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Gap Analysis of Family Planning Services in Georgia

FINAL REPORT

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2013

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2013

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**Gap Analyses of Family Planning Services in Georgia,
Final Report, 2013**

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ABBREVIATIONS

DH	District Hospital
DHS	Demographic Health Survey
FD	Family Doctor
FGD	Focused Group Discussion
FN	Family Nurse
FP	Family Planning
HIV	Human Immunodeficiency Virus
HSO	Health Service Operator
HUES	Health utilization and expenditure survey
IC	Insurance Company
ICDP	International Conference on Population and Development
IUD	Intra-uterine device
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOLHSA	Ministry of Labor, Health and Social Affairs
NGO	Non-governmental organization
Ob/Gyn	Obstetrician and gynecologist
PHC	Primary Health Care
PPP	Public Private Partnership
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHMT	Reproductive Health Mobile Team
RHNC	Reproductive Health National Council
SBCC	Social and Behavior Change Communication
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TV	Television
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

1.1 SECTOR CONTEXT

Since independence the health care system of Georgia is in a regular reform state. The first big-bang reform was initiated in 1996, introducing the separation of the health care financing, stewardship and provision. In 1999, the Government embarked on the privatization of the sector - all health providers became subject to the commercial law, majority hospitals and outpatient clinics were privatized, though stocks of the most of facilities were still under the state ownership. Shortly after the Rose Revolution, the government came up with two main reform plans: Plan I “100 New Hospitals” - massive hospital privatization, which aimed at downsizing and upgrading of the hospital sector. In result, majority of hospitals were privatized to private investors though the reform has been put on hold because of economic downturn and Russia -Georgia conflict in 2008.

Plan II “State Medical Insurance” - the novel approach for ensuring service provision to the poorest layers of population was directed to establishing and institutionalization of the Public Private Partnership (PPP) in the sector. Specifically, in 2007 the state financed health vouchers provided to the poor were exchanged by the latter into the health insurance policy, administered by the private insurance companies (IC). According to Health Service Utilization and Expenditure Survey (HUES) 2010, this reform showed to be successful in improving access of poor to health services and decreasing out of pocket payments.

The last intervention of the government in PPP scheme was the changes made in health care state programs in 2010. Eventually, ICs participating in governmental programs were bound to certain out of 26 “medical-administrative areas”, with obligation of constructing hospitals in these regions and making them operational by June 2012, thus ensuring service provision to beneficiaries of State Medical Insurance programs. In addition to this, starting from January 2012, the Government handed over the full responsibilities of the health service provision including public health services to the ICs, in their respective medical areas starting from January 2012.

The ICs are requested to: a) design and operate health service networks in their respective areas through rightsizing physical infrastructure and human resources; b) ensure continuous quality service provision to entire population including public health services; and c) administer selected state financed health programs. The purchasers of state programs contract the Health System Operators (HSOs) for implementation of the State Health Programs.

Apart from privatization of the health service delivery, the government ensured health coverage of the certain groups of population through State Medical Insurance programs such as most poor, teachers, children under five years old, students and pensioners. By end of 2012 the GoG was targeting about 1,4 million residents. Another 600, 000 possess private health insurance.

Since the parliamentary elections in October 2012, the new political party came into force and initiated state health insurance for non-insured individuals. While at the beginning the insurance package offered is oriented towards emergency medical care coverage, it is planned that the package will be further extended by second half of the 2013.

1.2 NEW MODELS OF HEALTH SERVICE DELIVERY

The government’s new big bang reform on complete privatization of health service delivery being materialized at the beginning of 2012, deserves close look as it will have certain implications on the delivery of effective public health services to the entire population. Effectiveness of proposed reforms

relies on network of providers and integration of services to provide a range of public health services and control the costs of services. In response, the new owners of district hospitals referred as Health System Operators (HSO) have to establish network relationships. More specifically, as a result of the reforms three major types of health service modalities are identified in the country. The first health service delivery system “Model A” - when the hospital is owned and operated by Insurance Company’s (IC’s) sister company “Health System Operator (HSO)” and the rest of the providers are either independent or owned by other investors. In this model the HSO has the responsibility of organization and provision of health services to entire population in the given geographical area, including those insured under the state medical insurance programs. The second health service delivery system, “Model B”, when all service providers are owned and operated by HSO except of village ambulatories and are responsible for service provision to entire population. And the Third health service delivery system “Model C” –when the HSO owns and operates few medical facilities and bear the responsibility of providing continuous health care services to the population, while other private investors own the majority of the medical infrastructure.

CHAPTER 2: PURPOSE OF ASSESSMENT

2.1 PURPOSE OF THE ASSESSMENT

The main purpose of the assessment is to identify strengths and weaknesses of FP services through the identification of programmatic gaps that require intervention or more in-depth assessment through other methodologies as well as provide recommendations that can inform the reforming health system design in Georgia by capitalizing on strength of the existing program and filling in revealed gaps.

FP services are more successful and sustainable if it comprehensively addresses the multifaceted determinants of health and if it includes synergistic interventions that:

- Attend to the availability and quality of services and other supply-related issues
- Strengthen health systems and foster an enabling environment for FP/SRH-seeking behavior
- Improve knowledge of FP/SRH and cultivate demand for FP/SRH services

Therefore, the assessment will carefully look at three main dimensions of the FP such as supply, enabling environment and demand; identify gaps and provide recommendations per each dimension.

2.2 ASSESSMENT METHODOLOGY

2.2.1 ASSESSMENT DESIGN

For the given assignment the Supply–Enabling Environment–Demand (SEED)™ Assessment Guide for Family Planning was used. This tool enables to identify strengths and weaknesses in FP service delivery through the identification of gaps that require intervention or more in-depth assessment through other methodologies. The tool was modified and adopted to Georgian context and assessed three components (supply, demand and enabling environment) that are interdependent and mutually supportive.

The SEED assessment framework contributes to a wide range of programme planning functions (Figure 1).

The study is a qualitative analysis of barriers that are influencing contraceptive access and utilization. Detailed data on patterns and determinants of utilization of family planning (FP) methods and reproductive health commodity security (RHCS) of the population has been gathered, including information on supply factors that promote or hinder contraceptive usage. The analysis involved a desk review of key reports and documents on behavior and culture related to contraceptive use in the region and focus group discussions with various target group representatives.

2.2.2 METHODOLOGY

Desk Review: Review of documents was a major part of the assessment. The desk review produced an evidence-based snapshot of the status of key variables under consideration in the assessment. It also provided background material for the preparation of the key informant interviews and a framework for the final report.

The Desk review utilized information collected through:

- FP/SRH country statistics from key sources, such as project documents; Service Provision Assessments; Reproductive Health Survey (RHS) reports; United Nations Population Fund (UNFPA), U.S. Agency for International Development (USAID), or World Health Organization

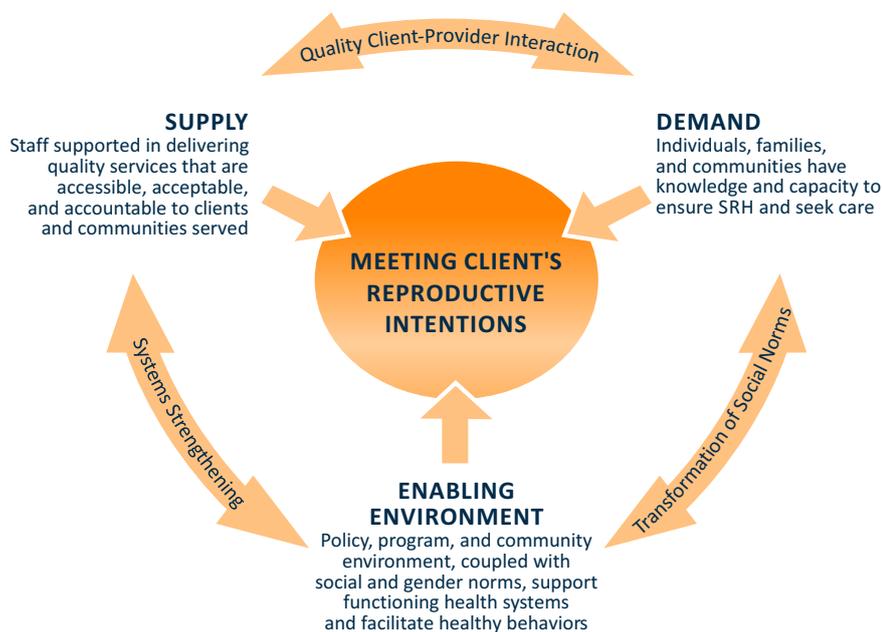
(WHO) documents; and reports on commodity procurement, among others; related development statistics (e.g., poverty levels, geographic access to health services, literacy rates, gender equality).

- National policies and guidelines.
- Assessment of the current programmatic context in which the FP services operates. Mapped out who is involved in FP programming and service delivery.

Once this information was compiled and synthesized, key informant interviews were conducted to investigate outstanding information gaps, as well as to verify or expand on the information in the desk review.

Figure 1: SEED Assessment Framework

Engender Health's Supply - Enabling Environment - Demand (SEED) Model for Family Planning Programming



EngenderHealth. The SEED™ Assessment Guide for Family Planning Programming

The focus groups were held with representatives from the following groups in society: i) Youth, ii) women; iii) FP service providers; and iv) pharmacists.

Key Informant Interviews (KII):

KI Topic guides were developed prior to interviews based on the Assessment Framework to help ensure systematic coverage of questions and issues grouped and targeted according to the stakeholder being interviewed. Interviews with policy makers, international organizations, donors, pharmaceutical companies and key government institutions were held to learn more about existing relationships, power structures and decision-making in relation to Reproductive Health Commodity Security.

Focused Group Discussions (FGD):

The assessment also applied FGD to obtain qualitative information about knowledge, attitude and practice of service providers and consumers. It attempted to learn about bottlenecks faced by each group named above. Separate FGD guides prepared customized for service providers and customers.

The following FGDs were represented in the frame of a given research:

1. Service providers
2. Women of reproductive age
3. Youth
4. Pharmacists

2.3 USERS OF THE ASSESSMENT

The main intended audience of the findings of the assessment is Government, UNFPA, Donors and the Implementing Partners involved in planning and programming. Findings and recommendations of the given research will guide their advocacy efforts to factor FP related issues in the new Health Care Strategy Document which is planned to be elaborated by the MOLHSA in 2013.

2.4 ETHICAL ISSUES ADDRESSED

While designing the assessment methodology, the principles outlined in UNEG ethical guidelines for evaluation/assessment were utilized and applied the following approaches:

- a. Kept research procedures (FGD and Semi-structured interviews) as brief and convenient as possible to minimize disruptions in respondents' work process;
- a. Ensured that potential participants can make informed decision through provision of the information about the purpose of assessment and final outcome as well as on the process and duration of interview and/or FGD. Respondents were also assured about the confidentiality of obtained information and allowed to refrain from answering the questions posed when they felt uncomfortable to respond;
- a. Key informants were interviewed face to face without other individuals. As for the FGD, the grouping applied to encourage open discussion around the assessment questions by avoiding presence of their superiors.
- a. Analyzed information as well as reported findings is presented accurately and impartially.

CHAPTER 3: ASSESSMENT FINDINGS

3.1 ENABLING ENVIRONMENT

3.1.1 LEADERSHIP

Georgia Lacks National of Family Planning Service Provision

It is almost more than a decade that international development partners advocate the government, though Georgia failed to develop the FP program that stipulates its vision towards improvement of the FP services in the country. In the past the Maternal and Child Health (MCH) Department of the Ministry of Labor, Health and Social Affairs (MOLHSA) was primarily charged with leadership role for FP related issues, as a result of structural reorganization of MOLHSA not a single structure is responsible for program development, service organization and resource allocation in the country. The only entity charged with coordination and elaboration of the FP policy recommendations is the Reproductive Health National Council (RHNC), operational at MOLHSA since the end of 2006, chaired by the First Lady of Georgia and represented by all key stakeholders, failed to promote FP policy on the government agenda.

In summary, the country lacks the vision for the improvement of FP services, lacks the responsible structure and/or entity for policy formulation, resource allocation and coordination of FP support made available to the country.

3.1.2 LEGAL ENVIRONMENT

National Legislation is harmonized with International Laws and Treaties though still has loopholes

The Georgian Law on Health Care contains language on family planning that echoes the intention of the international conventions to uphold the right of individuals to determine the number and spacing of the children. Article 136 states that: “each citizen of Georgia can independently decide on the number and timing of children to have. The state protects human rights in relation to reproduction in accordance with Georgian legislation. “In addition, Article 137 of the law places an obligation on the state to provide voluntary medical-genetic testing and counseling, free of charge, for couples desiring to have children.

An article 138 regulates the “production, import, and distribution of contraceptives” in accordance with “legislation of Georgia.” And Article 139.1 states that “protection of women’s health by decreasing the incidence of abortion” is a priority of the state.

Access to permanent methods of contraception (specifically, female sterilization) is regulated by law. Article 145 of the Law on Health Care describes the conditions for sterilization. Sterilization can be carried out only in the certified medical facilities. According to the law, a physician is only allowed to perform sterilization after a month’s waiting period is observed from the time of initial discussion of the issue with the patient. The last section of the article states that the patient should satisfy the criteria determined by Georgian legislation. The law does not point to other legislation that determines such criteria.

The Law on Medical Activities, adopted in 2001, contains language regulating the procedures for physicians to obtain license to practice in “closely related specialties”¹. Physicians licensed can obtain a license as a reproductologist after successfully completing a short post-graduate course². Physicians

¹ Article 12

² Article 12.3

specialized in other areas must complete the full post-graduate course and residency before being licensed to practice the clinical care included in the functions and responsibilities of reproductologist.³ The Georgian Law on Medical Activities⁴ also makes it mandatory for the physician to obtain written consent from the patient before performing any surgical intervention, including surgical contraception.

The Georgian Law on Patient's Rights contains no specific language about contraception or family planning services. Authorization of individual physicians and other service providers to practice preventive and curative medical care in Georgia is governed by the Medical and Pharmaceutical Activity Licensing Act, adopted in 2003.

Only three areas of specialization include family planning counseling and service provision in the examination required to obtain a license to practice, namely, Obstetrician, Obstetrician/Gynecologist and Reproductologist. Reproductology is a specialization dealing with clinical care, surgical interventions and counseling.

In summary, despite national laws designed to uphold people's reproductive rights and right of access to reproductive health care, along with significant amounts of resources and technical efforts invested in the sector, access to and use of family planning services remains quite limited in Georgia. FP counseling and services are still completely unavailable at the most basic level of the primary care system.

Barriers to access – or gaps between laws, policy and programs – are rooted largely in the area of licensing regulations and allocation of limited resources. The laws upholding the reproductive rights of Georgian citizens do not go on to link these rights directly with the right of access to quality FP services and information. Family Planning as a Critical Component of MCH Care, despite international standards that include family planning as an essential component of efforts to improve maternal and child health, as well as strong evidence that links family planning with enhanced maternal and infant survival, Georgia's National Health Strategy (2011-2015) does not include specific targets or measures to improve access to and utilization of family planning services

3.1.3 LICENSING, CERIFICATION AND ACCREDITATION

Georgia fails to fulfill the ICPD recommendation to make FP services universally available through the primary care system

An additional gap between fulfillments of the ICPD recommendation to make FP services universally available through the primary care system is the strict specialization and licensing system for providers in Georgia. Limiting family planning service provision to a narrow range of specialists has resulted in severely limiting access for women and couples who live in remote rural areas of the country. Since the development of the specialization of reproductology and the concentration of FP counseling and services on these specialists, some Ob/Gyns, who could otherwise be offering FP in the normal course of their work in Women's Consultations or maternity hospitals, have left this component of care up to the reproductologists. Although this has been addressed later, legislation still leaves some holes. Although contraception is clearly included in the medical education and licensing exams of Ob/Gyns, there is confusion among even the licensing authorities as to whether or not Ob/Gyns without the additional reproductologist specialization are authorized to provide family planning.

With the introduction of the family medicine, provision of FP services has been included in list of competencies for the Family physicians. Six month training programme in family medicine includes three day module on family planning, moreover additional trainings provided by UNFPA and USAID to family doctors on RH, including FP. However these initiatives have not been backed up by revision of the licensing regimen which legalizes provision of FP services at the PHC level.

³ Article 12.2

⁴ Article 44

3.1.4 POLICY DEVELOPMENT

Lack of Technical Capacity for the Formulation of the Evidence Based Policy

For number of years the MoLHSA lacked strong technical capacity for the formulation of the evidence based policy in different areas of the health care system including FP services. In addition, rapidly changing environment and leadership at the ministry, further constrained building strong ownership of the reforms and policies. In order to address this gap, UNFPA through its advocacy, technical and financial support heavily contributed towards establishment of coordination and policy advisory body at MoLHSA. Namely, the Reproductive Health National Council (RHNC) is operational at MoLHSA since the end of 2006. The RHNC brings together main stakeholders and sets a platform for policy dialogue on RH issues, generation of policy advice and coordination of all activities in the RH sector. However, effectiveness of this council in policy development can be judged by degree of FP related issues addressed by the recent National Health Strategy.

Recently, in 2013 the MOLHSA decided to address this gap and prepared the Ministerial Decree on the establishment of the “Maternal and Child Morbidity and Mortality Commission”. The commission is chaired by the Minister of Health and is comprised of Deputy Minister of Health, Head of Health Department, Head of State Health Regulatory Department, representatives of professional associations, National Center for Disease Control and Public Health, State Social Service Agency and representatives from Medical Education Institutions. The Commission is charged with the following functions:

- Based on the systematic analysis of MCH morbidity and mortality structure prepare evidence based policy priorities, including human resources and capacity development for health service delivery;
- Study individual cases of maternal and child death and develop appropriate recommendations
- Prepare proposals for the improvement of the access and the quality of services in different medical fields, including obstetric-gynecological, neonatology and pediatric care

It is believed that this commission will play a leading role in formulation of the evidence based MCH policies including the FP as well as routinely monitor policy implementation.

Family Planning is not explicitly acknowledged to be an important topic by the National Health Strategy

One of the strategic directions listed in Georgia’s National Health Care Strategy (2011 -2015) is “improvement of maternal and child health⁵”, but the section does not contain any references, strategies or monitoring procedures related to family planning service provision

Strategic direction 4.7 of the same document discusses “health promotion and establishment of healthy lifestyle” and lists selected topics to be addressed such as drug abuse, unhealthy diet, physical inactivity, alcohol and tobacco consumption and road safety. It is notable that FP is not considered as an important topic for health promotion and healthy lifestyle activities.

3.1.5 FINANCIAL RESOURCE AVAILABILITY AND ALLOCATION

Financing of the FP services is mostly reliant on donor funding. No state funding is made available for FP counseling or service delivery

The country remains to be dependent on external funding for effective implementation of FP mostly supported by UNFPA and USAID. The low priority that has been placed on making FP counseling

⁵ Strategic Objective 4, direction 4.3

and services available to the population is reflected in the allocation of resources to state-supported health programs. There are currently no state funds budgeted for family planning counseling or service delivery, and except for provisions stating that pregnant and post-partum clients should receive counseling and recommendations regarding contraception, family planning is not included in the description of any state health program. Furthermore, FP counseling and contraceptives are not considered in the benefits of neither state medical insurance packages nor in private insurance packages.

Donor Provided Free of Charge Contraceptives Cannot Meet Country Needs

Contraceptives are currently not included in the list of essential drugs covered through state health programs, nor are there any provision in the state health budget for procurement or distribution of contraceptives. Since the inception of modern family planning programs in Georgia, all contraceptives provided through the public/private sector have been brought into the country under the auspices of the UNFPA and USAID supported programs, and distributed in collaboration with the Ministry of Health under the authority of these programs. These supplies are now exhausted; with the exception of IUDs in some facilities, there are no longer any contraceptives available.

Providers have no incentives to provide FP services

Providers who are currently licensed to provide FP services have little financial incentive to do so, as they are not compensated through any of the state programs for this work. The few clients who are willing and able to pay for counseling services normally utilize this service only once, and many bypass the system altogether in favor of pharmacies where contraceptives can be purchased without restriction.

3.1.6 CONTRACEPTIVE SECURITY

Contraceptives are not Included in the List of Essential Medicines

As noted above, there are currently no contraceptives being supplied through state health programs, and despite WHO recommendations to the contrary, contraceptives are absent from Georgia's essential drugs list. Introduction of contraceptives into the public financed programs will require development of a system for inventory and supply logistics and reporting, as none currently exists. Even if providers at the village ambulatory level are trained to deliver family planning services, licensing and current restrictions on the amount of pharmaceuticals that can be kept at ambulatory level may prohibit the ambulatory from maintaining a reasonable stock of contraceptives and provide FP services.

3.1.7 QUALITY ASSURANCE SYSTEMS

Absence of Clinical Guidelines & Protocols at the Facilities and Absence of Guideline Compliance Monitoring System

UNFPA has been identified as the main partners of the Ministry of Labor, Health and Social Affairs in developing/updating the RH service guidelines and protocols. This initiative is considered to be a breakthrough in bringing the RH services to the internationally agreed standards that will contribute significantly to the improved RH status of the population in the country. According to the Law of Georgia on Health Care and the Decree # 94 of the Minister of Labor Health and Social Affairs (dated 27 March, 2006) the, MoLHSA, through partnership with national Professional Associations and UNFPA support, developed/updated clinical guidelines and protocols on provision of the reproductive health care.

It is noteworthy to acknowledge that UNFPA responded to the request of MoLHSA for the development of clinical protocols and guidelines in the area of Family Planning and Medical Abortion, capacity

development of RH service providers, as well as publishing of the final documents to make it available to decision-makers and RH health care providers all over the country. Operationalization of new guidelines has been heavily supported by donors through building professional capacity of RH service providers and managers, though the assessment revealed absence of these guidelines at the facility level as well as absence of the guidelines compliance monitoring system in the country.

3.1.8 GENDER ROLES

Men are not recognized as FP clients neither by national legislation nor by the Health Care Strategy

Family planning – and indeed, reproductive health in general – are most often considered in the context of gynecological care, or as a sub-specialty of women’s health care. Men’s access to services and information is practically limited by the fact that all FP services in the country are provided in women’s health facilities. Although there are anecdotal reports of men accompanying their female partners to consultations with reproductologists, this is by far the exception rather than the rule. Most men who accompany their partners for these visits are doing so in the context of infertility consultations, and not for family planning.

Categorization of family planning as only a woman’s health concern, and limiting provision of these services to facilities and providers serving women’s health needs is discriminatory. It prevents men from having access to critical health information, and limits their ability to participate as supportive, responsible partners in family planning and decision-making about reproduction and sexuality.

The commitment of Georgian law to equal access between men and women to healthcare is not reiterated in the National Health Strategy document, nor is it explicitly addressed in the state-supported health programs. It is also unclear what redress a woman or man would have if they felt that access to services and care were being withheld on the basis of gender.

3.1.9 YOUTH

The Reproductive and Sexual Health Needs of Adolescents and Youth are Largely Unmet

The reproductive and sexual health needs of adolescents are going largely unmet in Georgia. There are no state-supported sex education programs, no information targeted specifically at young people, nor are health service providers equipped with the skills to meet young people’s unique needs for information, counseling and confidential services. Since the RH Cabinets are normally housed within Women’s Consultations, and they are distinct and separate from the exam rooms where normal gynecological services are provided, young women and men who may be seeking advice and/or services have little hope of doing so with any degree of privacy.

In response of these challenges in 2012 the GoG developed and approved “Youth National Policy Document⁶” which emphasizes increase of access to youth-friendly reproductive health services through ensuring geographical access, availability of skilled health staff, and promoting formal and informal youth information and education regarding reproductive health issues.

⁶ Government Decree #1608, 17/08/2012, Tbilisi

3.2 SUPPLY

3.2.1 SERVICE DELIVERY MODALITY

Provision of FP services in specialized settings is a serious missed opportunity for enhancing access to these essential services for women and couples in rural areas

In past, the development of modern family planning services in Georgia has taken place largely under state programs sponsored by UNFPA and implemented in collaboration with the Zhordania Institute of Human Reproduction. Family planning services were provided, for the most part, in special “cabinets” established in either maternity hospitals or in women’s outpatient clinics (Women’s Consultations), by licensed reproductologists.

Although family planning is a routine part of the range of services offered by midwives, nurse practitioners and family physicians throughout the world, contraception was not included in either the pre-service curriculum or the description of duties of these providers in Georgia. Since the introduction of the Family Medicine as a form of primary health care delivery, the curricula for Family Physicians and General Practice Nurses, developed in 2001 in Georgia with international assistance under the primary healthcare reform programs, include only counseling for family planning, but not provision of methods. Hence, even after the status of selected village-level ambulatories were upgraded to that of “family practice center,” basic FP services still were offered only through the Women’s Consultations and RH Cabinets at District levels and above. This represented a serious missed opportunity for enhancing access to these essential services for women and couples in rural areas, increasing the use of modern contraceptive and, potentially, reducing the number of women for whom abortion is the only practical choice for limiting and spacing births.

Privatization of health service delivery did not foster integration of FP services in the PHC system

The situation has been further complicated with the privatization of health service provision in the country. If until 2012 FP services had been provided by Women’s Consultations and RH Cabinets mostly through public sector, the role of private health care providers were emphasized in 2012. In rural settings, FP services could have been provided by village doctors and nurses. Under the old system, patients could self-refer for FP services to Women’s Consultations or RH Cabinets. Self-referral was primary method for accessing FP services in the country.

A primary health care model is being proposed as the major system to be utilized for health care in Georgia starting from 2012. The family doctors (FD) and Family nurses (FN) being responsible for antenatal and postnatal services in their catchment area, have been identified as a first contact point for residents, while in past patients were going directly to specialized health care providers. It is notable, that all rural FD&FN became private providers since 2008. They are registered as an independent physical persons being licensed to provide health care services to the population though having no right for provision of FP services. FDs and FNs are sub-contracted by privately owned District Hospitals (DH) in their respective catchment area for provision of antenatal and postnatal services.

The privatization reform of health services delivery also resulted downsizing of physical infrastructure under public domain and consequently moving the functions of Women’s Consultations and RH Cabinets into the out-patient settings of the privately owned and managed by District Hospitals (Table 1). During the privatization of the district health infrastructure, the state failed to foresee integration of FP related functions into the DH thus state norms developed lacked requirements for FP service provision.

Table 1: Comparative analysis of FP service providers before and after the reform

2010		2012	
		PHC Health Providers	Private
Women’s Consultation	Public or Private	Functions of women’s consultations moved to outpatient department of the DH	Private
Reproductive Health Cabinets	Public or Private	Closed and Functions moved to DH	Private
Maternity Homes/ departments	Public or Private	Moved to DH and or remain as standalone private providers	Private

Although most Georgians are aware of the existence such services at PHC level, they still prefer to seek care from specialists. As a result, primary care physicians are widely under-utilized, with many patients preferring to go straight to seek specialists’ services. The findings revealed that in rural health clinics the antenatal and postnatal services are still provided by Ob/Gyns in case of their availability. Thus the latest reforms have not contributed towards changing the pattern of the FP service delivery in the country. This finding has been largely confirmed by the key informants interviewed during the assessment.

The number of gynecologists is often very limited in rural areas. They are largely concentrated in urban areas, and they often work at secondary health facilities with little connection to communities. Widening the range of providers enabled to offer contraception has been shown to improve contraceptive access, particularly where resources are most limited ⁷. Allowing general practitioners, whose numbers are greater and who are usually working closer to the population to provide family planning services, would quickly multiply the sites for family planning and increase access significantly.

3.2.2 MANAGEMENT, SUPERVISION AND QUALITY ASSURANCE

Absence of Management and Supervision function

The assessment was unable to reveal a structure(s) that is responsible for management, supervision and quality assurance of FP services in the country. The only structure under MOLHSA in charge of service quality is the Regulation Department, though the latter acts in response to complaints received either from the customer or from any other third party. Routine monitoring and supervision of the quality assurance is largely absent.

Another entity that could have been tasked with monitoring and supervision is the public financier, however as FP services are not included in state programs and/or state financed insurance programs these functions for FP services are absent.

Even though the private Health System Operators (HSO) subcontract the PHC providers for provision of antenatal and postnatal services within the frame of “State Village Doctor” programme, in the absence of allocation of the management fee in the programme and flexibility to introduce incentive based payments, HSOs appear to serve as a state fund channeling agency. Even supposing the FP service provision is factored in the state programs, with the given contractual arrangements with the public purchaser HSO will not be able to introduce operational and effective management and supervision systems. (G&P implementation, monitoring and clinical audit as a quality assurance)

⁷ Welsh MH; Stanback; Shelton J. “Access to modern contraception” in Best Practice & Research Clinical Obstetrics &Gynecology.Vol 20:3,P 323-338, June 2006. [http://www.bestpracticeobgyn.com/article/51521-6934\(05\)0901707/abstract](http://www.bestpracticeobgyn.com/article/51521-6934(05)0901707/abstract)

3.2.3 AVAILABILITY OF NECESSARY SKILLS

3.2.3.1 TRAINING

The role of the state in human resource capacity development is largely unclear

UNFPA and USAID continue to be lead agencies in responding to RH human resource capacity development needs in the country, especially of FP. Through the targeted capacity building interventions donors reached out to hundreds of healthcare professionals targeting improving their knowledge and skills in providing FP services, including youth friendly services the role of the state has not been enacted.

Operationalization of new FP guidelines was another important activity assisted by donors in order to improve the quality of FP services in the country. The FP training curricula for service providers and FDs being developed by Georgian Professional associations with UNFPA support, have received accreditation and certification by MoLHSA. Training sessions of providers and FDs were conducted according to accredited curricula.

Special curriculum has been developed providing training in youth RH issues and male oriented RH services along with certified training courses in women RH issues. Providers (including nurses, midwives, reproductologists, family doctors, Ob/Gyns, Military medical doctors and pharmacist) have been trained in youth-friendly RH service provision.

While the need and relevance of training interventions is obvious it is difficult to evaluate practical application of training in practice. Majority of training beneficiaries have emphasized a high satisfaction with the training program. The trainers have emphasized a high interest on the part of general practitioners/ family doctors in improving their skills and ability to provide FP and RH services.

RH Mobile Team (RHMT) model⁸ is another tested and effective mechanism of delivering quality RH services to the remote communities. RHMTs offer the quality of services that in many cases would not be possible to provide to the vulnerable population in the rural areas through the existing provider systems and current insurance mechanisms in the regions. However while the RH exams and counseling services are highly relevant and wanted, there is a little evidence of effective arrangements concerning continuity of care including treatment.

Albeit of all these efforts, the role of the state in building human resource capacity remains largely absent. While the needs for training of in practice health workforce has been taken care by donor agencies, production of qualified health personnel for further deployment in the sector has not been adequately addressed by the government. Even those equipped with necessary knowledge and skills lack motivation to deploy them into the practice.

3.2.3.2 AWARENESS AND ATTITUDES TOWARDS CONTRACEPTIVE METHODS

Although Awareness of Medical Personnel is High, There are Less of Those Who Know How to Use One or More Contraceptive Methods

Awareness and attitudes of physicians towards contraceptive methods⁹ were studied in 2010. Results of the survey show that vast majority of doctors (95-99%) have heard about one or more contraceptive methods. The same picture is repeated in general as well as according to gender, age, specialization, region and other features. Though, there are less of those who know how to use one or more

8 Georgian Society of Gynecological Endoscopy, Georgian Association of Clinical Pathologists XXI, Georgian Association of Obstetricians and Gynecologists, Georgian Reproductologists Association

9 G.Tsertsvade, Z. Bokhua, Awareness and Attitude of doctors towards Family Planning, 2010

contraceptive methods (30.7-89.9% depending on the contraceptive method). It is notable to mention the difference between the use of Injectable (53.2%), implant, female (45.3%) and male (30.7%) sterilization, diaphragm (56.4%) and female condom (58.2%). In summary, it can be concluded that doctors use more rarely the above contraceptive methods.

This was fully confirmed as doctors indicated their use of contraceptive methods into medical practice. Female condom is hardly ever used. The reason for this could be that female condoms were introduced only in small quantities and by few donor-funded programs. Use of male sterilization (1.4%) is also low along with implant (2.1%). It should be mentioned that general physicians/FDs are only entitled to use pills, male condoms and spermicides. Presumably, this is the reason for high use of above methods compared to intrauterine devices. In general IUDs are used more frequently than pills.

There is a high percentage of doctors that reject spermicides and male condoms due to religious reasons, 80% of the doctors objecting to calendar method believe that it brings side effects and complications, while hormonal pills, injectables and female condom is not favored by half of the doctors. Small group of doctors object to the use of family planning methods as they are not aware how to manage side effects and complications. It was revealed that doctors find the most difficult task to manage the side effects of implants (13.8%), injectables (7.7%), female and male sterilization (13.8% and 7.1% respectively).

Most of the doctors (or their partners) have had an experience of using lactation amenorrhea and calendar method as well as spermicides, intrauterine device, withdrawal and male condom. At the moment the most frequently used methods are intrauterine device and male condoms.

3.2.4 MIX OF FAMILY PLANNING METHODS

Varieties of contraceptives are available in private pharmaceutical market

Variety of contraceptives is available in the pharmaceutical market. Wide range of contraceptives is more accessible in urban settings than in rural. The geographical difference in availability of contraceptives is explained by low representation of network pharmacies in rural areas. The latter are located only in urban centers, while the rural areas are mostly served by small privately owned pharmacies who find economically non-viable to procure wide range of contraceptives in the low demand environment. Limited stock of IUDs and condoms were found available during the field visit to rural pharmacies.

Selected FP methods are Profitable for the Doctor and Health Facility

According to the same survey 2/3 of the doctors interviewed believe that use of family planning methods reduces fertility rate, while 1/3 thinks that it increases the fertility rate. Most of the doctors (84.9%) believe that abortion is not an acceptable method for family planning and use of contraception is more appropriate for this purpose. More than half of the doctors think that abortion and IUDs are profitable for the doctor and health facility. Only 28% of the doctors believe that use of contraception is more beneficial, while ¼ of the doctors believe that there is no difference between the two methods in terms of profitability.

Trainings appear to be the most important source of information on contraception for physicians

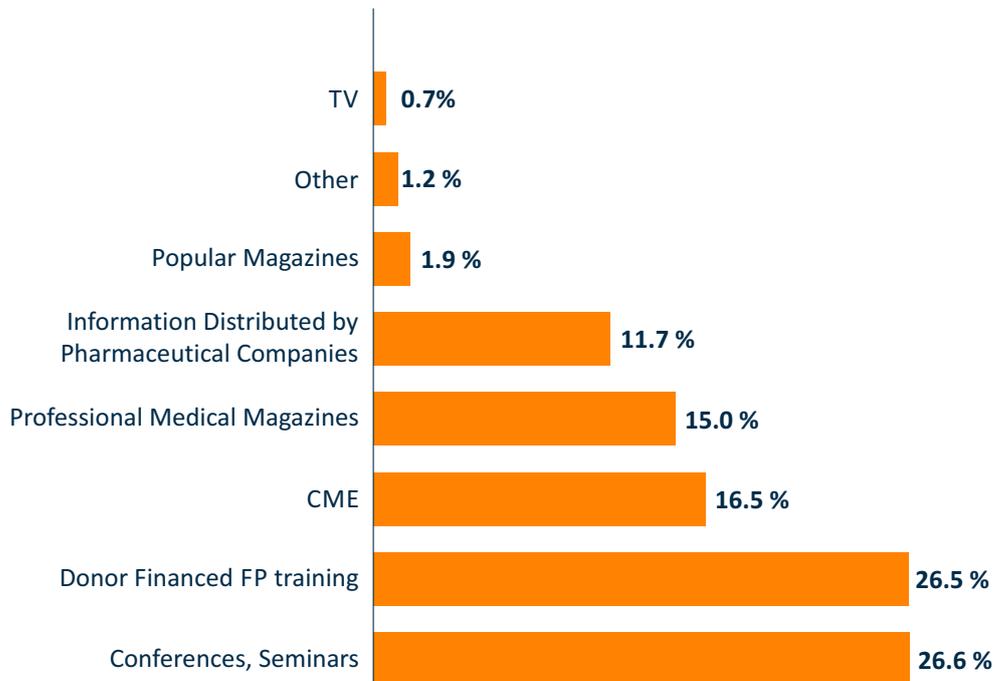
According to doctors the main information source on contraceptive methods is trainings on family planning methods held by different donors along with conferences and seminars. The smallest share falls on TV and popular magazines (Figure 2). According to the present analysis, the majority of FGD participants upgrade their professional education by attending local or international conferences and seminars. It is notable that the Georgian Government stopped financing of CME activities for last cou-

ple of years. The state funding is no longer available neither for participation in local or international conferences, or for seminars in support of physicians’ continuous education. The professional associations also fall short to meet member requirements; therefore these types of educational events at a lesser degree are financed privately by doctors and more frequently by Pharmaceutical companies. Thus the pharmaceutical market using their financial leverage in support of CME appears as the most powerful source of information.

Prescriptive behaviors of some service providers are unduly influenced by pharmaceutical companies through the provision of incentives

A range of methods is often available in the private sector, but injections, spermicides and the contraceptive patch are hard to find, even in private pharmacies. A particular concern is that pharmaceutical companies control the types of contraceptives that are available on the market. According to both key informant and policy-level interviews there is concern that the prescriptive behaviors of some service providers are unduly influenced by pharmaceutical companies through the provision of incentives. A midwife aptly explained this phenomenon as follows “to be honest, prescription depends on who paid the doctors for advertising.”

Figure 2: Physicians’ key sources of information on contraception¹⁰



3.2.5 CONTRACEPTIVE COUNCELLING

FP counseling is not a routine service rather provided on demand of the customer

Counseling for contraception often falls short of the need for full information about a range of methods. Two groups are especially critical, postpartum and post abortion women, since they identify those women most subject to unwanted conceptions in the future. For abortion cases the counseling trend is upward since 1999 but only to a mere third (33%) of cases (Figure 2), and only 14% received counseling for specific methods.

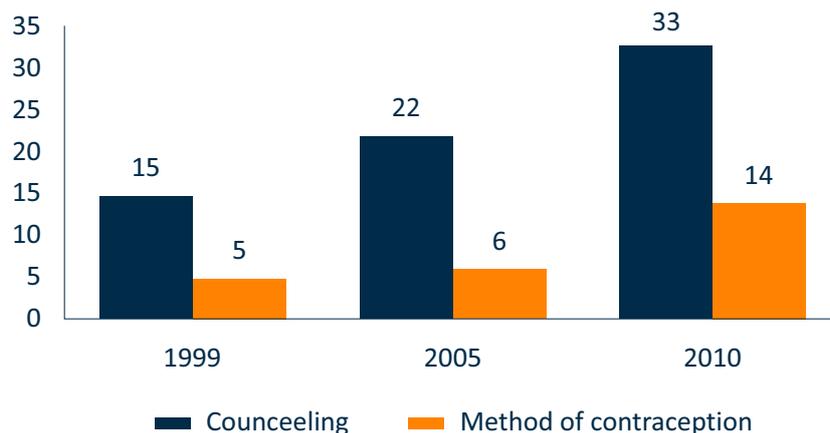
Sources of contraceptive advice vary widely. According to the Reproductive Health Survey, over half of past or current users (55%) mentioned an Ob/Gyn, but others started using their last method at the

¹⁰ Ibid 10

partner’s suggestion (24%), at their own counsel (9%), at the suggestion of a friend (5%), or relative (4%), bypassing any potential family planning counseling. About a tenth (9%) said that nobody had advised them.

The source depended largely upon the particular method. Nearly all IUD (94%) and sterilization (90%) users received advice from an Ob/Gyn, as did 78% of pill users. At the other extreme, only 12% of condom users did so. They were advised by partners (57%), nobody (20%), or friends/relatives (7%).

Figure 3: Receipt of contraceptive counseling at the time of an abortion on request (percent) 1999, 2005 and 2010



The findings of the given survey were confirmed by the focus group discussion with the women at the health facilities visited during the assessment. Moreover, the Ob/Gyns interviewed acknowledged that counseling is not a routine activity carried, rather provided on demand of the customer.

3.2.6 FP SERVICE ORIENTATION ON YOUTH/Youth Friendly FP Services

Country lacks policies and guidelines that support the provision of FP services to youth

Absence of policies and guidelines observed in the country serves as a main problem in organization and delivery of the youth oriented FP services.

Youth Friendly FP services are not offered alongside other health services that youth may seek

General health system that offers FP services does not restrict youth seeking care, though they lack youth friendliness. Even though the physicians can be trained on youth friendly counseling, the facility’s infrastructure may not at all instances ensure comfort, confidentiality and privacy of all clients as well as availability of information materials specifically targeted to youth. Moreover, services available to youth are not widely publicized and signs welcoming youth are not clearly displayed. According to the young individuals interviewed, the given circumstances are a barrier for youth to use services at the general health clinics, rather prefer to use stand alone youth reproductive health centers whereas they are available.

Donors have initiated a highly important youth RH services improvement initiative introducing a youth-friendly services concept. Several options have been tested with subsequent integration of youth-friendly services in the family medicine centers and other ambulatory clinics in an effort to ensure ownership and sustainability of the services and incorporation into existing outpatient institutions. However findings of the given assessment question the sustainability of such centers as in the absence of the state provision of contraceptives, these centers remain highly dependent on external support.

Youth lack the knowledge concerning contraceptive methods

As mentioned above, no particular efforts were applied by the government to ensure FP service orientation on youth. As there is no reference document that can shed the light on the degree of service orientation and availability of FP services to youth, the assessment was limited to research youth knowledge about contraception as well as satisfaction with received services by using survey funded by the UNFPA ¹¹. According to the named research young women lack the knowledge that they need concerning contraceptive methods and the pros and cons of each one. Here are the salient findings from questions related to their information:

- **Ever Heard of a Method:** Some young women (ages 15-24) have never heard of the main methods currently in use in Georgia. One fourth (26%) have not heard of the IUD, one third (34%) have not heard of the pill, and even 8% have not heard of the condom. The figures are nearly the same for unmarried young women as for the entire group.
- **Know How Methods are Used:** Fewer know how each method is used than those who have heard of it. About half say they do not even know how the condom is used, and about two-thirds do not know how the IUD or the pill is used. Again, the reports are similar for the entire age 15-24 group as for those never married.
- **Know Where to Get the Method:** Nearly a third (30%) of the age 15-24 group do not know where to obtain a condom, and half do not know where to obtain the IUD or the pill.
- **Sources of Information are defective:** those saying they had heard of at least one contraceptive method were asked for their most important source of information. Most (38%) of young women aged 15-24 named “friends, boyfriends.” Another 16% mentioned a relative, and 6% mentioned a partner/husband. A second type of source, of unknown reliability, was TV/Radio/Internet (15%). A doctor was mentioned by only 9%, a teacher only 2%, and parents only 5%. For the never married group the figures were much the same; more (42%) named “friends, boyfriends” as the most important source. Note that no source whatever is known among those who in the first place were not asked since they said they had never heard of any contraceptive method.

In summary, much remains to be done to provide reliable information to both married and unmarried young women. Substantial numbers of couples come to marriage with defective information about the methods, how they are used, and where to obtain them. Knowledge about the reliability of each method, its risk of failure, with an unplanned conception is very inadequate.

Young population desires more contraceptive information than they now possess

The 2010 RH survey confirms that young women want more information about contraception. Also, they have decided views about their preferred sources of such information. In the two age groups, 15-19 and 20-24, 62% and 67% respectively desired more information about contraceptive methods. These figures are actually higher than those in the older age groups (who already knew more).

When women were asked about the “best source” of information, gynecologists won out, with 37% and 52% of the two age groups naming them. Most others named impersonal sources: the mass media for radio/TV (27% and 20%) plus newspapers/magazines at 10% in each age group, and then books, with 9% and 9% respectively, as well as the internet (4% in each group). Few mentioned friends or mothers, or contraceptive users as the best source. One implication of these results is that gynecologists should pay close attention to their roles as educational sources for young women; also the mass media should remember that about a third of young women regard them as key sources for reliable information on contraception. Sensitivity to the mass media containing contraceptive information can be an issue to some people, but the survey found that over two-thirds of young women favored such broadcasts on TV or radio.

11 Reproductive health survey

Overall, the bulk of the young population desires more contraceptive information than they now possess. They look to gynecologists and the media as good sources, and they are comfortable with media inclusion of such information.

3.3 DEMAND

3.3.1 COST OF FAMILY PLANNING

Financial affordability of contraceptive in the commercial market varies according to the income groups

There are contraceptives for sale through the private sector. Oral pills, IUDs, condoms and spermicides are available for purchase in pharmacies in larger towns and cities. Whether or not this limits the access to contraceptives in the commercial market has been assessed in the focus group discussions and revealed that financial affordability varies according to the income groups.

Price of contraceptives influence the decision on use as well as defines choice of the method

The price elasticity of demand for a good is the proportionate change in the quantity demanded of that good relative to a proportionate change in its price¹². According to key informants, the cost is a key factor in use/non-use of modern contraception. Women are more eager to use contraceptives if provided free of charge. Some contraceptives – IUD and injections for example – are expensive to purchase and require additional expense for a doctor’s visit. When contraceptives are provided free of charge, about half of them can afford to cover visit costs and selected tests¹³.

The cost of unnecessary exams required by physicians in order to prescribe contraception puts contraception ever further out of reach

The cost of unnecessary exams required by physicians in order to prescribe contraception puts contraception ever further out of reach for those most-at-risk in society. Withdrawal often seems to be the method of default with regards to cost also: people use it because they have no other choice. *“I don’t like withdrawal and prefer to use a condom, which is possible to get sometimes from the clinic for free. But they are not always available.”*¹⁴

Women usually don’t have money to buy pills on a regular basis. The cost issue was confirmed by a key informant OB/GYN: “Our women pay attention first of all to cost. Even if a woman understands there are better methods available, she will choose the cheapest.” Furthermore, one of the FGD participant said that in economic terms, women prefer to use IUD as this method requires one-time payment at the beginning and lasts for several years, while pills requires to be purchased regularly and treatment schedule to be adhered to. This method although in some instances is cheaper of IUD, but less preferred by women.

In practice the private sector is fully free to dictate both the range of contraceptives that are on the market and their prices. There are no subsidies or insurance benefits for contraceptives.

In particular, modern methods are not affordable for low-income couples, those in rural areas and sexually active young people who depend financially on their parents or other relatives. Rural women must add on costs for travel to get contraceptives and related clinic visits. Many therefore prefer withdrawal or the cheapest contraceptive available at pharmacy.

12 Family Planning Programs: Getting the most for the money, Gaverick Matheny, View Point, Volume 30, Number 3, September 2004

13 http://www.undp.org.ge/index.php?lang_id=ENG&sec_id=40&pr_id=157

14 Participant of the Focus Group

The income and profit factors affect the supply of contraception as well as availability of FP services

Opportunity for profit is a factor that enters into the SRH equation for providers and determines both which services and products are offered and where they are offered. Primary health care reform followed by privatization of health care has increased client costs for SRH services and, affected the number of providers in certain places. For example, the gynecologist interviewed said that the number of the specialists had decreased significantly in rural areas due to the weak local economy and the inability of clients to pay for gynecological services.

The profit factor also affects the supply of contraception: there is more money to be made with a product that is in demand than a product that a client must be convinced to use, with a product with a higher profit margin than a product with a small mark-up (vacuum aspiration versus prescribing contraception), and where there are more potential clients (urban versus rural). This commercial aspect of service provision needs to be taken into account in planning for services that can be maintained over time.

3.3.2 SOCIAL MARKETING¹⁵

Condom Social Marketing is already Self-sustainable

Georgia introduced condoms social marketing project to make quality products increasingly accessible and affordable for young people. The project aimed to decrease the numbers of induced abortions by providing health care facilities with contraceptives. Contraceptive Supply Projects contributed to the development of RH services in Georgia and provided the population with a wide choice of family planning methods during 1993-2002. Partnerships with UNFPA and Population Service International (PSI), local NGO Caucasus Social Marketing Association (CSMA) in the field of Social Marketing played significant role in the success of condom social marketing. During the 2002-2004 UNFPA Georgia introduced condoms social marketing project to make quality products increasingly accessible and affordable for young people and was the pioneer to support “Social Marketing for Improved RH in Young People” aiming to develop product marketing strategies in the sphere of RH including launch/promotion of contraceptives, and related products and improving RH of young people through BCC campaigns and social marketing of condoms (special brand “Favorite”).

CSMA has been charged with the function to strengthen the condom distribution system in Georgia through social marketing of condoms. Project supported to promote the affordability of high-quality condoms, 1.3 million condoms were procured for a condom social marketing project. Condoms have been distributed through existing pharmacy chains as well as non-traditional distribution channels (supermarkets, gas stations etc.). One hundred and ten pharmacists from various pharmacy chains were trained in youth-friendly services and on modern methods of contraception. Condom vending machines were purchased and installed at alternative distribution venues in order to increase and ensure young people’s accessibility to high-quality, affordable condoms. At this stage the condom social marketing project is already self-financed and can continue working with existing turn-over, even expanding coverage of population with adding new distribution points (using condom vending machines and alternative non-traditional distribution places).

3.3.3 MASS MEDIA

Media coverage and communication for social mobilization lacks continuity

As part of the FP service gap assessment, the relation between the press publications and the SBCC approaches were studied. The data collection method used was review of approximately 20% of news items sampled from the 2009 -2012 set of news. However, due to the limited number of news during

15 Good Practice, Georgia, 2012

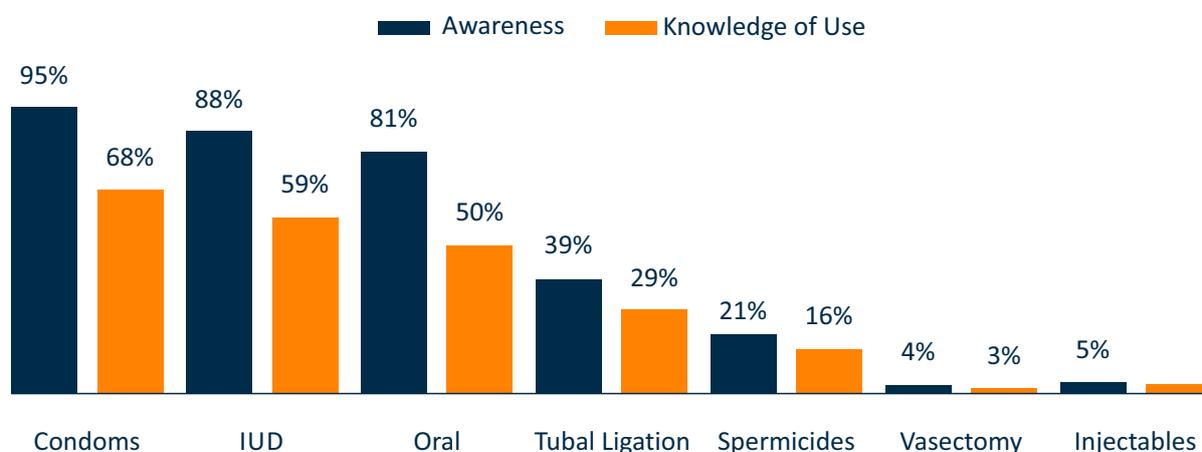
the period in question, 100% of materials were reviewed. The review revealed sporadic coverage of RH related issues including the FP and failed to demonstrate continuity over the last three years.

3.3.4 POPULATION AWARENESS, KNOWLEDGE AND USE

Awareness and Knowledge how to use contraceptives is uneven

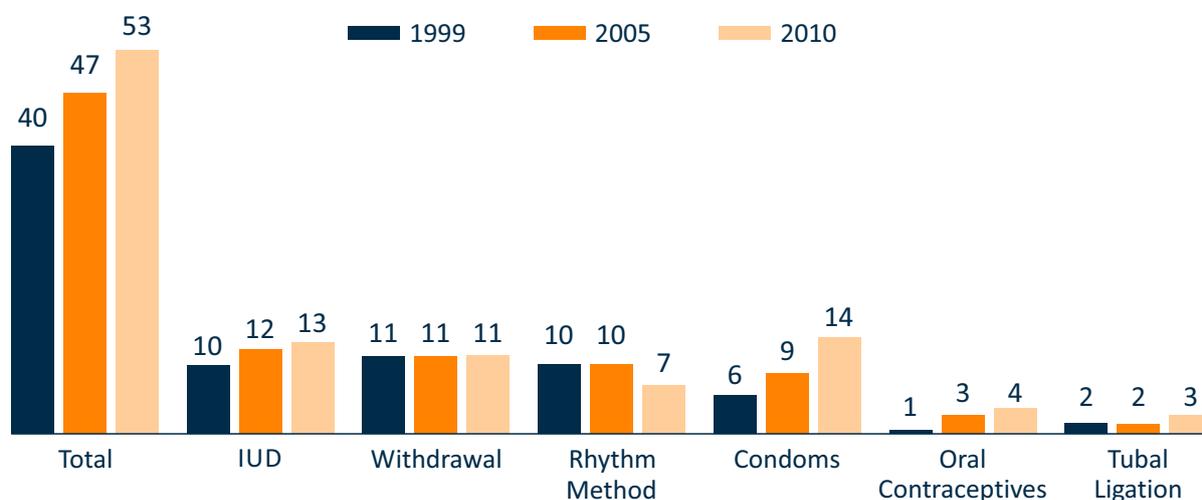
Knowledge about contraception is uneven, especially for knowledge of how to use each method. Virtually all respondents (96%) had heard of at least one modern method - particularly the condom (95%), IUD (88%), and oral contraceptives (81%), but only 39% of women had heard of tubal ligation and very few (4%) had heard of vasectomy. A sizeable gap exists for every method between awareness of the method and knowledge of how it is used (Figure 4).

Figure 4: Awareness and Knowledge of How to use modern contraceptive methods among women aged 15-44



Based on the RHS 2010 nearly all contraceptive use is among married women aged 15-44. More than half of them in 2010 (53%) are currently using contraception, including 35% using modern methods. The use of modern methods rose sharply from 20% in 1999 to 35% in 2010. For the first time, the prevalence of modern methods exceeded the prevalence of traditional methods, which declined. The greatest increases were for the IUD and condom (Figure 5).

Figure 5: Trends in contraceptive prevalence by specific method among married women aged 15-44 years (1999-2005-2010)



Condom use alongside of IUD is the most common method of family planning among married women, though still low

Among all current contraceptive users 26% were using the condom, followed by 25% using the IUD, 21% using withdrawal, 13% using periodic abstinence, 7% using the pill, 5% using tubal ligation, and 3% using spermicides.

Users prefer a different method from the one they are using, except IUD users

Many users would prefer a different method from the one they are using. Fully a third of condom users are dissatisfied, but nearly all IUD users were satisfied. Only 3% of IUD users desired a change. Pill users were intermediate at 17% and spermicides at 19% preferring a change. The most frequently cited reasons women gave for dissatisfaction with their current method included inconvenience, “nuisance” factors, low effectiveness thus risking pregnancy, and proneness to forgetfulness. In some cases users have tried alternative methods but find them even less satisfactory than the one they use.

The popularity of the IUD appears in another way: among women desiring to switch methods, over two-thirds (68%) preferred the IUD. Family size mattered, as interest in female sterilization rose with the number of children. Yet another sign of the IUD’s popularity came from women using no method at all but who plan to do so in the future: 47% preferred the IUD compared to only 13% to 14% for the condom or pill. This may reflect the history of the former USSR, in which the health system favored the IUD over such alternatives as the pill.

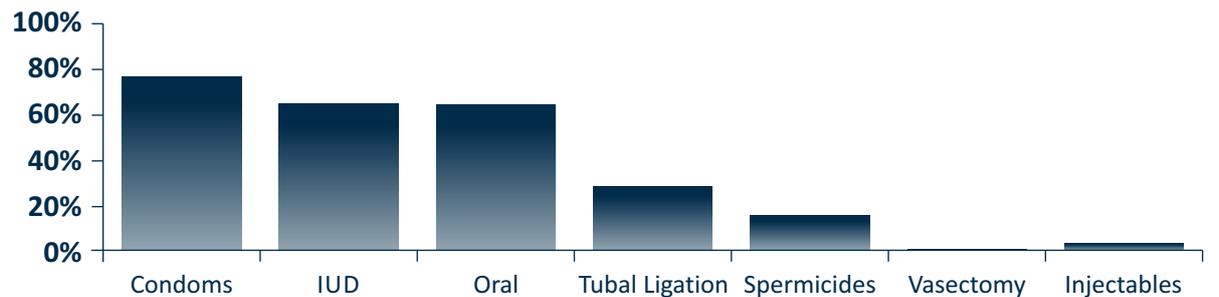
Also, most women do not know how effective the methods are. The failure rates (accidental conceptions) vary widely. While 3% of women correctly stated that IUDs are very effective in preventing pregnancy, only 16% believed that sterilization is very effective. Most women incorrectly thought that pills were not very effective.

Traditional method users (about a third of all users) are mistaken about the reliability of their method. About 75% of them considered their method equally effective or even more effective than modern methods. As to why they use it (rhythm or withdrawal) instead of a modern method, many cited fear of side effects, cost, poor availability, or lack of knowledge.

Sources of contraceptive supply is largely unknown

Many women do not know where to go to obtain contraception (Figure 6). Even condom sources are known by only 77% of women, leaving 23% apart. The percentage declines for each additional method shown in Figure 6, to only two thirds of women for the IUD and pill, and a mere one third for tubal ligation and much less for the other methods shown.

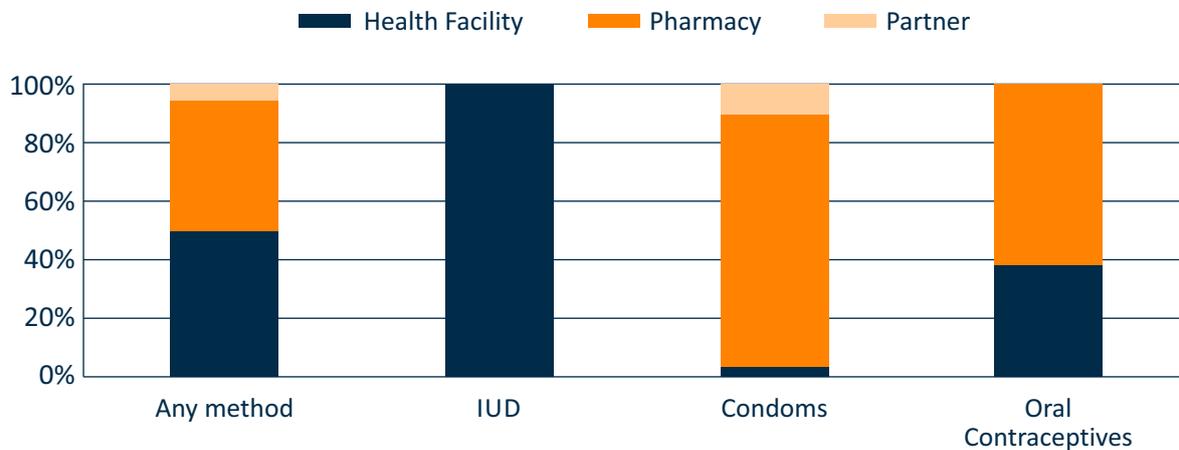
Figure 6: Knowledge about a source for specific modern contraceptive methods women aged 15-44 years



About half of women receive their contraceptives from facilities such as health care clinics/centers,

and district or regional hospitals with gynecology wards. Commercial sales, specifically pharmacies, were the second largest source (45%). About 5% used other sources such as partners, friends, relatives, and the open market (Figure 7).

Figure 7: Sources of supply for modern contraceptive methods among married women aged 15-44 currently using a method



This varies significantly by method: 87% of condom users go to pharmacies, as do 57% of pill users, while 99% of IUDs are obtained from health facilities, along with 38% of pill supplies. Pharmacies have gained since 1999: only 37% of users patronized them in 1999 but 45% did so in 2010. Most probably condom purchases at pharmacies are by husbands and most pill purchases by wives. Use of both condoms and withdrawal reflect the husband’s role and perhaps reinforce his sense of being the decision maker.

Lack of awareness and cost of contraceptives are the main reasons for not using a method

About half of married women (47%) do not currently use a method, and the reasons differ greatly across the age groups. In the youngest group (15-24) 55% are currently pregnant and another 24% wish to become pregnant. In the oldest group (35-44) 37% report female infertility, 16% are not sexually active, and 12% rely on douching. Thus the population is complex regarding who is interested in using a method, or switching methods, or feeling in need of a method.

Doctors interviewed think that the key reason for the population not using contraceptive methods derives from low awareness and high price of contraception. It is true that the lack of awareness is the key reason for not using contraception. The prioritization of the reasons for not using contraceptives has been confirmed by women participants of FGDs.

Large proportions of married women who are exposed to unwanted pregnancy lack contraception

One in eight (12%) married women wish to avoid pregnancy but are not using a method (“unmet need”). When these are added to the 19% who use traditional methods, the total unmet need for a modern method is 31% of all married women. “Demand” includes unmet need. It is simply the sum of unmet need and current contraceptive prevalence. The 2010 RH survey found 53% prevalence and 12% unmet need, so the total of 65% represents “demand.” That indicates the total percent of married women who would be using a method if all the unmet need were satisfied.

When the traditional method users are assumed to be also in need (of a modern method) they are shifted out of the using group and into the unmet need group, which then rises to 31% of married women, with only the modern users (34%) kept as the prevalence group.

Unmet need in 2010 was only half of the level documented eleven years ago, in 1999 (12% vs. 24%), since contraceptive use has increased; also some increase has probably occurred in women wanting the next birth. As of 2010, unmet need raised with rural residence, low education, and poor wealth quintiles. Most is for limiting rather than spacing, in a 2 to 1 ratio.

The size of the group in need differs sharply according to the woman's number of children. At no children most women are young and want their first child. At one child this jumps to 23% and then levels off at the high levels of 37% to 40% for larger numbers of children. This figure testifies to the large proportions of married women who are exposed to an unwanted pregnancy and lack contraception. (John Ross).

CHAPTER 4: SUMMARY OF FINDINGS

The results of analyses per each functional area are summarized below:

4.1 ENABLING ENVIRONMENT

LEADERSHIP	Georgia Lacks Leadership of Family Planning Service Provision
LEGAL ENVIRONMENT	National Legislation is harmonized with International Laws and Treaties though still has loopholes and requires to be revisited.
LICENSING, CERIFICATION AND ACCREDITATION	Georgia fails to fulfill the ICPD recommendation to make FP services universally available through the primary health care system. FP counseling and services are still completely unavailable at the most basic level of the primary care system. Barriers to access – or gaps between laws, policy and programs – are rooted largely in the area of licensing regulations and allocation of scarce resources.
POLICY DEVELOPMENT	Lack of Technical Capacity for the formulation of the Evidence Based Policy at the MOLHSA. Family Planning is not explicitly acknowledged to be an important topic by the National Health Strategy. Men are not recognized as FP clients neither by national legislation not by the Health Care Strategy. The reproductive and sexual health needs of youth are largely unmet.
FINANCIAL RESOURCE AND AVAILABILITY ALLOCATION	Financing of the FP services is mostly reliant on donor funding. No state funding is made available for FP counseling or service delivery. Donor Provided Free of Charge Contraceptives Cannot Meet Country Needs. Financial affordability of contraceptive in the commercial market varies according to the income groups. Providers have no incentives to provide FP services
CONTRACEPTIVE SECURITY	Contraceptives are not included in the List of Essential Medicines. The government mostly depends on donor funding of contraceptive supplies. Contraceptive security policy, part of RH policy
QUALITY ASSURANCE SYSTEMS	Absence of Clinical Guidelines & Protocols at facilities and nonexistence of guideline compliance monitoring system.

4.2 SUPPLY

SERVICE DELIVERY MODALITY	Provision of FP services in specialized settings is a serious missed opportunity for enhancing access to these essential services for women and couples in rural areas. Privatization of health service delivery did not foster integration of FP services in the PHC system.
MANAGEMENT, SUPERVISION AND QUALITY ASSURANCE AND QUALITY ASSURANCE	Absence of Management and Supervision function at MOLHSA

AVAILABILITY OF NECESSARY SKILLS]

The role of the state in human resource capacity development is largely unclear. In-service training of providers is fully supported by donor financed projects. Continuous Medical Education system is not demanded and financed by the government and is completely left for pharmaceutical industry support. Although RH/ FP issues are reflected in basic medical education curricula, in the absence of deployment policy is regulated by the market. Variety of contraceptives is available in pharmaceutical market.

MIX OF FAMILY PLANNING METHODS

Trainings sponsored by pharmaceutical companies, donors (UNFPA, USAID) appears to be the most important source of information on contraception for physicians, thus prescriptive behaviors of some service providers are unduly influenced by pharmaceutical companies through the provision of incentives.

CONTRACEPTIVE COUNCELLING

FP counseling is not a routine service rather provided on demand of the customer

FP SERVICE ORIENTATION ON YOUTH

Country lacks policies and guidelines that support the provision of FP services to youth. Youth FP services are not offered alongside other health services that youth may seek. Youth lack the knowledge concerning contraceptive methods. Young population desires more contraceptive information than they now possess.

4.3 DEMAND**COST OF FAMILY PLANNING**

The income and profit factors affect the supply of contraception as well as availability of FP services. Price of contraceptives influence the decision on use as well as defines choice of the method. The cost of unnecessary exams required by physicians in order to prescribe contraception puts contraception ever further out of reach.

SOCIAL MARKETING

Social marketing for condoms is self-sustainable, though results of the pill's social marketing yet has to be demonstrated.

MASS MEDIA

Media coverage and communication for social mobilization lacks continuity. The review revealed sporadic coverage of RH related issues including the FP and failed to demonstrate continuity over the last three years. These findings speak about absence of Government's communication strategy in support of raising population awareness about family planning and contraceptives.

POPULATION AWARENESS, KNOWLEDGE AND USE

Awareness and Knowledge how to use contraceptives is uneven among population by residency, gender and age groups. Condom use alongside of IUD is the most common method of family planning among married women, though still low. Users prefer a different method from the one they are using, except IUD users. Sources of contraceptive supply are largely unknown to the population. Lack of awareness and cost of contraceptives are the main reasons for not using a method. Large proportions of married women who are exposed to unwanted pregnancy lack contraception.

CHAPTER 5: RECOMMENDATIONS – WAY FORWARD

Recommendations provided below are based on the findings of the assessment and will aid the Government, key stakeholders and its development partners to elaborate new Health Care Strategy that addresses the FP service gaps and shortcomings identified at present.

5.1 ENABLING ENVIRONMENT

RECOMMENDATION #1: STRENGTHEN STEWARDSHIP FUNCTION THROUGH EVIDENCE BASED POLICY DEVELOPMENT

The MOLHSA faces a challenge to strengthen the evidence based policy formulation capacity. It is strongly believed, that the MCH council, being recently established at the Ministry, has the power to influence the political decisions of the government for the RH, therefore donor support can be instrumental in provision of technical and financial assistance to MOLHSA to better equip the council with evidence for policy advice formulation.

Another challenge facing the MOLHSA is to strengthen coordination of activities and policies within different sectors, governmental structures, as well as development partner's support. The MCH council, the way it is structured, will not be able to play this role. Therefore the GoG is advised to find the most suitable format of the Government structure and or group, that can insure inter sectoral approach towards policy development, implementation and monitoring and evaluation of the policy implementation.

Apart from above, the GoG should strongly support defining the package of important RH indicators and institutionalize in the routine data collection system. Routine information collection and analysis alongside with topic specific researches will enable the GoG to monitor the policy implementation progress and introduce corrective measures where necessary, as well as evaluate the impact of the proposed policies and strategies to ensure improved access of population to FP services.

RECOMMENDATION #2: REVISION OF RH POLICY HIGHLIGHTING FP AND DEVELOPMENT OF STRATEGIC IMPLEMENTATION PLAN AND ENHANCEMENT OF REGULATORY FRAMEWORK

It is recommended that GoG ensure revision of RH national policy and strategy, programs as well as enhancement of the current legislation in order to establish enabling legal base for effective implementation of the updated RH policy and the Strategic Implementation Plan. These documents should be based on the following principles of human rights, gender equality and lifelong approaches. Based on the new RH policy carry out detailed legal review and introduce revisions as need required.

RECOMMENDATION #3: ENSURE SUSTAINABLE FINANCING AND AFFORDABILITY OF RH/FP SERVICES

In the resource restricted environment GoG failed to ensure sustainable financing of the basic health services, including FP services. Even though the poorest segments of the population and the risk groups are covered by the state financed insurance schemes, the full package of RH services is not considered as eligibility service. Furthermore, the state regulation of the private health insurance market failed to address inclusion of basic FP services into the private health insurance products. The assessment also revealed affordability to FP services as important barrier. Thus the GoG is advised to elaborate national strategy addressing financial access barriers. More specifically, the strategy should propose the most effective financing modality(ies). One of the potential options could be inclusion of the RH/FP service coverage in the basic insurance package for state and private insurance packages, while depending on available state funding the basic package may consider to provide free or reduced-fee services to at least some clients. In addition, the state should allow flexible, results oriented payment and reimbursement systems for state insurance package administration.

RECOMMENDATION #4: INTRODUCE QUALITY ASSURANCE SYSTEM

Quality in family Planning can be defined as offering a range of services that are safe and effective and that satisfy clients' needs and wants. It can also be defined as "the way clients are treated by the system". Family planning is an issue related to individual rights, socio-economic development, and the health and well-being of women, couples, families and society at large. There is a huge unmet need for FP in Georgia and improving quality will increase the utilization of services. Hereafter, the GOG is advised to elaborate a straight forward strategy for ensuring the quality of the FP services. The recommended key Interventions for ensuring the FP quality to be considered by the government are:

- Integration of Family Planning with MCH services at various opportunities: ANC/PNC/Institutional deliver, Immunization, HIV counseling, youth clinics,
- Ensuring availability of trained manpower and other resources at all levels;
- Advocacy at all levels on importance of FP for improving maternal and child health
- Formation of quality assurance committee/structure (QAC) to be constituted at all, the national and districts level and regular assessment and assurance of the quality of services;
- Development of the state norms for adequate structure and equipment of health facilities;
- Elaboration of comprehensive work-force development strategy and plan for MCH & FP services;
- Protocols and standard guidelines developed and disseminated as well as guideline compliance audits institutionalized;
- Strengthening of Postpartum Family Planning Services;
- Accreditation of Private Facilities and empanelment of providers;
- Collating and utilizing data for improving outcomes;
- Expanding Basket of contraceptive Choice;
- Encouraging Male Participation in FP;
- Recognition and rewards for better performance, especially for FDs
- Replicating Best Practices.

5.2 SUPPLY**RECOMMENDATION #5: DEVELOP MOST EFFECTIVE FP SERVICE DELIVERY MODALITY THAT ENSURES POPULATION'S ACCESS**

In many countries, access to family-planning methods was initially restricted to health facilities, under strict control of medical practitioners, following outdated eligibility criteria and other unnecessary constraints¹⁶. The limitations of this medicalized approach were soon realized, and the success of many programmes has been closely linked to dismantling of administrative and medical barriers that impede quick, convenient, and appropriate access to methods. International guidelines have proved invaluable¹⁷. Research also shows that paramedical staff could insert intrauterine devices and provide injectable contraceptives to high clinical standards and that lay staff, after a short training period, could dispense pills and refer women for clinical methods^{18,19}. Evidence also suggested that an over-the-counter sale of pills without prescription is justifiable.

Considering lessons learned in other countries GOG is advised to design most effective service delivery modality that insures easy access to couples and youth. This is particularly important as Georgia has the most unregulated system based on private service provision. Particularly, the GOG should make decisive steps to delegate to the lowest service delivery level possible, the provision of all FP

16 Campbell MM, Sahin-Hodoglugil NN, Potts M. Barriers to fertility regulation: a review of the literature. *Stud FamPlann* 2006; 37: 87–98

17 WHO, Department of Reproductive Health and Research. Medical eligibility criteria for contraceptive use. Third edition, Geneva: World Health Organization, 2004

18 Bang SS, Song SW, Choi CH. et al. Improving access to the IUD: Experiments in Koyang, Korea. *Stud FamPlann* 1968; 27: 4–11.

19 Rosenfield A, Limcharoen C. Auxiliary midwife prescription of oral contraceptives: an experimental project in Thailand. *Am J Obstet Gynecol* 1972; 113: 942–49.

methods, without compromising safety or quality of care. Furthermore, strengthening the enabling environment including regulation and results based purchasing and payment modalities will further strengthen expansion of the FP service provision and increase access to quality RH/FP services to those in need.

RECOMMENDATION #6: ELLABORATE HUMAN RESOURCE DEVELOPMENT STRATEGY AND MAKE IT OPERATIONAL

The human resource demand of Georgia in the area of health care is broad and urgent. In order to alleviate this problem as soon as possible, it is crucial to recognize the magnitude and intensity of the problem, weigh actual capacity against the capacity needed to attain. It is recommended that a detailed strategic manpower plan is designed. The manpower need to be managed cost effectively yet meet the development goal of a more accessible, more equitable, and more effective health care and family planning (FP) delivery system.

The main reason for problems related to human resources is not only shortage of professionals, rather inadequacy of professional skills and unsatisfactory deployment. Manpower planning is affected by the type and quality of education, the workplace, and the organization of health care system. FP manpower should have a variety of skills and knowledge that are complementary. Moreover, planning should be responsive to the needs of the health system, the clients, and workers in an inter-sectoral system. FP workers need to receive training in how to be sensitive to those in greatest need.

To achieve above objectives the GoG needs to develop a human resource development plan pursuing following key strategic directions to improve health human resource planning and coordination:

1. **More effective planning and forecasting** - to develop the capacity for more effective health human resources planning and forecasting to support an affordable, sustainable RH/FP health care system.
2. **Supply of Health Providers** - to increase the number of qualified providers entering the health workforce. This will require enhancement of the undergraduate and postgraduate education curriculums by inclusion of RH/FP related topics. Furthermore, institutionalization of the Continuous Medical Education (CME) system will ensure maintenance of necessary skills and competencies in the highly privatized health care system Georgia possess at the moment.
3. **More Effective Use of Skills** - to increase productivity of health care providers by making full use of their skills; and to improve access to health care services for all Georgians, particularly in underserved areas, by addressing the maldistribution of health human resources;
4. **Creating healthy, supportive, learning workplaces** - to enhance working and learning conditions to maintain an experienced, dedicated workforce with the skills to provide high quality, safe, timely care;

RECOMMENDATION #7: ENSURE AVAILABILITY OF WIDE RANGE OF CONTRACEPTIVES AND SECURE ACCESS

Ultimately the contraceptive security in a country depends on its government. A donor may be able to provide and distribute supplies where a government lacks commitment but this is a less than ideal situation. Preferably a national government should have a clearly stated policy on contraceptive security which is seen to contribute to wider development needs. There should also be a national strategy and action plan based on a situation analysis which takes into account systems, capacities, and resources. There should also be no legal barriers to the import and accessing of those commodities.

5.3 DEMAND

RECOMMENDATION #8: CREATE ACCEPTANCE AND DEMAND FOR FP, WITH SPECIAL EMPHASIS ON POPULATION INFORMATION, EDUCATION AND COMMUNICATION

Achievement of the MCH MDG goals is one of the declared priorities of the GoG. Consequently the GOG is strongly advised to apply a three-pronged approach to improve population information, education and communication about RH in general and FP in particular. The first approach is public information, which is designed to keep the public and its leaders, in particular, informed about population trends and important developments. The second category is population education, through which population issues and their individual and societal implications are studied and discussed, in both formal and non-formal education. Ultimately, the aim of population education is to increase understanding of population issues and therefore, to improve an individual's ability to make informed choices. The third area is population communication. This refers to the mobilization of support for population-related activities, such as the creation of demand for family planning services.

Hence the National IEC strategy should be targeted at:

Increasing Awareness - Experience has shown that the most effective way to increase public awareness of population and health-related issues is to launch multimedia campaigns, employing television, radio, newspapers, magazines and specially prepared information booklets. A well-coordinated, comprehensive national awareness raising strategy can reach all uninformed.

Enhancing the role of communication - The GOG's strategy should determine not only the availability of services but also the amount of interest in and demand for them. To ensure success, communication planners must conceive, design and carefully implement a whole range of activities. Communication strategy need to be feasible, culturally acceptable and financially viable. In addition, the results of those strategies should be measurable.

Educating people about population issues and family planning - Population issues affect all aspects of life and must be treated as an integral part of school education. Children who grow up with an understanding of population and development issues and who learn about the importance of family planning and receive age and gender sensitive proper sex education become more responsible and informed adults, able to play active roles in social change and community development.

Population education, although being tested on pilot basis, still needs to be institutionalized if it is to play its full role. Ways need to be found to ensure that population education continues to be a standard feature of both formal and non-formal educational systems. For successful institutionalization of population education programmes the following has to be ensured:

- Government commitment and support, which are reflected in, inter alia, the financial and human resources necessary for implementation, and the required policy and legislative changes.
- The creation of a central population education unit, usually within a ministry of education, with sufficient trained staff.
- The dedication, commitment and motivation of a "core team" -- the central staff assigned to introduce population education -- which are of paramount importance.
- The availability of high-quality technical assistance and back-up. Thus far, UNESCO, with UN-FPA funding, is the primary source of international expertise on population education for the formal sector.
- Sensitization and awareness creation at the national level among decision makers, programme implementers and the media, as well as on the local level with parents, religious leaders and the public.
- Adequate training for educators and production of quality teaching materials.
- The elaboration of a carefully worked-out planning document for introducing population education.

ANNEXES

ANNEX 1: LIST OF DOCUMENTS REVIEWED

1. Ability to Pay for Contraceptives, USAID, 2006
2. Attitudes of Doctors toward Family Planning, UNFPA, 2010
3. Changes in Women's Reproductive Health in Georgia, UNFPA, 2010
4. Georgia National Health Care Strategy, MOLHSA, 2011 -2015
5. Good Practice, Georgia, UNFPA, 2011
6. Male Reproductive Health Survey. Tbilisi, Georgia: UNFPA, 2005, by Archil Khomasuridze, Jenaro Kristesashvili, and Giorgi Tsuladze
7. Behavior and Needs of young women in Georgia, J.A. Ross 2012
8. Reproductive Health in Georgia: Contraception, Abortion and costs, J.A. Ross, 2009
9. Reproductive Health Survey Georgia 2005 Final Report. 2007. Issued by National Center for Disease Control and Public Health (NCDC), Ministry of Labor, Health, and Social Affairs (MoL-HSA), Department of Statistics in Ministry of Economic Development, Centers for Disease Control and Prevention (CDC) Atlanta, Georgia USA, UNFPA, and USAID
10. Reproductive Health Survey Georgia 2010 Final Report. 2012. Issued by National Center for Disease Control and Public Health (NCDC), Ministry of Labor, Health, and Social Affairs (MoL-HSA), National Statistics Office of Georgia, Centers for Disease Control and Prevention (CDC) Atlanta, Georgia USA, UNFPA, USAID, and UNICEF
11. Review of Existing Reproductive Health Commodity Security Systems, Budgeting and National Capacities, and Progress Achieved with Family Planning Service Provision in the EECA Region, HLSP, 2009
12. RH and Legislative Review, USAID, CoReform, 2005
13. Women's Reproductive Health Survey Georgia, 1999-2000, Final Report. 2001. Issued by National Center for Disease Control (NCDC), Center for Medical Statistics and Information (CMSI), Ministry of Health and Social Affairs (MOH&SA), State Department of Statistics (SDS), Centers for Disease Control and Prevention (CDC) Atlanta, Georgia USA, UNFPA, UNICEF, USAID, UN High Commission for Refugees (UNHCR), and American International Health Alliance, Inc. (AIHA).

ANNEX 2: ASSESSMENT FRAMEWORK

#	Element	Indicator	Assessment Criteria	Method / Source of Information
SUPPLY				
1.1	Service Delivery modality	FP services are delivered through a variety of service delivery modalities	<p>Stationary facilities in the public and private sectors provide FP services</p> <p>Non-traditional sites provide FP services</p> <p>Mobile outreach services (MOS take place with adequate frequency to ensure that the communities served have regular access to follow-up services (e.g., resupply or removal of a method, support for side effects or complications).</p> <p>Community Based health services (If relevant to the local setting, national policies support the community-based provision of: Male condoms, Female condoms, Fertility awareness/standard days method (SDM); Education on the lactational amenorrhea method (LAM); Oral contraceptives; Injectable</p>	<p>Desk review:</p> <ul style="list-style-type: none"> - National policies/guidelines, - surveys, - program records, - service delivery protocols <p>Key informant interviews:</p> <ul style="list-style-type: none"> - Government program managers, - donors, - technical organizations, providers/managers/ staff, - community leaders, - professional associations, - trainers
1.2	Equipment and Staffing	Facilities are adequately equipped and staffed to provide quality FP services	<p>At facilities, contraceptive products and FP-related medical instruments and supplies are consistently available in adequate quantities</p> <p>There is adequate storage for contraceptive methods (e.g., commodities are stored in a dry location, off the ground, and protected from exposure to sunlight and pests).</p> <p>Facilities have basic client amenities (e.g., a basic level of cleanliness, a waiting area protected from rain/sunlight, a functioning client latrine, clean water, electricity, adequate lighting) with a separate space that ensures client privacy and confidentiality</p> <p>A system is in place to assure the timely maintenance, repair, and/or replacement of equipment</p> <p>Facilities have external signs advertising the availability of FP services</p> <p>Printed FP materials for clients (e.g., wall charts, flipcharts, pamphlets): Are visible; Are consistently available; Are up-to-date; Target men, youth, and other specific audiences; Reflect local languages, customs, and literacy levels</p> <p>Service providers are supplied with up-to-date job aids, guidelines, and/or other screening tools to enable them to appropriately screen, counsel, and serve clients.</p> <p>The facility has an adequate number of Appropriately trained staff to meet the FP needs of the average daily client flow (e.g., client waiting time is within a reasonable range).</p> <p>If relevant, CBHWs have access to reliable stocks of FP commodities, supplies, equipment, and job aids, as well as adequate storage for the FP methods they offer.</p>	<p>Desk review:</p> <p>Service Provision Assessments</p> <p>Key informant interviews:</p> <p>Government program managers, donors, technical organizations, providers/managers/ staff, CBHWs, and professional associations</p>

1.3	Availability of necessary skills	Providers and facility staff have the necessary skills to provide quality FP services	<p>Written national and facility-level policies and procedures for staff training are in place and adhered to</p> <p>Providers, including CBHWs, have high-quality Pre-service and in-service training in the following areas: FP basics; Client screening; Referral; Individual and couples counseling; IP; Method provision; Gender-sensitive counseling; Youth-friendly services; Integration of services</p> <p>Both the theoretical and the practical elements of training cover a broad range of FP methods, according to the level of the provider</p> <p>Pre-service training gives providers adequate practice in FP through an internship/practicum</p> <p>The trainer-to-student ratio, curriculum design, and teaching methods in pre- and in-service training support mastery of the skills needed to provide high-quality FP services</p> <p>Pre-service and in-service training curricula reflect current international standards</p> <p>There is an adequate supply of training materials(e.g., pelvic models for pre-service and in-service training).</p> <p>In-service trainings and follow-up are conducted periodically, as specified in a training strategy</p> <p>Staff are oriented to evidence-based national and international FP guidelines/standards</p> <p>Staff have other opportunities to improve their knowledge and skills (e.g., contraceptive technology updates).</p>	<p>Desk review:</p> <p>National/regional/local policies, professional association policies, training curricula</p> <p>Key informant interviews:</p> <p>Government program managers, donors, technical organizations, providers/managers/staff, community leaders,</p> <p>professional associations, and trainers</p>
1.4	Management, supervision, and QA/QI systems	Management, supervision, and QA/QI systems are operational	<p>National service delivery policies and guidelines define quality of care</p> <p>Managers are trained in: Facilitative supervision</p> <ul style="list-style-type: none"> - Logistics/commodity management - Analysis of data for decision making and QI <p>A functional supervision system is in place at all levels of the health care system, including community-based and mobile outreach services, if relevant:</p> <ul style="list-style-type: none"> - Staff have job descriptions in which roles, responsibilities, and performance objectives are clearly defined individually, as well as in teams, such that staff know what is expected of them. - Supervision visits occur regularly. - Supervisors use a facilitative supervision approach. - Employee performance reviews are done regularly and collaboratively; staff are given constructive, prompt, and effective feedback on whether they are meeting clearly defined performance objectives 	<p>Desk review:</p> <p>Service delivery guidelines and protocols, supervision guidelines, QA/QI guidelines</p> <p>and tools, human resource policies, health facility management guidelines</p> <p>Key informant interviews:</p> <p>Government program managers, donors, technical organizations, providers/</p> <p>managers/staff, CBHWs, community leaders, professional associations, and trainers</p>

			Facility staff are engaged in QA/QI: Facility managers, providers, and other staff are involved in continually assessing the quality of their services in relation to national policies and guidelines, clients' rights, and staff needs; in identifying solutions; and taking action to ensure client-centered care	
			Clients and communities are engaged in QA/QI: A system is in place to encourage feedback from clients on the quality of their visit	
			Community members or community representatives serving on health management committees or boards are involved in defining, appraising, and improving service quality	
			Public meetings/forums give community members an opportunity to learn about FP services and make suggestions on how to improve them	
			Managers receive adequate training and retrainings supervisory/managerial skills	
			Managers are held accountable through performance planning and evaluation systems	
			Management regularly seeks input from staff, and staff is included in decision making, as appropriate.	
			There are functioning processes and systems for: Managing facility revenues transparently; Managing facility resources and assets, such as equipment and supplies; Tracking the in-service training of providers	
			Various nonmonetary incentives are in place to ensure job satisfaction and high performance, recruitment, and retention, including those that satisfy employees (e.g., compensation, accommodation), as well as those that motivate employees (e.g., professional growth and learning, career progression, recognition).	
			Staff are rewarded individually and as teams for providing quality care (e.g., recognition, bonuses, career development opportunities, and/or other nonfinancial rewards).	
			Staff reward mechanisms do not contravene voluntarism and informed choice in FP.	
1.5	Mix of FP methods	A broad mix of FP methods is available	<p>A range of short-acting, long-acting, and permanent FP methods are consistently available to clients, including:</p> <ul style="list-style-type: none"> - Male condoms - Female condoms - Oral contraceptives (including emergency contraception) - Injectables - Implants - IUDs - Male sterilization - Female sterilization - Fertility awareness/SDM - Education on the lactational amenorrhea method (LAM) 	<p>Desk review:</p> <p>National FP policy/strategy documents, National List of Essential Medicines, Service Provision Assessments, DHS surveys, service statistics (e.g., number and type of commodities distributed), job aids/counseling tools</p>

			Clients are counseled on the full range of FP methods that are accessible, even if they are not available on-site	<p>Key informant interviews:</p> <p>Policymakers and government program managers, donors, technical organizations, providers/managers/staff, community leaders, professional associations</p>
			Where/when methods are unavailable, there is a functional referral system to help clients obtain their preferred FP method	
			Providers are not biased for or against any particular FP method	
			National policies and guidelines authorize the provision of FP methods and services at the lowest levels of the system that can safely provide them	
			The National List of Essential Medicines includes the contraceptives found in the WHO's Model List of Essential Medicines (WHO, 2010a)	
			FP screening, counseling, and service provision are based on the WHO Medical Eligibility Criteria for Contraceptive Use (WHO, 2010b) and WHO Selected Practice Recommendations for Contraceptive Use (WHO, 2004)	
			There are no unnecessary medical or administrative restrictions on contraceptive use and/or provision (e.g., menstruation or Pap smear requirements; age or marital status; or parental or spousal consent requirements)	
1.6	FP Services Integration with other health services	FP services are integrated with other health services	<p>FP services are a fully functional part of the design of the following health services:</p> <ul style="list-style-type: none"> - Primary care - Post-abortion care - Postpartum care - Prevention of mother-to-child transmission (PMTCT) of HIV <p>Where appropriate, FP services are integrated with the following health services:</p> <ul style="list-style-type: none"> - HIV and AIDS services (e.g., HCT, AIDS care and treatment, male circumcision) - Sexually transmitted infection (STI) services - Antenatal care - Child immunization and well-baby visits <p>FP services for men are integrated into other health services for men</p> <p>FP counseling messages include each method's degree of protection against HIV and STIs</p> <p>There is a functioning system of communication between the facility/provider making the referral and the facility/provider accepting the referral, so that client information is shared in a timely and confidential manner</p>	<p>Desk review:</p> <p>Service delivery guidelines or policies relating to service integration, inventory of services, service statistics, job aids that remind providers to inquire about the client's interest in other services, screening assessment criteria for integration</p> <p>Key informant interviews:</p> <p>Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders, professional associations, and trainers</p>

1.7	Referral systems	Referral systems are functional where FP methods or services are unavailable	<p>Policies endorsing referral systems are in place at all levels of the health care system, including referrals from the public to the private (for-profit and not for-profit) sector and vice versa.</p> <p>Service delivery guidelines for referral are in place and operational</p> <p>Providers, including CBHWs, are trained to counsel and refer FP clients for those methods and services that they do not provide</p> <p>To make referrals, providers use up-to-date lists of referral facilities that show services, locations, and contact persons</p> <p>A monitoring mechanism for the referral system collects data on the numbers of referrals in, the number of referrals out, reasons for referral, sources of referral, and outcomes of referral</p> <p>There is a functioning system of communication between the facility/provider making the referral and the facility/provider accepting the referral, so that client information is shared in a timely and confidential manner</p>	<p>Desk review:</p> <p>National and facility-level policies/ guidelines, facility records, service delivery protocols, systematic screening tools, job aids</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, providers/managers/staff, CBHWs</p>
1.8	Involvement of Private Sector	The private sector is involved in the provision of FP services	<p>Government policies support private-sector participation in the provision of FP services or commodities</p> <p>The government subsidizes private FP services and commodities (e.g., through tax breaks for private sector providers, a public voucher system, national insurance schemes, contracts with NGOs).</p> <p>For-profit and/or not-for-profit partners in the private sector (e.g., women's groups, faith-based organizations, pharmaceutical companies) have been identified for FP advocacy efforts, educational outreach, and service delivery</p> <p>Social marketing is used to expand the distribution of FP information, products, and services</p> <p>Social franchising is operational and inclusive in its geographic and demographic reach (e.g., the rural poor)</p> <p>Government policy has set and enforces national service delivery standards that apply to the private, as well as the public, sector</p> <p>Two-way referral systems link public and private health facilities and ensure clients the widest possible choice of FP methods</p>	<p>Desk review:</p> <p>National policy documents, DHS surveys, contracts with private providers, reports from social franchising or social marketing organizations</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, donors, technical organizations, private-sector providers/managers/ staff, community leaders, professional associations</p>
1.9	Youth orientation	FP services are inclusive of youth	<p>Policies and guidelines support the provision of FP services to youth (married or unmarried), in accordance with WHO Medical Eligibility Criteria for Contraceptive Use (WHO, 2010b) and WHO Selected Practice Recommendations for Contraceptive Use (WHO, 2004), and administrative barriers (e.g., notification or consent requirements, fees) are minimized, to ensure access to services.</p>	<p>Desk review:</p> <p>National policy documents, DHS surveys, reports from technical organizations, market segmentation analysis documents, service statistics, qualitative studies</p>

			<p>Providers are trained in youth-friendly counseling</p> <p>Providers are welcoming to clients and provide unbiased information about all methods regardless of their age, marital status, and number of children</p> <p>Trained female and male peer educators for youth are active</p> <p>The facility's infrastructure ensures the comfort, confidentiality, and privacy of all clients</p> <p>Service availability for youth is widely publicized and signs welcoming youth are clearly displayed</p> <p>Readily available SBCC materials specifically target youth; the materials encourage youth to prevent unintended pregnancy and STIs, and they address common questions and concerns of youth</p> <p>Youth community members are involved in the design and implementation of FP services</p> <p>FP services are offered alongside other health services that youth may seek (e.g., HCT)</p> <p>A range of programs (e.g., health, education, gender) build supportive social norms, empowerment, and self-respect among youth as well as the skills to negotiate contraceptive use with a partner and correctly use contraceptive methods.</p> <p>Schools have comprehensive SRH curricula and after-school programs that address FP/SRH.</p>	
1.10	FP counseling	Clients receive high-quality FP counseling	<p>A quality client-provider interaction (two-way, client-centered counseling) is supported</p> <p>Staff counsel all types of FP clients, including men, couples, married/unmarried women, married/unmarried youth, and continuing clients</p> <p>Clients are encouraged to invite their partners to FP counseling sessions for couples, which encourages joint decision making</p> <p>For programs that offer female or male sterilization, providers secure and document clients' informed consent as part of counseling</p> <p>Staff and (where relevant) CBHWs counsel clients on the full range of methods available on-site and via referral.</p> <p>Providers use job aids and other tools for counseling, such as FP flipcharts and/or samples of various FP methods to show clients</p> <p>Clients receive individual or couples counseling in a private space</p> <p>SBCC pamphlets or posters (which reflect local languages, customs, and literacy levels) support client education, decision making, and FP use</p>	

#	Element	Indicator	Assessment Criteria	Method / Source of Information
2. ENABLING ENVIRONMENT				
2.1	Leadership	FP programs have effective leadership	The FP program has a formal statement of its vision or primary purpose (e.g., mission, goals, strategy), and program leadership and managers organize and allocate resources in line with program goals and objectives	Desk review: National policies, strategic plans, costed implementation plans, 17 budgets, MOH Work plans, records of trainings on leadership and management, records of donor coordination meetings, program monitoring and evaluation reports, performance planning documents Key informant interviews: Policymakers and government program managers, donors, technical organizations, providers/managers/staff, community leaders, professional associations, and trainers
			The FP program is guided by a realistic, multi-year strategic plan that reflects realistic forecasts of population growth, includes preparations for possible scale-up to address unmet need and potential increased demand, and addresses both long-range human resource/staffing needs and financial/budget projections	
			Long-term plans are reviewed at set intervals (e.g., annually).	
			Program leadership has facilitated the development of a detailed FP work plan	
			The program convenes regular meetings with donors and technical organizations to coordinate FP support and minimize duplication of efforts and gaps in resources, programs, and services.	
2.2	Legal environment	The government has adopted evidence-based policies that are supportive of FP	such as: A national CS policy; A national youth FP/SRH policy; A policy that mandates regular updates of the curricula and materials used to train FP providers; Policies that encourage constructive male involvement in FP; Policies or guidelines on QA/QI; Policies or guidelines on community engagement	Desk review: National population, health, and FP policies; national health strategies and implementation plans; FP policies and guidelines; health budgets; National List of Essential Medicines Key informant interviews: Policymakers and government program managers, donors, technical organizations, providers/managers/staff, professional associations
			Every policy on FP is accompanied by operational plans, strategies, and/or guidelines That are: Designate institutional roles and responsibilities, Create time frames and activity plans, Delineate plans for monitoring and evaluation	
			The National List of Essential Medicines includes the contraceptives found in the WHO's most recent Model List of Essential Medicines	
			The country has no legal barriers prohibiting the importation or marketing of contraceptives (or related equipment/supplies), provision of certain FP services, or access to the full range of contraceptives	
			There are no unnecessary medical or administrative restrictions on contraceptive use and/or provision (e.g., menstruation or Pap smear requirements, age or marital status, parental or spousal consent requirements)	

2.3	Human and financial resources	Human and financial resources are available for FP and are allocated effectively.	<p>Funding for the FP program is generated from diverse sources (e.g., government, donors, the private sector, clients).</p> <p>FP is a funding priority at all levels of the health system. Examples of this can include: i) The national RH or FP strategy includes a costed implementation plan; The annual national/MOH budget contains a dedicated line item for FP; The annual national/MOH budget for FP has increased annually, in line with changing program needs; There are government-backed initiatives to facilitate FP financing, such as national health insurance schemes; Allocated funds are adequate to meet the FP program's stated goals; Allocated funds are appropriately distributed throughout the health care system; Allocated funds are released/expended at all levels of the health system in a timely manner. An HRIS is in place to train human resource managers to ensure the supply and retention of well-trained providers and staff. The minimum staffing standards for health facilities are adequate for high-quality FP provision. The geographic distribution of human resources is adequate to meet FP needs. If needed, the program offers providers incentives to work in underserved areas, such as remote rural areas. Salaries are adequate and appropriately set to ensure a highly motivated staff.</p>	<p>Desk review:</p> <p>National policies, national budget documents, statistics on the sources of expenditures in national health accounts,19 donor documents, data on the geographic distribution of the health workforce, costed implementation plans, operational plans for staffing, human resources information systems (HRIS)</p> <p>Key informant interviews:</p> <p>Government program managers, donors, technical organizations, providers/managers/staff, community leaders, professional associations, and trainers</p>
2.4	Decision Making	Programmatic decision making is evidence-based	<p>Evidence-based clinical and program guidance issued by WHO and relevant international professional associations (e.g., the international Federation of Gynecology and Obstetrics, the International Confederation of Midwives) are adopted and used as the basis for the development and review/updating of national standards, guidelines, and protocols.</p> <p>Systems for data collection, such as HMIS, LMIS, and HRIS are operational</p> <p>Monitoring and evaluation data, DHS data, RH surveys, and facility/ use data to inform programmatic decision making at all levels</p> <p>Staff are trained to monitor data quality, analyze data, and interpret results to inform decisions about contraceptive commodity procurement, training, and other service delivery issues</p> <p>To more effectively convey the benefits of and best practices in FP programming, the advocacy strategy is driven by evidence (e.g., international standards, research studies, projections of future FP needs).</p> <p>Relevant data and resources on best practices are made easily accessible to managers, providers, and decision makers at all levels of the program(e.g., through a knowledge management system, professional organizations, the MOH web site).</p>	

2.5	Contraceptive security	Contraceptive security measures are in place.	<p>National policies/procedures are in place to ensure product quality and availability (e.g., a CS strategy).</p> <p>The National List of Essential Medicines includes the contraceptives found in the WHO's most recent Model List of Essential Medicines.</p> <p>A well-functioning LMIS is in place to collect and report data.</p> <p>A commodity forecast is completed every three years and is updated annually</p> <p>CS at the "last mile"—i.e., to the SDP—is ensured through proper requisition and allocation procedures: Facility managers have the service delivery statistics and forecasting ability to predict and request the commodities, supplies, and equipment needed. Warehouse managers receive, fill, and transport orders to facilities in a timely manner. CS measures support CBS and mobile outreach services, where offered</p>	<p>Desk review:</p> <p>National CS policies/regulations, Service Provision Assessments, commodity forecasts, Contraceptive Security Index, National List of Essential Medicines</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, donors, technical organizations, providers/managers/staff, CBHWs, professional associations, trainers</p>
2.6	Advocacy	Advocacy efforts support the FP program	<p>An advocacy strategy has been developed, is being implemented, and includes the following: An emphasis on advocacy at all levels (e.g., national, regional, community)The establishment of an advocacy committee to plan and coordinate activities; Evidence from a situational analysis/environmental scan; Advocacy objectives and expected outcomes that are clearly defined, realistic, achievable, and measurable; Partnership (e.g., working groups of parliamentarians, coalitions of NGOs or religious leaders, individual champions²⁴) to advance advocacy objectives; Target audiences, including the decision makers who can realize the advocacy objectives, primary audiences such as legislators or government officials, as well as people in a position to influence those decision makers (secondary audiences), such as religious leaders and journalists; Channels of communication, activities, and materials; Tailored messages that have been pretested(if applicable); A monitoring and evaluation plan</p> <p>The program trains members of the media on FP basics and encourages them to cover FP issues regularly (e.g., through radio talk show debates about religion and FP, through investigative journalism about the factors that influence low CPRs).</p> <p>Stakeholders, including the government, donors, and service delivery and communications organizations coordinate their FP activities, including advocacy efforts</p> <p>Advocacy strategy, implementation, and monitoring and evaluation activities are guided by data.</p>	<p>Desk review:</p> <p>Advocacy strategy documents, advocacy coalition records</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, donors, technical organizations, community leaders, professional associations, and other key representatives of civil society</p>

2.7	Champions	Champions at all levels advocate for FP	<p>The head of government and/or other prominent political leaders at the national level speak publicly and favorably about FP</p> <p>Officials in the MOH and other ministries speak publicly and favorably about FP</p> <p>District/provincial political leaders speak publicly and favorably about FP.</p> <p>The FP program director is placed at a high administrative level, either within the MOH or elsewhere.</p> <p>Ministries other than Health (e.g., Finance, Education, Communication, Social and Women's Affairs, Youth) are supportive of FP.</p> <p>The national FP program identifies, trains, and supports FP champions at all levels.</p> <p>The program tracks the activities of champions to learn how numerous they are and to identify which activities are the most effective in advocating for FP.</p>	<p>Desk review:</p> <p>Public speeches and/or statements by political leaders, reports in the news media, national policies, program/advocacy documents, training curricula for champions</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, technical organizations, donors, community leaders, professional associations</p>
2.8	Community Engagement	Communities are engaged in addressing barriers to FP use.	<p>Explicit efforts are made to link FP program features to the community's own priorities (e.g., improved maternal health, fewer unsafe abortions, enhanced economic well-being of the family).</p> <p>Policy statements, strategy documents, and related implementation plans promote and support community engagement and participation in addressing FP and other health priorities</p> <p>Health facility managers have the knowledge, skills, and tools needed to support participatory community action planning processes to identify and address barriers to FP service use; regular meetings are held between providers (and other health staff) and community representatives</p> <p>Community resource persons (e.g., community leaders, CBOs, CBHWs) have been oriented to FP basics and the benefits of FP and have the knowledge, skills, and tools needed to lead and support community action planning processes that engage broader members of the community, including marginalized and disadvantaged groups, to identify and address barriers to FP service use</p> <p>Community advisory groups (composed of women and men, as well as members of marginalized and vulnerable populations [e.g., PLHIV]) actively participate in decision making regarding FP program design, budgeting, implementation, and evaluation.</p>	<p>Desk review:</p> <p>National health policies, strategies, and plans; FP program guidelines and tools</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders</p>

2.9	Social norms and gender roles	The FP program works to foster positive social norms and transform gender roles.	National FP strategies and implementation plans identify specific gender norms, practices, power imbalances, and other social norms (e.g., early marriage/childbearing, religious beliefs) affecting FP use, as well as specific steps to address these norms	<p>Desk review:</p> <p>National policies, guidelines, and/or training curricula; program records; work plans; local qualitative research.</p> <p>Key informant interviews:</p> <p>Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, professional associations, and trainers</p>
			National FP strategies and implementation plans recognize men as FP clients and as key partners for interventions to promote FP/SRH and transform gender norms (e.g., through trainings, workshops).	
			A range of intervention approaches—from service delivery strategies, SBCC campaigns, advocacy efforts at all levels, and community engagement—are being implemented to address social norms that hinder people from realizing their FP/SRH goals	
			Activities addressing social norms involve the arbiters of social norms, including opinion leaders, religious leaders, traditional leaders, and FP champions at all levels.	
			FP providers are trained in gender-sensitive counseling	
			SBCC strategies, messages, and materials are male friendly and promote the transformation of gender norms	

#	Element	Indicator	Assessment Criteria	Method / Source of Information
3. DEMAND				
3.1	Cost of FP	The program reduces the cost of FP to increase demand	Where the health system allows, the government provides FP services and commodities free of charge at public facilities	<p>Desk review:</p> <p>National policies and guidelines; DHS surveys; market segmentation analysis documents; records from voucher systems, sliding-scale systems, and/or health insurance schemes</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, donors, technical organizations, providers/managers/staff, CBHWs community leaders</p>
			Market segmentation analysis or other research has been conducted to help program managers target subsidies more efficiently.	
			Mechanisms are in place to ensure that FP services in the public and private ²⁸ sectors are affordable to all. For example: Service fees are based on a sliding scale of the client’s ability to pay and are available for free for those who cannot afford them; A voucher system is in place to assist low-income clients in accessing FP services; Health insurance eliminates or significantly reduces out-of-pocket payments for FP services; Health insurance may be public or private, including community-based health insurance	
			FP services are geographically accessible to all	
			FP services are available at hours that are convenient for all clients	

3.2	SBCC strategy	An SBCC strategy for FP is in place	<p>A communication strategy has been developed, is being implemented, and includes the following: Identification of primary and secondary target audiences; Identification of specific barriers to and motivations for FP use; Strategic selection of the communication channels and activities (e.g., participatory community theater, radio, peer education) that will be the most effective in reaching the target audience; A broad reach that extends into rural as well as urban areas; Continuous SBCC efforts throughout the year; Key messages that are grounded in behavioral theory and in-depth research of target audiences' knowledge, attitudes, and practices related to the use and nonuse of contraception; Close attention to new rumors or damaging claims about contraceptive methods, with prompt replies in the media to answer them</p> <p>SBCC messages are male-friendly and promote the transformation of gender norms</p> <p>SBCC messages emphasize the benefits of barrier methods as dual protection against unintended pregnancy, HIV, and STIs.</p>	<p>Desk review:</p> <p>National FP/SRH communication strategy, training curricula, facilitation tools and guidelines, SBCC materials</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, technical organizations, donors, community leaders</p>
3.3	Commercial and social marketing	Commercial and social marketing are used to create demand	<p>There are no legal barriers in the country that prohibit the marketing of contraceptives</p> <p>Market segmentation analysis is used to inform social marketing</p> <p>Social marketing takes place through multiple communication channels, including mass media and interpersonal communication</p> <p>Social marketing has an extensive reach (e.g., geographic, income level).</p> <p>The FP program supports the social marketing program(s) and coordinates messages with it/them.</p> <p>Continuous monitoring is used to follow the public response to the social marketing program for each method it offers, by price and brand</p> <p>For-profit companies are active in marketing brand name FP products</p>	<p>Desk review:</p> <p>Social marketing program records, market segmentation analysis documents, public/private partnership contracts, advertising</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, donors, technical organizations, community leaders</p>
3.4	Mass media SBCC approaches	The FP program utilizes mass media SBCC approaches	<p>The program utilizes a variety of mass media, print media, and new technology approaches, such as: Serial dramas on the radio, television, or video that combine entertainment and education to foster positive social norms and increase FP demand; Radio or televised discussions between talk show hosts, FP experts, and call-in listeners/viewers to convey factual information about FP; Generic (not branded) advertising for FP or specific methods; Posters, magazines, and other print materials that match the literacy level of the target audience and that use local languages whenever possible; mHealth31 approaches (e.g., text messages) to communicate about FP; information hotlines that allow the target audience to ask questions about FP</p> <p>Mass media interventions are linked with available FP services</p>	<p>Desk review:</p> <p>National policies, program records, Work plans SBCC materials, observation of mass media communications, DHS surveys, recent qualitative and quantitative studies</p> <p>Key informant interviews:</p> <p>Policymakers and government program managers, donors, technical organizations</p>

3.5	Engagement of communities and champions in SBCC	The FP program engages communities and champions in SBCC	<p>National FP/SRH communication strategies and plans articulate a strategic focus for community engagement and interpersonal approaches at the community level and define the role of local-level FP champions and community resource persons in leading these approaches.</p> <p>Community-level champions and resource persons have been identified, trained, and supported with appropriate facilitation and educational tools to lead individual and/or group discussions and dialogues on FP and facilitate community action</p> <p>Health providers, including FP staff, are responsible for liaising with community resource persons and champions in planning and conducting outreach activities and in providing technical support, as needed, to community engagement and interpersonal communication activities led by community partners.</p> <p>Community-level SBCC efforts are linked with available FP services</p> <p>The program tracks community outreach activities and identifies which activities are the most effective in creating demand for FP</p>	<p>Desk review:</p> <p>National strategy documents and guidelines, training curricula, reports from FP outreach events</p> <p>Key informant interviews:</p> <p>Government program managers, donors, technical organizations, providers/managers/staff, CBHWs, community leaders</p>
3.6	Peer Education	The FP program utilizes peer education	<p>Relevant types of peer educators (e.g., men, youth, PLHIV) are adequately trained in FP basics, peer education, interactive counseling, and referral</p> <p>Peer educators receive adequate supervision</p> <p>Peer educators conduct regular sessions/ events</p> <p>Peer education programs are monitored and evaluated</p>	<p>Desk review:</p> <p>National policies, program records, Work plans, school curricula, prior qualitative and quantitative studies</p> <p>Key informant interviews:</p> <p>Government program managers, donors, technical organizations, providers/ managers/staff, CBHWs, community leaders, professional associations, trainers</p>

ANNEX 3: SAMPLE OF FOCUS GROUP DISCUSSION GUIDE FOR CONSUMERS

ANNEX 3.1 GUIDE FOR SERVICE PROVIDERS

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
 - a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
 - b. every statement is right;
 - c. please do not hesitate to disagree with someone else;
 - d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review
5. Ask questions

Knowledge

- Have you received training in modern concepts of the FP?
- Do you have any guidelines for FP?
- What is the significance, if any, of providing quality integrated care?

Practice

- Do you feel that the training enabled you to fully apply, in your daily practice, what you have learnt? Why?
- How often do you apply the acquired skills and knowledge into work practice?
- Were you reluctant to accept new practices/procedures (reluctant to change)? Which ones? Why?
- Did the acquired knowledge and skills affect (could be both, positively and negatively) your self-confidence and the value you put on your daily work? Why?
- Is there a supportive supervision and monitoring system in place? Is this system able to support you to apply acquired skills, and reliable information and data for decision makers? Why? Please describe. What is your involvement in the monitoring process?

Barriers

- At the work place, are there some conditions that prevent you to correctly practice your skills? (i.e. non-confident in skills despite training, shortage/lack of basic equipment/amenities, drugs, time constraints, referral etc.). Please, describe.
- Is provision of the FP services included in the package of services financed either by state or private insurance?
- How you are reimbursed for FP services? Do you receive any incentive/did you expect to be incentivized /awarded for delivering quality services? Please, describe.
- How would you describe acceptance of modern contraceptives by consumers (woman, man, youth)?
- Are consumers willing to learn about FP? If not, please describe what are the reasons behind
- What will be your recommendation for improvement of the FP service quality and increase service utilization?

6. Ask if they would like to add further comments.
7. Bring the meeting to a close by summarizing the main points.
8. Thank you

ANNEX 3.2 GUIDE FOR CUSTOMERS

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
 - a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
 - b. every statement is right;
 - c. please do not hesitate to disagree with someone else;
 - d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review
5. Ask questions

Knowledge/Attitude

- Have you received any information regarding benefits of the FP and modern methods of contraception?
- What do you think about importance of the FP?
- How often you discuss FP related issues with your partner, peers, and friends?
- If not why please explain.
- Do you know where you can get the FP services?

Practice

- Do you use any method? If yes which one?
- If no, please explain why.
- Where do you usually get the FP services?
- Where you satisfied with the services received? If not please describe why.

Barriers

- What do you think what are the main barriers of getting service for you and your friends/ partners? Please list all barriers and provide explanation
- What do you think should be done to increase the knowledge/ attitude and utilization of services?
- Is there anything you can do to support the increase of knowledge/ attitude and utilization of services?

6. Ask if they would like to add further comments.
7. Bring the meeting to a close by summarizing the main points.
8. Thank you

