knowledge about the benefits and side effects of the supplies, which may partially account for ineffective use and the high discontinuation rate.

Statistics, Surveys, and Evaluations that Inform the Supply Side Issues: 1995 to 1999

Service Statistics

Without exception, spokespersons from the MOH, UNFPA, NGOs, and the World Bank stated that the MOH service statistics reporting family planning and abortion statistics were not valid. Service sites did not always report. In the case of abortion statistics, all who were questioned (with one exception) stated that abortion numbers were significantly underreported. All but one professional interviewee reported that abortion statistics should be multiplied by at least six and by as much as ten (the underreporting estimated in the 1999 "Reproductive Health Survey, Georgia"). This underreporting was attributed to doctors not wanting to report all of the income derived from performing abortions; it was reported that all the staff at facilities where abortions were performed were involved in the scam and received a portion of the fees charged the patient. All private sector institutions are supposed to report, but according to an MOH official, they do not report abortions. Since the MOH never analyzed the data for programming and policy purposes (perhaps because they recognized that it was not valid), the data was not used for policy

or program changes, except perhaps for the policy of discontinuing reimbursements for spontaneous abortion.

Surveys and Evaluations

The following three surveys provide information on the supply of family planning and abortion during this time frame. A survey conducted in 2002, evaluating the results of a major information, education, and communications effort implemented between 1999 and 2001, is reported for this time frame because the findings support this study's conclusions.

“Reproductive Health Survey, Georgia”

The results of this survey are summarized in the opening section of this report. Professionals interviewed stated that this survey was critical in persuading donors to provide additional inputs to increase the supply of family planning services.

Final Report on Family Planning and Reproductive Health Assessment in Georgia

This survey was funded by the United Nations Development Program (UNDP) to promote the development of a national policy on family planning by providing updated and reliable information about family planning and reproductive health. This was a national sample survey of 1,440 men and women. The contraceptive prevalence rate was estimated at 30 percent with condoms being the primary method used. The total abortion rate was 4.1. The major results of this study indicated that 72 percent had no idea where to get family planning supplies and services. Pharmacies were by far the major source for contraceptives.

Survey on Knowledge and Attitudes of Gynecologists towards Modern Means of Contraception and Counseling

This study was conducted after 1999, but the survey results are relevant for the period under review in this section. The objective of the study was to question experts and assess their knowledge about contraception. From a pool of 1,400 eligible respondents, 100 experts from Tbilisi Maternity Houses and Women's Consultations Centers were questioned. Responses were categorized by gender (man or woman) and trained experts (OB/GYNs trained in family planning or reproductologists) or untrained experts (general obstetricians/gynecologists).

Major Findings:

- Only 5 percent considered their financial condition good and 30 percent as bad.
- Only 23 percent did not practice abortion.
- 67 percent of trained experts provided counseling on methods of contraception after each abortion, 5 percent provided counseling in some cases, and 3 percent provided no counseling.
- 90 percent considered that abortion was not an appropriate method of birth control.
- Most were against voluntary sterilization.
- Most believed that doctors only should give information about contraception

- 41 percent considered contraception more profitable and 44 percent considered abortion profitable. Among trained experts, 47 percent considered abortion more profitable.
- 24 percent of patients started to use contraception after abortion.
- High levels of incorrect answers were given to questions relating to contraceptive methods.

The study concludes that most gynecologists support abortion because of financial self-interests; to solve this problem, a system that makes contraception more profitable to providers needs to be created.

“Care for Each Other Campaign”

A campaign to increase the demand for family planning services in clinics established by UNFPA in urban areas was launched in 1999. The Johns Hopkins University/Center for Communication Programs (JHU/CCP) played a major role in this effort, supported by USAID.¹ Campaign activities included training about contraceptive technology and counseling, promoting family planning services on TV and through other media, producing materials to improve counseling services, community outreach, and monitoring and evaluation.

An impact survey of some 1,500 women representing Tbilisi and Imereti was conducted, and the data file was secured for further analysis. (The JHU/CCP project was not completed.) In the “Reproductive Health Survey, Georgia,” a comparison of the contraceptive practices in 2002 to abortion experience in the preceding three years with women from those two cities three years earlier revealed significant changes. In Tbilisi, the proportion of married women using modern methods of contraception, mainly the IUD and condoms, increased from 25 to 37 percent and in Imereti from 21 to 35 percent. Women reporting an abortion in the preceding three years dropped from 35 to 25 percent in Tbilisi and from 33 to 26 percent in Imereti. This evidence strongly suggests that significant increases in contraceptive use and decreases in the abortion rate can be realized with program efforts. This conclusion is strengthened by the finding that around 90 percent of women surveyed recalled the “Care for Each Other Campaign” component, mostly the TV spots and the logo.

The percent of women at high risk of another abortion (married women who want no more children and who are not using any modern method of contraception and who are fecund and who had aborted their last pregnancy) declined in both cities. In Tbilisi, the level of high risk dropped from 17 to 7 percent three years later and in Imereti from 21 to 11 percent. Among all women who had an abortion, the proportion advised about contraception at the time of the abortion increased from 21 to 34 percent in Tbilisi and from 22 to 39 percent in Imereti. The percent that had heard of tubal ligation also increased from 55 to 71 percent in Tbilisi and from 62 to 67 percent in Imereti. (Very similar changes are evident for those women at high risk of another abortion.)

¹ Cobb, E. and Boulay, M. 2002. *Care for Each Other Campaign in Georgia: 1999-2002*. Baltimore: Johns Hopkins University Center for Communication Programs.

The data collected in both surveys can also address the question of whether the propensity to have an abortion changed. There are two measures often used to indicate propensity to have an abortion. The first is the proportion of married women having had an abortion in the preceding three years and the second is the proportion of pregnancies having been recently aborted. The first measure is an indication of the propensity of women to have an abortion, while the second is an indication of the observed decline in the proportion of women having an abortion. The second measure is influenced mainly by the rate of unwanted pregnancies. The direct evidence confirms a decline in the proportion of pregnancies recently aborted, from 49 to 34 percent in Tbilisi and from 50 to 38 percent in Imereti, indicating that the overall decrease in the proportion of women using abortion can be attributed to fewer unwanted pregnancies.

Donor Funding

It was not possible to obtain an accurate level of funding for reproductive health over the period from 1995 to 1999. However, UNFPA and USAID were the only donors providing any significant funding. Extrapolating from UNFPA funding levels for the period from 2000 to 2004, it is estimated that UNFPA provided approximately \$1.3 million for programs and \$900,000 for three years of commodities purchased in 1996. USAID's total health care expenditures in this period were less than \$4 million and half of this could be considered non-reproductive health expenditures. This would bring international donor funding levels for reproductive health to less than \$5 million.

The World Bank provided no direct funding for family planning or abortion during this time frame, from 1997 to 2004. During this period, UNFPA funded contraceptive supplies, strengthening of reproductive health services (primarily training doctors and midwives) and outreach activities, and the "Reproductive Health Survey, Georgia." UNICEF conducted a survey in 2000 "Children and Women in Georgia: A Situation Analysis" citing data collected in the late 1990's. Information about family planning and abortion were collected. WHO was primarily a coordination office and provided policy and technical advice during this period. The Zhordania Institute was a cooperating agency with WHO until 1999 when UNFPA took WHO's place.

USAID provided major funding for the "Reproductive Health Survey, Georgia." It also funded the Johns Hopkins University "Care for Each Other Campaign" in 1999. The project did not begin implementation until 2000. It provided funding for the two American International Health Alliance Women's Wellness Centers, only one of which was operational in 1999. Family planning was one of the services offered in these centers. The European Union (EU) funded the IPPF affiliate for family planning services to internationally displaced persons.

The Family Planning Supply Side: 2000 to 2003

The major purpose for collecting and providing family planning supply side information for the 2000 to 2003 period was to validate some of the conclusions made in this report for the 1995 to 1999 periods. The text below identifies only significant policy, programmatic, and other changes.

National Policies and Government Financing of Family Planning and Abortion

It was reported that Georgia has had a National Policy on Population since 2000. The United Nations reports that the government views the rate of population growth as “too low” and favors raising fertility. The former president introduced a draft-law on the artificial termination of pregnancy to parliament in 2002. Though it does not make abortion illegal, it presents new restrictions—even for pregnancies up to 12 weeks. A law on reproductive health was put before the parliament in early 2004.

In 1999, the government approved the National Policy Document of Georgian Health Care and the Strategic Plan of Georgian Health Care Development for 2000 to 2009. Significant attention was paid to the problem of reproductive health in both documents, including the need to develop a system of family planning and reproductive health care services and the implementation of measures against abortion.

Each year the Orthodox Church obtains the numbers of abortions from the government, and the church is working against the provision of abortion services. Due to underreporting, the church is only informed about 10 percent of the actual number of abortions.

The policies regarding government financing of family planning services have changed somewhat. As of June 2004, supplies remain free to the client through the government health system, and clients no longer have to pay for family planning exams and counseling provided by the UNFPA-funded mobile teams. Clients are still charged for examinations and counseling services if they are obtained through other facilities.

UNFPA has not funded contraceptive procurement since 2002. In 2003, the British and the Dutch governments donated pills and condoms through their economic assistance programs. The UNFPA- financed supplies were depleted in the latter half of 2004. As of late 2004, the Georgian government has not budgeted for the procurement of contraceptives.

A new World Bank Project is being designed and the new primary health care strategy could make family planning more available in rural areas. At this time, neither the government nor the World Bank intends to consider family planning or abortion services as elements of the Essential Service Package, which would insure that they were free to the client.

Conclusions

Given the World Bank findings on Gross National Income (GNI) and its appraisal, if the government does not purchase contraceptives for free distribution or a donor is not found, and if payment by the client for family planning services is required, the supply of family planning will continue to be constrained.

One should evaluate the impact of the UNFPA mobile team project to determine if the provision of free counseling and services has extended services to those previously not served.

It is not clear that the proposed law on abortion, should it be adopted, will restrict the number of abortions. It could result in more abortions being performed outside of the government health system facilities.

Providers and Service Facilities

During this period, two major family planning supply side efforts were initiated. One significantly increased or upgraded the training of family planning providers. The other significantly expanded the sites providing free family planning services throughout Georgia.

According to UNFPA, there were 1,476 practicing OB/GYNs in 2002. In 2001, UNFPA-funded training began for three mobile teams. The Zhordania Institute trained the staff physicians and nurses of these mobile teams, who in turn provided training to other reproductive health advisers and general practitioners in contraceptive technology, counseling skills, and diagnosis and management of reproductive health services in 64 sites. In total, UNFPA-funded reproductive health training was provided to 225 OB/GYNs and family doctors and 400 reproductive health service providers in the districts that the mobile teams visit.

USAID, through the Johns Hopkins University's "Care for Each Other Campaign" developed curricula and upgraded the training of many licensed family planning gynecologists and reproductologists, including contraceptive technology updates, counseling, and IUD insertion. It was reported that over 100 physicians were trained. Additional courses in providing quality customer services and community mobilization were held for physicians and also provided training for gynecologists. The Soros foundation supported the National Abortion Federation in providing a manual vacuum aspiration "Training of Trainers" course.

It has been reported that other NGOs offered reproductive health training to those providing family planning services in the government health facilities, but additional information could not be obtained on these efforts.

Government Health System Service Facilities

In 1999, UNFPA, the Zhordania Institute, and the Bureau for Medical Statistics all reported different numbers of facilities offering family planning services. It is commonly unofficially reported that all 27 Women's Consultations Centers had Reproductive Health Consultations and Family Planning Cabinets available at the same location. According to UNFPA, five regions of Georgia had 55 UNFPA-funded Reproductive Health Consultations at the beginning of 2000. Some of these Reproductive Health Consultations were located in polyclinics, but none were located in rural or high mountain areas.

By the year 2000, many professionals in Georgia were concerned by the high abortion rates and low prevalence of modern methods. UNFPA, the leading donor for reproductive health services, initiated a Mobile Family Planning Project implemented by the Zhordania Institute in 2001. Three mobile reproductive health teams were trained and stationed in Tbilisi, Kutaisi, and Batumi. The teams provide reproductive health services in hospitals in those cities and to 64 sites, including three hospitals, in the districts, visiting each location two or three times per year. The mobile teams visit some ambulatories, bringing family planning services to sparsely populated rural areas.

This project greatly expanded access to previously underserved populations. The mobile teams provide free family planning counseling, examinations, and supplies, and disseminate informational materials and organize educational sessions. However, abortions are not provided,

only referrals. The teams also offer on-the-job training to local reproductive health advisors and general practitioners in contraceptive technology, counseling skills, and management of reproductive health problems. Mobile teams visited 55 sites and provided free services to 10,000 women between March and December of 2001 and to 18,000 women in 2002.

Though the Johns Hopkins University project did not operate service facilities, it branded Reproductive Health Consultations with the “Care for Each Other Campaign” logo to indicate to consumers where providers had been trained and quality services and products were available.

Private Facilities

The variety of pills and condoms available to pharmacies has increased. It was reported that the cost of pills in rural areas was more expensive than in urban areas—some cost as much as 14 lari (or \$7.00 US) for a one-month supply. IUDs are also available for purchase. Emergency Contraception is not readily available through pharmacies.

It was reported that the cost of one month’s supply of oral contraceptives could be equal to one month of disposable income for the average Georgian. Families have to make a difficult decision between providing necessary food and purchasing the monthly supply of contraceptives.

The Social Marketing Project has provided training for approximately 90 pharmacists in rural areas and in Tbilisi in the last two years.

IPPF has expanded its family planning training, information, and education services efforts to new regions and American International Health Alliance has opened a new Women’s Wellness Center.

A knowledgeable NGO representative reported that a number of NGOs are working with polyclinics throughout Georgia to develop different models of care. He felt that this was a constraint to the provision of quality care. Differing models of care made it difficult for the government to develop standards for and ensure a minimum level of care in polyclinics.

Conclusions

The number of facilities reported to provide family planning services has increased dramatically. The new World Bank Project envisions the training and deployment of family doctors at the primary level. UNFPA wants to work with the government to enable this category of physicians to provide family planning services. If this policy was to be adopted, the number of facilities and providers offering family planning would be expanded significantly, especially for populations in rural and high mountain areas.

Information, Education, and Communication Activities

The USAID-funded Johns Hopkins University’s “Care for Each Other Campaign,” a three-year \$1.5 million project, was implemented in mid-2000. The goal was to improve Georgian reproductive health by increasing the use of family planning methods and reproductive health cabinets, raising awareness of sexually transmitted infections, and updating the skills of reproductive health workers. The objectives were to increase demand for modern contraceptive methods, demand for Population Services International socially marketed condom, and

utilization of the reproductive health consultations (cabinets) for family planning. The strategy was to increase the supply of and demand for family planning services.

The campaign used television and radio spots aired on national and regional stations, community events, and posters aimed at promoting modern contraceptives and family planning services. It also established a toll-free hotline operated by Claritas. This hotline is still operational, but is provides information about breastfeeding primarily. It still receives and answers calls on family planning and other reproductive health issues.

The USAID and UNFPA-funded Social Marketing Program implemented by Population Services International at the end of 2000, ended in June 2004. The program targeted youth through concerts, TV and radio spots, product placement, and pharmacist training. Beginning in May 2001, the project sold condoms at subsidized prices; the project sold 700,000 condoms in 2003. According to Population Services International, 3 million condoms are used annually. The organization also assists UNFPA in the distribution of contraceptives. A Georgian NGO hopes to raise sufficient funds to continue operation.

UNFPA funded a variety of outreach efforts that included distributing posters, calendars, and a *Handbook for Reproductive Health Service Providers*; organizing a workshop for mass media representatives; hosting a regular radio program; and planning symposia. UNFPA trained 90 journalists during this period. UNICEF is attempting to develop a Healthy Lifestyles Program for schools.

Some NGOs increased the scope of their information, education, and communication efforts. IPPF increased its sex education efforts. West Georgia Community Mobilization Initiative, implemented in 1998, worked on health education with local NGOs in the Kutaisi region. Though the communities did not consider family planning a priority, the doctors in the ambulatories did. The initiative trained 324 educators in 114 communities of 1,500 to 2,000 residents each. The Greek government initiated a reproductive health hotline in 1999 through a local NGO: Tanagoma.

As discussed earlier, information from a survey at the conclusion of the Johns Hopkins University “Care for Each Other Campaign” showed that the use of modern contraceptive methods increased significantly, while the number of reported abortions decreased.

Contraceptive Supplies

A major change during this period was the provision of free contraceptive supplies to those individuals receiving family planning services though the 55 sites visited by the mobile teams. The introduction of subsidized condom through the Social Marketing Program and more brands of pills and condoms in pharmacies were two other positive changes. The Zhordania Institute is still the only source for Norplant.

UNFPA, until 2002, and then Department for International Development (British government) and the Dutch government provided all of the same contraceptives as previously used in the government program. UNFPA also provided some NGOs with supplies.

Conclusions

An evaluation has not been conducted to determine if providing free family planning supplies through the mobile teams increased the number of modern method users, but anecdotal evidence and service statistics indicate that this was the case. The increased number of brands of contraceptives available through pharmacies indicated that sales were increasing and more individuals were using these methods effectively; the introduction and sale of 700,000 subsidized condoms by the Social Marketing Program increased the effective use of condoms.

It is reasonable to assume that there was a significant increase in the supply of contraceptives during this period, and that there were more effective users of modern methods of family planning.

Statistics, Surveys, and Evaluations that Inform the Supply Side: 2000 to 2003

Service Statistics

The MOH family planning and abortion statistics continue to under report abortions and do not reflect the number of family planning users accurately. UNFPA has been working with the MOH to create a reporting format that will capture information not previously recorded. For example, the new reporting form will recover how many women received family planning counseling and methods after an abortion. The form has been in use for more than six months and the results will be evaluated in July 2004.

Surveys

A couple of surveys were conducted, but the findings were local in nature or leaned heavily on the “Reproductive Health Survey, Georgia.” (They are cited in Appendix A.)

Conclusions

UNFPA’s efforts to work with the MOH to implement a new reporting format is a necessary first step in insuring the accurate reporting of abortions and family planning services. But the MOH must analyze the data to insure accuracy and adjust programs if required. It must follow-up with programs that do not provide accurate reports to insure that the problem is corrected.

Supply Side Summary Conclusions

Government Policies and Practices

The following factors hindered access to family planning supplies and services:

- A restrictive voluntary sterilization policy that limited clients who were eligible for the procedure and constrained who could perform the procedure.
- A policy that only licensed family planning gynecologists or reproductologists could provide family planning services.
- The lack of formal family planning curriculum in medical schools.
- The lack of reproductive health education in schools.
- The lack of family planning services in all facilities in the government health system.
- The lack of manual vacuum aspiration training for OB/GYNS.
- The lack of analyses of MOH statistics that would have led to the discovery that important information was not being collected and that data were not valid.

- The lack of data analyses by the MOH and donors ensuring that programs and funding to increase the accessibility and use of family planning were not considered.
- The decision during the design of the first World Bank Project to exclude family planning counseling and counseling and services from the free package of essential services to be provided under the World Bank Project.
- No public or private funding for major information, education, and communication activities.

Providers and Their Practices

- The “Reproductive Health Survey, Georgia” indicated that only eight percent of women received family planning counseling after an abortion and only five percent received a method of contraception or a prescription for one.
- The relatively high income gained from performing abortions motivated the underpaid, excess number of physicians to favor providing these services over family planning services.
- Pharmacists were not trained to effectively educate women seeking to purchase oral contraceptives. Though pharmacies were the main source for pills and condoms, one can assume that the lack of staff training negatively affected the quality and quantity of information provided to clients.

Health Facilities and Contraceptive Supplies

- Only 16 reproductive health consultations offered family planning services, for a fee, through the Government’s Health System. Contraceptives, while free to the client, may not have been available at all times. Many more facilities offered abortions, including some of the reproductive health consultations. Family planning services were essentially unavailable in health centers serving rural and high mountain areas.
- Oral contraceptives and condoms were readily available without prescription in urban and peri-urban areas through pharmacies, but the cost would have been a major constraint to a large percentage of the population. Pharmacies were scarce in rural and high mountain areas.

Information, Education, and Communication Activities

- No major efforts were undertaken in this period. This constrained the use of family planning given the lack of information available to the public about how to use family planning and where to get services. The evaluation of the major effort undertaken by Johns Hopkins University’s “Care for Each Other” campaign in 2000 indicates that if information and services are made available, the use of modern methods will rise significantly and abortions will decline.

Donor Funding

- With the exception of UNFPA, insignificant amounts of donor funding were available for family planning services; the World Bank Project excluded family planning from the Essential Services Package. As a result, clients had to pay for family planning services.
- Therefore, the women who were most likely to use family planning were those who had disposable income to pay for the services, did not live in rural or high mountain areas, or

had acquired accurate information about modern methods of family planning from sources other than public outreach efforts.

In conclusion, many more facilities offered abortion services than family planning services, and few providers were trained or licensed to provide effective family planning services. The family planning services that were available were located in urban and peri-urban areas. The relatively low rate of modern contraceptive use and the high abortion rate in Georgia are the result of the constraint in the supply of family planning and the economic incentive system for physicians, not the preference for abortion as a method of family planning.

KAZAKHSTAN

Recent History

After some years of economic decline, Kazakhstan registered economic growth beginning in 1996. The GNI/per capita (Purchasing Power Parity) was \$4,790 in 1999, according to the World Bank World Development Indicators, 2001. The World Bank designates Kazakhstan as a “Low Middle Income” country.

The population in 1999 was 14.9 million. The total fertility rate was 2.1. The United Nations projects a ten percent decline in the population by 2050. The government is concerned about low fertility.

In 1995, the Kazakhstan health care system still maintained most of the attributes of the Soviet style system. In this same year, the Government of Kazakhstan began a major restructuring of the primary health care system by creating a network of Family Group Practices that were to become financially and managerially autonomous. Clients were to enroll in a group practice of their choosing. Clients were responsible for an enrollment fee and co-payments for services. The government initiated and funded a Health Insurance Fund to pay a capitation fee to each of these practices. (The insurance fund collapsed in 1999.) In 1998, a World Bank loan was negotiated to replicate this model nationwide, but the government cancelled this loan in 2003. It has been reported by a knowledgeable source that the health system was in “chaos” between 1995 and 1999.

“Kazakhstan Demographic and Health Survey,” 1999

Abortion

Until recently, the apparent quality of data on abortions in Kazakhstan has been considered fairly reliable. Between 1986 and 1990, the MOH estimates of abortion rates compared with those from “Kazakhstan Demographic and Health Survey” were very close with rates of 75 and 71 abortions per 1,000 women respectively. This correspondence continued through 1995 with estimates of 55 and 57 respectively. But the estimates began to diverge in the period from 1996 to 1999; the MOH rate was 32 while the “Kazakhstan Demographic and Health Survey” rate was 47. The official estimates imply a much greater decline in abortions than those derived from the survey. The prevailing explanation for the deterioration of the official estimates is that an increasing proportion of women are having mini-abortions, which are typically performed in the private sector and tend not to be recorded in the official registration system. By 1999, nearly half of all abortions were being done with the vacuum aspiration technique. Given the increasing use of this procedure, the completeness of the registered data on abortions can be expected to deteriorate further. Disincentives for reporting abortions accurately further skew data.

The official abortion rate estimates since 1998, for women ages 15 to 49, show a further decline from 34 to 28 abortions per 1,000 women. If we assume that the undercount of abortions in the government statistics in 1998 (an undercount of 17 percent) has remained constant, the abortion rate in 2002 would be 34 rather than the reported 28, indicating no change. This is a conservative

estimate since the underreporting is probably getting worse because the proportion of abortions in the private sector is probably increasing.

Despite these uncertainties about the present situation, there is no doubt that the abortion rate in Kazakhstan declined significantly in the 1990s, by around 50 percent. The best guess that we can make for the years since 1998 is that the abortion rate has plateaued at a level that is on the low side among countries in this region and indicates a rate of about one abortion per lifetime.

Almost the entire decline in abortion between 1995 and 1999 occurred among ethnic Russians in Kazakhstan. Their total abortion rate fell from 2.74 for the 1993 to 1995 period to 1.75 in the 1997 to 1999 period. The overall decline among Kazakh women was from 1.11 to 1.06. Over a longer period, from 1975 to 1999, the ethnic Russians in the population experienced a 61 percent decline in the abortion rate while overall ethnic Kazakhs experienced a 39 percent drop. Part of the decline in the national abortion rate is probably due to the migration of ethnic Russians out of the country. In the short period of time between 1995 and 1999, the proportion of Russians in the female population dropped from 35 to 30 percent.

About half of all abortions in Kazakhstan were the result of contraceptive failure; the other half were the result of pregnancies conceived while no contraception was used. If all current contraceptive use were with modern methods and women with an unmet need for contraception adopted modern methods, the abortion rate could be virtually cut in half. Information about contraceptive counseling at the time of the abortion was not available.

In 2000, a national program to reduce the abortion rate was introduced and approved by the Kazakh government. The program includes the training of medical personnel, providing the population with contraceptive information, and establishing teenage pregnancy hotlines in major cities.

Contraceptive Prevalence

In 1999, 54 percent of the married women in Kazakhstan reported using a modern method of contraception, which denotes a very high level for the region. During the 1990s, there was a 50 percent increase in the use of modern methods paralleling a decline in abortions at the same rate. There is also a progressively earlier use of contraception: women who first used contraception before the second birth increased from 38 percent in the older generation (women currently age 50 to 54) to 64 percent for young women (currently age 20 to 24). Of particular importance for the abortion rate, the proportion of women using traditional methods of contraception, with higher failure rates, declined. The main method of contraception is the IUD, which is used by about two-thirds of women currently using any method. The condom ranks second in popularity and the pill third. Recognition of different contraceptive methods is widespread though less than half of all women had heard about male sterilization, implants, and female condoms. An estimated 56 percent of unmarried, sexually active women report using a modern method.

Despite the growing prevalence of contraceptive use, nine percent of married women in Kazakhstan are classified as having an unmet need for family planning: at risk of pregnancy, not using any contraception, and report that they do not want more children or want to postpone the next birth for at least two.

The pill shows the highest discontinuation rates (57 percent stopped using the method for reasons other than to get pregnant in the first year of use) and the IUD the lowest (10 percent). Method failure is an important reason for discontinuation. Side effects and health concerns are important reasons for discontinuing the pill.

Intentions to Use a Method

Women who are not using any method are about evenly divided into those who intend to use and those who do not intend to use a method. The former category intends mainly to use the IUD. Intention to use a method is associated with knowing where to obtain a method or service and with having used a method in the past.

Source of Supplies

In Kazakhstan, the principal source of contraceptive supplies is public hospitals where they are distributed free of charge. This is because of the primacy of the IUD. The pill and the condom are distributed mainly in private pharmacies. Because of the privatization of pharmacies in the late 1990s, private facilities have become increasingly important. However, as of 1999, public facilities were still the main source of supply for three-quarters of all contraceptive users.

Contraceptive Knowledge

Virtually all women in Kazakhstan in 1999 reported that they had heard of at least one modern method of contraception. There was less than universal knowledge of injectables (54 percent), of female sterilization (54 percent), and of male sterilization (29 percent). Familiarity with emergency contraception was remarkably high (33 percent) for a new method.

Only 14 percent of women reported having heard a radio or television message about family planning in the preceding few months but 42 percent saw such messages in the print media. A total of 26 percent recognized the Red Apple social marketing logo (described below). Women currently not using contraception who heard such messages were more likely to intend future use.

The Family Planning Supply Side: 1995 to 1999

National Policies and Government Financing of Family Planning and Abortion

The official government policy was to provide family planning services and supplies, including IUDs and injectables, free of charge to clients. Clients paid for pills and condoms and other contraceptives, except where UNFPA distributed free contraceptives in pilot sites.

Abortions were officially free of charge during this period. The Kazakhstan Demographic and Health Survey states that abortions “can be done free of charge; however, fee-for-service facilities have become available to perform min-abortions by manual vacuum aspiration.” During this period of limited government resources and initiation of health reform, the reality was that under-the-counter charges were the norm for family planning and abortion services, except for some of the services provided in poor rural areas, according to a knowledgeable source. The cost for an abortion ranged from \$8 to \$20.

Abortion is available without restriction up to 12 weeks and after that with certain restrictions.

According to the 1997 Law on Health Protection, surgical sterilization is permitted on a voluntary basis without restriction.

Providers

Kazakhstan had an excess of physicians. According to a World Bank Health Project Report, 2001, Kazakhstan had one physician per 286 inhabitants between 1990 and 1998, while in OECD countries, the average was 1 per 435 inhabitants.

OB/GYNs and trained family doctors could provide family planning services. Midwives could refill a client's supply of pills and provide family planning counseling and referral. Special licensing of family planning providers was not required.

Beginning in 1995, UNFPA funded an extensive training program for OB/GYNs, family doctors, and midwives. Teams of core trainers in each oblast conducted 43 workshops and trained 664 health workers. A training curriculum was developed and revised. USAID funded two service delivery and clinical training sites in Almaty.

Government Health Facilities

Family planning counseling and services were not offered at the lowest level in the posts staffed only by midwives and doctor's assistants. They were available at Central District Hospitals and Clinics in rural areas and in Outpatient District Women's Consultations in urban areas. After 1995, UNFPA set up and equipped a number of family planning cabinets in southern Kazakhstan in both urban and rural areas.

Family planning supplies were available in Women's Consultations through the facility pharmacy. Abortions were available in the same facilities as those providing family planning.

During the late 1990s, a few Family Group Practices provided family planning services in two oblasts. According to the "Kazakhstan Demographic and Health Survey," 37 percent of women reported that their usual source of health care was one of these practices.

Private facilities

Private facilities provided abortions.

Pharmacies were privatized beginning in 1994. They sold pills, condoms, and in some instances IUDs and injectables without prescription, making these methods more available than in the past. By 1999, all pharmacies had been privatized. Nineteen brands of pills were available in the country by the end of this period.

In 1995, 92 percent of women received supplies through the public sector. In 1999, 70 percent of pill users and 63 percent of condom users obtained their supplies through private pharmacies.

A few NGOs provided family planning services.

Public Information, Education, and Communication Activities

A major nationwide effort, which concentrated on three regions, was initiated in late 1994 and ended in 1998. The Red Apple Contraceptive Social Marketing made contraceptives available at an affordable price. It branded pharmacies, doctor's offices, and clinics that had modern approved methods and quality services were available. It also branded contraceptive products, including five brands of pills, one brand of condoms, and an injectable. It provided educational materials for the client and pharmacist. The project provided two-day training on modern contraceptives to thousands of pharmacists. In addition, it worked with manufacturers, distributors, and retailers to ensure that a reliable distribution system for products was in place nationwide.

The project advertised on radio, on TV, and in newspapers. The campaign advised women to look for "Red Apple" campaign branding, informed women about modern contraceptives and that pharmacists had received training and could answer their questions, and that information brochures were available. The project also launched a reproductive health hotline that is still operational today in over 10 cities. According to the "Kazakhstan Demographic and Health Survey," in Almaty eight of ten women had seen the "Red Apple," but only half knew what it signified.

An extensive community outreach program was funded by UNFPA and implemented through the Business Women's Association in Southern Kazakhstan and through the Association for Sexual and Reproductive Health, certified by IPPF, in Almaty. These organizations fielded more than 80 volunteers who contacted 80,000 women of reproductive age in order to provide reproductive health information.

The Republican Centre of Mother and Child Health stated that in 1995 it organized a widespread media campaign on the health consequences of unsafe abortions and the prevention of unwanted pregnancy, but no further information is available.

Donor Funding

According to the United Nations Population Fund document, Proposed Projects and Programmes, donor assistance to the reproductive health care sector totaled \$46 million between 1993 and 1997.

The World Bank provided no funding for reproductive health during this period.

UNFPA was a major donor for reproductive health, providing supplies, provider training, and community outreach. It also provided funding for selected technical assistance and national population activities implemented by Pathfinder International, Family Health International, WHO, and IPPF. The budget for the first country program initiated in 1995 was \$5.2 million for five years. The objectives were to reduce the high rate of abortion, increase the short birth intervals, broaden the contraceptive method mix, and promote informed contraceptive choice through counseling and information, education, and communication activities.

UNICEF and WHO provided funding and technical assistance for sex education efforts. WHO was also involved extensively in support for the establishment of the Kazakhstan School of Public Health in 1997.

USAID funded six family planning providers. JHPIEGO and the Association for Voluntary Surgical Contraception (AVSC) provided training for providers and some equipment. Johns Hopkins University Population Services Center provided technical assistance to develop national education campaigns on reproductive health issues. The Futures Group International worked to assist the country in reproductive health policy and resource mobilization and also implemented the “Red Apple” campaign. MACRO implemented the 1995 and 1999 Kazakhstan Demographic Health Survey with USAID funding. USAID also funded, with UNFPA, a study to improve the Contraceptive Procurement and Logistics System. The USAID-funded health reform project did not directly support reproductive health services, but some Family Group Practice centers did include these services where they were not previously available. The total USAID expenditure for health during the period of 1995 through 1999 was \$35 million. The German government provided some contraceptive supplies. The Dutch government provided support for population education and for the Kazakhstan School of Public Health that developed the first institution-based training curriculum for reproductive health.

The Soros foundation and the British Know-How Fund supported population education programs for adolescents and a research program on reproductive health.

Supply Side Summary Conclusions

Although government policy provided for free family planning and abortion services, under-the-counter charges were the norm, except in poor rural areas where both services were usually free. Abortion charges appear fairly high, which may have caused people to favor the use of family planning. Only two percent of those women using a modern method discontinued method because of cost. Of course, how many did not use contraception because of cost is unknown.

All OB/GYNs and some trained physicians could provide family planning services. Midwives could re-supply pills and make referrals for other family planning services.

All Women’s Consulting Centers, Maternity Houses, Polyclinics with Women’s Consulting Offices, many hospitals, and Family Group Practices provided family planning services, making family planning services at least as available as abortion services. According to the KDHS, 25 percent of those using modern methods and 20 percent of those having an induced abortion received these services from Women’s Consultations Centers.

Contraceptive use does not vary by region or by ethnic group—although there is a variation in methods. IUD usage accounts for more of the increase in modern method use since 1995 than any other method. Abortion is more prevalent in Almaty and the North and East regions where fertility is lowest. According to the “Kazakhstan Demographic and Health Survey,” significant increases in modern contraceptive use from 1995 occurred among older women indicating that modern methods rather than abortions are being used to limit births.

UNFPA and USAID funded reproductive health training for hundreds of physicians and thousands of pharmacists. Presumably, this made family planning more available to clients than during the period before 1995.

The “Kazakhstan Demographic and Health Survey” states that part of the success in reducing the abortion rate has been attributed to the social marketing of contraceptives and education programs supported by UNFPA. It can be assumed that the significant information, education, and communications efforts—including the “Red Apple” mass media campaign, the community outreach workers, and the reproductive health hotline—were interventions that were effective in the reduction of the abortion rate and increased use of contraception.

It can be assumed that the \$46 million in reproductive health related international assistance contributed to the increase in contraceptive prevalence and reduction in the number of abortions. The “Kazakhstan Demographic and Health Survey” states that “As a result of government’s policies and international assistance, reliance on abortion is diminishing in Kazakhstan.”

The privatization of pharmacies and marketing implemented by the Contraceptive Social Marketing Program are reported to have increased the locations where contraceptives are available and the numbers of brands available during this period. The privatization of pharmacies and purchasing efficiencies also resulted in a lower price of contraceptives. According to the “Kazakhstan Demographic and Health Survey,” the proportion of women obtaining their contraceptives methods from private facilities, pharmacies, has increased from less than one percent in 1995 to 23 percent.

According to the “Kazakhstan Demographic and Health Survey,” 37 percent of all pregnancies ended in abortion, the same outcome was reported in the 1995 survey. While the total abortion rate has fallen among Russian women by 33 percent since 1995, the rate for Kazakh women declined only slightly.

In conclusion, family planning services in Kazakhstan were more available than abortion services during this period. Family planning services were provided in the same government facilities as abortion services. Hundreds of providers were trained in reproductive health services. Thousands of private pharmacies throughout Kazakhstan sold numerous brands of pills and condoms as well as IUDs and injectables. An intensive social marketing reproductive health hotline and branding campaign for contraceptives increased knowledge of family planning sources and, according to the Demographic and Health Surveys Analytical Studies (“The Substitution of Contraception for Abortion in Kazakhstan in the 1990s”) intention to use a method has a direct correlation with exposure to mass media.

COMPARISON FINDINGS: 1995 TO 1999

Georgia and Kazakhstan have significantly different demographic and family planning profiles as shown in Table 1, based on 1999 data. Although the two populations are fairly similar in educational composition and in the proportion living in cities, Kazakhstan had a per capita income that was almost twice as high as that in Georgia. It also had a somewhat higher fertility rate. The abortion rate in Georgia was nearly three times higher than in Kazakhstan while contraceptive prevalence in Georgia was only half of the rate in Kazakhstan. The abortion rate in Kazakhstan declined by 25 percent between 1995 and 1999 while there has been little recent change in the high rate in Georgia.

Table 1

Indicators of contraception and abortion and other demographic characteristics for Georgia and Kazakhstan, based on 1999 data for women of childbearing age, 15 to 44.

	Georgia	Kazakhstan
Total abortion rate (1997 to 1999)	3.7	1.4
Percent using any contraception	25	49
Percent that know of a modern method	95	99
Percent using modern methods	12	39
Percent using traditional methods	13	10
Annual failure rate: all methods	0.19	0.06
Annual failure rate: modern methods	0.12	0.04
Annual failure rate: traditional methods	0.25	0.17
Percent of abortions resulting from method failure	32	50
Percent with unmet need for family planning	16	8
Percent of abortions resulting from unmet need	54	33
Percent never had sex	33	22
Percent never heard of the pill	32	13
Percent never heard of female sterilization	56	46
Percent of users obtaining modern contraception from public sector	54	74
Total fertility rate (1997 to 1999)	1.7	2.1
Percent urban	61	56
Percent with at least some university education	26	20
Per capita income (1999)	\$2,664	\$4,790

The difference between the two countries in contraceptive prevalence is particularly pronounced in the use of modern methods with a rate in Kazakhstan more than three times higher than in Georgia. Contraceptive failure rates are also lower in Kazakhstan although half of the abortions

in that country followed failures. In Georgia, most abortions are of pregnancies conceived in the absence of contraception.

As reported above, major differences were found in the supply of family planning in each country. Table 2 reproduces for Georgia the critical elements from the *Supply Side Conclusions* section. These conclusions report how family planning supplies have been constrained in certain policies and practices. The text in the Kazakhstan column describes how these differ, either in a positive or negative sense.

Table 2
Supply Comparisons of Georgia and Kazakhstan

Georgia	Kazakhstan
<i>Government Policies and Practices</i>	
A restrictive voluntary sterilization policy limited the clients who were eligible for the procedure and constrained who could perform the procedure.	No client eligibility restrictions or restrictions on who can perform the procedure. OB/GYNs can perform the procedure.
A policy that only licensed family planning gynecologists or reproductologists, likely numbering a few hundred, could provide family planning services.	All OB/GYNs and some specially trained physicians could provide family planning services. Midwives could provide referrals, refill prescriptions for pills, and provide condoms.
The lack of formal family planning curriculum in medical schools.	No formal family planning curriculum in medical schools.
The lack of reproductive health education in schools.	Some reproductive health education in schools.
The lack of family planning services in all facilities in the government health system because of the provider licensing provisions.	No licensing provisions.
The lack of manual vacuum aspiration training for OB/GYNS.	Almost half of the abortions provided were through manual vacuum aspiration.
The decision during the design of the first World Bank Project to exclude family planning counseling and services from the free package of essential services to be provided under the World Bank Project.	The government officially made family planning and abortion service free through its facilities. However, under-the-counter charges were the norm.
<i>Providers and Their Practices</i>	

Georgia	Kazakhstan
One institute conducted training for 400 OB/GYNs and midwives. OB/GYNs could not provide family planning services unless they were trained.	664 OB/GYNs, midwives, and family doctors received reproductive health training through 43 workshops. However, OB/GYNs did not need to be trained to provide family planning services.
The “Reproductive Health Survey, Georgia” indicated that only eight percent of women received family planning counseling after an abortion and only five percent received a method of contraception or a prescription for one.	The “Kazakhstan Demographic and Health Survey” did not collect this information.
The relatively high income gained from performing abortions motivated the underpaid, excess number of physicians to prefer providing these services instead of family planning services. Some OB/GYNs could only provide abortions and not family planning services.	All OB/GYNs could provide family planning services and abortions.
Pharmacists were not trained to effectively educate women seeking to purchase oral contraceptives. Though pharmacies were the main source for pills and condoms, one can assume that the lack of this training negatively affected the information given to the clients.	Under the Contraceptive Social Marketing project, thousands of pharmacists were trained to provide accurate information about all methods of contraception.
<i>Health Facilities and Contraceptive Supplies</i>	
Only 16 reproductive health consultations offered family planning services, for a fee, through the government’s health system. Contraceptives, while free to the client, may not have been available at all times. Many more facilities offered abortions, including some of the reproductive health consultations.	Hundreds of government facilities provided family planning services throughout Kazakhstan. Services were free in poor rural areas. In other areas, clients had to pay under-the-counter fees. Abortions were not provided in all facilities where family planning was provided.
Family planning services were essentially not available in health centers serving rural and high mountain areas.	Family planning services were unavailable only in isolated rural areas served only by a doctor’s assistant and midwife.
Oral contraceptives and condoms were readily available without prescription in urban and peri-urban areas through pharmacies, but the cost would have been a major constraint to a large percentage of the population.	Cost did not appear to be a constraint to purchase according to the “Kazakhstan Demographic and Health Survey.”
Pharmacies were scarce in rural and high mountain areas.	According to a knowledgeable source, pharmacies were accessible nationwide. Public pharmacies were available in Women’s Consultation Centers.

Georgia	Kazakhstan
<i>Information, Education, and Communication</i>	
No major information, education, or communication efforts were undertaken in this period.	Two major outreach efforts were undertaken: the “Red Apple” campaign and the community distribution projects.
<i>Donor Funding</i>	
With the exception of the UNFPA, insignificant amounts of international donor funding, less than \$5 million from all sources, were available for family planning services.	International donors provided \$46 million for reproductive health related services.

Georgia has many more providers of abortions than family planning services. Undoubtedly, the policy of limiting the provision of family planning services—examination, counseling, and provision of methods—to licensed family planning gynecologists and reproductologists has seriously constrained the number of facilities that offer family planning services. These professionals number in the hundreds. Physicians and midwives performing abortions number in the thousands. Many more facilities could offer abortion than family planning.

In Kazakhstan, no such restrictions were put on either facilities or providers. In addition, Kazakhstan was the beneficiary of a major information, education, and communications effort, training thousands of pharmacists, branding quality service and supplies, and attracting international donor financing almost ten times that of Georgia.

It is clear that the supply of family planning was significantly greater in Kazakhstan than in Georgia.

APPENDIX A

Individuals Interviewed or Providing Information

Alzhanova, Aida - UNFPA/Kazakhstan
Alakbarov, Ramiz - UNFPA/NY
Bultman, Jan - World Bank
Barnett, Courtney - Abt Associates
Boulay, Mark - JHU
Chawla, Mukesh - World Bank
Cobb, Lisa - JHU
Crane, Barbara - Ipas
Dannevig, Tanja - Population Services International (PSI)
David, Henry - Independent Consultant
Destler, Harriett - United States Agency for International Development (USAID)
Evans, Jeff - USAID
Feeney, Paula - USAID (Ret.)
Holmes, Paul – USAID
Izmailova, Khorlan – USAID, Almaty
Kenney, Asta - ZdravPlus/Central Asia Quality Health Project, John Snow International
Lazear, Mary Jo – USAID
Lule, Elizabeth - World Bank
Morris, Leo - Centers for Disease Control
Powers, Mary Beth - Save the Children
Schmidt, Marilyn - USAID
Ruschman, Don - Former Director, Somarc Project, Kazakhstan
Townsend, John - Population Council
Vandeviele, Marieka - IPPF
Williams, Megan - Abt Associates

Individuals Interviewed in Georgia

Asatiani, Tengiz - Tbilisi State Medical Academy
Avaliani, Nata - American International Health Alliance
Chkhatarashvili, Katy - Curatio International Foundation
Dershem, Larry - Save the Children, Georgia
Epstein, Sharon - Healthy Women Project, John Snow International
Gvetadze, Konstantin - Imereti Regional Public Health Department
Katsitadze, Irakli - World Bank Project
Khomasuridze, Archil - Zhordania Institute
Khomasuridze, Tamara - UNFPA
Khvedelidze, Irakli - PSI
Klimiashvili, Rusudan - WHO Regional Liaison Officer
Kristesashvili, Jenara - Zhordania Insitute
Kvirtia, Nana - West Georgia Community Mobilization Initiative
Larson, Kent - USAID
Nemsadze, Ketevan - Claritas
Nutsubidze, Nikoloz - Ministry of Labor, Health and Social Affairs

Pruidze, Nana Pruidze - West Georgia Community Mobilization Initiative
Shakhnazarova, Marina – Medical Statistics Bureau
Sirbiladz, Tamara – USAID
Tsagareli, Tea - Save the Children, Georgia
Tsertsvadze, George - Zhordania Institute
Tsintsadze, Marina - Medical Statistics Bureau
Tsuladze, George - Demographer
Tsuleiskiri, Nino - Association “HERA-XXI
Vadachkoria, Alexander - State Department for Statistics of Georgia
Vashakmadze, Khatuna - West Georgia Community Mobilization Initiative
Zaalishvili, Lasha - Open Society Georgia Foundation

Note: Many of those interviewed in Georgia held multiple positions in different organizations.

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APPENDIX B

Supply Side Data Collection Framework, by Year and Sources

Data	Years	Sources
Number of women, married women ages 15 to 44, married users by, method, source of method, urban or rural, age category, district	1999-2003, by year	MOH, RHS, 1999
Number of family planning providers (MDs and others, including NGOs), by type, district, urban or rural, public or private	1999 and 2002/3	RHS, 1999, MOH, NGOs, RH Institute*
Cost (including under the table) of family planning service, by type of provider and method	1999 and 2002/3	RHS 1999, MOH, NGOs, IPPF Affiliate, UNFPA, others
Contraceptive cost to user, by method and source	1999 and 2002/3	RHS 1999, UNFPA, IPPF Affiliate, MOH, other NGOs
Source and budget for contraceptives, by method Donor, government, pharmacy, other	1999-2003, by year	MOH, UNFPA, IPPF Affiliate, PSI, other studies
Insurance schemes that reimburse for family planning or abortion Who, where, amount	1999 and 2002/3	MOH, Curatio, other interested parties
Does MOH provide for free family planning services and contraceptives? Who provides these services? If not, what are the charges?	1999 and 2002/3	MOH, UNFPA, NGOs. Other interested professionals
Reproductive health and population policy	1999 and current	MOH, other interested professionals
Reproductive health policy for youth Services, Education		MOH, other interested professionals
Sterilization policy	1995 and current	MOH, other interested professionals
Abortion policy or regulations?	1995 and current	MOH, other interested professionals
Numbers of abortions, by age, provider, district, urban or rural, type of abortion procedure	1999-2002/3, by year	RHS, MOH, other interested parties
Where abortion by dilation and curettage provided? Types of facilities, by districts, rural or urban Anesthesia provided?	1999-2002/3	RHS, MOH, other interested parties

Where abortion by manual vacuum aspiration provided? Types of facilities, by districts, rural or urban	1999-2002/3, by year	MOH, other interested parties
Reproductive health training of providers: When, who, numbers, where, by whom, budget Evaluation	1995-2003, by year	MOH, UNFPA, NGOs, other interested professionals
Information, education, and communication: Type, audience (age and geographic area), when, by whom, message, annual budget Evaluations	1995-2003, by year	MOH, USAID, UNFPA, JHU, PSI, NGOs, other interested professionals
Social marketing: Products, audience, cost of products, sales, geographic areas, budget	1999- 2003, by year	PSI/Georgia
Donors: Who, when, annual reproductive health budget, for what, target audience, geographic areas, policies Evaluations	1995-2005, by year	UNFPA, USAID, WB, WHO **, other donors
Foreign and Georgian NGOs (each NGO) providing family planning, services, by types of services, numbers, methods, cost, district Annual budget for reproductive health services	1995-2003, by year	MOH, NGOs, donors, other interested professionals
Physicians per capita, by district, urban and rural	1999 and current	MOH
Continuity of contraceptive supplies	1995 on	MOH, UNFPA, surveys, NGOs, PSI, other interested professionals
Family planning information reliability and validity	1995 on	Reproductive health professionals
Attitudes of physicians toward family planning and abortion	2002	MSF Survey
Change in attitude by government regarding support of abortion	1995-present	Interviews of interested professionals and government officials
Family planning surveys	1995 on	All sources

*Staff at the Reproductive Health Institute will be a major source of data for most of the items listed in the table.

**WHO will most likely be a source for more required data items than listed.