Client Perceptions of Reproductive Health Services in Vladivostok and Novosibirsk, Russia

Working Paper

MotherCare

SEATS

Department of Public Health, Novosibirsk Oblast
Department of Health Services, Primorsky Krai
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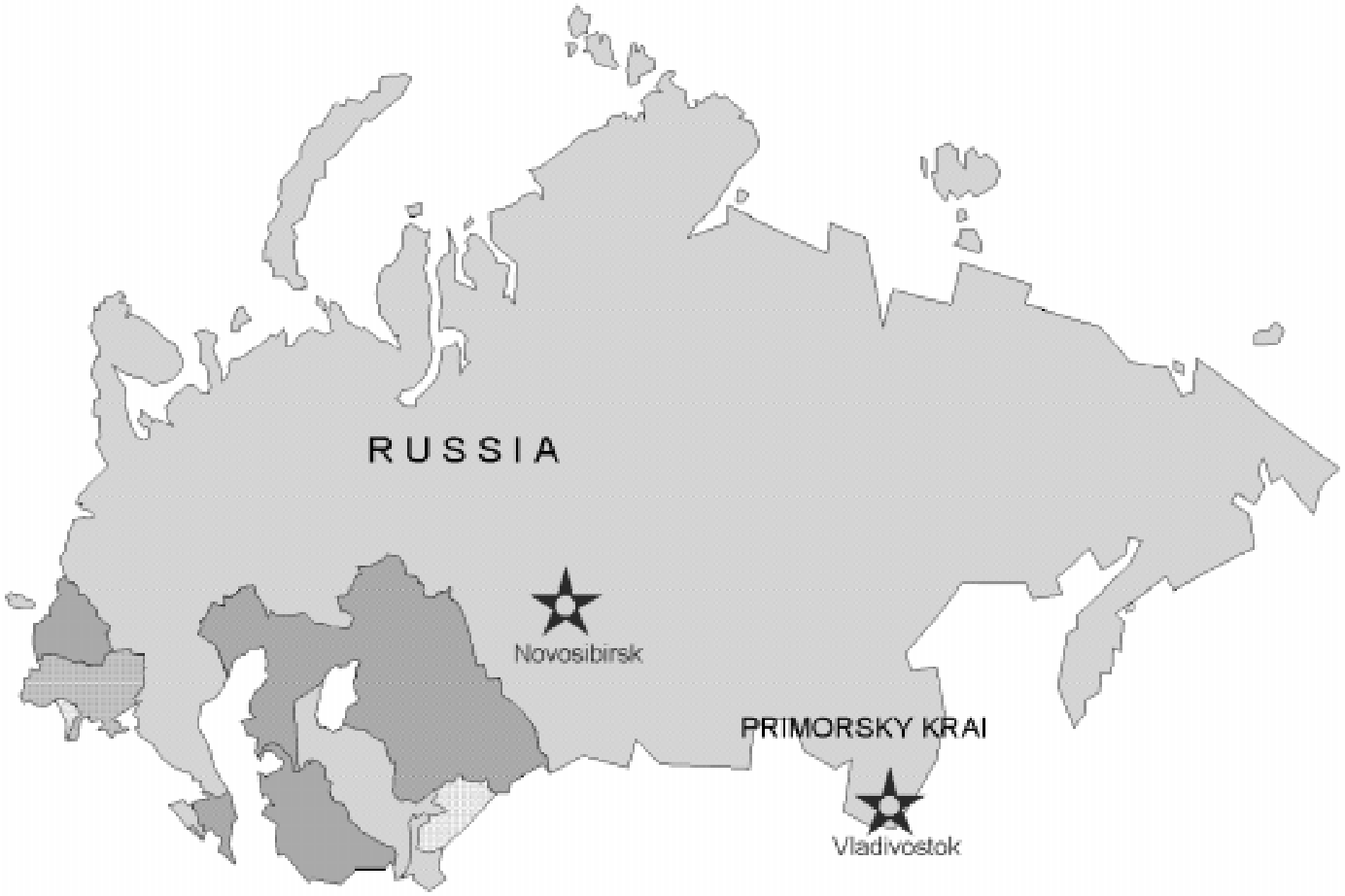
Acronym List

ACNM	American College of Nurse-Midwives
BASICS	Basic Support to Institutionalizing Child Survival Project
CA	USAID cooperating agency
COC	Combined oral contraceptive
CPR	Contraceptive prevalence rate
FGD	Focus group discussion
FP/RH	Family Planning/Reproductive Health
IEC	Information, education, and communication
IUD	Intrauterine device
JSI	John Snow, Inc.
LAM	Lactational amenorrhea method
OC	Oral contraceptive
PATH	Program for Appropriate Technology in Health
SEATS	Family Planning Service Expansion and Technical Support Project
STI	Sexually transmitted infection
USAID	United States Agency for International Development


RUSSIA
Novosibirsk
PRIMORSKY KRAI
Vladivostok

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Intro-

Primorsky Krai,[1] located in Russia's Far East (bordered by China, North Korea, and the Pacific Ocean), and Novosibirsk Oblast,[2] situated in Western Siberia in the geographical center of Russia, are two administrative divisions of the Russian Federation with similar health indicators. Although small family size is the norm, the contraceptive prevalence rate (CPR) is low. Women and service providers have become accustomed to using repeat abortion to control fertility: it has been estimated that up to 80% of Russian women of reproductive age rely on abortion as their method to control unwanted pregnancies and that the average Russian woman has 5-8 abortions in her lifetime. Historically, little or no technology from the West was permitted into the Russian family planning/reproductive health (FP/RH) program, leading to limited access to contraceptive methods coupled with a general lack of knowledge and, in many cases, distinct negative biases toward contraceptive methods among the medical community and the community at large. A substantial portion of the high rates of maternal mortality and morbidity are attributed to repeat abortion. Infertility is also high. Combined with the deteriorating health and social infrastructure and reduced employment opportunities, the health of women of reproductive age in these two areas is increasingly vulnerable (Eramova, 1995; United States Agency for International Development (USAID)/Moscow, 1995).

In response to this situation, the USAID Mission to Russia, in collaboration with the Russian government, designated Primorsky Krai and Novosibirsk Oblast as two of six regions to benefit from its Women's Reproductive Health Project. The purpose of the project is to reduce high levels of maternal morbidity and mortality by increasing knowledge and use of modern contraceptives. Breastfeeding support, education on the lactational amenorrhea method (LAM), and family-centered care principles were to be integrated into the project. Other activities implemented through a variety of USAID cooperating agencies (CAs) include: information, education, and communication (IEC) for the general public about the safety and health benefits of modern contraception, development of model family planning centers, enhancement of existing reproductive health training curricula, improved availability of contraceptives in the private sector, and policy dialogue at the local level. USAID identified the Family Planning Service Expansion and Technical Support Project (SEATS), managed by John Snow, Inc. (JSI), as the main CA to support service delivery activities in Primorsky Krai and Novosibirsk Oblast. MotherCare, a USAID-funded project also managed by JSI, works closely with SEATS to integrate breastfeeding and LAM into the service delivery activities. SEATS and MotherCare jointly sponsored and carried out this study in collaboration with counterparts at the Novosibirsk Health Administration and the Department of Public Health, Primorsky Krai.

Family Planning and Reproductive Health Services

Primorsky Krai's approximately 700 obstetricians and gynecologists are the primary providers of reproductive health services to the krai's population of 2.2 million. The capital city of Vladivostok has about 630,000 residents and 220 obstetricians and gynecologists**.** There are five maternity homes (i.e., inpatient hospitals), five women's consultations (i.e., outpatient clinics), and one family planning center (providing a broad range of infertility and limited contraception services) in Vladivostok. Contraceptive prevalence in the krai was estimated anecdotally at 35 percent (two-thirds of that being intrauterine devices [IUDs] and one-third oral contraceptives [OCs], although in Vladivostok it was estimated to be 28 percent (Eramova, 1995)).

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[1] A krai is an administrative division somewhat equivalent to a "waterfront state" in the United States.

[2] An oblast is an inland administrative division akin to a state in the United States.

Introduction

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A house on the road outside of Kuybyshev (Novosibirsk Oblast)

Novosibirsk Oblast, with a total population of approximately 2.8 million, has a health service structure similar to that of Vladivostok with a population of approximately one million. 1995 data indicate 800,000 women of reproductive age, 17 women's consultations in its capital city, Novosibirsk, 31 women's consultations in the "raions" (districts) and one municipal family planning center. These are all served by approximately 600 obstetricians/gynecologists in the Oblast.

As confirmed in this study, women receive prenatal as well as other women's health care at women's consultations and are referred to maternity clinics/hospitals for delivery. The maternity clinics deliver babies but generally appear to provide little in the way of contraceptive counseling and virtually no contraceptive services. Typically, women are told to contracept for a couple of years and are referred back to their local women's consultation for follow-up where they should receive contraceptive information and counseling. In Vladivostok, the well-equipped Krai Family Planning Center emphasizes infertility services and provides some contraception. At the time of the research, Novosibirsk was in the process of planning for the establishment of the Oblast Family Planning Center. In both sites, the women's consultations are busy outpatient services which provide relatively easy access to clients. In general, clinical practices are based on a medical model that does not appear to be client-oriented.

At the time the focus group discussions were conducted, the roles of nurses and midwives in direct contraceptive service delivery and counseling were minimal, limited to ancillary and support services. Virtually all patient interaction is provided by physicians, many of whom are subspecialists—some known as "contraceptologists" in Primorsky Krai. Reportedly, midwives and feldshers play a much more active role in rural areas; however, these functions were not reflected in krai or oblast personnel policy or the pre-service or refresher training of these providers.

Historically, older models of IUDs have been one of the most widely used methods of contraception in Russia; this is largely due to constraints in the availability of resupply methods as well as to strong provider and client concerns about the safety of hormonal methods. Providers also appear to be biased against LAM and voluntary surgical contraception.

Although the availability of modern contraceptives has been limited, the supply is reportedly improving. Nevertheless, the supply remains variable and price may be a significant barrier. Condoms, Depo-Provera®, and several brands of oral contraceptives are available, including Postinor for emergency contraception. Service delivery points generally have separate pharmacy kiosks which sell contraceptives. Contraceptives are provided at reduced prices for clients identified with limited income and most service sites provide contraceptives at no charge for those under the age of 18.

Purpose & Methodology

The purpose of this study was to gather formative information on client perspectives concerning family planning, maternity care, breastfeeding, and contraception, and to incorporate these findings into the training courses for service providers to be developed with technical support by SEATS and MotherCare. Information was collected on clients' preferences, role in decision making, expectations, and level of satisfaction with the quality of the services as then delivered. These were areas where little or no information had previously been collected and/or was available in either Novosibirsk Oblast and Primorsky Krai. Russian counterpart agencies, SEATS and MotherCare believed that they needed to learn more about women's and men's experiences and viewpoints before designing and introducing client-oriented service improvement activities, including provider training, service enhancements, policy dialogue, and IEC.

The focus group research was conducted with women who use the services of the women's consultations, postpartum women, and the husbands of postpartum women; these compose the main target groups of the USAID/Russia Women's Reproductive Health Project.

Research Methodology

Description of Focus Group Methodology

A focus group discussion (FGD) is a guided, in-depth exploration in which 6-12 people representative of a target population discuss their feelings, beliefs, opinions, and behaviors regarding a given research topic (Gorishti and Haffey, 1997). FGDs are not meant to be question-answer interactions, but rather free-flowing and spontaneous discussions among the participants themselves. A trained facilitator moderates the discussion using a research guide with open-ended questions and a note taker records the proceedings. FGDs attempt to discover how people behave, and, even more important, why they behave as they do. FGDs expose attitudes, perceptions of social norms, and correct and incorrect beliefs related to practices or products in question. They are useful for designing appropriate educational and service delivery strategies that respond to a population's needs and desires (Folch-Lyon and Trost, 1981; Gorishti and Haffey, 1997).

Organization of Focus Groups

In each city (Vladivostok and Novosibirsk), four focus groups were conducted in April 1996: one with women's consultation clients aged 20 - 30, one with women's consultation clients aged 15-20 (15 -18 in Novosibirsk), one with postpartum women, and one with husbands of postpartum women. In each study site, a total of 32 participants were recruited. The FGDs were held in the women's consultation of Maternity Clinic 3 in Vladivostok and in Women's Consultation 2 in Novosibirsk. Each FGD lasted about two hours. The research guides, one for each category of participant, encompassed: general impressions and satisfaction with clinic services, experience with breastfeeding and contraception, and sources of information on maternity care, breastfeeding, and contraception.

Table 1–Summary of Focus Group Discussions Conducted

Site	Group Participants	Age Range
Vladivostok		
n = 32	Women who use women's consultation	20 -30
	Sexually active young women who use women's consultation	15 -20
	Postpartum women	
	Husbands of postpartum women	
Novosibirsk		
n = 32	Women who use women's consultation	20 -30
	Sexually active young women who use women's consultation	15 -18
	Postpartum women	
	Husbands of postpartum women	

Trained Russian researchers conducted the FGDs under the leadership of a Russian sociologist with extensive experience in the focus group methodology. The researchers transcribed tapes of each group and wrote a summary report in Russian which was translated into English. This working paper is drawn from the translated reports.

Discussions in all groups were animated. In each site, certain topics sparked greater interest than others among participants, who often spoke at length about the subject. Consequently, the depth of information on topics varies between the two sites. For example, in Novosibirsk, reproductive health education was discussed in detail, while in Vladivostok, participants were more restrained in their comments about this matter.

Research Limitations

Limitations of this small study should be noted. Because participants in FGDs are not selected at random and, in fact, are recruited expressly because they possess certain demographic and experiential characteristics, the results of such qualitative research cannot be generalized to the population of users of reproductive health services in Primorsky Krai and Novosibirsk Oblast. In addition, although the project includes smaller towns in more rural areas of the two regions, all focus group participants came from urban areas, where experiences and perspectives may differ from those of the countryside. Additional groups with women and men representative of the sub-groups might have yielded richer and more reliable findings. Finally, participants may have been inhibited in their assessment of the quality of the services and interaction with providers because in some cases participants commented on their experiences receiving services at the same clinics where the FGDs were conducted (Gorishti and Haffey, 1997).

Pre-Implementation Issues

Concepts and examples of the client-centered approach were first introduced by SEATS/ MotherCare during three-day project launch conferences held in Novosibirsk and Primorsky Krai, February-March 1996.[3] However, these conferences were held before the project had gained permission from local health officials to conduct the focus group research intended to guide program design. Initial resistance was due to several factors, including the fact that this methodology was unknown at that time in both Primorsky Krai and Novosibirsk Oblast. There was also some skepticism concerning its soundness and potential value. In addition, it was not a standard procedure for researchers to be given free access to community members, with findings to be disseminated and incorporated in larger semi-public forums, such as policy discussions and service provider training.

During and after the launch conferences, discussion centered on the relative importance of client perspective, whether Russian clients in fact wanted the degree of information and involvement entailed in a client-centered approach, whether clients could effectively play an active role in reproductive health decision making, and whether it was sound, in general, to introduce this approach into reproductive health programs. Through these discussions, interest in clients' role and perspectives increased: one senior physician noted that the most important thing they had heard during the launch conference was that "*interpersonal contacts play so great a role in choice — your lack of recommendation, only the provision of information plays a leading role letting the client choose.*" There was also debate as to whether clients would, if given the opportunity, judge the quality of current services by dimensions similar to those presented in Clients' Rights, as outlined by the International Planned Parenthood

Rights of the Client

1. **Information**—to receive clear information to learn about the availability, benefits and management side effects of family planning methods.
2. **Access**—to obtain services regardless of sex, creed, color, marital status, location, or socio-economic class.
3. **Choice**—to decide freely whether to use family planning and what method to use at various phases in the reproductive life cycle.
4. **Safety**—to be able to practice safe and effective family planning.
5. **Privacy**—to have a private environment during counseling and service delivery.
6. **Confidentiality**—to be assured that any personal information will remain confidential.
7. **Dignity**—to be treated with courtesy, enthusiasm and attentiveness.
8. **Comfort**—to feel comfortable while receiving services.
9. **Continuity**—to receive appropriate contraceptive services and supplies as long as needed.
10. **Opinion**—to express an opinion on the services being offered without fear and with confidence that the opinion is considered valuable.

Adapted from International Planned Parenthood Federation (IPPF)

[3] The client-centered approach refers to the organization and delivery of services that take into account (a) knowing and meeting the needs and expectations of clients and ensuring client satisfaction and (b) ensuring the high performance of programs and service providers according to up-to-date clinical standards.

Federation, and the Bruce/Jain Framework for Quality of Care[4]. It was believed by some that Russians, used to long periods of struggle and limited resources, would not place much importance on issues such as privacy, choice among options, and physical comfort. Study findings from other countries on client satisfaction and continuation rates were interesting and influential to the Russian conference participants, but some felt they wanted to explore these issues in their own country context.

This interest, as well as the overall success of the SEATS/MotherCare launch activities, caused local health officials to reconsider the advantages and useful applications of the focus group methodology. The research was thus conducted and analyzed for use before the next round of policy discussions and training activities (May - June, 1996).

Use of Study Findings and Programmatic Outcomes

Once collected and analyzed, the study findings were used for a variety of activities. First and foremost, the results were used to familiarize policy makers, program managers, service providers, pre-service instructors and in-service trainers with client perspectives, and sensitize them to their importance in reproductive health service delivery. This provided a foundation for an evolving commitment to client-centered reproductive health programs and provided substance for the development of specific program strategies and activities. For program planning, the FGD findings were combined with other types of information, such as that gathered from key informants, direct observation, and later, service statistics.

Specifically, focus group findings were presented and discussed during policy discussions with local health officials and incorporated into the following project activities:

- **Design of Memoranda of Understanding and subsequent health administration regulations** detailing the level of quality services and client information and counseling to be provided at pilot program sites.
- **Clinical and counseling skills training on reproductive health,** including contraception, breastfeeding and rooming-in, and prevention and treatment of STIs, for physicians, including obstetricians-gynecologists, pediatricians, neonatologists, contraceptologists; nurses; midwives; and feldshers. These workshops included the development of mini-action plans for introducing the client-centered approach and monitoring and improving quality in general once participants returned to their sites.
- **Training of trainers for pre-service and in-service training.** These workshops were followed by curriculum development meetings that included design sessions for pre- and in-service training on client perspective and the client-centered approach.
- **Dissemination conference activities** for program planners and service providers from sites not originally included in the Novosibirsk Oblast and Primorsky Krai project pilot sites.

In each of the above training activities, special sessions were conducted explaining the focus group methodology and giving the overall findings. Emphasis was placed on the importance of client perspectives and expectations, with contrast to provider assumptions and current quality of existing services. FGD findings were further used during training to elaborate on specific issues, such as accessibility of services, client-provider interactions, expansion of method mix, special concerns of youth and young

[4] The Bruce/Jain framework contains fundamental elements for quality of care that many family planning programs use to assess their services. These elements are wide choice of contraceptive methods, counseling and client information, technical competence of service providers, interpersonal relations, mechanisms to ensure contraceptive continuity, and appropriateness and acceptability of services.

adults, the exclusion of husbands from the hospital during the birth and post-partum stays, the advantages of rooming-in of newborns, and correction of misconceptions or misinformation in relation to contraception and STIs.

Anecdotally and through observations and other information gathered during monitoring and assessment visits, the FGD findings and related training on the client-centered approach had a considerable impact on the Russian service providers who participated in the program and the way they interact with clients. Senior Russian counterparts collaborating with SEATS/MotherCare credit the FGD findings as a key factor in persuading service providers to consider the perspectives and role of the client in reproductive health decision making.

All of the 12 pilot sites re-organized their services and re-oriented their providers to apply the client-centered approach and introduce client counseling and information. Several of the pilot sites have taken further steps to routinely gather information on client perceptions, expectations and satisfaction, either by conducting periodic focus group-type discussions with clients or by approaches such as that of the Municipal Family Planning Center of Novosibirsk (site for pre-and in-service training) which deploys students to collect information on client satisfaction and then uses a collaborative approach to address and resolve issues raised.

Service Providers' Comments on Introducing Counseling and the Client-Centered Approach

"Women have told us they never thought they'd see the counseling method here in Novosibirsk — they said: 'we thought it was only for foreign women. But now there are posters and information and doctors explain everything.'"

"They're not our patients — they're our clients. They can decide."

"We used to call them patients and tell them what to do. Now we call them clients and give them the information — they decide and we support."

"We explain things effectively to clients and get them involved. The women now ask, 'why not before — why didn't you do it this way before?'"

"Now every doctor talks to every women about contraception. That never happened before."

"We realized we had to review our whole curriculum. For 30 years we had health classes for adolescents, but now the subject matter is changing — we replicated the list of topics you use — counseling, contraception, reproductive health, sexually transmitted diseases, mutual understanding between doctors, parents, teachers and youth — and we made it for adolescents in their regular program: grades 6 and 7 and 9, 10 and 11."

"We changed to your methods in the school for adolescents. We divided them into small groups and had discussion, video, participation — we had a completely different result — some young couples came forward for more information or to have counseling or to receive a contraceptive methods."

Members of master training teams developed by SEATS/MotherCare and deployed by the local health administrations in both Primorsky Krai and Novosibirsk Oblast refer to the focus group findings and integrate them into their own sessions on the client-centered approach. The Russian trainers have also developed a clinic-based training exercise where participants sit in on a focus group-type discussion as a first-hand introduction to client perceptions.

Church in Novosibirsk city built on the exact east to west geographic center of Russia.

Women's Consultations

Women's consultations provide a broad array of standard polyclinic services including gynecology, family planning, initial prenatal care, mini-abortions, and in some cases, immunization. In addition, they are frequently the first level for detection of sexually transmitted infections (STIs). In the passages below, the terms *women's consultation* and *women's clinics* are used interchangeably.

Use of Gynecological Care

Vladivostok

Most participants visited the clinic under the provisions of insurance coverage, which gave them the opportunity to select any clinic. In making their selection, the proximity of the clinic influenced the women ("assigned there"; "right next to where I live"; "picked the closest one"). The quality of services also played a role in the choice of clinic.

"I had a baby earlier at the maternity clinic. I heard people say that this is the best polyclinic. When I went for insurance coverage, they asked to assign me to this clinic. Here they have more specialists and ultrasound."

"I have gone to three women's consultations. I'm coming to this clinic now, and I consider it one of the best. I would like to be treated here only. This is a facility clinic, with all the staff and specialists right here."

"I asked my friends first where it's most pleasant to go, and they suggested I come here. I came, and I liked it. I've stayed with it."

Vladivostok street market (Primorsky Krai)

Most women visited a women's clinic for specific reasons, primarily in connection with pregnancy (abortion, prenatal care, postpartum examinations) or the treatment of diseases (cervical erosion, chlamydial infection, inflammation, endometriosis, and postabortion complications). Some working women went for job-related examinations, and a few young women also went to the clinic for "pains, uncertainty, age-related disorders."

One participant characterized her visits as follows:

> *"There were two visits this year. But not on my initiative—because of constraining circumstances. To make a special trip myself for prophylactic examinations—I don't go."*

The participants visited the clinic less frequently for prophylactic purposes, although a minority visited for preventive purposes—"to make sure."

> *"I changed partners, and I decided to go to the clinic to find out if I was all right, . . . whether I was sick or not."*

> *"I go for preventive examinations, to be sure everything is all right. Once every six months."*

Novosibirsk

Two factors dictated which women's consultation a client would visit: client's place of residence; and/or contact with a specific preferred physician. Some participants used the services of physicians who were recommended to them or whom they had selected themselves, regardless of their place of residence. The latter was the case for clients with difficult health conditions that required frequent visits to the doctor.

> *"One must have one's own doctor. A good one. I didn't go to the clinic where I lived: I think it's necessary to be serious about the examination, and at [that] clinic you don't get a serious examination."*

> *"I went to a doctor (of my own) after dissatisfaction [with others]."*

> *"I went to my district clinic. It was a kind of nightmare for me; then I found a good doctor. . . . I know that this doctor won't give me some kind of infection besides what I already have. I feel all right."*

Most participants visit a women's clinic "as needed" for pregnancy (including abortion) or treatment (cervical erosion, chlamydial infection, inflammation, infertility, endometriosis, cysts). Young women often mentioned anomalies in the menstrual cycle as reasons for visits to the consultations.

Visits for preventive services were not a widespread phenomenon. Almost all the recent birth mothers had undergone such an examination, because the maternity clinic strongly recommended it, and most of them intended to use IUDs in the near future. Only in the young women's group did participants report preventive visits to the clinic on their own initiative in connection with sexual activity.

With respect to gynecological care as a whole (examinations, in particular), the women often spoke of the unpleasant emotions they had experienced themselves or had heard about from others.

Impressions of Care Given by Physicians and Other Medical Personnel at Consultations

Vladivostok

Participants reported predominantly positive impressions of the physicians' well-meaning attitudes and their qualifications at the clinic in which the FGD took place.

> *"Here the doctors win you over. The doctor examines you thoroughly and takes care of you."*

> *"The gynecologists here are good, attentive specialists. They look me over well and answer any question I may have. You can talk to them, person to person."*

> *"The doctors are very good. The doctor is so attentive and kind."*

The young women especially emphasized the attentive attitudes of the physicians.

> *"I like my doctor very much; she acts almost like a mother to me. She's very kind. When I came to her for the first time, she showed me how to sit in the chair - I had no idea at all until then. She explained everything and showed me everything."*

> *"My doctor has quite a human, tactful, pleasant attitude. It's just interesting to deal with such a person. Questions about sex life, hygiene—they lay all that out on shelves."*

Some participants were more inclined to restrained evaluations.

> *"I wouldn't say that it's a very good relationship; it's all right. But I would like a little more sympathy from the doctor."*

A few women related negative experiences with the physicians at the clinic.

> *"Their attitude toward me was so crude that I really don't understand why I came. We came in with problems—abortions, diseases. When the doctors treat you crudely, you have the feeling that they mean something by it and are taking everything out on us. It's very unpleasant."*

One participant mentioned the subject of "influence".

> *"If I come to the doctor by way of influence, by agreement, then they look after me, and everything is fine. I like it then—there's a phrase, 'You treat her well!' But if I were a mere mortal and came in, how would they treat me? There are people in that situation, too."*

Some participants told how coming to the clinic for abortions prompted a hostile attitude.

> *"When they treated you in pregnancy, everyone wished you well. After pregnancy, I had to come in for an abortion—and something had gone wrong! The same doctor. The attitude was terrible. I came for an abortion—what crime is there in that? It was unpleasant."*

> *"I came for my first abortion. They could have said a few words of comfort. I was trembling in fear. Couldn't they have said something, offered a little support?"*

Participants were much less satisfied with their interactions with medical personnel other than physicians. The subject of lack of respect for client confidentiality by staff in the medical records office prompted a lively discussion in the young women's group.

> *"The say to you in a loud voice, 'What's your problem?' Or 'Look here, an abortion!' People are walking around....Why should everyone know about that?"*

Some young women reported that other medical personnel intruded on their interaction with the attending physician.

> *"I came for an appointment last year. The doctor looks at me and asks me something. A woman came in who had nothing to do with my examination and starting telling me how girls these days are undiscriminating and have adopted that kind of life. There was another time when another doctor came in and said, 'You don't know how to take precautions; in three months, you'll be in here again!'"*

> *"They put in a coil for me—it was painful and unpleasant. There was a crowd of students around. I would have thought they would have to ask permission to watch. It was an unpleasant feeling."*

Some participants discussed their negative experiences with medical personnel's attitudes.

> *"I went to have tests. At first I couldn't understand for a long time how they wanted me to sit. They said to me in a loud voice, 'Sit in this position.' I was sitting there and thinking how you could sit like that. She just threw my legs around. It was unpleasant—not painful, but. . . . Then she started to stick me, and I said, 'Excuse me, but isn't there something for the pain?' She shouted at me: 'So young, and already almost a whore.' I went away with tears in my eyes. They told me, "Be patient, the nurse here is like that.' I refused to go there again."*

In the young women's opinion, medical personnel's attitude toward young patients was often judgemental.

> *"They consider all the girls they see as potentially hopeless."*

> *"It's as if everyone gets the same diagnosis: once you come here, it means you're practically hopeless. That kind of attitude is an outrage! Everyone's life is*

different; you can't look at things that way. There has to be an individual approach, or you just open the door, and there's a piercing look. It alienates the patients."

Novosibirsk

Most participants expressed satisfaction with the physicians who were currently providing them care.

"I trust my doctor. I can talk about all my problems."

"Here the attitude is calm and sincere. I come here easy in my mind. . . . I don't even have any aversion to the gynecological chair. I come in calm and go away calm. I'm not afraid of pain, or the examination, or anything. Everything is done very tactfully."

The young women also had positive impressions of the physicians at the clinic where the study was conducted.

"They showed me a lot of attention and approached my problems with understanding."

"They seem to put themselves in my place."

"They are friendly people, responsive, understanding. When I came to the clinic for the first time—they support you, they behave so that you won't be afraid."

On the other hand, a few women receiving treatment had negative opinions.

"When you come in for an examination, she talks to you in such a way that it's terrible, and you don't want to come there anymore."

"My first experience in an examination office was one of crudeness. I didn't know anything; I was afraid of the gynecologic chair. I didn't know what to do, how to get ready, and no one explained anything. It wasn't good."

Some women described how they had sought out and found physicians with whom they were comfortable.

"You start by going to your own district, and you end up finding a 'qualified' doctor who really treats you properly, either at that clinic or at another clinic."

Other women believed that they have been "lucky" with physicians with whom they have interacted at the services near their place of residence.

Women's Health Services

Vladivostok

Most participants received the range of services they required within the clinic. Some women reported that they went to other medical institutions for certain services. Sometimes, the clinic referred them elsewhere.

> *"They sent me to the dispensary twice, for inoculation."*
>
> *"They sent me before and after childbirth. They did one smear here and sent me there for verification."*

In other cases, women sought out paid services on their own.

The participants wanted the opportunity to choose their own doctors, which is often not possible as the women's clinics are organized by neighborhood.

> *"Each person needs his personal doctor, who always takes care of him, and whom he likes. There are sections here. And if I don't like my doctor? I would like to have the choice of a specific doctor, whom I trust, who knows all your problems and whom you don't have to tell ten times how many abortions you've had."*

They also expressed a desire for treatment services to be available within the consultations.

Novosibirsk

The participants talked about other services provided by or expected of the women's clinic: ultrasound examinations, laboratory and clinical tests, and consultation with specialists. These services prompted criticism by many women.

The main problem with ultrasound examinations was the fact that they do not do them at the consultations but at another location (at the maternity clinic), where there is usually a long line. In fact, the participants reported problems with various tests, which they had to undergo at different locations, resulting in inconvenience.

> *"They are all at different places... the tests, different inoculations... There are lots of services that you have to get at different locations."*

When tests were done at the consultations, participants encountered the following difficulties: lines, poor quality of the examinations, and the loss of test results by clinic personnel.

> *"(My doctor) says: 'Well, what do they expect? Old reagents that don't produce colors anymore, a dim microscope, so you can't see anything. Glassware that doesn't get washed or is lost."*
>
> *"They took my blood here for a test. They do the test in week 15 [of pregnancy], and I did the test three times....The first time, they lost it; the second time, they 'mixed it up.'"*

Given these circumstances, women reported they were forced to decide about seeking paid services. In fact, many participants considered the problem of getting necessary medical service a matter of payment: "You can get any service for money."

> *"Whoever needs something quickly pays. If you want it free, you wait a month, or maybe more."*
>
> *"The doctor from Clinic X said, 'The person who does the tests isn't working here today. You'll have to go where you pay twice or three times as much."*

On the other hand, payment for services did not always guarantee the quality of the services.

> *"A certain doctor was treating me; she says to me, 'take trichopol, and everything will be all right.' My husband and I took it. I went and took a test (more than once), and the tests are very expensive. We finished the course of treatment, and then you pay again. The course of treatment is very expensive; they prescribe medicines that cost a lot of money. They treated us, and there was no effect at all."*

The following ideas were expressed with respect to access to specialists of the clinic:

> *"There are no real specialists here. There are just an obstetrician and a gynecologist, and that's all.*
>
> *"The specialists I think should be available are not always available—an oncologist, for example."*

Participants suggested that a public health service that offers home visits for pregnant women would be helpful.

> *"The obstetrician should call and ask questions. Maybe I wouldn't need to go in (for a scheduled appointment with the doctor), if I feel well. They come for the children; why not for me, a pregnant woman?!"*

Conditions at the Women's Consultations

Vladivostok

The conditions—cleanliness, comfort, and privacy—at the clinic received a fair evaluation. A few participants said that the conditions were satisfactory.

> *"The office is decent and clean. The doctor wears white. There is nothing to disturb the patient."*
>
> *"The offices are clean. Everything is all right."*

The desire for greater coziness and comfort was more common.

> *"It would be nice, if the offices were more comfortable, if it were warmer. There are many other little details."*

> *"I'd like something homey: flowers, rugs, something so you could come in and feel relaxed. Magazines for the women. So you wouldn't stand trembling in the doorway, but could come in with a calm feeling toward the doctor."*

The women reported that the lack of privacy in the present arrangement of offices and gynecologic exam tables caused them to have a feeling of vulnerability.

> *"I would like for the chairs [exam tables] to be more private, more protected, so that no one could see them by accident. Or for the screen to be larger. There is no feeling of security. The windows are even open in summer, on the first floor. It's unpleasant."*

> *"We have an office for two doctors. It's very uncomfortable: one person goes to one doctor, another to the other doctor, someone comes in for tests.... It's impossible to relax. The doctor says to relax, but the situation doesn't allow it."*

Participants also raised the issue of equipment and supplies.

> *"There used to be little towels and oil cloths on the chair; now you have to bring them along with you, and if you forget, you use some piece of paper."*

> *"I wish they had disposable instruments."*

> *"My doctor advised me to buy disposable specula. She told me, 'Wash it, and bring it with you, and it will be your speculum.' I buy disposable gloves at the drugstore and give them to the doctor."*

Novosibirsk

On the whole, participants expressed satisfaction with clinic conditions.

> *"If you graded based on medical conditions in the city, the conditions are not excellent, but they are good. There are worse places."*

> *"Ordinary conditions, standard for a district clinic. Satisfactory, maybe good."*

> *"No matter when I go, it's always been cleaned up, in the office and in the halls."*

On the other hand, women mentioned some unfavorable impressions.

> *"It's very cold in the offices in winter."*

> *"You're lying there in the chair, and a maid comes in—she washes the windows, she washes the doors, and you're lying there. It happened to me."*

Participants suggested that the consultation should serve pregnant women separately from the overall patient flow.

> *"I would like very much for the office that receives pregnant women to be separate in some way from all the other offices, so that there would be a kind of aesthetics and order there."*

Waiting Time

Vladivostok

Participants said the wait for service was at least an hour in the middle of the day and 30 minutes in the morning.

> *"I've had to sit in the waiting room for an hour or two. . . ."*

> *"I came in at lunch time and left after six o'clock."*

Most participants, based on their experience, tried to get appointments during morning hours.

> *"A year ago, I waited from 1:00 in the afternoon until 4:30. That experience made an impression on me, and I resolved to be the very first to come to see the doctors. So it's better for me to get up at 6:00. I come in at 8:00 and I'm first. Now I come by 8:30, because the doctor comes in at 8:00 and takes 20 or 25 minutes to get the office ready."*

Participants mentioned about 10 to 15 minutes as the optimum waiting time. The young women said that a long wait upset them and increased their fear.

> *"You sit in the waiting room, and the fear finds you there."*

For pregnant women, the wait to see the doctor took three forms: 1) waiting in the general queue, which can last for several hours—"In the general queue, it can take a long time, perhaps up to half the day"; 2) a preferential queue within the regular one—"We had our own line, and we took every other place. Normally there were two or three pregnant women a day. You had to wait a half hour to an hour"; 3) a separate time for receiving pregnant women—"The line was made up of pregnant women only. It could be an hour, or more, or less."

For pregnant women, long waiting lines left harsh impressions.

> *"The wait is very long—and that is very difficult . . . When there is a common waiting line, the regular gynecological patients start to look at you out of the corners of their eyes. You might sit there and say, 'Well, ladies, if I get to go ahead in preference to you, it's because it's hard for me to sit here.' They don't understand."*

Novosibirsk

The time spent on waiting to see the doctor was different for different patients. The patients who go to "their own" doctors did not normally have to wait.

> *"I don't stand in line. I go right in, and they see me."*
>
> *"I go in like the place is mine. Because I'm a frequent visitor to the polyclinics in general, I specify the time for my arrival. . . . If there are a couple of people already sitting there, I wait. Sometimes the doctor takes me at once."*

For others, the wait was usually less than 30 minutes. However, at times it was longer.

> *"The doctor's friends come in to see her, they talk, and they don't see the patients. The line gets longer; they (the doctors) discuss their own affairs and talk with their friends. The friends leave—and then you can get service."*

Nursing mothers often went through with no waiting.

> *"A nurse will notice me: 'You have to feed the baby,' and she calls me in."*

The young women considered a wait of up to 15 minutes acceptable; the older women considered 15 to 30 minutes acceptable.

Overall Assessment of Women's Consultations

Vladivostok—

Despite their negative experiences with gynecological services in general and in a few instances in the clinic where the study was held, most participants held positive overall impressions of the women's consultations. This positive impression was confirmed by the fact that many of the women had provided recommendations to their friends and relatives.

> *"I always recommend it to everyone. I think it's the best clinic."*
>
> *"I have recommended it to friends. They came, and they didn't regret it."*

Novosibirsk

The overall evaluation of a clinic depended mainly on the assessment of the attending physician's professionalism and good intentions. Participants emphasized that a highly-qualified, tactful attending physician is of primary importance to them.

> *"A good doctor eclipses everything else."*

Thus, the participants recommended to their friends not so much a particular clinic as a specific physician.

"I would recommend not the polyclinic but the doctor."

Some participants had already made such recommendations, and usually, people were grateful to them.

"Many of my friends come here. . . . I brought in a refugee from Armenia—and she liked it very much."

"I have advised more than one friend to come to this clinic. The last one I advised to come here to terminate a pregnancy. Everything turned out very well for her. [My friends] have been grateful."

Contraceptive Knowledge, Attitudes, and Use

Intrauterine Devices (IUDs)

Vladivostok

All groups, including the men, perceived the IUD as a reliable, long-term contraceptive. Its main advantages were its effectiveness and the fact that it is not a hormonal method. Although a few participants noted that IUD use could cause some harm, they generally saw it as safer than taking the pill.

"I'll use the coil—it's more reliable."

"I like the coil. Women can use it for a long time. If you want to get pregnant, you take it out."

"IUDs can also do some harm, but it seems to me that there's much less (than pills)."

Knowledge and use of the IUD were widespread among participants. They were better informed about IUDs than any other method.

"I plan to use the coil. And basically I don't know about anything besides the coil. In my crowd, everyone has talked mainly just about the coil all my life. And even my doctor talked about it when I was in the maternity clinic. They tell everybody right away—put in a coil."

Despite widespread knowledge and support of IUD use, participants expressed some concerns about the method such as inflammation, tumors, ectopic pregnancies, and sterility.

"The coil worries me—they put in a foreign object; it can become embedded, and they have to cut it out. I don't want it."

"I had endometriosis [using the coil], although they did not explain it clearly. Now I'm afraid that it [IUD] promotes inflammation."

Novosibirsk

In Novosibirsk the IUD received high marks overall from married male and female participants. They preferred its long-term use and relatively high level of reliability.

> *"They put it in for three to five years. That's an advantage."*
>
> *"It's the easiest. You put it in and don't think about it, unless there are contraindications."*
>
> *"I have the coil; they put it in for five years. I'll go five years . . . , then rest a little and put it back in. . . . There are no problems with the coil."*

The married women, in particular, viewed the IUD as a desirable method for postpartum use.

The young women noted that this method is not suitable for those who have not yet given birth.

> *"I have the idea that the coil isn't for us adolescents. It's for a later age."*
>
> *"The coil, it seems to me, is better after births, not at our age—there's more danger of ectopic pregnancy."*
>
> *"I asked whether I could get the coil. They told me that women who haven't given birth can't get it yet."*

Overall the men thought highly of this method because of the prolonged period of use and its convenience.

> *"The advantage is purely sexual—nothing gets in the way; everything is fine."*
>
> *"As soon as our first child was born, they put in the coil; and for five years, no problems —nothing. When we wanted a second child, they took it out, and that was it. And now they've put the coil in again."*

Those giving the method lower marks cited the following disadvantages: introduction of a foreign object into the body, lengthening of menstruation, unsuitability in the presence of contraindications, and, particularly, the inappropriateness of the method for women who have not given birth.

> *"For me, it's still a foreign object in the body—and I'm afraid of that."*
>
> *"It isn't 100 percent effective. That's a disadvantage."*
>
> *"Monthly periods are very long with the coil. There is a very short interval between periods. It's awful."*

Oral Contraceptives (OCs)

Vladivostok

Participants in Vladivostok made generally negative comments about OCs, citing side effects such as nausea, weight gain, infertility, and the disruption of the metabolism. Participants also complained about the high cost of pills and the inconvenience of taking them every day. Some misconceptions remained from the use of high-dose pills in the past, and some participants in both Vladivostock and Novosibirsk expressed a lack of trust in the pills and physicians administering them.

> *"I don't trust the doctors. The doctors experimented on us. They can't guarantee that these pills won't do something to my children, or to me. I'm just not going to experiment on myself."*

> *"I took Marvelon and had nausea and started to gain weight, so I quit."*

> *"I've heard the pills make you fat and disrupt your metabolism. Your hair starts to grow."*

> *"You have to take them everyday, and for me that's bothersome . . . I might forget—that's obvious. I sleep over and that's it."*

> *"Contraceptives cost so much now! Marvelon is 30 thousand . . . Not everybody has the 30 thousand . . . I don't always have it either, so I get along with simpler, cheaper methods."*

Novosibirsk

Participants in Novosibirsk were also less enthusiastic about OCs than about other methods. They criticized the method's side effects, cost, and inconvenience.

> *"All the same, it harms the woman's body. Some sort of shift in the hormonal background occurs in the body. Tumors of some kind can develop as a result. . . . It's undesirable. . . . It's better to use some kind of physiological methods that are more naturally acceptable."*

> *"We didn't have them before. And now they've brought them in, and everyone praises his own. Everyone will insist that your figure will be even better in ten years. In ten years go and find him, this fine fellow! He has already taken off and made money on these tablets."*

> *"Oncologists say that disrupting the hormonal background is undesirable. We know of a gynecologist-oncologist who does not recommend hormone tablets for young people—or for anyone. That doctor recommends the coil, and only the coil."*

> *"When the information was that the hormone treatment was harmful, all that made an impression on me, that settled it."*

There were more advocates of OCs among the younger women, who favored them for their effectiveness. They compared the pill to the condom, but mentioned that OCs offer no protection against disease. Only the young women raised the issue of disease protection, although others did point out that, when using OCs, one should make sure to have a trustworthy partner.

> *"It seems to me that the pill is the best of all. Pills are more convenient. Condoms cause discomfort. There is no risk [in using the pill] that it will break. Marvelon has the smallest quantity of hormones."*

> *"[Pills] don't get in the way of anything."*

> *"Pills are more convenient and safer than condoms—in protecting against pregnancy."*

> *"If you trust your partner completely, why not the pill?"*

Those users who did not experience negative effects from the pill reported being satisfied and discussed its positive features.

> *"I've been taking Marvelon for several cycles. It has a low hormone content. I'm not experiencing any gain in weight. I'm used to it; there are no problems—I take it just before going to bed, and that's it."*

> *"I have a hormonal disease. I use the hormone pills for protection. I like them, because they regulate the menstrual cycle and, at the same time, protect against pregnancy. I haven't had a single one of the problems that they have described as side effects."*

Participants also noted the side effects of OCs. They cited the disadvantages of OCs as weight gain, headaches, and nausea.

> *"The first time I was nauseous. . . . Then I simply "blew up" and gained ten kilograms . . . I got off the pill."*

> *"I got fat from them and then got off them, because my head started to hurt."*

> *"They change your feminine figure."*

In addition, some believed that the required daily dose was too burdensome.

> *"Today I take it, tomorrow I forget, later I take it—and I start to have some bleeding. I came in (to the clinic), and I couldn't understand anything—I took the pills, and my menstrual periods stopped. The doctor said, "It's because you didn't take the pills on time."*

> *"You have to take them every day and not forget. If you spend the night somewhere, and there are no pills in your purse, that's a terrible problem."*

"The pills have to go everywhere with you. You always have to have them with you; you can't forget to take them."

Other difficulties mentioned include vague delayed effects on the body, the high cost of the method, and its lack of reliability.

"The tablets are 100 percent effective for protection, but they can affect other things as well. They cure one thing and hurt another."

"You have to buy them [the pills], and it costs money: they are expensive."

"I don't trust the pill. A friend told me that she took the tablets and still got pregnant."

Emergency Contraception (Postinor)

Vladivostok

Many study participants reported use of emergency contraception regularly—as an alternative to the pill or IUD.

"My husband isn't home much. I've used Postinor. It's convenient. If I don't have sex more than three times a month, why should I take drugs? Still, I don't know, no one has recommended it to me. I stopped taking Postinor because it made me feel bad once—I took more than four tablets."

"I went to the doctor and they prescribed hormone pills according to my body, but I don't know whether I'll use them. I'm generally against hormones. I like taking one pill right after sex, and that's all. I know Postinor, but they don't recommend it for me, not for my age. During the dangerous days, if we don't have a condom, I take Postinor."

"You can only take four tablets a month. You can't take more than that, because they are considered very dangerous. They're only good for someone who has a very irregular sex life; once a week, for example."

Novosibirsk

No information was collected on this topic in Novosibirsk.

Condoms

Vladivostok

Participants reported using condoms in combination with traditional methods—sometimes only during the women's known fertile periods.

"The condom—on dangerous days."

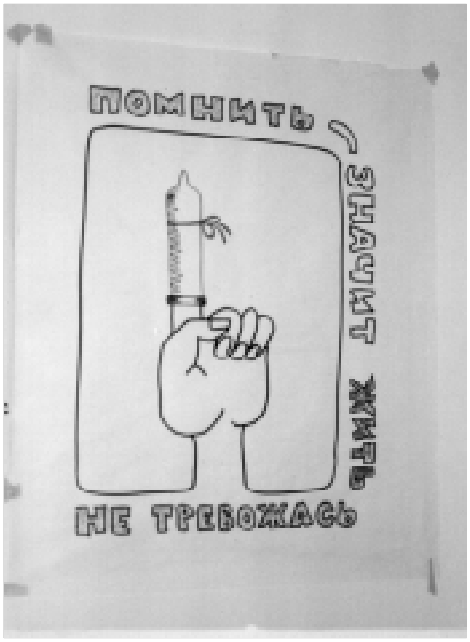
"Basically it's a method to be used when you have to."

In general participants considered condoms reliable, safe, and easily accessible, which they thought was a particular advantage.

"I trust condoms more. They're reliable."

"The plus for condoms is the psychological feeling of security. It relaxes me. That's very important."

"It's available. I went and bought one at the store."



Homemade IEC material, Novosibirsk city (Novosibirsk)

The main disadvantage associated with condom use was reduced physical sensitivity.

"My husband doesn't like condoms."

"You lose sensitivity."

"The condom is rather unnatural, and I don't get satisfaction."

Though most participants emphasized the positive aspects of condoms, the men said they were not reliable.

"It's unreliable, even if it's been tested electronically."

"The reliability is 36 percent, and chlamydia can pass through the walls."

Novosibirsk

Participants considered easy availability, simplicity of use, adequate reliability, and protection against diseases as the advantages of condoms.

"The condom is the best of all. It is the simplest to manage."

"I only use condoms, because they are the easiest to get."

"They are easy, trusty, reliable, and, finally, they sell them at any kiosk."

"It protects not only against pregnancy but against all kinds of diseases."

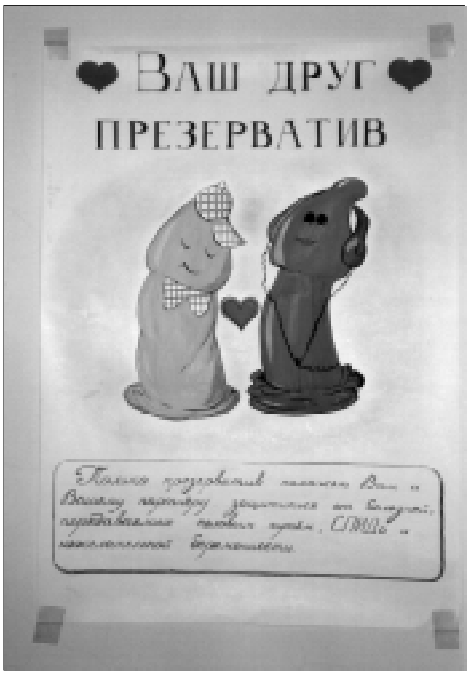
The condom received a much higher evaluation from the young women, while most married participants considered this method unsuitable for permanent use.

"It has no advantages, only constant disadvantages, for family life."

"Recommending the condom as a method for long-term use is impossible. It can get old. It's a method for 'just in case.'"

Some married women also discussed the use of condoms in combination with coitus interruptus and periodic abstinence.

"Just condoms, and my husband takes care of it: one abortion in six years. I count [days on the calendar], and on the dangerous days—coitus interruptus and a condom."



Homemade IEC material (Primorsky Krai)

Both men and women cited reduced sensitivity, awkwardness in the procedure for use, and the potential for breakage as the main disadvantages of condoms.

"It's uncomfortable with a condom."

"The feelings aren't the same—it's a disadvantage. It bothers me."

"It's a bother [that you have] to get them and put them on in advance. All this breaks the mood."

"I don't trust them [condoms], because many of my friends have had them break."

The young women suggested that uninformed, improper use could lower this method's reliability.

Some married participants felt they had no alternative but to use condoms in place of IUDs or OCs although they were dissatisfied with them.

"We use it, and we trust it, but we don't like it."

"We use only condoms . . . basically, they don't suit us."

Only twice did participants call condoms a playful method, allowing variety and innovation.

> *"You can buy different kinds—and get different kinds of pleasure from it."*
>
> *"The fact that you have to put it on—you can make it a kind of ritual with absolutely no problems at all."*

Some male participants supported condom use as a means to take personal responsibility for protection.

> *"You can be in control of this method yourself. Everything else is the woman's business. It [the condom] represents confidence and independence. And you are sure. You are responsible for yourself."*

Periodic Abstinence

Vladivostok

Participants saw periodic abstinence as a natural and healthy method even if used in combination with emergency contraception.

> *"A natural, physiological method is better for me; on the safe days, the douche. I take Postinor on the danger days, and that's enough."*
>
> *"It's the most effective and healthiest method."*
>
> *"During the danger period, I douche and use ointments. This involves stress, of course."*

Some participants mentioned the lack of reliability of periodic abstinence.

> *"The second child was an accident, because I miscounted. Now everything is regular and properly counted."*
>
> *"There's a 10 percent chance I might get pregnant. I feel uncertainty, fear, until menstruation starts. I pace and feel nervous; there is no feeling of confidence until it's over."*

Novosibirsk

Participants in Novosibirsk unanimously considered periodic abstinence unreliable.

Coitus Interruptus

Vladivostok

Most women participants believed that withdrawal was not an effective method. In addition, many felt that interrupted sex was not satisfying.

> *"With respect to interruption, I've had a son. I don't trust this method at all. I know that some spermatozoa reach the womb during sex, and one is enough."*
>
> *"Coitus interruptus doesn't satisfy me. I don't know about my husband—but I can guess."*
>
> *"...He has constant stress and doesn't get satisfaction."*

Most men, however, advocated the use of coitus interruptus as a natural and problem-free method.

> *"It's most suitable for me . . . It's proven to be the best. I give my wife pleasure and don't feel disappointment: she satisfies me in other ways."*
>
> *"You don't have to buy condoms or take pills."*
>
> *"You protect yourself and don't do yourself any harm."*

Novosibirsk

Participants, especially men, gave coitus interruptus a negative evaluation for its lack of reliability and for its restrictive nature.

Abortion

Vladivostok

The participants felt that the high prevalence of abortion was a consequence of women's careless attitudes and their ignorance of family planning methods and the adverse health consequences of repeat abortions. Some also mentioned men's lack of responsibility for their sexual activity as a cause of abortion.

> *"It's a matter of ignorance. . . . it's terrible in this day and time to not know what methods are available."*
>
> *"The first time [I had an abortion], I didn't use protection because I didn't know that you could be protected, to tell the truth. There was no information at all."*

"...[abortion] becomes a habit—it doesn't cost anything to have an abortion."

"It's a matter of an irresponsible attitude toward yourself and your health."

"They don't scare us about abortions. They say, abortion, abortion . . . "

"Men act out of a simple lack of responsibility for the consequences: they do their business and leave."

Upon hearing the harsh judgements of women who seek abortion, some participants were prompted to describe their own experiences as sexually active teens.

"When I was in school, we had a medical committee. The girls who were sleeping with guys—the teachers treated them like whores after that. It became known after a visit to the gynecologist."

"The first sexual contact was in the tenth grade. Something disrupted my cycle... I ran to the doctor. The result—a call to the director of the school . . . They made a similar call to my home. At home, I wasn't getting any support . . . they started to question me very roughly: with whom, when, and how long?"

Novosibirsk

For some participants, abortion was an acceptable method of birth control: it is effective, readily available, free, and relatively painless.

"I have a friend who only goes for abortions. It's a method for contraception. It probably simply never affected her. No problems ever arose. She got through it. She considers it (abortion) a lesser evil."

"Abortion is accessible. In any form: mini-abortion, anything. This relaxes one's vigilance. Previously it was painful, and there was the problem of waiting lists for abortions. Now it is readily available. They suggested abortion to me right off the bat. There was a conveyer there: one door for ultrasound examinations, and the other straight to abortion."

." . . now they do paid anesthesia. I went to sleep, woke up—and never felt a thing. Before everything was without anesthesia. It takes away the tension and the fear."

"Maybe they were thinking: the pill is harmful; condoms and coitus interruptus are inconvenient, and the feelings aren't right. But this, at least, is reliable, 100 percent. The doctors who do it know their business."

Others had moral objections to the procedure.

"For some this is even a problem psychologically—cutting off a life."

"What is most interesting is that practically everyone is conscious of this, and everyone does it anyway. They know that, yes, morally this is killing a living being; moreover, a lot of films now show how it is done. And it's a sin. Nevertheless, they go on, close their eyes to it; some smile at it, some don't."

Some discussed a change in their views of abortion because of information about it or personal experience with the procedure.

"There were a few situations, when there was some delay, when I somehow didn't see anything wrong. Well, yes, there is a method [abortion], and it works. It's terrible that I didn't think it was bad. But when it actually happened, then I understood how bad it was. That, first of all, it's murder."

"I thought about it (abortion) later. There were a lot of shifts in my thinking—it's murder, it's totally criminal. It has affected me. And my wife, her health. . . ."

Many participants advocated contraception over abortion.

"Abortion, of course, is not a good method; it's a poor method. It's better, of course, to use some kind of protection."

"You have to choose the lesser of two evils. Take the coil—endometriosis can develop from its use; for hormone tablets, it's still unknown what the effects might be, and they can cause hormonal disruption in the body. But abortion is harmful, too. You have to pick something, and the lesser evil is contraception (hormonal or the coil).

Some male participants felt that they could make their partners choose contraception over abortion and suggested intimidation to accomplish this.

A few male participants proposed the following ways to address the issue with other men.

- Persuasion:

  "Convince the young person that he bears some responsibility in a sex act without means for birth control for the birth of a child. Even if the woman has an abortion. So that the person thinks not only of himself, but of others. He thinks not only of himself, but of the future."

- Creating interest in information about sexuality:

  "Forcing them to think about the future and about responsibility is useless. When I was sixteen years old, I got a little book. Purely out of interest in the erotic, I read the whole thing—about contraception, everything was written there about every method. Lessons—those aren't interesting either. Maybe they could show some videos, with contraception featured in them. Then someone will be interested."

In the women's opinion, recognition of the possibility of infertility could be an argument in favor of contraception.

> *"I told her that because of her abortions, she simply could not be a mother. She is studying at the medical academy herself. A person doesn't think about her own health."*

Participants said that many factors, both personal and environmental, affect attitudes toward and decisions to use abortion.

They cited age as a factor in attitudes toward abortion. They remarked that young people became sexually active without being mature enough to make adult decisions about reliable contraception.

> *"It's probably a matter of youth. They don't think about what awaits them in the future."*

> *"She's still young, she can have abortions, and later, when she's had enough—without children—she finds herself alone. It's too late for her. Now they calmly go for abortions."*

> *"They don't think about anything at all. They commit murder, an action unpleasing to God. I've had such situations, too. I didn't think about anything either; I was younger then. And there were abortions. It's simpler somehow not to think about anything. We were still unmarried, and somehow I didn't feel like getting married. She went for abortions more than once. Still, the last time she didn't want to have an abortion, and I married a woman who was already pregnant; she gave birth and got a coil."*

Others felt that some knowingly engaged in risky sexual behavior, consciously planning to get pregnant, hoping that might solve problems in the relationship.

> *"Perhaps the woman wants to get pregnant in order to get married. But when she gets pregnant—he has no use for her. As a result, many women have to have abortions. No one will marry them, even if they are pregnant."*

Men and women described other conditions under which an unwanted pregnancy might result.

> *"It often happens somewhere in a group, in a drunken state, when nothing seems to matter. Such things often happen. They don't think."*

> *"It just doesn't make any difference when you're drinking. You don't have a care in the world."*

> *"Casual relations—this represents an attitude toward life."*

Women agreed that a man's refusal to use or his prohibiting his partner from using contraception could also lead to unwanted pregnancy and abortion.

"You love him, you do what you have to. You love him, you have an abortion. That's how it happens."

"My husband knocks on the door and says, 'You aren't thinking of me; you don't like it that I don't have a condom? You take care of protection! I'm against this, and this, and this'. So you run to have an abortion every day! And I have two children. How can I get along without a husband? I'll take him into consideration, and I'll go for abortions. That's the way it goes."

"Her boyfriend told a friend of mine categorically, 'no, you aren't going to take precautions, not even a condom, because I don't like it.' So she's had eight abortions already. He likes it better when she has abortions. He makes her do it."

The use of traditional methods for protection often resulted in unplanned pregnancy and abortion. Women who resorted to such methods and went through the experience of abortion often decided to use modern contraception.

"A friend of mine got pregnant. She was using coitus interruptus, and he did not do what they expected of him. She got pregnant. So she decided that it's better to use the pill. She had such bad impressions from the abortion that she said, 'I'm not having any more abortions.'"

Reproductive Health and Contraceptive Information

Vladivostok

Although some participants felt that there was an adequate amount of reproductive health and contraceptive information available, they pointed out that some of it was either too complex or too simple. Others felt that their level of knowledge was inadequate.

"There is quite a lot of information, and you have to choose what pertains to you. It's simplified too much in some of the literature."

". . .there is a lack of information about biological methods—some don't even understand them."

"I would like information about the female body; I would like to know what pills affect the body, all the organs; that's what I want to know."

Men cited books, brochures from clinics, interaction with wives and friends as sources of information.

"I always went to the clinic with my wife. If my wife goes, I go. I read the brochures. I go to the doctor; I'm interested in my wife's health."

"Just books. After school — there was a period — books, films, and interaction with male and female friends."

Other men expressed uncertainty concerning the role and participation of men in reproductive health matters.

> *"A guy doesn't need anything new. He's used to doing things his way."*

> *"It's mainly girls who take care of contraception."*

Adult participants expressed concern regarding the attitudes and behavior of youth in terms of contraception and protection against sexually transmitted infections.

> *"I know a lot of adults who carry condoms as protection. But young people - I haven't met a single one yet."*

> *" For most of them [teenagers] the attitude toward all this is - 'well, I know that condoms are available, and there's some other stuff, but it has nothing to do with me.'"*

> *"A kid might not even know that he can contract venereal diseases. He looks at the booklet after he's already had problems; before that he isn't interested."*

Potential sources of information preferred by participants were individual consultations with physicians, video-cassettes shown to youth, television broadcasts including films, advertisements and call-in shows with physicians followed by personal visits to the clinic, and printed materials.

> *"I would like to go to the gynecologist and have the doctor explain to me what applies to me personally."*

> *"They should have doctors who work there on television so you could call them and ask questions - a "hot-line type show.... if you're interested, you can go there for consultation."*

Most participants said their parents had given them very little information on contraception and reproductive health.

> *"Our parents were generally in the dark; they didn't know anything themselves."*

> *"Mama didn't even tell me about menstruation. She says now she was embarrassed to talk to me, and she asked a neighbor to talk to me."*

Men said their families had been more open to talking to them about sexuality and reproductive health.

> *"I could go to my parents about anything, and they would tell me."*

> *"When they (my parents) saw me with a girl for the first time, they told me everything at once."*

The participants felt that today there was more openness toward information on reproductive health, contraception, and sexuality and mentioned advertising on television as a reason for the change.

"There used to be more insensitivity in this regard. Everyone learned sooner on the side. Now they can learn openly. I think this is a very good thing indeed."

Novosibirsk

Women's self-evaluation of the adequacy of their knowledge of contraception and reproductive health varied. Some women maintained that they were sufficiently well informed because they took an active interest in these matters and tried to satisfy that interest.

"I think I'm adequately informed. If I encounter something new, I run to the library right away and then to my friends. I read and read. The more I know, the better I feel about it. I ask the gynecologist questions to learn more."

"If I haven't encountered some problem, and I heard what's being said about it, I have to know (read) about it."

"My husband initiated me into this life [sex life]. Now I'm trying. . . . I read AIDS information regularly. He supplies me with the literature and tries to help me come further into this life. I ask questions of the doctor."

Other women saw their level of knowledge as inadequate; they felt anxious in the presence of disease and needed more readily available information as well as clear, simple explanations and psychological sensitivity from doctors.

"I don't think I'm sufficiently well informed. They told me that they had found chlamydia in my examination and said that it might result in infertility—and I am in a panic over what it could be. I would simply like to find out more about what it is, that it isn't anything terrible, that they can cure it."

"Doctors speak their own language, and you can't understand it. I say to them, 'Explain it in Russian, a little more simply'. . . And they would interpret it. Not all the medical personnel—I'm in a different world entirely here."

"It's important for the doctor to be a psychologist. Because any information could have an effect such that it could strike a person down."

The young women said frequently that they would like to have additional information.

"There will never be enough. I know almost nothing about myself. You learn and learn."

"I don't know enough and would like to know more. Especially since everything is improved every day—all the protection methods. Every day it changes."

Participants felt that the most effective channels to inform the public about women's health, modern contraceptive methods, and the family planning center included television, special literature, and informational brochures distributed in stores, clinics, or on the subway.

When the role of the popular publication *AIDS-Info* was brought up, participants disagreed about its potential for disseminating information about modern contraceptive methods. Some women found the style of the publication to be offensive or inappropriate, pointing on that it contained "quite a lot of jokes" and is "in a distorted, cheap street form." Other participants did read the publication and believed that, when combined with other resources, it could provide useful information, particularly to young people who might find the casual tone more accessible than that of more technical literature.

> *"Let's have both this kind of literature and serious literature."*
>
> *"This paper attracts young people. They aren't going to buy some medical book. But they will buy this paper . . . , and maybe it will teach them something."*

In the men's group, one participant emphasized the importance of providing practical information, such as price, when advertising a family planning center. He also pointed out that individual privacy would be a key factor in the use of family planning services, particularly for young people.

> *"Not everyone can pay. This is how I see it. Anonymity is important. If a girl is 13 years old, she needs to be able to come there without identification, to avoid writing down any last name. The main thing is that the parents don't find out, and the prices are accessible."*

All groups mentioned the need to begin sex education at an early age and the special role of the family in this process.

> *"This matter must be introduced at an early age, gradually. The subject must be natural: where do children come from, love. So that there won't be unwholesome interest."*

Most participants listed the family—usually the parents and in particular the mother—as the ideal source of information about contraception and reproductive health.

> *"You have to start in the family, with the children."*
>
> *"The parents have to teach their own child."*
>
> *"It should come from the nearest person—the mother."*

However, the ideal situation and the actual situation were far apart. Open communication and mutual understanding between parents and children about sex-related issues were more the exception than the rule. A few participants recalled trusting mother-daughter relationships with frank discussion of sexual matters, but these cases were few and out of the norm.

> *"I got my first information from my mother. In about the second year of school, Mama had a talk with me about monthly periods, what they are and how it happens. Now I've already mastered that subject. It doesn't bother me. She discussed the subject of protection. She even said that each person has his own method: 'I use such and such methods, and you have to go to your own gynecologist and talk with her.'"*

"Everything was fine with me. Mama prepared me when I was a little girl. I could ask anything."

The more common treatment of sexual issues in the home seemed to be a combination of varying degrees of denial, avoidance, and censure.

". . . a little kid, you live a sex life, but it's embarrassing to talk about it."

"Someone brought me some pills. My relationship with my parents was such that when they found the pills, it was a disgrace."

"If they find out that their little girl went to the gynecologist at the family planning center, Mama will simply have a heart attack. Maybe you can explain to your parents first?"

The parents of some male participants did provide limited sexual education, often as literature and books rather than interactive conversation.

"I was 13 years old, and Mama left me a booklet and said, 'Well, read it later.' We had no more discussions or conversations. Did I read it? I did. Did I understand it? I did."

"I had a lot of books. They were readily available. They didn't lie around in plain sight, but I knew where they were. I was interested. I read them—but there weren't any conversations at all."

Many men reported that they learned about sex and contraception by chance, without the aid of their parents. Parents of these men did not discuss contraception with their sons.

"I didn't get any information from my parents. I got it from other sources—from talking to people, from the street, from books and magazines."

"There were no conversations. I had no father, and it was uncomfortable talking to my mother."

The absence of trusting relationships between parents and today's generation of 15- and 16-year-old adolescents about reproductive health had several contributing factors:

- Different standards and traditions in sex education: the older generation grew up with sex as a forbidden, "shameful" subject, censure of premarital sex, and the restriction of personal (sexual) freedom.
- Parents' lack of knowledge about and experience with modern contraceptive methods prevents them from sharing information or providing competent advice.

"There was no information at all about contraception; there weren't even any good condoms."

- Social and personal barriers prevent parents from communicating openly with their children about sex-related issues.

  "Parents run away from talking about this subject."

  "My parents won't talk at all—just don't go to them and don't ask. Or they start to talk, but everything is so abbreviated, so diffident that you can't understand anything."

- The lack of understanding of the problems of different generations, related to the decrease in the age at the initiation of sexual activity, the upward trend in the age at marriage, and the increase in premarital sex.

  "Parents always see their child as still a little one."

  "My mother started to talk with me about this subject when I got married [laughter in the group]—as if I could talk about it now."

  "I thought that parents first introduced that subject with a little child. My parents started talking to me when I was 12 years old. I think that's very late. I know some things, of course: from the street, and from friends. But it would have been better, of course, to have heard it from my parents."

Present-day parents of young children recognized the need to talk about reproductive health and sexuality with their children and said they were ready to educate their children about sex-related issues. Parents' methods for teaching the children depended upon their own attitude toward the issue of contraception: some parents preferred unrestricted interaction and discussion, while others limited themselves to providing books or other literature.

"I have a good little book, 'Anatomy for Children.' It has a grandfather, the spinal column, nerve cells, and jolly little boy spermatozoa. I don't think there will be any more problems. You can either read it or give it back promptly. It may even be the best alternative. You present it so the matter won't be hanging over your head. And so the information won't just worm its way in."

"My older daughter is seven and a half years old. I looked at a French encyclopedia—what's inside a person's body. And I bought it. Let her mother—I'm in my second marriage—let her mother hold educational discussions. I'll manage the matter later. And my second child, my son, I'll take care of him, at six or seven."

"I'll talk to my son, not when he's five, but starting at about ten, so that he'll be interested himself in talking about it. My wife will have to talk to our little girl. What am I supposed to do, sit and explain all her sex organs?"

"The father has to participate with his daughter, just as with his son, and explain things. As the mother does with the son. I'll start talking about this when he's five. Not specifically, but to work up to the subject according to his age. So that when he gets close to the age where he is ready for it, he will already know about everything."

The young women also pointed out that they need increased sexual education in schools.

> *"In anatomy in school we had this subject—the woman, how she gives birth, pregnancy. They told us, 'Read it at home,' that's all."*
>
> *"They told us that—about pregnancy—you'll find out all about it from your parents, and from the newspapers, but we can't teach that in school."*

Maternity Clinics

Only postpartum women and the husbands of postpartum women were asked about their experiences at maternity clinics.

Vladivostok

Most participants reported that their children were born in the maternity clinic affiliated with the women's consultation where the mother received regular gynecological and obstetric care; they often had an advance agreement with the clinic.

> *"My wife had an account and went through the whole course of care here."*
>
> *"My wife had received care here, so we wanted to come here."*
>
> *"I had a lot of problems with the pregnancy. I was here in the pathology department. So they assigned me here."*

One husband reported that his wife chose a particular maternity clinic "out of familiarity. There were all the conditions here that could not have been created at another maternity clinic." Some participants gave birth at a clinic because the ambulance took them there, their regular clinic was closed, or they were placed in a maternity clinic due to possible complications.

Women arrived at the maternity clinics by ambulance or by their own means. Some were already hospitalized in the pathology section of a clinic.

Novosibirsk

Most participants' children were born in the maternity clinic associated with their place of residence or where an ambulance took the mother. Some mothers had scheduled admissions to the maternity clinic two or three days before their due date; others were admitted in advance because of pathology (age of the mother, large fetus, or possible difficult birth).

Most births took place at Maternity Clinic R, which had a satisfactory reputation. "They say it's no worse than the others"; "They say it's the best maternity clinic." One mother selected the city hospital "because complications were a possibility, and I know all the doctors there." Another chose Maternity Clinic K: "My wife selected it herself. It was cozier."

Preparation for Labor, Delivery, and Breastfeeding

Vladivostok

The postpartum women received no systematic preparation for labor or childbirth. Breastfeeding education for most participants either was not offered or was fragmentary and haphazard. Most postpartum women received some education in infant care at the maternity clinic. The fathers hardly had discussed issues about childbirth and infant care with clinic staff, mainly because they considered their level of knowledge to be adequate. The young postpartum women had lower estimates of their own level of knowledge on many issues that concern mothers.

Postpartum women cited the following sources of knowledge and education:

- Lectures at the women's consultation and reading books:

  "How to give birth—I was preparing all the time. I read. I took courses, here at the clinic, and my husband attended."

- The attending physician's explanations:

  "(Before childbirth) the doctor came and explained how best to conduct yourself and the most comfortable position to take."

- Specific education in difficult cases:

  "I have a very long cervix, . . . and it didn't get any smaller. I took training here. But they finally took me to a psychotherapist and told me there that I would have to have a cesarean. It was good that they took me there, because I had hysterics. After the psychotherapist, they prepared me for the cesarean for about ten days."

- Their own experience:

  "It was my third child, so I didn't need anything special."

- Interaction with other birth mothers at the maternity clinic:

  "The girls who had already given birth came in and told us about it."

- Interaction with relatives in the medical field:

  "I have a sister who is a medical worker and a half-sister who is a technician. I was calm about it."

Some women mentioned that medical personnel provided more in the way of psychological support than specific advice on actions to take.

> *"It was a very human attitude. Everyone tried to calm me. Everyone was constantly coming in to check on me. But as far as preparing me—no one did that; no one told me how to go about giving birth. There was nothing in particular as far as that is concerned."*

"The doctors' attitudes, their kindness, the interaction—it was a kind of moral or mental support. But as far as explanations—there was no such thing. It was just the doctors' attitude. That helped."

Breastfeeding education was either nonexistent or unsystematic.

"Everything we got was very elementary. They brought the children to us; we were all mothers for the first time. And they all left at the same time, and we sat with them and didn't know what to do. They didn't explain anything to us at all. Thank God that our neighbors in the ward came to us and told us that you have to treat the breast with nitrofurazone."

"They told us how to prepare the breast. A midwife came and gave us cloths, which we treated, and that was all. But there was nothing in particular about how to feed the child. They placed the babies, and that was all."

"At first we didn't manage it. We gave birth on Friday, and on Saturday and Sunday, there was nothing. They brought the children and put them into our hands. They slept. Do you wake her up, give it to her? You don't know what to do. Saturday, Sunday—my little girl lies there and doesn't eat. And it was only on Monday that they brought the pediatrician, who said, 'Wake her up,' and showed me how to wake her up. And there was a poster there in the ward about how to wash the breast, how to prepare it and express the milk."

The lack of education led one participant to a difficult situation.

"They didn't tell us either. Although they did say that there wasn't any milk. First there is colostrum, and then on the third day it suddenly appears. It appeared that way for me, and no one told me anything. I was afraid; I was in such a state. I thought that I was getting a 'stone' in my breast. My mama told me all about it: 'You drink a little more liquid.' So I drank, all day long, I drank and drank for three days. And then both my breasts puffed up. My temperature rose. No one said anything. I went to the nurse. She expressed a little bit for me in the morning. It expressed poorly. It was thick. I tried all day to express it myself. Only in the evening did the nurse express the breast, and I felt better. . . . And expressed, but I didn't manage it well."

Rarely, the participants received some basic preparation for breastfeeding.

"I was lucky. We had women in the maternity clinic who knew everything. They were older. We called them 'the grandmothers.' They came and saw that I was young. They said that we had to breast feed. They showed how and why to do it. They said, 'Give it, give it. The baby opens his mouth. Give it to him.' The milk has to come with time. You've fed the baby, the nurse takes him away, and you sit and express the colostrum; the milk will come quickly.' And I already had milk on the second day."

One woman recalled with gratitude one of the maternity clinic workers.

> *"We had one 'grandmother' who gave us her home telephone number and said, 'If you have any questions that come up later, call anytime—don't hesitate.'"*

Another reported some breastfeeding education, but said she did not need it because this was her third child and she already knew.

Most participants received education in infant care at the maternity clinic. They attended classes and received verbal information at discharge. But according to one young mother,

> *"They said everything so fast, and they didn't touch on all the questions. And questions come up later that you didn't get to ask."*

Another woman shared this situation:

> *"There was a pediatric nurse . . . who conducts classes on her on initiative. You can't get anything out of the others."*

Some participants already had experience in caring for infants—their own, or nieces and nephews.

Some fathers attended lectures at the clinic and received leaflets: "General questions, like how to help changing diapers, what to bring to the maternity clinic, etc." Moreover, the men considered their level of knowledge about child birth and infant care to be adequate. Their sources of information were.

- Books:

  "There's plenty of information; you can find it anywhere—(especially) books."

- Their own experience:

  "This isn't my first marriage, and I have a son. I have life experience—how to bathe the child, change diapers, feed the child."

  "I watched my little sister grow up."

- Relatives:

  "Information from my grandmother is enough for me. She is a wise woman."

  "My mother and father are doctors. During the first month, my mother and mother-in-law came and told us and showed us some things."

The young postpartum women's opinions about the adequacy of their knowledge varied. Some thought that they had enough information for the moment; others were less sure.

> *"If I didn't read, it wouldn't be enough, especially since different books say different things."*

"There isn't enough information. Even the books don't have everything written down that you need to do, from beginning to end. My mother has forgotten everything. There are lots of questions that come up day by day, and you can't find the answers."

Novosibirsk

Most women had been prepared for childbirth by lectures for those already in a treatment facility, by explanations offered directly in the maternity clinic, or by discussions at the women's consultation. Not all had received education on breastfeeding. The participants considered the education on infant care inadequate. The men's responses suggested that they had no systematic education as expectant fathers.

Preparation for labor and delivery was most thorough for those who were in the pathology department.

"The doctors in charge of the ward gave us lectures and explained how to behave during the birth and how to handle labor pains—how to act in general, and how to keep from being afraid when labor begins. They told us how it would all be, and what the different periods are like."

Other women went to lectures at the clinics, discussed these issues with their doctors, or studied the literature independently.

"I read everything in the book ahead of time."

"When I was already lying in the hospital, they told me how massaging the stomach is necessary. This was when my labor started . . . . There was one little lecture, the students presented it, and they explained just what labor pains and contractions are."

When participants received education on breastfeeding, it took place mainly after childbirth in the maternity clinic and generally pertained to certain technical aspects of breastfeeding.

"The doctor in charge of the ward always came to us after births. He examined the breast himself and said what needed to be done. If someone had flat nipples, he said what needed to be done."

"Each of our examinations necessarily included the breast. And if someone had a problem, they helped. They drew out women's flat nipples. They showed me how to express milk."

"I talked with the obstetrician and the (section) doctor and asked questions, and they answered my questions."

MotherCare/SEATS master trainer Dr. Faina Shafigulina from Lesozavodsk (Primorsky Krai)

Some women got help from their neighbors in the ward.

> *"They didn't tell me anything at all; the women next to me in the ward taught me."*

The participants considered the education on infant care inadequate.

> *"A pediatrician came in at the maternity clinic and told us [only] how to take care of the ears, the nose and the umbilicus."*

> *"With us, the doctor only told you things if you asked."*

Some women reported that they had no education at all.

> *"Unfortunately, they didn't tell us anything."*

> *"I wish there had been more lectures about how to take care of the baby. I came home not even knowing how to change his diapers."*

The men claimed they received no systematic education as future fathers.

> *"In my opinion, no one offered us anything."*

> *"They wrote consultations for my wife on the prenatal and postpartum periods on a card we had. She went. All of it was for her, and I read a book."*

Participants also obtained information on infant care from books, from their parents, or their own experience.

> *"It's my second child, so in theory I already know everything. And I don't need any additional information. If I need anything, I have a book, and I read it and find the period in question. I refresh my memory. Everything is that way. I don't especially need it."*

> *"The information was adequate—what we knew from books and from our parents."*

On the other hand, one participant commented that books were not enough.

> *"I was surprised to see that theory and practice are different. . . . The baby proved not to be as ideal as he should have been. Children are all different."*

Unanswered Questions and Concerns About Maternity Care

Vladivostok

The postpartum women wanted more information on:

- Infant care and development:

  "Caring for the baby, what to feed the little one."

  "My little girl has a broken collar bone. How should I handle her?"

  "Everything to do with teeth."

- Their own condition and health:

  "I still don't know what to feed myself. It always seems to me that I eat something, and the baby has diarrhea or something. His stool is sometimes yellow, sometimes green. I always blame myself for not eating the right thing."

  "How to guard against pregnancy."

Novosibirsk

The course of labor and delivery, including cesarean section, scheduled childbirth, and anesthesia and features of the development of pregnancy, including retained placenta were issues that remained unclear among the women. They also had questions about the postpartum period and their depressive psychological state during this time.

- Cesarean section:

  "How does cesarean section differ from natural births? How is it best to give birth—oneself or by surgery? I haven't gotten any answers. They told me that both are fine. What they needed was to do a cesarean section. I wanted to give birth myself."

  "The practice is this way now: they try to do a cesarean section on everybody, emphasizing that it will protect the child. Birth trauma. But I think it's necessary to ask whether the woman wants it or not, and what she wants to do and how."

  "They do a cesarean on almost every other patient; they won't let you just give birth yourself. And the cesarean is more difficult for the baby—it has to come out all at once. Consequences are possible."

- Scheduled childbirth:

  " . . . It bothers me. I went in for scheduled childbirth—but can they do that at all? Is it possible to induce childbirth artificially? I had a situation with a large fetus, but they did a section on me anyway. And so that's how it went. Perhaps doing that in such situations isn't necessary, but they have an operation

scheduled. There is an element of insurance about it. But it's just subject to question somehow. And I still have questions inside."

- Anesthesia:

  "Is it necessary to perform anesthesia during labor pains? I didn't need it, but they did it. And later they start again. It seems to me that its more draining, psychologically."

  "I was interested in whether, if there are ruptures or incisions of any kind, will there be anesthesia? I'm afraid of pain. But I didn't ask that question."

- Retained placenta:

  "I had questions, for which I never received answers. I had retained placenta—why and how does this happen? Will it suddenly happen again? What should I do about it? Maybe I did something wrong during pregnancy."

- Postpartum condition:

  "My condition is rather strange—I have a kind of feeling that I'm always asleep. Could this be depression? Perhaps it's something else. But I don't know how to come back from it. Maybe it's an effect of the anesthesia that they administered, or of when they sewed me up."

  "A hormone drop. I read about it in a book. I also wake up in a cold sweat and have a feeling of weakness. Nobody tells me anything; nobody explains anything."

The men said that they would like to have more information about their wives' condition while they are in the maternity clinic and to have the opportunity to see them.

"When they put my wife in the maternity clinic before childbirth, I would like to talk with the attendant physician. There is no such opportunity."

"I would like to visit my wife at the maternity clinic right away, starting on the first day."

The spouses said they should show expectant fathers a video about birth at the maternity clinic.

Impressions of Medical Personnel at Maternity Clinics

Vladivostok

The postpartum women had generally positive impressions of the clinicians' work and their attitudes toward patients.

"I have remarkable impressions. They are very attentive. They helped a lot during childbirth, and a kind, humane attitude is very important to the woman."

> *"The doctors are generally wonderful. I was giving birth, and there were still students there. They helped me. Boys and girls—four people—did massage, and they all did it."*

> *"I was lying there (in the maternity section) alone; the midwife sat on the bed next to me. There was moral support, and I felt calm. All the doctors were near me."*

Some participants expressed a more neutral view.

> *"Basically they just do their job. I would like to see a little more participation from the doctors who do the rounds. And the pediatrician always goes so fast, practically running through the wards. She goes around every day; you can understand how she feels, but we aren't there every day.*

Nevertheless, another participant pointed out,

> *"At the maternity clinic, the personnel at least have a better attitude than at the other hospitals."*

One father gave a negative evaluation.

> *"I could tell from what my wife said. When they brought her to the maternity clinic, and the process of preparation for childbirth began, the changing clothes and so on, there were constant crude outbursts and an almost contemptuous attitude. I don't understand that, and I was shocked."*

Women's unfavorable responses more often pertained to middle-level and junior medical personnel.

> *"We had three shifts. There were younger and older women. It seemed to me that the younger ones manage the children even better, more carefully, more precisely than the older ones. It's just a job to them—nothing more."*

> *"Various children's nurses have a bad attitude. I would like it if they would say something to us. I'm even afraid to ask anything, because if I asked a question, she turned sharply and left, and didn't say anything. They [the babies] belch when you feed them—and you want to know about it. Why do they do that? Is it because of you? They don't explain anything. I would like more attention."*

Fathers also had negative observations to report.

> *"Basically, bad, negative behavior gets by on the part of the middle-level personnel—the nurses. The doctors are a little better. Something makes them feel a sense of duty."*

> *"I called from Korol to find out about how she was, because we hadn't seen each other in a long time. They were rather rude. They hang up the phone in a hurry.*

You want to know whether she's had the baby yet. 'No,' and that's all. Their attitude is offensive."

"I encountered incomprehensible red tape. You had to knock on some doors for a long time . . . go to a window constantly. The people walk by and don't pay any attention. You say to the nurse, 'Tell me, who is in charge here in the corridor; whom should I ask a question?' 'In a minute,' she says, and she walks away. Someone else walks by. 'Excuse, ma'am, may I talk to you?' She walked right by. Nothing from anyone, until you start to get angry.'"

One participant characterized the medical personnel as incompetent and explained her remark with an example.

"The duty nurses and midwives startle you with their incompetence. I often asked questions of the medical personnel. The incompetence struck me, almost to the point of tears. Here's an example. They prescribe a treatment procedure, a douche with hydrogen peroxide and so on, for most of the women before childbirth. I had very high leucocytosis. So in addition to peroxide, a trichopol vaginal suppository was prescribed for me. They went so far as to tell me I had a venereal disease, because trichopol had been prescribed, and trichopol is prescribed only for trichomoniasis infections. And when I started to explain that it's an antibiotic, and that it is even prescribed for children and adults with stomach disease, they told me that I don't know anything. They say, 'Trichopol is for venereal disease, and all of you who hide behind the door for treatment have venereal disease, and because of you with venereal disease we have all our problems in the maternity clinic."

Novosibirsk

The women had mostly positive impressions of the medical personnel at the maternity clinics and reported their treatment as one of the most pleasant memories of the stay in the clinic.

"I have good impressions. I am very grateful to the resuscitation team—the doctors and nurses literally brought me back from the next world. And I had training for labor. The nurse was very attentive. And everyone was there during labor, all the doctors, the pediatrician, cardiologists and others and the gynecology department—there were three doctors there. There was quite a crowd of people around me."

"I also have splendid impressions of the team with which I gave birth. I had a large fetus and was going through childbirth after the age of 30. I was on the table for an hour, and I had the feeling that they were giving birth along with me. They tried to tell me stories.... It was very healthy."

"I agree, it's very good. . . .I have no criticisms or complaints."

Some participants gave a less enthusiastic evaluation of the nurses' work.

> *"The doctors are good, but the nurses are terrible. They made me walk, get up, on the second day [after a cesarean section]. . . . A poor attitude."*
>
> *"When there was a change in shifts of nurses—some of them were on duty one day, others the next—you got the feeling that everything had changed. Some were useless."*
>
> *"The nurses came and went in the maternity section. We lay there, and there was no one there. The nurses came in, just asked how it was going, and left."*

Besides the treatment they received, women's most pleasant memories were of the newborn:

> *"When I saw the baby for the first time," and "that they put the baby at my breast immediately after birth."*

Answering the question about medical personnel was difficult for the young fathers, since they had practically no contact with them.

> *"They won't let you in there anyway."*
>
> *"It's a prison."*

Men reported encounters with medical personnel in only two cases: for discharge and for delivering "parcels."

> *"If they aren't accepting parcels, you can go in from the other side."*

Maternity Clinic Conditions

Vladivostok

Women who gave birth in Maternity Clinic B had poor impressions of the sanitary and hygienic conditions.

> *"The conditions in the maternity clinic are impossible. There is no hot water, nothing. To the point that when I came in to have a baby, they told me, 'Hold up your shirt, so it won't get wet, because there's nothing to change into.' And when I had given birth, and I asked them to put the baby on my stomach, they said to me, 'Then how will you wash yourself?' and didn't give it to me."*
>
> *"I have an awful impression from the washing. They wake you up at five in the morning and five in the evening. A line forms. You wash twice a day, with it*

running off you in a stream, especially the first two or three days. Everyone stands in line to wash. It's a terrible feeling."

However, the postpartum women who gave birth in other clinics reported no experience with such problems.

"They bathed us themselves in Maternity Clinic N. . . .They took care of us."

"At Maternity Clinic C, we had a bath with a shower for two wards. And you could go and bathe any time you wanted. You could sit in the rest room for five or ten minutes, if you can't manage at once. The nurses also bathed us in the morning and treated us. And you can go and be treated any time you want."

". . .They have established all the right conditions for the women: a television on each floor. They try there to provide comfort, a homey atmosphere for a person. I liked all of it."

One participant was upset with being put on the same floor with a client with a sexually transmitted disease.

"It was like this—a woman got a single room. We thought these were privileged patients, but it turned out that the woman had syphilis. And before this, we had gone to the bathroom of that room. It turns out it wasn't for us. All this was kept quiet. No one told us anything about her being sick, or that it wasn't a good idea to go to that bathroom. And when we found out, they said, 'You'll survive, there's nothing too terrible about it.' We were afraid to leave the ward all day, because she was walking around the floor touching everything. We were all afraid, but we survived."

This subject also came up with the fathers.

"I think isolated patients should be kept separate from the normal patients; for example, patients with gonorrhea shouldn't come out. They let one shift eat (in the dining room) with the healthy patients."

"I've run into that as well. They're there at the same time. That maternity clinic was closed twice while my wife was there. They take them in from the street, still infected, to give birth here at this clinic. Several people were infected."

Some women expressed a wish for televisions for the maternity clinic.

"It's boring to lie there; if there were just one television for each floor. If everything is all right, and you're healthy, you want something to think about."

Novosibirsk

The participants' negative comments pertained primarily to the unsatisfactory sanitary conditions after childbirth.

> *"The diapers are terrible. Everything ran out of them. They aren't treated with anything. Like wood. Cardboard. And a kind of gray color."*
>
> *"I lie there in an old hospital, and there's one shower for everyone, a pitiful shower, where there's nowhere to put a towel or anything else. And the restroom—one for everyone. There's trash in there, and garbage, and all kinds of packages. All this right there in the restroom."*

There were complaints about the way in which the infants were cared for.

> *"It seems to me they brought the baby in twice for feeding in the same diaper. They probably hadn't changed it."*
>
> *"They bathe the children under the tap (with untreated water)."*
>
> *"The babies lie there in wet diapers. The personnel don't get around to doing anything."*

Practically all the participants reported that they were forced to find medicines on their own.

> *"The anesthetics and drugs for contraction of the womb were ours."*
>
> *"My wife made up a list right away, because all her friends who had given birth had the experience that now one, now another, now a third drug was unavailable. I bought everything."*
>
> *"When my wife was already in labor, a nurse came up to me and said, 'I have a good drug, bring a hundred thousand.' I brought the money."*

The women had not yet encountered a situation in which they needed medical assistance and were unable to get it. In the group's opinion, "you can get any service for money."

Joint Childbirth

Attitudes Toward Joint Childbirth

Vladivostok

The postpartum women and fathers favored the idea of joint childbirth, seeing in it above all the chance for strengthening their relationships.

"I would like it, of course. I think my husband would like the idea."

"People I know have gone through it together. The husband trembles over his little daughter, and everything is fine with them. When we have a second child, we will do it together."

"I'm for it. Because both men and women need it. The man needs it to experience the torment the woman goes through in this process. Then you'll have a different attitude, not only toward your wife, but toward the child."

Bay at Russian Island, outside of Vladivostok city (Primorsky Krai)

But sometimes, the spouses' wishes did not coincide. Most often, either the wife or the husband feared a negative reaction by the husband after the birth.

"I suggested it to my husband. After that, he told me about an acquaintance of his; they went through childbirth together in Moscow, husband and wife. Excuse the comparison, but now the wife for two years has acted like a prostitute with him to try to seduce him. The husband is afraid of her since they did the joint childbirth. He's afraid of causing her harm. Just as soon as there is sexual contact, he loses everything, says he can't. Says he remembers it all. My husband told me all that and said, 'I don't want it to be that way; I'm afraid it would have that effect.'"

"I said at once that I would be present at the birth. They said to me, 'Yes, if you please, but you need some information.' Then they started to work with my wife. At first she agreed. They started to tell her, 'He won't love you any more, after he sees you give birth. The ones who are there for the birth have left their wives.

They don't have sex anymore. He probably compares the baby somehow with his phallus.' They started that kind of thing with my wife, and the end result was that she was against it. I agreed, mainly so my wife would be at peace—so she wouldn't think that I would leave her."

"Theoretically, I'd like to see it. But my wife would be against it because she's also read the literature. Men actually lose potency afterwards. Because there have been a lot of cases where the man was left impotent."

A few of the clients opposed joint childbirth.

"I can't even imagine it. No."

"I think it's strictly a woman's affair."

"I'm not a supporter. Because I had a friend, who saw all that stuff with his own eyes. 'I never saw anything so horrible. I couldn't sleep for three nights.' Since antiquity, birth mothers have been isolated, and women have given birth alone. And they just show the child to the father—showed him and then kept out of sight for a while. This lasted a few months."

The young women were divided. Some were in favor.

"I'm for it completely. For support. The husband can see the suffering the woman goes through in having their child."

Some young women expressed doubts.

"But I know of a case where he left his wife after that—the effect on his mind, a mental block. It pushed him away from the woman. It depends on the man. But in a place with poor care—better not to do it."

Other young women were unequivocally opposed.

"I wouldn't like it, and he wouldn't either. We've talked about it."

"I wouldn't want it. It would bother me."

Novosibirsk

Some participants, including most of the group of young women, had a positive attitude toward the presence of the partner or spouse at childbirth; they supposed that it would bring the couple closer together, that the husband would have the opportunity to support the wife, and that seeing the difficulty of labor for women would be useful to him.

"I would like for him to come in and experience what I was going through. He would see me in a different light, and I would feel better having someone to hold onto.

> *"I would even insist that he be present. It would provide colossal support, of course. When a person holds your hand, the two hearts beat together. Maybe he would value it more. Let him see how a woman suffers."*

One husband thought being present only during labor would be suitable participation.

> *"When they haven't yet taken you in to give birth. It would be easier for me then," he said. "But not the birth itself."*

Other participants, including almost all the postpartum women, had a negative response. They presumed that it would be unpleasant for the woman herself and would result in unnecessary experiences for the man.

> *"I wouldn't want it. Seeing all of that isn't necessary. The filth. Men are the fragile ones. They might not be able to take it."*
>
> *"Who takes care of whom—me or my husband?"*
>
> *"Frightful and unpleasant—psychologically and physically. Unpleasant for both me and him, probably."*

Some women commented that being alone would be easier for them.

> *"I would feel more at ease, if my husband were not there next to me. I think this is a process in which there is no time to cry about anything or to think. You think about how to give birth to the baby. And it would make no difference to me that there was someone next to me."*
>
> *"I wouldn't want a friend or loved one next to me. Concentrating inside myself would be easier for me in a way, to draw myself in to conquer that pain. I wouldn't want to be distracted."*

The postpartum women said their husbands would resist such an idea.

> *"He would refuse."*
>
> *"It's terrible for my husband, when I have pain. I don't know whether he could live through it or not."*

Nevertheless, a few said their husbands would approve.

> *"I think that he would like to share the crucial moment and the pain with me."*
>
> *"I told my husband that they will allow it; you have to submit an application. He said, 'Well, go ahead, I'm not against the idea.' He approved. (But I didn't.) My husband is a grown man, an adult; he's rational and understanding. He could stand it."*

The men often had a negative reaction.

> *"It doesn't interest me. There's no purpose to it. Perhaps they accepted it in the old day, or maybe they banished the fathers, for all I know."*
>
> *"About two or three weeks before, there was a program—childbirth with the husbands. My wife and I watched it, but we didn't think it was necessary. My wife felt the same way. What reason is there for it? She has nervous stress."*
>
> *"That has to be terrible."*

Less often, the men expressed the wish to be present when their wives gave birth.

> *"I would have liked to be there. But, first, they took her away in an ambulance; we had thought it would be later. We didn't have time. Second, my wife adamantly refused: 'I can't do it,' she said."*
>
> *"I believe that the father should be present at the birth. As the person closest to his wife, he should help matters somehow at a difficult moment. I think it's a good idea."*

Breastfeeding

Vladivostok

The infants of most participants in the postpartum groups were receiving exclusive breastfeeding or mixed feeding at the time of the study; they were being fed "according to a schedule" or on demand. Supplementary feeding is introduced at four to five months and is initiated upon the pediatrician's recommendation, even in the presence of a sufficient supply of breast milk.

The responses to questions about breastfeeding in the postpartum groups pertained to the actual situation, while the question about attitudes toward breastfeeding in the group of young women was of a purely speculative nature. The question was not asked in the group of clients of the women's consultations due to a lack of time.

Two fathers and two postpartum women had newborn children. The other fathers had infants from two to four months old. The other mothers had infants between one and twelve months old.

Novosibirsk

Questions about breastfeeding were somewhat different in the postpartum groups than in the other groups. In the parents' groups, questions pertained to the actual situation related to breastfeeding and the parents' plans about breastfeeding prior to the birth of the child. In the group of young women, the question about attitudes toward breastfeeding was of a purely speculative nature. In the group of clients of the women's consultations, some responses were about participants' experience, while some pertained to attitudes toward the future.

Opinions on Breastfeeding

Vladivostok

Parents had uniformly positive attitudes toward breastfeeding. They planned to breastfeed at least a year and would adjust the duration depending upon the availability of milk and the wishes of the child.

> *"I'll feed as long as there is milk." "...as long as the child will take it."*

All the parents emphasized the importance of breastfeeding for the health of the child.

> *"I don't think anything can replace breast milk. It's a unique food; there's nothing like it. There are no substitutes for it, not baby food or formula."*
>
> *"If you compare the children, the second is healthier and stronger (nursed up to two and a half years)."*
>
> *"I planned to do just breastfeeding. The advantages are beyond dispute, both financial and nutritional. (With milk) the child gets vitamins and immunity from the mother. I think that children fed with breast milk are much stronger than children fed artificial nutrients."*

The fathers exhibited an interest in natural feeding of their children and tried to promote it.

> *"My husband is also for it (breastfeeding). He wants me to be at peace and not upset."*
>
> *"He probably wants his child to be fed with breast milk more than I do."*

Most couples had discussed breastfeeding and decided in favor of it. Some had not discussed it, considering it reasonable "on the face of it." Only a few fathers did not participate in the decision to breastfeed or not: "I'm not competent."

The young women were also uniformly positive toward breastfeeding.

> *"Personally, I will feed my baby only with the breast."*
>
> *"Only natural feeding."*
>
> *"I will be at ease myself, and the baby will be healthy."*

Novosibirsk

Participants in all groups believed that mothers should breastfeed in the interests of the child.

> *"You have to feed the baby, regardless of whether you spoil your breasts."*
>
> *"The woman is meant to feed the child at her breast. She must do so, if she can."*

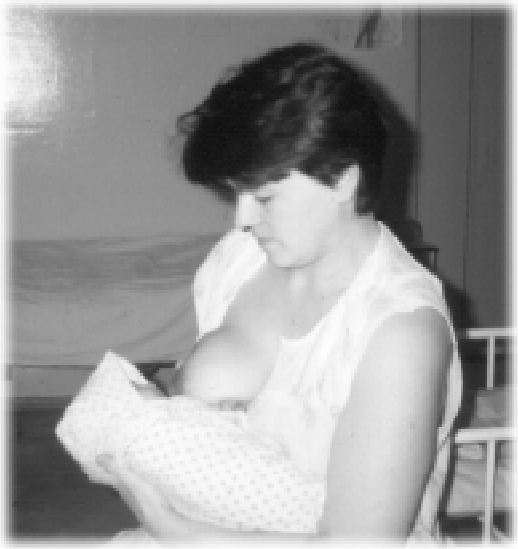
"We were committed to breastfeeding. There will be milk, and we'll breastfeed as long as it lasts."

Several parents believed that breastfeeding was not an issue open to discussion.

"It's natural. There can't even be any question."

"When I read the books, I just skipped the chapters about artificial feeding."

"...Breastfeed as long as possible. And that's all there is to it."



Woman breastfeeding in hospital, Vladivostok city (Primorsky Krai)

Knowledge of Breastfeeding

Vladivostok

Half the women in the postpartum period knew that the baby should be placed at the breast for the first time "immediately after birth."

"The baby has just come into the world from a sterile environment, and the colostrum is good for him. I have read and heard about it. One can say that there is no food like it anywhere else in the world. It can't be replaced. It is specifically colostrum and not milk. And when the child is born, he must get it at once."

Some women believed that the first time should be "after a few hours," and others did not know about this matter.

Half the fathers had information that the child should be placed at the breast for the first time "immediately after birth"; the rest did not have a clear idea.

Many of the young women also had no information about when the mother should place the baby at the breast for the first time. The rest knew that it should be done at once.

Novosibirsk

Information about when the mother should take the baby to her breast the first time varied. Fifty percent of the women in the postpartum period said "immediately," and the others had not thought about it. The most common answers among the men were "the next day" and "as soon as possible." Only one man gave the answer "immediately." The clients of the women's consultations thought "at once, as soon as the baby is born." There were other answers as well: "When they bring the baby in"; "during the first few hours, as needed, if the baby is hungry"; "depending on how the birth went; if everything was normal, you can do it immediately." The young women showed a lack of information in this area. Most believed that the first breastfeeding takes place two or three days after birth. They also

gave the following answers: “If my child were born in the morning, I could feed it in the evening”; “when they bring it”; and “when there is milk.”

Almost all participants gave a positive answer to the question of whether the mother should take the child to her breast during the first three days, arguing as follows:

> *“So there will be more milk; so the milk will come faster.”*
>
> *“Colostrum is the only thing that’s better than milk during these first few days. It’s important for the baby.”*

The nursing mothers’ arguments varied.

> *“Colostrum is necessary then. It’s the most valuable. More than milk.”*
>
> *“Colostrum is the baby’s first food. There’s nothing left in his stomach. So that the body takes over.”*
>
> *“The womb contracts from the (sucking) movements of the baby.”*

The parents’ notions about the ideal duration of breastfeeding were not very specific.

> *“Feed as long as possible.”*
>
> *“As long as there is milk.”*
>
> *“Up to nine months, maybe longer.”*
>
> *“A year, if it’s still possible.”*
>
> *“The longer the mother can breastfeed, the better—some people we know have a child four years old, and she still nurses. And she hasn’t been in the hospital once in four years.”*

The most frequently asked questions about breastfeeding were:

> *“Why do you run out of milk?”*
>
> *“Why do you lose it, no matter what you do?”*

Reasons for Breastfeeding

Vladivostok

Participants mentioned the convenience and the financial advantages as benefits of breastfeeding.

> *“It’s sterile food, and there are fewer problems with boiling (the bottles).”*

"Formulas—it takes so much time to prepare them. I think it's a good thing I breastfeed."

"I saw at the bazaar that formulas are 23 - 25 thousand. To me, that was like a bolt from the blue."

The parents' positive attitudes toward natural feeding dictated their plans for the duration of breastfeeding.

"As long as he'll eat; even for two years."

"Before the birth, we didn't even think about artificial feeding. I'll nurse as long as he'll eat."

"I'll nurse as long as there's milk, until about a year and a half."

The summer season of the year also influenced the duration of breastfeeding.

"It happens somehow with women that if summer comes and they are still nursing, they continue until fall."

"They say you can't stop during the summer, to avoid dysentery."

One mother explained that the duration of breastfeeding depended on her need to work.

"We depend a lot on my job. I planned to go to work at about eight months. I have quite a difficult financial situation: my husband earns very little, and if I don't go to work, I don't know what we'll do."

Novosibirsk

All the parents of newborns planned to breastfeed for various reasons.

"We wanted to. . . . it's effective and convenient."

"Nothing can take the place of mother's milk."

"It was easier for me to take out a breast that to sterilize a bottle and so on."

Others cited additional reasons.

"Breastfeeding passes on immunity."

"You must feed your baby with your own milk. This draws mother and child closer together."

Reasons for Not Breastfeeding

Vladivostok

Among possible reasons for a woman to refuse to breastfeed, participants mentioned concern about the impact of breastfeeding on a woman's physical appearance (figure, breasts). Some women said husbands' attitudes toward their wives' physical condition and "shape" during the postpartum period and the time of breastfeeding would also discourage breastfeeding.

> *"They refuse [to breastfeed] in connection with the fact that women these days place a great deal of importance on their appearance."*

> *"I think a woman who refuses does it out of her own self-centeredness. She puts her own breast ahead of a healthy child. Exercises with dumbbells can lift and tighten the breasts."*

> *"Also, some men are critical of their wives' figures. A friend of mine got married. Her husband demanded that she stay in perfect shape. She got pregnant and had a child. I can see that the child is sickly, while the mother is almost completely back to normal. It seems the husband thinks it's better to spend money on artificial feeding."*

Bad habits—"If she drinks and smokes"—were also mentioned, along with the influence of the parents' family and the parents' experience. "A lot depends on the parents. My mother used artificial feeding, and I'm doing the same."

Despite women's concerns about husbands' attitudes toward the effect of breastfeeding on their "shape," husbands unequivocally favored breastfeeding. Women's refusal to breastfeed prompted condemnation and even indignation.

> *"Then why did she have a child? Caring for the health of the child is the main issue—not her own appearance. Later, when the child is a little older, then she can start to put her appearance in order."*

> *"I have never heard of a woman's, a mother's refusing to breastfeed. I don't like the idea. Of course. When the child is young, I don't think it matters how the woman looks. She can take care of her figure later."*

Novosibirsk

Participants proposed several reasons why a woman may refuse to breastfeed, excluding medical contraindications and the lack of milk.

- "Cosmetic" reasons—the fear of spoiling the shape of the breasts and the figure:

  "Afraid to spoil their figures."

  "So as not to spoil their breasts."

"A friend of mind fed her baby for a couple of weeks, and that was all. So that her breasts would be beautiful, she said."

These reasons were considered unacceptable, especially by men.

"For the baby's sake, you can pump up the breasts with exercises later."

"The main thing is that the health of the child is more important."

- Lack of time:

"Perhaps the woman is still working. She is simply unable to feed the baby all day.".

One husband said that he could understand why a woman in the West might not be able to feed her baby, unlike here where women have time and support.

"Because of a lack of time. Everyone works in the West. A couple of weeks after childbirth, the mother gets up and goes back to work. Naturally, she has no time to feed the baby. Here the mother sits with the baby for up to three years. She doesn't work, and she gets assistance. That kind of mother can hardly refuse to feed her baby."

"I have met women who did not breastfeed for financial reasons. The woman was forced to work, because there just wasn't any money; in another case, the woman earned a great deal, so she couldn't quit her job."

"Feminists probably want more freedom."

- A lack of love for the child or of a sense of responsibility for it:

"They don't love their own children—what kind of mother is that?"

"They think only of themselves, not about the child."

"Young people are so irresponsible. It's simpler now with formula! More convenient. You take out a bottle, and that's all there is to it."

One participant justified the failure to breastfeed in this way:

"You have to start from the knowledge of what you want out of life. If you are an actress or you have something that is involved so that it will be sacrificed, you will feed the baby formula, but if you are an ordinary woman, nothing will do but that you breastfeed your baby."

Reality of Breastfeeding

Vladivostok

Only one mother indicated a lack of milk as the reason for stopping breastfeeding at three months.

> *"I only nursed for three months. I wanted to feed the baby, but I lost my milk. I took hormone preparations during pregnancy to avoid a miscarriage. And that seems to have shown up in the sudden decrease in the amount of milk. I said there would be problems."*

One respondent said that natural feeding was not typical among her circle of acquaintances, although she had been breastfeeding for a year.

> *"All my friends are surprised, because none of my friends used breastfeeding. And their children are rather puny."*

Novosibirsk

In Novosibirsk, despite the presence of favorable attitudes toward breastfeeding, only a few of the parents had carried out their plans in practice. The infants of most of the parents participating in the study were taking mixed or artificial feeding by the age of two months. Only three children under the age of three months were being exclusively breastfed.

The main reason mentioned for the transition to mixed or bottle feeding was an insufficient supply of breast milk. The criteria for determining the amount of milk were agitation by the child, inadequate weight gain, and the amount of milk expressed.

> *"I fed the baby for one and a half months. I didn't have enough milk either. She cried, and we didn't understand why she was crying at night right after coming home from the hospital. Then we understood that she just hadn't had enough to eat. We started giving supplementary feeding."*

> *"I have been giving the baby extra food for less than a week (the baby is one and a half months old). The first month, the baby took the breast well, but now I sense that there isn't enough milk. I still have a problem with my nipples. It isn't so easy to take care of them."*

> *"At first we couldn't understand why he was crying. Then we figured it out and looked, and there wasn't enough milk. The doctor told us what to use for supplementary feeding. We started the supplements, and he gradually began getting used to the bottle nipple. Later he wouldn't even take expressed milk through the bottle nipple. He refused it."*

Participants also cited poor preparation of the mammary glands for breastfeeding; as a result, the child would not "take the breast."

"We had a rather careless approach to it. I didn't prepare my breasts, and the baby practically wouldn't take the breast."

Concerning failed breastfeeding, participants wanted to know why the milk runs out, despite any efforts they have made.

Feeding Schedule

Vladivostok

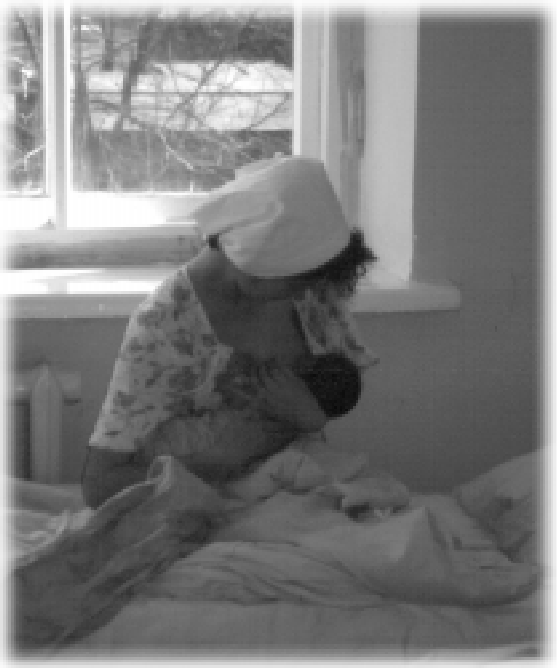
Among the participants were both parents whose children were fed "by the clock" or by a schedule—"We have a schedule"—and parents whose children are breastfed on demand. Some parents mentioned changes in the feeding system.

"He eats when he wants. Natural feeding, on demand."

"The first time we tried to keep to a schedule, but it gradually starts to slip, and now, finally, it's just on demand."

"With me, it seemed that I was feeding and feeding, all day long. Then things settled down by themselves: he started to eat every three hours. Every two hours is bad, and every three is fine. Actually, it's the way it's written: the baby worked out the time himself. Later it was every four hours, and now the baby waits four and a half hours, and eats well."

"Now we feed on demand, but at one time, on the advice of the doctors, and they were wrong, we tried to feed at definite times; there were problems with the baby's little stomach. So we decided not to listen to anyone, and to feed on demand."



Woman breastfeeding in hospital (Primorsky Krai)

In connection with frequent "demands," there was a fear of a shortage of milk.

"Up to three months, he ate every two hours, and I started to worry that maybe I wouldn't have enough milk. We tried giving him baby food, but he refused it."

Some postpartum women reported problems from feeding "on demand," especially at night.

"Now he eats almost everything (at 10 months). During the day, he tries to take the breast, but I don't want to do it any more. I wish he would stop. At night, he goes to sleep, and he wakes up in an hour—give him the breast! I lie down with him. And it turns out that he sleeps with me and nurses all night. It isn't good for me. I want to sleep."

"I haven't slept at all in 11 months."

"I also feed that way. I go to bed with my daughter every evening; she starts to nurse and then nurses all night. Only just now have I started putting her in her own bed [at five months]."

A mother of three children compared the advantages and disadvantages of different feeding systems based on her own experience; she talked about the negative effect on breastfeeding of feeding "by the clock."

"I used breastfeeding with the first one for six months, because I had listened to all the experts—feed only every three hours. There was less milk, it got thin, and I decided to feed him more. I did the additional feeding—and that was all. I fed the second one for two and a half years with the breast alone, you could say."

Novosibirsk

No information on thie topic was collected in Novosibirsk.

Supplementary Feeding

Vladivostok

The introduction of supplementary feeding comes at the age of four to five months and is at the pediatrician's recommendation, even in the presence of an adequate supply of breast milk.

"We use supplementary feeding. The pediatrician advises it."

"I used only breastfeeding up to five months, but then, vegetable puree, as they recommend. They say there aren't enough vitamins. The pediatrician said, 'Now start the vegetable puree."

Most parents whose children are breastfed consider supplementary feeding necessary.

"There needs to be something else besides milk. Then there's enough milk."

"You want there to be as many vitamins as possible. We drink juice. You need to use natural apple juice. It's better."

"For the time being, we've decided to limit ourselves to breast milk. We plan to start supplementary feeding somewhere around seven or eight months in the form of formula, vegetable purees, meat and so forth."

Only a few parents believe that breast milk provides complete nutrition, so that the child does not need supplementary feeding.

"Basically he didn't eat anything except from the breast. Even at a year and a half, I would have hysterics about why he wouldn't eat anything. They told me that it was because he gets everything he needs; he eats enough. And I survived it all. I was probably wrong: he obviously got everything, because he wouldn't take anything but the breast."

Novosibirsk

No information on this topic was collected in Novosibirsk.

Attitudes Toward Rooming-In

Vladivostok

Practically all the young women and the fathers favored the mother and child being together after childbirth— "It's necessary." In that way they would establish a closer bond.

"A bond develops between mother and child. It's important not to waste the first few days."

"Warmth and care for the child. I would caress, touch, and see that the child felt the presence of the mother, and the mother the child."

"The child should be with the mother. Because during the first hours after birth, the child and the mother should have the same biorhythm. That is to say that the baby is very sensitive to the mother's heart beat, from what I've been told. And that has a positive influence on breastfeeding."

One father said that separation of mother and child was "the norm."

The attitude of recent birth mothers was less unanimous. Some supported the idea: "It's very good." More often, they mentioned that not being with the child immediately is better: "Because it's very hard to get over childbirth," and "You have to rest after childbirth." Some were afraid that they would not know what to do with the baby. "Personally, I would be afraid that I wouldn't know how to handle him."

Novosibirsk

The parents of nursing children had the least enthusiastic view of the idea of rooming-in. Most opposed it. The men argued the need for their wives to rest after childbirth.

> *"I think it's a bad thing. My wife wouldn't get to rest. It would be better for someone to come in to feed the children. So that the mother could rest. The woman could lie in bed with the child."*

> *"It's better for her to rest first, as if she were at a spa. They brought the baby in and fed it. She didn't have to do anything. It's better to rest."*

A few were in favor.

> *"I think it's better together. Mama is always more at ease with the baby beside her."*

One respondent said that the desirability of rooming-in depended upon the conditions.

> *"If she is alone in the ward with the baby, it's a good thing. She can rest. But if there are several people, the children will take turns crying—one will fall asleep, and another will wake up, and all the women will suffer. If the conditions are ideal, then there should be contact between mother and child from the very first moments. This is important for everything to be good later on, and for the baby to have proper mental development. But in a separate ward. But if there are several people there, it's better to bring the baby only for feeding. Otherwise there will be no rest, and the milk will all be lost."*

The women cited the postpartum condition and the dangers involved with the birth of a first child as the reasons for their opposition to rooming-in.

> *"I was in no condition. It depends on experience. If it's the second child, why not, but with first, of course, you're in a panic."*

> *"I was in no condition. There were three other women in the ward with me, and they were in decent condition; on the last day of my discharge, they brought them into these wards. They didn't like it at all."*

> *"I'm against it. I wasn't ready and didn't know how to handle him."*

Some women held the opposite view.

> *"If the mother is able, then it's probably good. They need it."*

> *"It would be healthy, if the nurse were with you all the time. She could help."*

All the young women favored the mother being with the child because, "No one will take care of the baby like the mother."

"I would want my baby to be with me. So that I could look after him myself and change his diapers. When my sister was born, she was in a separate ward away from Mama. It's an outrage, the condition in which they discharged the baby from the clinic. Her entire bottom—there was just no skin at all! It was just raw! We spent a month with all kinds of powders, lotions and compresses."

"To be sure that he isn't crying, that he's at rest, that everything is as it should be—I would support the idea."

Most of the clients of the women's clinic were also in favor of rooming-in, although only under certain conditions: the presence of a nurse to help care for the child or a second or higher order birth.

"It seems possible to me, if there is a child's nurse there with you who will also care for the child and help, at least the first time."

"I agree, especially if its a first child, that there should be a nurse with me."

"With the second child, I would wish, with pleasure, to be together, so that I could see everything. I would do everything for the child myself."

The Lactational Amenorrhea Method (LAM)

A woman is 98% protected against pregnancy if she fulfills all of the following three criteria:

1. Menses have not yet returned
2. Infant is fully or nearly fully breastfeeding
3. Infant is less than 6 months of age

When any one of the 3 criteria changes, the woman should start using a complementary FP method immediately for continued protection.

Lactational Amenorrhea Method (LAM) Self-Study Module. Farrell et al. ACNM 1996.

Lactational Amenorrhea Method (LAM)

Vladivostok

Although most participants were familiar with the concept that breastfeeding provides some natural protection against pregnancy, they perceived breastfeeding as an unreliable method, which did not inspire confidence.

"I haven't had menstrual periods at all, but I still think I need protection."

"Nursing can't give you protection. You must take precautions, because you don't know when you might get pregnant accidentally."

"It's the most frightening thing that you have no menstrual periods, and you think everything is all right, but it could be pregnancy already. I nursed for two and a half years, and the only bad thing I can say is that I had no menstrual periods, but I didn't go to the doctor: I thought it was supposed to be that way. The doctor said, 'You could bring on an early menopause' which is harmful. So I stopped nursing—menstruation started, but I took precautions. I know I might get pregnant. I've even had an abortion."

"It depends on the body and the menstrual cycle. When they are nursing, 40 - 50 percent can get pregnant. You can wait a month to get protection and get a coil during the second month; you don't have to rely on it [breastfeeding]."

"I've read that nature makes it so that a woman can't get pregnant for two months, but then she has to take precautions using additional methods. Up to two months, I'll still use the douche to be sure."

Most participants were not familiar with LAM and the application of its rules for contraception. They repeatedly expressed interest in getting information about this method. "I don't know that method; maybe I could use it. I'd like to find out about it."

One respondent said she had received information about LAM at the maternity clinic.

"I heard a lecture about contraception. Maybe I didn't get it all, but I understood that you could be protected somehow. Natural protection during breastfeeding. I understood it this way: you count four hours from the period of breastfeeding; the closer to the four-hour mark (the end of the period), the greater the chance of getting pregnant. If I have sex immediately after nursing, it will be a natural barrier to conceiving a child. But later, they still recommend that you take artificial precautions, starting at five or six months, if I'm not mistaken."

The husbands who knew about the possible contraceptive effect of breastfeeding did not consider it an effective contraceptive method.

"No. I have a friend at work. He has a daughter seven months old, and he says that his wife is still nursing, and that she has gotten pregnant. No, nursing doesn't have any effect."

"It doesn't give protection. I've read about it."

One respondent said his wife used breastfeeding as a method: his wife was nursing and was not protected; there was pregnancy with an interval of two years.

"It gives protection, but only for a certain time."

Novosibirsk

The participants had the following information about LAM:

> *"If you feed the baby every two or three hours, without interruption, it protects against pregnancy"*
>
> *"The doctor told me that if you breastfeed your baby regularly, every three hours, it's 100 percent protection against getting pregnant."*
>
> *"I heard that if you will feed every two hours; if it's less often, you might get pregnant."*
>
> *"The doctor told me that starting six weeks after childbirth, you need protection. Regardless of whether you're breastfeeding or not."*

They also reported experiences they had or had heard about LAM.

> *"A friend of mine didn't menstruate for a whole year; she didn't get pregnant for a whole year; she used breastfeeding for a year and a half."*
>
> *"I used breastfeeding up to seven months—and I didn't menstruate either, but it didn't protect me."*
>
> *"I don't trust it. A lot of people breastfeed and get pregnant."*

The participants in the group of young women had no information about LAM.

Typical ornate architecture of a home in ????

Although the men and women who participated in these FGDs in both Vladivostok and Novosibirsk were relatively well informed about reproductive health and fairly satisfied with the services they received, their comments point to numerous areas where information and services could be improved.

In both gynecological and maternity care, service providers' failure to explain policies and procedures and to provide clear information and options relevant to the client's own situation led to frustration. This in turn contributed to clients' concern about the quality of care they received and what actions they could or should take to protect their own health. Participants also indicated a desire to play an active role in the decisions concerning their health and expressed interest in receiving more information in order to do so.

Women's Consultations & Maternity Clinics

Conclusions

Service providers' knowledge, attitudes, interpersonal skills and accessibility were frequently cited by FGD participants as influential in both participants' judgment of the quality of the services they received, and also their ability to obtain, absorb and act on information related to their reproductive health. Participants repeatedly cited the main factors in a positive evaluation of services as the providers' warm and caring attitudes, willingness to discuss the client's problems, and general competency. Discourteous and brusque behavior and failure to respect clients and their partner's privacy and confidentiality led many participants to have a cautious or negative attitude toward gynecological and obstetric services.

Young women described many instances of disrespectful treatment by service providers. Ironically, the young women were also the most likely to seek preventive reproductive health care.

Recommendations

- **Service providers, program managers, trainers and policy makers should be sensitized to the expectations and rights of all clients, regardless of age. The findings of these FGDs should be shared with these various groups involved in reproductive health, and their suggestions for feasible actions to foster a client orientation should be sought and implemented.**
- **Service providers, their trainers, and program managers should receive organizational support and formal training in clinical and client-counseling skills to implement the client-centered approach.**
- **Clients and their spouses should be given accurate, thorough and clear information on all aspects of reproductive health and encouraged by service providers to play an active role in decisions. New opportunities should be explored for client/family education during antenatal and postpartum periods.**
- **Clients and their spouses should be encouraged to be proactive and to ask questions when interacting with providers, and providers should be provided with adequate training and resources to counsel, educate, and respond to clients' needs and expectations.**

Contraceptive Knowledge, Attitudes, and Use

Conclusions

Although many women and men believed they were well informed about contraception, their responses indicated that for oral contraceptives, LAM, and periodic abstinence, in particular, their perceptions were often inaccurate. Fear of hormonal methods was widespread. Physicians also play a role in fueling negative attitudes toward methods other than the IUD. Participants mainly discussed the limited range of methods that had previously been more available in Russia. In addition, there was little or no mention of methods that are becoming increasingly available, such as injectables, low-dose combined oral contraceptives, and progestin-only contraceptives.

Recommendation

- **Clients and providers need accurate, state-of-the art information on the safety, effectiveness and continued use of the range of contraceptive methods. This should include the concepts related to helping clients select and use contraceptive methods that are appropriate for their reproductive intentions, sexual preference and lifestyle, and the increasing availability of methods formerly unavailable in Russia.**

Abortion

Conclusions

Numerous participants expressed concern about heavy or over-reliance on abortion to control fertility or solve the problem of unwanted pregnancy. They felt, however, that few other options were available that were acceptable for their health, often citing a lack of confidence in contraceptives or feared side effects, both often based on misconceptions. Other factors cited that led them to rely on abortion instead of contracepting included: the influence of medical professionals or partners; conflicts between use of condoms and their sexual preferences or those of their partners; a lack of access and information, especially among youth, concerning the availability and use of contraceptives; and a careless attitude.

Recommendations

- **Emphasis should be placed on the benefits and advantages of preventive services in general (including the use of contraceptives to control unwanted pregnancy and condoms to prevent the spread of sexually transmitted infections). These advantages should be presented both in terms of the individual's health and community well-being, and the efficiency of the health care system in an environment of limited resources.**
- **In addition, strengthening post-abortion and post-partum family planning should be undertaken in order to help limit unwanted pregnancies and provide clients with contraceptive methods appropriate to these aspects of the reproductive life cycle.**

Reproductive Health and Contraceptive Information

Conclusion

Some participants expressed fear and misconceptions relevant to the modes of transmission of sexually transmitted infections (STIs) and concerns about casual contact with individuals they believe to have STIs. Conversely, some participants pointed toward sexual behavior, especially among youth, that could put them at risk of infection; a lack of knowledge concerning the importance of protection; and reluctance to use condoms.

Recommendation

- **Clients and providers need accurate, state-of-the art information on the modes of transmission of sexually transmitted infections, risk behaviors, and various means of protection against STIs, especially the double protection against unwanted pregnancy and STIs provided by condoms.**

Conclusion

Both parents and young women believed that information on sexuality and contraception for youth would foster good reproductive health for all youth and use of contraception among sexually active young people. Nevertheless, parents were often ill prepared to provide this information, and it was largely missing from educational institutions.

Recommendation

- **Adults and other influential persons interacting with youth need communication skills and age-appropriate information on reproductive health to share with their children. Adolescents need information and services tailored to their needs and sense of privacy.**

Conclusion

Although participants relied on written materials (often books), relatives, friends, and the mass media for information on reproductive health, they favored television, video, and leaflets as the most effective media for learning about these subjects.

Recommendation

- **Multiple channels should be employed to disseminate information on reproductive health.**

Joint Childbirth

Conclusion

Although many participants approved of joint childbirth, unanimity was lacking. Nevertheless, it was clear that the spouses of postpartum women were unhappy with their almost total exclusion from maternity care; they wanted to be more involved (although not necessarily present) in the birth of their children.

Recommendation

- **Maternity clinics should offer couples the option of joint childbirth. Information on pregnancy, labor, and delivery should be made available to fathers and fathers-to-be; husbands should be allowed to visit their wives.**

Breastfeeding & Rooming-In

Conclusion

Despite the uniformly positive attitudes toward breastfeeding, participants had limited practical information on how to ensure successful breastfeeding.

Recommendation

- **Accurate, step-by-step information on breastfeeding should be offered to women and their partners during the prenatal period, while in the maternity clinics, and at postpartum follow-up visits.**

Conclusion

Some parents of newborn children were skeptical about rooming-in: they believed it would disrupt the mother's recovery from childbirth. Others were more enthusiastic about the idea.

Recommendation

- **The link between successful breastfeeding and rooming-in should be a key message for clients and providers. Maternity clinics should facilitate rooming-in of newborns. The option for rooming-in should be available to all women.**

Summary

Not only did the research detailed in this report provide important information for the design and implementation of specific project activities, while simultaneously modeling the importance of a client-centered approach, but it also introduced a new and useful methodology to the policy makers, service providers, and trainers of Novosibirsk Oblast and Primorsky Krai. Moreover, if time and funds had permitted, the research findings would have been channeled into an IEC strategy for families and providers.

At a policy level, the combined effects of policy dialogue, introduction of the client-oriented approach, enhanced clinical skills, and the Russian providers' growing experience with this framework led to a series of policy measures and regulations. Such policies, intiated by the Russians continue to enhance the provision of client counseling and respect for client rights in reproductive health decision making.

Through the cooperative efforts of all the players involved in this detailed work, the areas of Primorsky Krai and Novosibirsk Oblast enjoy greater reproductive health quality of care at every level. Continued attention to clients' needs, training and information dissemination allows new standards to be set and more candid and productive dialogues to take place. Clients' perceptions of reproductive health services in these regions will reflect this improvement and their expressions will play a significant role in encouraging further positive developments.

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