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# GEORGIA

FAMILY PLANNING

SITUATION ANALYSIS 2007



The Europe and Eurasia Regional  
Family Planning Activity

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John Snow, Inc. implements the Europe and Eurasia Regional Family Planning Activity.

The views expressed in this document do not necessarily reflect those of USAID.

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## ACRONYMS

BCC	Behavior change communication
CoReform	Cooperation in Health System Transformation in Georgia project
DFID	Department for International Development (UK)
EDL	Essential drug list
EU	European Union
FD	Family doctor
FP	Family planning
GDP	Gross domestic product
IEC	Information, education, and communication
IUD	Intrauterine (contraceptive) device
JSI	John Snow, Inc.
KAP	Knowledge, attitude, and practices
HWG	Healthy Women in Georgia – USAID-funded program
LMIS	Logistics management information system
MOLHSA	Ministry of Labor, Health, and Social Affairs
NCDC	National Center for Disease Control
NGO	Nongovernmental organization
ob/gyn	Obstetrician/gynecologist
OC	Oral contraceptive
PHC	Primary health care
RH/FP	Reproductive health/family planning
RHS	Reproductive health survey
SS	Supportive supervision
TAR	Total abortion rate
TFR	Total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

## SUMMARY

Georgia remains one of the three poorest post-Soviet republics, with 52.3 percent of its people living below the poverty line and 17.4 percent living in extreme poverty in 2004. The government initiated major reforms in the health care sector as early as 1995, with significant effort devoted to increasing access to basic health services. Family doctors (FDs) at the primary health care (PHC) level now provide basic family planning (FP) counseling and contraceptive services (except IUD insertion and sterilization). Nevertheless, over the last fifteen years, reproductive health indicators in Georgia have worsened, as has the general health status of the population. The fertility rate has dropped well below replacement level and the population growth rate is negative (-0.9). Use of modern contraception is low, while the rate of induced abortion as a means to limit fertility remains one of the highest in the region. Women, and even more so men, particularly in rural areas, have limited access to both information on the range of available contraceptive methods and providers of those services.

### TEN BEST FAMILY PLANNING PRACTICES IN THE EE/EA REGION

To better understand the situation in Georgia, the Activity reviewed progress against ten regional best family planning policy and program practices. This list is based on the 2005 Senlet and Kantner report, “An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region,” a recent literature review on global best family planning practices and programs, and field interviews in selected countries participating in USAID’s Europe and Eurasia Regional Family Planning Activity program. These best practices include:

1. **Liberalized provision of FP services.** National health regulations require that family planning counseling and services are readily available through a range of health professionals, including not only obstetricians and gynecologists, but also family doctors, general practitioners, pediatricians and nurse/midwives.
2. **Family planning counseling, services, and contraceptives are part of the Basic Health Benefit Package.** At the primary health care level contraceptives are provided to all women, regardless of ability-to-pay. A mix of different types of contraceptives are part of the country’s Essential Drug List.
3. **Up-to-date and evidence-based policies, regulations, guidelines, standards and supportive supervision systems are in place to ensure the quality of family planning services at all levels of health care:**
  - a) **Service providers** – A competency-based national qualification system is in place that allows health professionals to provide quality family planning counseling and services;
  - b) **Up-to-date national regulations set minimum standards** for health facilities, equipment, commodities and infection prevention;
  - c) **National guidelines and protocols for family planning counseling and service delivery** are evidence-based, widely available and updated regularly;
  - d) **Effective quality assurance and supportive supervision systems** are in place to ensure the quality of family planning services and strengthen provider performance and support, especially at the primary health care level;

- e) **National health protocols** require that postpartum and postabortion women are offered family planning counseling, methods and services;
  - f) **Breastfeeding and the lactational amenorrhea method (LAM)** are promoted as family planning methods.
4. **A broad range of family planning methods are available, accessible, affordable, and acceptable** in both rural and urban areas.
  5. **Special programs are in place that are designed to meet the needs of vulnerable target groups**, such as adolescents, internally displaced persons (IDPs), new urban migrants, prostitutes, and the very poor.
  6. **Family planning is part of pre- and in-service training programs for health care providers.** This includes the pre-service training programs in medical universities and technical schools for nurses, as well as in-service training for continuing medical education for doctors and in-service training for re-licensing health professionals, including midwives and nurses.
  7. **Contraceptive security is ensured through adequate planning within the government**, guided by a well-functioning Logistics Management Information System (LMIS) that enables targeting of subsidized contraceptives and efficient supply chain management of all contraceptive commodities throughout the country.
  8. **Adoption of a “culture” that promotes family planning counseling**, where providers and clients engage in frank and regular conversation about sensitive reproductive health issues and family planning and appropriate services are offered.
  9. **Family planning is actively promoted through social marketing and behavior change/social mobilization efforts**, including wide distribution of quality informational materials for clients and “job aids” for providers.
  10. **A well-functioning national health management information system** collects, analyses and uses FP data to monitor progress and evaluate and improve program effectiveness.

Georgia has made substantial progress in strengthening family planning programs in several key areas. At the same time, there is room for further improvement. The following table describes Georgia’s progress against the ten family planning best practices described above.

**Summary Table of the Georgia Situation Analysis**

Best Practices	Existing Situation	Needs Improvement
#1: Liberalized provision of FP Services	<ul style="list-style-type: none"> <li>• FP services widely available at primary and secondary health care facilities, including village ambulatory centers in USAID’s/Healthy Women in Georgia</li> </ul>	<ul style="list-style-type: none"> <li>• Nationwide expansion of FP services at PHC level</li> </ul>

	program target regions.	
#2: Family Planning counseling , services, and contraceptives are part of the Basic Health Benefit Package	<ul style="list-style-type: none"> <li>• USAID-donated contraceptives are available at most public health care facilities, including PHC clinics</li> </ul>	<ul style="list-style-type: none"> <li>• FP commodities not included in EDL</li> <li>• FP service not included in Basic Health Benefit Package</li> <li>• Providers are not compensated for FP services</li> </ul>
#3: Up-to-date and evidence-based policies, regulations, standards, guidelines and supportive supervision are in place	<ul style="list-style-type: none"> <li>• National evidence-based FP guidelines available</li> <li>• Rudimentary quality control system in place</li> </ul>	<ul style="list-style-type: none"> <li>• Need FP clinical guidelines dissemination and compliance monitoring</li> <li>• Supportive supervision at HWG sites needs expansion to national system</li> <li>• Lack of quality postpartum/ post abortion FP counseling</li> <li>• Lack of awareness of LAM as FP method</li> </ul>
#4: A broad range of FP methods are available, accessible, affordable, and acceptable in both rural and urban areas	<ul style="list-style-type: none"> <li>• Through HWG, good access to clinical &amp; non-clinical methods, including contraceptives</li> <li>• Most contraceptives available at pharmacies</li> </ul>	<ul style="list-style-type: none"> <li>• Medical barriers reduce client access to methods</li> <li>• Lack of affordable contraceptives and subsidization strategy</li> </ul>
#5: Special programs are in place to meet the needs of vulnerable target groups	<ul style="list-style-type: none"> <li>• Law protects right of youth to seek RH services</li> </ul>	<ul style="list-style-type: none"> <li>• Adolescent-friendly affordable services unavailable</li> <li>• Lack of specialized services for other vulnerable groups</li> </ul>
#6: FP training is part of pre- and in-service training for health care providers	<ul style="list-style-type: none"> <li>• Pre-service medical curriculum has 6 hours FP education</li> <li>• Competency-based continuous medical education training in FP available for doctors</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of evidence-based, competency-based FP training in pre-service medical education, both for medical university and nursing and midwifery school students</li> </ul>
#7: Contraceptive security is ensured through adequate planning within the government	<ul style="list-style-type: none"> <li>• Donated contraceptives are available at most primary and secondary level public health care facilities</li> <li>• Variety of contraceptives are available at market prices from the commercial for profit sector</li> <li>• LMIS in pilot districts</li> </ul>	<ul style="list-style-type: none"> <li>• No strategy on procuring family planning commodities and contraceptives independence.</li> <li>• Expanding LMIS nationwide and, incorporating all sources of donated or government-procured contraceptives.</li> </ul>

#8: Adoption of a “culture” that promotes family planning counseling	<ul style="list-style-type: none"> <li>• Unknown</li> </ul>	<ul style="list-style-type: none"> <li>• FP information and counseling provided “on request” only.</li> </ul>
#9: FP is actively promoted through social marketing and behavior change/social mobilization efforts	<ul style="list-style-type: none"> <li>• HWG has been successfully implementing a social marketing program.</li> </ul>	<ul style="list-style-type: none"> <li>• Not applicable</li> </ul>
#10: A Well functioning National Health Management Information System is in place.	<ul style="list-style-type: none"> <li>• Health statistics collected and submitted to National Health Statistics Office</li> </ul>	<ul style="list-style-type: none"> <li>• Include the LMIS into the framework and protocols of the national health management information system</li> </ul>

## I. PURPOSE AND METHODOLOGY

### PURPOSE

This review of the FP situation in Georgia was conducted as part of the USAID-funded Europe and Eurasia Regional Family Planning Activity. The Activity is a regional effort with an overall goal to leverage best practices in family planning in order to accelerate FP program implementation across the region and ultimately, to increase modern contraceptive use and decrease abortion rates.

This desk review is designed to:

- Assess factors that affect FP service delivery in Georgia;
- Identify and document supportive policies and best practices in FP program implementation; and
- Propose recommendations for scaling up best FP practices and new interventions to improve program effectiveness and increase utilization of contraception.

This Georgia review is one in a series of situation analyses of the FP environment in selected countries in the region, chosen for their interest in participating in this regional program. It first describes the background of the country, with a special focus on the health care system and the status of reproductive health. Then, each of ten best practices is reviewed within the country context and recommendations for focusing further interventions and resources are made.

## METHODOLOGY

In order to systematically assess the FP situation in each of the priority countries, the Europe and Eurasia Regional Family Planning Activity team began by reviewing Senlet and Kantner (2005), “An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region.” Reviewers then developed a questionnaire for in-depth interviews with key informants. Those interviewed in Georgia are listed in Annex III.

The team identified a list of ten FP policy and program best practices based on the Senlet and Kantner assessment report, a literature review on global best FP practices and programs, and field interviews. The team conducted a review of available documents and an internet search to obtain additional information on country background, policies, and programs in family planning. These ten best practices are briefly described in Annex IV.

This review of the FP situation in Georgia is a summary of the generally available literature with qualitative input from key stakeholders in country. The review’s intention is to serve as a basis for discussion of country and regional priorities for FP program improvement, based on the best available information. It is not intended as a comprehensive analysis of the country situation, but rather as a brief “snapshot” of this particular point of program development to guide future programming. Data included in this report are valid for the first quarter of 2007. Due to rapidly changing circumstances in the country, some information may have already changed.

## II. BACKGROUND

### COUNTRY CONTEXT

Georgia remains one of the three poorest post-Soviet republics, and its population still confronts severe socio-economic hardship. According to the State Department of Statistics in 2004, 52.3 percent of the people lived below the poverty level and 17.4 percent lived in extreme poverty. Most commonly, poverty is manifested by low and unequal distribution of income, high unemployment, labor migration, and insufficient housing. Table 1 (in Annex II) presents trends for the major Georgian social and economic indicators for 2002–2005.

Structural reforms and macroeconomic policy implemented by the new government improved conditions for fast economic growth. This followed the “Rose” revolution which resulted in peaceful regime change in November 2003, which brought down the corrupt and autocratic government that displaced President Eduard Shevardnadze. Government projects annual growth rates of gross domestic product of 6-7 percent between 2007 and 2010<sup>1</sup>. It remains to be seen, however, if fast economic growth will translate into improved economic status of the poor.

Georgia’s population is 4.5 million, of which 1.5 million reside in the capital, Tbilisi, and surrounding districts (*rayons*). The second largest city is Kutaisi, with a population of about 190,000. According to the 2002 census, Georgians represent 84 percent of the total population. The second largest minority ethnic groups are Azeri (6 percent) and Armenians (6 percent), clustered in Kvemo-Kartly and Samtskhe-Javakheti regions, respectively. The majority of

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<sup>1</sup> Basic Data and Directions for 2007-2010, Government of Georgia Tbilisi 2006.

internally displaced persons are concentrated in the major cities of Tbilisi, Kutaisi, Zugdidi, and Batumi. The country is divided into ten administrative regions and 65 districts (*rayons*). It has five major cities and one autonomous republic of Ajara. Two additional territories, the autonomous (break away) republics of Abkhazia and South Ossetia are outside of the de facto jurisdiction of the central Georgian government.

## HEALTH CARE SYSTEM

The government initiated major reforms in the health sector in 1995, with the aim of increasing access to basic health services. Major outcomes of reform activities in 1996–2002 include the reduction of redundant infrastructure through closure and privatization, introduction of new health financing models, separation of purchasing and service provision functions, new health legislation, and introduction of a family medicine-based PHC model. Despite a linear increase in public health expenditures since 2000, and its doubling in 2004 compared to the previous year, public expenditure on health was only slightly higher than 33 percent of total health expenditures in 2005<sup>2</sup>, leaving private and out-of-pocket payments as the major sources of financing for health care services.

The World Bank, European Union, and DFID have provided financial and technical support for comprehensive PHC reform. A national PHC master plan envisaged rehabilitation of approximately 717 PHC facilities (each covering several villages) and training of about 2,200 PHC teams, consisting of a family doctor (FD) and a nurse, by 2010. This was intended to give 91 percent of the country's population access to a PHC facility within a 15-minute drive from home. In February 2007, the State Minister's Office<sup>3</sup> initiated revision of the PHC master plan by developing options for situating PHC facilities in every village as well as for privatizing PHC services. The revised PHC master plan was not available at the time this review was written. PHC services are included in the Universal Health Benefit Package that is financed by the government for the entire population. The health reform strategy asserts that health services will be provided at three levels: primary (PHC team), secondary, and tertiary—or specialty—care levels.

FP counseling and the provision of contraceptives (except the IUD) are on the list of services that family doctors will provide to their assigned populations -- an average of 2,000 inhabitants in rural areas and 3,500–4,000 inhabitants in urban areas. Family doctors receive in-service training in FP counseling and service delivery under the 164-hour Mother and Child Health Care training module.

## REPRODUCTIVE HEALTH

Over the last fifteen years, reproductive health indicators in Georgia have worsened, as has the general health status of the population. The fertility rate has dropped well below replacement level and the population growth rate is negative (-0.9). Women, and even more so men, particularly in rural areas, have limited access to both information on the range of available contraceptive methods and providers of those services.

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<sup>2</sup> National Health Accounts, National Institute of Health and Social Affairs, MOLHSA 2005.

<sup>3</sup> Office of the State Minister for Reforms.

The highest fertility levels are among 20- to 24-year old and 25- to 29-year old women, accounting for 35 percent and 27 percent of the TFR, respectively.<sup>4</sup> Because of the low fertility level and high rates of out-migration of young people, Georgia is experiencing negative population growth, which is a major concern for the government. Despite high overall contraceptive awareness among women of reproductive age, knowledge about how to use both modern and traditional methods of contraception is low. The overall contraceptive prevalence rate in Georgia is 47 percent, of which modern methods account for only 26 percent, the lowest in the region. Although contraceptive use increased between the 1999 and 2005 Reproductive Health Surveys, there are still many people who can benefit from improved access to contraceptives. Unmet need for modern contraception is estimated at 44 percent.

The country continues to have one of the highest induced abortion rates in the region, with a total abortion rate (TAR) of 3.1. Abortion services are available without restriction during the first 12–14 weeks of gestation. Beyond this gestational age, abortion is available only on medical and selected socioeconomic grounds. Only 22 percent of women receive post abortion FP counseling and only 6 percent receive a contraceptive method or prescription after an abortion. The main reproductive health indicators are summarized in Table 2 (Annex II).

### III. TEN BEST PRACTICES IN FAMILY PLANNING: GEORGIA

The following describes the situation in Georgia regarding each of the 10 best practices.

#### ***BEST PRACTICE #1 – LIBERALIZED PROVISION OF FAMILY PLANNING SERVICES***

Until 2005, FP services were largely provided through the reproductive health cabinets, women's consultation centers, maternity houses, and tertiary care facilities located at rayon and regional levels and in big cities. There were virtually no FP services offered at village ambulatory centers. In 2003, the USAID-funded Healthy Women in Georgia (HWG) Program started piloting a program to provide family planning counseling and services by non-ob/gyns through village ambulatory centers. Currently, over 300 village ambulatories are offering FP services and free contraceptives (condoms and pills) donated by USAID. Family planning services are also provided at the recently rehabilitated FD centers (PHC level). In order for a health facility to be licensed for provision of FP services, there must be a licensed doctor, appropriate space, and equipment that meet specific criteria. Provision of IUD and sterilization services is authorized only at the secondary level of health care. Counseling for the IUD and sterilization is provided both at the primary and secondary levels and, if a client selects either of these two methods, s/he is referred to an appropriate secondary-level clinic.

#### **POTENTIAL FOCUS AREAS**

- **Re-enforce nationwide implementation of family planning service provision at PHC level and through family doctor centers.**

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<sup>4</sup> RHS Georgia (draft) 2005.

## **BEST PRACTICE #2 – FAMILY PLANNING COUNSELING, SERVICES, AND CONTRACEPTIVES ARE PART OF THE BASIC HEALTH BENEFIT PACKAGE**

The Ministry of Labor, Health, and Social Affairs (MOLHSA) and the Office of the State Minister for Reforms are currently finalizing plans for the second round of major health care reform. There is a consensus in the government that the State must take responsibility for some of the critical public health services currently offered through the primary care system, such as immunization, and village-level facilities will continue to provide these services. As of now, there is no consensus on the list of health services to be included in the basic health benefit package covered by the government. Currently, FP service provision is not included in the basic health benefit package and contraceptives are not on the essential drug list (EDL).

In close collaboration with the CoReform project and other interested groups, HWG is lobbying to include family planning in the basic health benefit package. USAID-donated free contraceptives have been provided to PHC centers and it has been demonstrated that quality FP services can be effectively provided at the PHC level.

### **POTENTIAL FOCUS AREAS**

- **In order to ensure that family planning services and products are reliably available and affordable, FP stakeholders should collectively advocate with the MOLHSA and State Minister’s Office to facilitate the inclusion of family planning services in the basic health benefit package, the addition of contraceptives to the EDL, and allocation of a budget for contraceptive procurement.**
- **In order to reduce the TAR by accelerating access to family planning, work with the MOLHSA, State Minister’s Office, RH Council, CoReform, WHO, World Bank, EU, and other health financing reform implementing partners to introduce fee-for-service reimbursement for the provision of FP counseling (including group counseling) and services and motivate service providers at different levels, including FDs at the PHC level.**

## **BEST PRACTICE #3 – UP-TO-DATE AND EVIDENCE-BASED POLICIES, REGULATIONS, STANDARDS, GUIDELINES AND SUPPORTIVE SUPERVISION SYSTEMS ARE IN PLACE TO ENSURE QUALITY OF FAMILY PLANNING SERVICES AT ALL LEVELS OF HEALTH CARE**

### **Service providers**

Only licensed FDs, ob/gyns, and reproductologists at the primary and secondary health care levels provide FP counseling and services. However, FDs are neither licensed nor equipped to provide IUDs and other permanent methods of contraception. Licensed providers at publicly financed clinics have little incentive to provide FP services since they are not compensated for this work.

## **Guidelines and protocols for FP service provision**

Until very recently, guidelines and protocols for family planning service provision were not available. UNFPA has now supported the MOLHSA to develop national evidence-based FP guidelines and protocols for services at all levels of health service provision. The MOLHSA has endorsed these. However, as yet, there are no mechanisms for monitoring adherence to the family planning protocols. Guidelines for postpartum and post abortion family planning service delivery are not among the list of recently developed guidelines.

## **Quality assurance and supportive supervision systems**

Supportive supervision is one of the key approaches to improving the quality of health care and the performance of health care providers. In general, inspection of the quality of publicly-funded health services is a responsibility of the purchaser—the State United Social Insurance Fund—while overall health service quality control in all health facilities is performed by the quality control department of the MOLHSA. However, current quality-control procedures take the form of old Soviet-style punitive control practices. Supportive supervision is not practiced as a methodology that involves and assists providers to improve the quality of health care services.

The USAID-funded HWG project has introduced and developed some elements of supportive supervision practices in their pilot facilities. However, the HWG supportive supervision system entails only external supervisors' visits to the pilot facility and has not been institutionalized.

## **Postpartum and postabortion family planning counseling and service provision**

Family planning counseling and services are not fully integrated and institutionalized in maternity hospitals and women's consultation centers. Though legislation requires providers to offer FP counseling and services to post abortion and postpartum clients, there are no public funds budgeted in state health programs for these services. Since providers are not reimbursed for these services and there are no quality assurance mechanisms in place, post abortion and postpartum FP counseling and services depend on the good will of the provider. In addition, ob/gyns are highly dependent on revenues obtained from abortion services, which limits their incentives to provide post abortion family planning counseling or methods.

## **Breastfeeding and lactational amenorrhea method (LAM)**

Breastfeeding is promoted at maternity hospitals and is widely practiced in both rural and urban areas. However, education and promotion of LAM as a contraceptive method are rarely provided.

## **POTENTIAL FOCUS AREAS**

- **Develop a framework, tools, curricula, and training materials for FP supportive supervision and a reporting system to plan, conduct, and document supportive supervision visits. Ensure training of appropriate program staff for conducting FP supportive supervision and introduce it as a routine function in health services management.**
- **Evaluate the quality of postabortion and postpartum family planning counseling services and design and introduce an intervention program in pilot regions to enhance the availability and the quality of FP counseling services. Advocate for country-wide implementation.**

- **Develop a strategic plan for dissemination and implementation of newly developed FP guidelines and protocols in the pilot districts. Use the supportive supervision mechanism in pilot sites to demonstrate its effectiveness and efficiency in ensuring adherence to family planning service protocols.**

## **BEST PRACTICE #4 – A BROAD RANGE OF FAMILY PLANNING METHODS ARE AVAILABLE, ACCESSIBLE, AFFORDABLE, AND ACCEPTABLE IN BOTH RURAL AND URBAN AREAS**

HWG has greatly expanded the availability of oral contraceptives (OCs), condoms and counseling for LAM through PHC providers, and these methods plus IUDs through women’s consultation centers. The project has provided USAID-donated contraceptives to PHC clinics, women’s consultation centers, and maternity hospitals. HWG has also delivered basic family planning training to pharmacists and equipped them with skills to assist consumers, especially young adults, to make informed decisions in favor of using modern family planning methods.

A wide variety of contraceptive methods including combined and progestin-only OCs, condoms, emergency contraception, IUDs, and injectables are available through pharmacies. No special prescriptions are required for purchasing different contraceptives. However, use of permanent methods is regulated by law. Licensed doctors in licensed health facilities can perform sterilization only after obtaining a written informed consent form from the client and after a one-month waiting period from initial counseling on sterilization.

There are no studies available describing provider behavior and attitudes regarding the provision of FP counseling and services, nor is there research evidence validating unnecessary screening and diagnostic procedures. Still, the HWG program has encountered medical barriers requiring clients to have unnecessary diagnostic tests prior to receiving various methods of contraception. For example, a Pap smear test is sometimes required for prescribing contraceptive pills. Unnecessary tests make contraceptive services less affordable.

HWG conducted ability-to-pay studies in 2004 and 2006. Among other findings, the studies determined that the percentage of contraceptive products for which consumers are unable to pay rose from 65 percent to 70 percent, and the richest quintile of the population is the only one within which consumers were able to pay for at least one brand of each major method. Subsidized contraceptives and FP services are still greatly needed.

### **POTENTIAL FOCUS AREAS**

- **Given that the Georgian Government will likely postpone efforts to focus on contraceptive security and procurement, advocate and promote dialogue with the MOLHSA and Reproductive Health Council to develop a subsidization strategy.**
- **Ensure that subsidization efforts guarantee a full complement of modern contraceptive methods (i.e., combined and progestin-only oral pills, condom, injectable) at the PHC level.**
- **Advocate for the availability of government-subsidized contraceptives through the PHC network for the poorest in the population.**

## **BEST PRACTICE #5 – SPECIAL PROGRAMS ARE IN PLACE DESIGNED TO MEET THE NEEDS OF VULNERABLE TARGET GROUPS**

Georgian health law protects adolescents' confidentiality in obtaining non-permanent methods of contraception and abortion services. Providers are not permitted to reveal this information to parents or legal guardians of adolescents<sup>5</sup>. However, there are no youth-friendly clinics to provide family planning and other reproductive health services for the youth population. Teenagers may be deterred from using PHC clinics by their unique need for information, counseling, and services in family planning.

A state-funded health promotion program has a sub-component of “support for reproductive health, family planning, and sexual education for youth,” though it does not specify how or by whom education will be carried out. Neither individual counseling nor group education related to FP and reproductive health is available on a consistent basis. There is no state-approved reproductive health education program in schools for youth. None of the state health programs finance family planning services for adolescents.

Over the last ten years, some local and international NGOs have conducted health education and health promotion programs at schools and at the community level that covered topics in family planning and the prevention of sexually transmitted infections. However, these programs were fragmented and did not produce a sustainable and consistent system for youth RH/FP education and service provision.

HWG's youth healthy lifestyles and youth-friendly pharmacies have been very popular and help meet the growing need of adolescents for information and services. Through an innovative youth-friendly pharmacy initiative, pharmacists are learning about family planning and reproductive health issues that affect adolescents. HWG also donates condoms to the SHIP project, which works with prostitutes.

### **POTENTIAL FOCUS AREAS**

- **Design and introduce the concept of creating a network of youth health centers for providing youth-friendly health promotion activities and services including family planning counseling and services.**
- **Advocate with the Reproductive Health Council and local and international organizations for the implementation of family planning programs that meet the needs of vulnerable groups such as street youth, prostitutes, internally displaced persons, and new urban migrants.**

## **BEST PRACTICE #6 – FAMILY PLANNING IS PART OF PRE- AND IN-SERVICE TRAINING FOR HEALTH CARE PROVIDERS**

Training on family planning counseling and service provision is included in medical education and postgraduate training and licensing programs for ob/gyns and reproductologists, as well as the retraining program for FDs. However, the classroom component of pre-service family

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<sup>5</sup> *Review and Analysis of Reproductive Health Legislation and Policy in Georgia*. 2005. Tbilisi: CoReform Project.

planning education is only six hours long and there is no clinical or skills-based training component. Family planning is not yet included in pre-service training program for nurses/midwives.

Postgraduate training on contraception, both for specialist and non-specialist doctors, is based on WHO recommendations. HWG designed a five-day (35-hour) competency-based FP service provision curricula for FDs, and the Family Medicine postgraduate program of the State Medical Academy approved a curriculum for continuing medical education and granted 25 credit points.

## POTENTIAL FOCUS AREAS

- **Reinforce and facilitate revision of pre-service family planning training curricula for medical students and its implementation in medical school training programs nationally.**
- **Revise and facilitate the process of nursing and midwifery training in the context of FP/RH for nursing schools.**

## ***BEST PRACTICE #7 – CONTRACEPTIVE SECURITY IS ENSURED THROUGH ADEQUATE PLANNING WITHIN THE GOVERNMENT***

Assuring the reliable and uninterrupted supply of contraceptives for all who want them, when they want them—the essence of contraceptive security—is a key requirement for developing and maintaining a quality family planning program and services.

In Georgia, contraceptives are available from two sources: at no cost from the public sector through UNFPA and USAID donations and at market prices from the commercial for profit sector ( Schering, Gedeon Richter, etc).

Currently, contraceptives provided to public sector facilities are sourced from international donors. Since 1993, UNFPA has provided free contraceptives to Georgia—mostly condoms, pills, and IUDs, but also spermicides, implants, and injectables. Contraceptives are distributed among the health facilities with FP service delivery points, except PHC clinics. USAID started to procure contraceptives (pills, IUDs and condoms) in 2005. They have been distributed through the HWG program to health care facilities, including PHC clinics in villages.

Government does not have a strategy for self-reliance and sustainability beyond donor support for contraceptives. In addition, currently there is little commitment for bearing the cost of these essential supplies for members of the population who are unable to pay and for whom access to contraceptives is not available.

A logistics management information system (LMIS) was introduced by UNFPA in 2002, through the provision of computer equipment and training to regional and *rayon* public-health centers. This system collects data on family planning clinical services and commodity statistics only from RH cabinets. The system does not provide basic information needed for logistics systems management, such as monthly consumption, stock on hand, losses, and adjustments for each method.

The HWG project has developed and implemented a simple and feasible LMIS, along with reporting tools, including a Geographic Information System. This system provides accurate quarterly information on service statistics—first visits, revisits, counseling visits, total visits, Couple Years of Protection (CYP) generated—as well as contraceptive logistics data—monthly consumption, stock on hand, losses and adjustments—to ensure the timely and optimal re-supply of contraceptives. This system could easily roll out into a national LMIS, incorporating all sources of donated or government-procured contraceptives.

#### **POTENTIAL FOCUS AREAS**

- **Advocate with the MOHLSA, State Minister’s Office for Reforms to begin budgeting for the procurement of public sector contraceptives.**
- **Conduct regular contraceptive forecasts and assess method and sector mix and family planning coverage.**
- **Collaborate with UNFPA to harmonize and improve the capacity of LMIS and advocate with the MOLHSA for its implementation nationwide.**

#### ***BEST PRACTICE #8 – ADOPTION OF A “CULTURE” THAT PROMOTES FAMILY PLANNING COUNSELING***

With the exception of HWG pilot sites and districts, FP counseling and services are provided at health care facilities only upon request. Clients who come to women’s clinics for other reasons are rarely offered information on family planning. Service providers are not reimbursed for family planning services; therefore, they do not have an incentive to offer them. Furthermore, ob/gyns collect higher revenues from abortion services than from family planning and, therefore rarely promote the use of contraceptives.

#### **POTENTIAL FOCUS AREAS**

- **Design and implement a strategy to ensure that all PHC clinics, RH centers, and maternity units nationwide are routinely offering counseling on FP and providing appropriate methods for their clients.**

#### ***BEST PRACTICE #9 – FAMILY PLANNING IS ACTIVELY PROMOTED THROUGH SOCIAL MARKETING AND BEHAVIOR CHANGE/SOCIAL MOBILIZATION EFFORTS***

HWG conducts both social marketing and social mobilization in Georgia. One of three HWG goals is to build informed and effective consumers, through IEC and BCC, social marketing and community mobilization activities. The project is implementing a successful social marketing campaign with the slogan “Contraception—The Modern Choice,” with the overall aim to produce a better informed public that practices and exhibits positive health-seeking behavior. HWG has produced many types of brochures, booklets, and posters for clients.

## POTENTIAL FOCUS AREAS

- **Continue and expand social marketing campaigns and IEC/BCC efforts into other regions of Georgia.**

### ***BEST PRACTICE #10 – WELL FUNCTIONING NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM COLLECTS, ANALYSES AND USES FAMILY PLANNING DATA***

The HWG program operates the computerized LMIS that provides accurate quarterly information on the number of consumers receiving different methods of contraceptives. It has conducted two Youth KAP studies, secondary analysis of the National Center for Disease Control (NCDC) RH Survey data, and conducted small studies and focus groups on a variety of topics including FP. With CDC/Atlanta and the CoReform project, HWG sponsored a full training course in RH Epidemiology for central- and local-level public health specialists, managers, and statisticians.

The National Health Statistics Office (NHSO) collects health data through public health (PH) specialists from rayon and regional levels and also directly from major central health facilities. Health regulations in Georgia obligate health facilities to collect and annually submit health statistical data to NHSO directly or through PH office.

## POTENTIAL FOCUS AREAS

- **Work with the MOLHSA to integrate the LMIS into the framework and protocols of the national health management information system, which is currently under development.**

## **FAMILY PLANNING PROGRAMS FUNDED BY USAID AND OTHER DONORS**

### **USAID**

#### **THE HEALTHY WOMEN IN GEORGIA PROGRAM (2003-2009)**

Implemented by JSI Research & Training Institute, Healthy Women in Georgia (HWG) is a five-year program that seeks to improve women's health in Georgia through: a) expansion of access to and utilization of modern contraception; b) making pregnancy safer by modernization of maternity care and evidence-based safe delivery; c) building a better informed health consumer and promoting positive health-seeking behaviors; and d) contributing to national health reforms by participating in reproductive health policy development and through institutionalizing evidence-based clinical practice guidelines and protocols.

In family planning, the HWG program undertakes a broad range of activities, including:

- Expanding the cadre of FP service providers and training of non-ob/gyn service providers in FP counseling and services;
- Conducting social marketing of modern FP and contraception;
- Creating youth-friendly pharmacies and providing healthy lifestyle education for adolescents, including topics on FP and other reproductive health issues;
- Training of pharmacists in FP counseling;
- Conducting community mobilization for promotion of FP services in rural areas;
- Developing the LMIS in partnership with the MOLHSA for ensuring contraceptive supplies for all income groups.

HWG program activities have an overall goal to influence the health policy agenda of the Government of Georgia and the thinking among reproductive health professionals and other key stakeholders.

#### **CoREFORM PROJECT – COOPERATION IN HEALTH SYSTEM TRANSFORMATION IN GEORGIA (2004-2008)**

The CoReform Project is implemented by Abt Associates and its subcontractors, CARE International and *Curatio* International Foundation. The goal of the RH and FP policy component of the project is achievement of an improved legislative, regulatory, and policy framework for increased supply and demand for quality reproductive health services. The project's strategy for development of RH/FP policy has been to assist the Ministry of Labor, Health, and Social Affairs (MOLHSA) through support of a national-level RH Policy Working Group.

Targeted outputs of the RH/FP policy component include:

- A **comprehensive review and analysis of the current policy and regulatory framework** governing provision of and access to FP and RH information and services, plus a series of recommendations to address identified gaps;
- A draft **national RH/FP policy** in support of enhanced access to and delivery of quality RH services;
- A **national RH strategy** that will provide guidance for operationalizing the RH/FP policy;
- **Draft legislation** in support of the Georgia RH/FP policy, in order to provide the MOLHSA and the government with a legislative basis on which to implement the policy.

Two additional products of the CoReform project produced in collaboration with national and international stakeholders are:

- **Analysis of RH/FP expenditures in the National Health Accounts** - intended to provide decision makers with more complete information on the sources and uses of funds for RH/FP services;
- **Reproductive Health Message Guide** - for the Ministry and NGO stakeholders to use as a tool in planning and coordination of reproductive health communication activities.

## UNFPA

UNFPA provides free contraceptives to Georgia including to conflict zones (Abkhazia and South Ossetia). Condoms are provided to NGOs working with vulnerable and high-risk groups as well as to the military troops.

Currently, major UNFPA program activities include:

- Operationalization of the RH Costing Tool at the MOLHSA for estimating FP-related costs according to national targets and indicators;
- Support to the MOLHSA for the development of clinical guidelines and protocols in FP service provision;
- Training of ob/gyns and midwives in FP counseling and services. From 2007, training may also be provided for FDs;
- Implementation of population IEC and RH surveys.

UNFPA supports youth-friendly FP services through BCC campaigns and social marketing of condoms.

## ANNEX II

### SOCIAL, ECONOMIC, AND REPRODUCTIVE HEALTH INDICATORS: GEORGIA

**Table 1: Social and Economic Indicators: Georgia 2002–2005**

Indicator	2002	2003	2004	2005
GDP mil US Dollars	3404.57	3983.30	5116.82	6404.31
GDP change %	5.50	11.10	5.90	9.30
GDP per capita US Dollars	756.57	885.17	1137.10	1423.20
Consumer price index (change % prev. year)	5.60	4.80	5.70	8.30
Overall public expenditure (% of GDP)	18.90	18.80	24.60	28.30
Total health care expenditure as % of GDP	7.30	6.40	5.60	5.40
Public expenditure on health as % of GDP	1.07	0.96	1.75	1.79
Public expenditure on education as % of GDP	2.20	1.90	2.90	2.50
Social protection as % of GDP	4.10	4.00	4.80	5.40
Poverty incidence (according to official subsistence minimum) %	52.10	54.50	52.30	-
Extreme poverty incidence %	15.10	16.60	17.40	-
Unemployment rate %	12.30	11.50	11.80	13.80

Source: Georgia Statistical Year Book 2005, Georgia National Accounts [www.statistics.ge](http://www.statistics.ge)

**Table 2: Reproductive Health Indicators: Georgia**

Indicator	Parameter
Total population	4.3 million
Population growth rate	-0.9%
Number of women of reproductive age 15-44 years	1.3 million
Total fertility rate per women reproductive age 15-44 years	1.6
Knowledge of at least one modern contraceptive method among women of reproductive age 15-44 years	97%
Contraceptive prevalence rate, all methods	47.3%
Traditional methods, all	20.7%
- Withdrawal	11.2%
- Rhythm method	9.5%
Modern methods, all	26.6%
- IUD	11.6%
- Condom	8.7%
- Pill	3.3%
- Female sterilization	1.4%
Most important reasons for not using modern contraceptives among women aged 15-44 currently using traditional methods	
- Fear of side effects	93%
- Lack of knowledge	78%
- Cost	75%
- Lack of access	50%
- Religion	50%

- Partner opposes	64%
Unmet need for modern contraception	44%
Total abortion rate (per woman of reproductive age)	3.1
Receipt of postabortion FP counseling	22%
- received a contraceptive method or prescription (postabortion)	6%
Maternal morbidity rate attributable to abortion	6.8%
Receipt of postpartum FP counseling *	31%
Infant mortality per 1,000 live births	23.8
Maternal mortality per 100,000 live births	23.4
Incidence rate of sexually transmitted infections (per 100,000 population)	
- Syphilis *	9.93 (2005)
- Gonorrhea *	23.46 (2005)
- Chlamydia *	20.1 (2005)
-Trichomoniasis *	76.4
HIV prevalence (UNAIDS 2006)	0.1%-0.2%
- number of verified HIV cases by 2006	1,028

Source: RHS Georgia 2005.

\* Georgia Health Statistics, NCDC 2005

## ANNEX III

### KEY INFORMANTS INTERVIEWED

#### **Ministry of Health**

Dr. Tamar Gabunia	Head of the Policy Department
Sofia Lebanidze	Head of the Health Department

#### **Zhordania Institute of Human Reproduction**

Dr. Gogi Tsertsvadze	Head, Department of Family Planning
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#### **JSI Healthy Women in Georgia Project**

Nancy Harris	Chief of Party JSI Research & Training Institute, Inc.
Dr. Kartlos Kankadze	Deputy Chief of Party
Dr. Lia Umikashvili	Field Technical Coordinator

#### **CoReform Project**

Barbara Seligman	Chief of Party
Ellen Pierce	RH/FP Policy Advisor

#### **UNFPA**

Tamar Khomasuridze	Assistant Representative
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## ANNEX IV

### LIST OF DOCUMENTS CONSULTED

*Basic Data and Directions for 2007-2010*. 2006. Tbilisi: Government of Georgia.

*Economic Development and Poverty Reduction Program Progress Report*. 2005. Tbilisi: World Bank.

*Georgia Health Statistics*. 2005. Tbilisi: NCDC.

*Georgia Reproductive Health Survey 1999*. Georgia. July 2001. Atlanta: Centers for Disease Control and Prevention.

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