

Report to the Department for International Development

Georgia Primary Health Care Development Project

Final report

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Contents

Acronyms and Abbreviations	3
Project team	4
Responsibility	4
Acknowledgments	4
1. Background	5
2. Project Achievements against logical framework	7
3. Output 1: Establishment of functional Family Medicine demonstration sites	8
4. Output 2: A new sustainable and affordable financing model for primary health care implemented.....	11
5. Output 3: Increased Ministry of Labour, Health and Social Affairs capacity to train PHC staff	13
6. Output 4: Promote access to basic services through population-based risk pooling to cover the costs of essential primary care drugs, developed and implemented in the FM demonstration sites.	16
7. Evaluation of achievements.....	17
7.5 Impact on Staffing and Staff Incomes	19
7.6 Service Utilization	20
8. Lessons learnt.....	22
Log frame Progress Report	23
Log frame Results	29

Acronyms and Abbreviations

CBHI	Community based health insurance
CDC	Centred for Disease Control
CIF	Curatio International Foundation
CPD	Continuing Professional Development
DFID	Department for International Development
EU	European Union
FM	Family Medicine
FSU	Former Soviet Union
GDP	Gross Domestic Product
GeL	Georgian Lari
GIS	Geographical Information System
GoG	Government of Georgia
GP	General Practitioner
GUSIF	Georgian United Social Insurance Fund
HHS	Health Household Survey
HIS	Health Information System
IEC	Information, Education and Communication
IHA	International Health Area
JHU	John Hopkins University
M&E	Monitoring and Evaluation
MIS	Management Information System
MoJ	Ministry of Justice
MoLHSA	Ministry of Labour, Health, and Social Affairs
NFMTTC	National Family Medicine Training Centre
NGO	Non-Governmental Organisations
NHA	National Health Accounts
NHMC	National Health Management Centre
OVI	Objective Verifiable Indicators
PHC	Primary Health Care
PHR	Partnership for Health Reform
SIDA	Swedish International Development Agency
SMIC	State Medical Insurance Company
ToT	Training of trainers
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

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Responsibility

Although this report has been commissioned by the British Government under British aid arrangements, the British Government bears no responsibility for and is not in any way committed to the views and recommendations expressed herein.

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1. Background

Prior to its independence Georgia enjoyed one of the highest living standards and levels of per capita income in the Former Soviet Union (FSU). Independence in 1991 was followed by decoupling from the Soviet economic system, civil war and by intense conflict with the Abkhazia and Ossetia Regions. The civil war, combined with a rapid transition to a market economy, left Georgia with a collapsed economy and a malfunctioning health system. The economic plight was worsened by an influx of some 300,000 internally displaced refugees to the capital city of Tbilisi and a further 200,000 displacement to other regions. By 1993, the economic output fell by 78%¹, and annual inflation had reached 8,400%². The per capita GDP declined from around an estimated US\$2,000 to US\$350 between 1990 and 1994. This rapid decline created much poverty.

However, economic stability and resumption of growth only benefited a segment of the society and further widened income distribution and inequalities. A World Bank household budget survey in 1999 demonstrated the existence of significant poverty and widening income distribution with trends reminiscent of those seen in Latin America, with only 11% of the population above the new experimental poverty line of 52 GeL (US\$23) per adult equivalent per month³. Further, World Bank projections showed that although the economic growth would have a major positive impact on alleviation of poverty this would be negated by rising inequality.

Prior to independence 4.5 percent of GDP was spent on health. The fiscal crisis of the transition years in the early 1990s hit the health sector particularly hard⁴. Government per capita expenditure on health declined to ~US\$0.8 (0.3% of GDP) in 1994⁵. In 1995 this had risen to ~US\$3.7, representing 1% of the GDP. In 1996 this expenditure amounted to US\$9. Although, these funds were earmarked not all were transferred from the State Budget to the MoH⁶.

With the collapse of government revenues from 1994, private spending became the major source of health sector financing. All of these forced the GoG to embark on the health sector reforms along with macroeconomic stabilization measures supported by the IMF and the World Bank.

The GoG initiated major reforms in 1995 through new legislation that enabled the commencement of structural and financing reforms of the health sector paving way for the introduction of and a social insurance model while upholding the principles of solidarity and equity. The underlying principles of the reforms were that:

- The health system should develop in accordance with the economic development in the country;
- The volume of services must be balanced with available financial and human resources;
- The system must aim at rational utilization of all resources.
- Based on these principles, GoG devised several reform initiatives which included:
 - Decentralization of healthcare management;
 - Transition from state-funded healthcare to the principles of social insurance;
 - Separation of the roles of central and municipal governments in health financing;

¹ Bonilla-Chacin E.M, Murrugarra E., Temourov M., Health Care During Transition and Health Systems Reform: Evidence from the Poorest CIS Countries, Materials for the Lucerne Conference of the CIS-7 Initiative, January 2003.

² Both J., Health Care Financing Strategy in Georgia 2002 - 2007, TNO, Tbilisi 2002.

³ Georgia Poverty and Income Distribution. Poverty Reduction and Economic Management Unit. Europe and Asia Region. World Bank. March 1999.

⁴ 1999 Annual Report of the Ministry of Health of Georgia, 2000, Tbilisi.

⁵ World Bank, Staff Appraisal Report No. 15069-GE, Georgia Health Project, Washington, 1996.

⁶ Atun R. Georgia. Case Studies in Health Management. BS008. Imperial College London. 2002.

- Granting autonomy [7,8] and privatisation of healthcare providers;
- Accreditation and licensing of medical institutions and personnel;
- Modernisation of medical education [9].

Since the commencement of health reforms in 1995 Georgia has been recipient of diverse donor assistance. The World Bank supported the country with major sectoral reforms including health care financing, reorganization of the MoLHSA, development and regulation of pharmaceutical market, improving the MCH service delivery to the public, reorganization of the Public Health Department and developing the national capacity for continuous education in to produce/train the critical human resources required for the sector.

The first DFID project (1996-1999) supported the World Bank Health I programme and piloted mechanisms for training doctors in Family Medicine (FM).

The second DFID financed Primary Care Development Project was designed in 1999 with input from the GoG, Tbilisi Municipality Health Department, the WB, and WHO. Due to delays at DFID with the Project approval the Project started almost one year after the design in August 2000 and ended in July 2003.

The purpose of the Project was to develop and implement a sustainable new model of Primary Health Care through Family Medicine to improve quality, access, and participation. This in turn would contribute to the goal of the Project to improve the health status of the (poor) population of Georgia.

The Project was designed to assist the Georgian Primary Health Care Reforms through four key outputs.

- Output 1 - Establishment of functional Family medicine demonstration sites in urban area to provide the platform for the national roll-out of the FM model
- Output 2 - A new sustainable and affordable financing model for primary health care implemented
- Output 3 - Strengthening of the human resource capacity to train staff to work in primary health care facilities based on family medicine model;
- Output 4 - Promote access to basic services through population-based risk pooling to cover the costs of essential primary care drugs, developed and implemented in the FM demonstration sites.

⁷ This refers to publicly owned units outside of direct state control which have degrees of freedom. Since legislation in 1995, hospitals and PHC providers in Georgia are autonomous legal entities.

⁸ Jakab M, Preker A, et al. (2002). Linking organizational structure to the external environment: Experiences from hospital reform in transition economies. Hospitals in a changing Europe. M. McKee and J. Healy. Buckingham, Open University Press.

⁹ Gamkrelidze A., Atun R., Gotsadze G., Maclehouse L. Health Care Systems in Transition: Georgia. The European Observatory on Health Care Systems. World Health Organisation; 2002:62.

2. Project Achievements against logical framework

After a rather long gestation period of almost one year from design the project started in July 2000 and ended at end of July 2003. This report covers the whole project period.

Delay in the Project start has meant that the funds budgeted by the MoLHSA and the Tbilisi Local Government for the refurbishment of the demonstration sites could not be utilised within the fiscal year of 1999. These funds could not be re-budgeted by the central and local governments in 2000 due to economic hardship and budget sequestration.

The Project sought to overcome this issue rapidly during the inception visit and identified an alternative source of financing. Georgia Social Investment Fund, financed by World Bank, was identified as the source for the Georgian counter-financing. GSIF agreed to provide up to US\$ 75,000 to each publicly owned demonstration sites with 20% of this sum has to come from Georgian sources (Municipality, polyclinic or the community). In total US\$ 225,000 were made available for three polyclinics. Of this US\$45,000 was provided by Tbilisi Municipality. This was agreed with the Mayor following a meeting during the inception visit then at the Chancellery in presence of HMA.

A local project office was established within the NHMC. A Local Project co-ordinator and a local project administrator were appointed. A Project Coordination Board comprising the local Project coordination team, representative from the MoLHSA, Tbilisi MHD, and the chiefs of pilot polyclinics was established to oversee the Project implementation. The PCB met on a weekly basis to review Project progress and submitted reports to the Project management, the MoLHSA and the DFID Georgia Office. .

Overall, the project was able to achieve the majority of the planned activities and outputs.

The Project enjoyed strong support from the Minister of Labour, Health and Social Affairs was managed key achievements and problems encountered in the whole project period are detailed in the report.

A monitoring and evaluation framework, based on the Project OVI's but expanding these with additional process, output, and outcome indicators was developed to evaluate project achievements. The framework was used for: (a) continuous monitoring of the project performance; (b) timely identification of deficiencies and problems that may arise, and; (c) enabling the partners at the end of the project to evaluate each component and attainment of the purpose. The evaluation was carried out in the five demonstration sites.

3. Output 1: Establishment of functional Family Medicine demonstration sites

Five primary care polyclinics were identified on the basis of discussion with MoLHSA and TMHD as potential FM demonstration sites. At three of the demonstration sites refurbishment costs were covered by the Georgian Social Investment Fund (SIF), Tbilisi Municipality and the DFID project. Funds allocated for refurbishment at different sites were as follows:

1. National Family Medicine Training centre (NFMTTC)

DFID	– 290,000 GeL
SIF	– 114,900 GeL
Municipality	– 28,600 GeL
Total	– 433,500 GeL

2. Children's polyclinic 9

SIF	– 84,280 GeL
Municipality	– 36,100 GeL
Total	– 120,400 GeL

3. Medical-preventive Center 1

SIF	– 109,000 GeL
Municipality	– 27,000 GeL
Total	– 136,000 GeL.

DFID decided that two of the demonstration sites, which were privatised at the very early stage of the project, were not eligible for covered refurbishment costs from their own financial sources.

Essential medical equipment and furniture were purchased in UK and Georgia for all five-demonstration sites. For this purpose the DFID Project allocated a further 9,558 USD.

All five Family Medicine Centres were opened in April 2002 and have been functional since. They have been approved and accredited as providers of PHC based on FM model.

A new PHC model based on FM (The Ambulatory Care Programme) was developed in the five demonstration sites, extending free coverage for the catchment populations of these FM centres. A key feature of the new programme was that the tripartite system of adult, women, and children services were consolidated under one roof in unitary FM Centres.

The Ambulatory Care Programme (ACP) was introduced in October 2002. New public sector contracts have been established with the MoH, SMIC, CDC, Public Health Department, and the Institute of Sexually Transmitted Diseases and the TMHD: in effect unifying disparate programmes as a single PHC programme.

3.1 Establishment of legal framework for the new system

The legal basis for the new PHC model based on FM was established. Temporary legal framework for the model was developed and Ministerial Decree issued for the following areas in April 2002:

- Temporary Statute of Family Medicine Practice
- Temporary Statute of Family Physician Duties and Competences
- Temporary Statute of General Practice Nurse Duties and Competences
- Temporary Statute of General Practice Manager Duties and Competences
- Family Physician re-training programme
- General Practice Nurse re-training programme
- General Practice Manager training programme
- Temporary Statute of Family Practitioner Trainer

- Temporary Statute of General Practice Nurse Trainer
- Temporary Statute of General Practice Manager Trainer
- Temporary Statute of Family Medicine Training Practice

The DFID PHC Development Project, National Health Management Centre, National Family Medicine Training Centre, Georgian Association of Family Physicians, and the Georgian Nurses Association developed these documents collaboratively.

Following the legislation each of the five FM Centres applied to the MoLHSA to be licensed as FMCs. The applications were approved.

3.2 Development of Terms of Reference and job descriptions for staff

Job descriptions were developed for all newly trained PHC staff working at the FMCs. These included practice managers, GPs, nurses, receptionists, accountants, cashiers, statisticians, laboratory staff, chief nurse, specialist-doctor, secretary, and the chief doctor.

3.3 Improving service quality: Developing evidence based guidelines

Evidence-based clinical guidelines in ten areas, as per the log frame, were developed by FMCs with the financial support of TMHD. There were ten care protocols per guideline area. The guidelines focus on the following areas:

1. Elderly care guidelines:
2. Palliative cancer care guideline
3. Well person and new patients health check
4. Child surveillance guideline
5. Management of Hypertension
6. Management of bronchial asthma
7. Guideline for the management of diabetes in primary care
8. Guideline of the management of STDs in primary care
9. Antenatal care
10. Guideline for the management of Coronary Heart Disease (CHD) in primary care

The documents were submitted to the expert panels at the MoLHSA and leading Academic institutions and subsequently approved. Despite discussions at TMHD and MoLHSA regarding the implementation of guidelines at all centres progressed slowly. Wider implementation of the guidelines has to be supported by training of all FMC staff and introducing tools for performance evaluation. Due to financial constraints that was not possible to accomplish.

3.4 Social marketing

A Social Marketing strategy was developed by the Project. This was widely circulated to all the key stakeholders. The strategy document identified general SM activities and instruments as well as FM centre specific activities and instruments.

Social marketing activities were supported by the DFID funded Oxfam Project implemented by Georgia Bioethics Society. The Oxfam Project distributed leaflets to patients on 'Bill of rights' and a Patient Ombudsman office was established in each of the FM Centres. The Oxfam Project produced information leaflets to patients on common conditions and these were distributed to patients.

The DFID Project financed social marketing activities to raise awareness of FM and the new PHC model. The social marketing was conducted by all the five FMCs in the summer of 2002 in preparation of the launch of the new PHC model based on FM and the new Ambulatory Care Programme. The FMC-led social marketing demonstrated a huge demand for the new AC Programme. Following social marketing a significant number of patients (children, adults, and the elderly) registered with the five FMC demonstration sites (for instance 19 300 contracted to NFMTTC).

3.5 Developing new information management systems for the FM model

The project provided technical assistance to develop a new health information system (HIS) at the FMCs. A detailed analysis of the existing HIS was undertaken. The FMCs collected data on current information processes according to the data collection instruments developed by the Project consultant.

Workshops were held with the key stakeholders and international development partners to discuss the findings of the analysis.

A MIS working group was established to develop the strategy for the new MIS. A strategic plan was developed following the mapping exercise and evaluation of the existing information systems. Recommendations have been made for a prototype system to address the most important information needs of the FMCs and to demonstrate the feasibility of automation of the information processes.

4. Output 2: A new sustainable and affordable financing model for primary health care implemented

The following activities were carried out by the implementing team:

1. A study of financial, staffing, and functional conditions of all pilot institutions participating in the Project over the three-year period for 1997-2000 was undertaken.
2. Consultations were undertaken with all the chiefs and staff of all the five FM demonstration sites was undertaken to identify demands and expectations from the Project.
3. A Household Survey of all areas covering the five demonstration sites and the City of Tbilisi was undertaken in December 2000. The detailed results of the HH Survey were made available in Georgian and English and disseminated to all key institutions and (central and city) health authorities.
4. A study of financing of primary care in Tbilisi and Georgia. The study provided detailed information about each institution, identified different initiatives in health financing in the country, and developed possible alternative scenarios of pilot financing models within the Project.
5. An options paper on the development of financing and organizational models of family medicine centres. These options were discussed with all the key stakeholder institutions involved in the Project.
6. Based on the discussions on financing model and the findings of the household survey data a new financing and Ambulatory Care Model was developed for the five demonstration sites, but also extended to the rest of Tbilisi.
7. A strategy for social marketing for the population served by the five demonstrations sites on PHC based on FM and the new Tbilisi Ambulatory Care Program and pilot polyclinics.
8. A further study exploring options for primary care financing based on a household survey of 2500 respondents to determine the willingness and possible roles for consumer contribution to health care. The work is in progress regarding identification of possible roles for public funds and development of mixed public-private financing model.

Evaluation of existing system of PHC financing in the City of Tbilisi and analysis for the elaboration of the options paper for PHC Financing model revealed that the funds from the municipal purchasers was the most significant source of income for the pilot facilities and provided 51% of funds in the annual facility revenues (Table 1).

Table 1 Source of facility revenues during 1997-1999 (3 year average)

Indicator	3 Year Average (1997-1999)	
	Total Gel	Per cent
Actual Revenues Generated	2,671,262	100%
a. Federal Programs	590,267	22%
b. Municipal programs	1,354,649	51%
c. FFS	726,346	27%

Therefore, the Project Coordination Board decided to concentrate on improving the financing from municipal purchasers (municipal programs) and develop proposals re-define and refine the municipal programme as the basis for the new financing model for the FMCs. The project team also aimed to secure the contracts for the *Family Medicine Centres* from other public purchasers (in particular the SMIC and PHD) but without an attempt to change the composition of their programs¹⁰.

¹⁰ Any changes enacted in the programs of SMIC and PHD would have resulted in changes on the national level. Considering the pilot nature of the project it was decided to only enact the changes on municipal level.

In 2002, the changes proposed by the project were incorporated in the municipal PHC Program, The Ambulatory Care Programme. The budget to finance these changes was approved by the City Parliament. New financing model, described in detail in respective document¹¹ produced by the project team, became operational in October 2002. Municipality of Tbilisi signed new contracts with all FMCs for the implementation of the new model. At the national level, policies for the national purchasers were not changed as SMIC and PHD contracted the pilot FMCs under their existing programs.

¹¹ Gotsadze.G., 2002 Concepts for Tbilisi Ambulatory Care Program for 2002

5. Output 3: Increased Ministry of Labour, Health and Social Affairs capacity to train PHC staff

The third output focused on training of human resources for the new PHC model based on FM. The human resources trained included Family Physicians, Primary Care Nurses, and Practice Managers in Tbilisi, as well as in Regions. Training programs for FP, PC nurses and PC managers were developed and approved by the Ministerial decree 'MoLHSA 15 April 2002'.

National Health Management Center acted as the "Umbrella organization" for re-training of Family Medicine human resources. National Institute for Health (NIH) (formerly the NHMC) provided supervision on the course implementation and its final evaluation.

5.1 Family Medicine demonstration sites as training centres

All the five family medicine demonstration sites were licensed as a family medicine training centres and received the right to deliver post-graduate education for Family Physicians. FMTCs were equipped and furnished to create a comfortable and effective training environment.

5.2 Training of Trainers

Eight trainers were trained in the period 1997-1999 within Know-How Fund Georgia PHC Project. These trained a further eight trainers. A further six trainers selected from second cohort of FPs (1998-1999) went through additional training module for FP trainers. The training of these six additional trainers was funded by NIH in 2002.

Fourteen Regional FM trainers (7 from Ajara, 2 from Shida Kartli, 5 from Imereti) were trained at National Family Medicine Training Centre: The first group of eight was trained in June-November 2002 and the second group of six in March-July 2003;

A further four Family Physicians trained by the Master trainers in Mtskheta, trained under USAID/AIHA financed project have been trained as FM Trainers.

There are now a total of 22 FM Trainers in Tbilisi, 7 in Ajara, 2 in Shida Kartli, 5 from Imereti and 4 from Mtsketa-Mtianeti region, a total of 40. The number of FP trainers working at each FMTC and the regions is presented in Table 2.

Table 2: Number of FP trainers at each of the Tbilisi FM demonstration site and then regions

Family Medicine Training Centre	No of FP trainers
National Family Medicine Training Centre	9
Adult's polyclinic 28	6
Children's polyclinic 9	3
JSC "Vere-21"	2
Medical-Preventive Centre 1	2
Ajara	7
Shida Kartli	2
Imereti	5
Mtsketa-Mtianeti	4
Total	40

5.3 Training of Trainees

GP training was conducted successfully. There are now 94 certified family physicians (84 in Tbilisi and 10 in Mtskheta) trained in the period 1997 to 2002. A further 42 have been trained and 41 successfully passed summative assessment. They will take State Licensing examination in 2003 and 2004. Currently there are an additional 53 doctors in training to become specialist in FM.

- 47 PHC physicians were retrained at demonstration sites in 1998-1999 by 8 FP trainers (46 were licensed as FPs). Nine of these were not a staff of demonstration sites;
- 43 PHC doctors were retrained at demonstration sites in 2001-2002 by 16 FP trainers. Forty of these completed training successfully and on the basis of State Licensing Exam were certified as FPs. All of them were staff of demonstration FM centres;
- A further 34 PHC doctors enrolled in the GP re-training course in November 2002 and will end in November 2003. The training is being conducted by 22 FP trainers;
- Eight newly trained regional Family Medicine Trainers retrained 32 PHC doctors in regions (13 in Imereti, 13 in Ajara and 6 in Shida Kartli). The training took place locally at PHC facilities identified by regional health authorities. The training commenced in March and completed in July 2003. 31 out of 32 were successful at summative assessment.
- Ten PHC doctors were re-trained by NFMTTC master trainers in Mtskheta PHC centre within USAID/AIHA funded Mtskheta-Milwaukee partnership project during 2000-2002. Four of them were re-trained as FP trainers. With the continuing support of NFMTTC they are training 19 PHC doctors from Mtskheta-Mtianeti region. Training started in May 2003;
- FP trainers conducted short courses on CHD prevention for PHC doctors working in Tbilisi. 120 doctors were trained in May 2003 at NFMTTC. The training activities were funded by WHO Euro office;
- NFMTTC developed training programme for CME of Family Physician trainers "Incorporating Evidence Based Medicine in the teaching of health care professionals". The programme was accredited by the state CME accreditation board in October 2003.

5.4 Training of PHC Nurses

Training programme for PHC nurses was developed by the project and approved by the MoLHSA in April 2002.

Eight PHC Nurse Trainers (rather than six as per log frame) were trained in 2001. These trainers trained thirty PHC nurses in the five demonstration FM Centres. The training included rational prescribing programme, financed by the WHO, and delivered by the WHO consultant and her team. The summative assessment of these nurses was undertaken by the local examination board. Twenty-nine were successful and one failed. A further six potential PHC nurse trainers were identified from the cohort of 29 who passed the summative assessment. They have been trained as PHC nurse trainers. The training was completed in March 2003. Summative assessment took place at the end of March 2003 and all six were successful. There are now a total of fourteen PHC Nurse Trainers.

5.5 Training of PHC Managers

Training programme for PHC managers was developed by the project and approved by the MoLHSA in April 2002.

Five PHC managers were trained in the first year of the Project and successfully passed their summative assessment. These PHC Manager Trainers trained 10 PHC Managers (6 from Tbilisi, 2 from Shida Kartli, and 1 each from Mskheta and Ajara). The training started in March 2003 and ended in July 2003.

6. Output 4: Promote access to basic services through population-based risk pooling to cover the costs of essential primary care drugs, developed and implemented in the FM demonstration sites.

Activities under this component were implemented in cooperation with WHO. The experience of DFID funded WHO drug reimbursement programme, implemented in Kutaisi was used as a model. This programme included some risk-pooling elements, which made possible to redistribute the resources from rich to poor and from healthy to ill population.

Good progress has been made on the essential drugs component of the Project. An 'Options Paper' discussing the possibility of developing and implementing a drug reimbursement scheme for pharmaceutical products in the five FMC demonstration sites was developed by the WHO and circulated in October 2002 for comment to all stakeholders. Subsequent discussions resulted in refinement and finalisation of this paper as a 'Concept Paper' identifying payment system, essential drugs, and the operational basis for the scheme implementation.

The TMHD have agreed a budget of 100,000 GeL representing 1GeL per capita for the Drug Reimbursement Scheme for the patients of the five FM demonstration sites. The Scheme will initially cover 100,000 patients and will gradually be rolled out to Tbilisi.

An agreement is being developed between WHO and the TMHD to be documented in a Memorandum of Agreement (MoA), identifying roles and responsibilities of each party. Following the MoA the Scheme will be operationalised. A Scheme co-ordinator and project management local staff were appointed in August 2003.

6.1 Training on rational prescribing

Training on rational prescribing was conducted at NFMTTC by a WHO consultant in October 2002. 30 FPs and FM trainees participated in this training. A second course was held for a new group of Family Doctors in the beginning of 2003.

In addition, the WHO consultant arranged training in rational prescribing for nurses in January 2003.

Support was given to the development of a National Drug Formulary (with emphasis on primary care) and a national committee to prepare such a publication was established.

A survey of prescribing habits of Family doctors was planned to be conducted by 6th year medical students who followed the rational drug course of the Department of Pharmacology of the Tbilisi State Medical University. The survey will be done as a retrospective cohort study with a fixed list of analysis indicators.

7. Evaluation of achievements

A monitoring and evaluation framework, based on the Project OVIs but expanding these with additional process, output, and outcome indicators was developed to evaluate project achievements. The framework was used for: (a) continuous monitoring of the project performance; (b) timely identification of deficiencies and problems that may arise, and; (c) enabling the partners at the end of the project to evaluate each component and attainment of the purpose. The evaluation was carried out in the five demonstration sites focusing on two broad areas of increased access and patient satisfaction.

Monthly reports against parameters detailed in the Monitoring and Evaluation document were provided by the FMCs starting from October 2002 to June 2003.

7.1 Increased access

Development of the new model of PHC service provision based on FM model, establishment of the FMCs, changing the quality and content of services and changes in the legislation have helped improve access. These changes have helped achieve an increased utilization of services by the population by 47%, when compared to 1999 figures. However, significant change in the populations' behaviour will need time and sustained social marketing.

Evaluation confirmed an increased production of services by the newly established FMCs. The volume of services as measured by increased service provision and amount of revenue in Gel attracted as a result of these services, increased by 17%. However, the FMCs have not been paid fully for these services: the 'public contractors' have only paid 61% of these revenues. Revenue recovery for the FMCs stands at 61%.

Increased production of services and revenues generated by the facilities were mainly due to higher production under the public programs and not at the cost of population. More so, the amount of money spent by the population in volume terms decreased by 39% when the utilization increased by 47%.

7.2 Patient satisfaction

The Household Survey conducted at the start of the DFID Project showed the very high dissatisfaction with the District Doctor's service with only 3.4% expressing satisfaction with these services at the polyclinics.

The Project undertook a detailed patient satisfaction survey using a structured questionnaire to evaluate the degree of patient satisfaction. The questionnaire, using a five point Likert scale for each key parameter to be measured, was used as a self-administered tool and provided to patients attending three of the five FM Centres over a period of one week. In total 300 forms were returned by patients. Of these only 274 (91.3%) were regarded to be complete and appropriate for analysis. Results of data analysis demonstrated a strong satisfaction level with the new services, the personnel, and the facilities of the newly established FMCs. Patients were not burdened with the cost of treatment.

7.3 Impact on Revenue Recovery

Revenue recovery by sources of financing is presented in the Table 2. According to the findings patients still remain to be the best source for recovering the cost of treatment, while Public Health Department was the worst performer among the public purchasers.

Revenue recovery rate from Municipal authorities remained low and ranged around 53%. SMIC paid FMCs 67% of the billed amount. Average recovery rate still 61% remained low and has not changed. The recovery rate remains similar to that identified in the initial research carried out by the Project team for the period 1997-2000 when the three year recovery rate was calculated¹² for the PHC facilities in the City of Tbilisi. These low levels were mainly caused by low recovery rate from public purchasers. Thus, overall performance of public purchasers has not improved in the City mainly due to poor fiscal performance of the local Government.¹³

Table 2 Revenue recovery by source of financing for FMCs

Source of Financing	Billed (Gel)	Received (Gel)	Revenue Recovery %
From Municipality	406,919	214,932	53%
From SMIC	57,050	38,188	67%
From Public Health Department	7,982	3,229	40%
From Patients	107,635	91,341	85%
Sub-Total for medical services	579,586	347,690	59.98%
From other sources	16,951	18,082	107%
Total	596,537	365,771	61%

7.4 Impact on Volumes of Revenues

In terms of volumes, 70.2% of services were produced under the municipal programs and 11.2% for other public purchasers. Patients had to pay for only 18.6% of services produced by FMCs. However, analysis of actual contribution showed that patient contributions accounted for 26.3% of total cash revenues generated by the facilities and municipality only 61.8% (Table 3). Therefore, the FMCs still significantly rely on revenues from patients and this pattern is unlikely to change given the circumstances where public financing for the sector is so low. Nevertheless, some positive changes were observed detailed below.

Table 3 Share of Each Source of Financing in Total Services Produced and Revenues Received.

Source of Financing	Billed (Gel)	Received (Gel)	Share of Source in Total Billed Amount	Share of Source in Total Revenues
From Municipality	406,919	214,932	70.2%	61.8%
From SMIC	57,050	38,188	9.8%	11.0%
From Public Health Department	7,982	3,229	1.4%	0.9%
From Patients	107,635	91,341	18.6%	26.3%
Total for medical services	579,586	347,690	100.0%	100.0%

Analysis of services revealed an overall increase in volume of medical services in terms of monetary value by 17% (Table 4). However, actual average monthly cash revenues increased by only 3%. The average monthly revenues from municipality and SMIC increased

¹² Gotsadze.G., Bennett.S., 2001 Primary Health Care Financing in Georgia: Background Paper, Curatio International Foundation, Tbilisi.

¹³ The World Bank 2002, Public Expenditure Review: Georgia, Report No.: 22913-GE.

by 29% and 75% respectively, but most importantly, the volume of cash contributions received from the patients declined by 39%. The revenues generated through *co-payments* and *fee-for-service* fell by 39% despite an increase in the service utilization levels. Increased utilization along with decreased revenues from patients could be proxy indicator that financial access barriers decreased for the public.

Table 4 Changes observed in average monthly revenues pre and after the project (Gel)

	<i>Total Services Produced</i>	<i>Actual Revenues Generated</i>	Out of Total Revenues			
			Municipal Sources	SMIC	Public Health Department	Fee For Service/Co -Payments
Prior to the project	53,593	45,991	21,806	1,177	7,171	15,837
After project	64,398	47,299	30,705	4,774	403	11,418
Per cent Change	17%	3%	29%	75%	-1677%	-39%

7.5 Impact on Staffing and Staff Incomes

Analysis of the human resources of the five demonstration FMCs revealed that, with the exception of Adult Polyclinics N9 (where the number of medical staff increased by 66%), all FMCs were able to significantly reduce the excessive staff documented at the project initiation (Table 5). Average reduction of 38% was achieved in staff numbers. Increased volume of revenues along with staff optimisation seems to have resulted in higher monthly incomes for the FM specialists. The average monthly medical staff income of Gel 30-40, documented at the project initiation, increased to 168.4 Gel/month within nine months the new financial model being functional (Table 6). Income for nurses also increased to 82.4 Gel/Month from 30/month GeL, but it was not true for the sub specialists, whose income remained low at 28.2 Gel/month due to a decline in referral rates from the FM specialists.

Table 5 Impact of the new Model on staff and GP income

Facility	Medical Staff Before	Medical Staff After	% Change in Medical Staff
Chugureti polyclinic	113	50	-56%
Paediatric Polyclinic N9	69	36	-48%
Polyclinics N1	171	121	-29%
Adult Polyclinics N9	29	48	66%
Adult Polyclinic N 28	96	78	-19%
Average			-38%¹⁴

Table 6 Average Monthly Income for Various Staff Categories (Gel)

Staff Categories	Chugureti Polyclinic	Paediatric No. 9	Polyclinic No. 1	Vere No.9	Polyclinic No. 28	<i>Mean</i>	Confidence Interval 95%	
							Lower Bound	Upper Bound
GP	194.3	161.0	187.0	147.5	151.8	168.4	142.5	194.3
Nurses	136.8	61.9	89.3	66.0	58.3	82.4	41.7	123.1
Specialists	17.8	34.6	0.0	45.3	43.3	28.2	4.6	51.8

¹⁴ For average reduction calculation, Adult Polyclinic No.9 was omitted.

7.6 Service Utilization

Monthly reports were provided by the FMCs on service utilization and staff workload, Table 7. The utilization rate and the staff workload increased significantly following the introduction of the new Model. Introduction of the new FM and financing model and subsequent staff rationalization at the FMCs has resulted in a doubling of the overall service utilization that reached 2.01 visits per enrolled individual per annum.¹⁵ This rate is much higher than national average 1.36 (SMIC 2002) and that from the pre-project rate – 1.39 (visits per person per annum) documented during initial assessment of the pilot facilities.

The increase in utilization was not even in all facilities with higher increase in utilization rates in Paediatric Polyclinic No.9 and in Polyclinic No.1 that have a large number of children (8).

Staff rationalization also contributed to increased workload per GPs. Monthly visits per doctor increased from average 1.012 visits to 1.999. These figures yet are not comparable to those observed in UK (8.030 NHS consultations per unrestricted principal¹⁶) and other western countries but the rate has almost doubled in a very short period.

Table 7 Service Utilization and Staff Workload

Facility	Prior to the Project ¹⁷		During the Project		
	Annual Visits per Enrolled Population ¹⁸	Annual Visits per Doctor ¹⁹	Annual Visits per Enrolled Population ²⁰	Annual Visits per GP ²¹	Annual Visits per Specialist
NFMTC	1.09	663	1.0	1,867	663
Paediatric polyclinic N 9	2.40	581	4.3	2,911	389
Polyclinic N1	1.51	543	2.4	1,412	141
Adult Polyclinic N 9	0.88	2,636	1.0	1,730	577
Polyclinic N 28	1.07	636	1.3	2,074	135
Average	1.39	1,012	2.01	1,999	381

Table 8 compares utilization rates per 1,000 population prior to and after project implementation. First column represents utilization rates detected by the household survey for different age groups, while the other columns provide data obtained through monthly reports from FMCs. It is apparent that utilization rates have increased across all age groups, but changes are more significant among elderly people, where the rates have increased by almost 20 times. The new care model and financing for the FMCs were aimed at decreasing financial barriers to access for children under the age of 15 and elderly above the age of 65 years. The removal of financial barriers has had a positive impact on the utilization rates by these age groups.

¹⁵ Data obtained for the several months were extrapolated to calculate annual utilization rates.

¹⁶ RCGP Information Sheet May 2001, No3,

http://www.rcgp.org.uk/rcgp/information/publications/information/infosheets_index.asp#info

¹⁷ Obtained from the initial survey of the pilot facilities conducted in early 2000 and based on 1999 facility annual statistical reports.

¹⁸ Based on annual number of visits and size of catchment population

¹⁹ Represents all doctors in the facility including specialists

²⁰ Averaged for 5 month based on supplied reports and projected for a year

²¹ Based on 5 month averages obtained from the monthly reports of the FMCs

Table 8 Service Utilization by Age groups per 1,000 people per month

Age Groups	Utilization Captured by Survey ²²	Utilization After Project Implementation			
		No	Mean	95% Confidence Interval	
				Lower Bound	Upper Bound
0-5 Year Old	<u>76.5</u>	19	<u>275.4</u>	151.1	399.7
6-15 Year Old	<u>38.2</u>	19	<u>150.0</u>	85.0	215.0
16-64 Year Old	<u>6.2</u>	19	<u>92.3</u>	35.2	149.4
65+ Year Old	<u>13.9</u>	19	<u>289.2</u>	155.4	423.0

Analysis of utilization by age groups for each facility shows that the transition from old Soviet type polyclinic to new FMC model has began but is not yet fully achieved. The results (Table 9) demonstrate that for polyclinics No 9, No 28 and Chugureti the increase in utilization by children is least marked. These facilities were previously adult clinics and utilization by children under 15 has not increased substantially. The polyclinic No.9 was a paediatric clinic and still provides services predominantly to children although the number of adults attending the clinic has increased substantially. The Polyclinic No. 1 has made most progress in serving a mixed age group.

Table 9 Average monthly volume of service utilization by age groups in different FMCs

Age Groups	Chugureti polyclinic	Adult Polyclinic N 9	Polyclinic N 28	Paediatric polyclinic N 9	Polyclinic N1
0-5 Year Old	0	35	2	947	347
6-15 Year Old	5	55	18	1,754	2,410
16-64 Year Old	344	464	1,736	220	6,040
65+ Year Old	821	991	2,186	22	2,270
Average per month for all age groups	3,343	2,356	3,024	2,713	4,306

²² Gotsadze.G., Gzirishvili.D., Bennett.S., Ranson.K., 2001. Health Service Utilization and Expenditures in Tbilisi – 2000: Report of a Household Survey. Curatio International Foundation. Tbilisi.

8. Lessons learnt

This has been one of the most complex health project implemented in Georgia. Despite a challenging environment the Project achieved most of its objectives.

Implementations of health sector reforms in Georgia have been adversely affected by:

- Unfavourable environment for evidence-based policy formulation on national and regional levels.²³
- Financing and human resource constraints
- Failure to involve critical stakeholders and in particular the general public in the reforms.
- Rapid decentralization and creation of autonomous providers with a high degree of provider autonomy and a lack of clear definition of roles and functions of regional/regional health authorities
- Fragmented financing.

The implementation of the reforms has been further hampered by factors that can be addressed by the donor agencies. These include:

- a) The length of time taken by donor and development agencies to develop and design projects, a process which consumes significant amount of scarce human resources.
- b) Misalignment of Donor Project cycles between themselves and with those of the Central and Local Governments in Georgia, adversely affects project implementation.
- c) Reforms cannot take place in a vacuum and should not be driven by external implementing agents. Reforms must be owned and led by the GoG, the MoLHSA and key stakeholders effectively drawing local and international technical assistance. There has been a predominance of donor driven projects: even though local partners have been involved and engaged donors still drive the design process with significant duplication.
- d) Difficulties encountered in coordinating donor efforts are underestimated and inadequately resourced. Although the MoLHSA has provided strong leadership of the reforms the support given to the MoLHSA necessary to ensure effective donor coordination has been limited as the accountability of the Projects have tended to be more to the funding agencies than to the Government.
- e) The difficulties associated with implementing complex reform projects (especially in an environment like Georgia where interests of stakeholders are very finely balanced) can be underestimated by those not closely involved with implementation of reform programmes. This can be particularly acute with post hoc evaluations that provide 'a snapshot view'. These can be misleading, be of limited value, and lead to 'technical autism'.
- f) Lessons and aid instruments from other regions can be valuable but must be used with caution.
- g) Implementing PHC reforms is complex and a lengthy process. Chances of success can be increased by ensuring continuity of key actors to develop and build trust, multifaceted and multilevel interventions simultaneously addressing regulation, legislation, financing, organisational arrangements, provision, resource allocation, and incentives. Short-term projects with limited financing often create unrealistic expectations and disconnection between goals and outputs.
- h) Ongoing analysis and lesson learning should be encouraged with adequate resources afforded to create a 'learning environment'.

²³ Gotsadze.G., Jugeli.L., 2003 Report on Final Evaluation of Georgia Health I Project Financed with The World Bank Credit, ID Number: GE-PA-8414. Tbilisi.

Log frame Progress Report

Outputs	OVIs	Progress towards achievement of outputs
Output 1 FM demonstration sites functional		
<p>Activities</p> <p>Before Project start Selection, and staffing of the 5 demonstration sites</p> <p>Allocation of population to new FM Centres (to include women, children and men)</p> <p>Project Activities</p> <p>1. Refurbishment, equipping of demonstration sites</p> <p>2. Baseline (household and user) survey.</p> <p>Identify extent of community and user participation Utilisation levels Development of a framework for evaluation</p> <p>3. Establishment of legal framework for the new system</p> <p>4. Development of new PHC Model: Definition of roles and responsibilities of the PHC team members</p> <p>5. Development of referral and counter-referral systems</p> <p>6. Development of information systems</p> <p>7. Social marketing (not financial) to increase the awareness, involvement, and ownership of the new model by the community and the users.</p> <p>8. Monitoring of the new model</p>	<p>By end of year 1:</p> <p>1.1 Five demonstration sites functional</p> <p>1.2 New organisational structures (management and human resource) established</p> <p>1.3 New legislative framework developed for functioning of FM Centres</p> <p>1.4 Public service contracts established (i.e. between founders [TMHD and Federal] and FMCs)</p> <p>1.5 Open enrolment commenced</p> <p>1.6 New clinical guidelines introduced and operational for 5 conditions</p> <p>By end of year 2:</p> <p>1.7 New information systems developed</p> <p>1.8 New clinical guidelines introduced and operational for a further 5 conditions (bringing the total to 10)</p> <p>1.9 Increase enrolment of patients by 10% in demonstration sites</p> <p>By EOP:</p> <p>1.10 Increase enrolment of patients by 30%</p>	<p>OVI</p> <p>1.1 Refurbishment, furnishings and medical equipment completed, FM centres opened at the end of April.</p> <p>1.2 Organisational structures within the FMCs established.</p> <p>1.3 Legislative framework developed and approved by the Ministerial decree (15.04.2002.).</p> <p>1.4 Contracts developed and implemented in October 2002.</p> <p>1.5 Open enrolment commenced based on SM activities. TMHD is not going to interfere and issue any order on this.</p> <p>1.6 Clinical guidelines developed for 4 conditions and piloted in NFMTTC</p> <p>1.7 MIS working group has been created to develop strategy for the new FMC information systems. Project provided TA to draw up a blueprint for the new MIS.</p> <p>1.8 New guidelines have been developed for a further 6 areas bringing the total to 10 guidelines and 100 protocols</p> <p>1.9 Social marketing increased enrolment beyond 10%.</p> <p>1.10 Enrolment increased in all demonstration sites by over 10%</p>

Outputs	OVIs	Progress towards achievement of outputs
9. Evaluation of the new model 10. Development of plans and appraisal for nation-wide roll-out of the new model These activities will be implemented through consultant inputs, 2 study tours, 3 seminars, and capital investment.		
Output 2 New financing model for PHC implemented		
Activities 1. Development of alternative options for financing PHC 2. Options for joint financing and provision identified (solidarity fund concept and community participation explored) 3. Appraisal of financing options and the sustainability of a proposed package nationally 4. Test options in 4 demonstration sites 5. Evaluation of demonstration 6. Selection of optimal model 7. Development of plans to implement new financing system nationally	Options identified by year 1 2.1 Appraisal of alternative options completed by year 1 2.2 Options implemented and tested at 4 demonstration sites by year 3 2.3 Evaluation of demonstrations by year 3 2.4 Selection of optimal model by year 3 2.5 Model adopted by year 3	2.1 Options identified (June 01). An options paper produced and submitted to MoLHSA (June 2001). 2.2 Appraisal undertaken and implementation of the new financing scheme started in October 2002. 2.3 Being implemented. 2.4 The new model has been implemented in the 5 demonstration sites. 2.5 New model was evaluated for selection and wider roll-out
Output 3 Human Resource Capacity for new PHC model established		
Activities Year 1 1. Sixteen trainers trained in previous KHF Project deliver short course modular re-training programme for 80 rural doctors 2. Selection and skills assessment of a further 8 trainers from 2 regions 3. Selection and developmental needs	By end of year 1: 3.1 NFMTTC renovated, equipped and functional as training centre 3.2 Eighty rural doctors trained at NHMC in modular course by 16 Trainers 3.3 Five primary care practice manager selected and development needs assessed	OVIs 3.1 The NFMTTC is fully operational 3.2 Eighty rural doctors have been trained in modular courses (by the FM Trainers) 3.3 Five primary care practice managers selected and needs assessed and started training one year

Outputs	OVIs	Progress towards achievement of outputs
<p>assessment of five primary care manager trainers</p> <p>4. Development of the curriculum for training primary care manager trainers</p> <p>5. Training of primary care manager trainers</p> <p>6. Selection, educational and skills assessment of 6 nurse trainers</p> <p>7. Medical School accreditation consultancy-situational analysis</p> <p>8. Development of the Framework for the accreditation of Medical Schools</p> <p>9. Evidence based medicine training</p> <p>10. Development and implementation of EB care guidelines</p>	<p>3.4 Manager curriculum developed</p> <p>3.5 Six primary Care nurse trainers selected and developmental needs assessed</p> <p>3.6 Nurse curriculum developed</p> <p>3.7 Framework for accreditation of medical schools developed</p>	<p>early, successfully completing their training in Georgia, UK, and Sweden. All passed their assessments in September 2001.</p> <p>3.4 Management curriculum developed and approved by the MoLHSA in April 2002.</p> <p>3.5 One-year training programme for the eight Primary Care Nurse Trainers completed - as opposed to six (in Georgia and the UK). All passed their assessments in September 2001.</p> <p>3.6 Nursing curriculum developed and approved by the MoLHSA in April 2002.</p> <p>3.7 A framework has been developed by the Project and approved by the MoLHSA. It is awaiting approval by the Ministry of Education. Actual accreditation has not yet started but is planned in the World Bank Project.</p>
<p>Year 2</p> <p>Selection of 8 Trainers from 2 Regions (Batumi-Ajaria and Kutaisi-Imereti)</p> <p>Training of 8 trainers at NFMTTC</p> <p>Selection of 20 FM physicians at 5 demonstration sites</p> <p>Training of 20 FM physicians in 5 demonstration sites</p> <p>Selection of the second cohort of primary care manager trainers</p> <p>Training of the second cohort of primary care manager trainers</p> <p>Training of 6 nurse trainers at NHMC</p> <p>Selection of 24 primary care nurses</p> <p>Selection of a second cohort of 6 nurse trainers</p> <p>Accreditation of medical schools</p> <p>Evidence based medicine training</p> <p>Development and implementation of EB care</p>	<p>By end of year 2:</p> <p>3.8 Eight FM trainers trained from 2 regions (Batumi-Ajaria and Kutaisi-Imereti)</p> <p>3.9 Twenty FM physicians trained at 5 demonstration sites</p> <p>3.10 Five primary care practice manager trainers trained at NFMTTC</p> <p>3.11 Six primary Care nurse trainers trained at NFMTTC</p>	<p>3.8 Eight FM trainers from three regions (Imereti, Ajara and Shida Kartli) completed training in November 2002. Seven passed summative assessment in February and one in April 2003.</p> <p>3.9 Thirty-eight FM physicians (as opposed to 20) and ten from Mtskheta completed training course in June 2002. Thirty-six passed the state-licensing exam in November 2002 and the summative assessment in Feb 2003.</p> <p>3.10 Five PC practice manager-trainers completed training in Georgia, UK, and Sweden. All passed their assessments in September 2001.</p> <p>3.11 Eight (as opposed to six) primary care nurse trainers trained and passed exams successfully.</p>

Outputs	OVIs	Progress towards achievement of outputs
<p>guidelines for 5 conditions</p> <p>Year 3</p> <p>Selection of Training of 32 FM physicians in 2 regions</p> <p>Training of a group of 32 FM physicians in 2 regions</p> <p>Selection of the second cohort of 12 Trainers from 3 Regions [Ajara, Imereti, Gori-Kartli]</p> <p>Training of 12 Trainers</p> <p>Training of 24 Primary Care nurses and 6 Primary care nurse trainers</p> <p>Selection of a cohort of 10 primary care managers</p> <p>Training of 10 primary care managers</p>	<p>3.12 The legal environment for accreditation of medical schools established and accreditation commenced</p> <p>By end of Project:</p> <p>3.13 Eight regional FM Trainers train 32 FM physicians in the two Regions</p> <p>3.14 A further 12 Trainers trained [from 3 Regions Ajara, Imereti, Gori-Kartli]</p> <p>3.15 Further twenty FM physicians trained at 5 demonstration sites</p> <p>3.16 Five practice manager trainers train 10 practice managers</p> <p>3.17 A further six primary care nurse trainers trained at NFMTTC</p> <p>3.18 Eight nurse Trainers train 24 Primary Care nurses</p>	<p>3.12 Framework developed by the Project and approved by the MoLHSA. Awaiting approval by the Ministry of Education. Accreditation has not yet started but is planned in the World Bank Project.</p> <p>3.13 Eight Regional FM Trainers started training 34 physicians from the three regions.</p> <p>3.14 Six trainers from Ajara (4) and Imereti (2) started training in March 2003 and completed training in July 2003.</p> <p>3.15 A further 34 doctors (as opposed to 20) are being trained from 3 PHC Centres in Tbilisi. Training started in November 2002 and ended July 2003.</p> <p>3.16 Ten practice managers trained including two from Ajara, one from Mtskhata Mtuianeti and one from Kartli. Training started in March 2003 and ended July 2003.</p> <p>3.17 Six PHC nurse trainers trained and passed exams in February 2003.</p> <p>3.18 Thirty nurses (as opposed to 24) trained between June 2002 and Jan 2003. Twenty-nine passed assessments and one failed. Six of these were trained as trainers (OVI 3.17)</p>

Output 4 Risk pooling scheme for essential primary care drugs developed and implemented in demonstration sites	
Activities	Action
4.1 Development of alternative options for drug reimbursement scheme-This will be done with a very close collaboration with second output of the Project	4.1 Alternative options developed and presented to TMHD. Political and conceptual discussions with the MoLHSA have resulted in the commitment of the ministry to earmark a certain part of the per capita health budget for drugs. <u>This is a major breakthrough and a huge support for the FM concept as well as the risk-pooling scheme.</u> Preliminary data collected on expected enrolment per FM Centre as a basis for financial calculations The PC list has been developed and approved. On basis of this list the drug formulary is being developed. This document will be finished and printed by end of 2003. Completed and presented to the MoLHSA and TMHD Set of M&E indicators has been prepared with targets for 2001, 2002, and 2003.
4.2 Option appraisal and selection	
4.3 Design of an evaluation plan and development of indicators	
4.4 Primary Care essential drugs list and formulary development	List developed and analysed according to good prescribing practice and disease prevalence figures in Georgia. An evaluation was carried out yet as to how these drugs are placed on a Georgian Essential Drugs List. List has been further analysed and recommendations on drug choice, drug requirements, and treatment cost have been drafted, based on an independent review.
4.5 Social marketing (through the project)	No action. Relates to 4.6
4.6 Involvement/contracting community pharmacy network	Project manager appointed and the activities for the operational implementation by a local project manager commenced. Potential pharmacies near FMC's are identified. Involvement based on final decisions regarding risk-pooling option (4.1).
4.7 Refinement of information system (database) for the scheme (developed in DFID funded Drug reimbursement project in Imereti region)	Information system available in draft form. Further detailing after 4.1 – 4.2 and in collaboration with local project manager (see 4.6).

Outputs	OVIs	Progress towards achievement of outputs
4.8 Training in rational prescribing	Participation of physicians in preparation of drug requirements overview based on rational prescribing principles. Family physicians participated in an IHA workshop on rational prescribing.	
4.9 Training of primary care staff and pharmacists in use of the information system	60 Family Doctors and 30 PHC nurses trained on rational prescribing. 18 FM physicians have been trained as trainers.	
4.10 Implementation of the scheme	No action. After 4.6	
4.11 Evaluation of the scheme	To be started in April 2004	
4.12 Development of plans for national roll-out of the scheme	By end of 2004	One outcome of 4.1 is that there will be a strong link between the risk-pooling schemes in this project with an upcoming project on Primary Health Care from the World Bank in certain rural areas. Political commitment regarding shared funding also extends to this new project.

Log frame Results

Output 1 - FM Demonstration sites are established and functional

Indicators	Baseline	Target for 2002	Target for 2003	Result	Comment
Impact Indicators					
FM demonstration sites are established and functional	N/A	5 FM sites refurbished, furnished and equipped with medical, training and office equipment.		Partially completed only 3 out of 5 were refurbished	Partially Achieved
	N/A	On average there are 100 families enrolled per GP	On average there are 300 families enrolled per GP	On average 529 families enrolled per GP (according to last month reports)	Achieved
	0.02 outpatient contacts per person per month.	Increased utilization of FMCs by 10%	Increased utilization of FMCs by 30%	0.17 outpatient contacts per person per month.	Achieved Utilization increased by 85%
Process Indicators					
5 FMCs are remodelled & equipped	Old deteriorated buildings	5 FMC's are remodelled	N/A	Partially completed only 3 out of 5 were refurbished	Partially Achieved
	Lack of medical, educational and office equipment	5 FMC's received medical, educational and office equipment	N/A	Completed	Achieved
New legislative framework is developed for FM Centres	No legislative framework exists for FMCs	Legislative framework developed and MoLHSA Decree Issued.	N/A	Decree No. 103/O; issued on April 15th, 2002	Achieved
	Facilities do not have license to offer FM based services	FMCs are licensed to employ GPs and offer services to diverse age groups of population.	N/A	Facilities obtained license and are legally allowed to offer services to diverse age groups.	Achieved
	Facilities do not have contracts with diverse public financiers	Public service contracts are signed with Municipal Health fund, SMIC and PHD/NCDC	N/A	All facilities have enter into the contract with all public purchasers	Achieved

Indicators	Baseline	Target for 2002	Target for 2003	Result	Comment
New organizational model for FMCs is developed and implemented	Old polyclinic organizational model with no clear definition of the roles and responsibilities of FM/GP doctors, PHC teams	New organizational model is developed	N/A	Completed	Achieved
		Roles and responsibilities of the PHC team members clearly defined.	N/A	Completed	Achieved
		Each FMC staff members have clear job descriptions.	N/A	Completed	Achieved
		Referral-counter referral system developed	Specialists are not accessed without GPs referral	Not Implemented by all facilities	Not achieved
MIS for FMCs is developed and implemented	Soviet style (paper carrier) information system exists.	Critical requirements for MIS are defined.	N/A	Requirements developed	
		N/A	PC Software, that allows to capture critical data is developed and implemented		
		N/A	Staff is trained in operating the software and producing the needed reports.		
Social Marketing Strategy Developed and implemented that helps to attract population to FMCs	No SM Strategy available	SM Strategy developed and accepted by the stakeholders		Document describing SM strategy is available	Accomplished
		Implementation of SM commences	Implementation of SM continues	SM Implementation started with the help of OXFAM	Accomplished
		<u>One new Seminar and/or health schools of 4-5 different types developed by the FMC per month.</u>	<u>One new Seminar and/or health schools of 4-5 different types developed by the FMC per month.</u>	On average 14 new seminars and/or health schools were developed by FMC per month	Achieved

Indicators	Baseline	Target for 2002	Target for 2003	Result	Comment
		2. Seminars and/or health schools conducted by the FMC per month	4 Seminars and/or health schools conducted by the FMC per month	On average 16 seminars and/or health schools were conducted by FMCs per month	Achieved
		40 of follow-up phone calls and 50 home visits made by the PHC Team per month	60 of follow-up phone calls and 70 home visits made by the PHC Team per month	On average 637 of follow-up phone calls were made per month	Achieved
		50 individuals participate in the seminars and/or health schools at the FMC per month.	100 individuals participate in the seminars and/or health schools at the FMC per month.	On average 243 individuals participated	Achieved
	Very low	Level of population's knowledge about FMCs and services they offer increase to 20%;	Level of population's knowledge about FMCs and services they offer increase to 50% ;	Not evaluated	Not Evaluated
	87%	Increase level of population's satisfaction with the services offered by FMCs by 2%.	Increase level of population's satisfaction with the services offered by FMCs by 5%.	Patient Satisfaction Survey proves high satisfaction with services offered by FMCs	Achieved but is not represented in %-ages
Increased population enrolment with demonstration sites	N/A	15 new families (and/or 55 individuals) enrolled with FMCs per month per GP	20 new families (and/or 72 individuals) enrolled with FMCs per month per GP	On average 5.76 (28% of target) new families enrolled per month per GP or 25.7 (35% of target) individuals per GP per month.	Not achieved
		1000 individuals receive services from FMCs per month	1500 individuals receive services from FMCs per month	On average 2826 individuals receive services per month	Achieved
		Total number of families registered with each doctor per month (reach 100 at the end of the year).	Total number of families registered with each doctor per month (reach 300 at the end of the year).	On average 529 families registered per GP	Achieved

Output 2 - New financing model for PHC implemented

Indicators	Baseline	Target for 2002	Target for 2003	Results	Comment
Impact Indicators					
New financing model for FMCs is developed and implemented	N/A	New financing model is developed and implemented	New financing model is evaluated, necessary changes incorporated and recommendations for national rollout presented.	Final report of evaluation is available with recommendations	Achieved
Process Indicators					
Develop alternative models for FMC financing	N/A	Existing PHC financing & organization is evaluated	N/A	Completed, Report: PHC Financing in Georgia; Background Paper; February 2001	Achieved
		Alternative financing options package developed and disseminated among stakeholders	N/A	Completed, Report: PHC financing model for pilot facilities; June 2001	Achieved
		Proposed alternative options are appraised and sustainability evaluated	N/A	Completed	Achieved
Financing model developed, agreed among stakeholders and implemented	N/A	Financial model for FMCs finalized and agreed among stakeholders.	N/A	Completed	Achieved
	N/A	Implementation of Financial model is supported with GoG (Tbilisi municipality) regulations.	N/A	Completed	Achieved
	N/A	New Financial Model Starts Functioning	N/A	Completed	Achieved
Appraisal of financing options and the sustainability of a proposed package nationally	N/A	N/A	Financial model is appraised and recommendations for national roll-out made	Financial model appraisal report is prepared	Achieved

Output 3- Human Resource Capacity for new PHC model established

Indicators	Baseline	Target for 2002	Target for 2003	Results	Comments
Impact Indicators					
Family Medicine training centres established and functional	N/A	NFMTTC renovated, equipped and functional as training centres	61 FPs are trained at demonstration sites	43 were retrained in 2001-2002 34 will complete training in November 2003 Total 77 will be trained at demonstration sites (2001-2003)	Achieved
		Other (four) FM demonstration sites renovated, equipped and functional as FM training centres	15 Practice Managers are trained at demonstration sites	15 practice managers trained at demonstration sites (This include manager trainers 10 managers + 5 manager trainers)	Achieved
			24 General Practice Nurses are trained at demonstration sites	24 GPN trained at demonstration sites	Achieved
Process Indicators					
Training facilities renovated and equipped with necessary equipment	N/A	NFMTTC and 4 other facilities are renovated and equipped with necessary training equipment	N/A	Completed	Achieved
Training program for FPs	N/A	Curriculum developed and approved by the MoLHSA	Training Program evaluated and amended if needed	Decree No. 103/O; Annex 5 issued on April 15th, 2002	Achieved
Development of the curriculum for training primary care manager trainers	N/A	Curriculum developed and approved by the MoLHSA	Training Program evaluated and amended if needed	Decree No. 103/O; Annex 7 issued on April 15th, 2002	Achieved
Development of the curriculum for training primary care nurses and nurse trainers	N/A	Curriculum developed and approved by the MoLHSA	Training Program evaluated and amended if needed	Decree No. 103/O; Annex 6 issued on April 15th, 2002	Achieved
Legal framework for NFMTTC and the Retraining sites are developed & implemented	N/A	Legislative framework developed and MoLHSA Decree Issued.	N/A	Decree No. 103/O; Annex 11 issued on April 15th, 2002	Achieved
		Retraining sites are licensed to carry out training activities.	N/A	All facilities obtained license that permits training activities to be carried out.	Achieved

Indicators	Baseline	Target for 2002	Target for 2003	Results	Comments
Human Resource Capacity for Training facilities developed	N/A	8 FM trainers trained from 3 regions (Batumi-Adjara (3) and Kutaisi-Imereti (3), Kartli-Gori (2))	12 FM trainers trained from 3 regions (Batumi-Adjara (5) and Kutaisi-Imereti (5), Kartli-Gori (2))	14 FM trainers trained from 3 regions (regions (Batumi-Adjara 7 and Kutaisi-Imereti 5, Kartli-Gori 2)	Achieved
	N/A	5 general practice manager trainers trained at demonstration sites	5 general practice manager trainers trained at demonstration sites	5 general practice manager trainers trained	Achieved
	N/A	8 nurse trainers trained at demonstration sites	6 nurse trainers trained at demonstration sites	14 nurse trainers in total trained at demonstration sites	Achieved
Facilities train the staff for PHC	N/A	16 trainers trained in previous KHF Project deliver short course modular re-training program for 80 rural doctors	18 FM physicians trained at demonstration sites	80 physicians trained in short courses. 40 FP completed training at demonstration sites (All are staff of FMCs) In addition to this 34 PHC doctors from Tbilisi are currently being trained at demonstration sites (training will end in November 2003) 7 of them are staff of demonstration sites.	Achieved
		43 FM physicians trained at demonstration sites	32 FM physicians in the three regions	32 FP trained in regions	Achieved
		24 PCN are trained at demonstration sites	24 PCN are trained at demonstration sites	24 PCN completed training	Achieved
			10 primary care managers are trained	10 managers completed training	Achieved
Development and implementation of EB care guidelines	Not available	5 EB care guidelines developed and implementation commenced at demonstration sites	5 more EB care guidelines developed	10 guidelines and 100 protocols developed	Achieved
				Patient records resemble application of guidelines by doctors	Partially Achieved

Indicators	Baseline	Target for 2002	Target for 2003	Results	Comments
Medical School accreditation consultancy-situational analysis; Development of the Framework for the accreditation of Medical Schools	Not available	Framework for accreditation developed and proposed to the MoLHSA and Ministry of Education for comments	Framework for accreditation accepted and decree issued by MoLHSA and MoE	Framework for accreditation accepted and decree issued by MoLHSA	Partially achieved