The National Composite Index for Family Planning (NCIFP)

GEORGIA 2017 Scores and 2014-2017 Trends[i]

What is the NCIFP?

A tool that supports FP2020's[ii] efforts to improve the policy environment for family planning (FP), the NCIFP provides information on FP program activities that are not readily available in national demographic or reproductive health surveys or service statistics systems. The NCIFP measures the existence of FP policies and program implementation based on 35 items that fall under five dimensions: **Strategy, Data, Quality, Equity,** and **Accountability**.

Strategy – whether a national FP strategy/plan exists that includes quantified objectives, targets to reach the poorest and most vulnerable, projected resource requirements, and support for wider stakeholder participation. Also included are two items that affect strategy implementation: high-level leadership and regulations that facilitate contraceptive importation or production.

Data – whether the government collects/uses data on special sub-groups (e.g. the poor) and their access, private sector commodities, and the quality of service statistics. It also includes data-based evaluation and research to improve the program.

Quality –whether the government uses WHO standards of practice (SOP), task-sharing guidelines, and quality of care indicators in public and private facilities. Quality of care (QOC) also considers the adequacy of structures for training, logistics, supervision, IUD and implant removal, and informed choice, including informing clients about the permanence of sterilization.

Accountability – whether mechanisms exist to monitor discrimination and free choice, review violations, report denial of services, enable facility-level feedback, and encourage communication between clients and providers.

Equity - whether anti-discrimination policies exist, providers discriminate against special groups, the population has easy access to modern contraceptive methods (referring to STMs meaning short-term methods, or LAPMs meaning long-acting and permanent methods), and services are provided to underserved populations through community-based distribution (CBD).

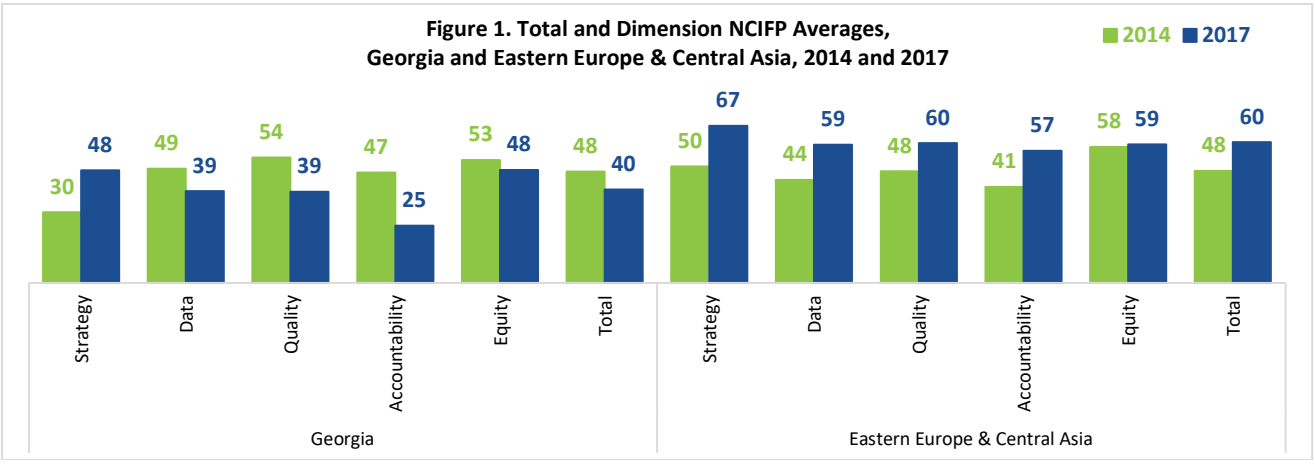
First undertaken in 2014, the NCIFP builds on the long-standing National Family Planning Effort Index (FPE). In 2017 Avenir Health's Track20 project (funded by the Bill and Melinda Gates Foundation to assist countries participating in the FP2020 Global Initiative) administered a new round of NCIFPs to assess current national FP program status and changes since 2014. NCIFP data are intended for policy and planning use by each country's FP stakeholders. The analysis of 2014 and 2017 data that are summarized in this brief is based on the 2014 methodology that used yes-no response categories to questions regarding the country's FP program.

Georgia vs Eastern Europe and Central Asia Results

Figure 1 shows Georgia's total NCIFP score of 48 in 2014 declined to 40 by 2017 compared to the region's total score increasing from 48 in 2014 to 60 in 2017. Georgia averaged lower in 2017 for all dimensions except Strategy.

- In 2014, Georgia's highest rated dimensions were Quality (54) and Equity (53). Its highest scored dimensions in 2017 were Equity and Strategy (each averaged 48). After declining by almost half, Accountability ranked the lowest in 2017.
- The region's highest rated dimension was Equity in 2014 and Strategy in 2017. The region's lowest ranked in both years was Acountability despite the dimension's score improving in 2017.

Figure 1. Total and Dimension NCIFP Averages, Georgia and Eastern Europe & Central Asia, 2014 and 2017

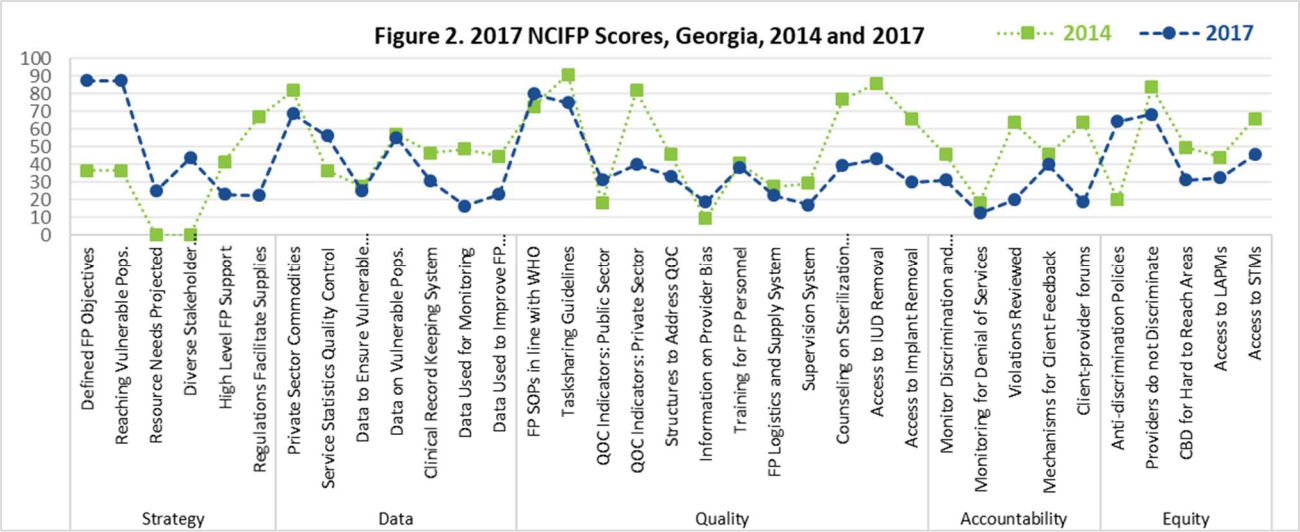


Individual NCIFP Trends, 2014 and 2017

Assessments of individual NCIFP items over time indicate which FP program activities are progressing, stagnant, or deteriorating. Figure 2 shows that Georgia's scores for about 20 items fell from 2014 to 2017. Most scores were in the 40s or below.

Strategy –The FP strategy's objectives and focus on vulnerable groups had improved scores (88) in 2017. Ratings rose from 0 to 44 for the strategy's support for diverse participation and to 25 for estimated resource needs, but fell to the 20s regarding regulations that facilitate contraceptive importation (from 67 in 2014) and high-level support (from 41 in 2014).

- **Data** – The only score for this domain that increased was service statistics quality control (56). Scores for data on population sub-groups and data use to ensure access for the most vulnerable hardly changed; scores fell for data on private sector commodities (69), clinic recordkeeping/feedback (31), data use for program improvement (23) and for monitoring (16) .
- **Quality** –Only three items had improved ratings in 2017: the use of WHO SOPs (from 73 to 80), QOC indicators in public facilities (from 18 to 31), and provider bias monitoring (from 9 to 19). While the training system was almost stagnant at 38, the ratings of all remaining items fell in 2017. Tasksharing guidelines scored 75 (down from 91), compared to 40s for QOC indicators in private facilities and access to IUD removal; 30s for sterilization counseling, clinic/community structures to monitor QOC, along with access to implant removal; and around 20 for the logistics and supervision systems.
- **Accountability** – The ratings of all five items declined. Violations review and client-provider forums dropped from 64 each to only about 20 in 2017. From scores of 45 in 2014, monitoring discrimination and free choice and client feedback mechanisms fell to 31 and 40, respectively. The rating for mechanisms to report denial of services became even lower (from 18 to 13).
- **Equity** – While the score for anti-discrimination policies rose from 20 to 64, ratings declined in 2017 regarding provider non-discrimination of certain population groups (68), access to STMs (46) and LAPMs (32), and CBD coverage (31).



Implications

According to the 2010 Georgia Reproductive Health Survey (GRHS)[iii], the total fertililty rate (TFR) was 2 lifetime births per woman for the period 2007–2010 which is higher than the TFR of 1.6 births per woman for 2002–2005. Traditionally, Georgian women start and complete childbearing at an early age, but the 2010 survey suggest a gradual transition to fertility postponement. The total induced abortion rate fell from 3.7 lifetime abortions per woman in 1997–1999 to 1.6 abortions per woman in 2005-2010. Most Georgian women achieve their desired family size before age 30, after which unplanned pregnancies are more likely to end in induced abortions. The abortion rate is higher among rural women, the less educated, and those of Azeri descent; these suggest unequal access to services among disadvantaged subgroups. Majority of women who chose abortion cited as reasons the desire to stop childbearing (51%) and the desire to space the next birth (18%). In 2010, 21% of all women aged 15–44 used modern methods compared to 35% among married women. 2010 was the first time that the modern prevalence rate exceeded the traditional rate.

Strengthening Georgia's FP program is thus very important as a means to improve the health of women and families and reduce the reliance on induced abortion as a means of controlling fertility especially among the most vulnerable populations. Georgia's NCIFP results indicate predominantly low or declining scores for a large number of FP program components: the strategy's resource requirements, high-level support, and regulations affecting contraceptive products; data on vulnerable segments of the population and private sector commodities as well as data-based monitoring and program improvement; the use of QOC indicators in public and private facilities; various systems and operations that support the provision of high quality services; a range of accountability mechanisms; and equity efforts to counter provider discrimination, reach the underserved, and ensure access to STMS and LAPMs along with IUD and implant removal. Although the challenges are many, the NCIFP study also showed FP activities with relatively high or improved ratings - the strategy's quantifiable objectives and focus on vulnerable groups, stakeholder participation, service statistics, QOC protocols and structures, and anti-discrimination policies- which can be the bases of efforts to improve the program.

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[i] Suggested citation: Avenir Health Track20. "The National Composite Index for Family Planning (NCIFP): GEORGIA 2017 Scores and 2014-2017 Trends". 2017 NCIFP Policy Brief Series (2019).

[ii] FP2020 is a global initiative involving governments, civil society, local, and international organizations work together to enable more women and girls to use contraceptives by 2020. See http://www.familyplanning2020.org/

[iii] http://ghdx.healthdata.org/record/georgia-reproductive-health-survey-2010-2011