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The RESPOND Project Study Series:
Contributions to Global Knowledge

Report No. 11

Reproductive Health and Family Planning Services Received by Public-Sector Clients in Baku, Azerbaijan

Margaret Eichleay, FHI 360
Teymur Huseynov, Public Health and Reform Center
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The RESPOND Project
c/o EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@respondproject.org
www.respondproject.org

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Acronyms and Abbreviations

ACQUIRE	Access, Quality, and Use in Reproductive Health
ANC	antenatal care
AZN	manat (currency of Azerbaijan)
ECP	emergency contraceptive pill
E&E	Europe and Eurasia
FP	family planning
GNI	gross national income
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
MOH	Ministry of Health
ob-gyn	obstetrician-gynecologist
RESPOND	Responding to the Need for Family Planning through Expanding Contraceptive Choices and Program Services
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States dollars
USSR	Union of Soviet Socialist Republics
WHO	World Health Organization

Executive Summary

Several countries in Eastern Europe and Eurasia have a markedly high abortion rate and low prevalence of modern family planning (FP) methods. Explanations for the extensive use of abortion and low use of modern methods in the region cover a broad range of factors at both the health care system level and the individual level. One system-level factor that has received little attention with respect to reproductive choices is the pervasiveness of informal payments for health care. Although not thought to explain all of the reproductive health (RH) choices that women make, it is theorized that informal payments create disincentives for providers to promote FP options. This project intended to gain a more complete picture of how this system operates and understand the role payments play in RH service provision and the decision to use FP in two countries: Azerbaijan and Albania. This report focuses on Azerbaijan.

Data were collected in March 2012 at nine facilities in Baku, the capital of Azerbaijan. Interviews were conducted with 60 obstetrician-gynecologists (ob-gyns) and with 203 women seeking abortion, 180 women receiving antenatal care (ANC), and 16 women receiving FP services.

The results of these interviews suggest that the drivers of low contraceptive use in Baku are complex and potentially involve both financial and nonfinancial factors.

Financial Factors

The majority of women paid for RH services in Baku, regardless of whether the service was an abortion or ANC and despite their being entitled to receive these services for free. Payment for one ANC visit was lower than that for one abortion visit; however, the payment for the birth of a child far exceeded payment for an abortion.

Among abortion clients, those who paid were less likely to have been counseled on modern contraceptive methods than were those who did not pay. We tested two potential reasons for this relationship: (1) Providers change their counseling behavior based on payment; or (2) clients pay for the type of service they want and some do not want counseling. Neither hypothesis was supported by the data. In addition, we found no evidence that providers actively discourage FP.

Lastly, providers recommended more follow-up visits and tests/procedures for contraceptive users than is recommended by the World Health Organization (WHO). Extra visits not only require more time from clients, but they could increase the amount paid for services and promote the perception that modern methods are a concern for client health.

Nonfinancial Factors

The provision of FP services to abortion clients in this study was very low. Only 20% of abortion clients left the health care facility with a contraceptive method (condoms or the intrauterine device [IUD]), and the majority of clients said that their providers did not talk

about contraception with them (61% of abortion clients, 74% of ANC clients). Providers reported that their clients' lack of knowledge is an impediment to their offering counseling, indicating a need for better communication between providers and their clients. Among those clients who did discuss FP with their providers, the ob-gyns supported contraceptive use; however, the providers did not present a comprehensive list of options. Given that more than 80% of abortion clients listed abortion as their least preferred option of determining their number of children, providers should give clients accurate and comprehensive FP information, to enable them to fully meet their RH intentions. Though many women were familiar with more common methods (the IUD and the pill), most women were unfamiliar with emergency contraceptive pills and did not know where to find them. This finding is especially important for the reduction in repeat abortions among this population, who use withdrawal as their primary contraceptive method.

Both abortion and ANC clients indicated an intention to use modern contraception in the future, and more than 40% stated that they would prefer to use an IUD. Yet these women still had concerns about the safety and effectiveness of the IUD and of oral contraceptives. Most of their concerns focused on their perceptions of negative health consequences of modern methods, some of which were unfounded. Some providers also believed that modern contraceptive methods have a negative impact on health, and this could also impact the provision and uptake of modern methods. In addition, many providers had received IUD training that lacked a practical component (actual insertion of the IUD), which could make doctors reluctant to perform the insertion. Although 100% of providers reported being confident in their ability to counsel clients on FP, their knowledge of FP methods was less than optimal: Only 36% could put the IUD, pill, condoms, and withdrawal in their correct order of effectiveness at preventing pregnancy. This confidence, mixed with a lack of accurate knowledge of the methods, may result in the propagation of myths among potential contraceptive users.

This study did not assess the stocks of contraceptive supplies at participating facilities, but anecdotal evidence suggests that IUDs and the pill are rarely available at the facilities, which could partially explain the low provision of methods. In previous years, the United Nations Population Fund (UNFPA) has provided supplies, but as of 2011, the Azerbaijan government has been entirely responsible for stocking contraceptives. Without a concentrated effort to improve contraceptive security, FP use is unlikely to change.

Our recommendations are to:

1. Encourage health care providers to offer comprehensive contraceptive counseling, especially for abortion clients, by:
    a. Creating a protocol for comprehensive postabortion care that includes FP counseling on all available methods
    b. Creating incentives for adhering to protocols, such as by implementing performance reviews and making FP counseling an indicator of performance
2. Educate health care providers on comprehensive FP service provision, by:
    a. Modifying FP curriculums used for in-service and preservice training to emphasize the relative effectiveness of methods, the severity and likelihood of side effects, hands-on IUD insertion, and counseling skills

b. Advocating that medical professional associations disseminate updated information on clinical practices, through joint consensus statements and continuing education programs

3. Inform women, and the general public, about FP options through diverse venues, by:
   a. Promoting conversations between partners, between physicians and clients, and within families
   b. Educating people about multiple methods, what to expect as reasonable side effects, myths and misperceptions, and informed choice.
4. Harmonize national FP and abortion protocols with WHO or other evidence-based guidelines to ensure that excessive follow-up visits and procedures do not act as barriers to FP uptake.
5. Ensure availability of modern contraceptive methods by adding them to the Essential Drug List.
6. Conduct research to better understand:
   a. The best ways to educate providers and the public on FP, including the types of messages that are most culturally appropriate
   b. The rationale behind the high number of follow-up visits and reliance on ultrasound, to revise training curriculums to encourage prevention and best clinical practices
   c. The prevalence, continuation rates, and costs of contraception purchased in pharmacies

Introduction

Background

Several countries in Eastern Europe and Eurasia have a markedly high abortion rate and a low prevalence of modern contraceptive use. In this region, total abortion rates are some of the highest in the world (Sedgh et al., 2012; Westoff, 2005; Serbanescu et al., 2005). Although reported use of contraception is high, many couples use traditional methods, such as withdrawal (Serbanescu et al, 2005); in fact, withdrawal is the most commonly used family planning (FP) method among currently married women in the Caucasus.[1] This reliance on nonmodern contraceptive methods leads to a high rate of unintended pregnancy and consequently a high abortion rate (SSC & Macro International, 2008).

Explanations for the region's high abortion and low contraceptive use rates span a broad range of factors on both the demand and the supply sides. On the demand side, inadequate knowledge and negative attitudes about modern contraception inhibit uptake of FP (CDC & ORC Macro, 2003; Serbanescu et al, 2005). On the supply side, the organization and financing of health care postsocialism, government policies, and limited access to modern methods all present barriers to contraceptive use (CDC & ORC Macro, 2003; David et al., 2007; Kovács, 1999). One supply-side factor to which little attention has been paid with respect to reproductive choices is the pervasiveness of informal payments for health care.

Informal payments for health care are quite common in former socialist countries (Shishkin et al., 2003; Lewis, 2000; Vian & Burak, 2006; Balabanova et al., 2004). An informal payment is "a direct contribution made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers" (Gaal et al., 2006). To understand the role of informal payments in the region, the cultural and historical context must be understood. Informal payments are, in part, a product of the shared socialist history of the region. Health care systems under the USSR and other socialist regimes in the region were centrally planned. This meant that supplies, staff, prices, and treatments were strictly controlled. Because health facilities could not regulate these inputs to manage client load, waiting time and quality were used to ration care (Ensor, 2004; Lewis, 2000). This facilitated a system of using personal connections and/or payment to obtain faster and more attentive service. When socialism collapsed in the region, many countries did not have the funds or supplies to maintain the highly centralized system (Allin, Davaki, & Mossialos, 2006; Balabanova et al., 2004). The scarcity of funds, and subsequent reduction in staff salaries, further strengthened the informal payment system, as public-sector employees tried to earn a living wage by charging clients directly (Ensor, 2004; Shishkin et al., 2003).

Two ways in which the system of informal payments could incentivize provider actions are by influencing the type of services provided or by influencing the numbers of tests or procedures provided. If one service offers a substantially higher source of income than

[1] MEASURE DHS STATcompiler. Accessed Oct. 8, 2012, at www.statcompiler.com.

another, physicians might promote the more profitable one (Kovács, 1999). For example, very high payments for abortion services might deter providers from encouraging FP services if the latter provide less revenue. The second incentive provided by these payments could apply if the payments are made on a fee-for-service basis. If providers are paid by the number of tests or procedures performed, then they have an incentive to promote more tests than might be necessary.

The informal payment system operating in this region creates incentives that may affect contraceptive demand and provision. Although such incentives may not fully explain all of women's reproductive health (RH) choices in the region, the U.S. Agency for International Development (USAID) Europe and Eurasia (E&E) Bureau asked the RESPOND Project[2] to explore how the informal payment system might motivate the use of FP relative to abortion as one factor in RH decision-making. In response, the RESPOND Project developed a background paper on informal payments for RH care in the E&E region (Patel & Janowitz, 2010) and then conducted two country-specific studies on the issue, in Azerbaijan and Albania. This report is specific to the study in Azerbaijan.

Azerbaijan Context

The Republic of Azerbaijan is home to nearly 9.5 million people, 20% of whom live in the capital city of Baku (CIA, 2012). The population is primarily Muslim (93%) and is highly literate, with 99% of people over the age of 15 being able to read and write (CIA, 2012). In 2009, the monthly gross national income (GNI) per capita was 321 Azerbaijani new manat (AZN) (US $400) (World Bank Group, 2012). As of the latest raise in December 2011, physicians working in the public sector are paid an average of 234 AZN per month (US $298) (RFE/RL, 2011), only 72% of the per capita GNI.

Health System Organization

Azerbaijan's health system provides care primarily through public-sector Ministry of Health (MOH) facilities. Access is intended to be universal. In 2008, the National Concept on Health Financing Reform outlawed user fees for a basic package of services and pharmaceuticals received at state facilities; FP counseling/method insertion, antenatal care (ANC), and abortion services are included in this package of services, but FP methods themselves are not.

In Baku, RH services are offered in maternity hospitals, women's consultations (small clinics serving only women), the National Ob/Gyn Research Institute, an FP center, perinatal centers, and polyclinics. Due to a recent restructuring of facilities, some maternity hospitals and women's consultations have been merged. All facilities provide FP counseling and ANC,

[2] RESPOND is a five-year USAID Leader with Associates Cooperative Agreement awarded in October 2008, the purpose of which is to address the need for family planning through expanding contraceptive choices and program services. Its overall objective is to increase the use of high-quality FP/RH services. The role of research in RESPOND is to add global knowledge to the field, with a focus on informing policy development and programming and demonstrating the effectiveness of selected models and approaches in field programs. RESPOND is led by EngenderHealth, in partnership with five organizations, including FHI 360, which provides support for research on RH.

although the latter is provided at women's consultations much more frequently than at maternity hospitals. All but the polyclinics and perinatal centers perform abortions. Women's consultations provide only outpatient services and, per official policy, only provide abortions to women who have been pregnant for six weeks or less. Those pregnant for up to 12 weeks receive abortion services at maternity hospitals.

RH and FP in Azerbaijan

The RH profile of Azerbaijan is characterized by a high abortion rate and low modern contraceptive prevalence. Seventy percent of Azerbaijan's female population is of reproductive age (ages 15–49). While the total fertility rate is 2.0 lifetime births per woman, the abortion rate is 2.3 abortions per woman over her reproductive life cycle (SSC & Macro International, 2008), demonstrating that many women have more abortions than births in their lifetime. Modern contraceptive use is quite low among married women (14%), and the method most frequently used by married women is withdrawal (33%) (SSC & Macro International, 2008). Of the modern methods, the intrauterine device (IUD) is the most commonly used; 9% of currently married women use an IUD (SSC & Macro International, 2008).

By law, Azerbaijan permits abortions at will for women who are less than 12 weeks pregnant. Between 12 and 28 weeks of gestation, abortion is permitted only under certain medical and socioeconomic conditions (e.g., death of husband, divorce, having a child with disabilities, etc.) or with the approval of a panel of physicians (MOH 2003; United Nations Secretariat, 2008). Only obstetrician-gynecologists (ob-gyns) are permitted to perform abortions, and abortion service provision is part of the medical school curriculum. Abortion care, whether medically indicated or voluntary, is part of the basic package of services and therefore is required by law to be provided free of charge at public-sector facilities. Although there is no national protocol on postabortion care, postabortion FP care is mentioned in the ANC protocol (MOH, 2008), which states that FP counseling should be provided to women immediately following abortion or miscarriage or within seven days and that the ideal practice is to counsel women on FP prior to the abortion or before she leaves the clinic.

USAID and UNFPA have put significant effort into improving modern contraceptive use in Azerbaijan through research and programs. From 2004 to 2010, the USAID-funded ACQUIRE Project sought to increase the availability of, access to, and use of FP/RH services (ACQUIRE Project, 2010). ACQUIRE's approach included activities to strengthen the health system, train providers and improve FP/RH curricula, encourage private pharmacies to offer FP methods, and educate communities about FP/RH. The project actively participated in the development of the National RH Strategy, which was approved in 2008. In addition, ACQUIRE provided technical assistance to the MOH in the development of FP clinical guidelines and protocols, including eight on FP methods and one on FP counseling, which are now part of the National Reproductive Health and Family Planning Protocol (MOH, 2009). The ACQUIRE Project built capacity in service providers from seven districts and Baku City through training in FP counseling, IUD insertion, and quality improvement. The National Medical University adopted ACQUIRE's training curricula for their preservice training courses.

Despite these efforts, FP use and an accurate understanding of modern methods' health risks remain low. A recent study conducted by the International Planned Parenthood Federation (IPPF), in partnership with the Public Health and Reforms Center in Baku and UNFPA, demonstrated that men and women in Baku and two other districts of Azerbaijan feel that modern methods, particularly oral contraceptives, are harmful to their health. Participants in these focus groups also reported not receiving counseling from providers (IPPF European Network, 2012). In addition, the Private Sector Partnerships (PSP)-*One* Project, led by Abt Associates with USAID funding, found that 19% of a nationally representative sample of married women were currently using a modern method. Among nonusers, they found the greatest proportion of women (37%) to be in a group identified as "aware ambivalents"; these women have heard of several modern methods, but have little interest in using them (Patsika et al., 2009).

Political support for FP has been mixed in Azerbaijan. Although the National RH Strategy developed by the MOH with ACQUIRE's input was approved by the MOH in 2008, it has not yet been passed by the legislative branch of the government as of the writing of this report. In addition, although the MOH intended to add the IUD and oral contraceptives to the Essential Drug List in 2008–2009, which would require them to be available in the country, they were not added. The Essential Drug List is amended annually, but no modern methods have been included. They are also not included on the list of drugs to be provided for free in government facilities.

From 1994 to 2004, FP methods were provided for free by the UNFPA at public-sector health care facilities (Senlet & Capps, 2009). The methods provided through this program were the Copper T IUD, condoms, the pill, and injectable hormonal contraceptives. After 2004, the stock of free contraceptives diminished, and a study conducted in 2007 demonstrated that methods were commonly out of stock and that injectables were absent from all sampled facilities (Bradley et al., 2007). The Global Fund and social marketing organizations may still provide condoms (Senlet & Capps, 2009). Women can obtain contraceptive methods from private pharmacies, where they must pay for them. The Mirena© IUD is available only in very few private pharmacies.

Informal Payments

Informal payments for health care services in the public sector are frequent and expected in Azerbaijan. In fact, more than three-quarters of respondents of the World Bank's Living Standards Measurement Survey in Azerbaijan paid informally for health services (Lewis, 2000). RH services are no different: Using data from the Demographic and Health Survey, Patel & Janowitz (2010) found that at least 74% of women who reported having an abortion, getting an IUD, receiving ANC, or delivering a child at a public-sector facility in Azerbaijan reported paying something for services. Delivery services were the most expensive, followed by the cost of one ANC visit, getting an IUD, and lastly, having an abortion[3] (Patel & Janowitz, 2010). In Azerbaijan, there is no official fee for RH services received in the public sector; therefore, any payment is an informal payment.

[3] Among those who paid and knew what they paid.

Objectives

The goal of this study was to better understand the attitudes, behaviors, and motivations contributing to the reliance on abortion relative to FP in Baku, to design interventions that increase the provision and use of modern contraception.[4] The specific objectives of the formative research were to:

1. Describe women's knowledge of, attitudes toward, and motivations for using contraception
2. Describe providers' knowledge of and attitudes about contraception
3. Identify what providers tell women about contraception and explore providers' motivations for these discussions, including financial motivations

[4] USAID is prohibited by law from paying for the performance of abortion as a method of FP or motivating or coercing any person to practice abortions. Since the enactment of legislation in 1973, recipients of U.S. FP assistance have been legally prohibited from supporting abortion as a method of FP using U.S. funds. USAID places high priority on preventing abortions through the use of FP, saving the lives of women who suffer complications arising from unsafe abortion, and linking those women to voluntary FP/RH services that will help prevent subsequent abortions. USAID assistance in the Europe and Eurasia region is to expand access to and use of modern FP methods and thereby decrease reliance on abortion. Findings from this study will provide further information on how to increase modern contraceptive use for women in countries where abortion is legal, thereby decreasing reliance on repeat abortion.

Methods

Study Design

This was a descriptive study of RH services at public-sector women's health facilities in Baku, Azerbaijan. Interviewers asked structured questions to ob-gyns and women seeking three types of services: abortion, ANC, and FP during two weeks in March 2012. Approval to conduct the study was obtained from the Protection of Human Subjects Committee of FHI 360 and from Azerbaijan's MOH.

Sample and Participants

Facilities

The facilities of interest for this study were public-sector health facilities in Baku that provide abortions, FP, and ANC services. We selected only facilities that provide all three services because we wanted to interview providers who had the capacity to provide these three services. Thirteen facilities/pairings in Baku met our criteria; we aimed to select a convenience sample of the 10 largest facilities. Due to the sensitive nature of the questionnaire, four facilities refused to participate, and we were left with a total of nine participating facilities.

Clients

The client population of interest was women who had received abortion, FP, or ANC services at the selected public-sector facilities in Baku. These three client types were used because they represent a set of women who were in immediate need or future need of FP and who would be seeking services for which contraceptive counseling should be offered. In addition, we wanted to examine the cost of abortion services within the context of other RH services, so we included ANC and FP clients to serve as a comparison. Clients were recruited as they exited the facility or after discharge by the medical staff. Clients were interviewed in a secluded part of the facility upon consent.

To be eligible for this study, clients must have:

1. Been at least 21 years old, or aged 18–20 and married[5]
2. Visited the health care facility on the day of the interview for an abortion, FP provision or counseling, or ANC
3. Not received general anesthesia[6]

The client refusal rate for this study was 26%. Refusals included individuals who did not wish to participate at recruitment and those who stopped the interview before it had been completed. Possible reasons for refusals are described in the Limitations section. A total of 405 client interviews were completed in total; four were dropped from the analysis because they

[5] Although 18 is the age of majority in Azerbaijan, it is considered culturally inappropriate to ask unmarried women under the age of 21 about the use of FP and about abortion.

[6] Women who had general anesthesia would not be able to give informed consent after the procedure.

were conducted after the end of the data collection period, and two more were dropped because the interview was not conducted according to protocol (Table 1). The final client sample size was 399 clients.

Table 1. Overview of participant recruitment, by client type

No.	No. of clients			
	Abortion	ANC	FP	Total
Recruited	279	243	29	551
Ineligible	5	0	0	5
Refused	69	63	9	141
Dropped from analysis	2	0	4	6
Final sample size	**203**	**180**	**16**	**399**

Providers

We interviewed 60 ob-gyns who provided at least one of the services of interest (abortion, FP, or ANC services) at the selected public-sector facilities. Lists of currently employed ob-gyns were obtained from each facility, and a sample proportionate to the number of providers at the facility was randomly selected to achieve a total sample of 60. Providers were recruited in-person at the end of their shift. Interviews were conducted at the facility, in a private area wherever the provider felt most comfortable.

Data Collection

SIAR Research and Consulting, a local research agency, hired 16 female interviewers to collect data for 10 days in March 2012. On all 10 days, data were collected for abortion clients at all facilities. Information was collected from ANC and FP clients on two days at each facility. There were fewer data collection days for ANC and FP clients than for abortion clients because the ratio of ANC clients to abortion clients in preliminary service statistics was roughly 5:2. ANC and FP clients were interviewed on the same days because they were all seen by the same providers and left from the same exit. Due to budget constraints and the low client flow for FP, no extra efforts were made to obtain a larger sample of FP clients. Clients were offered a taxi ride home from the interview (up to 6 AZN, or US $8) in compensation for their time. Providers were to be offered a small edible gift, such as a pastry, for their participation.

Four data collection instruments were used for this study: one for each type of client, and one for providers. All instruments consisted primarily of closed-ended questions, but some questions were open-ended, to allow respondents to provide more detailed responses about their motivations for particular behaviors.

Definitions

Modern Contraceptive Methods

In this report, the contraceptive methods considered "modern" were: the IUD, oral contraceptives, condoms, the contraceptive ring, spermicides, and emergency contraceptive pills (ECPs). Implants and injectables would also be considered modern, but they were never mentioned by the respondents.

Side Effect Misconceptions/Overstatements

Previous studies have shown that women and providers in Azerbaijan consider side effects (or health concerns) a major barrier to modern contraceptive use (IPPF European Network, 2012; SSC & Macro, 2008). Although modern methods have common side effects, some side effects that women are concerned about may be medically unrelated to the methods themselves or overstated (Serbanescu et al., 2005). For this study, the following health concerns were considered overstated or misinformed. We did not differentiate between hormonal and nonhormonal IUDs.

Method	Side effect misconceptions/overstatements
Combined oral contraceptives (the pill)	Breast disease, cancer, cysts, death, hair growth, health problems, hormonal dysfunction, infertility, itching/redness, liver damage, uterine problems
IUD	Allergies, cancer, distention, erosion, hair growth, hormonal changes, infertility, inflammation, kidney disease, migration, skin problems, weight gain

Unnecessary Tests and Follow-Up Visits

Previous studies in Azerbaijan have shown that providers recommend unnecessary tests and excessive numbers of follow-up visits to clients so as to increase their income (Armand et al., 2007; Bradley & Mursagulova, 2006). Providers were asked what procedures they "typically" request for FP clients and how many follow-up visits they "typically" request. Physicians' and clients' reports of tests/procedures and the number of follow-up visits were compared with World Health Organization (WHO) guidelines and Azerbaijan's national protocol for FP/RH. It was important to ask about the visits routinely recommended for abortion clients as well, to compare them with FP clients. This comparison enables us to see if providers routinely request excessive numbers of tests and follow-up visits for all services, or just for FP.

Analysis

Analyses in this study are descriptive. Frequencies with chi-square tests, means, and medians are presented. To analyze open-ended questions, text responses were translated from Azeri to English by SIAR Research and Consulting staff, entered into SPSS, and then exported to Excel for grouping by theme. A few questions to which women gave very similar responses were grouped during the translation process.

Income Level

For this study, client income was assessed using three categories of family total monthly income. The categories were based on expert opinion, placing the monthly per capita gross national income (GNI) in the middle-income category and making the categories of similar ranges to those in a parallel study being conducted in Albania.

Knowledge Questions

For questions related to knowledge, the proportion of respondents giving the correct response is reported. Those who responded with "don't know" were coded as incorrect.

Payments

All financial data are reported in Azerbaijani new manat (AZN). Interviewers explicitly asked respondents to use new manat rather than old manat. The conversion rate to U.S. dollars was that for the midpoint of the data collection period: March 15, 2012 (0.786 AZN=US $1.00).[7] Either the mean or median is reported, depending on the skewness of the data.

Two types of payment data are reported in this document: the total amount paid for the visit on the day of the interview, and component costs for medications received at the facility, lab tests received at the facility, and staff. The total payment encompasses payment for the procedure, tests received at the facility, medications provided during and for use after the procedure, registration, and staff. For women who reported component costs that did not exactly sum to the total payment, we used the lesser of the two totals, to ensure a more conservative estimate. Unless otherwise noted, tests and labs for abortion clinets may have been received on a day other than the abortion procedure, but were received in the facility of interest.

Ranking Exercise

To understand relative opinions about contraceptive methods and abortion, both clients and providers were asked to put a series of cards in order of various themes. Each card showed a different method of contraception: the IUD, the pill, condoms, ECPs, and withdrawal; in addition, one card showed the word abortion. Clients were then asked to place these cards in order of: safety, effectiveness, ease of use, partner preference, family preference, and personal preference. Providers were asked to rank safety, effectiveness, and clients' preference. In addition, providers ranked barriers to contraceptive counseling. The barriers listed on the cards were: knowledge, supply, client demand, profitability, time constraints, and health concerns.

Respondents were allowed to remove a card from the exercise if they were unfamiliar with it. Any card that was ranked by fewer than 75% of respondents was not used in our analyses. Analyses of the ranked cards were restricted to respondents who used the same cards in the exercise. Pair-wise comparisons of card rankings are presented.

For the question asking clients and providers to rank various contraceptive methods in order of effectiveness, the correct order, from most to least effective, was: IUD, pill, condoms, withdrawal (Hatcher et al., 2011).

Protection of Human Research Participants

This study was approved by the Protection of Human Subjects Committee of FHI 360 and by Azerbaijan's MOH. To protect confidentiality, no identifying information was collected from clients. Although provider names were required to contact a random sample of ob-gyns, these names were not recorded on any survey forms, and physician recruitment lists were discarded as soon as data collection was finished. Information collected in this study was kept in confidential folders during the day of data collection and was then stored in a secured cabinet at the end of the day. No interviews were conducted without the participant's oral informed consent.

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[7] XE Currency Table: AZN—Azerbaijani New Manat. Accessed Oct. 2, 2012 at: www.xe.com/currencytables/?from=AZN&date=2012-03-15.

Results

A woman's decision to use modern contraception to regulate her fertility or to rely on withdrawal and/or abortion to prevent unwanted births is influenced by many factors. The results presented here are divided into sections that deal with these factors. The first section describes the study samples: For clients, this includes their socio-demographic characteristics; for providers, this includes their training and their current service provision experience. The second section presents client use, intention to use FP, and the methods and counseling received at the health facility. The remaining sections examine the potential reasons for the intention to use and receipt of FP methods: health system factors (Section 3), knowledge (Section 4), and beliefs (Section 5). The section on health system factors focuses on the location of services, barriers to service provision, tests for different RH services, the number of recommended follow-up visits, and payments for care.

Due to the very small sample size for FP clients, results from that questionnaire are presented at the end, in Section 6.

1. Participant Characteristics

1.1. Provider Demographics, Training, and Service Provision

Table 2 (page 12) presents the characteristics of the physicians included in this study. All participating ob-gyns were female. Their average age was 50, and they had been working as ob-gyns for an average of 23 years.

Only seven of the 60 interviewed providers offered abortion services (12%),[8] but nearly all provided ANC services (98%). Seventy percent of ob-gyns reported that women visit them specifically for FP services.

Most ob-gyns reported receiving RH trainings fairly recently. More than 75% reported that they had been trained in FP and ANC services within the past five years. This compares with only 42% who reported having been trained in abortion services within the same time frame; in fact, 50% of providers interviewed had never been trained in abortion services. FP trainings focused primarily on the IUD, the pill, and condoms, which are the most commonly used modern methods in Azerbaijan. ECPs and injectable contraception, which are also available in the country, were covered in trainings for fewer than one-quarter of ob-gyns. This finding has implications for the ability of providers to offer comprehensive FP counseling. In addition, for many providers, IUD training did not encompass a practical insertion component; only 22% of providers ever inserted an IUD during training. This lack of competency-based IUD (clinical and practical) training could influence providers' confidence in offering the method.

[8] During the planning stage of the study, local researchers reported that in their experience, all ob-gyns were trained in and practiced a mixture of abortion, ANC, and FP services; however, many of the participating ob-gyns reported that they do not actually perform abortions.

Table 2. Provider demographics and services offered

Characteristic	Provider mean or % (n=60)
Female (%)	100
Mean age (in years)	50
Mean years working as ob-gyn	23
Type of clients seen (%)	
Abortion	12
ANC	98
FP	70
Last ANC training (%)	
Within the past year	33
1–5 years ago	50
More than 5 years ago	12
Never	5
Last abortion training (%)	
Within the past year	24
1–5 years ago	18
More than 5 years ago	8
Never	50
Last FP training (%)	
Within the past year	40
1–5 years ago	35
More than 5 years ago	17
Never	8
FP methods trained to discuss* (%)	
IUD	75
Pill	73
Condoms	60
ECPs	23
Injectables	18
Implants	13
Female sterilization	10
Other†	23
Has inserted IUD during training (%)	22

* Multiple responses possible

† Other includes: calendar rhythm, spermicide, and contraceptive ring.

1.2. Client Demographics

Table 3 shows the characteristics of the abortion and ANC clients interviewed in this study. Abortion and ANC clients were similar in regard to marital status, education, and income, but differed in RH characteristics. With an average age of 26, ANC clients were younger than abortion clients (average age, 30). In addition, ANC clients had fewer children and had had fewer abortions than the abortion clients; this finding remains after controlling for the number of abortions (Table 4, page 14). It appears that the ANC and abortion clients who were interviewed were at different stages in their reproductive life cycles.

Abortion clients' parity varied by their number of prior abortions. Women who had no children or one child were more likely to have had one abortion, whereas women with two or more children were likely to be having a repeat abortion (Table 4). This suggests that women use abortion as a means of regulating family size.

Table 3. Client demographics

Characteristic	Client type	
	Abortion mean or % (n=203)	ANC mean or % (n=180)
Mean age (in years)	29	26
Married (%)	95	99
Total monthly income of family (%)		
0–200 AZN	11	5
201–500 AZN	63	66
≥501 AZN	21	21
Don't know	3	5
Refused	2	3
Highest level of schooling (%)		
Primary/basic	6	6
Secondary	37	39
Some higher	32	24
Complete higher	26	31
Any children (%)	93	59
Mean no. of children	1.8	0.9
Ever had abortion prior to interview (%)*	64	37
Mean no. of abortions*,†	2.6	0.6

* Only 151 ANC clients responded to this question.
† For abortion clients, this includes current abortion.

Table 4. Percentage distribution of clients, by number of children, according to prior abortion status and client type

No. of children	% abortion clients		% ANC clients	
	No prior abortion (n=73)	1 or more prior abortions (n=130)	No prior abortion (n=95)	1 or more prior abortions (n=56)
0	14	4	59	4
1	38	15	34	41
2	42	56	6	43
3 or more	5	25	1	12

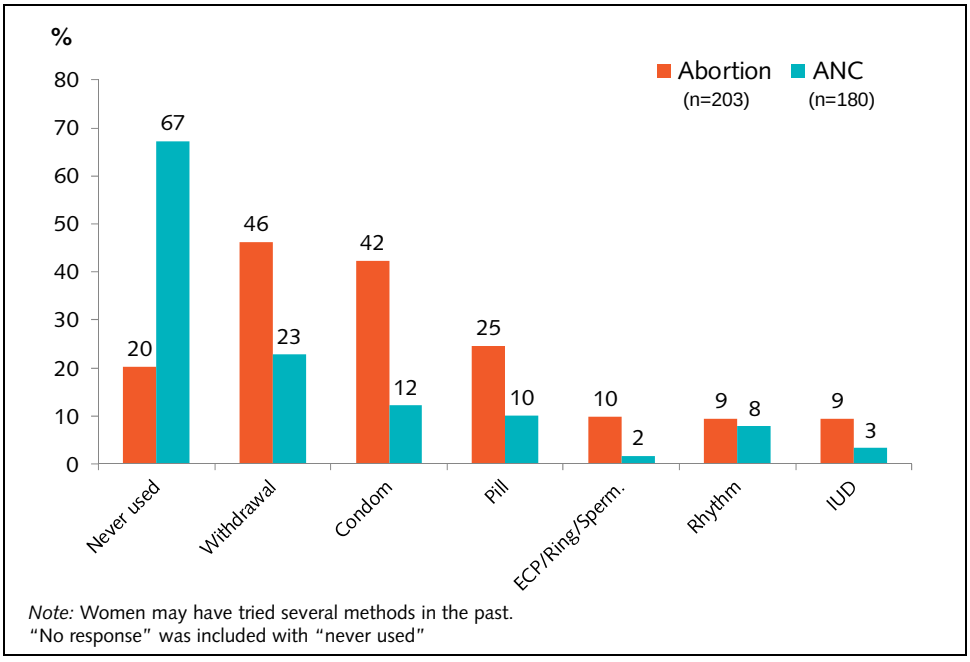
2. Use of FP

2.1. Past FP Use

Abortion and ANC clients differed substantially in their past FP use (Figure 1). Whereas the great majority of abortion clients had tried some type of FP method, only one-third of ANC clients had. Furthermore, 62% of abortion clients had tried a modern method, compared with only 19% of ANC clients (data not shown). This difference is consistent with the differences in number of children shown in Table 4. For both types of clients, withdrawal and condoms were the most commonly tried methods, followed by the pill.

Eight women were using a modern method other than the condom[9] when they became pregnant: Six abortion clients and one ANC client were using the pill, and one abortion client was using a spermicide (data not shown).

Figure 1. Percentage of clients who ever used various methods of FP, by client type



Note: Women may have tried several methods in the past. "No response" was included with "never used"

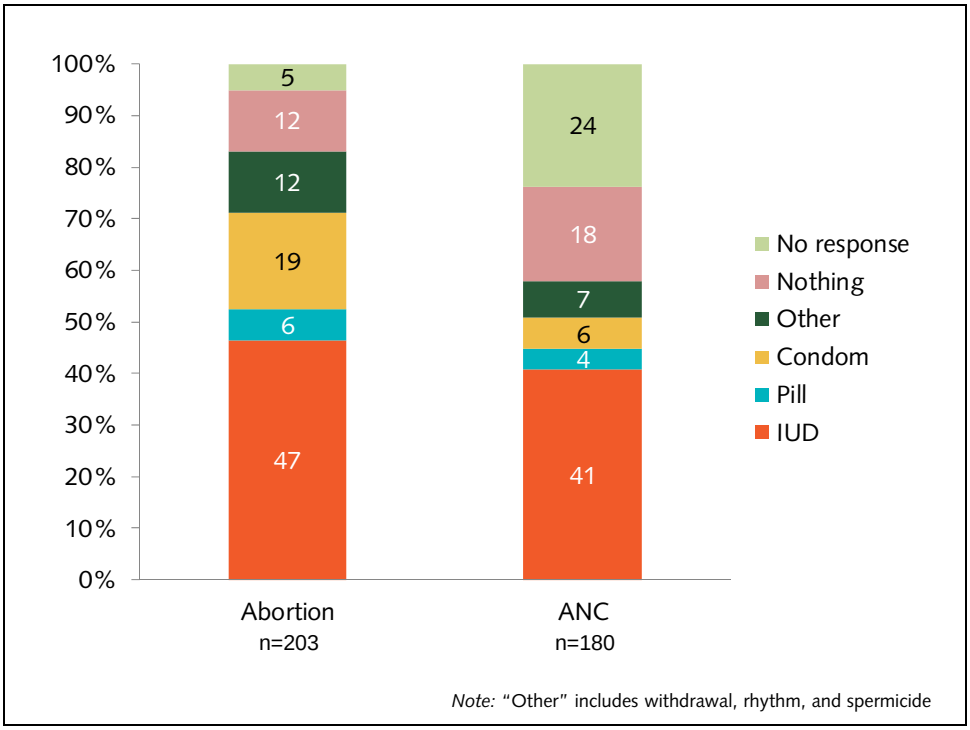
[9] We did not ask women who were using condoms if they became pregnant while using a condom.

2.2. Intention to Use FP

Clients' intentions to use FP for pregnancy prevention are shown in Figure 2. Seventy percent of abortion clients and 50% of ANC clients expressed a desire to use modern methods in the future. The difference between the two groups of women is consistent with their differing number of children; abortion clients have more children than ANC clients and therefore intend to use FP methods in the future more frequently than those with fewer children.

Women in both groups favored the IUD—47% of abortion clients and 41% of ANC clients. Some clients in both groups said they would do nothing to prevent pregnancy; of these women, most said they wanted to become pregnant. Nearly one-quarter of ANC clients did not respond to this question.

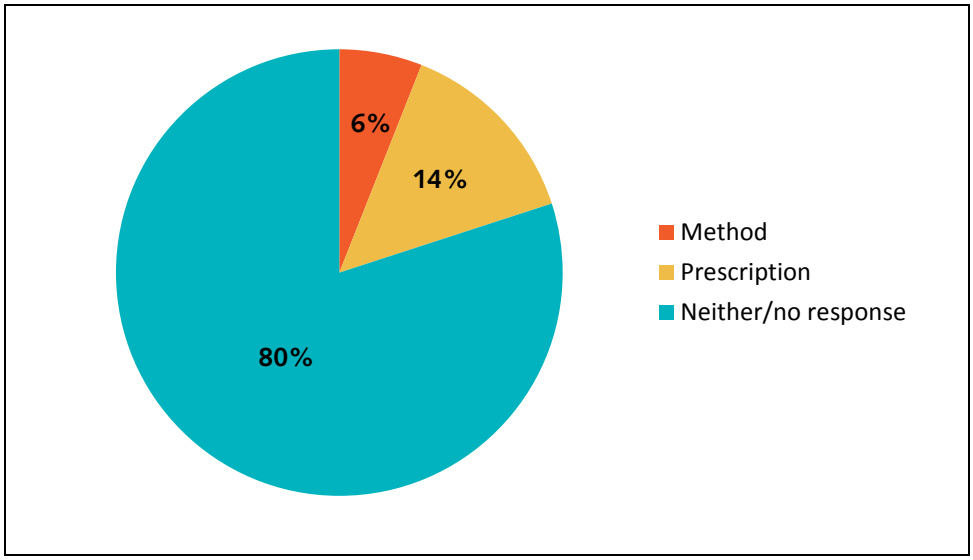
Figure 2. Percentage of clients reporting an intention to use various methods of FP, by client type



2.3. Clients' Receipt of FP Services

One way to encourage uptake of contraception postabortion is to provide an FP method or a prescription for one before a woman leaves the health care facility. In this study, only 6% of abortion clients left the facility with an FP method (Figure 3, page 16); 3% of women took condoms, and another 3% had an IUD inserted immediately postabortion. Another 14% left the facility with a prescription for a method; most of these women had a prescription for an IUD (9%). Local investigators interpreted the translation of "prescription" for an IUD to mean that these women will purchase the IUD at a pharmacy and then return to the facility for the IUD to be inserted. (Prescriptions are not a requirement for the purchase of an IUD.) It is possible that a greater proportion of women will return for an FP method after some time has passed, since some providers in this study believed that it is most suitable to insert an IUD one month postabortion (see Table 16) and because the facilities may not have had a method available.

Figure 3. Percentage distribution of abortion clients, by whether they received FP during an abortion visit



One reason for the extremely low uptake of FP postabortion could be that fewer than 40% of abortion clients reported that a provider discussed FP during their visit (Table 5).

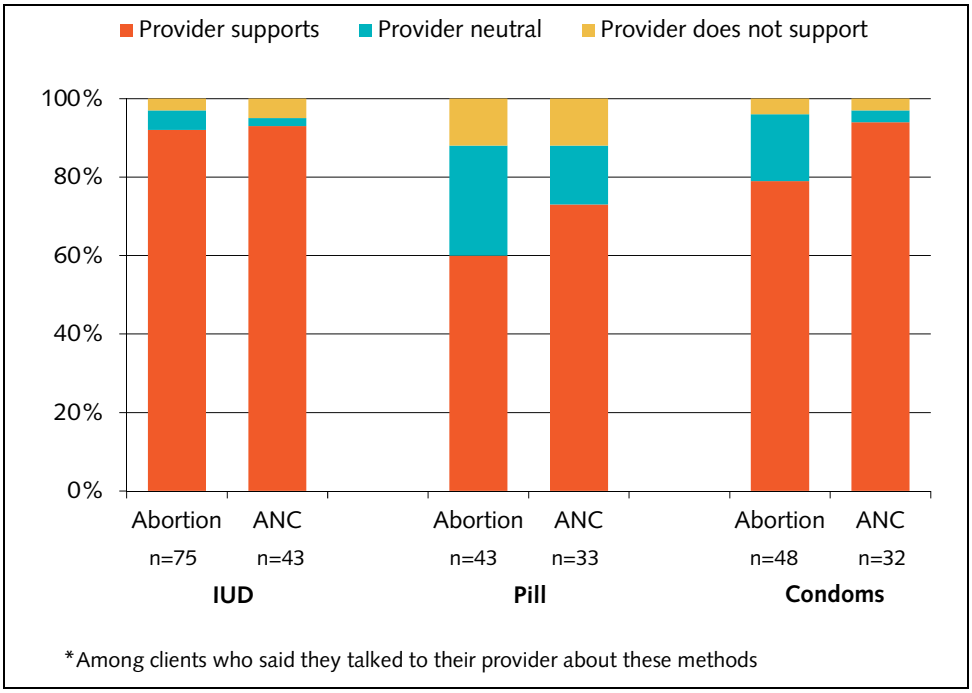
Among the 39% of abortion clients who said a provider discussed FP methods with them, most providers encouraged their clients to use them (Figure 4). This was especially true for the IUD. Very few clients reported feeling that their physician actively discouraged the use of an IUD, the pill, or condoms; providers who discouraged their clients may have done so for health reasons—for example, if the client had a contraindication to use of that method. The proportion of clients who felt that their provider was neutral about pill use was higher than for the IUD or condom. While neutrality could be viewed as a sign of good counseling practices, these results are difficult to interpret, since we do not know if the neutrality was accompanied with a discussion of diverse methods and adequate information.

Table 5. Percentage of clients reporting that a provider mentioned* FP methods, by method

Method mentioned	% of clients	
	Abortion (n=203)	ANC (n=180)
Any method	39	26
IUD	37	24
Condoms	24	18
Pill	21	18
Spermicide	12	5
ECPs	2	3
Progestin ring	<1	<1

* Provider may have mentioned method at current visit or previous visit related to this abortion/pregnancy.

Figure 4. Percentage distribution of clients, by report of provider support for modern method use, according to client type and method



3. Health System Influences

3.1. Location of Services

One measure of access to FP is whether potential users know where to obtain methods. All methods are available at private pharmacies, but the IUD can only be inserted in hospitals. The majority of women know where they would go to get the IUD, condoms, and the pill. Health care facilities were the most frequently reported location for receiving an IUD (77% abortion, 60% ANC clients), whereas pharmacies played the major role in access to condoms and the pill (Table 6).

ECPs are available at pharmacies in Baku; however, 76% of abortion clients and 84% of ANC clients did not know where they could get ECPs. This is consistent with the fact that when asked directly about ECPs, 75% of abortion clients and 83% of ANC clients said they had not heard of them (data not shown).

Table 6. Percentage of clients who know a source for FP methods, by source location, client type, and method

	Health facility		Pharmacy		Partner/family		Don't know	
Method	Abortion % (n=203)	ANC % (n=180)	Abortion % (n=203)	ANC % (n=180)	Abortion % (n=203)	ANC % (n=180)	Abortion % (n=203)	ANC % (n=180)
IUD	77	60	17	29	0	0	6	11
Condom	0	<1	78	80	10	2	12	18
Pill	4	9	77	62	0	<1	19	28
ECPs	3	3	21	12	0	0	76	84

3.2. Providers' Perception of Barriers to Contraceptive Counseling

Providers were given cards listing six barriers that could possibly impede contraceptive counseling and were asked to rank them. The six barriers were: supply, client demand, health concerns, profitability, knowledge, and physician time constraints. Providers ranked knowledge and health concerns as the two primary barriers (Table 7). When asked to expand upon their reasons for choosing these two barriers, providers who mentioned knowledge as a primary barrier most often cited the lack of knowledge on the client's side (59%), although a few said that it was on the provider's side (13%). Providers who said that health concerns were one of the primary barriers to contraceptive counseling explained that contraception causes health problems (38%) and that a woman must be healthy to start using contraception.

A small number of providers (six) said that they are not the person clients visit about contraceptive counseling; instead of the ob-gyn, they explained, clients go to the Women's Consultation unit to see a nurse or elsewhere for FP. To investigate this possibility, we examined how many of our abortion clients interviewed at Women's Consultation units were counseled on FP. Among the 109 abortion clients interviewed in Women Consultation units, only 43% were counseled.

Table 7. Percentage of providers reporting various barriers to contraceptive counseling

Listed as one of the two biggest barriers	% (n=60)
Knowledge	77
Health concerns	57
Demand for contraceptives	42
Supply of contraceptives	20
Time	5
Profit	0

Contraceptive supply was mentioned as one of the two biggest barriers to counseling by 20% of providers.

Time was not frequently listed as one of the major barriers to contraceptive counseling by ob-gyns. Only three of the 60 providers listed it among the top two constraints. Although personal conversations with physicians in preparation for this study suggested time is a sizable factor in the ability of physicians to offer comprehensive counseling, this was not demonstrated in the data.

Similarly, no providers listed profitability in the top two barriers to contraceptive counseling. In fact, the interviewers reported that most providers were offended by the inclusion of the card "profitability" with the other barriers, and nearly all doctors ranked it as the least important barrier. Due to the sensitive nature (and illegality) of informal payments in public-sector facilities, this result was expected.

3.3. Informal Payments for Services

Proportion who paid

In this study, approximately two-thirds of all clients reported paying for RH services at public-sector facilities (Table 8). ANC clients reported paying for their visit more frequently than did abortion clients (66% vs. 57%). Of those who reported paying, the greatest proportion paid for laboratory tests and for physician services (Table 9). Roughly 20% of each client group did not respond to the payment questions, and we cannot be sure of why (Table 8).

Table 8. Percentage of clients paying for visit, by client type

	% of clients	
	Abortion (n=203)	ANC (n=180)
Paid	57	66
Did not pay	23	19
Did not respond	20	15

Table 9. Percentage of clients paying for specific services, among those who received goods/service at the facility

	No. who received service	% who paid
Abortion clients		
Registration	203	29
Medicine*	106	5
Labs/procedures*	165	65
Ultrasound	161	64
Blood test	66	38
Urine test	29	48
Staff	197	65
Doctor	169	64
Nurse	160	41
Registration clerk	173	34
Lab technician	96	30
Ultrasound staff†	203	38
ANC clients		
Staff	177	76
Labs/procedures	158	81
Registration	180	19

* Sample size varies. For abortion clients, women were included in the row for labs/procedures and medicines if they received them at the facility in which the interview was conducted. This enables us to rule out the purchase of these goods/services at a private facility or pharmacy. Tests may have been received on a prior visit.

† Ultrasound staff were only identified as payment recipients in an "other" category. For this table, we assume that anybody who did not mention an ultrasound staff member did not pay one. The percentage paying should be interpreted with caution.

Of those who paid, most clients did it to receive better and/or faster services (64% abortion, 58% ANC). Those who paid for abortion or ANC services were significantly more satisfied with their services than were those who did not pay ($p<0.05$; data not shown). The second most common reason for payment was that clients felt they had no choice in the matter (55% abortion, 47% ANC). About one-third of clients said that they paid out of respect for the physician.

Table 10. Percentage of abortion clients counseled on modern method and timing of payment, by payment status

	% of clients who paid (n=133)	% of clients who did not pay (n=44)
% counseled on modern methods	31	70
% who paid after seeing doctor	75	n/a

To examine how payment related to service provision, we ran several crosstabulations. Payment for abortion-related services was related to counseling practice. Whereas only one-third (31%) of women who paid were counseled on modern FP, 70% of those who did not pay were counseled ($p=0.0006$) (Table 10). However, the majority (75%) of abortion clients paid after seeing the ob-gyn, suggesting that providers did not decide to counsel or not counsel a client based on payment. In fact, paying before or after the procedure was not related to counseling practice. (Among those who paid after services, 29% were counseled; among those who paid before receiving services, 21% were counseled [$p=0.36$].)

Another theory for the relationship between payment and lack of counseling is client demand for counseling. If clients do not want to be counseled and they pay the physician, they may dictate physician practice. To examine this, we considered client satisfaction and counseling among those who paid and intend to use contraception; we assumed that these women want to be counseled because they want to use contraception. Among paying women who intended to use contraception, 60% who were counseled on modern methods were satisfied, compared with 45% who were not counseled and were satisfied, but this difference is not statistically significant ($p=0.17$). Therefore, the reason for the association between counseling practice and payment remains unclear.

Size of payment

The amount paid by those who paid something for services varied substantially; this variation was likely due to differing levels of client health, differences in pregnancy stage for ANC clients, and variability in relationships between physicians and clients. For payment data, the median, rather than the mean, is reported, due to the skewness of the data.

Abortion clients paid more for services than ANC clients did for one visit (Table 11). Among those who reported paying something for services, the median payment for abortion-related services was 45 AZN (US $57), whereas the median payment for ANC and FP services was 20 AZN (US $25) per visit (Table 11).[10] This amount includes money exchanged for laboratory tests, medical procedures, staff gratuities, and medications received at the facility. Although it

[10] Abortion service payment may include payment for tests received on a different day.

looks as if abortion carries a higher financial incentive than ANC, it is important to recognize that providers reported asking ANC clients to come for an average of 7.8 visits during their pregnancy (data not shown). Although we cannot estimate how the cost per ANC visit might vary with the gestational age, it is probable that women pay something at each visit, given all of the necessary tests. In addition, a pregnant woman's greatest expenditure will be at the time of delivery; ANC clients expected to pay a median amount of 600 AZN (US $762) when the baby is born (data not shown). Therefore, the total cost paid to have a baby well exceeds the total cost of an abortion.

Table 11. Median payment for selected services, in new manat and U.S. dollars, among those who paid, by client type

	Abortion			ANC		
Service	n	AZN	US $	N	AZN	US $
Total amount paid	131	45	57	119	20	25
Registration	58	4	5	-	-	-
Medicine received at facility	5	15	19	50	17	22
Labs received at facility	107	10	13	158	10	13
Ultrasound	103	10	13	132	10	13
Blood test	25	5	6	83	5	6
Urine test	14	3	4	90	3	4
All staff gratuities	126	45	57	102	16	20
Doctor	108	38	48	80	10	13
Nurse	66	5	6	33	5	6
Registration clerk	59	3	4	32	5	6
Ultrasound staff	78	10	13	56	10	13

Note: The component costs (labs, medicine, registration, staff) do not sum to the total amount paid in this table because of the varying sample sizes. The total amount paid should be interpreted as the minimum amount paid at the facility, as we calculated the total in two ways and took the lesser amount. In addition, payments are reported for labs that may have been received during a prior visit.

Payments were further divided into payments to staff, payments for laboratory tests, payments for medicine, and payments for supplies either provided at the health facility or brought to the facility with the client. For abortion clients, payments to staff comprised the largest expenditure. For ANC clients, the largest expenditure was for medicines obtained at the facility (Table 11). Prices for tests did not vary by type of client (Table 11).

Among clients who paid gratuities, payments to the physician who performed the abortion (38 AZN) were nearly four times as high as those made to the ANC physician (10 AZN). Gratuities for nurses were fairly constant, at 5 manat, regardless of the services received (Table 11).

3.4. Tests/Procedures Received and Recommended

Received by client

In preparation for an abortion, either on the day of the service or during a preceding visit, 91% of clients received an ultrasound (Table 12, page 22). (Some of these women received it at another facility.) Of those who received an ultrasound, 62% paid something for it (Table 13, page 22). No other test was received by such a large proportion of clients (Table 12). For those

who paid for services, an ultrasound was the most costly of the potential tests and procedures recommended for clients. At 10 AZN (US $13), ultrasound was twice as expensive as the reported fees for blood, urine, and tests for sexually transmitted infections (STIs) (Table 13).

Table 12. Percentage of abortion clients receiving various tests and procedures

Test/procedure	% (n=203)
Ultrasound	91
Blood test	37
HIV	21
Urine test	17
Pregnancy test	17
Other STI	14

Table 13. Number and percentage of abortion clients who paid for a test/procedure, and mean amount they paid

Test/procedure	No. who paid	% who paid, among those who got test	Amount paid	
			AZN	US $
Ultrasound	115	62	10	13
Blood test	26	35	5	6
HIV	5	12	5	6
Urine test	17	50	5	6
Pregnancy test	n.d.	n.d.	n.d.	n.d.
Other STI	6	21	5	6

n.d.=no data

Tests/procedures recommended by provider

Previous studies have suggested that providers require unnecessary tests and procedures prior to starting their clients on contraceptive methods (Armand et al., 2007; Bradley & Mursagulova, 2006). Placing these requirements on modern methods can serve as a barrier to access; it can also influence women's opinions about the safety of these methods. We asked providers what tests or procedures they typically recommended prior to inserting an IUD or prescribing oral contraceptives.

Of the 51 ob-gyns who responded to the question about tests prior to IUD insertion, 82% said they require an ultrasound (Table 14). Although it is crucial to rule out pregnancy prior to IUD insertion (WHO, 2012), an ultrasound is not the only way to do so, nor is it the least expensive way. An ultrasound is not mentioned in Azerbaijan's national FP/RH protocol for otherwise healthy potential IUD clients.

Prior to prescribing oral contraceptives to their clients, 30% of ob-gyns said they require an ultrasound (Table 14). According to the WHO's Medical Eligibility Criteria, an ultrasound is not indicated for oral contraceptive users, nor is it essential to rule out pregnancy prior to starting the pill, as long as the provider is reasonably certain that a client is not pregnant

(WHO, 2010). Azerbaijan's national FP/RH protocol also does not indicate a need for ultrasound prior to initiation of pill use. Nearly half of providers recommended blood and/or hormone tests prior to starting clients on the pill. WHO does not mention a need for such blood tests prior to pill initiation (WHO, 2004).

Table 14. Percentage of providers who routinely recommend tests/procedures before clients start to use FP, by method

Tests/procedures	% of providers recommending test before client starts method	
	IUD (n=51)	Oral contraceptives (n=60)
Pelvic exam/Pap test	84	13
Ultrasound	82	30
STI test	29	8
Hormone/blood test	10	47
Pregnancy test	12	5
Other*	10	3

* Other includes: glucose, liver test

3.5. Follow-Up Visits

Asking clients to return for follow-up visits is a way to protect against potential complications, and WHO offers guidance as to the appropriate number of follow-up visits for various health procedures. Although some clients will require more visits than others due to underlying health conditions or poor reactions to procedures, the WHO recommendations are for the typical client. Doctors who habitually request a greater number of follow-up visits than the WHO recommends could harm health system efficiency and misrepresent the level of concern a client should have regarding the services received. In this study, we asked abortion clients whether their provider asked them to return for a follow-up visit, and we asked providers how many visits they typically requested for women in the first year of using oral contraceptives or an IUD. To better understand how FP recommendations compared with abortion recommendations, we also asked providers how many postabortion follow-up visits they suggested. Providers were instructed to think about their typical practice, so that they would not respond as if they were treating complicated cases.

For both oral contraceptives and the IUD, providers recommended more visits than the WHO does. Providers reported requesting an average of 2.8 follow-up visits for clients in the first year of pill use (Table 15, page 24). Almost all (90%) typically request more than one follow-up visit; this finding is in contrast with WHO's recommendation of one annual visit plus an additional follow-up visit in the first three months of use, for a maximum of two routine visits in the first year (WHO, 2004). For clients in the first year of IUD use, the ob-gyns interviewed in this study recommended an average of 2.5 follow-up visits (Table 15). During these visits, the doctors would check the placement of the IUD, test hormone levels, check for infection, and perform an ultrasound. The WHO recommends one visit 3–6 weeks after insertion (WHO, 2004), yet nearly all (94%) of the interviewed ob-gyns who had inserted an IUD in the prior three months reported routinely asking for more than two follow-up visits.

To see if providers similarly request excessive follow-up visits for other types of clients, we asked them how many they recommend for clients postabortion. Among the seven providers who offered abortions, most (five) said they recommended at least one postabortion follow-up visit. Yet only 25% of abortion clients said they were asked to return for a follow-up visit to check for complications and ensure a complete abortion. WHO strongly recommends that "there is no medical need for a routine follow-up visit following uncomplicated surgical abortion" (WHO, 2012). This guideline has been revised from the earlier edition of the Safe Abortion guidelines (WHO, 2003), which had suggested that one follow-up visit might be necessary.

Table 15. Average number of follow-up visits for women initiating IUD or oral contraceptive use

	Ob-gyns		
	n	Average no. of visits recommended	WHO-recommended no. of visits
IUD*	51	2.5	1
Pills*	49	2.8	1–2

*Number of routine visits recommended in the first year of use
Note: Sample sizes for ob-gyns reflect the number of providers who have inserted an IUD in the past three months and the number who provide oral contraceptives.

4. Knowledge of Fertility and FP

Given the low use of modern contraception, it is important to consider how much women really know about their fertility and about FP. As the source of much FP information, health care providers also need to have correct knowledge of FP options.

4.1. Clients' Knowledge of FP Methods

More than 85% of each type of client had heard of the IUD. When asked to mention all FP methods they had heard of, most women could name the IUD, the pill, condoms, and withdrawal. Women were not very familiar with ECPs (Table 16).

Table 16. Percentage of clients who can spontaneously name/describe FP methods, by client type

	% of clients	
Method	Abortion (n=203)	ANC (n=180)
IUD	88	91
Condom	75	76
Pill	72	71
Rhythm/calendar	30	27
Withdrawal	60	58
ECPs	11	13
Spermicide	22	16
Other*	6	5

*"Other" includes the progestin ring, the lactational amenorrhea method, and herbal methods

Table 17. Percentage of clients and providers who correctly ranked FP methods in their order of effectiveness at preventing pregnancy, and percentage who incorrectly ranked the pill and IUD

	% of clients		% of providers (n=60)
	Abortion (n=149)	ANC (n=102)	
% who correctly ordered methods by effectiveness	21	16	37
% who incorrectly ranked:			
Condoms as more effective than pill	63	65	35
Condoms as more effective than IUD	26	28	27

Note: Correct order, from most- to least-effective, was IUD, pill, condoms, withdrawal.
Data are for those who responded about all four methods.

When asked to rank the most commonly used methods in Azerbaijan by their level of effectiveness, more than two-thirds of clients knew that the IUD is the most effective and that withdrawal is the least effective (data not shown). Still, fewer than a quarter of clients knew the correct order for all four methods (IUD, pills, condoms, withdrawal); the error occurring most frequently was women rating condoms as more effective at preventing pregnancy than the pill (Table 17).

Knowing who women go to for advice about FP is important to understanding the provider's role in the decision to use contraception. Both abortion and ANC clients cited health providers most frequently as a source of FP information (Table 18). Husbands and partners were the next most consulted, closely followed by family members. Very few clients reported seeking advice from pharmacists.

Table 18. Percentage of clients who know sources of FP information, by client type

Source	% of clients	
	Abortion (n=203)	ANC (n=180)
Health professional (doctor/nurse)	53	74
Partner	39	28
Family	40	22
Friends	22	13
Pharmacist	1	2
Other (nobody, books, internet)	9	6

4.2. Providers' Knowledge of FP Methods

Since women lack comprehensive FP information and rely on health care providers to get this information, the next section examines ob-gyns' FP knowledge. Only 37% of ob-gyns could correctly place the most commonly used FP methods in order of effectiveness (Table 17); this is a smaller proportion than among interviewed clients. Like clients, some providers ranked condoms as more effective than the pill. Notwithstanding, 100% of providers were confident in their ability to counsel clients on FP options (data not shown). Of those providers who

offer FP services and who had inserted an IUD in the preceding three months, 45% knew that the IUD can be inserted immediately postabortion[11] (Table 19). Among the seven providers who offered abortion services, two did not know that the IUD is a suitable option postabortion (data not shown).

Table 19. Percentage distribution of providers, by knowledge of how soon an IUD can be inserted postabortion*

	% (n=51)
Immediately	45
After 1 week	6
After 1 month	45
After her next period	2
After 3 months	2
Total	**100**

*Among those who have inserted an IUD in the past three months.

4.3. Clients' Knowledge of Fertility

A considerable proportion of clients were uninformed about their fertility. Correct use of traditional contraceptive methods is improved if women understand the most fertile time in their menstrual cycle. Similarly, to avoid repeat abortions, clients need to know how quickly they might become pregnant postabortion. Only half of both abortion and ANC clients had basic knowledge of the female reproductive system (i.e., that they are most fertile halfway between two menstrual periods) (Table 20). In addition, only about 60% of abortion and ANC clients knew that fertility returns immediately postabortion (Table 20). The 34% of abortion clients who did not know how soon they can become pregnant again will be at risk of another unintended pregnancy within the week.

Table 20. Percentage of clients holding correct beliefs about fertility, by client type

Fertility belief	% correct	
	Abortion (n=203)	ANC (n=180)
Most fertile halfway between menses	51	56
Fertility returns immediately:		
Postabortion	66	59
After stopping oral contraceptives	54	38
Following IUD removal	46	50

[11] Some interviewers reported that providers answered this question with what they "advise" clients, rather than what they know to be true (e.g., advise insertion after one month, rather than immediately).

5. Personal Beliefs and Influences

In addition to knowledge, beliefs and the opinions of loved ones are individual-level factors that influence a woman's decision to use a contraceptive method. In this section, we review data gathered on reasons for contraceptive use, concerns about methods, and how women rank methods relative to other methods and abortion.

5.1. Reasons for Use

As reported in Section 2, most clients said they would use an IUD in the future to prevent pregnancy. These women reported choosing the IUD because it causes the least amount of worry and has the fewest side effects (Table 21). These explanations were shared between abortion and ANC clients.

The second most popular method for future use was condoms. The majority of those who choose to use condoms said it was because of the method's low cost; other common responses were personal control and not having to worry about it (Table 21).

Table 21. Percentage of clients reporting various reasons for choosing IUD or condoms to use in the future, by client type

	% of clients	
	Abortion	ANC
IUD	**(n=95)**	**(n=74)**
It causes the least amount of worry.	52	35
Partner likes it the best.	15	11
I can control it.	13	10
It is least invasive.	13	16
It has the fewest side effects.	11	28
Doctors know how to do it/advised.	7	8
It is nonhormonal.	4	4
It is least expensive.	4	4
Other	11	3
Condom	**(n=39)**	**(n=11)**
It is least expensive.	49	64
It causes the least amount of worry.	26	9
It is least invasive.	13	0
It has the fewest side effects.	10	9
Partner likes it the best.	8	9
I can control it.	3	18
It is nonhormonal.	0	9

5.2. Concerns about Modern Methods

Because the IUD and pill are the most effective methods that are commonly used in Baku, we asked women and their providers how they felt about these methods. The majority of respondents stated they had no concerns about oral contraceptives or the IUD (Table 22). However, providers had more concerns than clients, and their concerns were more about the pill than about the IUD. Of those with concerns, side effects were the most frequently mentioned. For both abortion and ANC clients, the side effect concerns about the pill were split between actual side effects (such as headaches and nausea) and overstated or misinformed ones (such as excessive hair growth, allergies, liver damage, or cancer). Women held similar concerns about the IUD: Overstated or misinformed concerns about such side effects as weight gain, allergies, cancer, and erosion of the uterus were the most frequently mentioned.

Ob-gyns shared some of these concerns about pill and IUD use (Table 22). Of those with concerns about the pill, the majority were concerned about side effects: Half reported concerns about actual side effects, and half had overstated or misinformed concerns about hair growth, general health problems, and increased risk of breast cancer. The physicians' concern about breast cancer is not unfounded; however, it demonstrates outdated knowledge. Prior to 1975, high-dose oral contraceptives were associated with a higher risk of breast cancer, but since then, research has shown that low-dose pills have no effect on breast cancer risk (Hatcher et al., 2011). Providers had far fewer concerns about the IUD; those they held had to do with weight gain and permanent infertility.

Table 22. Percentage of clients and providers reporting various concerns about using oral contraceptives and the IUD, by respondent type

Concern	% of clients		% of providers (n=60)
	Abortion (n=203)	ANC (n=180)	
Oral contraceptives			
Concerned	16	9	45
Actual side effects	*7*	*6*	*23*
*Overstated/misinformed concerns**	*9*	*8*	*23*
Not concerned	65	49	55
Unfamiliar with method	18	28	0
No response	1	14	0
IUD			
Concerned	20	8	15
Actual side effects	*4*	*4*	*10*
Overstated/misinformed concerns†	*12*	*6*	*10*
Not concerned	76	60	85
Unfamiliar with method	<1	8	0
No response	4	24	0

* Overstated/misinformed side effects for pills: breast disease, cancer, cysts, death, hair growth, health, hormonal dysfunction, infertility, itching/redness, liver damage, uterine problems

† Overstated/misinformed concerns for IUD: allergies, cancer, distention, erosion, hair growth, hormonal changes, infertility, inflammation, kidney disease, migration, skin problems, weight gain

Concerns and other reasons for nonuse were further explored with clients using an open-ended question about why more women do not use modern methods. More than half of abortion clients and 53% of ANC clients thought that women lacked adequate information about modern contraception. Health and safety concerns were the second most common answer for both types of clients (Table 23).

Table 23. Percentage of clients offering various reasons why women do not use modern contraceptive methods, by client type

	Abortion (n=203)	ANC (n=180)
Lack of information/knowledge	52	53
Health/safety concerns	33	20
Not discussed by doctor	8	3
Lack of personal responsibility	6	6
Expense	1	7
Other*	6	9

* Other: personal reasons, partner disapproval, lack of trust in effectiveness, fear of permanent infertility

5.3. Ranking of Abortion and FP Methods

To further examine attitudes about contraceptive methods and abortion, we examined how clients and providers ranked cards by various themes.

Ease of use

Women are unlikely to choose a contraceptive method that is difficult to use. The method that was reported to be the easiest to use by abortion clients was withdrawal (40%) (Table 24, page 30). In contrast, the greatest proportion of votes for easiest method among ANC clients was for the IUD (32%) (data not shown). Yet, the IUD was ranked more difficult to use than the other three contraceptive methods by 44% of abortion and 36% of ANC clients (Table 24). The overwhelming majority (more than 80%) of abortion and ANC clients ranked abortion harder to use than all of the contraceptive methods (Table 24).

Perceptions of safety

Previous studies have shown that women in Azerbaijan have fears about the safety of hormonal methods of contraception, but few studies have asked how these safety concerns for modern contraceptives compare with the perceived safety of induced abortion. We found that two-thirds of all respondents perceived abortion as the least safe way to regulate their fertility (67% of abortion clients, 63% of ANC clients, and 93% of providers) (Table 24).

In general, condoms and IUDs were perceived as the safest modern FP methods. Withdrawal was seen as safer than modern methods by a large proportion of clients. About half of clients ranked withdrawal as safer than the pill (57% of abortion clients, 42% of ANC clients); similarly, withdrawal was ranked as safer than the IUD by 46% of abortion clients and by 35% of ANC clients (data not shown).

Perceptions of cost

Another factor that might influence women's use of abortion and FP methods is cost. Clients were asked to rank abortion and contraceptive methods by cost over one year. Three-quarters of clients perceived condoms to be less expensive than the pill over the period of one year (data not shown). More than 80% believed condoms to be less expensive than the IUD over one year (data not shown). About one-third of clients viewed the IUD as the most expensive method, and about half ranked the annual cost of an IUD over that for abortion (Table 24).

Preferences

The vast majority of clients (80%) ranked abortion as the least preferred way to avoid having a child (Table 24). The IUD was the most preferred contraceptive method for 60% of abortion clients and 53% of ANC clients. Clients feel that their partners and families also prefer the IUD. Only 10% of clients reported liking withdrawal the best; this is also consistent with their perceptions about their partners' and families' preferences.

Table 24. Percentage of clients ranking abortion and FP methods, by theme and client type

Rankings and preferences	% of clients	
	Abortion (n=149)	ANC (n=102)
Ease of use		
Withdrawal is easiest.	40	28
IUD is harder than all 3 other methods (pill, condoms, withdrawal).	44	36
Abortion is hardest.	87	82
Safety		
Abortion is least safe.	67	63
Pill is safer than abortion.	85	81
Annual cost		
IUD is most expensive.	34	27
IUD is more expensive than abortion.	53	42
Client preference		
Client likes abortion least.	83	88
Client likes IUD most.	60	53
Client likes withdrawal most.	10	15
Partner preference		
Partner likes IUD most.	48	56
Partner likes withdrawal most.	7	6
Family preference		
Family likes IUD most.	68	61
Family likes withdrawal most.	9	10

Note: Out of those who ranked five cards (abortion, IUD, pill, condoms, withdrawal)

6. FP Clients

Due to the low levels of FP service provision in Baku's health facilities, we interviewed very few FP clients (n=16). With such a small sample size, we did not want to calculate proportions and compare these clients with the other two client groups. However, some observations from this small sample are worthy of note.

The 16 women seeking FP services at health facilities that provide a range of RH services were 28 years old, on average, with 1.6 children and 2.6 abortions. These FP clients were more similar demographically to abortion clients than to the ANC clients. This finding is worthy of note because it demonstrates that women who are seeking contraception have experience with childbearing and abortion but have decided to take preventive measures.

The 16 FP clients interviewed had fairly good knowledge of the most fertile time in their menstrual cycle and return to fertility postabortion. The majority (12 of 16 women) were also familiar enough to name several methods of contraception (IUD, condoms, rhythm, and calendar), yet fewer than half of the women (seven) mentioned oral contraceptives. Among women seeking FP services, all but three knew that the IUD is a long-acting method, effective for at least five years.

Even after visiting an ob-gyn for FP services, clients' knowledge of the relative effectiveness of contraceptive methods was only fair. Only three of 12 women could put the methods in their correct order of effectiveness at preventing pregnancy. The majority still ranked the pill as less effective at preventing pregnancy than condoms. Side effects (both real and medically unrelated concerns) still played a large role in their concerns about using the pill.

All but three of the FP clients interviewed chose to use an IUD, and half of them had an IUD inserted on the day of the visit. It is not surprising that most women in our sample chose an IUD; as seen in Table 5, most women would go to a pharmacy, rather than to their doctor, to get oral contraceptives. Most said they chose an IUD because the doctor advised it, it causes the least amount of worry, and their partners like it better than other methods.

Of the eight women who had an IUD inserted on the day of the visit, seven paid for the services and one refused to answer the question. Among the seven who paid, the median payment was 35 AZN (US $44). The woman who refused to answer the payment question reported that before arriving at the facility, she had expected to pay about 30 AZN (US $38). These payments included everything paid at the facility on the day of the interview; for most women, this did not include the actual IUD. Only one woman reported bringing an IUD with her to the facility, but she did not respond to the question about how much it cost.

Five more women were prescribed an IUD on the day of their visit and were getting the necessary tests. Of these five women, three paid, and the average payment was 13 AZN (US $16.50).

Of the 16 FP clients, seven reported having an ultrasound on the day of the visit, and three reported having blood work.

Limitations

Before reaching conclusions from this study, some limitations should be discussed.

Lack of Variation in Payments

Ideally, to determine the role of financial incentives on FP service provision, we would conduct a study in facilities that varied in the level of informal payment as well as in the level of FP provision. However, due to the ubiquity of payments and low levels of FP use, this ideal study was not possible. Future research could better address this question if variation in payment levels could be achieved, either through interventions or between geographic areas.

Refusal Rate

Results in this study are limited by the 26% refusal rate among clients, described in the methods section of this report. Some possible reasons for one-quarter of women's declining participation include the following:

- This study involved two very sensitive subjects: abortion/FP and informal payments. Part of the high refusal rate is probably due to women's not wanting to discuss these issues with the interviewer.
- Interviewing women after they have seen a physician, particularly for abortion clients, is difficult, as this is a very sensitive time. Some women did not feel well enough to be interviewed. Unfortunately, given that we wanted to know how much women had paid for services and what services were provided, we could not interview them prior to their visit. Due to the confidentiality issues of this study, we did not wish to take their phone numbers and attempt to contact the women once they had left the health facility.
- At some facilities, physicians told their clients not to respond to our survey questions. This may be related to the increased government attention to informal payments and other forms of corruption over the past two years. All head doctors in participating facilities were supportive of the study and had agreed to participation prior to study implementation, but in some instances facility staff members were not cooperative. In these situations, the in-country investigator met with the facility head doctor to reiterate the study goals, assure them of confidentiality, and ask them to speak with their staff again.

The main implication of a high refusal rate is participant bias. If refusal was not random, then we could be missing responses from certain types of clients. Not knowing exactly why women declined to participate further limits our ability to understand the impact of our response rate on our results. It is possible that women who did not participate were feeling less well, were less wealthy, or were more likely to pay informally than those who participated, but we cannot know for sure.

Nonresponse

Many respondents reported paying for services but did not report the size of their payment. Nonresponse to payment questions was expected due to the sensitive nature of these questions. Given the reluctance to respond, we expect that both the proportions of clients who paid and the amounts paid are underestimated in this study.

Sampling

The very small number of FP clients interviewed limits the ability to draw conclusions about these women, but it also highlights the importance of improving the use of contraception in Azerbaijan, as well as the need to use non–clinic-based survey methods for future studies of FP clients. In addition, results show that most women get pills and condoms from pharmacies rather than from physicians. Our sampling strategy did not capture women who were going to the pharmacy to get oral contraceptives, so we cannot determine how their views and/or experiences differ from women seeking contraception at health facilities.

Our sampling strategy did not reach a large number of abortion providers. Consequently, many questions we asked of abortion providers regarding procedures, practices, and beliefs could not be presented in this report. It is possible that abortion providers have opinions and attitudes about contraception that differ from those of the providers interviewed for this study (primarily ANC and FP providers); however, we cannot speculate as to the extent or direction of this potential difference.

In Azerbaijan, two types of providers can counsel clients on FP: ob-gyns and midwives. We interviewed only ob-gyns because they are the primary providers of FP services (Patsika et al., 2009). In our questions to clients, we were careful to ask if a health provider, not necessarily their ob-gyn, talked to them about FP. In this way, we hoped to capture their experiences with all potential FP counselors.

Compensation

Reports from the data collection team suggest that providers were not compensated for their time, as outlined in the consent form. This protocol violation was reported to the Protection of Human Subjects Committee of FHI 360. We do not believe that this violation impacted the validity of provider responses.

No women accepted the taxi fare home, which was offered as part of the informed consent process. At some facilities, rumors started that the taxis would take women to another location for further questioning. Throughout the study, the data collectors and supervisors informed women that the taxi would take them directly home, but still no women accepted the taxi fare. We do not feel that the lack of using the taxi service per se impacted the study findings; however, this fear is symptomatic of the general reluctance to talk about sensitive issues. This fear could explain some of the high nonresponse rates to some questions.

Discussion and Key Findings

This study explored the factors influencing women's choices to use FP methods and abortion, including the impact that financial incentives might have on providers' provision of RH services.

Payments

The goal of this study was to explore the possibility that payments for health care impact the use of FP in Baku, Azerbaijan. The majority of women paid for RH services in Baku, regardless of whether the service was an abortion or ANC. Payment for one ANC visit was lower than that for one abortion visit; however, the payment for the birth of a child far exceeds payment for an abortion. The bulk of payment for abortion services was made to physicians, but we found no evidence that providers actively discourage FP use.

Payment for abortion-related services was related to counseling practices. The proportion of women counseled on modern methods was much smaller among those who paid than among those who did not pay. We tested two potential reasons for this relationship: (1) providers change their counseling behavior based on payment, or (2) clients pay for the type of service they want and they do not want counseling. Neither hypothesis was supported by the data. Counseling was not related to whether a woman paid before or after services, so this relationship is unlikely to mean that providers tailor their counseling approach based on payment. Similarly, among paying clients who want to use modern contraceptives, satisfaction was not linked to being counseled on a modern method. We cannot be sure why having paid for services was negatively associated with being counseled on modern contraceptive methods. This issue merits further research.

This study shows some evidence that providers recommended more follow-up visits and tests/procedures for contraceptive users than the WHO recommends. Extra visits not only require more time from clients, but could also increase the amount paid for services. In addition, the need for extra visits could inflate client perceptions that modern methods are risky. These visits could contribute to the surprising perception among clients that the IUD is an expensive method to use. Physicians also recommended ultrasound for clients who want to initiate the IUD and oral contraceptives. Given that ultrasounds are a procedure women are likely to pay for informally, they may be a financial and logistical barrier to pill use.

Nonfinancial Factors

Several nonfinancial factors likely impact modern contraceptive use in Baku. The provision of FP services to abortion clients in this study was very low. Only 20% of abortion clients left the health facility with a contraceptive method, and the majority of providers did not talk about contraception with their clients. Considering that the interviewed clients considered health professionals a main source of FP information, this represents a missed opportunity. Providers feel that their clients' lack of knowledge is an impediment to offering counseling; this could indicate a need for better communication between providers and their clients. While ob-gyns

who discussed FP with their clients supported contraceptive use, they did not present a comprehensive list of options. Given that more than 80% of abortion clients listed abortion as their least preferred option of determining their number of children, providers should give clients accurate and comprehensive FP information. Though many women were familiar with more common methods (the IUD and pill), most women were unfamiliar with ECPs and did not know where to find them. This finding is especially important for the reduction in repeat abortions among this population, who are primarily using withdrawal.

Both abortion clients and ANC clients indicated an intention to use modern contraception in the future, and more than 40% want to use an IUD. Yet these women still had concerns about the safety and effectiveness of the IUD and oral contraceptives. Most of their concerns focused on the perceived negative health consequences of modern methods. Some providers also believed that modern contraceptive methods have a negative impact on health, and this could also negatively affect the provision and uptake of modern methods. In addition, provider training in IUD insertion lacks a practical component, which could make doctors reluctant to perform the insertion.

Providers' knowledge of FP methods was less than optimal. Given that the IUD is the most popular modern method in Azerbaijan and that previously implemented programs have trained providers on postpartum and postabortion IUD insertion, ob-gyns in Baku should be fairly knowledgeable about the timing of insertion, yet fewer than half knew that an IUD can be inserted immediately postabortion. In addition, only 37% of providers could list FP methods in the correct order of effectiveness, and 23% of providers had antiquated or unfounded concerns about oral contraceptives. However, 100% of providers reported they were confident in their ability to counsel clients on FP. This confidence, mixed with a lack of accurate knowledge, could propagate myths among potential contraceptive users.

Contraceptive methods are not yet included in the Essential Drug List and are not purchased by the government. This study was not able to assess the stocks of contraceptive supplies at participating facilities, but anecdotal evidence suggests that IUDs and the pill are rarely available at the health facilities, which could partially explain the low provision of methods. In previous years, UNFPA has provided supplies, but as of 2011, the Azerbaijan government has been entirely responsible for stocking contraceptives. Without a concentrated effort to improve contraceptive security, FP use is unlikely to change.

In terms of enhancing communication with the public about women's health, the Azerbaijan government is developing two strategies. A Communication Strategy for Public Health is currently under review. In addition, in conjunction with the Ob/Gyn Research Institute, a Reproductive Health Communication Strategy that supports client-focused care is in development. These are positive signs for improving FP counseling practices through political commitment.

Political will was a major component of a June 2012 High-Level Consultative Meeting in Brussels on Promoting National Ownership on Reproductive Health Commodity Security Using Evidence-Based Advocacy. This meeting, attended by government representatives, UNFPA, and the International Planned Parenthood Federation (IPPF), outlined several recommendations for improving contraceptive access and security in Eastern Europe and Central Asian countries (IPPF & UNFPA, 2012). Recommendations focused on seven areas:

increasing government commitment; improving awareness about the characteristics of modern contraceptives; improving service providers' attitudes, knowledge, and skills, as well as the range of providers offering methods; making a wider range of methods available; improving the affordability of modern methods; and addressing social norms, expectations, and gender dynamics (IPPF & UNFPA, 2012). These recommendations align well with the purpose and findings of our study. We hope that this study strengthens the arguments for implementing our recommendations and strengthening RH policy and health system reforms in Azerbaijan.

Recommendations

Although this study was conducted only in Baku, the organization of health care services, including the system of informal payments and personal connections, operates in the rest of Azerbaijan, as well as in several other countries in the region. This study's results are not statistically generalizable (even within Azerbaijan), but given the similarities in health care systems and FP choices in the region, the following recommendations may be applicable more regionally.

1. Encourage health care providers to offer comprehensive contraceptive counseling, especially for abortion clients:
   a. Create a protocol for comprehensive postabortion care that includes FP counseling on all available methods.
   b. Create incentives for protocol adherence, such as implementing performance reviews and making FP counseling an indicator of performance.
2. Educate health care providers on comprehensive FP service provision:
   a. Modify FP curriculums used for in-service and preservice training to emphasize the relative effectiveness of methods, the severity and likelihood of side effects, and hands-on IUD insertion and counseling skills.
   b. Advocate that medical professional associations disseminate updated information on clinical practices through joint consensus statements and continuing education programs.
3. Inform women, and the general public, about FP options through diverse venues.
   a. Promote conversations among partners, between physicians and clients, and within families.
   b. Educate people about multiple methods and about what to expect as reasonable side effects, myths and misperceptions, and informed choice.
4. Harmonize national FP and abortion protocols with WHO or other evidence-based guidelines, to ensure that excessive follow-up visits and procedures do not act as barriers to FP uptake.
5. Ensure the availability of modern contraceptive methods by adding them to the Essential Drug List.
6. Conduct research to better understand:
   a. The best ways to educate providers and public on FP, including the types of messages that are most culturally appropriate
   b. The rationale behind the high number of follow-up visits and reliance on ultrasound, so as to revise training curriculums to encourage prevention and best clinical practices
   c. The prevalence, continuation rates, and costs of contraception purchased in pharmacies

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