

IMPROVEMENT OF FAMILY PLANNING IN KAZAKHSTAN THROUGH APPLICATION OF UNFPA/WHO APPROACHES

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
FP	Family planning
HIV	Human Immunodeficiency Virus
IUD	Intra-uterus device
PMTCT	Prevention of HIV transmission from mother to child
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WHO	World Health Organization

I. Background

Family planning (FP) allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility including primary, secondary and tertiary prevention of sexually transmitted diseases. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.

Reproductive rights are affirmed in the international bill of rights for women. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly. Article 16 item e) of the Convention presumes that women have rights to „decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.” Article 12 item 1 of the Convention prescribes that „States Parties shall take all appropriate measures... to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”. Kazakhstan ratified CEDAW in 1998. Countries that have ratified or acceded to the Convention are legally bound to put its provisions into practice. In addition Kazakhstan committed to implement Programme of Cairo International Conference on Population and Development of 1994 and Millenium Development Goals including by 2015 to achieve universal access to sexual and reproductive health in accordance with the objective 2 of the Goal 5 (improve meternal health).

The country is interested that family planning policy is fully matched with requirements of international treaties and international best practicies. The consultant received the assignment from UNFPA, which provides assistance to the country within the framework of the Country Programme, to analyse situation on family planning proivisions in the country and to develop recommendations to bring it in full accordance with UNFPA and WHO-advocated approaches.

II. Aim and scopes of the mission

The aim of the mission was to assess strengths and weaknesses of the current policies to insure access of the population of Kazakhstan to family planning (FP).

Scopes of the mission included the following focuses:

- Guaranties of universal access of the population to FP:
- ✓ FP services to and products for women:
 1. Women with contraindications to pregnancy
 2. Women with low incomes
 3. Women residing in rural areas
 4. Adolescents and young people
 5. External and internal migrants
 6. People with disabilities
 7. Premenopausal women
 8. Sex workers
 9. Drug injectors
 10. People with HIV

- Variety of FP services and products provided by primary healthcare settings:
 1. Prevention of unsafe abortion
 2. Contraceptive advice and prescriptions
 3. Contraceptives supply, including in the framework of post-abortion care
 4. Emergency contraceptive pill
 5. IUD and hormonal contraception implants
 6. Cervical smears
 7. Sexually transmitted infections (STI) and reproductive tract infections (RTIs) checks and treatment
 8. HIV counseling and testing
 9. Pregnancy testing and counseling
 10. Pre-menstrual syndrome
 11. Fertility awareness and education, including advice to women facing problem to get pregnant
 12. Breast checks
 13. Addressing violence against women
 14. Human Papilloma Virus (HPV), hepatitis A and B vaccines
- FP at secondary and tertiary levels of healthcare:
 - ✓ Access to in vitro fertilization
 - Variety of contraceptives available in pharmaceutical market of Kazakhstan
 - The applied clinical protocols of FP
 - ✓ National protocol of family planning
 - Linkages of FP strategies, STI prevention and treatment and prevention of HIV transmission including PMTCT
 - National informational resources on FP
 - Integration of FP into the activities of AIDS Centers, Youth Health Centers
 - Linkages of FP centers with civil society organizations
 - Monitoring of access to FP
 - Governmental financial commitments to insure the access to FP

III. Methodology of assessment.

The assessment included focus interviews with experts and analysis of basic reference materials provided by UNFPA. Totally 12 national experts from 8 agencies have been interviewed.

A. List of interviewed experts:

UNFPA Country Office:

1. Professor Alexandr Kossukhin, Assistant Representative;

Department for Organization of Health Services, Ministry of Health (MoH) of the Republic of Kazakhstan:

2. Dr. Azhar Tulegaliyeva, Head of Department
3. Dr. Gazima Bermagambetova, Head of Health statistics and analysis Unit
4. Dr. Magripa Yembergenova, Head of Mother and Child Health Unit

Sanitary and Epidemiologic Surveillance Committee, MoH of the Republic of Kazakhstan

5. Dr. Aigul Katrenova, Expert (HIV/AIDS) of Epidemiological Surveillance Unit

National Research Centre for Maternal and Child Health

6. Professor. Talshyn Ukybassova, Deputy Medical Director on Ob/Gyn

Kazakhstan Association for Sexual and Reproductive Health (IPPF member)

7. Dr. Nadezhda Petukhova, Chairperson of Astana City Affiliation;

Astana City Center for Healthy Lifestyles

8. Dr. Marat Kurmanov, Director of Center
9. Dr. Gumira Tokbayeva, Head of Youth Policy Department

WHO Country Office

10. Professor Gaukhar Abuova, WHO National Professional Officer on Mother and Child Health

Astana City Maternity Hospital No.3

11. Dr. Zhanerke Azhetova, Deputy Head of Out-Patient Unit, Chief of Family Planning Service in Astana
12. Dr. Zaure Kairbekova, Doctor of Family Planning Unit

List of legal documents and regulations, regulations and papers analyzed:

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- ✓ Code of Republic of Kazakhstan “On Health of the Population and Health Systems” adopted in September 2009 (in Russian) <http://www.mz.gov.kz/>;
- ✓ The State Program for Health Care Development in the Republic of Kazakhstan “Salamatty Kazakhstan” for 2011 – 2015 (in Russian) <http://www.mz.gov.kz/> ;
- ✓ Resolution of the Government of Kazakhstan of 21.12.2007 No 1260 “On Approval of the Programme Healthy Lifestyle for the period of 2008-2016” (in Russian) <http://www.egov.kz/> ;
- ✓ Decree of Minister of Health of Kazakhstan of 28 October 2009 No 595 “On the measures to develop reproductive healthcare of citizens and family planning services” with Приказ Министра здравоохранения Республики Казахстан от 28 октября 2009 года № 595 (with the appropriate instruction) [h\(in Russian\) http://www.kazlab.kz/index.php?option=com_docman&task=cat_view&gid=53&Itemid=38&limitstart=20](http://www.kazlab.kz/index.php?option=com_docman&task=cat_view&gid=53&Itemid=38&limitstart=20)
- ✓ Decree of Minister of Health of Kazakhstan “On the activities of family planning and human reproduction centers in the Republic of Kazakhstan” of 27 December 2001 No 757 with the appropriate model regulation(in Russian) http://www.03portal.kz/na/3/index.php?option=com_content&task=category§ionid=16&id=36&Itemid=65

- ✓ Decree of Minister of Health of Kazakhstan of 29.03.2004 No 295 “On the approval of establishment of friendly cabinets” (in Russian) www.rcaids.kz/files/00000161.doc
- ✓ Decree of Minister of Health of Kazakhstan of 19 October 2006 No 491 “On the Establishment of Youth-Friendly Services” (in Russian) <http://hls.kz/uploads/41z.doc>
- ✓ Situation Assessment on HIV Transmission from Mother to Child in the Republic of Kazakhstan and effectiveness of PMTCT programmes in five Oblasts^ Report, UNICEF, 2011 (in Russian):
- ✓ Indices of Health and Health system of Kazakhstan in 2010, Ministry of Health, Astana, 2011 (in Russian): <http://www.minzdrav.kz>
- ✓ Women and Men in Kazakhstan: Statistical Book, Agency of Statistics of the Republic of Kazakhstan, Agency of Statistics of the Republic of Kazakhstan, Astana 2011 (in Russian): http://www.stat.kz/publishing/2010/Men_Women_RU.pdf
- ✓ Kazakhstan in 2010: Statistical Yearbook Astana, 2011 (in Russian): <http://www.stat.kz/publishing/Pages/publications.aspx> ;
- ✓ Kazakhstan Multi-indicator Cluster Survey 2006, Agency of Statistics of Kazakhstan, Almaty, 2007 (in English) http://www.childinfo.org/files/MICS3_Kazakhstan_FinalReport_2006_Eng.pdf

IV. Findings and commentaries

1. Code of The Republic of Kazakhstan “On Health of the Population and Health Systems” guarantees access of the population to FP. However article 102 of the Code acknowledges rights to select means and methods of contraceptives, whereas it says nothing about government commitments to meet contraceptives needs of the population.

Therefore, the Code must be updated and brought in accordance with CEDAW, an international treaty outlining that people should enjoy rights “to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.” It means that the government has to take commitments to make contraceptives available to everyone including vulnerable population groups.

All relevant documents regarding SRH and FP have to be revised and changed so that the access of the population, especially vulnerable groups, to SRH care would be improved.

Vulnerable groups are women with low income, women residing in rural areas, adolescents and young people, external and internal migrants, people with disabilities, people with HIV, drug users, sex workers.

2. There is no policy of contraceptive supply and of SRH commodity security in the country.
 - i. Kazakhstan population has free over-the-counter access to all registered contraceptives in the pharmacies.
 - ii. All pharmacies are private and licensed.
 - iii. The price for contraceptives is not fixed and varies among pharmacies.

iv. The availability of contraceptives in the internal market is determined by private entrepreneurs. If they decide to sell contraceptives to the population of Kazakhstan then contraceptives become available in pharmacies. If they decide that selling contraceptives do not give them anticipated profits the population of Kazakhstan can not purchase contraceptives in the country. E.g. time to time tablets of 750 mg Levonogesterel (Postinor) are becoming not available to clients, whereas Postinor is the only one registered medication for emergency contraception.

v. Officially, available contraceptives' spectrum in the pharmaceutical market of Kazakhstan covers all contraceptive types, exclude implants and female condoms.

vi. Although there are lists of drugs provided to the population free of charge and at reduced costs none of contraceptives are included there. Contraceptives are not free of charge for the general population.

vii. Depending on local situation women with contraindications to pregnancy can become eligible to receive contraceptives free of charge. However, their eligibility is not guaranteed legally. Local healthcare authorities are committed, but not obliged to provide women with contraceptives. The eligibility criteria to receive contraceptives for free are based on the approved list of extra-genital diseases, abnormalities and conditions making the pregnancy risky. Currently the average coverage of such women with contraceptives is about 50 percent varying in different regions of the country from 0 to 75%. At the moment contraceptives supply is funded from local budgets. MoH allocated central budget funds for 2012 to cover needs of contraceptives of all eligible women. The contraceptives are distributed among target women population by a gynecologist at the local state out-patients during visits.

viii. MoH takes some care of contraceptives supply only for women, who have contraindications to pregnancy. Other groups of women including poor women, women with disabilities, women with HIV, sex workers, migrants and other marginalized groups, who do not want to have children, are not eligible to receive contraceptives for free. Proposal of contraceptives for people with HIV and people with high risk of acquiring HIV is limited to condoms provided by AIDS Centers at the expense of the Global Fund grant.

ix. In 2011, MoH requested UNFPA support to purchase contraceptives for their follow-up distribution free of charge.

x. Whereas needs of vulnerable population groups of contraceptives are largely unmet (11.6 percent in accordance with national survey of 2010) international donors including UNFPA are facing difficulties to provide their supply as humanitarian aid, because the country legislation strictly prohibits importing of unregistered medicaments and medical devices. Good quality medication with the same active substance available at the same dosage as the registered one is considered to be unregistered if its trade name or its producer or even its package are different from the one indicated in registration documents.

xi. Percentage of the health care budget allocated to SRH care and percentage of government spending on FP as percentage of general health expenditure is not recorded.

3. MoH has the data collection and compilation regarding FP issue: contraceptives usage.

i. After learning how and what kind the data regarding this issue are collected for the official statistical presentation, reliability of data has to be discussed

as all contraceptives are over-the-counter and the correct information regarding the certain contraceptive methods (emergency contraception, hormonal contraception, IUD, condoms, spermicides, calendar method) from the private medical institutions, and from the state institutions as well, is not available and reliable and depends from data provider.

ii. The forms that require collecting and reporting of the numbers of complications of hormonal contraceptives and IUDs could be abolished as value of the information regarding this issue is questionable and to move from the registration of reportedly registered cases to the population surveys, so that to be aware of the situation in FP.

iii. MoH has no information on monitoring and analysis of FP service, because in fact the matter has to be guided. There is a need to use a clear matrix of indicators to characterize results of FP program impact (reduced numbers of unwanted pregnancies in the general population, births given by adolescent girls and abortions), outcomes (decreased unmet needs of family planning and unmet needs of modern contraceptives) and outputs to achieve the above mentioned outcomes - increased demand of services through raising awareness of different population groups; improved capacities of duty bearers – health providers; making national protocols of family planning based on WHO recommendations available; making service delivery points more accessible and insuring supply with broad spectrum of contraceptives with special focus on socially vulnerable women.

iv. Also, the data of reportedly registered abortions is not indicative. It is obvious that many abortions are underreported due to the following reasons:

1. improper filing especially in private health settings;
2. not filing by healthcare workers to avoid possible publicity in governmental settings for informal payment;
3. increased practices of applying medical abortions outside of healthcare institutions, while medications to perform such abortions are available;
4. abortions are performed in contiguous Central Asian countries, since the cost is much lower than in Kazakhstan.
5. criminal abortions (such cases are revealed in hospital, if the serious post-abortal complication is developed) still exist, but with tendency to decrease. Post- abortal FP and contraception counseling is still formal.

4. There are no community-based policies to cover people with special needs by FP. In particular it is related to disabled people, migrants, including internal, adolescents, drug users, sex workers, people living with HIV and others.

- i. Girls under 18 have no legal capacities to take independent decisions even of examination by gynecologist not involving their parents or legal guardians; they are not eligible to receive contraceptives. Whereas youth-friendly clinics have been established in the country and development of sound information resources regarding SRH and FP and sexual education of the population were seen in the visited Astana Center for healthy lifestyles development and Youth friendly clinic, there was no information about the same resources within the country and whether their services were acceptable for adolescents.
- ii. Internal migrants, including those coming from rural to urban areas for seasonal work, have no rights to use services of governmental primary healthcare settings free of charge, including FP, because funding is not allocated for them in the

healthcare budget of their temporary place of residence. They are eligible to emergency care only.

- iii. Kazakhstan receives tens thousands of illegal immigrants coming from neighboring countries, where the cost of living is much lower. They are in no case eligible to receive health service package funded by the government including FP.
- iv. Whereas syphilis is widely spread among sex workers (up to 25% in accordance with survey), and that fact supports the conclusion, that they do not use condoms regularly and hence face high risk to get unwanted pregnancy, friendly clinics for vulnerable population groups, which are available in each of the big cities, limit their services to STI treatment and condoms promotion and do not offer dual contraception. Drug injectors, clients of syringes and needles exchange points and friendly clinics, do not receive contraceptives (except condoms).
- v. In 2011, a significant number of women with HIV were becoming aware of their HIV status in the period of delivery or in the postpartal period. Although most of them were either drugs injectors (or their sexual partners) or sex workers i.e. clients of AIDS service organizations, they have not been offered contraceptives to avoid unwanted pregnancy.
- vi. In 2011, one of three pregnancies of women with HIV was terminated artificially. It is obvious, that in certain cases the period of pregnancy, when women with HIV referred to obstetrics service, was too late to offer them abortion and they gave births to unwanted children. A significant number of women with HIV givebirth reiteratively. It is clear that prevention of unwanted pregnancies is not in place for this group of population.

5. The population groups, particularly vulnerable to HIV, are exceptional case to apply WHO recommended protocols for STI cases management.

- i. The general population is not yet eligible to receive free of charge STI diagnosis, treatment and counseling on anonymous basis.
- ii. STI treatment is not fully integrated into SRH service.
- iii. The management of syphilis and uncomplicated gonorrhoea cases is still a privilege of dispensaries for skin and venereal diseases (gonococci pelvic peritonitis is managed by gynecologists), which apply outdated treatment protocols presuming long-term hospitalization of patients (e.g. secondary syphilis is treated by administration of water-soluble penicillin injections every 3 hours for 28 days).
- iv. Patients with STI are not eligible to receive medicaments for free if out-patient regimen is used.
- v. Services of private sector are too expensive.
- vi. Unacceptability and/or unaffordability of STI treatment to the population is a significant determinant of infertility caused by complications of reproductive tract infections.
- vii. The official statistics regarding STI, except HIV, incidence and prevalence is still questionable.
- viii. Whereas *in vitro fertilization* has been included into the FP service package, guaranteed by the government financial allocations, it covers less than 1/4 of couples in need.
- ix. At the same time too low attention is paid to prevention of infertility including STI treatment and prophylaxis of unwanted pregnancies and unsafe abortions.

6. No national protocol for FP is in place
 - i. Officially, FP service at primary health care level is provided by FP cabinet.
 - ii. In 2011, UNFPA printed out WHO guidelines for family planning, which have been distributed among about 300 service delivery points (FP centers).
 - iii. The national level guidelines for the sexual and reproductive health (SRH) and FP care are not developed. Previous local initiatives and activities on this issue were reported. Translated in Kazakh and Russian languages WHO and UNFPA recommendations, guidelines and protocols, tools regarding SRH and FP exist and in use. No special course regarding SRH and FP is developed and implemented in curricula of training specialists at university and college level.
 - iv. Consultancy regarding FP and contraceptive choice is done traditionally and mainly by gynecologist who is, actually, secondary and tertiary level specialist. Other professionals also rely mainly on Ob/Gyn recommendation.
 - v. The stake of midwives is minimal, while physicians of other specialties are practically not involved. Other professionals rely on Ob/Gyn recommendation. In rural areas, where only midwife's service is available, FP advice, even IUD insertion, is done by midwife. There is no officially determined level of competencies on FP issues among professionals.
 - vi. Post- abortal FP and contraception counseling remains formal and is duty of physician who has managed procedure.
 - vii. There is no information on who is dealing with emergency contraception.
 - viii. Only IUD is available as a long acting contraceptive method, no implants.
 - ix. FP centers (cabinets) play the role of service delivery points rather than of methodological centers responsible for training, advice and monitoring of FP implementation.
 - x. Priority activities to produce the outputs - changing training curricula for postgraduate and undergraduate medical students, issuing more EIC materials, strengthening the involvement of civil society, establishment of the national consultation group to adapt WHO protocols on FP and to develop the national protocols mandatory for implementation, clarification of the list of socially vulnerable population groups to provide supply with contraceptives free of charge, making variety of contraceptives available at the internal market, insuring better conditions for receiving contraceptives as humanitarian aid and so on.

7. FP service at primary health care level as properly operating FP cabinet has to include the below elements:

- i. Cytological testing of uterine cervix – secondary prevention of uterine cervical cancer.
According to the learned information, PAP smears are taken at FP cabinets. It seems that the unorganized/opportunistic cervical cancer screening exists. There are no organized cervical cancer screening signs.
- ii. Breast checks by mammography – secondary prevention of breast cancer.
According to the learned information, the equipment for mammography is available. However, check is ignored in many cases breast. It seems that the unorganized/opportunistic breast cancer screening exists. There are no organized breast cancer screening signs.

- iii. Testing of sexually transmitted infections (STI) and reproductive tract infections (RTIs) checks and treatment – prevention infertility caused by the tubal factor and an ectopic pregnancy in future.
According to the learned information, STI testing is available at FP cabinets. Gonorrhoea is usually diagnosed by Gram's staining of smears with follow-up microscopy, giving probability of discovering gonococci in 50% of cases only. It means that 50% of women with acute gonorrhoea do not get a proper diagnosis. As WHO treatment protocols are not necessarily applied in such cases, women with gonorrhoea, that was not diagnosed, are wrongly treated. There are no tracing in these cases and partners, who may have asymptomatic gonorrhoea, do not get treatment. Thus, gonorrhoea persists in the population.
Syphilis and gonorrhoea cases are reported to and the appropriate treatments are provided by skin and venereal dispensaries only. Gynecologists are eligible to treat all other STI including Chlamydia infection, genital warts, genital herpes and trichomoniasis. The medical reasons of banning treatment of syphilis and gonorrhoea by gynecologists are unknown.
WHO advocates that STI treatment must be integrated into SRH care and STI cases must be managed at all health settings, where patients refer.
- iv. Fertility awareness and education, including advice to women facing problem to get pregnant – prevention of infertility in future.
According to the learned information, in most cases, physician has no time to talk to clients regarding education issue, while capacities of midwives are not used for this purpose, also EIC materials are not available in all cases
- v. HIV counseling and testing – prevention of AIDS development.
According to the learned information, all pregnant women are eligible to double, provider initiated, testing for HIV during pregnancy. All visitors are encouraged to pass voluntary testing for HIV also.
- vi. Pregnancy testing and counseling – management of the normal pregnancy in accordance to the existing protocol.
According to the learned information, it operates well.
- vii. Addressing violence against women – woman rights issue.
That issue is not addressed at all. Syndromes of beaten women, post-traumatic stress reactions and other psychological syndromes are not diagnosed. Although psychologists and social workers are available in health sector the referral system has not been developed. Victims of violence do not receive juridical and psychological support. Lack of communication skills is a serious weakness of gynecologists.
- viii. Human Papilloma Virus (HPV), hepatitis A and B vaccination – primary prevention of cervical cancer and hepatitis.
No vaccination is proposed in any form including to vulnerable groups. Free of charge vaccines are not available.

V. Recommendations

1. All relevant legislation and regulation documents regarding SRH and FP should be revised and updated in accordance with existing CEDAW.
2. The age of acknowledged capacities of adolescents to take sufficient decisions of their own to refer and receive reproductive healthcare should be reduced to 15-16 years in accordance with the average age of actual physical and sexual maturity of girls and boys;

3. The national guidance based on UNFPA and WHO approaches needs to be improved to specify norms and regulations, management and capacities of health workers to provide qualitative FP and SRH services in Kazakhstan. FP services must include techniques of applying contraception and contragestion including making diagnosis of health conditions influencing the decisions of using methods to prevent unwanted pregnancy, education, prevention of STI and HIV transmission, preconception counseling, infertility management, making early diagnosis of breast and cervical cancer;
4. The statute document on FP cabinets should be revised and made fully congruent with updated legislation and clinical guidance.
5. There is a need to develop a national policy of contraceptives supply and security of family planning commodities insuring accessibility and affordability of wide variety of contraceptives to all groups of the population with special focus on vulnerable population groups;
6. Efforts should be taken to create better demand of contraceptives through development, printing and distribution community-based and gender sensitive information and education materials, creation and maintaining web resources and collaboration with civil society;
7. Monitoring of FP programmes must be improved. There is a need to develop clear targets with measurable indicators to monitor the results. Along with collection of reportedly registered data population surveys should be applied to measure programme outputs, outcomes and impact.
8. Expediency to record and report on the registered data related to SRH and FP should be reanalyzed, and reassessed, so that to replace not applicable data with indicators having high value to monitor and evaluate programmes;
9. Ensuring quality of FP service for all population groups' requirements, linkage and joint management among all services providing SRH and FP in Kazakhstan is needed.
10. The list of health professionals empowered and obliged to provide FP services in country should be stated clearly and their competence level has to be clearly stated; general practitioners, midwives have to be listed. Listed professionals have to get adequate pre-service and in-service trainings.
11. Since approved national FP and contraception counseling [translated documents and tools for SRH and FP] exists for different population groups, guidelines/protocols for all level health care providers have to be matched with WHO, UNFPA recommendations, documents, tools etc., and have to be developed for clinical practice by the organized Steering Committee, including all stakeholders involved in FP and SRH care. According to the developed guidelines/protocols, there will be a possibility to set up obligations and request to provide the widest possible range of safe and effective FP methods for the listed professionals empowered and obligated to provide FP services in country at primary, secondary and tertiary health care level.
12. The developed guidelines/protocols have to be included in the general medicine training curricula for students.
13. Professionals, providing FP services at primary health care level setting, have to be trained in the following topics:
 - ✓ Prevention of unsafe abortion
 - ✓ Post-abortion care
 - ✓ Contraceptive advice, prescription, supply
 - ✓ STI screening and counseling

- ✓ HIV screening and counseling
 - ✓ Cervical cancer screening and prophylaxis with HPV vaccination
 - ✓ Breast cancer screening and self-examination counseling
 - ✓ Other issues: pregnancy spacing, infertility, violence against woman
14. Appropriateness of the state financial commitments to provide contraceptives for the certain groups of female population, especially vulnerable, should be discussed – since the mechanism of distribution and follow-up is unclear and questionable from effectiveness and cost-effectiveness (efficiency) points of view. Other mechanisms and channels how to effectively cover and supply the target population have to be discussed. The other population groups, apart from women with serious extragenital diseases, have to be included in the target group list. Gradually, state financial commitments and, sequentially, mechanisms to ensure universal access to contraceptives in Kazakhstan might be discussed. Building cooperation with UNFPA to receive contraceptives at reduced costs should be discussed.
 15. Regular and systematic monitoring of FP service has to be established, using basic indicators to measure the access to FP, and carry out systemic quality assessment of FP service, supporting supervision and implementation of FP concept.