



JSI Research & Training Institute Inc.



Healthy Women in Georgia (HWG) Program

Republic of Georgia Contraceptive Availability Assessment: Final Report

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DELIVER Project November, 2004



Funded by the U.S. Agency for International Development USAID.

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Acronyms

ATP	Ability to Pay
CCP	Central Contraceptive Procurement System
CIF	Curatio International Foundation
CMIS	Center for Medical Information and Statistics
COC	combined oral contraceptive
CPR	contraceptive prevalence rate
CPT	Contraceptive Procurement Table
CSL	Commodity Security and Logistics Management Division (USAID)
CSMA	Caucasus Social Marketing Foundation
CYP	couple-years of protection
EPI	Expanded Program on Immunization
FDA	Federal Drug Administration
GNI	gross national income
GOG	Government of Georgia
HMIS	health management information system
HWG	Healthy Women in Georgia Project
IEC	information, education, and communication
LMIS	logistics management information system
MOH	Ministry of Health
MoLHSA	Ministry of Labor, Health and Social Affairs
MT	mobile teams
NGO	nongovernmental organizations
OC	oral contraceptive
POP	progestin-only pill
PSI	Population Services International
RH	reproductive health
RHS	Reproductive Health Survey
TAR	total abortion rate
TFR	total fertility rate
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WRA	women of reproductive age
WTP	willingness to pay

Executive Summary

A contraceptive availability assessment was carried out in the Republic of Georgia in October – November, 2004 for JSI's Healthy Women of Georgia (HWG) Project. The assessment was guided by three objectives:

- 1) **Identify contraceptive availability issues**, such as public sector supplies, availability and affordability in the private sector, existing policies, supply chain constraints, etc.
- 2) Provide USAID and the HWG Project **with short and medium-term recommendations** regarding contraceptive availability.
- 3) Conduct **specific analyses**:
 - Medium-term contraceptive needs forecast and estimation of costs
 - Affordability of contraceptives
 - CPTs and shipment ordering schedule for USAID donated supplies

Over the past several years UNFPA has been the only provider of donated contraceptives to the public health system. Recently, those donations have been reduced, resulting in concern about the short and medium-term availability of contraceptives. USAID/Caucasus has agreed to donate contraceptives to the government system to address the short and medium-term supply shortfall. In a parallel process USAID, HWG, UNFPA and other stakeholders are also interested in determining what are the long-term barriers to contraceptive availability and developing strategies to address them.

The family planning situation in Georgia is similar to that in many of the republics of the former Soviet Union. In comparison to its level of development and education, use of modern contraception is relatively low, and families depend upon abortion to limit fertility – a high total abortion rate of 3.7 contributes to the low total fertility rate of 1.4. Facility and human resource infrastructure exists, but they are poorly equipped, and staff salaries are low and are not distributed regularly. Also, certain prejudices against safe, hormonal contraceptives remains from the past.

There are also certain limitations on who can provide family planning services and supplies. Reproductologists (a sub-specialty unique to Georgia) and OB/GYNs are the only providers who are normally allowed to provide family planning services. As a result, contraceptives are not available below the Rayon (district) level in rural ambulatories, forcing clients to travel to district, city and regional facilities.

Several government facilities visited were either stocked out of contraceptives or had large quantities of expired pills inside the RH cabinets. Service providers in many facilities stated that they did not have the option of distributing free supplies, but were instead forced to send clients to private pharmacies. Providers consistently stated that their clients could not afford contraceptives in the private sector, and were clearly concerned by the absence of supplies.

A convenience sample of private pharmacies was visited to assess availability in the commercial sector. A broad variety of contraceptives were found in cities and towns, at a variety of prices. There is an inexpensive combined oral contraceptives generally available (*Rigevidon*) at a median price of \$1.10. The manufacturer plans to continue to supply this product. While this price appears low by Western standards, an *ability to pay* analysis was carried out that found even this low-priced product was out of reach for a significant portion of the population. The analysis indicated that the bottom 40% of income earners could not afford this or other commercial contraceptives, except IUDs, which costs, as expressed by CYP, is significantly lower than other supply methods. The comparison of income and price also suggests that the wealthiest 60% of the population can afford at least one brand in each of the method categories.

The consultants found significant interest among policy makers and providers at all level in providing family planning services and contraception as a desirable option to continued reliance on abortion. This support, coupled with existing infrastructure and apparent rising demand, led to the following summary recommendations:

- **USAID/Tbilisi should immediately procure a supply of combined oral contraceptives, Progestin-only Pills, condoms and IUDs for use in public sector clinics. It is estimated (with limited data) that the financing that has been set aside can provide the public sector with full-supplies through 2008.**
- **A contraceptive logistics system should be established and managed within the Department of Public Health to maintain a full supply of contraceptives at the facilities which currently provide family planning services.**
- **The MoLHSA should consider targeting of free contraceptives to those families who cannot afford to purchase them in the commercial sector.**
- **Efforts should be made to expand availability of family planning services and supplies in rural areas.**
- **The reported 34% importation tariff on condoms should be reduced to match the importation tariff for other commercial sector pharmaceuticals – currently 5%.**
- **A contraceptive availability task force should be convened by the MoLHSA.**
- **Social marketing of the “Favorite” brand of condoms should continue.**

Based on the findings and analyses, the recommendations have been distilled into the following short-term suggested actions. These actions cover immediate, minimum effort to address contraceptive availability in Georgia. Broader, medium and long-term issues are addressed within the context of the recommendations detailed in section 5.0

- **USAID/Caucasus should immediately place orders for combined orals, progestin-only orals, condoms, and IUDs.** Current facility stock levels are low and all combined oral contraceptives in the country have expired. USAID has been notified and the orders have been entered into NEWVERN procurement system.
- **The USAID contraceptives must be registered in Georgia.** The consultants have asked that CSL contact the manufacturers. This has occurred, and the process has been started. The Deputy Minister of Health assured the consultants that this would be managed expeditiously by the MOH.
- **The HWG Project should hire a Contraceptive Security and Logistics Advisor.** The Scope of Work for this employee is attached as Appendix 8. The advisor should be physically located within the offices of the MoLHSA and work closely with the RH policy advisor also supported by USAID. The advisor will work in collaboration with the MoLHSA's Department of Public Health and other departments to address both logistics and related availability issues.
- **A follow up logistics assessment and system design workshop should be programmed to precede the arrival of the USAID supplies.** The Scope of Work for this visit should include a) review of the CPTs, b) development of an initial distribution plan for nearly 100 facilities, c) design of the logistics system and the LMIS. An option to consider would be to have the JSI Logistics advisor in the Romanian Bilateral Project participate in this visit, in order to enable him to provide follow-up assistance and enhance regional cooperation.

Background

This report does not go into an extensive background on the family planning situation in Georgia. For such a background assessment, the consultants refer you to a report written by Suzanne Olds and Charles Westoff: *Abortion and Contraceptives in Georgia and Kazakhstan.*, June 30, 2004.

However, the basic context¹ in Georgia is—

- a decreasing TFR—1.4 estimated in 2003 (World Bank 2004)
- low contraceptive prevalence, reported at 19.8 percent for modern methods in 1999
- a high dependence on abortion for fertility control, resulting in a TAR of 3.7
- unmet need for family planning services, estimated at 25.8 percent in 1999
- uneven and evolving health sector privatization
- low monetary income and a government with very limited financial resources.

This assessment was requested by the USAID Mission/Caucasus, and was precipitated by the decision of UNFPA to end their donations to the public system in Georgia², largely because of financial constraints. The objectives of the assessment are to—

1. Identify *contraceptive availability issues*, such as public sector supplies, availability, and affordability in the private sector, existing policies, supply chain constraints, and others.
2. Provide USAID and the Healthy Women in Georgia (HWG) Project with *short- and medium-term recommendations* regarding contraceptive availability.
3. Conduct *specific analyses*:
 - medium-term contraceptive needs for forecast and estimation of costs
 - affordability of contraceptives
 - Contraceptive Prevalence Tables (CPTs) and shipment ordering schedule for USAID-donated supplies.

¹ Also see the 1999–2000 Georgia Reproductive Health Survey (Serbanescu et al. 2001).

² At the time of this writing it was unclear when the 2005 UNFPA contraceptives would arrive in Georgia.

2.0 Methodology

2.1 Objectives

- Identify contraceptive availability³ issues (contraceptive security) (e.g., stock levels, financing, policies).
- Provide USAID and HWG with short- and medium-term recommendations.
- Conduct specific analyses, including—
 - medium-term contraceptive needs forecast and estimation of costs
 - affordability of contraceptives
 - CPTs and shipment ordering schedule for USAID-donated supplies

The consultants carried out a nationwide assessment by visiting public health facilities, commercial pharmacies, and private hospitals in the Tbilisi area, and Western and Eastern Georgia. They reviewed contraceptive stocks, assessed procedures for data collection and processing, and interviewed providers about the availability of contraceptives, client demand, and provision of services. In Tbilisi, in addition to service providers, the team was able to meet with key government policymakers, donor representatives, NGOs and commercial providers.

2.2 Where We Went

- Tbilisi
- Imereti region: Kutaisi, Chiatura, Zestaphoni, Samtredia
- Ajara region: Batumi, Kobuleti
- Kakheti: Telavi, Sagarejo, Gurjanni
- Hospitals, combined facilities (maternity hospitals/women's consultation centers/reproductive health cabinets)
- Nineteen private pharmacies: a convenience sample that included rich and poor, city, small town, and rural areas.

2.3 Central-level Stakeholders We Met

(a partial list⁴)

- Ministry of Labor, Health and Social Affairs (MoLHSA)
- UNFPA
- Zhordania Institute
- Association of OB/GYNs
- Curatio International Foundation (CIF)
- Gedeon Richter Pharmaceuticals
- Save the Children
- Caucasus Social Marketing Foundation (CSMA)
- Center for Medical Information and Statistics (CMIS)

³ The term *contraceptive security* (CS) did not translate accurately in Georgia. Instead, the term *contraceptive availability* has been used in this report to refer to CS.

⁴ See appendix 1 for a complete list.

3.0 Findings

3.1 Reproductive Health Policies

1. *There is a strong commitment to support family planning as an alternative to abortion.* Georgia is a country facing a declining population, both through emigration and a low birth rate. It would be natural for some pronatalist who live in the country to be critical of family planning efforts, believing that that family planning is detrimental to maintaining an appropriate level of population for the country. However, Georgia is also a religious country and many, from the top of the government health system down to service providers, believe that the abortion rate is inappropriately high; they support accessibility of family planning services and contraceptives as a preferred means for families and women to control their fertility. In fact, one senior official referred to the high abortion rate in a term that was translated as *barbarism*; one hospital director said the OB/GYNs in his facility were religious, and had jointly agreed to provide family planning services without charging fees—largely because they wanted to promote family planning to reduce the number of abortions.
2. *There is confusion as to **who** can provide family planning services.* Georgia is unique in having a subspecialty called a *reproductologist*—a physician (usually, but not always, an OB/GYN) who has received extra training related to reproductive issues. Some claim that *only* reproductologists can provide family planning services and prescribe contraceptives—others disagree. In actual practice, when the facility was staffed with a reproductologist, they provided most, if not all, of the family planning services. However, in facilities where there was no reproductologist, the services were provided by the OB/GYNs on staff—with little apparent concern. The confusion around the providing these services, and even, outright disagreement, is a policy issue that needs to be resolved at a high level of government in order to improve availability, particularly to rural women and families. There may be scope to carry out some operations research to increase access to services, particularly in rural areas, by providing training to non-reproductologists and non-OB/GYNs who would then be allowed to provide family planning services and/or supplies under the supervision of a rayon-level reproductologist.
3. *Condoms are allegedly taxed at a rate of 34 percent upon import, rather than the 5 percent charged for drugs and medical equipment.* There are no local manufacturers, and they are unlikely to be any in the future (the international condom market is fiercely competitive). Therefore, there is no need to protect a local industry. Condoms should be taxed at a lower rate, as drugs, particularly because of their dual role in disease prevention as well as family planning.

3.2 Provision of Family Planning Services

This area has been covered in more detail in *Abortion and Contraceptives in Georgia and Kazakhstan* (Olds and Westoff, 2004). However, there are certain important issues related to service provision that affect both access to and dispensing of contraceptives.

4. *Significant numbers of physical and human resources exist to provide family planning services, ranging from excellent to poor.* As is common in the former Soviet Union, there is an abundance of facilities and physicians. However, partially because of their abundance, the facilities are usually inadequately maintained and equipped, staff are poorly paid, and salaries are not regularly issued. Of the seven *combined facilities* visited (maternity hospital, Women's Consultation Center, and Reproductive Health Cabinet in one location), two had their resident reproductologist on long-term leave. In these situations, the OB/GYNs provided family planning services. Neither of the two rural ambulatories had either OB/GYNs or reproductologists and, therefore, did not provide family planning services. Access to family planning services and commodities is clearly an issue for the rural population, particularly the poor rural population.

5. *There appears to be a shift in provider preference toward OCs and away from IUDs.* This is counter to the traditional teachings in the region that hormonal contraceptives are dangerous. This shift, in itself, underscores the willingness of providers to consider new technical information. One opinion expressed in the Olds and Westoff report (2004) is there may be too much caution on the part of providers about IUDs because of a perception that IUD use is associated with higher infection rates in Georgia. However, because of the low desired fertility in Georgia, and the fact that women have a child shortly after marriage, longer-term contraceptives are ideal for many families. In future training provided in the country, it may be necessary to include additional information on the selection of the appropriate women for use of the IUD.
6. *Related to the finding above, providers report a shift in client demand for pills, particularly among younger clients.* This has apparently happened as a result of the advertising for *Diane-35* and increased knowledge of the benefits of OCs among young women.
7. *There is little interest among providers to use Depo-Provera[®] as a contraceptive.* The majority of OB/GYNs the team spoke with during visits to health facilities noted the dual-use of *Depo-Provera[®]* as a therapeutic agent. However, these same providers reacted negatively to its use as a contraceptive, saying “Women don’t like the side effects.” A notable exception was among providers who serve a large Azeri population. They stated that Azeri women did not like to take pills.⁵ The privacy of the use of *Depo-Provera[®]* was also mentioned by physicians as an advantage to some women.
8. *There is very little use of permanent family planning in Georgia:* Almost all of the few tubal ligations that are carried out are done in conjunction with high-order caesarians. It would seem that sterilization would be an ideal method for users in Georgia, because women tend to complete their families early, and there is a great need for limiting methods. However, with its negative population growth, there is great reluctance to support any method that would *permanently* limit a woman’s fertility.
9. *It was universally reported that most of their clients could not afford the contraceptives in the pharmacies.* One person interviewed (an OB/GYN in Sagarejo) said that “Of 500 family planning clients in the facility, only five could easily afford contraceptives.” The affordability of contraceptives is addressed in section 4.0.

3.3 Contraceptive Supplies and Logistics

10. UNFPA has been donating and distributing contraceptives for several years in Georgia. While some of this discussion may appear critical of the organization, particularly around issues of distribution, it must be noted that UNFPA had not planned to take on the role of *distribution*. However, because of disruptions within the government, the local office reluctantly took the role of distributing the donated contraceptives. This is a technical task that UNFPA/Tbilisi and its mobile teams (MTs) in the regions were not adequately resourced to carry out. The consultants, though, feel it is important to note the problems in the current system in order to avoid duplicating them in any systems designed in the future for the distribution of donated (or government-purchased) contraceptives
11. *Distribution of contraceptives has been uneven.* UNFPA has distributed supplies through three reproductive health (RH) MTs, based in Batumi, Kutaisi, and the Zhordania Institute in Tbilisi, as well as through several nongovernmental organizations (NGOs). UNFPA supplies the MTs with vehicles, equipment, information, education, and communication (IEC) materials, and contraceptives. On a regular basis, the MTs visit Rayon level facilities for one day and provide free services to the poor. These services encompass a broad range of RH and women’s health services, including family planning. The MTs also deliver contraceptive commodities (UNFPA 2003). The quantities of contraceptives do not appear to be based on any dispensed data. However, we were told that calculations were made based on the population served by each facility. There also seems to be

⁵ These statements are, of course, anecdotal and the contraceptive method preference of ethnic sub-populations has not been empirically examined by the authors.

no methodology for collecting data on actual consumption or stocks on hand. As a result, both overstocks and stockouts occur. One Women's Consultation Center visited, in the Regional capital of Telavi, had no contraceptives in stock, and staff there stated that they had not had supplies for two years, while another clinic had 17 months of supply of OCs that had expired.

12. *All the donated combined OCs expired by the end of October 2004.* Both *Marvelon* and *Rigevidon* were provided by UNFPA, using a windfall contraceptive procurement donation from DFID and the Dutch foreign aid agency. Complicating this procurement is that it was a one-time order, and the manufacturers labeled the packages with a three-year shelf life. Unfortunately, this resulted in the expiration of a significant numbers of pills in the central warehouse and in health facilities. The only unexpired pills remaining in the public system are *Exluton* POPs, which are used in Georgia only for lactating mothers.
13. *General availability was uneven, and generally unsatisfactory.* The consultants visited seven public sector city, region, or rayon-level facilities in Kutaisi, Zestaphoni, Chiatura, Sagarejo, Telavi, and Tbilisi. Following is a summary of availability:
 - Two facilities had no contraceptives.
 - No facilities had COCs beyond October 2004.
 - Two additional facilities were stocked out of IUDs.
 - Only one facility had *Depo-Provera*[®].
14. *Collection of logistics data is not yet routine.* Some facilities recorded dispensed-to-user data in notebooks, but such data collection was not routine. During 2004, dispensed data was added to *Form 2*, the national health management information system (HMIS) form, which is submitted by each facility to the CMIS. However, there is no reporting of stock on hand. The CMIS collates the information and produces quarterly reports, culminating in an annual report in March of the following year. While the annual report represents 100 percent reporting by facilities, the quarterly reports do not accurately reflect dispensed contraceptives or the provision of services. The CMIS staff tries to ensure completeness of reporting after the end of the year. However, even with 100 percent reporting, the CMIS report is not completely accurate because, currently, there is no mechanism for auditing the quality of the data reporting from the field.

4.0 Ability to Pay for Commercial Sector Contraceptives

Georgian gross national income (GNI)⁶ per capita has risen during the past several years, from U.S.\$750 in 1999 to \$860 in 2003 (World Bank, 2004). Despite this, pharmacy retail prices for contraceptives remain relatively high for all segments of the population, most notably the bottom 40 percent of income earners. For example, the popular *Sico* brand German condom sold in pharmacies and other retail outlets sells at an average price of U.S.\$.40 cents (.22 Tetri) per unit. Used as contraception for one year, or for one couple-years of protection (CYP), *Sico* would cost the bottom 20 percent income group nearly 10 percent of their annual income. Conversely, *Sico* costs the wealthiest 20 percent, only 1.0 percent of income. In an effort to help ensure that affordable contraceptives are available to the poor, and wealthier clients have appropriate retail options, the following contraceptive ATP analysis examines the relationship between price and income to determine if additional options are needed.

4.1 Key Concepts

The *ability to pay* (ATP) refers to how easy it is for consumers to find the money necessary to pay for, in this case, contraceptives. The analysis assumes that the lower the relative cost of contraceptives, in relation to income, the greater the ability of users to pay for them. The approach used to measure ATP involves deriving the average annual income of contracepting couples by *income quintile* (five equal population sub-groups) and comparing this to the cost of CYP for different methods and brands, and from different sources. An estimate frequently used to measure ATP assumes that expenditure on contraceptives should be no more than 1 percent of per capita income (Harvey 1994). Users exceeding 1 percent of income on contraceptives are considered to be unable or *less likely to pay*. The 1 percent estimate may be biased toward middle-income populations with more disposable income than toward poorer income groups. Therefore, estimates of ATP sometimes consider a lower income threshold, such as .5 percent, for the poorest 40 percent of the population. Analysis of RH accounts in South Asia (Institute of Policy Studies 2004) suggest estimates of around 0.5 percent of income on contraceptives may be more realistic given household expenditures on other (reproductive) health care services and commodities. Contraceptive costs by method and brand, and by source are then compared to income quintiles, producing a cost to income ratio expressed as a percentage. This analysis provides an indication of what methods and brands are affordable to each income quintile.

In contrast to ATP, willingness to pay (WTP) reflects the value customers place on contraceptives. Consumers, of course, may make decisions to spend more than 1 percent of income because of the value they place on the product. Interviews with pharmacists and physicians in Georgia indicated that some women were willing to pay very high prices for the OC *Diane-35* because of the positive affect it has on skin complexion. While this evidence is only anecdotal, there is a marked distinction between the ability and willingness to pay. In the absence of an alternate, defining benchmark, this analysis categorizes users as unable to pay if the price exceeds 1.5 percent of annual *couple* income (2 x per capita income). This does not mean households are unwilling to pay, but certainly *less likely*, given their income. Users will be considered able to pay if the price is below 1.5 percent of income.

4.2 Sampling Method

The consultants visited 19 commercial pharmacies in the Tbilisi, Kakheti, Imereti, and the Ajara regions to determine available brands, methods, price—and for the purpose of other related analyses—consumption patterns and availability. The pharmacies represented *convenience* samples. However, in a sense, the sample was also purposive. They made an effort to obtain a diverse sample, including urban, peri-urban, and rural pharmacies in several regions across the country in wealthy, middle-class, and poorer neighborhoods. In general, there was broad availability of contraceptives in urban areas and very little in rural areas. In urban pharmacies, notably in Tbilisi and Batumi, there was more availability and choice of expensive brands.

⁶ GNI per capita was used to provide an absolute comparison between income and prices. This method does not take into account purchasing power parity (PPP) that considers the relative cost of goods and services when calculating income.

Pharmacies there reported the sales of oral contraceptives (OC) and condoms with prices ranging from U.S.\$50 for the former to more than \$7.00 for one cycle of pills.

Figure 4.0 represents the median cost of each brand per CYP. Both the OC *Diane-35* and *Marvelon* cost in excess of \$80 for one CYP (OC CYP=15 cycles). The IUD *Nova T200* is the most cost effective brand at \$1.83/CYP. The previously socially marketed brand *Favorite* is the least expensive condom at \$15.47/CYP.⁷ Availability of *Depo-Provera*[®] was limited to 25 percent of the sampled pharmacies, and the price varied widely from \$2.00 to \$4.00. (See figure 4.1 and appendix 6 for median prices and a full list of the sampled pharmacies, prices, locations, and brands.)

Figure 4.1 – Median Retail Price by Method

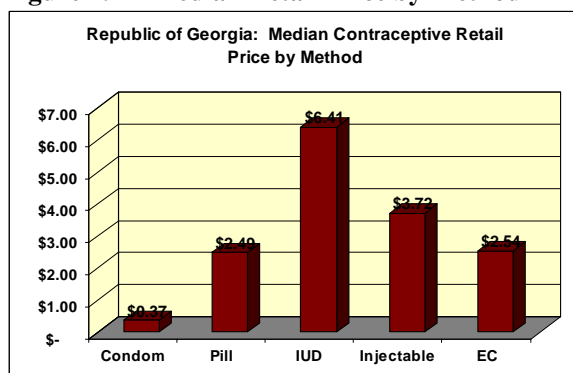
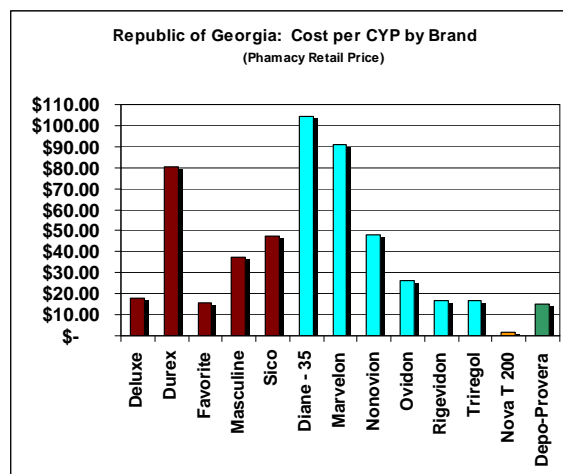


Figure 4.0 – Retail Pharmacy Cost per CYP by Brand



4.3 Deriving Average Income by Population Subgroups

Estimating the ATP for contraceptives first requires data on the percentage of national income by population sub-groups.⁸ For this analysis, total population is divided into five separate income groups, or quintiles. Each group represents 20 percent of the population. The quintiles run along a continuum, with Q5 representing the wealthiest 20 percent of the population and Q1 the poorest. Mean per capita income for each quintile was calculated using World Bank income data for 2003 and income distribution data from 2001 (World Bank, 2004). For this analysis, per capita income was then multiplied by 2, which provided an estimate for *contracepting couple* income by quintile.

Figure 4.2 – Per Capita Income Distribution 2003

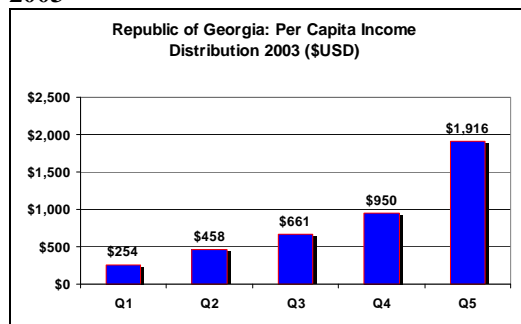
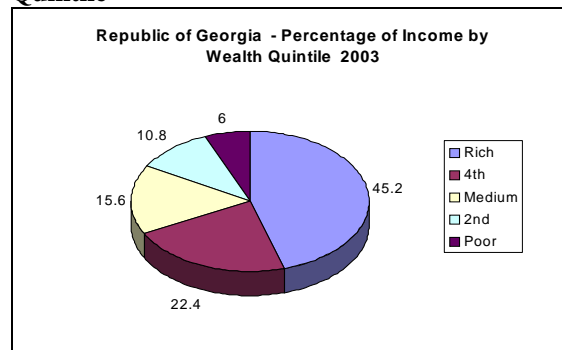


Figure 4.3 – Percentage of Income by Wealth Quintile



⁷ *Favorite* condoms were financed and procured by Population Services International (PSI) through 2003. PSI no longer operates in Georgia. However, the local social marketing group, Caucasus Social Marketing Association (CSMA) continues to explore options to reintroduce the brand with support from private capital. Many retailers queried the sampling teams for information about *Favorite* as stocks in the country are nearly gone. In July 2004, sales of *Favorite* were approximately 100,000 units per month.

⁸ (World Bank 2003). Percent income by quintile figures are from 2001.

As shown in figures 4.2 and 4.3, the wealth disparity between Q5 and Q1 (the wealthiest and poorest 20 percent of the population) is significant. Quintile 1 earns only 13 percent of the income of quintile 5. The top 40 percent (Q4 and Q5) account for almost 68 percent of total income. The bottom 40 percent account for 17 percent. This inequity of income distribution by quintile is common in many countries in the region and even in much wealthier countries. However, nearly 80 percent of total health expenditures, including contraceptives, are paid out-of-pocket (Curatio International Foundation 2004), making income levels an important determinant of access to health care.

4.4 Contraceptive Prices

Contracepting Couple Income

In looking at the impact of condom prices on the success of social marketing programs, Philip Harvey (Harvey 1994) suggested that there is a strong negative correlation between contraceptive prices and sales in the social marketing programs he examined. He arrived at this conclusion by using *per capita income* to determine the percentage of income required for contraceptive purchases. While his analysis focused only on condoms sold through social marketing programs, there is no reason to suggest that this does not apply to other contraceptive methods. Using per capita income to estimate affordability is not a perfect solution. Some contracepting couples have access to either household or spousal income. Applying a 1 or 1.5 percent income threshold to this income group, as opposed to per capita (single person) or household, is reasonable if you assume that contraceptives are purchased by one or the other but not by both (Chawla et al. 2003).

4.4.1 Contraceptive Prices

Table 5.0 presents the median condom, pill, IUD, and injectable unit prices recorded from the pricing survey by method and brand. As shown, there are significant price differences within methods. The expensive *Durex* brand condom is five times the price of *Favorite*. Prices for both *Diane-35* and *Marvelon*, as noted earlier, are many times greater than *Rigevidon* and *Triregol*.

Table 4.0 – Median Contraceptive Unit Price

Method	Brand	Median Price \$\$ ⁹	Median Price Lari
Condom	<i>Deluxe</i>	\$ 0.15	\$ 0.08
Condom	<i>Durex</i>	\$ 0.67	\$ 0.37
Condom	<i>Favorite</i>	\$ 0.13	\$ 0.07
Condom	<i>Masculine</i>	\$ 0.31	\$ 0.17
Condom	<i>Sico</i>	\$ 0.40	\$ 0.22
Oral Pill	<i>Diane-35</i>	\$ 6.96	\$ 3.85
Oral Pill	<i>Marvelon</i>	\$ 6.05	\$ 3.34
Oral Pill	<i>Nonovion</i>	\$ 3.20	\$ 1.77
Oral Pill	<i>Ovidon</i>	\$ 1.77	\$ 0.98
Oral Pill	<i>Rigevidon</i>	\$ 1.10	\$ 0.61
Oral Pill	<i>Triregol</i>	\$ 1.10	\$ 0.61
IUD	<i>Nova T 200</i>	\$ 6.41	\$ 3.54
Injectable	<i>Depo-Provera</i> [®]	\$ 3.72	\$ 2.05

⁹ Rate of exchange: 1.81 Lari = 1.0 U.S.\$ (11/08/04)

4.5 Ability to Pay: Comparing Costs to Income Quintiles

The annual cost for each brand was determined by multiplying the unit price by the CYP factor for each method. CYP factors used for the analysis were 120/condoms, 15/pills, 3.5/IUD, and 4/injections. Cost, as a percentage of annual income, was determined by dividing the annual cost per CYP for each brand by contraceptive couple income for each wealth quintile (see table 4.1).

Income by quintile was derived using 2001 World Bank figures (which were the most recently available) and the 2003 per capita GNI figure for Georgia. As discussed in the previous section, per capita and household income may be used in place of this. In those cases, to determine expenditure levels, *divide* the expenditure percentages in table 5.1 by 2 to match household size (i.e., 4), or *multiply* by 2 to determine annual cost on an individual (per capita) basis. Amounts expended for contraceptives above 1.5 percent of annual contraceptive couple income are usually considered excessive. Contracepting couples may be *willing to pay* in excess of 1.5, 2.0, or 3.0 percent of income. However, an assumption was made that 1.5 percent, for the Georgian context, is the ceiling where customers reach their maximum ATP. In table 4.1 percentages of income at or exceeding 1.5 percent are shaded green figures below this are shaded yellow.

Table 4.1 Cost as a Percentage of Annual Income

Contracepting Couple Gross National Income in Dollars and Lari								
Source: Commercial Pharmacies			Q1	Q2	Q3	Q4	Q5	
		\$USD	\$ 509	\$ 916	\$ 1,323	\$ 1,899	\$ 3,832	
		GEL	921	1,657	2,394	3,437	6,936	
Method	Brand	Cost per CYP	Cost as a Percentage of Annual Income					Median
CONDOM								
	<i>Deluxe</i>	\$ 17.68	3.48 %	1.93 %	1.34 %	0.93 %	0.46 %	1.34 %
	<i>Durex</i>	\$ 80.66	15.86 %	8.81 %	6.10 %	4.25 %	2.10 %	6.10 %
	<i>Favorite</i>	\$ 15.47	3.04 %	1.69 %	1.17 %	0.81 %	0.40 %	1.17 %
	<i>Masculine</i>	\$ 37.57	7.39 %	4.10 %	2.84 %	1.98 %	0.98 %	2.84 %
	<i>Sico</i>	\$ 47.51	9.34 %	5.19 %	3.59 %	2.50 %	1.24 %	3.59 %
PILL								
	<i>Diane - 35</i>	\$ 104.42	20.53 %	11.40 %	7.89 %	5.50 %	2.72 %	7.89 %
	<i>Marvelon</i>	\$ 90.75	17.84 %	9.91 %	6.86 %	4.78 %	2.37 %	6.86 %
	<i>Nonovion</i>	\$ 48.07	9.45 %	5.25 %	3.63 %	2.53 %	1.25 %	3.63 %
	<i>Ovidon</i>	\$ 26.52	5.21 %	2.90 %	2.01 %	1.40 %	0.69 %	2.01 %
	<i>Rigevidon</i>	\$ 16.57	3.26 %	1.81 %	1.25 %	0.87 %	0.43 %	1.25 %
	<i>Triregol</i>	\$ 16.57	3.26 %	1.81 %	1.25 %	0.87 %	0.43 %	1.25 %
IUD								
	<i>Nova T 200</i>	\$ 1.83	0.36%	0.20%	0.14%	0.10%	0.05%	0.14%
INJECTABLE								
	<i>Depo-Provera®</i>	\$ 14.87	2.92 %	1.62 %	1.12 %	0.78 %	0.39 %	1.12 %

4.5.5 Observations

- Table 4.1 indicates that Q1 and Q2—the poorest 40 percent of the population—cannot afford any commercial brand of contraceptive except the IUD *Nova T 200* which, in terms of cost per CYP, is significantly less expensive than other brands.
- For Q2 *Rigevidon*, *Triregol*, *Deluxe*, *Favorite*, and *Depo-Provera*® are relatively affordable compared to the other brands.
- Q5 appears able to pay for most brands; even *Durex*, *Diane-35*, and *Marvelon*, while unaffordable in strict terms, amount to just over 2.0 percent of income.
- There is a significant scope for continued *commercial sales* among the *top 60 percent* of income earners. This group can afford brands within each method.
- Many of the higher-priced oral pills and condoms remain unaffordable to middle-income earners (Q3).
- *Depo-Provera*®, *Favorite*, *Rigevidon*, *Triregol*, and *Nova T200* are the least expensive brands by method category.
- Free public sector contraceptives should possibly be targeted to the bottom 40 percent.

The scope of the ATP analysis was not intended to be comprehensive or final. Rather, it is intended to be one examination, among several, that seek to support a broader range of contraceptive supply initiatives. Incomes, prices, and the accuracy of data do change. Therefore, analyses regarding pricing, affordability, and willingness to pay should be regularly performed. An immediate and central question that the analysis does raise is—Are there other programs that serve the poorest 40 percent of the contracepting population? The preceding discussions indicated that access to and availability of contraceptives at many rayon, regional, and urban public facilities is below desired levels. Strong evidence from this analysis indicates that the bottom 20 percent–40 percent of users cannot afford to pay for contraceptives. Further, efforts at providing subsidized socially marketed condoms by CSMA for segments of Q2, Q3, and Q4 have stalled. The ATP analysis indicates that there may be scope to reintroduce *Favorite* as a low-priced alternative condom and, *possibly*, a subsidized oral pill.

Georgia is in a period of economic recovery. The preceding analysis was simply a snapshot of the estimated ATP based upon the most recent and accurate income data. However, income levels, and, therefore, affordability, are not static but will likely continue to change, perhaps dramatically, in the medium-term. From 1994 to 2003, GNI per capita nearly doubled, from \$480 to \$830 (World Bank 2003). This increase in monetary income has resulted in a growing population who can afford commercial sector contraceptives. Prices have, of course, increased as a result of generalized inflation. Yet, if this increase in GNI continues, as the trend suggests, then a regular, perhaps annual, reexamination of ATP should be performed to inform Government of Georgia (GOG) policymakers, donors, and technical partners about which groups remain unable to afford contraceptives and which groups should be encouraged to source the commercial sector.

As a comparison, several service providers were asked about charges for abortions, and the responses range from 20 to 35 Lari (\$11.05 to \$19.33). These prices would tend to be expensive compared to less expensive contraceptives. However, the need for an abortion is an acute need, and families will find the funds to finance an abortion, while commercial contraceptives would require a regular expenditure on a preventive, less urgent commodity.

5.0 Recommendations

5.1 Contraceptive Supplies and Logistics

1. *USAID/Tbilisi should immediately procure a supply of COCs, POPs, condoms, and IUDs for use in public sector clinics.* Both the interview with providers and the ATP analysis indicate a substantial need for free contraceptives in the system. The consultants have developed projections of consumption for the program. However, the projections are based upon population data that often is not as good a predictor of future consumption as distribution data. Therefore, the procurements should be front-loaded. Then consumption should be monitored and future shipments adjusted according to needs.

Detailed Contraceptive Procurement Tables (CPTs) and shipping schedules are included as appendices 2 and 3. In addition, the summary of estimated costs for the USAID Mission are shown in table 6.2 in the following section.

This will be the first time that USAID/Caucasus has procured contraceptives through the USAID system. A detailed description of the process is attached as appendix 5.

2. *A contraceptive logistics system should be set up within the Department of Public Health to maintain a full supply of contraceptives at the facilities that currently provide family planning services.* To the extent possible, the design of the logistics system should take advantage of existing expertise and methodologies developed through the Expanded Programme in Immunization (EPI), and use existing transportation resources. The parameters within which the system will be developed are explored in more detail in appendix 5.

2a. *A logistics system design workshop should be organized by the MoLHSA/Department of Public Health, with technical input from HWG and JSI/DELIVER projects before the first shipment of contraceptives arrive (scheduled for March 31, 2005).*

2b. *A simple logistics management information system (LMIS) should be designed for management of the logistics system, program monitoring, and scheduling of future shipments.* Initial distributions to the service facilities will be calculated using the data available from CMIS and allocated to the facilities. Future supplies should be need-based, and driven by information on quantities dispensed to users and stock on hand.

5.2 Reproductive Health Policies

1. *The Ministry of Labor, Health and Social Affairs (MoLHSA), Department of Public Health should provide leadership for family planning supply issues, policies, and coordination.* A new government was put in place in November 2003 during the *Rose Revolution*. Many of the new deputy ministers, department heads, and senior staff are keen to provide engaged leadership. The MoLHSA is occupied in a number of reforms and HWG staff should regularly provide them with briefings and evidence-based analysis. However, coordination, particularly of supply issues, is an operational matter; and, therefore, should be carried out by the department closest to operational activities of the regions and rayons. Some policy issues, particularly licensing and certification to distribute contraceptives, will need a certain amount of higher-level input, but should eventually be implemented by the Department of Public Health.
2. *The MoLHSA should consider the targeting of free contraceptives to those families who cannot afford to purchase them in the commercial sector.* The provision of free contraceptives is intended to expand availability and use principally among the poorer segments of society, and those without ready access to commercial outlets. Sustainability will eventually depend upon a vibrant commercial sector supply and a recovering economy that will eventually allow more clients to purchase contraceptives. Therefore, it is important to target the supplies to avoid direct competition with the commercial sector. The easiest way to target free supplies to those most at need is to target the free supplies to the rural areas (poorer, less

access) and to towns that are in particular economic distress (such as Chiatura, where many mines have been closed and unemployment is high). The data from the forthcoming 2005 Georgia Reproductive Health Survey (RHS) will help inform policymakers about both where and to what extent this type of targeting should occur.

3. *Make an effort to expand availability of family planning services and supplies to the rural areas.* Currently, women in rural areas have to travel to the rayon level to receive services and supplies, because reproductologists and OB/GYNs are not located in rural areas. There is a potential for training other specialists (theraputists, pediatricians) to provide either family planning services or to resupply clients under the direction of a reproductologist at the rayon level.
4. *Reduce the reported 34 percent importation tariff on condoms to match the importation tariff for other commercial sector pharmaceuticals—currently 5 percent.* The existing tariff rate is probably causing higher prices than would otherwise be found at retail outlets (see section 4.0 tables 4.0 and 4.1). It is recommended that the Abt Associates Policy Advisor, sitting in the MoLHSA, address this issue with ministerial departments.
5. *The MoLHSA should convene a contraceptive availability task force.* This group could be important coordinating multiple donors, and eventually lobby for self-financing of commodities in order to ensure the availability of contraceptives to the families that need them. An example of potential organizations to be represented would be—
 - MoLHSA, both operational and policy levels
 - UNFPA
 - HWG
 - CARE's Policy Project
 - USAID
 - Zhordania Institute
 - CSMA.
6. *Target the existing stocks of Depo-Provera® to selected locations where there is potential demand, as well as a willingness of providers to use the injectable product.* The consultants did not find general acceptance among providers for the use of *Depo-Provera®* as a contraceptive. However, anecdotal reports implied that it may be of high demand among certain populations. This method is very popular in some countries, and could become so in Georgia if carefully introduced. *Depo-Provera®*, as a method, requires careful counseling regarding the disruptions to the menstrual cycle, which almost always occur. Its introduction should be carried out in some pilot areas, and acceptance and continuation carefully monitored. It should be noted that on November 17, 2004, the Food and Drug Administration (FDA) issued an announcement that a *black box* warning would be required on *Depo-Provera®* as a result of two research studies that found decreases in bone mass among users. This situation may make this recommendation irrelevant. USAID/Washington is following the issue closely and will provide further guidance.

5.3 Commercial Sector

1. *Social marketing of the “favorite” brand of condoms should continue.* This brand has proven to be popular and it fills a specific price niche, which expands the affordability of condoms both as a family planning method and to prevent infections. The public health importance of condom use calls for some attention to this issue. The *favorite* brand was previously donated by Population Services International (PSI). Replacement of a source for this condom is a complex undertaking and is beyond the scope of this consultancy.
2. *Social marketing of a new brand of OCs is probably not warranted.* The existing Gedeon-Richter commercial brand—*Rigevidon*—is currently marketed at about \$1.10, which leaves little room for the introduction of a cheaper brand. In fact, it would be impossible to introduce a cheaper brand without a significant subsidy, which is unlikely to be a sustainable option.

6.0 Forecasting Contraceptive Use and Estimating Costs

To determine future consumption of contraceptives, it is often useful to have past consumption data to establish a trend. Past consumption data over time, for example from 1999–2003, indicates the contraceptive prevalence rate (CPR) trends and potential changes in the contraceptive method mix. This data usually takes the form of contraceptive logistics data contained in an LMIS system. In Georgia, an LMIS, effectively, does not exist. Beginning in the mid-1990s, the GOG, with support from the World Bank, began to privatize its health system. The result, intended or not, is the absence of a central procurement mechanism for essential medicines and contraceptives and the lack of incentive, until recently, for a central-level LMIS that captures commodity consumption patterns¹⁰. There has and continues to be contraceptive donations by UNFPA and, as noted earlier, they have recently made efforts to implement a HMIS/LMIS reporting system. However, the contraceptive consumption data reported over the past 12 months (when data was available), has been incomplete. Further, health facilities simply refer patients to commercial pharmacies to purchase contraceptives when their RH cabinets are stocked out—and this use is not captured in any reporting. Therefore, the consultants felt that existing data on use was inadequate as a basis for projections.

6.1 Using Demographic Data to Estimate Contraceptive Consumption

Estimating costs and determining specific procurement schedules first requires estimating trends in future consumption patterns, both in the public and private sectors. Because actual past consumption data is not available, this analysis used demographic or population data to estimate past and future contraceptive consumption. The primary consideration in making the demographic-based forecast was that the accuracy of the forecast is dependent upon making informed assumptions regarding future CPR and TFR. Using 1999 baseline data from the Georgia Reproductive Health Survey (RHS 1999), including CPR, TFR, method mix, rate of abortion, and other variables, a 1999–2010 consumption estimate was developed. The estimate also took into account informed assumptions from a variety of Georgian reproductive health/family planning experts about future changes in CPR, method mix, and decline in the rate of induced abortions. *It should be noted that the use of demographic information, as outdated as the 1999 RHS, introduces a significant amount of potential inaccuracy into the forecasts.* A new RHS is currently being prepared, and results should be available during the first half of 2005. When these results are published, the projections should be revised to reflect the current situation.

Developing demographic-based forecasts requires numerous and complicated calculations to predict consumption patterns. Because of this, The Futures Group International (TFGI) developed a software program called *Spectrum*¹¹ that performs the forecasting calculations and takes into account the impact of projected mortality, women of reproductive age (WRA), and other variables to produce forecasts. The forecasts are only as good as the data that is entered into the program. Assumptions made to develop the following forecasts will need to be regularly reexamined in view of any additional data, notably accurate logistics-based consumption figures.

6.1.1 Contraceptive Users

As mentioned, certain assumptions were made about future CPR and the total induced abortion rate (TAR) in order to estimate the number of contraceptive users. Figure 6.0 illustrates projected CPR, TAR and TFR through 2010. These projections represent CPR and TAR goal assumptions entered into the software program *Spectrum*. Demographic data in the forthcoming 2005 Georgia RHS and other sources may indicate that these assumptions should be revised in the future. However, based on past trends, current data

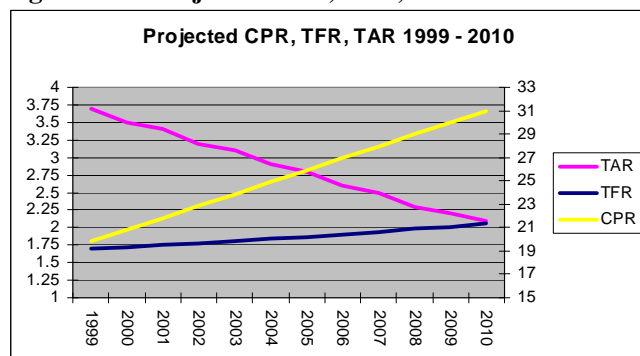
¹⁰ See World Bank country reports, health sector reform documents, and Curatio International Foundation for the rationale and consequences of privatization of the health sector.

¹¹ Contact the Futures Group International in Washington, DC, to request a copy of *Spectrum*. The software can also be downloaded from their website: www.tfgi.com.

and key informants¹², the assumptions were used to estimate the number of contraceptive users. Assumptions entered into *Spectrum* included a 31 percent CPR and 2.2 TAR in 2010. The net effect of these assumptions was an increase in TFR to slightly over replacement level at 2.1, despite the increase in CPR. The projected trends indicate that it is possible to increase both the use of modern contraception and the fertility rate, if the induced abortion rate falls.

The overall projected increase in the use of modern methods of contraceptives is due, of course, to the projected increase in demand for family planning services. Using *Spectrum* analyses, it is estimated that the number of total users will grow from 190,000 in 1999 to nearly 300,000 in 2010. As figure 6.1 illustrates, growth in the number of users will come primarily from the private sector. This is due in large part from the estimation that oral pill sales will become more popular and will be purchased mainly at pharmacies.

Figure 6.0 – Projected CPR, TFR, and TAR 1999–2010

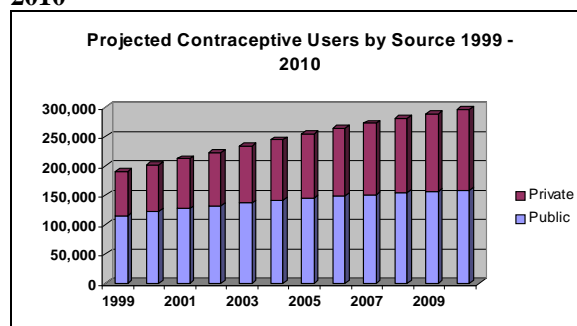


percentage of contraceptives obtained from the public sector decreased from 61 percent to 53 percent between 2004–2010 (see figure 6.1). The previous discussion on ATP is also relevant when looking at the source mix. The affordability analysis indicated that 40 percent of the population of contracepting couples cannot afford to pay retail prices. Yet, currently, 61 percent of users obtain their supplies from the public sector. Although it is beyond the scope of this analysis, questions should be raised if whether the market is segmented in accordance with

MoLHSA policies. The current source mix combined with the ATP analysis provides preliminary conclusions that some clients, possibly up to 20 percent, could be encouraged to move to the private sector.

It is important to note that no assumptions were made about changes to the future source mix. The contraceptive source mix from the 1999 RHS was entered into *Spectrum* and held as a constant through 2010. However, assumptions about method mix included the increased commercial sector demand for oral pills and condoms from 1999 to 2004. As a result, the

Figure 6.1. Contraceptive Users by Source 1999–2010



6.2 Estimating Contraceptive Costs

In 1999, there were an estimated 190,000 users of modern contraceptives in Georgia (RHS, 1999). This figure is expected to rise by nearly 50 percent to 290,000 by the end of 2010. In 1999, the total cost of the four methods proposed for use in the public sector—condoms, IUDs, oral pills, and injectables—amounted to less than \$90,000¹³. Injectable contraceptives did not register any noticeable usage (see table 6.0). The projected increase in the use of modern contraceptive methods to 31 percent in 2010, coupled with the projection that nearly 40 percent of the bottom income earning population cannot afford to pay retail prices, is estimated to result in the total public sector costs rising 58 percent to \$154,000 in the year 2010. In the same year, as illustrated in table 6.0, condoms and injectables will amount to more than two-thirds of the total cost. While the method mix will slowly shift to oral pills and injectables, there will still be more users

¹² GNI has continued to trend upward during from 2000–2004. Historically, this is correlated with a rise in CPR. Key informants and site visits to health facilities confirm the 1999 rate of abortion (3.7) may be trending downward possibly impacting TFR.

¹³ Unit prices used to calculate public sector contraceptive costs are the 2005 USAID prices contained in the *USAID Procurement Guide and Product Catalog 2004*. They are no-logo condom: .0492; Depo-Provera®: .95; Copper T: 1.55 and both Lo-Femenol and Ovrette: .218. These prices are exclusive of a 5.5 percent processing fee and freight charges.

of IUDs and condoms and their cost per CYP is greater than oral pills and injectables, making them less *cost effective* in strict economic terms.¹⁴

Table 6.0. Public Sector Contraceptive Costs by Method 1999–2010

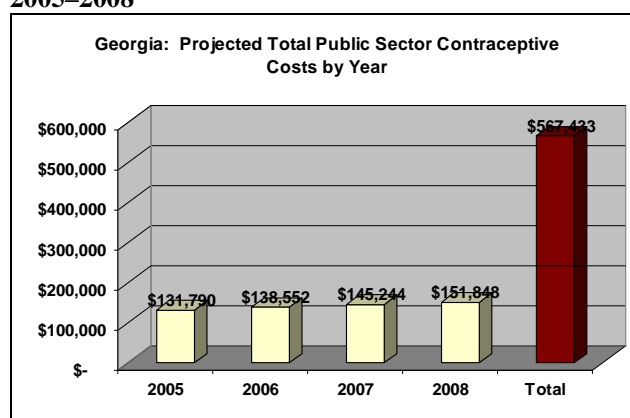
Condom		Injectable		IUD		Pill		Total
1999	\$ 34,475	1999	\$ -	1999	\$ 49,296	1999	\$ 6,066	\$ 89,838
2000	\$ 36,486	2000	\$ -	2000	\$ 48,619	2000	\$ 6,420	\$ 91,526
2001	\$ 38,540	2001	\$ 1,780	2001	\$ 49,707	2001	\$ 7,743	\$ 97,770
2002	\$ 40,571	2002	\$ 3,741	2002	\$ 50,614	2002	\$ 9,161	\$ 104,088
2003	\$ 42,564	2003	\$ 5,880	2003	\$ 51,334	2003	\$ 10,667	\$ 110,446
2004	\$ 44,503	2004	\$ 8,185	2004	\$ 51,872	2004	\$ 12,254	\$ 116,814
2005	\$ 46,374	2005	\$ 10,646	2005	\$ 52,235	2005	\$ 13,913	\$ 123,168
2006	\$ 48,170	2006	\$ 13,252	2006	\$ 52,429	2006	\$ 15,637	\$ 129,488
2007	\$ 49,883	2007	\$ 15,987	2007	\$ 52,456	2007	\$ 17,416	\$ 135,742
2008	\$ 51,507	2008	\$ 18,839	2008	\$ 52,325	2008	\$ 19,243	\$ 141,914
2009	\$ 53,038	2009	\$ 21,793	2009	\$ 52,021	2009	\$ 21,109	\$ 147,960
2010	\$ 54,466	2010	\$ 24,831	2010	\$ 52,133	2010	\$ 23,002	\$ 154,432
TOTAL	\$ 540,576	TOTAL	\$124,934	TOTAL	\$ 615,040	TOTAL	\$162,633	\$ 1,353,346

Determining the total cost on a year-by-year basis for both the private sector is more difficult to estimate. The *Spectrum* projections determined how many contraceptives will be sourced from each sector. For example, in 2006, customers will purchase nearly 9.4 million condoms from the private sector and 938,000 will be dispensed through public clinics. What is not known are the prices, brands, profit margins, various taxes, and other price components to determine the true cost of commercial condoms nor is the specific source of funds known (other than that they are all purchased through out-of-pocket expenditures).

6.2.1 – Medium-Term Public Sector Costs

This report has recommended that USAID/Caucasus procure condoms, IUDs, a COC, and POP for the Georgia public health system between 2005–2008. During this period, a regular review of program effectiveness should occur to revise projections and shipping schedules and determine if it is feasible to continue support beyond 2008. For this timeframe, figure 6.2 illustrates the cost per year based on projected demand. These costs are based on 2005 USAID prices but do not reflect handling and freight charges; expired or damaged products; or the cost to fill the pipeline and maintain minimum stock levels. The cost projection reflecting some of these

Figure 6.2. Projected Public Sector Contraceptive Costs 2005–2008



¹⁴ It should be noted that condoms also offer dual protection from pregnancy and sexually transmitted infection (including HIV/AIDS). Therefore, it is reasonable to assume that the cost effectiveness of condoms can be greater than their cost per CYP.

additional considerations was submitted to USAID/Caucasus as part of the CPT documentation.

7.0 Contraceptive Procurement Tables

The preparation of CPTs and the approval of proposed order quantities by USAID's Contraceptive Security and Logistics Management Division (CSL) are required before orders can be placed. In addition, because USAID/Caucasus is ordering contraceptives for the first time for Georgia, the Mission must ensure that the proposed products are properly registered, by the appropriate regulatory authorities, for use in-country (DELIVER 2004). At the time of this writing, the proposed contraceptives have not been registered by manufacturers with the pharmaceutical regulatory authorities in Georgia. The deputy Minister of Health, Mr. Varlam Mosidze, has pledged his support to expedite the process between the manufacturers and the Ministry's pharmaceutical department. JSI/HWG and JSI/DELIVER, USAID/Washington, and USAID/Caucasus are also supporting this process. As mentioned before, the preparation of the CPTs was based largely on population or demographic data entered into the *Spectrum FAMPLAN* module. The selection of demographic-based forecasts to estimate past and future consumption was necessitated by the absence of consumption data and any LMIS infrastructure.

As of November 2004, all public facilities were stocked out of COCs and POPs. The stock of condoms and IUDs is mixed, with many facilities either stocked out or below what would routinely be considered a minimum level.¹⁵ It is, therefore, a priority to begin the ordering and shipment process of the following contraceptives to minimize the negative impact on clients of current stock levels in the MoLHSA's family planning program.

Product	Proposed Quantity	Months Of Stock	Receipt Date
• Condom: 52 mm no logo	1,096,000	17	03/31/05
• IUD: Copper T	34,000	16	03/31/05
• COC: Lo-Femenal	55,000	17	03/31/05
• POP: Ovrette	17,000	17	03/31/05

Taking into account the necessary lead time detailed in USAID's procurement guidance, and the relative urgency and limited quantities of the first order, the proposed receive date entered into the *PipeLine* software shipment schedule is *March 31, 2005* (see appendix 3 for a summary of the proposed shipment schedule (2005–2008). *Also, in appendix 2, you will find the completed CPTs for the above products.* It is likely, even anticipated, that modifications will occur in the second 2005 proposed shipment or in 2006. It should be noted that the dispensed data column in the CPTs was based on projections, not on past consumption. Therefore, the small quantities indicated as *shortfall* or *surplus* in the CPTs require no immediate action until consumption patterns can be verified in 2005 through the introduction of a basic LMIS.

Another source of data that will inform modifications to the proposed shipment quantities (and methods) is the *2005 Georgia Reproductive Health Survey*. The survey is expected to be completed in early 2005, with preliminary results available in the spring. At that time, JSI/DELIVER will be able to verify the CPR, TFR, method, and source mix assumptions used in the original *Spectrum* forecasts. It is certain that the 2005 Survey will suggest that changes be made to the estimated consumption forecasts and, therefore, order quantities. For procurement purposes, this data will need to be reconciled with any LMIS data the system is able to generate at that time.

Finally, one more factor that may cause a change in the order schedule and/or quantities ordered is the potential continuation of UNFPA contraceptive procurements. UNFPA oral pills, condoms, and IUDs may possibly arrive in Georgia for use by public health facilities (through distribution by UNFPA RH MTs) sometime in 2005. Preceding this arrival, both UNFPA and USAID should coordinate quantities, methods, and shipments, with technical input from JSI to ensure the appropriate method mix and to avoid any stock imbalances.

¹⁵ All oral pills expired in October 2004. Stock status of IUDs and condoms were estimated with select field visits to 9 public facilities in 3 regions and through key informant discussions.

8.0 Next Steps

- *USAID/Tbilisi should immediately place orders for combined orals, progestin-only orals, condoms, and IUDs.* CSL has been notified and the orders have been entered into NEWVERN.
- *The products to be ordered by USAID must be registered in Georgia.* The consultants have asked that CSL contact the manufacturers. This has occurred and the process has been started. The Deputy Minister of Health assured the consultants that this would be managed expeditiously by the Ministry of Health (MOH).
- *The HWG Project should hire a contraceptive security and logistics advisor.* The scope of work for this employee is attached as appendix 8. This person should be housed in the MoLHSA offices, either with the Care Policy Advisor or in the Offices of the Department of Public Health.
- *A follow-up logistics assessment should be programmed to precede the arrival of the USAID supplies.* The scope of work for this visit would include (a) review of the CPTs, (b) development of a plan for initial supplies to all facilities, and (c) design of the logistics system and the LMIS. An excellent option would be to have the JSI logistics advisor in the Romanian bilateral project participate in this visit, which would enable him to provide follow-up assistance.

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<http://devdata.worldbank.org/hnpstats/>

Appendices

Appendix 1 - List of Key Contacts

- **USAID/Caucasus**
 - Tamara Sirbiladze, CTO
- **JSI HWG Project**
 - Nancy Harris, Interim CTO
 - Sharon Epstein, Outgoing CTO
 - Nino Berdzuli, Clinical Coordinator
- **Ministry of Labor, Health and Social Affairs (MOLHSA)**
 - Varlam Mosidze, Deputy Minister
 - Zaza Bokhua, deputy head dept. of health policy
 - Levan Baramidze, Head of public health department
- **Caucasus Social Marketing Association (CSMA)**
 - Irakli Khvedelidze, director
- **Curatio International Foundation**
 - Ketevan Chkhatarashvili, President
- **Zhordania Institute of Human Reproduction**
 - Archil G. Khomassuridze, Director
- **Gedeon Richter¹⁶**
 - Zaza Charkviani, Director
- **Aversi Pharmaceuticals**
- **UNFPA**
 - Tamar Khomasuridze, Interim Country Representative
- **Kutaisi Maternity Hospital**
 - Leri Khonelidze, Director and Head UNFPA Mobile Team
- **Center for Medical Information and Statistics (CMIS)**
 - Marina Shakhnazarova, Head, division of data analysis
 - Manana Tsintsadze, Deputy Director
 - Maia Kereselidze, head, dept. of health statistics
- **Georgian Obstetrics and Gynecology Association**
 - Tengiz Asatiani, President
- **Maternity House of Zestaphoni**
 - Dr. Kote Botchorishvili, Head Gynecology
- **Kutaisi Women's Wellness Center**
 - Dr. Lali Gvetadze, Director
- **Chiarua Maternity Combined Facility**
 - Dr. Tsiuri Savalitze, Chief Doctor
 - Dr. Miranda Jankhotali, Reproductologist
- **Telavi Women's Consultation Center**

¹⁶ GR is a Hungarian pharmaceutical manufacturer that imports oral pills and other products to the Georgian market.

- **Save the Children, Georgia**
- Larry Dershem

Appendix 2 - Contraceptive Procurement Tables 2005–2008

Procurement Table - No Logo Condom									
Pipeline 3					Run Date: 06-Nov-04				
Republic of Georgia					Run Time: 11:20 PM				
MoLHSA					Page 1 of 1				
Prepared By: rrao					Desired Months of Stock Min=10 Max=18 End of Year=17				
Date Prepared: 06-Nov-2004									
Product: No Logo 52 mm non-colored condom					(All Numbers in Thousands)				
					2004	2005	2006	2007	2008
1	Beginning of Year Stock				0.0	392.6	1,207.2	1,345.5	1,390.7
2	Received/Expected								
	(a) Received								
	(b) Expected					1,708.0	1,066.30	1,006.2	924.3
	(c.)Transfers/Adjustments in				1,250.0	0.0	0.0	0.0	0.0
3	Estimated Dispensed								
	(a) Dispensed to Users				857.4	893.4	928.0	961.0	992.3
	(b) Losses/Transfers Out				0.0	0.0	0.0	0.0	0.0
	(c.) Adjustments Out				0.0	0.0	0.0	0.0	0.0
4	End of Year Stock (EYOS)				392.6	1,207.2	1,345.5	1,390.7	1,322.7
5	Desired EYOS						1,361.4	1,405.8	1,405.8
6	Net Supply Situation								
	(a) Surplus								
	(b) Quantity Needed						15.9	15.1	83.1
7	Quantity Proposed						0.0	0.0	0.0
8	Supply Shortfall						15.9	15.1	83.1

Procurement Table Copper T

Pipeline 3

Run Date: 06-Nov-04

Republic of Georgia

Run Time: 11:20 PM

MoLHSA

Page 1 of 1

Prepared By: rrao

Date Prepared: 06-Nov-2004

**Desired Months of Stock
Min=10 Max=18 End of Year=17**

Product: Copper T (IUD)

(All Numbers in Thousands)

					2004	2005	2006	2007	2008
1	Beginning of Year Stock				0.0	18.3	45.4	37.3	45.2
2	Received/Expected								
	(a) Received								
	(b) Expected					59.0	24.00	40.0	32.00
	(c.) Transfers/Adjustments in				50.0	0.0	0.0	0.0	0.0
3	Estimated Dispensed								
	(a) Dispensed to Users				31.7	31.9	32.1	32.1	32
	(b) Losses/Transfers Out				0.0	0.0	0.0	0.0	0.0
	(c.) Adjustments Out				0.0	0.0	0.0	0.0	0.0
4	End of Year Stock (EYOS)				18.3	45.4	37.3	45.2	45.2
5	Desired EYOS						45.4	45.3	45.3
6	Net Supply Situation								
	(a) Surplus								
	(b) Quantity Needed						8.1	0.1	0.1
7	Quantity Proposed						0.0	0.0	0.0
8	Supply Shortfall						8.1	0.1	0.1

Procurement Table - Lo-Femenal

Pipeline 3

Run Date: 06-Nov-04

Republic of Georgia

Run Time: 11:20 PM

MoLHSA

Page 1 of 1

Prepared By: rrao

Date Prepared: 06-Nov-2004

**Desired Months of Stock
Min=10 Max=18 End of Year=17**

Product: Lo-Femenal (COC)

(All Numbers in Thousands)

					2004	2005	2006	2007	2008
1	Beginning of Year Stock				0.0	27.4	69.3	84.7	89.3
2	Received/Expected								
	(a) Received								
	(b) Expected					90.3	69.80	65.2	74.80
	(c.) Transfers/Adjustments in				70.0	0.0	0.0	0.0	0.0
3	Estimated Dispensed								
	(a) Dispensed to Users				42.6	48.4	54.4	60.6	66.9
	(b) Losses/Transfers Out				27.4	0.0	0.0	0.0	0.0
	(c.) Adjustments Out				0.0	0.0	0.0	0.0	0.0
4	End of Year Stock (EYOS)					69.3	84.7	89.3	97.2
5	Desired EYOS						85.8	94.8	94.8
6	Net Supply Situation								
	(a) Surplus								
	(b) Quantity Needed						1.1	5.5	-2.4
7	Quantity Proposed						0.0	0.0	0.0
8	Supply Shortfall						1.1	5.5	-2.4

Procurement Table - Ovrette

Pipeline 3

Run Date: 06-Nov-04

Republic of Georgia

Run Time: 11:20 PM

MoLHSA

Page 1 of 1

Prepared By: rrao

Date Prepared: 06-Nov-2004

**Desired Months of Stock
Min=10 Max=18 End of Year=17**

Product: Ovrette (POP)

(All Numbers in Thousands)

			2004	2005	2006	2007	2008
1	Beginning of Year Stock		0.0	3.3	15.0	20.4	22.8
2	Received/Expected						
	(a) Received						
	(b) Expected			23.8	19.0	17.5	17.60
	(c.) Transfers/Adjustments in		14.0	0.0	0.0	0.0	0.0
3	Estimated Dispensed						
	(a) Dispensed to Users		10.7	12.1	13.6	15.1	16.7
	(b) Losses/Transfers Out		0.0	0.0	0.0	0.0	0.0
	(c.) Adjustments Out		0.0	0.0	0.0	0.0	0.0
4	End of Year Stock (EYOS)		3.3	15.0	20.4	22.8	23.7
5	Desired EYOS				21.5	23.7	23.7
6	Net Supply Situation						
	(a) Surplus						
	(b) Quantity Needed				1.1	0.9	0.0
7	Quantity Proposed				0.0	0.0	0.0
8	Supply Shortfall				1.1	0.9	0.0

Appendix 3 - Pipeline Proposed Shipment Schedule 2005–2008

Shipment Summary by Supplier

Report Period: Jan 2005 - Dec 2008
1 of 1

Run Date: 11-Nov-04

Page: Run Time:

Republic of GeorgiaMoLHSA
12:39 AM

Category: ALL
Supplier: USAID
Status: Ordered, Planned, Received, Shipped

Supplier

Type	-----Costs-----						
Product	Receipt Date	Quantity	Status	ID	Product	Freight	Total
USAID							
Condoms							
No Logo 52 mm	31-Mar-05	1,096,412	Planned	104	57,013	3,991	61,004
No Logo 52 mm	30-Nov-05	611,936	Planned	105	31,821	2,227	34,048
No Logo 52 mm	30-Jun-06	571,151	Planned	106	29,700	2,079	31,779
No Logo 52 mm	31-Dec-06	495,150	Planned	83	25,748	1,802	27,550
No Logo 52 mm	30-Jun-07	496,116	Planned	86	25,798	1,806	27,604
No Logo 52 mm	31-Dec-07	510,056	Planned	87	26,523	1,857	28,380
No Logo 52 mm	31-May-08	428,233	Planned	88	22,268	1,559	23,827
No Logo 52 mm	30-Nov-08	496,169	Planned	89	25,801	1,806	27,607
Intrauterine Device							
Copper T	31-Mar-05	34,000	Planned	29	55,590	3,891	59,481
Copper T	31-Dec-05	25,020	Planned	96	40,908	2,864	43,771
Copper T	30-Sep-06	24,116	Planned	97	39,430	2,760	42,190
Copper T	30-Jun-07	24,069	Planned	98	39,353	2,755	42,108
Copper T	31-Dec-07	15,972	Planned	99	26,114	1,828	27,942
Copper T	30-Jun-08	15,945	Planned	100	26,070	1,825	27,895
Copper T	31-Dec-08	16,104	Planned	101	26,330	1,843	28,173
Orals - Combined							
Lo-Femenal	31-Mar-05	55,200	Planned	48	12,034	842	12,876
Lo-Femenal	30-Nov-05	35,086	Planned	49	7,649	535	8,184
Lo-Femenal	31-May-06	32,376	Planned	50	7,158	501	7,659
Lo-Femenal	31-Dec-06	37,523	Planned	51	8,296	581	8,877
Lo-Femenal	06-Jun-07	36,000	Planned	52	7,960	557	8,517
Lo-Femenal	31-Dec-07	29,259	Planned	102	6,469	453	6,922
Lo-Femenal	30-Jun-08	38,843	Planned	103	8,588	601	9,189
Lo-Femenal	31-Dec-08	36,000	Planned	53	7,960	557	8,517
Orals - Progestin only							
Ovrette	31-Mar-05	16,814	Planned	56	3,665	257	3,922
Ovrette	31-Oct-05	7,073	Planned	67	1,542	108	1,650
Ovrette	30-Apr-06	9,600	Planned	58	2,123	149	2,271
Ovrette	31-Dec-06	9,395	Planned	40	2,077	145	2,223
Ovrette	30-Jun-07	8,495	Planned	90	1,878	131	2,010
Ovrette	31-Dec-07	9,069	Planned	91	2,005	140	2,146
Ovrette	30-Jun-08	9,112	Planned	92	2,015	141	2,156
Ovrette	31-Dec-08	8,472	Planned	93	1,873	131	2,004

Appendix 4 - USAID Contraceptive Procurement Guidance

The proposed procurement of contraceptives through the USAID/Caucasus Mission for Georgia's public health program represents significant support for the availability of contraceptives in the country. The 2005 – 2008 CPTs completed by JSI and the Mission have formed the basis from which to develop an ordering schedule. The following guidance, adapted from past procurement guidance,¹⁷ represents the key steps that need to occur before product can arrive in-country.

Contraceptive Procurement Timeline

- 1.1 Typically, 2005 CPTs should be done between October, 2004 and March, 2005
- 1.2 In January of 2005 CSL reviews the projected needed quantities and determines the actual funding levels necessary to procure 2005 quantities (including ordering processing fee and freight). The Missions' contraceptive account balance will be taken into account.
- 1.3 In February CSL will send the information in 1.2 to the Mission in a "snapshot" report. The Mission will then decide the level of funding to allocate to central contraceptive procurement by the end of March, 2005.

(Note: The proposed receipt date of March 31, 2005 for the first shipment of contraceptives does not provide the typical lead time CSL requests to process orders. It is likely that the process will need to be expedited to receive product on the proposed date and address the supply public sector supply shortfall)

Transferring Required Funds

- 2.1 All funding requests for shipments through calendar year 2005 (CY2005) must be submitted to the central contraceptive procurement system during fiscal year 2004 (FY2004). This will give the Commodities Security and Logistics Division (CSL) enough time to set production levels for CY2005 and to plan the obligation of funds.

Missions provide funds for contraceptive procurement through any mechanism permitted by reengineering. Funds already obligated by Missions (MAARD funds) can be provided under the conditions outlined in section II (see 2004 USAID Procurement Catalog). Direct all funds for contraceptive procurement to the Central Contraceptive Procurement Project, 936-3057. Missions that provide funding for contraceptives, including field support funding, should advise CSL by e-mail of their funding source and how funds will be transmitted.

- 2.2 Annually, CSL will also advise Missions of the surcharge percentage they will be assessed to cover system costs, including—
 - Inland transportation to the USAID warehouse and warehousing of USAID products.
 - Quality assurance monitoring and independent quality surveillance of contraceptive manufacturers.
 - Management and maintenance of the central contraceptive procurement database (NEWVERN).

The surcharge is a percentage of the total value of the commodities, adjusted annually based on actual charges. The surcharge value must be included in the funds transferred to CSL each year, and is charged to the Mission for each shipment made. The charge is reflected in the Mission's Statement of Contraceptive Account. The surcharge for products shipped in CY 2005 is approximately 5.5 percent of product unit price.

- 2.3 Summary of funding action:

¹⁷ Adapted in large part from the USAID Procurement Guide and Product Catalog, 2004.

1. Confirm funding levels.

Review funding estimates for contraceptive procurement based on the last CPT. CSL may ask you to clarify any revisions. Funding estimates must include the cost of contraceptives, freight, and surcharge.

2. Consider current contraceptive account balance.

Review your current contraceptive account balance before calculating funds needed for new contraceptive shipments. Look at the account balance after all shipments are scheduled to ship through the end of CY2005, and adjust your FY2004 funding as needed.

3. Make funds available for contraceptive procurement.

Take the steps required to make funds available for central contraceptive procurement, either through the field support funding mechanism or through a MAARD (for funds obligated by the Mission).

Ordering Contraceptives

3.1 The completion and submission of a CPT does not, by itself, result in an order for contraceptives in USAID's Central Contraceptive Procurement (CCP) system. The orders resulting from the CPTs are not processed until CSL receives your order e-mail. To order contraceptives, send an order to the attention of your country backstop at CSL (Joan Robertson), by e-mail.

3.2 *A complete order contain(s) the following information:*

- Product being requested.
- Quantity being requested.
- Anticipated arrival date.
- Mode of shipment (air or sea)
- If the shipment should go door-to-door or door-to-port (door-to-door costs more for the Mission)
- Recipient information.
- Who should receive copies of the shipping documents (usually USAID and the recipient)
- If there is special documentation needed (donation certificate, certificate of analysis, etc.)
- Instructions about any deviations from standard shipping instructions.

Note: Sample order e-mail, CPTs and 2005 proposed products and quantities have been developed.

3.3 Lead-time:

- Since most sea shipments take two to three months, and CSL needs time to process your order and assemble your commodities, try to order at least six months before the needed arrival date. We try to respond to shorter lead times, but you are more likely to receive what you need, when you need it, if we have more time.
- Completed CPTs include a proposed shipping schedule for the commodities needed. After approving the CPTs, the Mission should check the current contraceptive account balance to determine the total additional funding needed. Funding should cover the value of all new shipments, as well as any shortfall for existing shipments. The Mission must send a contraceptive order e-mail to the country backstop at CSL.

Tracking shipments and Receipt of Products

4.1 Orders are entered when CPTs and the accompanying order e-mail are received and approved by CSL.

After orders are entered, CSL will send regular monthly cables with information about pending contraceptive shipments for recipients in your country. The cables include sections listing—

- Orders scheduled to ship in the next six months.
- Shipments that have departed and are awaiting receipt confirmation.
- Notification of shipments that shipped 12 months ago for which shipment status has not been obtained.
- Shipments to your country charged to other agencies or cooperating agencies (CA).

Unless the Mission responds otherwise, 12-month-old shipments will be marked received-in-full on the estimated receipt date.

4.2 *Acknowledging Receipt of Shipments*

For the final step in the ordering process, USAID/W sends a Receiving Report to Missions requesting confirmation of receipt of shipments.

A Receiving Report is faxed to the Mission. If fax does not transmit, the receiving report is sent by pouch and a copy of the export invoice (or commercial invoice), packing list, and bill of lading is attached.

The Receiving Report requests that the Mission that placed the order verify the arrival of the shipment and return a copy of the memo by e-mail, fax, or mail to John Snow, Inc., at the following address:

*Attn: NEWVERN
JSI/DELIVER
1616 North Fort Myer Drive, 11th Floor
Arlington, VA 22209
USA
FAX: 703-528-7480
E-mail: newvern@jsi.com*

Appendix 5 - Logistics System Design

Privatization of the Georgian health sector has resulted in the devolution of regulatory oversight and budgetary responsibilities away from the central level to the regions, rayons (districts), and health outposts. The consequence of privatization regarding the delivery and availability of public health commodities has been the absence of central-level procurement and distribution of many essential medicines, including contraceptives. Currently, aside from the proposed USAID contraceptive procurements, the sole source of supply for public sector consumption is the contraceptive distribution by UNFPA reproductive health MTs. As these distributions have decreased in facilities throughout Georgia; women typically must purchase products at pharmacies with the advice of the attending OB/GYN or reproductologist. It is unclear when additional UNFPA contraceptives will arrive. However, prior to the proposed arrival of USAID contraceptives in March 2005, an agreement on a basic contraceptive distribution system will need to be made to ensure contraceptive availability to public sector clients.

Discussions between the consultant team and Dr. Levan Baramidze, Head Department of Public Health for the MoLHSA, resulted in the following preliminary system design decisions:

- Central-level warehouse space will be made available by the MoLHSA for USAID contraceptives.
- A preliminary decision was made by MoLHSA to use the existing EPI delivery system, including transportation and funds for fuel, to *push* contraceptive stock to regional warehouses located in Tbilisi, Kutaisi, and Telavi.
- The nearly 100 district (rayon)-level facilities, including city hospitals and other combined facilities above the health post level, will use existing EPI transportation to *pull* contraceptives to their RH cabinets and try to ensure an adequate stock level.
 - A follow-up by JSI consultants will probably be necessary to help examine and increase the quality of CMIS data reported from the facilities. This data, if accurate, will assist in the development of minimum and maximum facility stock levels. However, it is an unknown what form a future LMIS will take.
 - It has been recommended that a logistics system design workshop take place early in the first quarter of 2005 to make final decisions about the distribution system. These efforts will likely focus on decisions regarding the numbers of tiers in the system, reporting forms, the benefits of push and pull systems, and the feasibility of building on the existing CMIS system to obtain consumption, stock, and adjustments data.

Appendix 6 - List of Commercial Pharmacy Prices, Brands, and Location

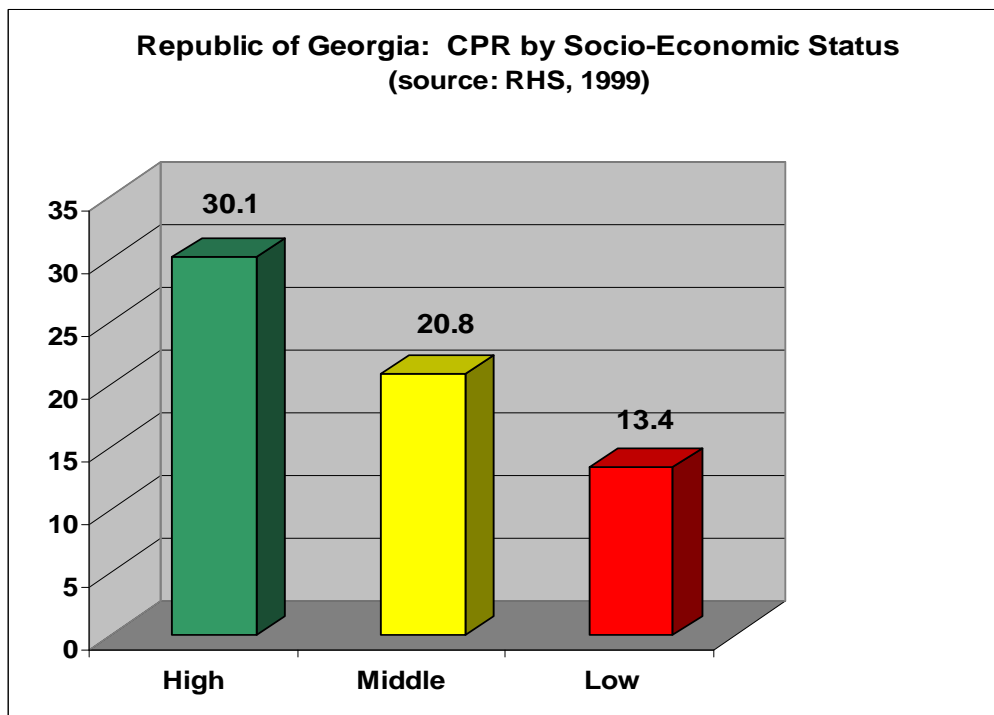
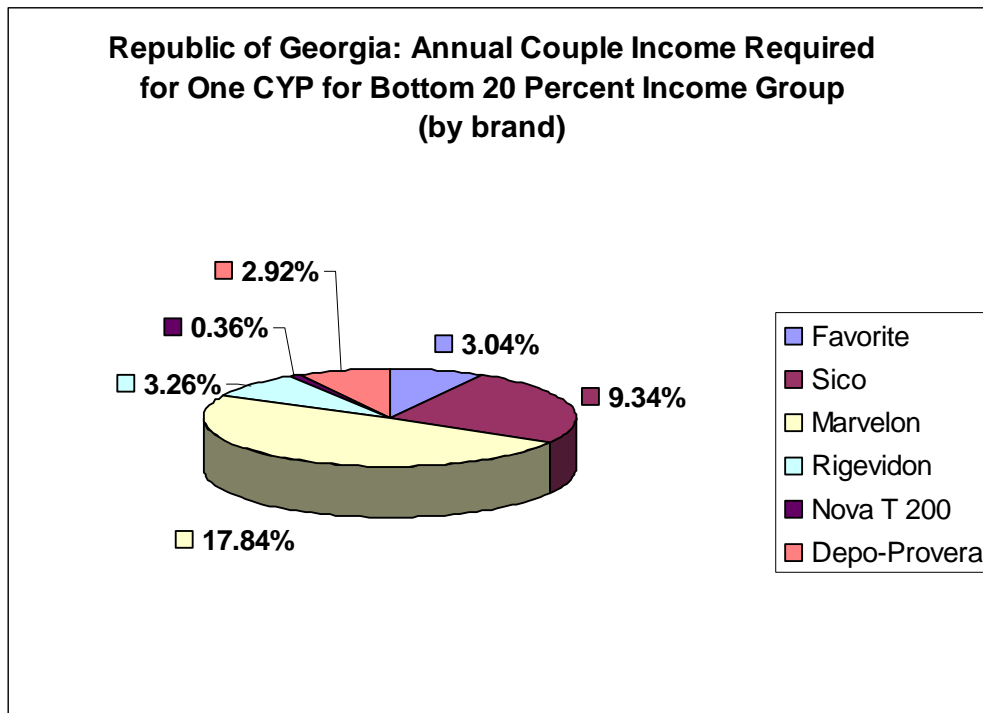
Method	Brand	Price Per Pack (GEL)	Unit Price (GEL)	Unit Price \$USD	Region	City	U,R (P)	Facility	Monthly Dispense	Stock
Condom	Bumper	1	0.33	0.18	Kakheti	Sagarejo	R	18		
Condom	Carex	4	0.33	0.18	Kakheti	Sagarejo	R	18		
Condom	Classic	1	0.33	0.18	Ajara	Kobuleti	PU	15	813	
Condom	Deluxe	0.45	0.15	0.08	Tbilisi	Tbilisi	U	13	600	
Condom	Deluxe	0.6	0.20	0.11	Imereti	Zestaphoni	PU	3		
Condom	Deluxe	1	0.33	0.18	Imereti	Zestaphoni	PU	1		
Condom	Deluxe	1.5	0.50	0.28	Tbilisi	Tbilisi	U	8		
Condom	Durex	3.5	1.17	0.64	Ajara	Batumi	U	16		
Condom	Durex	3.55	1.18	0.65	Tbilisi	Tbilisi	U	7		
Condom	Durex	3.65	1.22	0.67	Tbilisi	Tbilisi	U	6		
Condom	Durex	3.65	1.22	0.67	Tbilisi	Tbilisi	U	13		
Condom	Durex	4.5	1.50	0.83	Tbilisi	Tbilisi	U	9		
Condom	Durex	6	2.00	1.10	Tbilisi	Tbilisi	U	8		
Condom	Esteem	0.8	0.27	0.15	Kakheti	Sagarejo	R	18		
Condom	Esteem	1	0.33	0.18	Imereti	Zestaphoni	PU	1	3	
Condom	Esteem	1	0.33	0.18	Imereti	Zestaphoni	PU	2		
Condom	Favorite	0.7	0.23	0.13	Tbilisi	Tbilisi	U	6		
Condom	Favorite	0.7	0.23	0.13	Tbilisi	Tbilisi	U	13	600	
Condom	Favorite - B	0.4	0.40	0.22	Imereti	Zestaphoni	PU	1		
Condom	Generic-R	0.5	0.17	0.09	Imereti	Chiatura	PU	11		
Condom	Harmony	5	0.42	0.23	Kakheti	Gurjaani	PU	19		
Condom	Imotex	4.5	1.50	0.83	Tbilisi	Tbilisi	U	7		
Condom	Kaif	1	0.33	0.18	Imereti	Samtredia	PU	14	30	
Condom	Lifestyle	1.9	0.63	0.35	Ajara	Batumi	U	16		
Condom	Masculine	1.05	0.35	0.19	Tbilisi	Tbilisi	U	13		
Condom	Masculine	1.65	0.55	0.30	Tbilisi	Tbilisi	U	6		
Condom	Masculine	1.7	0.57	0.31	Imereti	Kutaisi	U	5		
Condom	Masculine	2	0.67	0.37	Tbilisi	Tbilisi	U	9		
Condom	Masculine	3.6	1.20	0.66	Tbilisi	Tbilisi	U	7		
Condom	Sico	2	0.67	0.37	Tbilisi	Tbilisi	U	7		
Condom	Sico	2	0.67	0.37	Imereti	Zestaphoni	PU	2		
Condom	Sico	2	0.67	0.37	Tbilisi	Tbilisi	U	10	250	
Condom	Sico	2	0.67	0.37	Tbilisi	Tbilisi	U	17		
Condom	Sico	2	0.67	0.37	Kakheti	Gurjaani	PU	19		
Condom	Sico	2.1	0.70	0.39	Imereti	Zestaphoni	U	1		
Condom	Sico	2.1	0.70	0.39	Imereti	Samtredia	PU	14	90	

Method	Brand	Price Per Pack (GEL)	Unit Price (GEL)	Unit Price \$USD	Region	City	U,R (P)	Facility	Monthly Dispense	Stock
Condom	Sico	2.15	0.72	0.40	Imereti	Kutaisi	U	5		
Condom	Sico	2.5	0.83	0.46	Imereti	Zestaphoni	PU	3		
Condom	Sico	2.5	0.83	0.46	Kakheti	Sagarejo	R	18		
Condom	Sico	2.6	0.87	0.48	Ajara	Kobuleti	PU	15		
Condom	Sico	2.6	0.87	0.48	Ajara	Kobuleti	PU	15	488	
Condom	Sico	3	1.00	0.55	Imereti	Kutaisi	U	4	90	
Condom	Sico	3	1.00	0.55	Tbilisi	Tbilisi	U	8		
Condom	Sico	3	1.00	0.55	Tbilisi	Tbilisi	U	9		
Condom	Unidus	0.2	0.20	0.11	Imereti	Chiatura	PU	11		
Condom	Vulcan	2	0.67	0.37	Imereti	Kutaisi	U	5		
Condom					Imereti	Chiatura	R	12		0
EC	Postinor	4.5	4.50	2.49	Imereti	Zestaphoni	PU	3		
EC	Postinor	4.5	4.50	2.49	Imereti	Kutaisi	U	4		
EC	Postinor	4.6	4.60	2.54	Tbilisi	Tbilisi	U	6		
EC	Postinor	4.6	4.60	2.54	Tbilisi	Tbilisi	U	13		
EC	Postinor	4.6	4.60	2.54	Ajara	Batumi	U	16	1	
EC	Postinor	5	5.00	2.76	Tbilisi	Tbilisi	U	9		
EC	Postinor	6	6.00	3.31	Kakheti	Sagarejo	R	18		
Injectable	Depo-Provera®	3.65	3.65	2.02	Tbilisi	Tbilisi	U	17		
Injectable	Depo-Provera®	6.71	6.71	3.71	Ajara	Batumi	U	16		
Injectable	Depo-Provera®	6.75	6.75	3.73	Tbilisi	Tbilisi	U	7		
Injectable	Depo-Provera®	7.5	7.50	4.14	Imereti	Chiatura	PU	11		
IUD	Nova T 200	6.3	6.30	3.48	Tbilisi	Tbilisi	U	17		
IUD	Nova T 200	11.6	11.60	6.41	Ajara	Batumi	U	16		
IUD	Nova T 200	14	14.00	7.73	Imereti	Samtredia	PU	14		
IUD	Pregna 38A	3.5	3.50	1.93	Ajara	Kobuleti	PU	15	7	
Pill	Diane-35	4.5	4.50	2.49	Imereti	Kutaisi	U	4		
Pill	Diane-35	12.6	12.60	6.96	Imereti	Kutaisi	U	5		
Pill	Diane-35	12.6	12.60	6.96	Tbilisi	Tbilisi	U	6		
Pill	Diane-35	12.6	12.60	6.96	Tbilisi	Tbilisi	U	13		
Pill	Diane-35	12.6	12.60	6.96	Ajara	Batumi	U	16	2	
Pill	Diane-35	12.6	12.60	6.96	Tbilisi	Tbilisi	U	17		
Pill	Diane-35	12.7	12.70	7.02	Tbilisi	Tbilisi	U	7		
Pill	Diane-35	13.6	13.60	7.51	Imereti	Samtredia	PU	14		
Pill	Diane-35	14	14.00	7.73	Imereti	Zestaphoni	PU	3		
Pill	Diane-35	14.5	14.50	8.01	Tbilisi	Tbilisi	U	9		

Method	Brand	Price Per Pack (GEL)	Unit Price (GEL)	Unit Price \$USD	Region	City	U,R (P)	Facility	Monthly Dispense	Stock
Pill	Diane-35	15	15.00	8.29	Kakheti	Sagarejo	R	18		
Pill	Jeanine	8.6	8.60	4.75	Tbilisi	Tbilisi	U	17		
Pill	Jeanine	15.8	15.80	8.73	Imereti	Kutaisi	U	5		
Pill	Logest	11.95	11.95	6.60	Tbilisi	Tbilisi	U	7		
Pill	Logest	13	13.00	7.18	Tbilisi	Tbilisi	U	6		
Pill	Logest	13	13.00	7.18	Tbilisi	Tbilisi	U	13		
Pill	Marvelon	5.9	5.90	3.26	Tbilisi	Tbilisi	U	17		
Pill	Marvelon	8	8.00	4.42	Imereti	Chiatura	PU	11		
Pill	Marvelon	10.8	10.80	5.97	Imereti	Kutaisi	U	5		
Pill	Marvelon	10.95	10.95	6.05	Tbilisi	Tbilisi	U	7		
Pill	Marvelon	12	12.00	6.63	Tbilisi	Tbilisi	U	8		
Pill	Marvelon	12	12.00	6.63	Tbilisi	Tbilisi	U	9		
Pill	Marvelon	12	12.00	6.63	Imereti	Chiatura	PU	11		0
Pill	Microgynon	3.3	3.30	1.82	Tbilisi	Tbilisi	U	17		
Pill	Nonovion	5.3	5.30	2.93	Imereti	Kutaisi	U	4	4	
Pill	Nonovion	5.8	5.80	3.20	Imereti	Kutaisi	U	5		
Pill	Nonovion	5.8	5.80	3.20	Tbilisi	Tbilisi	U	10		
Pill	Nonovion	7	7.00	3.87	Kakheti	Sagarejo	R	18		
Pill	Nonovion	11.5	11.50	6.35	Kakheti	Gurjaani	PU	19		
Pill	Ovidon	3	3.00	1.66	Imereti	Kutaisi	U	5		
Pill	Ovidon	3	3.00	1.66	Ajara	Batumi	U	16		
Pill	Ovidon	3.05	3.05	1.69	Tbilisi	Tbilisi	U	7		
Pill	Ovidon	3.05	3.05	1.69	Tbilisi	Tbilisi	U	10		
Pill	Ovidon	3.2	3.20	1.77	Imereti	Samtredia	PU	14		
Pill	Ovidon	3.4	3.40	1.88	Tbilisi	Tbilisi	U	9		
Pill	Ovidon	3.6	3.60	1.99	Imereti	Zestaphoni	PU	3	2	
Pill	Ovidon	3.6	3.60	1.99	Ajara	Kobuleti	PU	15		
Pill	Ovidon	4	4.00	2.21	Kakheti	Sagarejo	R	18		
Pill	Rigevidon	1.9	1.90	1.05	Imereti	Kutaisi	U	5		
Pill	Rigevidon	1.9	1.90	1.05	Ajara	Batumi	U	16	15	
Pill	Rigevidon	2	2.00	1.10	Tbilisi	Tbilisi	U	8		
Pill	Rigevidon	2	2.00	1.10	Tbilisi	Tbilisi	U	9		
Pill	Rigevidon	2	2.00	1.10	Tbilisi	Tbilisi	U	10	10	
Pill	Rigevidon	2	2.00	1.10	Imereti	Chiatura	PU	11		0
Pill	Rigevidon	2	2.00	1.10	Imereti	Samtredia	PU	14	5	
Pill	Rigevidon	2	2.00	1.10	Kakheti	Gurjaani	PU	19		
Pill	Rigevidon	2.3	2.30	1.27	Imereti	Zestaphoni	U	3	3	
Pill	Rigevidon	2.4	2.40	1.33	Ajara	Kobuleti	PU	15		
Pill	Rigevidon	3	3.00	1.66	Kakheti	Sagarejo	R	18		

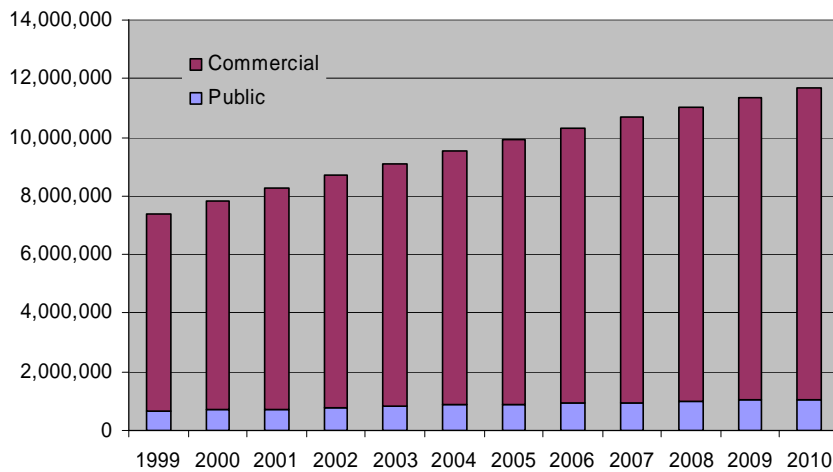
Method	Brand	Price Per Pack (GEL)	Unit Price (GEL)	Unit Price \$USD	Region	City	U,R (P)	Facility	Monthly Dispense	Stock
Pill	Rigevidon	3.05	3.05	1.69	Tbilisi	Tbilisi	U	7		
Pill	Triregol	1.73	1.73	0.96	Ajara	Batumi	U	16		
Pill	Triregol	1.9	1.90	1.05	Kakheti	Gurjaani	PU	19		
Pill	Triregol	2	2.00	1.10	Imereti	Samtredia	PU	14		
Pill	Triregol	2.2	2.20	1.22	Ajara	Kobuleti	PU	15		
Pill	Triregol	3.05	3.05	1.69	Tbilisi	Tbilisi	U	7		

Appendix 7 - Additional Pricing and Affordability Figures

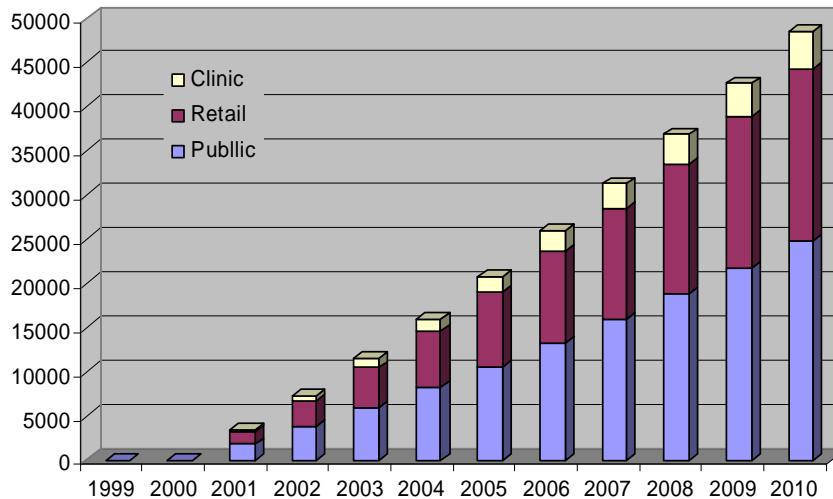


Appendix 7A - Additional figures on Projected Contraceptive Use

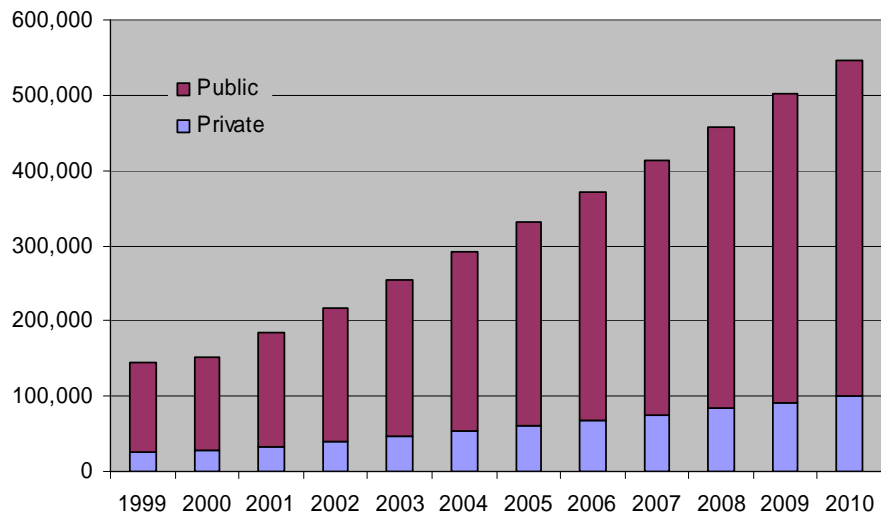
**Georgia: Estimated Condom Demand by Source
1999–2010**



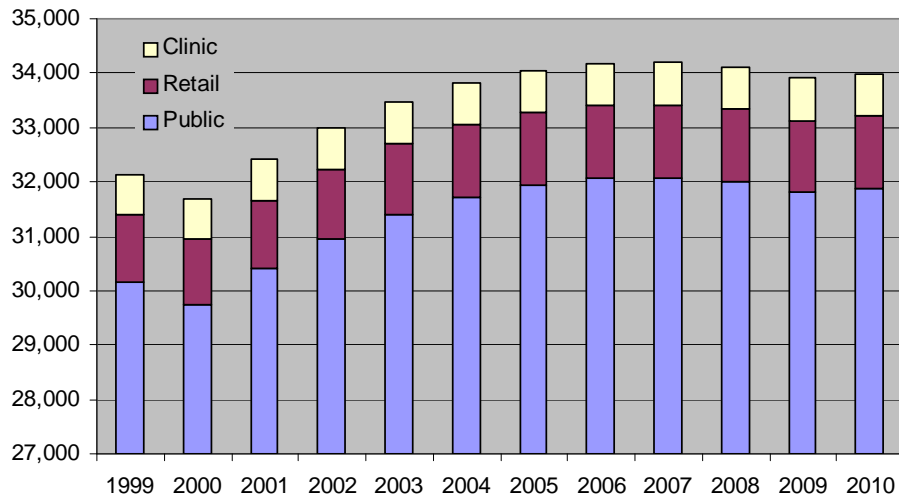
**Georgia; Estimated Injectable Demand by Source
1999–2010**



**Georgia: Estimated Oral Pill Demand by Source:
1999 - 2010**



**Georgia: Estimated IUD Demand by Source
1999-2010**



Appendix 8 - Scope of Work for Contraceptive Security and Logistics Advisor

Fundamental to the success of any family planning program in any country is assured supplies and availability of contraceptives at all levels of the service delivery system.

A month-long JSI Contraceptive Security needs assessment was undertaken in late October 2004 to determine the status of CS in Georgia. The overall goal will be to use the assessment to strengthen capabilities in government and the private sector to ensure availability of contraceptives for the increasing numbers of users in Georgia.

Based on the needs assessment and under the overall leadership and supervision of the ECIS/HWG Chief of Party, the Advisor will be trained by JSI experts to our organization's approach to CS and logistics. Working with short-term JSI experts, she or he will collaborate with JSI experts and stakeholders to develop a specific plan of work and schedule, and will subsequently implement the plan, collaborating and coordinating with the Government of Georgia, including the MoLHSA and regional health authorities, the Caucasus Social Marketing Association (CSMA), the Georgian commercial sector, the U.S. Agency for International Development, UNFPA, and other current or potential providers of contraceptives to Georgia.

Specific Responsibilities

The Advisor will:

1. Participate in the JSI/HWG CS assessment and subsequently take selected short and medium-term action on priority CS issues identified, but limited to, in the assessment. They include:

- CS collaboration and coordination between partners at the national level
- contraceptives forecasting and procurement
- transportation and storage
- inventory control, stock levels and ordering systems
- logistics management information system (LMIS)
- commercial sector distribution and sales reporting
- monitoring and evaluating progress

2. Address relationships between LMIS and Health Information System (HIS) reporting with reference to inventories, off-takes, sales, re-supply etc., and patterns of contraceptive use including acceptance of contraception by method, continuation/discontinuation patterns, "switching" among methods, etc.

3. Train Mo, regional health authorities and health providers in:

- inventory control, stock status and ordering
- good storage and handling practices
- local procurement

4. Arrange and hold Contraceptive Technology Update Conferences.

5. Undertake surveys of pricing and affordability, and of clients' ability and willingness to pay for contraceptives.

6. Provide CS technical assistance, training and management support to JSI's partner organizations and staff to implement their respective ECIS/HWG components.

Qualifications

Substantial experience managing family planning operations and/or contraceptive supplies and logistics in the public or private sector.

Strong analytical skills applied in past employment to family planning or other RH data derived from management information system reports.

Fluency in English.

Strong computer skills – experience working with databases, spreadsheets, analytical software.

Desirable:

Clinical training in family planning and reproductive health.

Familiarity with 1999 Reproductive Health Survey data, desirable.