

Georgia Health Sector Reform Programme - CNTR 02 4201
Primary Health Care - Human Resources Work Stream

**INSTITUTIONAL MAP OF AGENCIES INVOLVED IN HR & SERVICE DELIVERY IN
GEORGIA**



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Disclaimer

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1 Introduction

1.1 Outline & Coverage of Report

This report has been produced in the context of the OPM Georgia Health Sector Reform Project, CNTR 02 4201. A specific reason for producing it, building on the international experience, has been the evidence that training without proper institutional foundations is bound to create waste and demoralization. Confirming this, repeated training efforts in Georgia have fell short of any impact commensurate with the financial and organizational investments that they have entailed.

The reform of the Primary Health Care (PHC) system in Georgia will require analysis of,

- the policies which form the framework for its operation and the way the system is managed - the regulatory (“stewardship”) function,
- the services that are provided & how they are provided - the service production function
- the quantum and training of health care providers, technology, premises and equipment, etc - the resource generation function
- the way the system is financed - the financing function.

This Report will address the institutional aspects of the human resource (HR) and service production aspects of the PHC system in Georgia. A separate Report will deal with issues related to the roles & functions, skills & competencies of the major groups of personnel involved in the PHC system, “*PHC – Roles & Functions in Georgia, The Current Situation*”. The importance of the connection between the two papers and their place at the cornerstone of the PHC system should not be overlooked; appropriate and good quality health care services cannot be provided unless practitioners have the appropriate skills etc and these skills cannot be produced without a strong institutional structure to govern curricula development, delivery of training, licensing, accreditation, quality improvement etc. Both papers are thus closely connected and should be read in conjunction.

This Report is required to address the three major classifications of personnel working in the PHC system, doctors, nurses and practice managers. There is very detailed discussion of the institutions involved in the training of doctors and nurses and the flow of training, licensing requirements and issues of quality in Georgia. The Report also briefly considers the need for quality in the institutions directly involved in the delivery of PHC as well as issues of patient rights and clinical ethics.

Managers in the PHC System

Because the role of management is so narrowly defined in Georgia and is regarded as a Public Health function, only qualified doctors can, in fact, if not in express legal provisions, become managers of public clinical institutions (see below). The supply of managers in the PHC market is restricted to doctors who have completed a residency in Public Health & Health Care Management. Only persons who have passed the state certificate exam in health care organization can sit for the management examination. The management program is discussed in “*PHC – Roles & Functions in Georgia, The Current Situation*”. There is little of additional value that can be added in this paper. Consequently, the institutional aspects related to the training of managers are not discussed in depth in this paper. However, this very fact that management is

so narrowly defined leads to the conclusion that the status and qualifications of managers should be improved.

Structure of the Report

During development of this Report a great deal of material has been collected and a number of papers commissioned to provide detailed information of how PHC operates in Western Europe. All of this material has been collected separately and indexed for the Georgian policy makers to use. It is included with this official deliverables as a useful source of reference material for those interested in understanding the issues better and for people in the PHC system generally. This collection of material is entitled “*Supporting Material Related to “Institutional Map of Agencies Involved in HR and Service Delivery”*”. However, the extraordinary organisational and administrative complexity of the Georgian bureaucracy means that misunderstanding or errors of omission or interpretation may have occurred. Notwithstanding this the Consultant is confident that the main picture that has emerged is accurate and that the conclusions & recommendations set out in the final section are valid.

The detailed structure of the Report is shown in the Table of Contents which appears immediately before this section. In summary, the Report will address,

- Brief Historical Background to PHC in Georgia
- Discussion of the Definition of Primary Health Care
- Supply & Education of Doctors
- Supply & Education of Nurses
- Assurance of Continuous Clinical Competence
- Accreditation of Training Institutions
- Quality of Health Care Facilities
- Issues of Patient Rights
- The Role of Professional Associations
- Service Delivery Issues – what services and how they reach the patient.

At the end of each section the Report will summarise the areas that the Consultant believes should be addressed to strengthen the institutional framework for PHC system in Georgia. These “conclusions”, as it will be explained, are not things that must necessarily be done immediately but represent the major changes which will have to occur in the medium term if PHC in Georgia is proceed from a strong base towards the standards of Western Europe .

Accordingly, the final section of the Report will summarise the conclusions under two headings, those things that should be done immediately and those things which can be done more gradually.

1.2 Historical Background

Any discussion of the current institutional map for PHC in Georgia must be undertaken with some historical perspective. Thus a brief outline of the service delivery system that was inherited from Soviet times and the changes that ensued after 1991 is appropriate (it will be also addressed at the beginning of each the sections below). The features of the 'Semashko' model as applied in Georgia were,

- a massive supply of "primary" health care provided by specialists in ambulatories and polyclinics within a segmented structure, each taking care of women, children, TB patients, etc. separately
- healthcare was free at the point of service
- healthcare staff were salaried but at very low levels
- legally, private practice was not allowed
- an abundance of beds and specialized staff in non highly technologically equipped hospitals.

In organizational terms the system was very centralized in Moscow where the Ministry was responsible for planning, controlling and financing the system with a Georgian Health Authority as a regional administrative body monitoring activities and reporting back to the central authorities in Moscow.

The system is well described in the Report by David Gzirishvili and George Mataraze for UNICEF/HNI 1998 as follows:

"Primary care comprised prevention, health monitoring (so called "dispanserisation"), and outpatient care. The network of health care institutions delivering primary health care included:

1. *Polyclinics:*
 - Adult*
 - Paediatric*
2. *Women consultations,*
3. *District/village clinics ("feldsher points", ambulatories),*
4. *Factory polyclinics/medical points*
5. *Specialised outpatient clinics ("dispensers")*
 - Endocrinologic*
 - Psychiatric*
 - STD/Skin Diseases*
 - Psycho-neurologic*
 - Rheumatologic*
 - Cardiologic*

Primary care institutions were staffed by general practitioners (more specifically internists) and by wide range of specialists (mostly polyclinics). Primary care institutions performed almost all routine laboratory and instrumental investigations.

Each person was assigned to a district doctor - the above mentioned general practitioner (GP) of the primary care institution based on a residence. There was no free choice of the district doctor.

The district doctor played a role of gatekeeper referring the patient to specialists, lab/instrumental investigations and to secondary/tertiary health care institutions. Thus, for hospital admission a patient needed special referral permission rendered by GP except of emergency cases when ambulance service provided admission”

Two major points should be noted about this system,

- Officially PHC centres were principally staffed by generalists supported in an internal referral network by specialists when required. However, this role was often undermined in practice by an unofficial system where patients (particularly from the higher income groups) self-referred privately to specialists in hospitals. Nonetheless the gatekeeper role of PHC doctors was established as a principle at this time.
- The system was financed, managed and delivered by the central State as a complete entity. Staff were employed on the basis of capitation norms, 1 doctor + 1 nurse per 2000 population. There were no job specifications or contracts of employment. While there were ostensibly workload measurements or standards they were rarely observed. Utilisation of health services varied wildly across the country and there was no incentive for cost control or efficiency in the delivery of services.

The PHC Strategy Report 2000 acknowledged the legacy of the Soviet period and described the infrastructure of the health care system toward the end of this period as being *“top-heavy with the major feature being specialised in-patient based institutions with ambulatory clinics among the least well used”*

As it is well known, the period of transition from the Soviet period was characterised by significant civil conflict, political disturbances and major disruption to the social and economic systems of the country. The consequences of this changing situation was a further deterioration in PHC as physicians loss of income from the state system increasingly forced them to seek more informal payments through the so-called ‘out of pocket’ payments from patients. The ambulatory and polyclinics deteriorated and reduced their activities and some effectively ceased functioning.

In 1995 the Government commenced reform of the health system with the belief that there needed to be a radical change in the underlying principles behind the institutional arrangements inherited from the previous Soviet period. It decided to move away from a centrally planned and controlled, top down institutional model to a more market oriented approach following the principles of the Bismarck model used by a number of countries in Western Europe. In this model there are three functional responsibilities,

- a) determining overall policy needs and priorities
- b) purchasing services to meet those needs and
- c) delivering these services by means of a network of service providers.

These functions were separated as follows,

- The Ministry of Health (MoH) would maintain control of policy and set State priority health programmes to meet assessed need. It would be responsible for establishing the norms for a basic package of benefits that the population would receive free of charge

- The Regional health authorities and a regionally administered Insurance Fund would purchase these services as a package from service provider units
- Service providers would be privatised and would compete in the market place for contracts for the State service packages from the regional authorities/insurance fund
- Any services above the basic state package could be purchased by the population from the service provider of their choice in an open market.

The reform process also aimed to include medical education, medical science and health information systems together with the accreditation and licensing of medical institutions and staff.

In terms of primary care the overarching strategic principles behind the reform of curative medicine system in Georgia were stated in the Government's Georgian NHS Policy Report published in 1999 as:

- **Equity in Medical Care** - the same health service entitlement for all people
- **Equity of Access** – services to be accessible by the whole population
- **Affordability** - services that are affordable by the whole population

In short, the Government of Georgia intended to increase private-sector participation in the health system and limit the State's role to such areas as health promotion, immunization, establishing a regulatory framework, accreditation and licensing, research and education. It wanted also to ensure access to essential services for the most vulnerable groups.

The Government's intention in relation to Primary Health Care (PHC) was set out in the document titled Georgia's "Primary Health Care Strategy". It presents a framework designed specifically for Georgia, and its stated intention was to inform the implementation decisions taken by the Government in the course of an overall healthcare reform. It was prepared in 1999 and is used here as a reference point from which to develop a definition of PHC and its place in the overall health system.

The Primary Health Care Strategy states that,

"Primary health care is a concept that means different things in different contexts, and often there is a blurred distinction between it and public health. Many elements of public health, such as immunization, preventive health measures and health promotion, are often implemented at the primary health level, and in some countries it will be the public health department that will be in charge of those activities, though it must coordinate them with the primary health care network."

Given the virtual disappearance of the previously established "gatekeeper" principal whereby primary care prevented unnecessary referrals to the more expensive secondary ambulatory and ultimately inpatient care, the statement could go further and say that there is an even greater confusion, or blurring of distinction, between primary care and secondary care.

The Strategy also referred to what is commonly known as a "Basic Benefits Package" (BBP). The words used are that there would be a limitation of,

“.....government financing of health care to a minimum benefit of essential services, leaving the remainder to be financed by a combination of out- of- pocket payments and insurance (whether private or public).”

If the issue of HR management for PHC is to be properly considered in terms of institutional responsibility and service delivery, the concept of a BBP needs to be better defined. To not do so runs the risk that functions with different objectives become organisationally confused and, inevitably, badly managed.

1.3 What is Primary Health Care?

Thus, there needs to a brief discussion of the issues of public health v primary care v secondary/tertiary care. Indeed this discussion is not intended to address the issues in any depth but rather to clarify the use of the terms (for a more detailed account the reader is referred to the paper titled, “Primary Care: Western European Best Practice Of Institutional Involvement And Responsibilities In Human Resources Policy” which is an annex to the Report, “*PHC Roles & Functions, The Current Situation*”

Public Health versus Primary Health Care

There are two main things that distinguish Primary Health Care (PHC) from Public Health activities. Firstly, access to PHC is initiated by the personal decision of an individual to seek medical advice/service. Secondly, Public Health activities, by and large, do not, as a matter of course, provide or deliver care to an individual. Rather public health programmes develop and enforce standards of behaviour that protect public health (sanitation and hygiene issues) and(based on epidemiological analysis) identify where care is needed, promote activities that will obviate or reduce the need for care etc. The actual care is best delivered by the PHC network. It is acknowledged, in passing, that some countries may use delivery points other than the PHC network to deliver public health programmes such as mass immunisation. However, the general principal that one area provides care and another identifies needed care is still valid.

Aside from sanitation and hygiene issues, the Public Health Service focus should be on identifying current or emerging threats to public health (communicable diseases, increasing rates of costly/fatal conditions etc) and then doing two things. Firstly, determining how to encourage the relevant groups within the community to seek advice/treatment and then how to provide that treatment. The normal and obvious option to meet the latter need is to use the PHC system. This view reinforces the concept that the PHC system is primarily a delivery network

Another way of expressing the difference is to consider “wants” and “needs”. Roughly speaking, the PHC practitioner is primarily faced with satisfying what individuals want, i.e., more or less, to know why they do not feel well and then to help them feel better. The main task of the Public Health functionary is to identify the real health (improvement) needs of the community and then to convince them to want treatment.

In other words, it is not that PHC is not concerned with preventative medicine and the promotion of healthy behaviour but it is primarily focused on the area where people health “needs” and health “wants” overlap.

This argument is being laboured here because of the different view that seems to permeate the Georgian PHC Strategy; for example,

“In general, primary health care is a health policy model that seeks to support the general health of the population through structures that promote health and means of improving health. The institutions involved in supporting primary health include such actors as general practitioners, nurses, pharmacists, social workers, and other health providers, and institutions such as clinics, government offices and private sector organizations that aim at achieving better health for all. Citizens are an essential contributor to the development of the services.”

This form of expression has a strong emphasis towards public health functions. However, it needs to be considered in practical terms. While it is a view may suit a theoretician who has a “helicopter” view of the world, it is arguable that the ordinary citizen would see the PHC system as a service delivery mechanism that provides him with access to treatment for acute and chronic conditions and minor injuries. In considering reform of that system it would be important as well to give substantial weight to this view. If the above statement was qualified by a recognition that that PHC is a part of a larger system that exists to maintain and improve the health of the community the argument here might be less strident. However, the Strategy specifically talks of the PHC system and of health promotion and improvement. This is true as far as it goes but the role of the PHC system is essentially health service delivery. Within the MoHLSA and the Public Health Department it is important that this difference be given organisational expression.

Primary Health Care versus Secondary Health Care

As noted by the PHC Strategy Report (quoted previously), one of the legacies of the Soviet system is the preponderance of specialists located in Ambulatory Care Centres and Polyclinics and a dysfunctional referral system. This seems to have led to a situation where the idea of primary care and secondary care has been lost and replaced by a notion of ambulatory care and inpatient care. Thus, any service which is not inpatient is ambulatory and all ambulatory services are *de facto* considered primary health care.

This view is evidenced by the way the BBP concept is given legal form in Georgia by the State Ambulatory Programme (refer Annex 22 in the Supporting Material for this Report) for all areas outside Tbilisi and the Municipal Ambulatory Programme (refer Annex 23 in the Supporting Material for this Report) for citizens of Tbilisi and, until 1 July 2004, Batumi. Attachment A to the Report itself provides a summary of both documents. Both documents regard attendance at a polyclinic, an ambulatory care centre or a mono-profile dispensary (for example) as part of the primary health care system. However, the Georgian Government has formally accepted the principle that the primary care doctor is a generalist and should act as gatekeeper to more specialised services. This inconsistency between the articulation of the Basic Benefits Package (in the SAP/MAP) and the concept of a gatekeeper is probably a major reason why observance of the gatekeeper principle has all but disappeared. Equally, as the BBP is required to cover “essential services”, the omission of any inpatient services from the BBP is a further cause for concern and confusion. While this approach goes beyond the strict boundary of either PHC or even ambulatory care it must be noted that a definition of essential services (which is what the BBP is intended to be) will cause conflicts and confusion.

In this context the ideal BBP should contain the following elements. It should,

- distinguish between primary care and secondary care and between ambulatory care and inpatient care
- focus on primary care with the aim to encourage individuals to utilise the overall health system and to facilitate that utilisation
- the funding of secondary care, particularly secondary ambulatory care, should be designed to encourage return of the patient to the care of the primary care doctor/ team as soon as possible
- consolidate funding to the greatest extent possible at the point of delivery so that neither providers nor patients are motivated to pervert the sensible operation of the system
- ideally, provide some hospital care.

To give a context to the drawing of the institutional map this Report will assume that the PHC system will refer to services provided by practitioners who are part of a facility which is designed to be the point of first contact between an individual and the system for a given episode of illness.

Application of this definition means that when the responsibility for care of a patient is passed from the doctor who provided the initial contact to another doctor or institution, the patient has moved out of the PHC system. Equally, if the care of the patient is passed back to the point of initial contact, the patient is deemed to be again part of the PHC system.

The development of a new BBP and associated payment systems/incentives for Georgia should be structured so as to encourage entry to the health system and prompt return to the PHC.

Major Issues to be Addressed

1. The function of public health should be understood as conceptually separate from the function of primary health care delivery and this should be reflected in the organisational structure
2. Public health function should be understood as the identification of community need and the development of strategies to turn community “need” into individual “want”.
3. Primary Health Care delivery should be understood as the delivery of services to meet the “wants” of the community and the identification of individual need.

2 The Training & Supply of Medical Practitioners

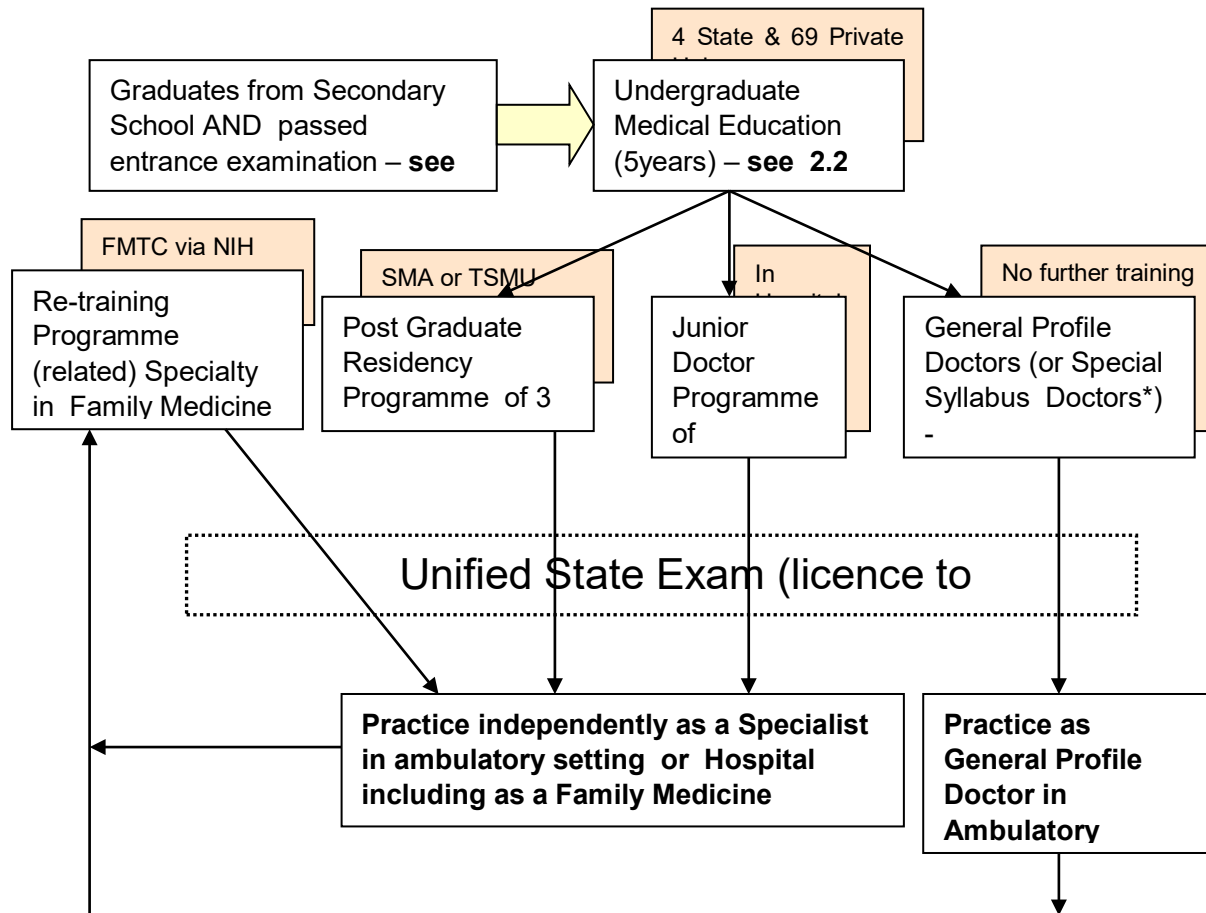
2.1 Introduction

Under the current legislation in Georgia the Ministry of Education (MoE) is in charge of regulation of undergraduate medical education institutions whereas the Ministry of Labour, Health & Social Affairs (MoLHSA or MoH) is responsible for the management and coordination of the process of post graduate education (residency) and continuous medical education. Because of the confusion referred to above between primary care and secondary care the discussion which follows covers the training of all levels of medical practitioners, general profile, specialists, military doctors etc..

The normal mechanism for supplying appropriately trained doctors in Georgia is through the Higher Medical Education system which has two levels which must (with some exceptions) be completed before doctors are allowed to treat patients. Following successful completion of the State Unified Exam there is a third level of training, Continuing Medical Education. The first two levels of training are,

- Level 1 Undergraduate Education - involves study in the general medical education which comprises a largely theoretical base but with some clinical contact (“pre-training”). Most students follow a broad knowledge based syllabus in general medicine initially as an underpinning basis for further more specialized study. At this level, students are required to indicate the specialty they intend to pursue at the next level. This is part of the criteria for selecting recruits for post-graduate training (see later). The period of study is 5 or 6 years depending on the specialty chosen. This is expanded at 2.2 below.
- Level 2 Postgraduate Education - a graduate from Level 1 normally follows a residency programme for 2-4 years in a particular specialty (eg. “cardiologist”, “urologist” etc) at an approved Post Graduate Medical Institution. This builds on the previous theoretical training but has a greater clinical input. However, a graduate from Level 1 may also become a “Junior Doctor” or move directly into the ambulatory sector as a General Profile Doctor. This is expanded at 2.3 below.

The following diagram illustrates the broad process. Each major function will be further discussed in detail.



The “special syllabus doctors” referred to above are those students who follow more restricted syllabi from the outset in specialized faculties including areas such as the Faculties of Military Medicine, Psychosomatics, Doctor and Lab. Technician . The rationale for such specialized undergraduate programmes is unclear and they appear to be contrary to the principles of the Georgian higher medical education .

It might also be noted here that this Paper does not deal with the training, licensing etc of Dentists although, from time to time, there is mention of this profession in the medical education field.

2.2 Undergraduate Medical Education for Doctors

Undergraduate medical education in Georgia is provided by 4 State and 69 private educational institutions which are referred to as Higher Medical Education Institutes. The State institutions are,

- Tbilisi State Medical University
- Faculty of Medicine of State University
- Faculty of Dentistry at the Academy of Sport

- Faculty of Medicine of Gori State University

Of the 69 private institutions that offer higher medical education programmes, 24 offer only medical programmes; of these, 22 are in Tbilisi.

All of these institutions are subject to the accreditation processes of the MoE. This process is covered in Section 5 below.

The State funds an agreed number of undergraduate medical places in each new cohort of the 4 State medical institutions. The number of state funded places is determined by Ministry of Economics in agreement with Ministry of Education and MoLHSA with final authorization given by a State Order after approval for the commitment of funds has been given by the Ministry of Finance. It is not understood how the total number of funded places is distributed between the four institutions.

This Consultant has not found evidence of any manpower planning process in terms of defining the future numbers of graduate doctors needed (as cohort output numbers) and then planning the required cohort input numbers to be funded by the State. Equally, there is no consideration of the size of the annual input cohort in each of the private universities.

In fact, the State Order is largely a formality as the approved numbers each year are based on historical numbers. The number of students requested from State Institutions varies little from year to year and corresponds to their basic needs to maintain historical staffing levels of “trainers”. The State institutions can source additional funding by offering additional places on a fee paying private basis.

Entry requirements for the places in all these undergraduate medical institutions include a secondary school certificate and “satisfactory” results in an entry examination involving elements of Chemistry, Biology, Georgian and English. The criteria for determining “satisfactory” is based on a ‘norm’ referencing system for determining the successful applicants without reference to achieving an agreed standard for each element. Contrary to the usual practice in Western countries, there is no independent examination body responsible for approving an agreed entry standard for all undergraduate medical education. Each institution sets its own entry examination and assesses its own candidates without reference to any external verification of the results. There is no external appeal process.

The only form of accreditation takes the form of one-off approval of the competence of the examining staff from each state medical institution by the Ministry of Education, refer Section 6 below. All State institutions are required to appoint a Board to set examinations and that Board must be approved by the Ministry of Education. Private institutions are not subject to this requirement. However, it is believed, that most do, in fact, seek MoE approval of the composition of their examination Boards.

Students then follow a 5 year programme which is largely class based theory. Some limited time is allocated in the programme for clinical work experience as assistants. This is usually begun after completion on 4th year of basic education when students have a one month experience in nursing practice and subsequently they undertake a 6 week period of training as a doctor’s assistant.

In Soviet times there was one teaching programme for the whole territory of USSR, revised and approved once in every 3 or 4 years. This process was at first continued in Georgia and the last approval was given in 1995. Subsequently the MoLHSA, without the agreement of the MoE, issued a guideline paper that relaxed the rules covering the medical programme syllabi permitting 15% variations in each discipline. Although this paper does not have a legal status in practice it has led to variations in programmes offered by the educational institutions.

2.3 Postgraduate Medical Education for Doctors

Upon completion of theoretical and clinical medicine education in Level 1 the higher medical institution issues appropriate certificates. At this stage the graduate doctors are deemed to have passed the first underpinning knowledge stage of their profession but they are not yet allowed to practice medicine independently (from June 1, 2001). They can then follow a number of possible routes to develop their clinical knowledge and acquire the necessary clinical skills as follows:

- Proceed onto a State administered postgraduate “state residency” programme in their chosen specialty, including Family Medicine (see 2.3.1 below) and, if they wish, then undertake a “mini residency” to gain a second specialty in Family Medicine (see 2.3.3 below)
- Undertake further research and teaching activity in the theoretical fields of medicine or in other fields of health care in research or education institutes. However this cannot involve independent medical practice on patients. This is not dealt with further in this Paper.
- Seek an appointment as a junior doctor usually in a hospital working as an assistant and under the direct supervision of a clinical specialist (see 2.3.2 below). A Junior Doctor, on completion of the three year period under supervision is thus a full recognised specialist including in Family Medicine.
- Sit for the State Unified Exam and seek appointment as a General Profile Doctor in an ambulatory care centre. Doctors who followed the “special syllabus” mentioned previously follow this route. This area is discussed under the mini-residency heading at 2.3.3 below.

Postgraduate medical education in Georgia is primarily organized through internship or residency programmes for each of the specialities.

The MoLHSA is principally responsible for the regulation of postgraduate training. This includes,

- direct control of the numbers of residency places offered as part of its workforce planning role in order to control the supply of specialists entering the health system at each cohort stage.
- directly funding a specified number of these residency places each year and establishing in consultation with the institutions offering places, how many places in total (including self funding places) can be offered each year.
- determining the duration and volume of the residency course together with the doctor’s professional associations

The control of entry to postgraduate is the only gesture towards manpower planning and control of the number of licensed practitioners. The MoLHSA has recognised the over supply of doctors

in Georgia and has recently used the residency programme as a means to reduce market entry numbers. These numbers are shown in section 2.3.1 below. However the existence of the parallel alternative junior doctor system undermines the effectiveness of this control mechanism. There is no restriction placed by the MoLHSA on the number of junior doctor placement/jobs. Specifically, a junior doctor who completes a supervised term in a hospital and is certified accordingly (refer section 2.3.2 below) is entitled to sit for the Unified State Exam.

One of the main requirements for entry to a particular residency course is that the chosen specialty should correspond to the education course (faculty) taken in the higher medical institution during level 1 undergraduate training. The selection of candidates for State funded places in these residency programmes is undertaken competitively through an entrance examination that is only prepared by the State Medical Academy (SMA) under the provisions of MoLHSA decree (01.10.2003 #223/o) which clarifies the composition of State examination committee for residency examination and passes the organizational responsibility of residency examination to SMA. The priority in the selection process of candidates belongs to the head of the residency programme.

The State Residency Programme System

These residency programmes are delivered by a small number of academic medical institutions. and they are accredited by MoLHSA. The 2004 residency programme management and organization is being implemented by:

- Tbilisi State Medical University (TSMU)
- State Medical Academy (SMA)
- Ltd stomatological clinic "Unident";
- JSC "Emergency cardiological center" (for the 2002 contingent)

Any institution wishing to offer a residency programme submits an application to the 'Post Graduate & Continuous Education Board' (PGCEB) which is part of the MoLHSA.

Its members are appointed by MOHLSA and at present include senior staff of a number of educational institutions According to MoLHSA decree (21.11.2002 #332/n) PGCEB is composed with 33 members, members should be changed once in every 3 year, but the principle of composition remains the same: 6 representatives from professional associations, 6 – from higher medical educational institutions, 6 – from SMA, 6 – from scientific research institutions, 5 – from medical facilities, 4 – from MoLHSA. It is not clear why the SMA is given separate representation equal to all of the other higher medical educational institutions. Also, the size of the Board gives some cause for concern; inevitably a lot of work is done by committees and the apparent balance of competing interests at Board level may be lost in a smaller committee.

The procedures for approval of a residency programme are:

- Legal or physical entity (university, academy, scientific-research center, professional association, initiative group) submits a written statement on the proposed residency programme for each specialty to a residency programme directorate at the PGCEB.

- The Residency programme project team are approved by MoLHSA decree upon the recommendation of the PGCEB. This body assesses the applications and recommends approval etc to the PGCEB.
- The PGCEB should discuss the residency programme and list of institutions that will be supporting the delivery of the residency programme e.g. clinics, hospitals and medical institutes etc. that are proposed as appropriate for that particular programme by the programme team;
- The PGCEB then decide whether the application has sufficient competence to deliver a such a Residency programme and, if so, recommend to the MoLHSA accordingly. MoLHSA would then approve the programme by Ministerial decree.

In practice State Residencies are largely restricted to the State Medical Academy as shown in the table below thus granting the SMA a virtual monopoly across most specialties. The only exception is in specialties in the Faculty of Prophylactic Medicine which are located at the State Medical University.

There are different financing sources for the postgraduate medical education residency programme as follows:

- Private or self-financing (SF). – residents pay USD1250 per year. The number of self funding residency places is restricted by the MoLHSA. A total of 67 places were approved for self financing - see table below.
- State funding - also at USD1250 per year for each resident and funded from either,
 - MoLHSA, Education and Science State Programme Department – a total of 53 places were approved Including 10 earmarked for Abkhazti and Ajara). Of these 53 places, 20 were given to SMU - see table below under MoH F. The criteria for selection is the passing of a 3 stage entrance examination.
 - The State also funds additional places at the SMU through the MoE. This support takes the form of funding support for teaching staff on an hourly basis from the Faculty budget. The legal basis for this funding is not clear. Each residency place is worth 200 hours per year but only up to a defined maximum funding level. In 2004 there were 9 places funding through this system which is used only by State Medical University for residency programme implementation at their clinics and only SMU students are admitted. The entry requirements are “an excellent diploma and recommendations”.

TABLE: RESIDENCY PLACES 2004

Specialism/Funding source	State Medical Academy		State Medical University			
	(MoH F)	(SF)	(MoE)	(SF)	(MoH F)	
Dermatologist	2	1	1		2	
Endocrinologist	2	3	1	1	1	Ajara
Neurologist	2		1			
Oncologist	2	1				
Anaesthesiologist	1	2				
Infectious diseases specialist	1	2				
Crisis medicine specialist	1		1		1	
Physiotherapist	1					
Lab. Doctor	3					
Neonatology	1	4				
Ophthalmologist	2	2				
Family doctor	4	2				
Pathologist	3					
Parasitologist	1					
Paediatrician	1	4	1	1	2	Abkhazeti
X-Ray specialist	1	3			1	Ajara
Public health specialist	2	1				
Toxicologist	1					
Psychiatrist	1	2				
Gynaecologist/obstetrician	1					
Gastroenterologist		1				
Surgeon thorax		2				
ENT specialist		1		1	1	Ajara
Rheumatologist		2				
Reflex therapist		1				
Urologist		2				
General surgeon		1	1	1		
Dentist		13		8	2	Ajara Abkhazeti
Dentist orthopaedist		2				
Dentist orthodontist		1		1		
Cardiologist				1	1	Abkhazeti
Therapist(Internal Medicine)			1		1	Abkhazeti
Reproductive health specialist					1	Ajara
Epidemiologist					1	
Curative physical training specialist					1	
General hygiene specialist					1	
Communal hygienist					1	
Labour hygienist					1	
Nutrition hygienist					1	

Specialism/Funding source	State Medical Academy		State Medical University		
	(MoH F)	(SF)	(MoE)	(SF)	(MoH F)
Radiation hygienist					1
Occupational Diseases			1		
Psychotherapy			1		
Totals	129	33	53	9	14
					20
					inc 5 Ajara 5 Abkhazeti

Criteria for Determining Residency Places

A Western European model for determining the number of residency places would be based on the planned numbers of specialists required as a functional output from an on-going human resource planning process led by a Health Ministry; the criteria for determining the location of each specialist residency place would be as follows:

- the adequacy of scope & depth of training experience residents will experience
- the level of professional specialist knowledge and skills available to supervise that residency experience often through a team led by a highly experienced medical consultant (or general practitioner in family medicine specialty) with time allowed to supervise
- linked to the above would be evidence of a supporting knowledge base and research expertise available
- and the adequacy of the physical resources in terms of training facilities, equipment and learning resources available

Unfortunately in Georgia the criteria for determining residency places in Georgia appears to be based more on politics and political support than on rational criteria of need or best practice. There are no published guidelines from PGCEB outlining their criteria for choosing the locations of the residency places in each specialty.

In a situation of extreme resource constraint institutions compete aggressively for survival. Thus there are understandable competitive tensions between the SMA and the SMU as providers of these residency places. The evidence from an analysis of the figures indicates that the MoHLSA appears to largely endorse the State Medical Academy as the main provider whilst the MoE support residency places at the State Medical University.

Residency Places 2004	State Medical Academy		State Medical University		Totals
	No Places	% of Total	No Places	% of Total	No Places
MoH F	33	62%	20	38%	53
MoH F exc. Faculty Prophylactic Medicine	33	92%	3	8%	36
MoE F	0	0%	9	100%	9
Self Funded (approved by MoH)	53	84%	10	16%	63
SF Approved by Ajara	0	0%	4	100%	4
Self Fund exc Dental Faculties	37	97%	1	3%	38

The skew in favour of SMA by the MoLHSA is illustrated above with 92% of MoH funded curative medicine places being allocated to the SMA and 97 % of MoH approved self funding places (excluding dentistry) being allocated to the SMA. Despite few resources and limited experience in Family Medicine (refer section 2.3.1.2 below) the SMA has exclusive control of the Family Medicine residency programme with 4 state funded places and approval for 2 self funded places. While it could truly be said that no institution in Georgia could claim to be well versed in family medicine and that few resources nationally have been available for the development of family medicine, granting a monopoly is unlikely to lead to a great improvement..

The patronage of the SMU is illustrated by the 100% support it receives from the MoE, Ajara and Abkazeti. The MoE funded residency places are not based on any assessment of health-related or market need for these specialists; instead these 9 placements at the SMU are based in faculties each year where there is an under-utilisation of current teaching staff. Additional hours through residency needs are only requested for specialties where the staff utilisation hours are below the norm required to receive full funding from the MoE for the Faculty teaching staff salaries.

Since the residency institute enactment (from 2000-present) more than 500 residents entered the residency course. Those are graduates from 32 different higher medical institutions.

Evaluation of the Residency Programme System

The evaluation of the Residency Programme System is in two parts. Firstly, given the PHC focus of this Report, the evaluation is directed to the Family Medicine area. Then the wider system, as it applies to all specialties.

The comments related to the Family Medicine Residency Programme are,

1. The residency programme accreditation documentation for the Family Medicine Residency Programme at the SMA (see Annex 13 in the Supporting Material to this Report) is comprehensive and largely follows standard European Curriculum of clinical knowledge for a Physician or Internal Medicine Doctor. The Program is implemented by the Family Medicine Faculty and Cathedra of the State Medical Academy of Georgia.

2. The residency programme is not subject to any form of external review or quality control process although there is a form of internal quality assurance system
3. The actual delivery of the programme can also be somewhat problematic for a number of reasons:
 - i) The number of patients attending the placement medical clinics are small and therefore residents do not experience the full incidence of medical conditions and treatments laid down in the curriculum.
 - ii) The clinics that are used for clinical exposure often have difficulty meeting the scheduling requirements of the residency places and have sometimes withdrawn their support to such training activities.
 - iii) There is a significant shortage of approved Family Medicine “specialist vocational trainers”/tutors for the programme and consequently the PGsMA contract other qualified (under temporary decree) trainers from the Family Medicine Training Centre.

The comments related to the overall Residency Programme System are,

1. The residency approval system is very centralised and controlled by the PCGEB who act as the sole arbiter over determining which medical organisations are approved to run residency programmes.
2. There is no right of appeal against the Board’s decision. The practical consequence of this centralized power is that the State Medical Academy has sole approval for postgraduate medical education and training. This issue was highlighted by the EUA (European University Association) Evaluation Report on Tbilisi State Medical University in October 2003 on Medical Education in Georgia when comparing it to good international good practice stated:

“the Government (Georgia) decision of placing postgraduate medical education under the control of the MoLHSA & the Academy of Advanced Training Of Physician (the SMA) is questionable in what seems a reminiscence of the old Soviet system.”
3. Accreditation processes are very weak and only based on a written application prior to commencement of the programme. The PGCEB has no independence in the approval process, some members of the Board are effectively approving programmes from their own institutions. There is a conflict of interest in their roles and they are then leaving themselves open to criticism of a lack of objectivity in their decision making.
4. There appears to be no on going monitoring of the operation of the residency programmes in practice. To verify that residents in practice actually follow the programme specified in the application.
5. There is no evaluation procedure in place to assess the success of these programmes in terms of achieving their original objectives.
6. As Annex 13 in the Supporting Material to this Report shows the programme specifications are quite detailed in terms of possible resource inputs and structure but there is no evidence of the outcomes of these programmes in terms of actual competencies that the individual doctor on the programme have achieved. It is unclear how their skills are assessed in terms of educational supervision and signed evidence of vocational skills acquired.

2.3.2 The Junior Doctor System

In all circumstances, the law has it, a graduate from the Level 1 part of the system cannot practice independently. Those who move into the State Residency Program (see above) receive

further theoretical training and gradual exposure to direct clinical work with patients. Under the system of “Junior Doctor” the Level 1 graduate works, usually in a hospital, under the direct supervision of a specialist who carries the full responsibility for the patients’ care. Duties and responsibilities of the junior doctor are determined by their contract with their employer, which must be a licensed medical institution.

However Article 100 from the law on “Doctor’s activities” also regulates junior doctors. If the junior doctor wishes to become qualified then their employer has a mandatory obligation to inform the PGCEB and before the year 2006 a junior doctor can be approved to practice independently if they fulfil the following criteria:

1. That the work duration in their chosen specialty is not less than the residency course duration in the same specialty and that the work performed complies with the requirements considered in the residency programme of this specialty and
2. That the junior doctor certifies that he/she was working under supervision of the person of an appropriately skilled and trained specialist throughout this period.
3. That they pass the state certification exam.

Logically, a junior doctor who meets the above criteria would become a fully fledged specialist with the same rights and responsibilities as one who came through the State Residency Program. However, the Junior Doctor concept is relatively new and, apparently, not fully understood. The obvious opportunities for less rigorous examination of the skills of a Junior Doctor would counsel caution in this regard.

Specifically, the weaknesses of this approach to training may be summarised thus,

1. The varied skills that the junior doctor acquires over their job experience period are dependant on the particular circumstances of each individuals job post, the patients seen and the illnesses encountered over this period. Thus the quality of “graduates” will be quite varied.
2. Some doctors learn many appropriate skills working with a high quality skilled practitioner who is willing and able to act as coach and mentor to develop their skills at diagnosing and treating patients. As a matter of contrast others merely do supportive jobs and are taught very few actual developmental skills relating to clinical practice. The fact is that there is no systematic process for ensuring consistency of approach by clinical supervisors. Again, variation in quality is inevitable.
3. There are no monitoring mechanisms in place to ensure all junior doctors follow the same curriculum as the residency programmes.
4. There is no systematic process for testing the Junior Doctors clinical skills at the end of their placement/job experience as an outcome of this process.
5. A corollary of the lack of monitoring of the standard of their competence is that there is no accountability for those doctors who are supervising their job experience which is a basic tenet of the Western European model of doctors training.

2.3.3 Specialty Licensing and the Mini Residency Programmes

The problem of having some doctors able to independently treat patients after 5 years undergraduate training (the “General Profile Doctors”) could be one of the reasons why doctors

in ambulatory care settings were not held in high regard by the community. One possible solution to this problem was to recognise General Practice or Family Medicine as a specialty in its own right and this has been done in Georgia. To become a Family Medicine Specialist it is necessary to complete the Residency Programme run by the SMA. This is a new programme and as yet there are no graduates.

In this context the first DfID Project trained a number of Family Medicine Specialists and opened a number of Family Medicine Training Centres. Since then the FMTC and its certified trainers (under contract from the National Institute of Health) have introduced a 6 month retraining programme (known locally as a “mini-residency”) which is mainly aimed at re-training General Profile Doctors but which, in theory, is available to any Specialist in a related field. The current problem with this retraining programme is, at the moment, it does not have full legal status and operates under a temporary statute.

Determination of what is “a related field” is by MoLHSA which laid down guidelines on which specialties were regarded as related – refer Annex 7 in the Supporting Material to this Report. The approved specialties for this retraining programme are as follows:

- general profile doctor
- general profile military doctor
- general profile doctor paediatrics
- paediatrician
- specialist of internal diseases
- gastroenterologist
- nephrologists
- lung specialist
- rheumatologist
- cardiologist
- doctor in psycho therapeutics

The principle behind this decree was that many specialty programmes followed broadly similar curriculum and skills development. It is not clear how much success the FMTC program has had in attracting Specialists rather than General Profile Doctors. However, there is no doubt that in principle it is a sensible and practical way to allow family medicine doctors to be relatively quickly trained.

2.4 Licensing of Medical Practitioners

Theoretically, MoLHSA recognizes the need to control both the number and the quality of doctors entering the PHC market and seeks to regulate this process through two bodies as follows,

1. The Post-graduate and Continuous Medical Education Board that is responsible for regulating the quality of the doctors in terms of their skills and competency in each specialty – discussed above.

2. The State Certificate Granting Board that is responsible for regulating the numbers of doctors entering the market by examination of those deemed suitably qualified although this is, at best, a crude tool for workforce planning.

The detailed terms of reference of these Boards are included in Annex 3 and Annex 4 in the Supporting Material to this Report.

The State Residency Programme described previously is the mechanism used by the PGCEB to determine a doctors appropriate level of skills for practice. On satisfactory completion of the residency programme or the registered junior doctor programme, the concerned doctors undertake the 'Unified State Certification Exam' which is administered by the State Certificate Granting Board.

This Board is created by the Minister of Health and approves the State Unified Exam and the subsequent issue of certificates in accordance with procedures agreed between the Ministry and the doctors' professional associations and approved by the Minister for Health. The procedures referred to are known as the manual of the "High & Secondary Medical Institution State Certificate Granting Board". The membership of the Board is the Minister for Health as Chairman plus representatives of the Ministry, the higher medical institutions, state entities which have a medical service, doctors' professional associations, the community and the medical institutions.

The State Certificate Granting Board issues the doctors with an individual certificate that effectively allows them to undertake independent medical practice within the specialist boundaries defined by the residency programme for a defined period of time (that initially is 5 years). Certification exams are held twice a year (in spring and in autumn). An applicant who fails the exam can sit again at the next sitting. There is no limitation on the number of times a candidate may sit for the examination.

There are no numerical entry restrictions or quotas to this exam. The numbers of doctors sitting for the Unified State Exam over the past 2 years is shown in the table below.

TABLE: UNIFIED STATE CERTIFICATE EXAM RESULTS 2002& 2003

	No. of Entries	No. Passing	% Pass Rate
2002			
Specialist Doctors	8776	5540	63%
General Profile Doctors & Pharmacists	3066	1796	59%
2003			
Specialist Doctors	2288	1509	66%
General Profile Doctors	1001	496	50%
<i>Totals over the 2 years</i>	<i>15131</i>	<i>9341</i>	<i>62%</i>

In the period of 6 years since the exam was introduced in April 1998 until January 2004 the total number of doctors achieving the certificate is 25,152

Whilst this number may be somewhat inflated by a number of practicing doctors wishing to renew their licence under the new licensing system it is overwhelming evidence of the shortcoming of this system as a supply side control in this labour market.

More worryingly from a societal point of view, the major weakness of State Unified Exam is that the exam is not a test of a doctors competence or skills to become 'fit for purpose'. It is merely a test of memory. This type of system has become widely discredited in Western Europe as a test of a doctors fitness to practice medicine independently.

Specific shortcomings in this examination are worth noting,

- Initially, prior indication of the exam questions and answers were provided although additional questions have been added each year
- There is insufficient variety of questions each year to make the exam different
- Cohort timing of examination during the year to avoid duplication or unfair advantage
- Consistency of marking is not provided and there is no verification process to ensure fairness
- Inadequacy of appeals procedures

A number of other factors mitigate against the use of this exam as either an assurance of basic quality or a quota system to restrict numbers. These include,

1. The fear of complaint or legal action that might be taken by those doctors who might deem themselves eligible if they were restricted entry, i.e. a restraint of fair competition
2. The management of the transition to this new licensing process has led to very large numbers of existing doctors requiring the new licence since its introduction. Since introduction of this system nobody has right of independent medical activity without re-certification. But in practice that has meant that all Georgian practicing doctors were granted re-certification.
3. The supply side pressure built up through the large numbers of doctors coming through the first level of undergraduate training.

2.5 Major Issues to be Addressed

1. A formal system of medical manpower planning (incorporating rolling 5 year forecasts) should be introduced as a responsibility of the Public Health Department (public health function). This should cover all classes of medical practitioners.
2. In the current difficult circumstances it is important that the funds to be directed to medical training be under the control of MoHLSA
3. Funds for training of medical personnel should be related to the desired number of students (manpower planning) and should be distributed on the basis of the ability of each institution to attract recruits.
4. "Special syllabus" (military doctors etc) curricula and training facilities/faculties should be abolished and these types of practitioners absorbed into the mainstream education system.
5. The entry requirements for both undergraduate and postgraduate training should be made much more stringent and consistent with the manpower planning function and should include an appeal mechanism.
6. Undergraduate training should be restructured to provide more and earlier patient contact so as to facilitate the earlier graduation of Family Medicine Specialists.
7. The "Junior Doctor" system should be abolished to ensure that there is only one path to specialisation, through PGCEB and formal training.
8. PGCEB should be restructured and made smaller to avoid regulatory capture by the training institutions. Perhaps a starting point could be to have an independent Chairman (from MoHLSA), equal representation (no more than 2 each) from SMA and TSMU, a representative from the Ministry of Education and 2 from the Professional Associations.
9. Postgraduate entrance examination to be standard for all training institutions and to be set by PGCEB.
10. As a strategic approach, expand & promote the mini-residency programme to quickly provide a quantity of Family Medicine Specialists. Eventually, wind up this programme and incorporate into postgraduate study to emerge as FMS
11. State Unified Exam to be abolished. Issue of a "License to Practice Medicine" to be dependent on success in post-graduate studies & granted by the State Certificate Granting Board

3 The Training & Supply of Nurses

3.1 Historical Background

In Soviet times nurses education was controlled by centralized system from Moscow. Under this system each area would have a designated medical school at secondary level that would be centrally funded to provide nurse education. The system was planned on a regional geographical level so that there would be no over lap or duplication of education and training services in any area.

In Tbilisi this system was manifested in the form of 3 nursing schools as follows:

- **School No 1** (established in 1918) specialized in general nursing, diagnostics and midwifery
- **School No 2** in pharmacy, feldsher nursing and dental nursing
- **School No 3** also general nursing and midwifery

Altogether there were 13 nursing schools across Georgia as a whole. They were state funded, their curriculum was centrally determined and they were all required to follow it rigidly.

The Reforms of the mid 1990s abolished this system and replaced it with a “free market” for any secondary institutions to offer nurse education and training. The 13 previous state medical schools continued to receive some central funding until 2000 and were required to submit their education and training programmes for re-approval to the MoLHSA Science and Education Dept. every 3 years. By virtue of this reform, these 12 secondary medical schools (excluding Batumi) became independent juridical entities (L.T.D.), their property belonging to the State Property Department (Ministry of Economics) and requiring students to pay for their education.

There is no nationally approved curriculum although the previous State-approved colleges still maintain a 2 year syllabus - this is referred to in the Report, *“PHC Roles and Functions in Georgia, The Current Situation”*.

Entry to these programmes can be from class 9 (age 15) and then students would follow a 3 year programme, or from class 11 (age 17) in which case the programme is reduced to 2 years. The initial year of the three year program is a condensed version of the secondary classes 10 & 11 with the actual nursing syllabus being 2 years after that and being the same as for class 11 entrants.

3.2 Current Situation

The status of nursing is currently very low and cannot currently be regarded as a proper profession.

After the sector was opened to the free market there are now, in addition to the original 13 State institutions, more than 75 secondary level institutions (private schools) offering nursing programmes in Georgia (see Annex 11 of the Supporting Material to this Report).

Compared with the substantial legal basis behind all other forms of Georgian medical institutions there is remarkably little legal basis behind nursing. It has a very low profile in the MoLHSA and in the law of Georgia on "Health Care" where there are few references to it except some very general points such as explaining that nurses should observe ethical values – respect people's dignity, fairness, etc. The Educational system for nurses consists only of secondary education-level schools. There is no specialization, licensing and continuous medical education for nurses.

The Georgian Nurses Association (GNA) is currently lobbying to establish a firmer legal basis to support the profession and in April 2004 the MoLHSA issued a Decree on an approved list of nurse specialties (see Annex 15 in the Supporting Material to this Report). The GNA has also recommended the establishment of an executive position of a Chief Nurse Office within the MoLHSA whereas at present the State organization structure of nursing in Georgia within the MoLHSA formally has two components,

1. Division of Nursing and Social Work
2. The National Centre of Nursing - which in reality is currently defunct.

In order to try to fill the nursing educational gap a number of NGOs are now offering training courses for nurses and issuing certificates. Trying to support this approach, some employers, heads of medical establishments, etc. are making attendance compulsory. The Georgian Nurse Association is also very active in the training field and is offering internationally supported programmes.

There is thus competition for donors' money between training providers, but there is no check on the quality or consistency of standards for these programmes and there is also no form whatsoever of State support or accreditation.

There is no system for accrediting nursing education courses or for licensing nurses either. The already mentioned MoLHSA decree has no meaningful purpose in practice since employers choose their staff irrespective of their nursing qualifications or background. Strictly speaking, any type of nurse can be employed anywhere in the system.

It has been estimated by Marina Sakhvadze, GNA President, in a draft Paper on the current situation on Nursing Policy for the MoLHSA that there are now over 30,000 unemployed nurses in Georgia. This Paper is part of a series of Nursing Policy briefs submitted to MoLHSA (see Annex 16 in the Supporting Material to this Report) and the issues raised in this research into Nursing Policy may be summarized as:

- Lack of recording and statistical monitoring of nursing activity since the reforms of the mid 1990's has constrained any form of nursing activity policy planning or control in Georgia.
- The existing system of basic and continuous education does not satisfy nurse activity requirements as an independent profession.
- There is no strategic vision for nursing and thus no research and education processes to support nursing
- The existing multi profile nurse education centers (medical colleges, family nurse preparation centers, secondary medical personnel training institutions, continuous medical education center – nurse component, new partner centers – Mother's and children health care center in

Kutaisi, Mtskheta-Mtianeti region, nurse school in Tbilisi) do not share education programs and teaching methods and do not coordinate education process.

- Due to the lack of a common strategic vision on nursing, the needs of the country in terms of numbers of appropriately trained and skilled nurses are not accounted for in this free market system and the public interests is not taken into account through proper professional qualification .

3.3 Major Issues to be Addressed

1. The Government should acknowledge the important role nurses play in any good quality PHC system. This is particularly so in the context of the current resource constraints.
2. Nurses should be involved in the same HR policy development process referred to doctors above including human resources planning, standard entry requirements, the equivalent of undergraduate and postgraduate training, licensing on completion of accredited training, etc..
3. The development of a professional Nurses Association should be encouraged. Such association should be empowered and involved in training and related activities.

4 Quality Assurance & Continuous Medical Education (CME)

4.1 Background to CME in Georgia

In 2001 following a review of International Practice in monitoring quality of clinical practice the MoLHSA introduced a third level of medical education in Georgia in the form of Continuous Medical Education (CME). Following the initial granting of a license to practice (as already explained, following a residency programme) it is mandatory for doctors to undertake a continuous medical education process (CME).

Prior to the issue of the Presidential Decree #478, November 24, 2001 which gave legal force to CME a research paper was prepared (refer Annex 6 in the Supporting Material to this Report). This paper identified three options about the agent for the introduction of CME,

- Field professional associations;
- Executive government;
- High medical institution;

This research paper argued that due to a lack of organizational development and financial resources amongst the Professional Associations and Research Institutes, CME would initially be managed centrally by the MoLHSA through the PGCEB (mentioned above in connection with postgraduate training). However the decree envisaged that over the period from 2001 -2010 control over the CME programme would gradually be devolved to the Professional Associations as their organizational competence and financial resources became more developed.

At present, licensing of doctors is valid for 5 years after which renewal must be applied for. This is achieved by again sitting for the State Unified Exam and a doctor is only eligible to re-sit for this exam if he has accumulated at least 100 credit hours of continuous medical education. However, the Minister has recently removed the right of trainers to charge for CME courses. Of course, these CME courses are no longer viable and are not being run. It is not clear what will happen when the next State Unified Exam is held and doctors do not have the necessary number of credit hours. One option which is believed to be under consideration is to establish 2 different ways for renewal the license: either sit and pass the exam or collect sufficient credit hours.

There are two main forms of CME:

1. Attendance at taught courses with credit hours given dependant on the length of the programme
2. Approved research activities in the form of participation in conferences, publication of papers or undertaking a scientific masters degree.

A Distance Learning option was previously offered but has been withdrawn due to difficulties of verification.

MoLHSA decree #25 of January 23, 2004 approves the basic documentation for CME programmes, criteria for issuing credit hours and etc. (refer Annex 7 in the Supporting Material to this Report).

4.2 Commentary on CME Process

There are a number of problems associated with this system:

1. The competition for resources has led to a proliferation of CME programmes which are rather disjointed and difficult to assess/accredit. The PGCEB has been overwhelmed with accreditation requests. In short, there are too many programmes for effective accreditation; about 393 accredited programmes have already been offered for CME by different institutions. Some examples are shown (refer Annex 8 in the Supporting Material to this Report).
2. Some Board members responsible for accrediting CME programmes have a conflict of interest in this process since they also represent the CME programme delivery organizations
3. There is duplication and lack of co-ordination of these programmes and a lack of involvement of professional associations or representatives of service deliverers This could lead to a restricted and narrow definition of CME activity.
4. The specialist emphasis exacerbates the narrowness of the CME curricula activities
5. The absence of any external verification process may devalue these CME programmes. In particular, there is not any system in place for the public authorities to credibly verify attendance or satisfactory completion of any CME programme.
6. It is a very competitive market with limited knowledge sharing or opportunities for dissemination of good practice. Choice may often be determined by the relative price of the CME event rather than its particular content relevance to a family doctor.
7. There appear to be several inconsistencies in approach that could devalue the importance of CME amongst the profession as some doctors will be able to undertake more CME activity than others. For example, as programmes are on a fee basis with no research funding and although (according to Article 96 from law on “Doctor’s Activity”) a practicing doctor has the right to demand paid leave from the employer in order to participate in the CME system, doctors in smaller PHC centres are themselves the “employer” and they complain of a lack of resources both in time and finance
8. There is no funding in the SISUF contract for ambulatory services to cover CME costs or to reimburse the expenses related to the participation in CME programmes.
9. There are specific problems for medical personnel in regions since the majority of CME programmes are based in Tbilisi
10. There are also exceptions to the CME rules Doctors who hold scientific degree from before November 1, 1997 are granted an automatic re-approval without passing exams and without participation in CME if:
 - The candidate of medical sciences has at least 10 years work experience in the relevant specialty in the last 15 years;
 - The doctor of medical sciences has at least 5 years experience in the last 10 years.

4.3 Development of Clinical Guidelines

There are 22 Medical Research Institutes in Georgia all based in Tbilisi (see Annex 17 in the Supporting Material to this Report). These institutes fulfil a number of roles and functions within the Georgian Healthcare system including:

- Tertiary clinical consultation diagnosis and treatment in clinic outpatient and in-patient settings.
- Research and advancement of knowledge within particular specialties
- Development of specialised medical education materials
- Dissemination of new information /advancements in scientific medical research

In broad principle terms they have a national remit with regard to their respective specialties to promote best practice. They have a responsibility to analyse clinical practices through research into the incidence of high morbidity or mortality and to develop treatment protocols within their specialist areas determining best practice across the country and to then disseminate this information through medical conferences and publications.

The responsibility for advancement in clinical protocols in each specialty is therefore highly centralized in these Institutes, all of whom are based in Tbilisi. This system is a continuation of the Soviet method of concentrating research and development in very narrow specialized institutions. There are also guidelines produced by groups of specialist doctors (eg gynaecology) and, for family medicine, by the FMTCs in Tbilisi. In this latter area, each FMTC assumed responsibility for preparing guidelines for 2 chronic diseases. However, as far as can be ascertained, the guidelines have not been approved or distributed.

Specific problems with regard to the current configuration of SMRI's with regard to developing clinical practice in PHC can be summarized as:

- Too many individual SMRI's and other bodies are acting in an uncoordinated manner
- SMRI's are highly knowledge advancement driven and NOT practice driven.
- They are all based in Tbilisi with little realistic contact in the regions
- None of the SMRI's are researching on Primary Care and their dual role as tertiary care organizations exacerbates this problem
- They view clinical practice from a very narrow perspective. The incidence of chronic illnesses and health problems encountered in PHC settings is a much wider than in any single tertiary specialty.
- There is no independent review of guidelines to ensure consistency.

4.4 Major Issues to be Addressed

CME

1. All efforts to improve CME should include a strong focus on PHC & Family Medicine
2. The MoHLSA should appoint a CME Advisory Committee for each specialty and require PCGEB to submit all applications for accreditation of CME programmes to the appropriate Advisory Committee.
3. Members of each Advisory Committee should be eminent in their field and, if possible, members of a significant professional association and not necessarily a member of the PCGEB.
4. Each Advisory Committee should be required to consider, inter alia, the number of similar programmes (in terms of content) and to ensure that proposals are consistent in this regard.
5. Require all CME courses to be accredited by PCGEB on the basis of advice from the appropriate Advisory Committee.
6. Incentives should be developed to both encourage doctors from outside Tbilisi to attend CME courses and for trainers to offer courses in rural and regional areas.
7. There should be no exemptions from CME requirements, and compliance should be properly monitored

CLINICAL GUIDELINES

1. Family medicine should be included in the responsibilities of at least one SMRI for the preparation of Clinical Guidelines.
2. The Advisory Committees suggested in relation to CME should also guide the development of Clinical Guidelines and their ratification for use.

5 Accreditation of Medical Teaching and Training Institutions

5.1 The Accreditation Process & Its History

Following the collapse of the Soviet system in Georgia and the liberalising of the market for medical education a large number of educational institutions were established to offer various types of medical education. At present, 69 Private Institutions are accredited to deliver Higher Medical Education in addition to 4 public Institutions. (see Annexes 10 and 11 in the Supporting Material to this Report).

The accreditation process for initial approval of these institutions as able to deliver medical education is through the submission of a written application and prospectus to the Ministry of Education. The main criteria are mostly input-related and include the existing physical resources and human resources to deliver a medical programme. The requirements emphasise being led by a person with a PhD. and having more than 60% of professor-teachers with scientific degrees. Also the institution is required to submit details of the clinical base where practical training would take place. However in practice this is unlikely to be observed as many of the training facilities simply have no clinical facilities and the clinics and hospitals do not receive any direct funding for such training function.

After an Institution receives approval there is no formal ongoing system of accountability to the Ministry of Education or MoLHSA for these Medical education establishments. This is evidenced by the following:

- To the best of our understanding, the Ministry of Education is not aware of how many accredited organizations are still operating
- There is no reporting of numbers recruited or graduating from these medical education establishments
- There is no follow up system, inspection or the like to ensure that accreditation requirements are being followed in practice
- No information on their activities is recorded for the purpose of monitoring.

Such state of affairs is widely recognised as a problem and there have been a number of unsuccessful attempts to improve the situation. In 1996 an Accreditation Board for Higher Educational Institutions was established by a joint decree of MoLHSA and MoE (#476/444, 1996). This Board was given the role of initiating a process of certification of higher medical institutions as the first stage of regulating higher medical education in Georgia. However since its initial establishment the Board has not effectively functioned and the process of accreditation of Higher Medical Institutions has simply ceased.

The above mentioned EAU Evaluation Report on the Medical Education at TSMU states the following on this topic,

“since independence over 50 new (higher level medical) training institutions have opened some with questionable training standards creating a major challenge for policy makers. Around 14000

students are enrolled in these institutions with around 3000 graduating yearly (of these 500 are graduates from TSMU).

The quality of these new schools is unknown, but is suspected to be low in many. Less than 5% of graduates from these schools took and passed the state final certificate examination 1998. In 1998 around 80% of medical graduates of these new colleges remained unemployed”.

Then, in 1998 the Ministry of Education was given the responsibility to establish an accreditation process for higher medical education in Georgian through a Presidential order # 418, dated 20 July, 1998. In this regard the EAU Evaluation Report (2003) states,

*“Under new legislation passed in 1998 responsibility for accreditation of medical education was passed from the MoLHSA to the Ministry of Education and since this time the accreditation process has effectively ceased. The need for strengthened accreditation is apparent both to prevent students wasting time on **inadequate education and to ensure public safety”***

It seems worth to mention again here that the only criteria for ensuring quality of outputs from these medical training institutions is the final State Unified Certificate exam (refer to section 2.4 above).

5.2 Accreditation Guidelines & Commentary

Finally, MoLHSA requested technical support (of DfID) to include the elaboration of basic documentation for accrediting higher educational institutions in Georgia in the framework of joint DfID MoLHSA (known as DFID, project I).

In 2001, as a result of MoLHSA request, 2 experts were sent to Georgia and delivered 2 workshops with the participation of all stakeholders. There the principles of accreditation of higher educational institutions in Georgia in general and particularly the issue of accreditation of higher medical schools were discussed and negotiated. The final version of this documentation for Accreditation of Georgian Medical Education and Training Institutions was produced by DfID-1 for the MoLHSA (see Annex 9 in the Supporting Material to this Report) in August 2001. However to date it has not been implemented, the reason given being that it has not been ratified by Parliament and thus it carries no statutory authority.

A recent development in Georgia was the signing in June 2004 of a ‘memorandum of understanding’ between the Family Doctor’s Academy of USA and the Tbilisi SMU. This established a joint faculty of the High Medical School of Columbia-Missouri University and Tbilisi SMU for postgraduate education in field of family medicine with a 3 year postgraduate education programme for family doctors accredited by the Family Doctor’s Academy of USA. SMU is hence provided with a whole programme package, curricula, syllabuses and teaching modules for postgraduate medical training of family physicians. This arrangement is also not yet “accredited” (also note that this somehow further contradicts the monopoly of the SMA in post-graduate training).

On the other hand, there currently are 129 secondary nursing institutions (“faculties”) in Georgia, (Annex 11 in the Supporting Material to this Report). However, and as already explained, there is

no system proper to accredit the programmes of these training institutions or validate the qualification outcomes.

5.3 Major Issues to Be Addressed

1. The accreditation process would be dramatically & quickly improved by the ratification of the Guidelines for the Accreditation of Georgian Medical Education & Training Institutions prepared by DfID in 2001.
2. This should be accompanied by proper oversight of the scheme by public authorities

6 Monitoring Standards of PHC Services and Facilities

6.1 Why Monitoring is Necessary

It is well known that if the aim of PHC is to deliver services that the public need and want then it is important that decisions made by clinicians in PHC are broadly acceptable to the public. The market reforms in Georgia in the mid 1990s were introduced with the view that patient choice would be a key driver to improve clinical effectiveness and efficiency. The reforms were necessary as the services have collapsed, poor performance had become entrenched and public needs and wants were not being met.

The market approach may (with many qualifications: for a market to operate effectively the consumer must be fully informed about their choices and know exactly what they are buying, but this is clearly not the case in PHC anywhere in the world) apply in a purely private sector market. However, where the government wishes to provide a public service that is aimed to meet a basic service need which is 'free to eligible patients' then the market alone is an insufficient mechanism for ensuring that services meet minimum standards.

Therefore a prerequisite for determining an effective PHC service is an effective independent institution that will scrutinize the activities of the clinicians in PHC on behalf of patients and on behalf of government to ensure that the services provided are at the least meeting minimum acceptable standards. This section deals principally with the latter need to ensure government scrutiny of clinical activity.

6.2 Summary of the Current Situation

PHC delivery facilities are effectively governed by the "Law on Entrepreneurial Activities". The majority of PHC facilities in Georgia are owned by the State Department of Property of the Ministry of Finance and the remainder have been privatized and thus are limited companies owned by the clinicians. The reforms of the mid 1990s forced clinical staff in the PHC sector to privatize their services and register under this legislation or lose any rights to practice.

The clinical activities of the PHC centres are monitored in two ways

1. The MoLHSA Department of State Standards, Norms and Licensing monitors the licensing requirements on staffing and premises
2. The MoLHSA Control Inspection of Medical Aid, Pharmaceutical Activities and Legal Turnover of Narcotics Department is de facto in charge of controlling all the activities of PHC organizations.

Licensing

In terms of governing medical activity the main law is titled, "Licensing of Medical and Pharmaceutical Activities". It requires PHC facilities to apply for a licence to undertake specified clinical activities from their premises. The procedure for applying for this licence require the facility to determine which services it wishes to provide and to meet the requirements of the

“passport” (see 6.2.2 below) for that type of service and to then submit their licensing documents to the above mentioned MoLHSA Department of State Standards, Norms and Licensing. Once the license is granted the facility enters into contractual relations with both the public health department and the federal and municipal/regional health financiers henceforth having to fulfill the responsibilities outlined by these contracts.

Passport, Hygiene Certificates & Specialist Lists

In 2003 the “Passport for Medical Institutions” referred to above was introduced. The “passport” is a document prepared and published by the MoLHSA. It specifies the conditions that must be met as a compulsory pre-requisite to obtain a licence to operate each different type of medical facility and is organised by type of institution. For example, for “General Medical Practice, family doctor” it covers such matters as the level at which such a facility may operate, the personnel required, the equipment required, the activities that may be carried out etc. The activities are defined in terms of a list of investigations and disorders based on the ICD (International Classification of Diseases) # 10. In principle, there is supposed to be a clear correlation between the “permissible” activities and the organizations’ level, even if respecting their specific features.

Thus, if a medical facility wants to be licensed for rehabilitation activities, the passport requirements will be different for an adult’s polyclinic compared with say a children’s polyclinic or an adult’s hospital. But the “passport” does not provide one systematic definition for the various categories of health service organizations. It has thus resulted in a fragmented system of ad hoc organizations operating in the PHC sector with licensing approvals given –as indicated above- on an individual facility basis.

Furthermore, in order to get a license for developing medical activity, each facility is requested not only to have its Passport but also a “Hygiene Certificate” as well as information on specialists (copy of a State Certificate) in charge of the specific activity for which license is being requested.

6.3 Commentary on Licensing Laws

A serious problem is that licenses for medical activity are given in Georgia without time limits, that is, they are permanent. This has implications on the variety, quantity and quality of service production since this permanent approval is granted on the basis of the initial written submission without subsequent follow up, review or audit of the organizations actual activities.

The intention behind the introduction of the Passport was sound in that its aim was to regulate the market to ensure some common standards across PHC organizations. However in practice it has not been applied universally to all the PHC organizations, many of whom are still operating under permanent licences granted before the Passport was introduced in 2003.

This issue has been further confused within the MoLHSA. itself through the development in the Department of Standards, Norms and Licensing of another parallel (non legal) guidance document that specifies the requirements on the issues of licensing and “passportization” of facilities in Georgia. It indeed is a comprehensive, technically sound document but it appears to duplicate much of the content of the “official” Passport. This guideline document was developed jointly by the NGO Genesis and Department of Standards, Norms and Licensing through donor support. However, it has no status in the licensing process.

Meeting passport requirements is at best only an initial permit to deliver medical services based on a resource capacity application. Its intention is thus not to act as any form of monitoring mechanism on actual clinical services. Whilst in principle the MoLHSA licensing Department can undertake monitoring visits to ensure compliance with the licence, this is little more than a resource tick and check audit exercise. Furthermore in practice there is little evidence that even this type of basic monitoring is actually undertaken on a regular or systematic basis.

6.4 Clinical Monitoring Process

The MoLHSA Control Inspection of Medical Aid, Pharmaceutical Activities and Legal Turnover of Narcotics Department (CIM) is the institutional organization responsible for monitoring standards of clinical practice in PHC in Georgia. In principle CIM is an independent body free to investigate the clinical activities of all PHC organizations and to undertake a clinical audit of their clinical procedures.

The main purpose of this Department lies in its original establishment in 1995 when it was called the State Inspection of Legal Turnover of Toxic, Narcotic and Psychotropic Substances and it was assigned the responsibility to control the market for high risk drugs (narcotics). This was a direct result of turbulences in the post Soviet period when the pharmaceutical market in Georgia had been totally unregulated. Its original purpose was simply to control the production, wholesale and retail marketing together with foreign trade in toxic narcotic and psychotropic drugs.

Under later arrangements it became called the MoLHSA Control Inspection of Medical Aid, Pharmaceutical Activities and Legal Turnover of Narcotics Department (CIM). It has in practice a wide remit as an inspection department across a wide range of medical activities as shown below,

- Quality control of medical aid provided to population in medical facilities;
- Control on medical service provision defined by Health Care State programmes;
- Control on adequacy of patients investigation and treatment (based on assessment of medical documentation) with state standards and methodical recommendations;
- Control on adequacy of medical services provided in medical facilities to licensed activities of the same facility;
- Control on utilization of diagnostic and treatment means by medical facilities;
- Quality control on pharmaceutical activities in pharmacies;
- Quality control on pharmaceutical activities in Pharmaceutical industry;
- Quality supervision of Georgian and imported medicines;
- Quality assurance of controlling the legal turnover of narcotics on the whole territory of Georgia;
- To issue the act on offences according to offence codex, article 239;
- To undertake other separate tasks at the request of the MoLHSA.”

The CIM can in principle directly sanction PHC organizations when they find the latter have transgressed the agreed procedures or have been found guilty of clinical malfeasance. The CIM can simply cancel their licence to practice thereby rendering them illegal as a PHC organization.

It must be noted, however, that in a fully functioning Bismarckian system of national health insurance the role of validation of services and their quality would be the responsibility of the purchasing authority, as an integral part of their mandate.

6.5 Effectiveness of the Clinical Monitoring Process

Unfortunately the way in which the inspection service of the CIM has been established and the legal context within which operates in Georgia precludes it from operating effectively. There are several reasons for this.

The main principle of good governance for effective inspection services is that they should be **independent** from any line responsibility for those services. Independence is thus a critical element of effective audit /inspection activities and it safeguards the position of the inspector from any undue pressure or external influence. The basic criteria for ensuring independence are as follows:

- Independence of appointment and security of tenure in office...free from any interference by the State in the recruitment and selection of investigative staff
- Independence of approach....free to decide how, where and when they will undertake investigations.
- Independence of access ...free to obtain any information they require carry out an investigations
- Independence of reporting...free to make their findings and conclusions available to whoever the inspector wishes without any interference, suppression or amendment by external

The CIM Department is directly managed by the MoLHSA which to some extent means its staff have a measure of employment independence from PHC services (since the PHC staff are self employed entrepreneurs and the facilities are the responsibility of the Property Department of the Finance Ministry). However those responsible for managing the PHC system in the regions are also appointed by the MoLHSA directly causing a potential conflict of interest if required to investigate regional staff.

The CIM Department also does not have freedom of reporting rights. As MoLHSA employees, its staff are required to report to the Minister and it is possible therefore for any unfavourable findings to be removed or amended before wider dissemination.

The catch-all functional statement above '*To undertake other separate tasks at the request of the MoLHSA*' also effectively emasculates the CIMs independence of approach and access since it means they can be directed to undertake any task required by the MoLHSA.

In practice however the most significant shortcoming of the present CIM system is procedural in nature and it relates to its access and methods of investigation over PHC services. The prevailing philosophy of the healthcare reform process to date in Georgia has been one of 'hands

off' by Government and that there should be minimal interference in the free market. This philosophy manifests itself in PHC services through the Law on Entrepreneurial Activity and the Law on Medical Activities. Under these Laws the MoLHSA CIM is required to first apply for a court order to undertake an investigation into the activities of any PHC centre (with the exception of checking on staff licenses). However unbelievable it may sound, the law stipulates that the judge will only grant a warrant permitting an inspection/investigation to take place on the basis of reasonable prima facie evidence; evidence which in turn was dependent on the judge having given the permit to carry out the inspection that should generate such evidence.

In practice, when the MoLHSA Department wishes to carry out an investigation or receives information (for example, from customers' complaints) about non-conformance with any requirements at any facility, they must first request permission from the Courts. In practice this can be a lengthy process despite the guidance that judges should respond to a request within 24 hours, which is seldom honoured. Also to exacerbate the position in practice judges have proved to be reluctant to grant permissions for investigations.

Effectively the CIM has therefore by means of this contradiction to try and gather sufficient information as evidence without being allowed any access to the PHC centre or its staff as part of an investigation process.

6.6 Major Issues to be Addressed

LICENSING

- All licenses to PHC facilities should have a time limit of no more, at least initially, than 3 years.

CLINICAL MONITORING

- The functions of CIM should be rationalised and partly transferred to a single authority responsible for purchasing PHC services on behalf of the community, when and if such a body is ever established.

7 Patient Rights and Clinical Ethics

7.1 Patient Rights

Background

During the Soviet period there was no recognition of the western European notion of patient rights. Under the Semashko model people's health and social well being were centrally planned by the State and there was no recognized institutional development of civil rights. There were no democratic institutions or patient organizations, and individuals rights were just prescribed by the State. The State also controlled public information and awareness of health issues.

In PHC this meant that a District Doctor was responsible for the health of a specified population area based around a Rayon. Each individual in the Rayon was assigned to a district doctor in a compulsory registration system and they received the services that the State determined they should receive. Officially there was no formal system of choice for the people. These services were free and in PHC they included sickness prevention, health monitoring and curative outpatient care. District doctors exerted significant control over peoples lives with regard to healthcare. Theoretically, they were the gatekeepers to secondary care and individuals were dependant upon their referral to access wider diagnostic investigations or specialist secondary/tertiary care. In short, individuals were dependant upon the State and their demands of the PHC system were circumscribed by this system. Their expectations were limited merely to the list of services that they were told they could receive.

Over a period leading up to the end of the Soviet Union individuals (particularly the more wealthy) who had some higher expectations were able to informally access wider services through unofficial payments to clinicians. However this system officially was against the norms of the State law.

The Healthcare Reform Period from 1995

With the collapse of the Soviet system and the ensuing civil wars the notion of 'citizenship' in terms of individuals having rights and responsibilities as taxpayers and voters in a democratic system was the principle behind the changes in institutional arrangements that followed. The reforms developed after this transitional period were aimed ostensibly at breaking up the monolithic power of the State over the individuals lives and in the PHC sector this was presented as the notion of 'patient choice' of healthcare provider.

However the reforms were largely driven from the centre by government formally adopting Western European institutional arrangements. There was limited development of community awareness or public rights issues. In other words the institutions were developed effectively on a supply side through formal decree. However there was no history of public participation or debate in the formation of these institutions. Parliament was in practice dominated by a single party and tended to ratify policy decisions of the Executive with limited debate and no community involvement. The level of awareness of individuals about their 'rights' as citizens still remained very low.

The economic difficulties over this period also precluded the development of peoples' awareness of their potential power as taxpayers. In addition these economic factors leading to a deterioration in PHC services mitigated against the development of the notion of consumer rights amongst the general population. Consequently there was no parallel development on the demand side of institutional development over patient rights. This was in stark contrast to some earlier ex Soviet countries such as Poland, Hungary and Czechoslovakia where institutions representing peoples rights had been developed over some time prior to independence.

Consumer Satisfaction

In support of the democratic reform process a number of NGOs became very active in Georgia in the field of developing community participation and raising awareness of peoples rights. The Save the Children Fund, for example, have undertaken Household Poverty Surveys since 1995 which included questions on consumer satisfaction with medical services. It is difficult to gauge the significance of these surveys in terms of raising consumer expectations and the Survey of 1996 indicated relative satisfaction with the newly reformed medical services, with 61.4 % of the respondents indicating no problems with the service. However following the disruptions of the transitional period the expectations of the population for PHC services became very low.

7.2 Clinical Ethics

Background

It is well known that doctors in Europe and the USA have found themselves facing a number of specific ethical dilemmas over the last 25 year as in such multicultural societies the pluralism of ethical beliefs can cause conflicts between physicians beliefs about what is best for a patient and patients' value systems.

In the last 25 years most of the countries of the EU and USA have enjoyed a period of relative economic and political stability. A natural corollary of this has been the development a consumer culture where this increasing power of consumers has led to individuals increasingly exerting their democratic rights as individuals to question the decisions of doctors in their clinical practices. In these modern democracies this has led to individuals claiming infringements of their rights seeking redress through litigation in their legal systems. Therefore the medical professions and health institutions in these countries have sought to strengthen ethical codes of clinical practice and give clear guidance to physicians and patients on their rights.

The Main Principles

The basic tenets of the patient rights in healthcare system in Georgia were very clearly enunciated by Rui Nunes in the Bilateral Conference on Research and Medical Ethics of the Council of Europe and the Georgian MoLHSA 15th July 2003 as follows:

1. Respect for persons and the need for free, informed consent
2. Protection of incompetent persons (children and psychiatric patients)
3. The ethical imperative to maximize benefits and minimize harms (beneficence and non-maleficence)
4. Privacy rights and confidentiality for the patient

5. Justice in access to healthcare (equity)
6. Accountability of healthcare professionals
7. Responsibilities of ethical review committees

In Western countries there are a wide variety of institutional arrangements aimed at monitoring ethical standards in clinical practice this usually involves the following :

1. The Professional Associations in their role as standard setters ensuring that members adhere to code of professional conduct thereby maintaining the reputation of the medical profession and safeguarding the value and status of the medical professions
2. The state legal systems will have enacted legislation based on the European Convention on Human Rights thus establishing the basic rights of patients in healthcare systems
3. Healthcare delivery or commissioning organizations often have their own independent medical ethics committees whose purpose is to ensure the organization maintains the highest levels of clinical ethics in its activities. Often this has been driven by a need to safeguard the organization from potential litigation actions by patients.

In this context, the widely adopted institution for the setting and monitoring of ethical standards is a Medical Ethics Committee. It is usually comprised of independent members drawn from range of different disciplines including the medical professions, the legal profession and patient representatives as lay representatives. They are usually chaired by a senior person who does not have direct line executive responsibility for clinical service delivery thus safeguarding their independence

7.3 Evaluating of Patient Rights & Clinical Ethics System in Georgia

Legislation on Patient Rights

Clearly the Georgian Government has tried to ensure a sound legal basis for protecting patient rights which formally complies with the sound principles established in Western Europe and the USA. However this system is mostly legal (as opposed to administrative) and again there is ample evidence of a top down supply side mechanism for institutional arrangements. The only recourse open to an individual who believes their rights as a patient have been infringed is through direct litigation through the Georgian Court system.

Having such single sanctioning system is in practical terms unworkable because:

- Its is too costly for individuals (there are limited funds available for legal aid in Georgia)
- The legal system in Georgia cannot cope with a large number of individual claims
- Patients do not yet regard themselves as having individual rights as consumers of health services in Georgia
- There is no informal power amongst patients due to the lack of development of patient rights organizations
- The Court procedures are very lengthy and unresponsive to individuals

- Decisions taken by the Courts are too removed from the PHC sector where the clinical activity that affects the individuals rights are happening
- Access to the legal system for individuals outside Tbilisi and the major towns is very difficult
- Information on patient rights are not well publicized in PHC centres especially outside Tbilisi.

A recent report prepared by Givi Javashvili and Guram Kiknadze of the State Medical Academy (Health Care Ombudsman First Steps 2002) recognizes several of these issues, makes some international comparisons and recommends the establishment of an ombudsman system for Georgian Healthcare Institutions.

Whilst this report is a good blueprint for a Georgian ombudsman system, in practice this would still be a top down approach with the service delivery or commissioning organizations establishing ombudsmen as a check on their own power over the patient. It could therefore be a valuable “first step” but procedures similar to those extant in more developed democracies of the EU and US would have a greater impact on the situation in Georgia.

Patient Empowerment

The most successful development of patient rights systems have been in countries where the population have harnessed their informal power through solidarity initiatives as informed stakeholders pressurizing PHC organizations to ensure patient rights are respected at a local level. However, one significant difference in the development of patient rights and clinical ethics in Georgia from other Western countries is that there has been very little development on such demand side of institutional development in the former.

To date little attention has been paid to this issue in Georgia through community mobilisation of patient rights organizations or the development of independent institutions lobbying for patient needs on a local basis. Patient rights remain a theoretic concept developed centrally and enshrined in legal decrees but without any effective implementation mechanism.

The position in Georgia in terms of patient participation in PHC was well argued by David Gzirishvili and George Mataradze for UNICEF/HNI 1998 as follows:

“in Georgia citizens play the role of mere user or beneficiary. Their social activity first of all is directed toward the improvement of essential living conditions like electricity or food and in less extent to health care. Although the burden of health expenditures is commonly recognised, population is inert to express initiative.

Health Care Reform in Georgia even formally did not seek to enhance citizen involvement. The population's and patient's views have been ignored although in political debates this factor is frequently used to justify one or another decision”.

Professional Associations

The other crucial criteria for successful monitoring of ethical standards in PHC clinical activity are the development of strong Professional Associations that can monitor the ethic standards of their members. In this way they act both as a protection for their members by issuing clear codes of

conduct and advise and as a safeguard for the patients by applying meaningful sanctions for any breaches of this code by a clinician.

At this juncture the professional associations in the PHC sector are at a very early stage of development in Georgia. They do not yet seem to have the capacity in terms of sufficiently trained and competent professionals to take on the responsibility of setting and monitoring ethical standards of clinical practice across Georgia as a whole.

Medical Ethic Committees (MEC)

Some work has been done to establish medical ethics committees in Georgia over the past 5 years. This initiative has been well described in the research paper on the Legal Basis Structure and role of MECs in Georgia presented by Givi Javashvili to the Bilateral Conference on Research and Medical Ethics of the Council of Europe and the Georgian MoLHSA 15th July 2003 (See Annex 12 in the Supporting Material to this Report). In this paper he states that a “Charter on MEC was adopted by Ministerial order No 128 in 2000 recommending that all medical institutions should set up MECs the purpose of which should be,

“the humanization of medical practice, promotion of patient rights and protection of their dignity and autonomy”

This purpose is to be accomplished by “educating healthcare personnel, identifying the ethical issues relating to medical care and by analyzing these issues and providing recommendations”. However whilst the Charter recommends MEC for ALL medical institutions in Georgia it had in fact been adopted in principle by only 9 healthcare organizations by July 2003, none of which were from the PHC sector.

In practice the development of MECs as a mechanism for monitoring ethical standards in PHC is much more problematic in Georgia due to:

1. The lack of managerial organization and accountability mechanisms within the current PHC system in Georgia
2. The lack of co-ordination between PHC centres within the different regions
3. The diversity of institutions in the PHC sector
4. The wide geographical disbursement of PHC medical facilities (these latter two not Georgian-specific)

7.4 Major Issues to be Addressed

1. Establishment of an Ombudsman along the lines suggested in **Health Care Ombudsman First Steps 2002** would be a good first step to establish patient rights but eventually there would need to be a system closer to that applying in EU etc
2. Encouraging the development of strong associations of health care professionals and involving them in the idea of respect for patient rights and the need for greater ethical standards would assist in the development of these areas in Georgia

8 Organisation of Service Delivery

8.1 Summary of Service Delivery Organisation

The main organizational principles on which PHC systems are reflected in the way the various functional roles are institutionalized and interrelate to each other as a complete system. The main functional roles within a PHC system have been described in the OPM-produced Paper on European Best practice as:

- the provision of services to patients and populations,
- the movements and referrals between each level providers,
- patients' payment of insurance premiums, or taxes,
- providers' way of payment (contracts for services)
- scientific and policy knowledge (as reports and guidelines) and
- regulation by government.

As already explained, the Government of Georgia chose in the health service reforms of the 1995-2000 period to adopt a Bismarckian system with the following features,

1. government through the MoLHSA having a role in policy (establishing the state programmes) and including scientific and policy knowledge together with the regulation of the market (licencing and accreditation),
2. the Insurance Fund and regional administrations with a dual role of collecting payroll taxes and of "purchasers" administering the contracts with providers e.g. Basic Benefits Package (BBP)
3. the provision of services and referrals were left to market forces with doctors services privatized and patients freedom of choice of providers

The health services are thus provided by a wide range of clinical units that are Registered under the Law on Entrepreneurial Activities and the Law on Medical Activities. They have not changed in their basic definition from the Soviet period. The only substantive change in terms of physical access to services is the development of Family Medicine Centres as a consequence of the DfID 1 Project. There are now 5 of those centres in Tbilisi and 2 regional centres outside the city.

In addition local hospitals also offer out patient specialist services on a fee for service basis. Providers provide services to the population at large in a competitive market. Patients have the right to choose their provider and the referral system is based on contacted funding. If a patient requires free services under one of the State programmes they are referred to a PHC clinic that is contracted (by SISUF or by a Municipality) for the delivery of that particular service.

8.2 Department of Public Health

At the highest level, responsibility for the delivery of primary health care services lies with the Department of Public Health (PHD) which is part of the Ministry of Labour, Health & Social Affairs. Within the PHD, primary care is managed at the national level by the Public & Primary Health Care Management Division (PPCD). The head of the PHD is appointed by the Prime Minister and is accountable in the first instance to a Deputy Minister of Health and the head of PPCD reports to the head of PHD.

The PHD comprises 4 divisions,

- Administrative
- Public & Primary Health Care Management
- Disease Prevention (including epidemiological surveillance & the control and management of epidemiological situations)
- Financial Management

The Public & Primary Health Care Management Division is responsible for,

- Developing public health policy
- Supporting the elaboration & implementation of State health care programs
- Managing contractual arrangements with relevant providers
- Supporting the implementation of public & primary health care strategy
- Participating in the establishment & development of a PHC model based on family doctors.

The Disease Prevention Division is responsible for,

- Coordinating epidemiological surveillance and epidemiological control at central executive level.
- Providing local providers with details of obligatory activities & public health parameters for municipal programs.

The Public Health Department also coordinates the activities of the following public health institutions,

- National Centre for Disease Control & Medical Statistics
- Research Institute for Skin & Sexually Transmitted Diseases
- Research Institute for Medical Parasitology & Tropical Medicine
- Research Institute for Narcology
- Research Institute for Labor Medicine & Ecology
- National Centre for Nutrition
- Practical Centre for Infectious Pathology, AIDS & Clinical Immunology
- Centre for TB & Lung Diseases.

The PHD is currently carrying out three programs as follows ,

1. Management of epidemiological surveillance & epidemiological situations
 - Conducting epidemiological surveillance activities
 - Assuring functioning of the NCDC& MS by providing funds
 - Control & prevention of malaria
 - Assure functioning of public health information system at regional & rayon levels
 - Reduction of infectious diseases by immunisation programmes
 - Proper identification of births and deaths
2. Prevention of socially dangerous diseases by
 - Identification of cases of drug abuse by provision of epidemiological surveillance & preventative measures
 - Prevention of outbreaks of illness caused by iodine deficiency
 - Identifying the influence of radiation on the population
 - Establishing a system for epidemiological surveillance of cardio vascular disease
 - Revealing extent of HIV/AIDS in high risk groups via research, consultations and epidemiological surveillance
 - Preventing STD in high risk groups
 - Assure the target group of the population have access to safe blood and blood products.
 - Promotion of a functioning cancer register
3. Promotion of healthy lifestyle & disease prevention by,
 - Delivery of preventative consultations to relevant, vulnerable or high risk social groups
 - Distribution of information regarding the health risks of smoking, alcohol abuse
 - Monitoring of immunisation levels
 - Promotion of health to those who work in bad conditions.

These programmes are implemented on a contractual basis with the various public health institutions listed above and whose activities are coordinated by the PHD. Primary health care providers are involved only in the contracts for epidemiological surveillance and situations as sub-contractors to the rayon polyclinics, which in turn contract with the NCDC&MS. These contracts relate in epidemiological situations to the supply of vaccines. The activity of delivering the immunisation is via a contract with SISUF

Service points are classified into four levels,

- Level 1 – point of first contact and offer primary medical-social care and emergency medical care. This level is also expected to provide education and health promotion activities.

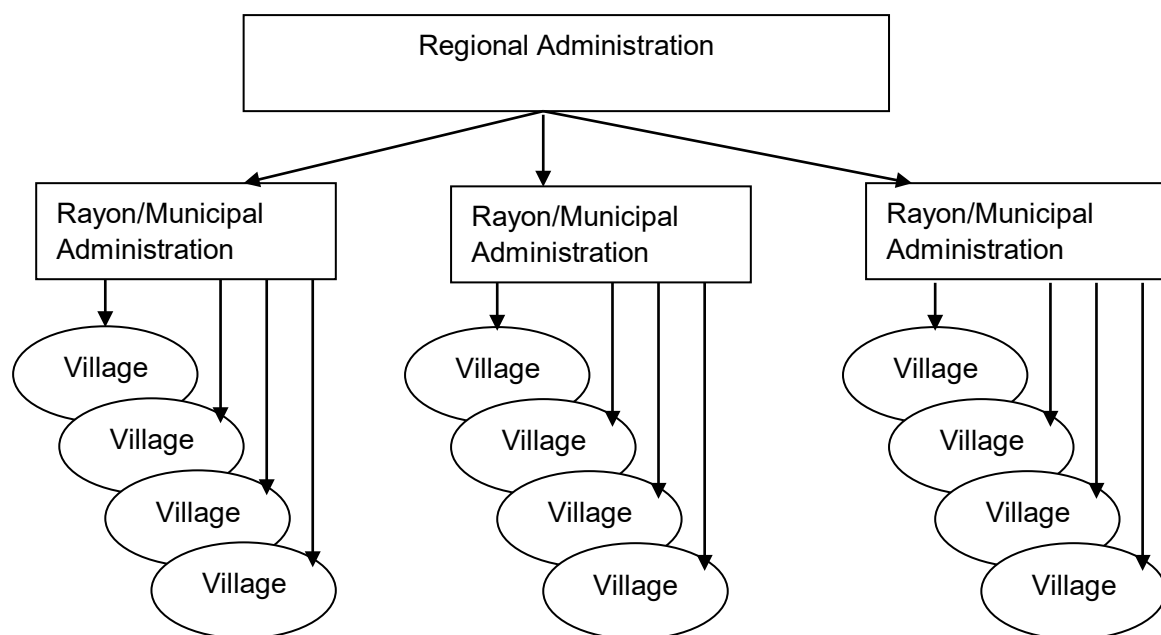
- Level 2 – expected to provide general profile medical care in the following specialties, general surgery, internal medicine, general paediatrics, obstetrics/gynaecology and general dentistry.
- Level 3 – responsible for specialised medical care
- Level 4 – these institutions provide “high technological medical care”.

The types of specific types of service points assigned to each level is specified. The OPM paper on “Roles & Functions” identifies the problems with the apparent intent of the above classification and the types of centres actually included in each level.

8.3 Types of Service Points & Hierarchy

Public administration in Georgia is structured hierarchically from the national level through 12 regions with each region comprising a number of rayons (or districts). Tbilisi is treated differently because of size but it maybe regarded as a rayon for the purposes of its position in the administrative hierarchy. Tbilisi, more than other rayons, is likely to be referred to as “municipal”.

The lowest level of service is provided at the village level. Within each region the arrangement might be depicted as follows,



While the major city in each region is the seat of regional administration it is also a rayon or district in its own right. Thus any delivery facilities situated in a regional centre are generally regarded as rayon level centres or facilities but occasionally one may be described as a regional facility. Equally, there are ambulatory care centres (considered as village level facilities) which

are located in a rayon centre and serve the population of that town rather than of the whole district or rayon.

Having said this there is apparent confusion in many quarters as to precisely where a given health facility fits in the overall scheme. This probably is linked to the peculiar combination in Georgia of the above described system, inherited from Soviet times, and the newly established free market in health service delivery, by which facilities continue to be public property whereas the staff are purely independent contractors.

In any case, it seems that little purpose is served by this rigid devotion to hierarchy in the current circumstances of extreme resource constraints; the aim should be instead to put service delivery points where they efficiently meet the needs of most people. In this context the EU Survey in Kakheti and the development of a possible network of PHC facilities based on the maximum time it would take a person to reach the centre was a valuable exercise and provides Georgia with a useful tool for development of the PHC system nationally. The number of people served by a location should govern the level of services provided.

Ambulatory care facilities participating in the SAP have different descriptions and functions in different documents etc. However, they may be generally regarded as General Health Care Facilities or Specialised Health Care Facilities. The following table shows the types of facilities (we currently know of) under these two headings.

General Health Care Facilities	
Medical Point	Usually in very small villages and staffed by a single nurse.
FAP (First Aid Point)	Similar to the Medical Point but staffed by a more highly qualified nurse.
Ambulatory Care Centre	The major ambulatory care facility providing general profile services. Staffed by one or more General Profile Teams – refer “Basic Benefits Package”. Some centres may be privately owned and such centres may receive SISUF contracts.
Railway Ambulatory Care Centre	This type of centre have different names but usually refer to centres originally established to serve the employees of particular industries. They are managed and funded as parallel health systems by other Ministries
Family Medicine Centres	Established under a DfID-1 project. There are 5 in Tbilisi and 1 in each of 2 regional centres.
Specialised Health Care Centres	
Dispensary	Usually at the regional centre and providing specialised care for specific diseases/ conditions, such as: TB, oncology psycho-neurology, cardio-rheumatology, STD and dermatology
Polyclinic	Providing specialised care for children up to the age of 15 years and for adults over 15 years at the town or village level, i.e., for the citizens of the town or village. There may be separate physical buildings for each group (children, adult) or the two services may be combined in one facility. In the bigger cities they will usually be in separate premises.
Rayon Polyclinic	As for “polyclinic” but servicing the whole district, not only the local town.
Women’s Consultation Centre	Providing specialised care for pregnancy at the rayon level

Hospital/Polyclinic	Specialised care attached to a hospital – effectively, the outpatient department at a hospital.
Treatment & Diagnostic Centre	Laboratory and imaging services at the rayon level
Maternity & Children’s Centre	Providing specialised care for mothers & children

8.4 Management & Ownership of Ambulatory Care Facilities

Virtually all ambulatory care facilities are owned by the Government via the State Property Department within the Ministry of Economics. However, the operations of the facilities are private businesses established under the Law on Entrepreneurial Activity. This has led to the emergence of a number of larger businesses comprising a variable number of health care facilities as well as individual centres operating alone.. The businesses are joint stock companies (ie, limited liability companies) and usually comprise a number of ambulatory care centres and a polyclinic (either rayon or other). The company thus formed contracts with the SISUF or the Ministry or the rayon administration (the municipality) to provide specified services. The details of the funding provisions are not dealt with in this Paper.

All polyclinics have a full time manager who is appointed by the regional representative of State Property Department) with MoLHSA agreement or, in the larger businesses, the “supervisory board”. Medical facilities with a turnover of more than 100,000 GEL and stock capital of more than 30,000 GEL are required to have a supervisory board. It will comprise 1 person appointed by the State Property Department (which owns all health facility premises on behalf of the Government) and two persons elected by the staff of the polyclinic.

Within limits spelled out in the SAP (see notes on Basic Benefits Package) services are expected to be provided free of charge to citizens of the village/town/rayon in which the centre is located. If specialist care is required the patient will be referred to the appropriate specialist and, again subject to limits specified in SAP, the service should in principle be provided free. If a patient goes directly to a specialist he is regarded as a private patient and maybe charged by the specialist according to the “internal standards” set for that polyclinic. The schedule of charges which comprise the “internal standard” must be publicly posted at the facility but is not required to be approved by any Government authority.

While Ambulatory Care Centres are intended to provide only general care and are thus only funded by the Government (i.e. MOH, SISUF and the Rayon) for those services the business manager (be it the polyclinic manager or an individual centre) is allowed to provide extra services which, if utilised, are paid for in full by the patient. The rates charged are established by agreement between the centre manager and the provider of the extra services. The method of remuneration of the provider and the quantum of that remuneration are also a matter of agreement between the provider and the centre manager. Additional revenue earned by the centre from extra services is not required to be retained by the centre but may be used to help fund the basic services it is required to provide to all of the citizens of that village; it may also be shared among all of the doctors and managers as extra income.

Facilities which wish to enter into a contract with SISUF etc. as it was explained, must be licensed. The license is known as a “passport” (see previously at section 6). The type of services that a facility may provide is based on the conditions of the “passport”. The volume of services

the facility contracts to provide is based on the population covered by the facility (this also is included in the “passport”) and on the volumes undertaken in the previous year. Funds are provided to the facilities on a monthly basis at 1/12 the amount of the annual contract. No adjustment is made to funding if contracted volumes are not provided.

In theory, contracts are offered for specific numbers of specific services. These are detailed in the State Ambulatory Programme and the Municipal Ambulatory Programme. The contracts impose two types of obligation on the doctor.; firstly, to ensure that certain services are provided and, on the other hand, to provide other services when deemed necessary. All of the services specified must be provided free of charge. Any other services must be paid for by the patient at the “internal standard” of the facility. There are no clinical guidelines or similar to guide the content of the services to be provided. In fact, the contracts should barely called as such but rather are no more than a restatement of what is in the relevant Ministry programme document or budget.

There is no clear system of managerial governance of PHC facilities in Georgia. Some PHC centres employ managers (with medical background) to undertake this work whilst in other smaller centres the doctors undertake these duties themselves. Each PHC as an institution is required to have a member of staff who has passed a certificate exam in Health Care Management.

8.5 Staffing Levels

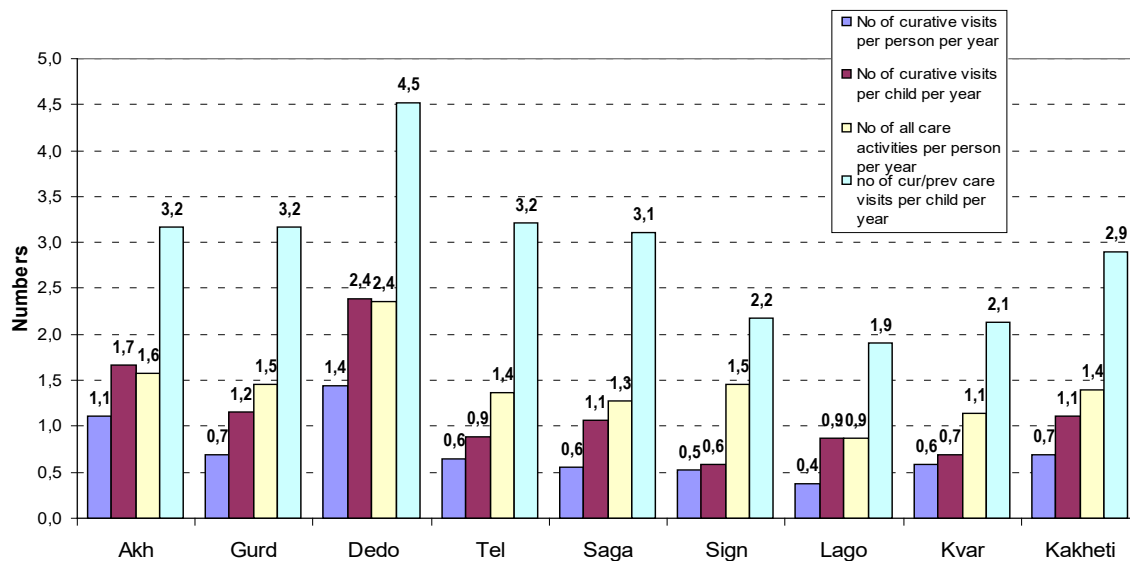
Consultation services are provided at Ambulatory Care Centres (in generic terms, the other types of facilities varying around the same parameters) by medical teams which are either,

- General Profile, comprising 1 doctor and 1 nurse and, “recommended”, 1 generalist paediatrician.
- Adult Specialised, at the rayon and regional level only, on the basis of referral from the General Profile Team and comprising ophthalmologist, endocrinologist, neurologist, ENT, surgeon, oncologist, psychiatrist, laboratory technician, X-Ray specialist, 3 nurses and 1 DOT (directly observed treatment) nurse
- Children Specialised, at the rayon level, and comprising neurologist, surgeon, ophthalmologist, ENT and 1 nurse who is also responsible for the delivery of vaccinations.
- Vertical Program Teams in Tbilisi only and for adults comprising cardiologist, endocrinologist, ophthalmologist, neurologist and oncologist.
- Vertical Program Teams in Tbilisi only and for children comprising neurologist, ophthalmologist, ENT and cardio-rheumatologist.

The number of General Profile Teams required at a given facility will depend on the population of the area covered thus,

Size of Population	Number of Teams Financed
Up to 2500	1
2501 – 4500	2
4501 - 6500	3
6501 - 8000	4
Thereafter, for each additional 1500 population	1 extra team

While these ratios requirements (targets) are comparable with Western European levels, the evidence gathered by the EU in Kakheti indicates that officially the level of patient consultation activity (visits) is very low,



(Source EU Survey Report Facility Assessment October 2003 Section 5)

Furthermore, empirical evidence shows that even these official records of consultations are likely to be overstated, since the clinics are required to achieve particular minimum levels of activity to receive funding from the ‘State Ambulatory Programme. It is therefore in their financial interest to ensure that the data supplied to the Regional Administrators/SISUF meet these minimum activity requirements. The lack of funding from the State has exacerbated this over-recording as doctors seek to at least maintain an official presence in the locality and, no doubt, to protect their jobs.

There are no adequate validation or audit systems to monitor achievement of these workload norms. It is therefore not surprising that the EU activity data appears to accord more or less with these minimum requirements, whereas anecdotal evidence from visits to these centres have hardly found any patients at all.

Case Study: Service Provision in Gurjaani

To evaluate this issue in practice the consultant chose to examine the delivery of one particular State programme in one rayon in Kakheti. The programme was “ante and post natal care” and the rayon Gurjaani. The following findings in the form of a case study based on fieldwork investigations illustrate the underlying defects of the present system.

The current PHC facilities in Gurjaani include:

- 1 Rayon Polyclinic (includes Children and Adults)
- 2 adult Polyclinics together
- 1 Women’s Consultation Centre in Gurjaani Town.
- 18 Ambulatory Centres in the villages
- a Railway Fund subordinate Polyclinic in Gurjaani Town

- 6 medical points in the more remote villages

The polyclinic and all the ambulatory centres with the exception of 3 ambulatories in the villages of Velistsikhe, Vazibusani and Gurjaani (village) are operated as one organization. They have a single budget and are all accountable to the Rayon Polyclinic Director. The three ambulatories above operate as separate managerial arrangements and are organized as limited liability companies however –again- they deliver the services from buildings that are state owned assets

The Gurjaani Primary Care Organisation (i.e. the single managerial organization headed by Rayon Polyclinic) has been experiencing very difficult financial circumstances for the past 4 years and is now is effectively insolvent. They reported:

- arrears of State funding of GEL 350,000
- accumulated regional funding arrears of GEL 80,000, and
- in terms of time a debtor day period of 35months!

It was reported that in previous (Soviet) periods each doctor employed in the Gurjaani rayon service received consultation visits by patients on average between 15 and 20 times per day; feldsher midwives were similarly active in the rural villages of the rayon.

However now **officially** they admit to an average of only 3-5 patient consultation visits per doctor per day, that is an officially recognised reduction of 75-80%.

In examining the usage of the ante/post natal care services in the women's consultation centre in Gurjaani the following issues were noted:

- the reforms of the mid 1990's abolished the felsher midwife system in the villages of Gurjaani and replaced them with the women's consultation centre in Gurjaani town. The centre has 3 full time gynaecologists and they are responsible for all the pregnancy registrations and monitoring visits in the rayon.
- Many women from the villages do not wish to travel to the Gurjaani Women's Centre for registration or subsequent birth and resent the removal of the previous local midwife service
- New mothers tend to travel to parents' residence (often in another district or region) and, probably due to the administrative procedures involved, do not seek the available care. In other words, while a follow up referral service available it is not used. This also has implications for information flow and statistical collection.
- Therefore the village ambulatory paediatricians are not informed of the births and are unaware for some time of the children's existence. This perversely leads to
 - no children's services being offered to these new born infants,
 - incorrect registration pregnancies and births
 - delays and possible omissions in vaccinations
 - no ante natal or post natal care for the mother

The Referral System

Notwithstanding the long standing acceptance of the principle of “gatekeeper” for medical services in Georgia, there is, effectively, no longer a gatekeeper function for PHC. Because there is no structural incentive for a patient to first seek the advice of a General Profile Doctor, patients prefer to go directly to a specialist.

Also there are no specific clinical guidelines in Georgia defining when a referral should be made. The choice of referral is primarily driven by how that ‘episode’ of care will be funded. If the patient has to pay they prefer to see a specialist, whereas if the episode is covered by a State Programme/benefits package, then the clinician will refer the patient to the PHC center that receives that funding from SISUF/Region/Municipality. Therefore there is no continuity of care for the individual patients in any systematic way.

The pattern of referral is broadly indicated in the table below for the Kakheti Region from the EU Facility Report and this indicates that despite apparent specialization between facilities there is a very broad referral pattern across all types of PHC centres. Some of the features are as follows:

- Dispensaries receive 42% of their referrals for surgery, ophthalmology and neurology. However 10% of their workload also relates to general internal medicine (supposedly the domain of polyclinics and ambulatories)
- Women’s Consultation Centres appear to receive only 28% of their referrals for Obstetrics and Gynaecology, but 28% of the workload is for cardiology services.

Distribution of referrals by specialities and facility type (in %)

Facility Type	Surgery	Orthopaedics	Traumatology	Paediatrics	Neurology	Gynecology	Obstetrics	Internal Medicine	Cardiology	Pneumology y/TB	Oncology	Infectious diseases	Psychiatry	Dermatology	ENT	Ophthalmology	Total
Dispensary	14.2	2.1	2.4	1.8	14.2	5.3	6.5	10.0	7.4	8.0	2.1	2.4	0.3	2.1	7.4	14.2	100.0
Medical Point	7.4	1.2	8.8	6.7	15.3	4.7	2.5	7.2	15.0	1.6	2.4	4.8	0.7	4.7	6.8	10.4	100.0
FAP	2.2	0.0	5.6	10.1	13.5	10.1	7.9	6.7	10.1	3.4	9.0	0.0	0.0	5.6	7.9	7.9	100.0
Ambulatory	9.4	2.2	4.7	6.2	13.6	6.3	6.8	5.8	13.3	4.0	3.4	5.3	1.7	3.2	6.6	7.4	100.0
Ch Polyclinic	9.7	6.0	4.3	17.3	15.9	0.9	0.6	1.4	8.5	2.3	1.7	11.4	1.7	4.0	8.5	6.0	100.0
Adult Polyclinic	8.9	1.0	3.4	5.6	14.8	7.6	7.4	4.8	13.8	1.0	3.9	5.1	1.5	13.6	4.3	3.4	100.0
Women's Consultation	0.0	0.0	0.0	0.0	11.0	12.2	16.3	7.0	28.5	1.7	5.8	4.1	4.1	4.7	1.7	2.9	100.0
Rayon Polyclinic	7.7	0.8	3.4	10.1	11.8	1.0	7.8	9.2	10.7	9.8	2.7	4.5	3.0	0.7	3.8	13.1	100.0
Other	18.6	2.2	2.3	11.1	4.7	5.0	4.8	5.8	11.0	3.7	1.3	2.9	0.7	8.0	6.9	11.1	100.0

As indicated, the ongoing reforms in Georgia have given service delivery facilities autonomous status and freedom to determine most service parameters (the range of activities to be delivered is up to the facility manager). There is no concept whatsoever of anything comparable to a self-sufficient network that would be expected to provide comprehensive primary health care to the population; access to specialists (and to hospitals!) is virtually unrestricted and no referral system proper exists within PHC facilities or with hospitals.

8.6 Service Definition & Contracting Arrangements

The State Ambulatory Programme defines what is effectively the Basic Benefits Package for citizens outside of Tbilisi while the Municipal Ambulatory Programme serves the same function

for Tbilisi residents. The documents themselves are contained in “*Supporting Material for Development of an Institutional Map and Defining the Roles & Functions of PHC Personnel*”. They are annually prepared by MoHLSA. Unfortunately these two documents are a complex mixture of general service descriptions, service numbers, staffing levels, management rules and funding information. Attachment A to this Report summarises the provisions of the documents as they relate to services; i.e., it attempts to show what is in the Basic Benefits Package.

The principal purchaser of PHC services is SISUF which administers the state programme at a regional level. This is done through a contract with the PHC organizations that specifies which staff within the PHC are contacted to deliver the various elements of Basic Benefits Package. However, other services are purchased by the regional office of the Ministry of Health.

For services not covered by any State or Municipal Programmes the PHC organizations charge patients on a fee for service basis. Charges are levied through a published internal tariff system referred to as ‘Internal Standards’. This fee is collected by the PHC centre and is deemed as income for entrepreneurial activities and regulated by the Tax Authorities.

Ambulatory Care Arrangements Outside of Tbilisi

The allocation of funds across the various individual centres and the amounts paid to staff of the centres (particularly individual doctors and nurses) is matter for agreement within the total business. However, the amount paid to the business is based on an allocation (set out in the State Ambulatory Programme) for a General Profile Medical Team.

General Profile medical teams are currently funded at the rate of 373 GEL per month or, if covering high mountainous regions, 410 GEL per month. This funding comprises 6 items including specific funding for salaries of the doctor and the nurse (these components were referred to previously. The money is paid to the PHC Centre by SISUF). The allocation takes no account of health needs or socio-economic characteristics. The components of the allocation are,

Component	Standard Funding (GEL/monthly)	Funding for High Mountain Regions (GEL/monthly)
Doctor Salary	100	135
Nurse Salary	70	94
Payroll related taxes payable by the Business	53	71
Medicines	30	30
Laboratory & Diagnostic Tests	50	30
Administrative Expenses.	70	50
Total Monthly Funding	373	410

The SAP provides that the salary components cannot be varied; i.e., the amount shown is the salary paid. For other items, a variation by transfer to another item (except salaries) of up to 10% is allowed. In Kakheti the Consultant believes that the heads of the ambulatory-policlinic units are keeping in some villages the (officially abolished) Medical Service Points and are paying salaries to nurses from savings in their administrative expenses allocation.

The SAP recommends that a facility which has more than 3 General Profile teams (and thus receives 150 GEL per month for laboratory/diagnostic examinations) should allocate around 50%

of this sum to cover salaries of the medical personnel involved with these services. Accordingly, the minimum salary for doctor-laboratory technician is 70 GEL/month. For a nurse in this area, a figure of 60 GEL/month is stated but the basis for this determination is not stated. For high mountainous regions the recommendation applies to facilities which have more than 5 teams; this also provides funding of 150 GEL/month for laboratory/diagnostic examinations.

The SAP directs that a specialist doctor's salary should be not less than 80 GEL per month and that of a specialist team nurse not less than 60 GEL per month. In 2004 doctors from specialist team were receiving 100 Lari per month. There are 3 exception specialty areas:

1. TB specialist has the highest fixed salary (150 Lari) because until September 1,2003 TB specialists were financed also based on volume of performed consultations and evidence shows that it was equal to 150lari.
2. Gynecologist from women consultation centre is contracted fee-for service basis.
3. Psychiatrist from psycho-neurological dispensary is contracted fee-for service basis.

Ambulatory care services provided at hospital outpatient departments are not included in the SISUF contracts and are paid for by the patient at the "internal standard" of the hospital.

Immunisation Arrangements Outside of Tbilisi

The SAP requires the supply and administration of "routine vaccines" (except mumps) for children up to two years. Vaccines for mumps, measles and DT, Td, OPV and Hepatitis B vaccines for citizens more than 2 years old will be purchased through other "vertical programs".

Vaccines are stored by NCDC&MS and distributed among rayon centres and they are distributed to the villages as required. This includes "Cold Chain" items which require special handling. Vaccinations are required to be carried out by the General Profile Team Nurse.

Specialised Ambulatory Care Arrangements Outside of Tbilisi

Specialised ambulatory care comprises special programmes and funding for TB, ambulatory psychiatry, oncology and pregnancy. Financing of the institutions delivering specialised care, including mono-profile dispensaries, is based on executed work which implies fee for service payment. The basis for funding may be,

- Budget article principle – lump sum allocation in the budget
- State standard maximum prices –
- Average tariff – a form of case-mix funding
- Capitation

Medical Examination of Citizens in the Military

These service are provided by General Profile and Specialist Teams. Some services are provided at "the collecting-distributing points". As these are not "essential" service for the community at large, it is unclear as to why these services are funded from the primary health care budget and not from the military budget.

Funding Ambulatory Care in Tbilisi

The SAP severely limits the free services to adults of Tbilisi and covers only the children from 3 to 15 years (children 0-3 being covered by the SAP) and adults over 65 years. The population in the 15 to 65 years range are required to pay for services received at the rate according to the “internal standard”. MAP places no explicit limits on the services that are covered but, equally makes no reference to specific items (e.g. visit to doctor, home visit by nurse, X-Ray etc).

Payment is made on a capitation basis to the facilities subject to the following conditions,

Facility Type	Minimum Patients per Doctor	Minimum Districts covered by 1 facility	Expected number of visits per annum
Children Polyclinic	660 children	10	1908 (= 7.5 per day)
Adult Polyclinic	2400 adults	10	2076 (= 8.16 per day)
Family Medicine Centre	2000 children & adults	9	2076 (= 8.16 per day)

Interestingly, the MAP also refers to working hours being from 0930 to 1930. If allowance is made for 1 hour lunch etc this means that the average consultation time per patient in a children’s polyclinic is around 72 minutes and for other centres approximately 66 minutes.

The annual capitation rates are,

- 15.25 GEL for more than 65 years
- 1.36 GEL for 15 to 65 years
- 7.36 GEL for 3 to 15 years

Funding is paid in twelve equal monthly instalments but is adjusted if the expected number of visits is not achieved. The funding adjustments are,

- 80% or more achievement of targets receives full funding
- 60 to 79% achievement of targets receives 80% of full funding
- less than 60% achievement of targets receives 60% of full funding and contract cancellation is discussed.

It is understood that this provision for reduction in funding has recently stopped.

The MAP requires that District Therapist should receive no less than 110 GEL/month and a district paediatrician not less than 80 GEL/month. Facilities are obliged to allocate 48%-50% of programme income to the payment of salaries and associated taxes, 12%- 15% to the managers salary and 35% for the indirect costs of the facility.

8.7 Major Issues to be Addressed

1. Streamline the extreme complexity of the PHC system.
2. Abolish the multitude of different titles for PHC centres and replace it with only two – General Care Centre or Specialist Care Centre which will be located according to geographic access criteria and provide a range of services appropriate to the population served.
3. If the Bismarckian model is to be the basis for PHC, then nominate one authority as the single, central purchaser of medical services.
4. Articulation of BBP should be a public health responsibility and should be in two parts, one describing services to be provided under the package as a part of the Government's health priority assessments and the other, a describing the general services regarded as "essential"
5. As a consequence of item 3, introduce a system whereby tenders are called for the supply of medical services described in BBP. Contracts should be (within a framework) individually negotiated between the purchaser and the provider. Negotiations would be normally restricted to matters of quality, volume and price. This would provide a greater transparency in the charging system in PHC
6. Allow greater flexibility in the type of person who may be appointed a manager of a General or Specialist Care Centre, and their qualifications.
7. Devise and introduce a system of payments to doctors which would provide incentives for both specialists and primary care doctors and the patients to respect and support the referral system and the gatekeeper principle.
8. Remove examinations for military service from the BBP

9 Professional Associations

The development of professional medical associations in Georgia is still at an early stage and there are many of them in existence. There is, in any modern health system, a need for strong professional associations to protect and promote (at least) clinical standards and ethical behaviour. Because of the variety of special interests within the medical profession in any country it is inevitable that “splinter” or special interest groups will emerge. This is not necessarily a bad thing so long as there is at least one strong, overarching body for each group of professionals, doctors, nurse and practice managers.

At the moment the main existing associations involved in primary care are dealt with below. However, a summary of the position is as follows,

- The Georgian Medical Association (GMA) appears to have a number of roles which could be conflicting in that it appears to:
 - advise the MoLHSA on the suitability of other professional associations to set standards
 - protects the rights of patients and
 - protects the rights of physicians
- Whilst the Georgian Family Medicine Association (GFMA) appears to be a largely campaigning organization aimed at raising the status and protecting the position of the Family Medicine profession in Georgia it has also tried to raise clinical standards in PHC through the development of clinical guidelines for specific FM services. Ideally, it should be a specialty group within the GMA.
- The Georgian Nurses Association (GNA) is also acting primarily to raise the status of nursing as a recognized profession in Georgia, but to date it has had little impact.

9.1 The Georgian Medical Association (GMA)

The national organization representing Georgian physicians was founded on October 1989 when physicians from different regions of Georgia were called by initiative group and met at the First Congress of the GMA in Tbilisi. GMA is first independent professional union of Georgian physicians based on principles of democracy, which was formed at the end of Soviet Perestroika period.

Established as an overarching body with a dual role of promoting both the rights of patients and physicians. The Georgian Medical Association acts as a referee for the Ministry of Labour, Health and Social Affairs for any professional association that intends to resume a responsibility on setting and maintaining professional medical standards in Georgia.

The Mission Statement of the GMA is,

Caring for the Georgian general population through caring for Georgian physicians.

The Aims and objectives of the Association are,

- To promote and defend health-related human rights – the basic rights of patients and physicians

- To help physicians to continuously improve their knowledge and skills through postgraduate and continuing education
- To evaluate national human resources planning for health care services
- To promote medical research activities
- To encourage development of national approved curriculum for medical specialties
- To participate in the elaboration of public health policy for optimal reform of health care system and improvement of public health care
- To facilitate activity of medical NGOs and private sector
- To coordinate health care professional network in close co-operation with Ministry of Health and WHO-Europe
- To find financial support for realization of useful health care initiatives
- To organize forums and discussions of actual professional and organization problems of national health care

9.2 The Georgian Family Medicine Association

This is a national association more narrowly defined to represent the interests of family physicians, general practice nurses and managers. The association was founded in November of 2003 through a merger of the Georgian Family Medicine Association (1995-2003) and Family Medicine Trainers Association (2001-2003). Also among the founders are representatives of the State Medical Universities (State Medical University and Faculty of Medicine of the State University), National Institute of Health, Tbilisi Municipality Health Department and regional departments (Imereti, Shida Kartli, Mtskheta-Mtianeti, Adjara, Kakheti) of health and social affairs.

The purpose of the association is contribute towards the development of Family Medicine based PHC system in Georgia through:

- Setting and maintaining high professional standards for FM human resources: physicians, nurses and managers
- Evaluating functional characteristics of family medicine model
- Contributing towards the professional development and growth of FM HR through participating in developing of postgraduate and undergraduate professional training programmes for FM human resources
- Developing evidence based clinical and practice management guidelines and contribute to it's implementation
- Introducing research methodology at PHC setting which may lead to improved problem identification, setting specific problem solving ways and quality improvement
- Sharing experience of other countries where family medicine is well advanced discipline or on the early stage of it's development
- Collaborating with different governmental and non governmental organizations which may play an important role in the developing of Georgian FM model

- Protecting professional rights of FP HR and ensuring their effective functioning

The GFMA has tried to raise the standards of service quality provided at PHC level through the development of evidence-based clinical guidelines. These guidelines for PHC services were developed by the GFMA with the financial support of Tbilisi Municipality Health Department. The guidelines focus on the following areas:

- Elderly care guidelines:
- Palliative cancer care guideline
- Well person and new patients health check
- Child surveillance guideline
- Management of Hypertension
- Management of bronchial asthma
- Guideline for the management of diabetes in primary care
- Guideline of the management of STDs in primary care
- Antenatal care
- Guideline for the management of Coronary Heart Disease (CHD) in primary care

Wider implementation of the guidelines has to be supported by training of all FMC staff and introducing tools for performance evaluation. GFMA is seeking for financial assistance to ensure that evidence-based guidelines and performance evaluation tools are implemented.

Unfortunately, there are two professional associations competing for membership among the same group of doctors. This is not a satisfactory situation as efforts of both organisations to improve the standing and quality of family medicine will be diverted to the more urgent business of survival.

9.3 Family Doctors Association of Georgia

The Family Doctors' Association was formed in December 2003 with the objective, "To promote creating of effective primary health care system in Georgia through implementation of high quality standards of medical services delivered by family doctors".

The tasks of the Association are stated as,

- Encourage the development of family medicine as a specialty (discipline);
- Defend and represent family medicine interests in terms of specialty;
- Encourage the training and preparation of the family doctors of appropriate qualification;
- Promote the embedment and maintenance of the high professional standards between the family doctors;
- Defend the rights of the family doctors through providing professional activities in the frames of their competence, including different manipulations (among the surgical);

- Improve and maintain the professional activity standards of medium medical staff working in the PHC field and encourage the professional growth of medical personnel of this specialty.
- Improve and maintain the professional working standards of the managers of the PHC sphere and develop the professional growth of this human resources;
- Educate the patients and whole population in the health issues.

In the short time since it has been formed the Association has performed the following,

1. The preparation of an informatory document: "Primary health care development international project coordination: primary health care coordination board" and "primary health care management committee" (December 2003)
2. The preparation of 500 test-questionnaires for family doctor certification exams. The test-questionnaire was translated from the US family doctor's association handbook (The monograph collection; AAFP, Home Study, 1996-2001) and it was adapted to the local conditions and availabilities;
3. The translation of the handbook on family medicine has begun. Essentials of family medicine-Philip D. Sloane, Lisa M. Slatt, Mark H, Ebell, Louis B. Jacques, 4-th edition, 2002, Lippincott Willains&Wilkins, USA, ISBN 0-78-17-3391-X) Exclusive permission was granted for the translation. It is planned to complete the work by the end of the year.

There seems to be a degree of competition between this Association and the previously mentioned Family Medicine Association. There seems little doubt that the interest of Family Medicine would be better served if this branch of medicine spoke with one voice.

9.4 The Georgian Nurses Association

Main non governmental sector regarding nursing is Georgian Nurse Association. The president of the association is also the head of division of nursing in the MoLHSA. The Association is in charge of preparing judicial basis for nursing. But still there is a huge gap in Georgia regarding nursing. This can only be effectively addressed within the context of structured reform to the whole system.

9.5 Major Issues to be Addressed

- The MoHLISA should actively support the formation and development of professional associations for doctors, nurses and practice managers and encourage special interest groups to be part of the major associations.

10 Summary of Conclusions & Recommendations

This final section of the Report is presented in two parts. Firstly, the summary conclusions and recommendations of the Consultant for the initial steps towards reform of the PHC system.

The second part of this section provides a diagram (similar to that presented in section 2.1) showing what the institutional arrangements would look like if the conclusions of the Consultant's analysis were implemented. A list of all of the major issues raised in the body of the Report is also attached as a reference aid.

The issues raised in this Report (and in the Report, *"PHC Roles & Functions in Georgia, The Current Situation"*) will need to be addressed as the reform of PHC progresses. Of course, the sequence in which tasks are done will need to be carefully considered and the wishes of MoHLSA clearly understood. To assist in this area, Attachment B has been prepared. It deals with every issue raised in the two reports and puts them in a time horizon under the headings, "Central Issues", "Training Issues" and "Service Delivery Issues". The sequence selected by the Consultant should not be seen as a strong view or recommendation; it is simply a possible approach which can be used by the decision makers as a starting point.

10.1 Summary Conclusions

1. The PHC system is extremely complex and so full of exceptions at all levels that it can hardly be called a system. This is directly related to the way the State Ambulatory Programme is being implemented, which also results in a pre-dominance of the specialist medical profession, at the expense of nursing and other staff.
2. Together with the financial barriers to access represented by high co-payments, this multitude of institutions, rules and exceptions are no doubt responsible for the very low uptake of PHC services by the Georgian population.
3. There are serious problems all over the HR Institutional Map in Georgia, which means that there is no effective management or control over either the quantity or the quality of the workforce.
4. The lack of accreditation and good governance in particular leads to the real possibility of incompetent doctors practicing on the population.
5. An excess reliance on free market competition in the production and management of HR seems to be directly linked to the current situation and threatens to undermine the faith in the system of the Georgian society.

10.2 Recommendations

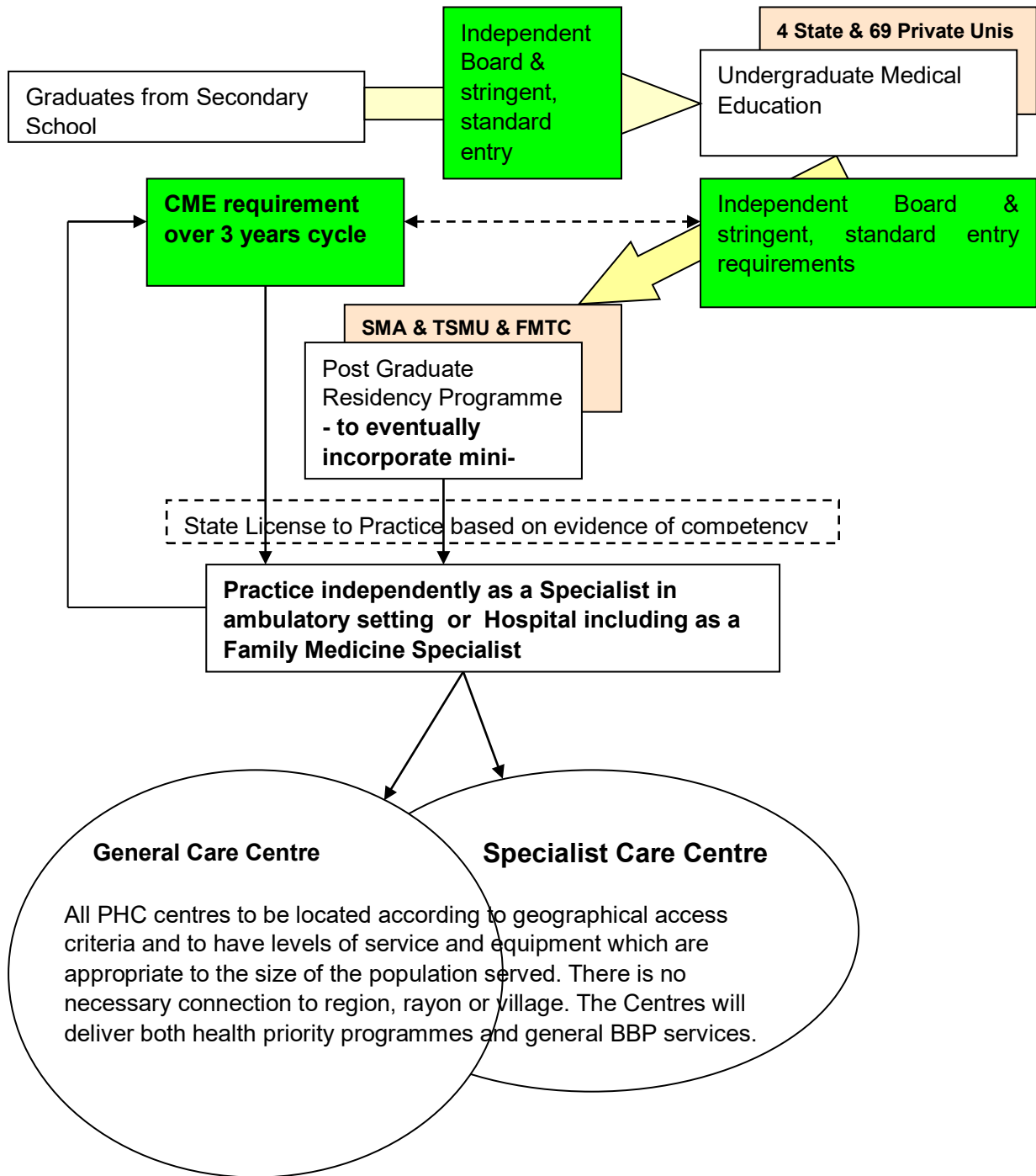
It is recommended that,

1. the Government adopts the diagram in section 10.3 below as a broad representation of how it wishes the PHC system in Georgia to be structured.
2. this depiction should be used to ensure consistency between the activities of various donor organisations involved in the development of the PHC system

3. a high level project plan be developed by OPM (HR & Service Delivery Workstream) to illustrate how the desired system could be brought into being.
4. the following issues in the list of priority items below (based on consideration of the major items identified for discussion in the Report itself) be addressed immediately,
 - The MoHLSA to issue an official policy statement in defense of PHC as a priority for action along the lines of the issues below under items 1, 2 and 3 below.
 - The recently created Human Resources Planning unit in the MoHLSA should be supported to the fullest possible extent, in the spirit of item 4 below.
 - As a first step to reduce the previously mentioned complexity of the system as per item 33 below, the MoHLSA should commence investigation of ways to reduce the many titles for PHC centers to the two suggested at item 34 below.
 - The MoHLSA request the recently established HR-related working groups to consider each of the 40 items identified in this Report (section 10.3 below) and the 15 similarly identified issues of the report on Roles and Functions in PHC and to advise if changes along the lines suggested would, in a structured and progressive process of Reform, contribute to positive improvements in HR and PHC service delivery in Georgia
 - The MoHLSA to establish better coordination of the development of Family Medicine in Georgia (clinical guidelines, protocols, etc). This must be with participation of at least SMA, SMU and FMTC and FMC who currently appear to act independently of each other.

10.3 Description of a New PHC System

The following diagram, like the one in section 2.1, is focussed on the HR aspects of the system. Other major issues raised for consideration in this Paper tend to relate to the detail of how these institutional arrangements should be supported. The major issue not reflected in this diagram is the idea that public health (identification of community “need” and conversion to individual “want”) and primary care (treatment of individual “want” and identification & treatment of individual “need”) need to be managed separately albeit with a great deal of communication and co-operation.



The major issues suggested for consideration in this Report are,

10.4 Major Issues to be Considered

Conceptual Issues

1. The function of public health should be understood as conceptually separate from the function of primary health care delivery and this should be reflected in the organisational structure

2. Public health function should be understood as the identification of community need and the development of strategies to turn community “need” into individual “want”.
3. Primary Health Care delivery should be understood as the delivery of services to meet the “wants” of the community and the identification of individual need.

Issues Related to Training of Doctors

1. A formal system of medical manpower planning (incorporating rolling 5 year forecasts) should be introduced as a responsibility of the Public Health Department (public health function). This should cover all classes of medical practitioners.
2. In the current difficult circumstances it is important that the funds to be directed to medical training be under the control of MoHLSA
3. Funds for training of medical personnel should be related to the desired number of students (manpower planning) and should be distributed on the basis of the ability of each institution to attract recruits.
4. “Special syllabus” (military doctors etc) curricula and training facilities/faculties should be abolished and these types of practitioners absorbed into the mainstream education system.
5. The entry requirements for both undergraduate and postgraduate training should be made much more stringent and consistent with the manpower planning function and should include an appeal mechanism.
6. Undergraduate training should be restructured to provide more and earlier patient contact so as to facilitate the earlier graduation of Family Medicine Specialists.
7. The “Junior Doctor” system should be abolished to ensure that there is only one path to specialisation, through PGCEB and formal training.
8. PGCEB should be restructured and made smaller to avoid regulatory capture by the training institutions. Perhaps a starting point could be to have an independent Chairman (from MoHLSA), equal representation (no more than 2 each) from SMA and TSMU, a representative from the Ministry of Education and 2 from the Professional Associations.
9. Postgraduate entrance examination to be standard for all training institutions and to be set by PGCEB.
10. As a strategic approach, expand & promote the mini-residency programme to quickly provide a quantity of Family Medicine Specialists. Eventually, wind up this programme and incorporate into postgraduate study to emerge as FMS
11. State Unified Exam to be abolished. Issue of a “License to Practice Medicine” to be dependent on success in post-graduate studies & granted by the State Certificate Granting Board.

Issues Related to Training of Nurses

1. The Government should acknowledge the important role nurses play in any good quality PHC system. This is particularly so in the context of the current resource constraints.
2. Nurses should be involved in the same HR policy development process referred to doctors above including human resources planning, standard entry requirements, the equivalent of undergraduate and postgraduate training, licensing on completion of accredited training, etc..

3. The development of a professional Nurses Association should be encouraged. Such association should be empowered and involved in training and related activities.

Issues Related to Quality of Practitioners Services

1. All efforts to improve CME should include a strong focus on PHC & Family Medicine
2. The MoHLSA should appoint a CME Advisory Committee for each specialty and require PCGEB to submit all applications for accreditation of CME programmes to the appropriate Advisory Committee.
3. Members of each Advisory Committee should be eminent in their field and, if possible, members of a significant professional association.
4. Each Advisory Committee should be required to consider, inter alia, the number of similar programmes (in terms of content) and to ensure that proposals are consistent in this regard.
5. Require all CME courses to be accredited by PCGEB on the basis of advice from the appropriate Advisory Committee.
6. Incentives should be developed to both encourage doctors from outside Tbilisi to attend CME courses and for trainers to offer courses in rural and regional areas.
7. There should be no exemptions from CME requirements, and compliance should be properly monitored
8. Family medicine should be included in the responsibilities of at least one SMRI for the preparation of Clinical Guidelines
9. The Advisory Committees suggested in relation to CME should also guide the development of Clinical Guidelines and their ratification for use, with emphasis on PHC

Issues Related to Accreditation

1. The accreditation process would be dramatically & quickly improved by the ratification of the Guidelines for the Accreditation of Georgian Medical Education & Training Institutions prepared by DfID in 2001.
2. This should be accompanied by proper oversight of the scheme by public authorities.

Issues Related to Licensing & Quality of PHC Facilities

1. All licenses to PHC facilities should have a time limit of no more, at least initially, than 3 years.
2. The functions of CIM should be rationalised and partly transferred to a single authority responsible for purchasing PHC services on behalf of the community, when and if such a body is ever established.

Issues Related to Patient Rights & Clinical Ethics

1. Establishment of an Ombudsman along the lines suggested in "*Health Care Ombudsman First Steps 2002*" would be a good first step to establish patient rights but eventually there would need to be a system closer to that applying in EU etc

2. Encouraging the development of strong associations of health care professionals and involving them in the idea of respect for patient rights and the need for greater ethical standards would assist in the development of these areas in Georgia.

Issues Related to Service Delivery

1. Streamline the extreme complexity of the PHC system.
2. Abolish the multitude of different titles for PHC centres and replace it with only two – General Care Centre or Specialist Care Centre which will be located according to geographic access criteria and provide a range of services appropriate to the population served.
3. If the Bismarckian model is to be the basis for PHC, then nominate one authority as the single, central purchaser of medical services.
4. Articulation of BBP should be a public health responsibility and should be in two parts, one describing services to be provided under the package as a part of the Government's health priority assessments and the other, a describing the general services regarded as "essential"
5. As a consequence of item 35, introduce a system whereby tenders are called for the supply of medical services described in BBP. Contracts should be (within a framework) individually negotiated between the purchaser and the provider. Negotiations would be normally restricted to matters of quality, volume and price. This would provide a greater transparency in the charging system in PHC
6. Allow greater flexibility in the type of person who may be appointed a manager of a General or Specialist Care Centre, and their qualifications.
7. Devise and introduce a system of payments to doctors which would provide incentives for both specialists and primary care doctors and the patients to respect and support the referral system and the gatekeeper principle.
8. Remove examinations for military service from the BBP.

Issues Related to Professional Associations

1. The MoHLSA should actively support the formation and development of professional associations for doctors, nurses and practice managers and encourage special interest groups to be part of the major associations.

ATTACHMENT A: BASIC BENEFITS PACKAGE

The BBP in Georgia is not defined other than by inference from common usage of the term in health policy circles generally. Within this constraint the BBP in Georgia is documented in the State Ambulatory Programme (SAP). The Programme applies to all citizens except, in most cases, those of Tbilisi who are covered by the Municipal Ambulatory Programme (MAP); note, some services in the SAP (eg specialised ambulatory care and doctor visits for children 0-3 years) in fact apply to all of Georgia.

The following notes combine the provisions of the two documents to show what services are included in the Basic Benefits Package, whatever the legal base for that coverage.

Services are provided free of charge up to specified limits for different types of service. Within the limits (which are detailed later herein) the services to be provided free at the point of service are,

- Visits to the general profile team for all citizens of Georgia **except** adults in Tbilisi between 15 and 65 years.
- (SAP covers the children in all of the country and all of the adults outside Tbilisi (including high mountain regions) while the MAP covers children from 3-15 years and adults over 65 years in Tbilisi).
- Home visits, outside of Tbilisi, by the general profile team to children up to 15 years and adults over 65 years as well as invalids
- X-Ray for children up to 3 years, TB patients, invalids, adults over 65 years and the disabled. This applies only to people outside of Tbilisi. Note, this apparent provision of the SAP is inconsistent with the obligatory minimums and “free if needed” services shown elsewhere; see table later herein.
- Laboratory examinations are covered by SAP for children up to 15 years, adults over 65 years, disabled people (it is compulsory for people with diabetes and disabled to receive 6 blood glucose tests 6 times pa).
- Immunisation in accordance with standards (what, when & to whom) which are set in the “national calendar”. (This component aims to identify all citizens who should receive vaccination according to the calendar and to ensure that they are so vaccinated. In addition, this component is required to react to “epidemiological situations”, ie, epidemics of, for example, measles. Finally, this part of the BBP is to participate in WHO programmes for the eradication of diseases such as polio.) These services are the responsibility of the General Profile Team Nurse
- Specialised ambulatory care for all citizens of the country (under SAP),
 - **TB** - General Profile Teams are expected to identify all cases of TB encountered in the normal course of work and ensure that all necessary diagnostic examinations are undertaken. The primary care team is also responsible for all visits required by the “state standard” and those necessary for the administration of chemical prophylactics. These services will follow the DOT principle and include bacterioscopic monitoring, patient visits to the doctor, home visits by the nurse. These services are provided at a Dispensary (mono or multi profile) or at a regional or rayon Polyclinic

- **Pregnancy** - The services are provided on the basis of referral and comprise specialist supervision of pregnancy and timely identification of possible complications plus necessary treatment thereof. These services are provided at a Women’s Consultaion Centre or a regional or rayon polyclinic. The services included are shown later herein.
- **Psychiatric illnesses** - This component of the BBP provides specilaised monitoring of psychiatric patients. It also provides patients with the necessary “major medications” in accordance with “state standards”. The specialist is required to,visit, determine initial diagnosis, complete form 88 and issue a health certificate. These services are provided at a Dispensary (mono or multi profile) or at a regional or rayon Polyclinic
- **Oncology** - The aim of this service is “oncologic disease prevention” and revealing such diseases at an early stage of development. The services comprise the early detection of cancer and the systematic provision of oncological prevention activities by improving the ocnological disease recording system. These services are provided at a Dispensary (mono or multi profile) or at a regional or rayon Polyclinic. The services included are shown later herein.
- In addition to other visits, medical examinations are provided for all adults preparatory to their compulsory service in the armed forces. Two occasions of service are required, firstly when a citizen is 15 years old (comprising a specialist consultation) and later between 18 and 27 years immediately before service in the armed forces commences. These latter services are conducted at “the collecting-distributing points” and include a blood analysis test, a urine analysis and an ECG, if necessary.

In addition to the above services, **in Tbilisi**, there is provision for ambulatory care for children to 15 years and for the elderly, over 65 years which appears to be without limitation or obligatory minimums. In addition, 4 free home visits per year are provided to veterans of WW2, patients confined to bed and terminally ill oncology patients.

There is also a “vertical programme” in Tbilisi covering treatment for selected chronic diseases,

- Heart Ischaemic Disease
- Hypertension
- Diabetes
- Bronchial Asthma
- Oncological Diseases
- Parkinsons Disease
- Epilepsy.

This vertical programme also covers certain laboratory tests related to the above listed chronic conditions,

- Common blood test
- Haemoglobin, leukocyte count & erythrocytes osmotic fragility test
- Blood glucose test
- Creatinine

- Common urine test
- Urine glucose test
- Test for ketone bodies in urine
- ECG.

Patients are expected to be referred to this programme and are then entitled to the above service free of charge. Otherwise, charged according to the “internal standards” of the facility.

The “**free of charge**” services referred to above fall into two categories, those which must be provided (“obligatory minimum”) and those which are free, if required. The following table shows the numbers of each type of service which will be provided to each cohort of the population. The services are required to be performed “according to the standards defined by the program” for citizens outside of Tbilisi and include,

Type of Service	Children < 1 year	Children 1-15 years #	Adults 15 to 65 years *	Adults > 65 years
Obligatory Minimum Services				
Vist to Doctor	6	4	-	-
Home Visit by Doctor	1			
Home Visit by Nurse	10	2 **	- **	- **
Visit to Specialist	4	-	-	-
Common Blood Test	1	1	1	-
Common Urine Test	1	1	1	-
Analysis of Faeces	1	-	-	-
Additional Services which are free, if needed				
Visit to Doctor	-	-	4	4
Home Visit by Nurse	-	-	4	4
Visit to Specialist	-	4	8	8
X-Ray	1	1	1	1
Test Blood Clotting Time	-	1	1	1
Common Blood Test	-	-	-	1
Blood Glucose Test	-	1	1	1 ***
Analysis of Faeces	-	1	1	1
ECG	-	-	-	1 ****
Common Urine Test	-	-	-	2

* Note, no free services are provided to this category of citizen in Tbilisi. Figures in this column therefore refer to the population outside of Tbilisi but includes high mountain regions.

- ** Up to 12 Home visits by a DOT nurse are free for TB patients
- *** Up to 6 blood glucose tests will be provided for elderly diabetics
- **** Up to ECG's for patients with ischaemic heart disease
- # These limits apply only to children 0 to 3 years in Tbilisi. Children 1 to 15 years are covered separately and no limits are set in MAP

In Tbilisi, the MAP provides for no restrictions to services other than home visits to are veterans of WW2, patients confined to bed or terminally ill oncology patients where 4 free visits are covered.

Services provided under the **specialised ambulatory care for pregnancy** are,

Visit to Gynaecologist (approx, 13 th , 20 th , 30 th and 36 th week)	4
Common Blood Test	1
Glucose Blood Test	1
Blood Grouping & Rhesus Test	1
Common Urine Test	4
Gynaecological Smear Investigation	1
Wasserman Test	1
Haemoglobin Test	2

Services provided under the **specialised ambulatory care for oncology** are,

- Visit to Specialist where there is suspicion of cancer
- Necessary follow up visits after completion of treatment

For **specialised ambulatory care for TB** and **Psychiatry** the services to be provided are to the extent considered necessary by the “program” and includes visits to the specialist and all necessary medicines.

Neither the SAP nor MAP make any reference to entitlement to pharmaceuticals or to the need for hospitalisation or inpatient services.

At various place and in various contexts the SAP/MAP refer to various types of service delivery points. These are discussed in separate notes, “Management of PHC in Georgia”. Similarly, the funding arrangements are covered in that paper.

ATTACHMENT B: POSSIBLE TIME HORIZONS FOR ALL MAJOR ISSUES

Time Horizon	Development of HR & Service Delivery Issues Central to Both Training & Service Delivery	
	Item Ref	Description
Immediate	R&F 1	Acknowledge that the concepts of knowledge, skills and competencies are different and that while all must be addressed in the training of PHC staff, competency is the major objective.
Immediate	R&F 3	Agree that self-concept values and motives is crucial to achieving the degree of commitment of the PHC staff that will be strong enough to back up the changes and minimise the risk of failure of PHC reform.
Immediate	R&F 5	Agree the need to ensure that training & re-training of health service providers will involve not only improvement in skills & knowledge but also an acceptance of competence as the major criteria for the evaluation of training.
Immediate	R&F 6	Agree that a pre-requisite to reform of the PHC system is a change to the underlying structures and objectives of the Georgian health system & develop such things
Immediate	R&F 9	Direct that a threshold issue in the PHC system that Georgia wants is that the primary care doctor should be competent to provide an initial diagnosis and treatment for all simple or common presentations and should also be competent to refer appropriately to specialist care. Training must support this view.
Immediate	R&F 15	Acknowledge that the only way a sensible PHC model can be effectively implemented in Georgia is as a complete substitute for the current PHC organizations. The change required is so big that it requires considerable support and encouragement from all levels of the bureaucracy and the community.

	Training Issues		Service Delivery Issues	
	Item Ref	Description	Item Ref	Description
Immediate	IM 13	Expand & promote the mini-residency program to quickly provide a quantity of FM Specialists.	R&F 2 & 12	Agree that clear statements of roles and functions are indispensable to organize PHC work in a meaningful way. Understand that problems with HR goes well beyond the over-presence of specialists. Relates to the absence of clear roles and functions as well as issues of skills and competences.
Immediate	IM 15 to IM17	The Government should acknowledge the important role nurses play in any good quality PHC system & direct that Nurses be involved in the same HR development process as for doctors. Assist Nurses Association to develop & encourage & empower & involve them in training and related activities.	R&F 4	Acknowledge that unless tasks and responsibilities are assigned to personnel & linked with their skills there will be no way to allocate resources, determine the necessary facilities, etc.

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	Training Issues		Service Delivery Issues	
	Item Ref	Description	Item Ref	Description
Immediate	IM 41	MoHLSA should actively support development of professional associations for doctors, nurses and practice managers & encourage special interest groups to be part of the major associations.	R&F 13	Recognise that PHC reform cannot be effectively implemented merely as complementary to existing medical organisations within the current system
Immediate	IM 31/32	Establish Ombudsman along the lines suggested in <i>“Health Care Ombudsman First Steps 2002”</i> & encourage professional ass’ns to be involved in the idea of respect for patient rights and greater ethical standards.	R&F 14	Agreeing that the present pilot FM centres are very vulnerable to pressure from the existing specialist organisations which have a privileged and unfair competitive position. Thus, FM Centres are not being utilised to their full potential.
Immediate			IM 1 to 3	Clarify functions of PHD so public health is understood as conceptually separate from the function of PHC delivery. Public health function is understood as the identification of community need & development of strategies to turn community “need” into individual “want”. Primary Health Care delivery is understood as the delivery of services to meet the “wants” of the community and the identification of individual need.
Immediate/Short Term	IM 5	Funds for medical training be under the control of MoHLSA	IM 4	Medical manpower planning to incorporate rolling 5 year forecasts as a responsibility of the Public Health Department (public health function). To cover all classes of medical practitioners.
Short Term	IM 6	Funds for training of medical personnel should be related to the desired number of students (manpower planning) & be distributed on basis of ability of each institution to attract recruits. See Service Delivery - Item IM 4	IM 33/34	Abolish the many different titles for PHC centres and replace it with only two – General Care Centre or Specialist Care Centre Aim, to streamline the extreme complexity of the current PHC system. See also Item 34, below
Short Term	IM 9	Undergraduate training s be restructured to provide more & earlier patient contact.	IM 34	New types of PHC centres (IM 33/34 above) to be located according to geographic access criteria and provide a range of services appropriate to the population served.

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	Training Issues		Service Delivery Issues	
	Item Ref	Description	Item Ref	Description
Short/ Medium Term	IM18 to 21	Improve CME by a strong focus on PHC & F M. Appoint a CME Advisory Committee for each specialty and require all applications to be submitted to appropriate Advisory Committee. Each Advisory Committee to consider, inter alia, the number of similar programmes (in content) & ensure that proposals are consistent in this regard. Members of each Advisory Committee to be eminent in their field &, if possible, members of a significant professional association.	IM 35	If the Bismarckian model is to be the basis for PHC, then nominate one authority as the single, central purchaser of medical services.
Short/ Medium Term	IM 25/26	Assign responsibility for FM Clinical Guidelines to at least one SMRI. CME Advisory Committee to also guide development of Clinical Guidelines and their ratification for use, with emphasis on PHC .	IM 37	As a consequence of item 35, introduce a system whereby tenders are called for the supply of medical services described in BBP. Contracts to be (within as framework) negotiated between the purchaser and the provider. Negotiations restricted to matters of quality, volume and price.
Short/ Medium Term	IM 11	PGCEB be restructured & made smaller. Perhaps, an independent Chairman (from MoHLSA), equal representation (no more than 2 each) from SMA & TSMU, a representative from the Ministry of Education and 2 from the Professional Associations.	IM 36	Assign responsibility for development of BBP to PHD. It should be in two parts, (1) describing services to be provided as a part of the Government's health priority assessments and (2) describing the general services regarded as "essential".
Short/ Medium Term	IM 27/28	Ratify & bring into law Guidelines for the Accreditation of Georgian Medical Education & Training Institutions prepared by DfID in 2001 & start proper oversight of the scheme by public authorities.	IM 39 R&F 8, 10 & 11	Devise and introduce a system of payments to doctors which would provide incentives for both specialists and primary care doctors and the patients to respect & support the referral system and the gatekeeper principle. This includes incorporating Vertical Programmes into the general, two level, delivery system
Short/Medium Term	IM 23/24	Develop incentives to both encourage doctors from outside Tbilisi to attend CME courses & for trainers to offer courses in rural & regional areas. Should be no exemptions from CME requirements & compliance be properly monitored	IM 40	Remove examinations for military service from the BBP.
Short/Medium Term	IM 22	All CME courses to be accredited by PCGEB on the basis of advice from the appropriate Advisory Committee.	IM 29	All licenses to PHC facilities should have a time limit of no more, at least initially, than 3 years.

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		Training Issues		Service Delivery Issues	
	Item Ref	Description	Item Ref	Description	
Medium/ Longer Term	IM 8	Entry requirements for both undergraduate and postgraduate training be much more stringent and consistent with manpower planning function and should include an appeal mechanism.	IM 30	Functions of CIM to be rationalised & partly transferred to a single authority responsible for purchasing PHC services on behalf of the community.	
Medium/ Longer Term	IM 12	Postgraduate entrance examination to be standard for all training institutions and to be set by PGCEB.	R&F 7	Progressively remove “passport” system in its current form	
Medium/ Longer Term	IM 14	Abolish State Unified Exam. Issue of a “License to Practice Medicine” to be dependent on success in post-graduate studies.	IM 38	Allow greater flexibility in the type of person who may be appointed a manager of a General or Specialist Care Centre, and their qualifications.	
Longer Term	IM 7	Abolish “Special syllabus” (military doctors etc) & absorb this training into mainstream education system.			
Longer Term	IM 10	Abolosi “Junior Doctor” system to ensure that only one path to specialisation, is through PGCEB and formal training.			

ANNEXES

Annex 1: The determination of the quantity of field residency contingent, residency program planning, accreditation and financing procedures

Normative Acts

1. Post graduate specialization (residency)

Decree of the Minister of Labor, Health and Social Affairs #364/n
December 27, 2002, Tbilisi

“On the determination of the quantity of field residency contingent, residency program planning, accreditation and financing procedures”

in accordance to the sub-point “b”, point 5, article 154 and point 4, article 99 of the Georgian law on “Health Care”

Declare:

1. Approve the attached procedures on the quantity of field residency contingent, residency program planning, accreditation and financing.
2. Abolish the decree of the Minister of Labor, Health and Social Affairs #208/n, November 15, 2000 on the “rules of residency exams”.
3. Enact the decree upon publishing.

Amiran Gamkrelidze

Annex 1A: Procedures on the quantity of field residency contingent, residency program planning, accreditation and financing

1. The mentioned rule determines the general principles of medical personnel professional training envisaged by the field residency programs of Georgia and the main organizational requirements for its implementation.
2. Residency studies are performed with the special program, which should comply with the state standards of professional training and international recommendations. Post graduate and continuous medical education board performs the monitoring on of residency program accreditation and its implementation quality on the whole territory of Georgia.
3. There are two ways of residency studies:
 - a. State Financing
 - b. Private financing
4. The decree of the Minister of Labor, Health and Social Affairs based on the recommendations of the post graduate and continuous medical education board determines the residency program management and organizational entities and the number of residents on an annual basis.
5. Residency program management and organizational entities are financed by the Ministry of Labor, Health and Social Affairs on a contract basis – in accordance to the resident number to be financed by state calculated from the education fee of on resident.
6. Financial support of the resident preparation by the private order is determined though the agreement between the private client and program management and organizational entities.
7. The individual plan for the preparation of each resident is worked out by the program-directorate approved by the Minister of Labor, Health and Social Affairs.
8. The first stage of residency program teaching should be dedicated to the basic course of the relevant medical field.
9. The activities of the resident should be recorded in detail in the personal journal approved by the Ministry of Labor, Health and Social Affairs.
10. Acceptance to the residency course is carried out through unified entrance exam, on the basis of competition.
11. Residency entrance exam unified state commission is created annually in accordance to the decree of the Minister of Labor, Health and Social Affairs.
12. The organizational-technical provision of the residency entrance exams can be implemented by structures under the ministry subordination on the basis of the decree of the Minister of Labor, Health and Social Affairs.
13. The right to participate in the residency state examinations has the person with the diploma certifying his high medical education – in accordance to the Georgian legislation.
14. The person wishing to participate in the residency state examination should submit the statement indicating the entities of residency program management and organization, where one wishes to cover the program, together with the necessary documents determined by the entrance commission – in case he passes the entrance exam successfully.

15. Entrance exams are performed in three stages:
 - a. Stage I covers 300 test questions in medicine generally;
 - b. Stage II – Written exam in specialty;
 - c. Stage III – Interview the members of the specialty program-directorate.
16. The unified state entrance examination commission performs the distribution of the future residents in the institutions on the basis of exam results and considering their desire, who are permitted to perform residency program management and organizational provision for the given year in accordance to the specialty.
17. Monthly stipend will be given to the residents, which will be preliminary considered in the agreement signed upon entrance. Annual leaves of the residents will be considered by the existing legislature.
18. The resident missing the program for a month with the inexcusable reason will be dismissed from the residency.
19. The resident is obliged to submit to the program-directorate the report on his activities twice in a year during the whole residency course.
20. While residency report review, if their activities will be assessed as unsatisfactory they might be dismissed from the course on the decision of the program-directorate and approval of the Ministry;
21. Upon completion of the residency course program-directorate issues the recommendation for each resident to be presented into the state certification board.
22. Upon completion of the residency course resident is given the relevant certificate (diploma), indicating the specialty. On the basis of this he is permitted to the certification exam.

Annex 2: The approval of the contingent in accordance to the residency specialties and exam organization

Decree #223/o

**Of the Minister of Labor, Health and Social Affairs
October 1, 2003, Tbilisi**

On “the approval of the contingent in accordance to the residency specialties and exam organization”

In accordance of the law of Georgia on “Health Care”, point 4, article 99 and the decree #207/n, September 19, 2003 of the Minister of Labor, Health and Social Affairs on the “determination of the procedures on the quantity of field residency contingent, residency program planning, accreditation and financing”

Declare:

1. To approve the quantity of the residency contingent for 2004 through specialties (see the annex).
2. To approve the composition of the examination commission (see the annex).
3. Assign state Medical Academy to organize the entrance exams of the residency program.
4. The documents for the residency program can be submitted from October 1 to October 22, 2004.
5. Hold entrance exams through October 25-31.
6. Assign the unified state examination commission (I. Kalandadze) to prepare the list of those who passed the exam in a week after the completion of the examination period and based on the results of applicants and indicating the program management and organizational entities and financing (state or private) – for the preparation of the decree of the Minister.
7. 2004 residency program management and organization be implemented by:
 - a. Tbilisi state medical university
 - b. State medical academy
 - c. Ltd stomatological clinic “Unident”;
 - d. JSC “Emergency cardiological center” (for the 2002 contingent)
8. Enact the decree upon signing.
9. Control will be executed by the Minister itself.

Amiran Gamkrelidze

Annex 2A: The composition of the residency examination state commission

1. I. Kalandadze – Deputy Minister of Labor, Health and Social Affairs (Chairman)
2. N. Emukhvari – Pro-rector of the Tbilisi state medical university (deputy), Program-Director with the specialty of “Internal Medicine”
3. N. Kochlavashvili – Head of the residency department of state medical academy (deputy)
4. D. Kordzaia – Deputy Head of the department of science and education at the ministry of Labor, Health and Social Affairs
5. G. Khupenia – Head of the sub-department of science and education at the ministry of Labor, Health and Social Affairs
6. M. Tsiklauri – senior specialist of the department on science and education at the ministry of Labor, Health and Social Affairs
7. I. Pavlenishvili – Program-director, specialty “Neonatology”
8. N. Manjavidze – Program –director member, specialty “Pediatrics”
9. G. Naneishvili – Program director, specialty “Psychiatry”
10. Ph. Todua - Program director, specialty “radiology”
11. G. Khechinashvili - Program director, specialty “TB”
12. E. Botsvadze - Program director, specialty infectious diseases”
13. G. katsitadze - Program director, specialty “Toxicology”
14. G. Chubabria - Program director, specialty “Parazitology”
15. A. Katsitadze - Program director, specialty “Dermatovenereology”
16. R. shakarishvili - Program director, specialty “urology”
17. M. Sheklashvili - Program director, specialty “Hematology”
18. D. Tvildiani - Program director, specialty “Cardiology”
19. N. Kakulia - Program director, specialty “Resorts’
20. D. Metreveli - Program director, specialty “Endocrinology”
21. B. Mosidze - Program director, specialty “Surgery”
22. Z. Kheladze - Program director, specialty “Critical Medicine’
23. R. Gagua - Program director, specialty “Oncology”
24. N. Lebanidze - Program director, specialty “anesthesiology”
25. R. Kutubidze - Program director, specialty “Children Surgery”
26. P. Kintraia - Program director, specialty “Gynecology”
27. Sh. Japaridze - Program director, specialty “Otorinolaringology”
28. M. Phirpilashvili - Program director, specialty “Traumatology”

29. B. Iashvili - Program director, specialty "Plastic Surgery"
30. G. Bochorishvili - Program director, specialty "Urology"
31. I. Beradze - Program director, specialty "Ophtalmology"
32. G. Didava - Program directorate member, specialty "Pathology"
33. O. Gerzmava - Program director, specialty "Public health care and management"
34. M. Iverieli - Program director, specialty "Therapical Stopmatology"
35. G. Menabde - Program directorate member, specialty "Therapical Stomatology"
36. M. Margvelashvili - Program director, specialty "Orthopedica Stomatololgy"
37. Z. Gvenetadze - Program director, specialty "Surgical Stomatology"
38. D. Telia - Program director, specialty "Alergology"
39. I. Mchedlishvili - Program director, specialty "Epidemiology"
40. K. Gelashvili - Program director, specialty (general hygiene, communal hygiene, Labor hygiene, feeding hygiene, children and adult hygiene, radiational hygiene)
41. M. Tvaladze - Program director, specialty "Vessel Surgery"
42. M. Kandelaki - Program director, specialty "Reflexotherapy"
43. N. Tatishvili - Program director, specialty "Children Neurology"
44. E. Kartvelishvili - Program director, specialty "Reumatology"
45. T. Abuladze - Program director, specialty "Proctology"
46. G. Beradze - Program director, specialty "Gastroenterology"
47. E. Saakadze - Program director, specialty "Professional diseases"
48. T. Zakariadze - Program director, specialty "Pulmonology"
49. T. Bukia - Program director, specialty "Laboratory medicine"
50. G. Kiknadze - Program director, specialty "Family doctor"
51. T. Topuria - Program director, specialty "Homeopathy"
52. G. Iejava - Program director, specialty Narcology"
53. D. Tsverava - Program director, specialty "Sports medicine"
54. G. kavtaradze - Program director, specialty "Doctor psycho therapist"
55. A. Khomasuridze - Program director, specialty "Reproduction"
56. Z. Vadachkoria – Program director, specialty "Children Stomatology" (Ortodonty)
57. G. Pipia - Program director, specialty "Heart Surgery"
58. Z. Robakidze - Program director, specialty "Transfusion"
59. K. Kipiani - Program director, specialty "Angiology"

Annex 2B: Quantity of the contingent of the residency according to the specialties

#	Specialty name	Number of places	
		Fully State Funded	Self Funded
1	Internal Diseases	-	1
2	Pediatrics	1	1
3	Psychiatry	1	-
4	Radiology	1	1
5	Infectious Diseases	1	1
6	Toxicology	1	-
7	Parazitology	1	-
8	Dermatovenerology	2	1
9	Neurology	2	-
10	Hematology	-	1
11	Resortology	1	1
12	Endocrinology	2	1
13	Surgery	-	2
14	Critical Medicine	1	1
15	Oncology	2	-
16	Anesthesiology	1	1
17	Children Surgery	-	1
18	Gynecology	-	1
19	Otolaringology	-	1
20	Traumatology	-	1
21	Plastic Surgery	-	1
22	Urology	-	1
23	Ophtalmology	2	1
24	Patanatomy	3	-
25	Civil health care and management	2	2
26	Alergology	-	1
27	Epidemiology	1	-
28	General hygiene	1	-
29	Communal hygiene	1	-
30	Labor hygiene	1	-
31	Feeding hygiene	1	-
32	children and adult hygiene	1	-
33	Radiational hygiene	1	-
34	Children neurology	-	1
35	Reumatology	-	1
36	Proctology	-	1
37	Gastroenterology	-	1
38	Professional diseases	-	1
39	Pulmonology	-	1
40	Laboratory medicine	2	2
41	Family doctor	4	-
42	Homeopathy	-	1
43	Narcology	1	1
44	Vessel surgery	-	1

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#	Specialty name	Number of places	
		Fully State Funded	Self Funded
45	Reflexotherapy	-	1
46	Medicative physical culture and sports medicine	1	1
47	Doctor psycho therapeutics	-	2
48	Heart Surgery	-	3
49	Neonatology	1	1
50	Transphusiology	-	1
51	Angelology	-	1
Stomatological Specialties			
52	Therapeutic stomatology	-	61
53	Orthopedic stomatology	-	2
54	Orthodontic	-	1
55	Surgical stomatology	-	2

Quantity of the contingent of the residency according to the specialties purposefully for the Abkhazeti Autonomous Republic

#	Specialty name	Number of places	
		State order	Paid order
1	2	3	4
1	Pediatrics	3	-
2	Cardiology	1	-
3	Internal Diseases	2	-
5	Therapeutically Stomatology	1	-
<i>Totally</i>		7	0

Quantity of the contingent of the residency according to the specialties purposefully for the Adjara Autonomous Republic

#	Specialty name	Number of places	
		State order	Paid order
1	2	3	4
1	Radiology	1	-
2	Neurology	-	1
3	Endocrinology	1	-
4	Surgery	-	1
5	Pediatrics	-	1
6	Otorinolaringology	1	-
7	Ophthalmology	-	1
8	Therapeutically Stomatology	1	-
9	Reproduction	1	-
10	Cardiology	-	1
11	Anesthesiology	-	1
12	Infectious diseases	-	1
13	Dermatovenerology	-	1
14	Rheumatology	-	1
<i>Totally</i>		5	9

Annex 3: Terms of reference for higher and secondary medical institution - state certificate granting board

Roles and functions of Board:

- To approve state certification exam programme, criteria of knowledge evaluation, the rule, schedule and place of exams;
- To create the exam commissions together with higher medical institutions and doctor's professional associations;
- To discuss and approve the results of state certification exams;
- Board makes decision on the issuance or refusal to issue the state certificate based on submitted documents.

Annex 4: The list of related specialties

General profile doctor (3 years work experience)	- Internal diseases - Family doctor
General profile military doctor (3 years work experience)	- Internal diseases - Family doctor
Internal diseases	- Gastroenterology - Nephrology - Pulmonology - rheumatology - Resortology and physiotherapy - Clinical Pharmacology - Alergeology – Immunology - Cardiology - Endocrinology - Family doctor - Neurology - Dermato-venerology - Professional pathology - Medicative physical culture and rehabilitation, sports medicine - Phtisiatry - Hematology - Parasitological - Homeopathy - Reflexotherapy
Gastroenterology	- Internal diseases - Family doctor
Nephrology	- Internal diseases - Family doctor
Pulmonology	- Internal diseases - Family doctor
Rheumatology	- Internal diseases - Family doctor
Physiotherapy	Internal diseases
Clinical pharmacology	Internal diseases
Alergology-immunology	Internal diseases
Children alergology-immunology	Pediatrics

Cardiology	- Internal diseases - Family doctor
Endocrinology	Internal diseases
Children endocrinology	Pediatrics
Infectious diseases	Parasitological
Critical situation medicine	Children toxicology
Family doctor	- Internal diseases - Pediatrics - Gastroenterology - Nephrology - Pulmonology - Rheumatology - Cardiology
Neurology	Internal diseases
Children neurology	Pediatrics
Dermato-venerology	Internal diseases
Professional pathology	Internal diseases
Medicative physical culture and rehabilitation, sports medicine	Internal diseases
Phtisiatry	- Internal diseases - Pulmonology
Children Phtisiatry	- Pediatrics - Children pulmonology
Hematology	- Internal diseases - Transpusiology
Children hematology	Pediatrics
Transpusiology	Hematology
General surgery	- Torakal surgery - Plastic surgery - Proctology - Traumatology-orthopedy - Urology - Cardio surgery
Torakal surgery	- General surgery - Cardio surgery

Plastic surgery	General surgery
Proctology	General surgery
Traumatology-Orthopedy	General surgery
Urology	General surgery
Cardio surgery	- General surgery - Torakal surgery
General profile doctor psycho therapeutics (3 years work experience)	Doctor psycho therapeutics
Doctor psycho therapeutics	- Gastroenterology - Nephrology - Pulmonology - rheumatology - Resortology and physiotherapy - Clinical Pharmacology - Alergeology – Immunology - Cardiology - Endocrinology - Family doctor - Neurology - Dermato-venerology - Professional pathology - Medicative physical culture and rehabilitation, sports medicine - Phtisiatry - Hematology - Parasitological - Homeopathy - Reflexotherapy - Psychiatry - Necrology
General profile doctor pediatrics (3 years work experience)	- Pediatrics - Family doctor
Pediatrics	- Children gastroenterology - Children nephrology - Children pulmonology - Neonatology - Children alergology-immunology - Children cardiology - Children endocrinology - Children infectious diseases - Children critical situation medicine - Children toxicology - Children neurology - Children phtisiatry - Children hematology - Family doctor

Children gastroenterology	Pediatrics
Children nephrology	Pediatrics
Children pulmonology	- Pediatrics - Children phtisiatry
Children infectious diseases	Pediatric
Neonatology	Pediatrics
Psychiatry	- Narcology - Court psychiatry - Psycho therapy
Court psychiatry	Psychiatry
Psycho therapeutics	Psychiatry
Necrology	Psychiatry
General profile doctor stomatologist (1 years work experience)	Therapeutic stomatology
Therapeutic stomatology	Children therapeutic stomatology
Surgical stomatology	Children surgical stomatology
Orthopedic stomatology	Orthodontic
Orthodontic	Orthopedic stomatology
Children therapeutic stomatology	Therapeutic stomatology
Children surgical stomatology	Surgical stomatology
Epidemiology	Civil health care and management
Parasitological	Infectious diseases
Civil health care and management	Epidemiology
General profile doctor prophylactics (1 years work experience)	- General hygiene - Children and adult hygiene - Feeding hygiene - Communal hygiene - Radioational hygiene - Labor hygiene - Civil health care - Epidemiology

General hygiene	- Children and adult hygiene - Feeding hygiene - Communal hygiene - Radioational hygiene - Labor hygiene
Children and adult hygiene	General hygiene
Feeding hygiene	General hygiene
Communal hygiene	General hygiene
Radioational hygiene	General hygiene
Labor hygiene	General hygiene
Patanatomy-clinical pathology	Court medicine
Court medicine	Patanatomy-clinical pathology
General profile doctor laboratory worker (1 years work experience)	doctor laboratory worker

Annex 5: Approval of the composition and manual of the post graduate and continuous medical education board

**Decree #332/n
of the Minister of Labor, Health and Social Affairs
November 21, 2002 Tbilisi**

on the “approval of the composition and manual of the post graduate and continuous medical education board”

In accordance to the article 30 of the law on “Doctor’s activity”

Declare:

1. Approve the composition and manual of the post graduate and continuous medical education board (annex 1 and 2);
2. Enact the decree upon publishing.

Amiran Gamkrelidze

Annex 5A: The composition of the post graduate and continuous medical education board

1. Amiran Gamkrelidze – Minister of Labor, Health and Social Affairs – chairman of the board;
2. Marine Gudushauri – First deputy Minister of Labor, Health and Social Affairs;
3. Iagor Kalandadze - Deputy Minister of Labor, Health and Social Affairs – Deputy Chairman;
4. Dimitri Kordzaya – Deputy Head of the department of science and education of the ministry of Labor, Health and Social affairs;
5. Ramaz Khetsuriani – Rector of the State Medical University;
6. Besarion Kilasonia – Pro-rector of the State Medical University;
7. Nino Vepkhvadze – Head of the prophylactic cathedra of the State Medical University’
8. David Gordeladze – Dean of the medical faculty of the Tbilisi state University;
9. Vladimer Margvelashvili – Head of the stomatological department pf the Tbilisi State University of Iv. Javakhishvil
10. Neriman Tsintsadze – Dean /of the medical faculty of the Batumi state University of Shota Rustaveli;
11. David Tvildiani – Rector of the high medical institution “Aiety”

12. Phridon Todua – Director of the light and intervention therapy scientific-research institute;
13. Giorgi Naneishvili – Head of the supervisory board of psychiatric scientific-research institute;
14. Giorgi Khechinashvili – Head of the supervisory board of phtisiatric and pulmunology national center;
15. Zviad Kirtava – Director of the national training center of the ministry of Labor, Health and Social affairs;
16. Otar Vasadze – Director of the National Institute of health;
17. Paata Imnadze – Director of the Disease control national center;
18. Shota Gogokhia – Director of the Abkhazeti branch of the institute of resorts and physiotherapy
19. Gia Lobjanidze – Doctor's association of Georgia;
20. Tamar Dekanosidze – Pathologo-anatomic society of Georgia;
21. Giorgi Bochoorishvili – Georgian urologists association;
22. Tengiz Asatiani – Gynecology association of Georgia;
23. Nodar Lomidze – Georgian Surgeon association;
24. Alexandre Bakuridze – Georgian Pharmaceutics association;
25. Tengiz Tsertsvadze – Head of the supervisory board aid, clinical immunology and infectious disease center;
26. Revaz Gagua – President of the oncology national center;
27. Alexandre Aladashvili – Doctor of the emergency cardiology center;
28. Irakli Sasania – director of the children's hospital (republic)
29. Tamaz Shaburishvili – Head of the Tbilisi "Heart-vessel clinic", ltd.
30. Roman Shakarishvili – Rector of the state medical academy, deputy head of the board;
31. Irakli Pavlenishvili – Pro-rector of the state medical academy;
32. Guram Kiknadze – Dean of the family medicine department of the state medical academy;
33. Givi Javashvili – Head of the family medicine cathedra of the state medical academy.
34. Secretary of the board – Nana Kochlavashvili – Head of the residency department of the Tbilisi state medical academy.

Annex 5B: Terms of reference and functions of the post graduate and continuous medical education board

I. General provisions

1. This manual determines post graduate and continuous medical education board (further – “the board”) competence, creation and activity rules.
2. The board is the organ of holding activities for prolonging state certificate validity for the new term, which is created by the decree of the Minister of Labor, Health and Social Affairs in order to prepare and carry out postgraduate professional training and d continuous medical education necessary activities.
3. The purpose of the board is to create and develop post graduate and continuous medical education system in Georgia and encourage its normal functioning.
4. The board performs its activities based on the laws on “Doctor’s activities”, “health care”, other laws, decree of the president #478, 2001, this manual and other normative acts.

II. Board functions and competence

The functions of the board are:

1. Discussion of the issues related to the post graduate professional training and continuous medical education, preparation of appropriate recommendations and submitting for the approval at the Ministry of Labor, Health and Social Affairs (further – the ministry);
2. Preparation of recommendations on defining the methods of post graduate professional training and continuous medical education;
3. Preparation of the conclusions and proposals related to the post graduate professional training and continuous medical education and other programs of accreditation;
4. To determine criteria of granting credit hours for participation in the post graduate professional training and continuous medical education and other programs and upon necessity preparation of proposals, decisions and conclusions for periodic improvement;
5. Preparation of decisions on granting credit hours for post graduate professional training and continuous medical education;
6. Preparation of recommendations of the duration of post graduate professional training and continuous medical education and other forms of accreditation (not less then one year and not more then two years);
7. Preparation of the criterion for certifying medical personnel participation in the programs and granting credit hours for the retrospective accreditation of the CME implemented programs during 2 years before holding the first meeting of the board; Preparation of appropriate conclusions on program accreditation and medical personnel participation.
8. Determine the quantity of credit hours and prepare recommendations on the increase in accordance to the law of Georgia on “Doctor’s activities”, in order to extend the validity of the state certificate.

9. Discussion of the relevance of the professional activities of the junior doctors to the diploma of the professional training and its duration; preparation of the conclusion on the abovementioned;
10. Determine the criteria of granting credit hours for the participation in the foreign country continuous medical education different programs and upon necessity prepare recommendations on their periodic change;
11. Planning and implementation of the activities related to the provision of postgraduate and continuous medical education programs;
12. Discussion of the appellations related to the post graduate professional training and continuous medical education program accreditation and participation in other forms of continuous medical education;
13. Information availability for the post graduate professional training and continuous medical education program accreditation and participation in other forms of continuous medical education;
14. Work out format of specialty description and discussion of particular specialties;
15. Preparation of the conclusion on the relevance of specialty specification to the post graduate professional training and continuous medical education programs;
16. Preparation of the project on changes and amendments in the manual of the board;
17. Discussion and approval of all the conclusions and documents prepared by the board sub-commission and also the decisions made by the presidium.
18. Discussion and approval of the annual report of the board;
19. Selecting chairmen and members of sub-commission from the board;
20. Expert panel approval;
21. Hearing and evaluation of the annual reports and sub-commission ongoing activities;
22. Preparation of proposals related to the sub-commission activity;
23. Determination of relevant activities, which provide postgraduate professional training and continuous medical education program preparation on the basis of consensus in the medical field;
24. Analysis of the problems and material expertise in the field of postgraduate professional training and continuous medical education;
25. Preparation of normative acts for postgraduate professional training and continuous medical education and their discussion.

Board cooperates with the territorial entities of the Ministry and in the frames of the competence is responsible to:

1. Evaluate problems related to the continuous medical education in the regions, prepare recommendations related to the determination of the priority directions of continuous medical education;
2. Provide with the information on continuous medical education programs in the country and abroad on the basis of central continuous medical education data for the personnel working in the regions;
3. Organization of the invitation of the continuous medical education implementers in the regions;

4. Recording of the credit hours granted by the CME program implementers in the regions.

III. Board composition

1. Board personal composition is limited to 33 members; The composition is determined by the Minister of Labor, Health and Social Affairs once in 3 years, in accordance to the following principle:
 - 6 members from doctor's professional associations and other public organizations;
 - 6 members from high medical institutions;
 - 6 members from Georgian state medical academy;
 - 6 members from medial scientific institutions;
 - 5 members from medical institutions;
 - 4 members from the ministry
2. Board is chaired by the Minister of Labor, Health and Social Affairs, deputies are appointed by the chairman from the member of the board.

IV. Board structure

Board structure is determined with the following components:

- Board will have permanently working unit presidium;
- Sub-commissions, panel of specialists, experts and advisors are created in the board to perform main functions, which also performs consultation functions;
- Secretariat is working in the board; also the database of other forms of postgraduate and continuous medical education programs is created.

V. Board presidium

1. Board presidium (further – the presidium) represents the permanently functioning organ between the breaks of board meetings.
2. The composition of the presidium is determined with 11 members; Presidium includes chairman, of the board, deputies, chairmen of the sub-commissions and the rest members of the presidium are elected at the meeting of the board;
3. Presidium can invite the associated member of the presidium (members), who is not citizen of Georgia. Associated member should be recognized expert in the field of postgraduate and continuous medical education;
4. Elections of the members of the presidium are held in compliance of the following procedures:
 - Close elections, if the number of candidates exceeds vacant positions in the presidium;
 - Presidium members are nominated by the board members;
 - Board elects vote counting commission of 3 people; Commission counts the number of bulletins and hands to the board members, after which bulletin collection and counting is performed;

- Results of closed voting are valid, if the proper bulletin quantity will not be less than 2/3, or 22 members.
 - If two or more candidates collected the same number of bulletins, additional voting will be held with the same procedure;
 - The results of closed voting and presidium new composition are approved by the board with the open voting;
 - If number of candidates do not exceed vacant numbers in the presidium, the new composition of the presidium is elected through open voting;
5. Board approves the associated candidates of the presidium with the simple majority of votes;
6. The meeting of the presidium is called on the basis of suggestion of three or more members of the presidium.
7. Function of the presidium:
- Discussion of the issues presented by the sub-commission and their approval at the meeting;
 - Preparation of recommendations on postgraduate and continuous medical education literature and methodology (which will be used for preparing test-questionnaires) and their submitting to the board;
 - Preparation of meeting agenda and meeting organization.
8. Presidium has a secretary, who records meetings, keeps them and provides technical supply of the work.

VI. Sub-commissions of the board

1. Sub-commissions are created in the board to perform main functions of the board:
- Sub-commission of accreditation of continuous medical education programs;
 - Sub-commission of accreditation of postgraduate professional training programs;
 - Sub-commission of studying the implementation of postgraduate and continuous medical education programs;
 - Appellation sub-commission;
2. The functions of sub-commission on accreditation of continuous medical education programs are:
- Accreditation evaluation of the postgraduate and continuous medical education programs. Determined the credit hours to be granted for each program and submitting of the decision at the board meeting;
 - Making decisions on granting credit hours by preliminary determine criteria;
 - Candidate and doctor dissertation;
 - Monographs, handbooks and scientific article publishing;
 - Scientific discovery, which is registered in accordance to the Georgian legislature;
 - Participate in the conferences of other countries, the organizers of which issue CME credit hours.

- Preparation of ongoing and annual reports on the executed activities and submitting to the board;
 - There are 7 members in the accreditation sub-commission. The chairman and members of sub-commission are elected from the board.
 - CME accreditation sub-commission holds regular work meetings, where relevant issues are discussed and decision is made on the following issues:
 - On the reasonability of accreditation of postgraduate and continuous medical education programs;
 - On the reasonability of granting credit hours for particular activities to doctor's;
 - On the additional studying and expertise of the issue;
 - On the necessity of discussion of the CME program accreditation at the presidium and board meetings;
 - On the approval of the ongoing and annual reports of CME accreditation sub-commission.
 - Working group is created at the CME accreditation sub-commission, members of which are not board members. The mentioned work group:
 - Performs the primary expertise of CME problems and other forms of education on the basis of preliminary worked out criteria and prepares conclusions to discuss at the meeting;
 - Determines the necessity of inviting expert-consultant, provides the preliminary selection of the expert from the panel, negotiates the candidate with the members of the commission and organizes his invitation;
 - Studies the documentation submitted by the applicant and prepares preliminary conclusion on granting credit hours;
 - Performs other duties.
3. The functions of the sub-commission of accreditation of postgraduate professional training programs are:
- Presenting decisions related to the postgraduate professional training program accreditation to the board;
 - Studying programs of other countries and determination of relevance of the Georgian programs;
 - Discussion of the relevance of the professional training taken by junior doctors to the postgraduate professional training accredited program in the relevant specialty and its duration;
 - There are 7 members in the postgraduate professional training program accreditation sub-commission. The chairman and member are elected by the board;
 - Postgraduate professional training program accreditation sub-commission holds regular work meetings, where the following issues are discussed and decision is made:
 - On the reasonability of postgraduate professional training program accreditation;
 - On the postgraduate professional training program credit hour system evaluation;
 - On the necessity of further study of the issue and additional expertise;
 - On the necessity of additional discussion of postgraduate professional training program accreditation issues at the presidium and/or board meeting;

- On the approval of the postgraduate professional training program accreditation sub-commission ongoing activities and annual reports;
- A working group is created at the sub-commission of postgraduate professional training program accreditation. Its members are not board members.

The mentioned working group:

- Holds the preliminary expertise of the postgraduate professional training program accreditation on the basis of preliminary determined criteria and prepares preliminary conclusion for further discussion at the sub-commission meeting;
- Determines the need of inviting expert-consultants, performs the selection of the expert from the expert panel, negotiates the candidacy with the members of the sub-commission and organizes invitation.
- Executes other tasks assigned by the sub-commission.

4. The functions of appellation sub-commission are:

- Appellation discussion and decision submission to the board in case of being refused to provide postgraduate and continuous medical education program;
- Appellation discussion and decision submission to the board in case the CME credit hour applicant is refused to be granted credit hours for particular activities or getting less credit hours than was envisaged;
- Preparation of ongoing and annual reports on the works executed by the appellation commission and submitting it to the board;
- There are 5 members in the appellation commission. The chairman and member are elected by the board;
- Appellation commission holds regular working meetings, where the reasonability to satisfy some appellation is discussed and decision made. If the sub-commission cannot make decision on the appellation issue, the decision is made to discuss it at the Presidium and board meeting;
- A working group is created at the appellation sub-commission. Its members are not board members.

The mentioned working group:

- Holds the preliminary expertise of the appellation material and prepares preliminary conclusion for further discussion at the sub-commission meeting;
- Determines the need of inviting expert-consultants, performs the selection of the expert from the expert panel, negotiates the candidacy with the members of the sub-commission and organizes invitation.
- Executes other tasks assigned by the sub-commission.

5. The functions of the sub-commission studying the implementation on postgraduate professional training and continuous medical education programs:

- Evaluation of the implementation process of the accredited postgraduate professional training and continuous medical education programs, evaluation of relevance to the requirements determined by accredited conditions, recommendations on improvement, ceasing program implementation, accreditation or cancellation and submitting to the board;

- Preparation of ongoing and annual reports on the executed activities;
- Formulating plans and methods of postgraduate professional training and continuous medical education accredited program evaluation;
- Preparation of the conclusion on the results of evaluation of postgraduate professional training and continuous medical education form;
- There are 7 members in the postgraduate professional training and continuous medical education program implementation sub-commission. The chairman and member are elected by the board;
- A working group is created at the postgraduate professional training and continuous medical education program implementation sub-commission. Its members are not board members.

The mentioned working group:

- Studies the implementation process of postgraduate professional training and continuous medical education programs and prepares conclusion on the evaluation results;
- Determines the need of inviting expert-consultants, performs the selection of the expert from the expert panel, negotiates the candidacy with the members of the sub-commission and organizes invitation.
- Prepares recommendations on improvement of implementation of postgraduate professional training and continuous medical education programs, ceasing program implementation, or accreditation cancellation.

VII. Registry of postgraduate professional training and continuous medical education programs and other forms of continuous medical education

1. The registry of postgraduate professional training and continuous medical education programs and other forms of continuous medical education programs is created at the board (further – the registry), which is the database, where all the details on postgraduate professional training and continuous medical education programs is reflected. The existing information is available for everyone, for which the board provides:
 - Permanent update of the web-site on postgraduate professional training and continuous medical education programs;
 - Preparation and publication of periodic bulletins;
 - Information supply to other periodic publications;
2. The data to be included in the registry on postgraduate professional training and continuous medical education programs is defined by the board.

VIII. Activity procedures and principles of the board:

1. Board performs activities by preliminary defined agenda. The meeting is led by the board chairman deputy chairman;
2. The board is authorized to hold meeting and make decision if 2/3 of the members attend the meeting. Board meeting is called at least once a month.

3. Decision is made after voting, if the positive reply exceeds the negative. In case of vote distribution, chairman's vote is decisive.
4. Next meeting agenda of the board is worked out by the board presidium on the basis of opinions expressed at the previous meeting or information and proposals submitted to the board during the intervals of the board meeting.
5. Board presidium together with the secretary sends the board meeting agenda to the members one week ahead the meeting;
6. Board meeting formulates and approves the agenda of the next meeting before completion of the previous meeting;
7. Board presidium invites non-member individuals at the meeting in case of necessity. Board members are informed about the invited persons together with the agenda;
8. Board might use the resources of the department of postgraduate professional training and continuous medical education of the Medical Academy in order to perform its functions.

IX. Election of board presidium, chairmen of board sub-commissions and members

1. Election of board presidium, chairmen of board sub-commissions and members is carried out by closed voting, if the number of candidate exceed vacant positions;
2. The names of candidates for the positions of board presidium, chairmen of board sub-commissions and members are announced by board members;
3. 35. Board elects vote counting commission of 3 people; Commission counts the number of bulletins and hands to the board members, after which bulletin collection and counting is performed; Results of closed voting are valid, if the proper bulletin quantity will not be less then 2/3. If two or more candidates collected the same number of bulletins, additional voting will be held with the same procedure; The results of closed voting and presidium new composition are approved by the board with the open voting;
4. 36. If number of candidates do not exceed vacant positions in he presidium, the new composition of the presidium is elected through open voting;

X. Receipt of applications on postgraduate professional training and continuous medical education accredited programs;

1. Receipt of applications on postgraduate professional training and continuous medical education accredited programs, with the attached documents are submitted to the board secretariat in closed envelope in two copies. Other necessary documents for postgraduate professional training and continuous medical education accredited programs are:
 - a. For the accreditation of postgraduate professional training programs:
 - Application filled in by the head of postgraduate professional training program;
 - Description of postgraduate professional training program, which includes the information required by the board;
 - Description of the applicant's organization with the indication of material-technical resources and patient loading indicator;
 - The list of the postgraduate professional training programs implemented by the applicant's organization before;

- Personal data of those participating in the postgraduate professional training programs and diplomas/certificates.
- b. For the accreditation of continuous medical education and other programs:
 - Application should be filled in by the supplier of the continuous medical education program;
 - Description of continuous medical education program, which includes the information required by the board;
 - Description of the applicant's organization;
 - The list of the continuous medical education programs implemented by the applicant's organization before;
 - Personal data of those participating in the continuous medical education programs and diplomas/certificates.
- 2. Application registration with the relevant number is performed at the secretarial journal and database and submitting date and supplier (the organization of postgraduate professional training and continuous medical education) is fixed;
- 3. Secretariat transfers the accreditation documentation to the accreditation commission working group.

XI. Accreditation document expertise by the accreditation sub-commission

1. Work group expert studies the accreditation documentation, which at the first page includes the evaluation of the submitted documentation and determination of relevance to the required list. It is send back to the secretariat with the conclusion, where the improper document list is indicated;
2. Work group expert evaluates postgraduate professional training and continuous medical education program on the basis of presented documents and by preliminary determined criteria. Expert gets relevant consultations from the sub-commission members, upon necessity.
3. The criteria for postgraduate professional training and continuous medical education programs is formulated by the board and approved by the Ministry;
4. Working group expert determined the necessity of inviting expert, selects candidate, negotiates it with the chairman of sub-commission or other members of sub-commission and provides invited expert with the necessary documentation in a written form, who prepares the conclusion on concrete issue;
5. Working group expert prepares preliminary conclusion on the basis of accreditation documents and conclusion of the invited expert;
6. In case the conclusion is negative, or the invited expert thinks that postgraduate professional training and continuous medical education program does not deserve accreditation, he should indicate the foundation of refusal in detail. Supplier has the right to submit the program once again after considering the remarks;
7. If the conclusion is positive, or the invited expert thinks that postgraduate professional training and continuous medical education program deserves accreditation, he should indicate:
 - Accreditation duration:
Quantity of credit hours for continuous medical education programs, which should be granted for the participation in the above program.

8. Working group expert submits the preliminary conclusion to the members of accreditation sub-commission. The conclusion is discussed at the meeting of accreditation sub-commission and final conclusion is being formulated, which is signed by the chairman of sub-commission.
9. Conclusion is transferred to the board presidium, which will finally discuss the conclusion at the next meeting.
10. The issue of postgraduate professional training and continuous medical education program accreditation is discussed during a month after submitting.
11. The conclusion on postgraduate professional training and continuous medical education program accreditation is discussed by the accreditation sub-commission at the earliest meeting of the board. So, the conclusion is issued not later than month after submitting;
12. The conclusion of the board is transferred to the secretariat, which records the conclusion on accreditation (positive and negative) in the journal or database and gives the relevant documentation to:
 - a. The supplier of postgraduate professional training and continuous medical education programs;
 - b. The relevant territorial entities, which have the obligation for the promotion of continuous medical education process in their region, upon necessity;
 - c. The registry manager of the postgraduate professional training and continuous medical education programs;
13. The registry manager of the postgraduate professional training and continuous medical education programs registers the information in the database within 48 hours (48 hours do not include public holidays and week-ends).

XII. Statement for appellation

1. The statement on appellation is submitted to the secretariat then it is registered in the journal and database with the indication of registration date. After this the accreditation documentation is submitted to the appellation sub-commission working group.
2. Working group expert studies the statement on appellation, conclusion of accreditation sub-commission and relevant documentation. It guides with the accreditation criteria while evaluation. Expert gets consultations from the sub-commission members upon necessity.
3. Working group expert determines the necessity of inviting expert, selects candidate, negotiates it with the chairman of sub-commission or other members of sub-commission and provides invited expert with the necessary documentation in a written form on the preparation of the conclusion;
4. Working group expert prepares preliminary conclusion on the basis of accreditation documents and conclusion of the invited expert;
5. In case the conclusion is negative, or the working group expert thinks that appellation should not be satisfied, he should indicate the foundation of refusal in detail.
6. If the conclusion is positive, or the working group thinks that should be satisfied, he should indicate the foundation for the change of the appellation sub-commission decision;
7. Working group expert submits the preliminary conclusion to the members of appellation sub-commission. The conclusion is discussed at the meeting of appellation sub-commission and final conclusion is being formulated, which is signed by the chairman of sub-commission.
8. Conclusion is transferred to the board presidium, which will finally discuss the conclusion at the next meeting. In case of positive decision, the same meeting determines program accreditation length and for the continuous medical education – the number of credit hours.

In case of negative decision, program suppliers have the right to submit the program with the considered remarks, once again.

9. Appellation sub-commission discusses the issue during a week after submitting.
10. The conclusion on appellation is approved by the appellation sub-commission at the earliest meeting of the board. So, the conclusion on appellation is issued not later than 37 days after submitting;
11. The conclusion of the board is transferred to the secretariat, which records the conclusion on accreditation (positive and negative) in the journal or database and gives the relevant documentation, written and electronic to:
 - a. The supplier of postgraduate professional training and continuous medical education programs;
 - b. The relevant territorial entities, which have the obligation for the promotion of continuous medical education process in their region, upon necessity;
 - c. The registry manager of the postgraduate professional training and continuous medical education programs;
12. The registry manager of the postgraduate professional training and continuous medical education programs registers the information in the database within 48 hours (48 hours do not include public holidays and week-ends).

XIII. Discussion of the implementation of postgraduate professional training and continuous medical education programs

1. Board will formulate necessary activities for the appropriate implementation of programs.
2. Performs monitoring of program execution. The opinion of those specialists who cover the given program might be asked during monitoring process.
3. In the frames of competence evaluates the implementation of postgraduate professional training and continuous medical education programs. Formulates proposals for the improvement of program implementation.
4. In case of noncompliance of the program implementation and program envisaged activities, board discusses the issue and makes decision on the cancellation of program accreditation or its temporary ceasing.
5. Formulates evaluation plans and methods for the postgraduate professional training and continuous medical education accredited programs; Based on the results of evaluation prepares relevant conclusions on the execution of necessary activities.

Annex 6: Continuous medical education system reorganization concept in Georgia

Approved by the decree of the President of Georgia #478, November 24, 2001
(Extract)

Annex 6A: Options for the organisation and management of a national programme of CME in Georgia

Based on the experience of the western countries there are several options for implementing CME system at the national level:

- National field medical associations (Portugal, Norway and some other countries of central Europe, medical specialty board in the USA);
- Other, different from National field medical associations, professional organizations (Great Britain, Ireland – king colleges);
- Ministry of Health care together with the regional health care organs (Swiss, Greece, Luxemburg, Belgium);
- Doctor's training institutions (countries of Central and Eastern Europe);
- The combination of the above-mentioned.
- Hence, there are three options for the model:
 - Field professional associations;
 - Executive government;
 - High medical institution;

Which model from the listed above should Georgia choose? It is obvious, that the chosen model should satisfy the following criteria:

1. Financial resources;
2. Technical resources;
3. Organizational experience and resources;
4. Work experience in continuous medical education system;
5. Relations with the medical institutions or with the potential suppliers of the CME programs (in the center and regions);
6. Familiarization with the existing situation not only in one field, but in the whole medical sphere.
7. The possibility to react on acute situations in the field of population medical service through selecting program suppliers and program preparation and accreditation.

Below you will see the relevance of each model to the criteria.

1. On doctor's professional associations

Nowadays several tenths of professional associations are registered in Georgia. Their active participation and in the continuous medical education system formulation and functioning is necessary. It should be considered that the capacity of these organizations is very restricted currently. Majority of them exists only nominally and activity coefficient is very low. They lack financial, technical resources and do not have organizational experience. In this terms the fact that while preparing test-questionnaire for certification exams, the majority of them was prepared by the initiative of the Ministry and through their financing of the experts is worth mentioning? Renewal of test-questionnaires is now carried out by the initiative of the State Medical Academy. The role of professional associations, with some exceptions is very low.

From the abovementioned, it is not under doubt that professional associations due to the lack of financial, technical and organizational resources will not be able to independently perform activities of CME system formulation. At the same time, everything should be done to include them in this process, implementation and development and later take the leading role of this process.

2. On executive government – Ministry of Labor, Health and Social Affairs

The preparation of reforms in health care system and among them in medical education system and realization of directions reflected in it is the due to the ministry. The ministry complies with these criteria more then any other organization. At the same time the following facts should be emphasized:

- One of the main strategic directions of health care reform is the decentralization of the management system and transferring management tools vertically;
- The ministry will have to invite specialists from “outside”, accordingly provision with the working place and conditions (space, technical equipment, technical personnel and so on), which will relate to the difficulties. Thus, relations with the stakeholders, utilization of their resources and function delegation to them will be necessary (high medical institutions, field medical institutions, scientific-research institutions).

From the abovementioned, the ministry can take this function only in case of necessity and considering the current situation we face this necessary case.

Hence, national entity of CME implementer should be created at the Ministry of Labor, Health and Social Affairs through the supervision of the ministry. In order to achieve the goals of the national center the resources of all stakeholders and function delegation should occur.

3. State medical academy, state medical university and medical faculty of Iv. Javakhishvili state university might be considered from the high medical institutions for postgraduate education

- State medical university: was traditionally always occupied with bachelor's degree studies. The main function of the medical university, as the leading high medial institution is to formulate bachelor's degree policy and strategic directions and implement them in life. Hence, as any other leading medical institution, medical university, due to the known reasons has to overcome many difficulties in education process. It is obvious that the potential of the

state medical university should be appropriately and completely used to formulate and implement CME system (preparation of programs, participation in the accreditation and so on).

- Medical faculty of Iv. Javakishvili state university; the faculty is newly formed and is at the development stage. At the same time, it has significant potential to participate in the formulation of CME system and functioning.
- Postgraduate education state academy (former doctor's training institute): was traditionally always occupied with the issues of qualification. Currently, difficulties of the certification process were completely loaded to this institution. The education profile of the academy, in accordance to the new goals is facing transformation from formulation and improvement of executive educational technology based on the entire network of system formulation. Thus, the participation of the academy in the formulation and enactment of CME system is necessary.
- Academy has relevant experience in education issues collected for decades. Therefore, the distance of medical society from modern requirements in CME system will be easier for the academy to overcome.
- Academy has relevant intellectual potential to determine postgraduate education and implement CME policy.
- Requirement on postgraduate education has significantly decreased in the recent years. Thus, academy and accordingly personnel have lost their function. To let academy implement CME system formulation and carrying will really be a very significant stimulus for the personnel. They will be interested in system formulation, since this is the possibility of their professional growth and income increase. This will be the possibility to create new work places and employ many experienced and high level specialists.

4. Medical profile scientific-research institutes

There is a number of scientific-research institutes in the country (Therapy, cardiology, pediatrics and others), which are staffed with experienced and highly qualified personnel. It is obvious, that the majority of scientific-research institutes, in accordance to their possibilities should become the active participant and basis of CME system formulation and implementation.

At the same time, the fact that, for any high medical institution, professional association or scientific-research institute becoming the basis of the CME system formulation and implementation it will be necessary to:

- have the support of the government and especially of the ministry on Labor, Health and Social Affairs;
- Stimulating the participation of professional associations in CME system formulation; Maximum assistance to increase the role of public organizations.

It is obvious, that neither of the high medical institutions, professional associations or scientific-research institutes have the financial capability to independently implement CME system. Hence, state protection in the system formulation is necessary. The transformation period might be considered 5-10 years and significant part of the expenses will be reimbursed by the government. After system formulation, state share in the CME system will considerably decrease due to the following sources:

- Medical personnel contractor;

- Medical personnel itself;
- Other sources allowed by the state legislature.

The evaluation and certification/recertification (determine the credit hours for education programs, credit hour annual and total (5 year) obligatory minimum, determination of total credit hours, determination of obligatory minimum for admission to the exams, methods for certification and evaluation) of the medical personnel participation in CME should be the competence of medical specialty representatives (post graduate and continuous medical education board, specialist sections and professional associations). Technical personnel participation and participation of the society representatives for transparency is also allowed. Hence:

- a. Post graduate and continuous medical education board will be formed at the Ministry of Labor, Health and Social Affairs in the form of “post graduate and continuous medical education board” with the leadership of the Ministry of Labor, Health and Social Affairs.
- b. CME organ will exist in this form till 2010.
- c. Post graduate and continuous medical education board will become independent from 2010.
- d. CME organ will include:
 - Representatives of the Ministry of Labor, Health and Social Affairs
 - Representatives of post graduate state medical academy
 - Representatives of doctor’s professional associations and other public organizations
 - Representatives of high medical institutions
 - Representatives of medical institutions
 - Representatives of medical scientific institutions

In addition, work share of each participant should change year to year in the following way: Obligations of the ministry should decrease, in parallel the role of doctor’s professional associations should increase, considering the fact that after creating relevant social-economic situation in the country, in case of strengthening of these associations, CME system will have two equal basis – high medical education institutions together with the scientific-research institutes and doctor’s professional associations.

Annex 6B: Discussion of options for the financing of CME

1. Financing of the post graduate and continuous medical education board.

Continuous medical education is not entirely financed by doctors in any country. In the transitional period (system formulation process, which will continue about 5-10 years) financial protection of the state is needed. In parallel, the income source for the post graduate and continuous medical education board might be:

- Taxes for CME program accreditation.
- Other incomes permitted by the legislature.

2. Financing of specialist participation in CME

Doctor specialist should be ready to pay some amount for the participation in the CME system, particularly:

- In the case of individual medical activity the amount paid for the doctor should include the sum for the participation in CME.
- The sum paid for medical service in the medical institution should contain the sum considered for the participation in the CME system.
- In the amount allocated for the state medical programs from the budget the sum for the doctor's participation in the CME programs should be considered.
- Insurance companies should participate in the financing of the CME programs.
- The participation of the pharmaceutical companies with strictly assigned terms is allowed, which restricts advertising some goods, thus:

CME system expenses should be part of the medical service expenses. Thus, when financing health care system CME system financing should also be considered. How and what principle should be used to finance CME system is to be decided.

Part of the amount for the participation in the CME programs might be paid by the doctor itself: While determining medical service tariff the doctor of independent medical activity should consider the necessary sum for the participation in the CME.

The employer of the doctor while determining medical service tariff should consider the amount for the participation in CME system.

Some kinds of incentives might be considered for the doctors to encourage their participation in the CME programs; for example: paid leave, reimbursement of the sum for the participation or attendance of the courses and so on.

Insurance companies should participate in the process of specialist participation in CME.

All the abovementioned sources might be used with different combinations.

Annex 7: Activities to provide doctor's participation in the continuous medical education for prolonging of the state certificate validity

**Decree #25/n
of the Minister of Labor, Health and Social Affairs
January 23, 2004, Tbilisi**

“on the activities to provide doctor's participation in the continuous medical education for prolonging of the state certificate validity”

in accordance to the point 3, article 31, sub point “f”, point 3, article 98 and article 99 of the law of Georgia on “Doctor's activities” (Georgian legislative Matsne #18, 28.06.2001, articles 61-62)

Declare:

1. Approve:
 - a. Accreditation criteria of continuous medical education attendance programs (annex A).
 - b. Criteria for awarding credit hours for the participation in the attendance programs of the continuous medical education (annex B).
 - c. The form of representing continuous medical education attendance programs (annex C).
 - d. The format of the non-attendance continuous medical education programs (annex D).
 - e. The anonymous questionnaire of the program assessment by the listener (annex E).
 - f. Main elements of the list form of the continuous medical education attendance program (annex F).
 - g. Registration form of the certificate issuance (annex G).
 - h. The criteria of issuing credit hours for the providers of the continuous medical education attendance programs; program accreditation and time limits of holding them; assessment criteria of doctor's successful participation in the programs (annex H).
 - i. Time limits of keeping records of issuing credit hours related to the program implementation and accreditation of other forms of continuous medical education programs and the list of responsible persons (annex I).
2. Necessary continuous medical education credit hours of prolonging validity of the state certificate should be collected in the specialty of prolonging validity of the certificate or related specialties.
3. In order to prolong the validity of the state certificate, credit hours of continuous medical education in recertification the doctor should gain with systematic work. Hence, time limit when the doctor has not gained any credit hours should not exceed 12 months.

4. Perform retrospective accreditation of long-term programs of the continuous medical education of 2002 and 2003 (more than 1 month). Determine the quota for participation in the mentioned programs by the following principle: 1 month – 10 credit hours.
5. Credit hours for the participation in the programs of international organizations of 2002-2003 will be issued through the rules determined for short-term programs. Awarding credit hours will be performed on the basis of providing participation certificate.
6. Annul decree #91/n of the Minister of Labor, Health and Social Affairs of April 14, 2003 “on the approval of the quantity of credit hours of CME in order to be accepted at the state certification exam for prolonging the validity of the state certificate” (Georgian legislative Matsne, part III, 01.04.03, #36, article 319).
7. Enact this decree upon publishing.

Amiran Gamkrelidze

Annex 7A: Accreditation criteria of continuous medical education attendance programs

In the process of accreditation of continuous medical education attendance programs the post graduate and continuous medical education board guides with the preliminary worked out and approved criteria. The board determines the compliance of the presented program to the mentioned criteria and gives either the positive or negative response. Therefore, on the basis of negative response it should be indicated which criteria was not satisfied, which itself will be the basis of program improvement.

1. Actuality, need

The necessity of CME course in the issues considered by the program is assessed, for which the board, first of all discusses the relevant points of the program – “purpose of the program”, “goals of the program”, “aiming contingent” (who should participate) and “certifying program necessity”.

Program actuality might be certified with the arguments listed below. Hence, it is possible, that the actuality of the issue be indicated by the several factors together. Only one criterion, in some cases might not be enough to certify program actuality.

The following might verify the actuality of the program:

- a) Program is focused on the disease/pathologic situation, which according to the epidemiological data conditions disease prevalence and fatality, invalid high indicator in our country, region or medical institution.
- b) Program is based on the methods or technologies of diagnostic, prophylactic and rehabilitation recommendations (guidelines) worked out and recognized by the new facts, which the program author searched on the basis of studying other sources of scientific-professional literature and information;
- c) Program is focused on the spheres, where periodic renewal-recertification of the knowledge and skills is necessary, since adequate usage of any diagnostic and medicative methods might be connected with the serious risk (for example: different procedures, cardio-pulmonic

reanimation and others; preparation in the mentioned issues might be recommended with the certain periods: for example: annually or once in two years);

- d) Program is dedicated to the prophylactic, diagnostic or medicative methods, the uncertified usage of which is frequent and that's why it becomes expensive.
- e) Program concerns the sphere (disease/pathologic situation management, prophylactic activities) where the significant variation of prophylactic, diagnostic and medicative principles, methods and standards are fixed (different specialists/institutions use different approaches).
- f) The priorities of the issues revealed in the program are determined while assessing medical service quality on the basis of doctor's lack of knowledge and skills.
- g) The issue is included in the priorities determined by the post graduate and continuous medical education board together with the professional associations.
- h) Previous program evaluation results of the CME participants indicate the actuality of the program (listener interview).
- i) Doctor's interviewing results reveal the actuality of the program (institution, region).

2. Used material, literature and so on.

- a) The material reflected in the program (the information to be presented to the listener, which is presented in terms of annotations and thesis) should comply with program purpose and aims;
- b) The material reflected in the program should be based on the results of then usage of internationally acknowledged scientific methods, medicine principles (not the knowledge and skills of individual doctors). Hence, the material should be new and reflect professional standards of modern medicine;
- c) The positive factor should be the usage of recommendations, standards and algorithms of internationally acknowledged professional associations, organizations and groups.
- d) The material indicate in the program should comply with the main literature of the program – the information submitted to the listener, which is presented in terms of annotations and thesis.

3. Teaching methods:

- a) The possibility of goal achievement, set by the methods of the program should be assessed. For example: if the program aims gaining of the practical skills, accordingly methods used in the program will give the listener the possibility to practically execute work. Assisting doctor in some manipulation or some other methods might be used.
 - (recommendation, method or technology might be acknowledged by authoritative international organization (for example: international professional associations, WHO and others) or by the national entity (for example: professional association or state structure, which is responsible for the medical service quality) and where the level of medical science and medical service quality complies to the international standards (for example: EU countries, USA, Canada and others).
- b) Interactive methods of teaching should be used, which provides active participation of the listener: Discussion, clinical discussions of concrete cases, situational tasks, speeches of the listener prepared through preliminary given material, clinical case computer imitation and others;

The characterization of the mentioned material should be assess by the board (the

sample of situational task or clinical case and others), which is given in the program and samples, to ensure that program supplier has the ability to create and use such materials;

- c) The assessment of demonstration material is important. The program should be accordingly illustrated. The board should study the list of demonstration material and assess attached samples. Demonstration material should comply with the main content of the summary;
- d) Board assesses the printed material prepared for the listener. Printed material should reflect program content and main conclusions, recommendations: also the recommended literature and other resources (for example; internet sites and others);

4. Ways of program effectiveness evaluation:

- a) Board discusses the adequacy of listener evaluation methods. The relevance of the program material to the questionnaire and exam issues should be determined;
- b) Is the practical skill evaluation method used or are the listeners taught practical skills;
- c) Program should include listener evaluation (tests, situational tasks, practical skill evaluation method).
- d) Is the presented method of program evaluation adequate? Hence, program should necessarily consider program evaluation by the listener. The questionnaire should include main questions. Program implementer might include other questions as well.

5. Duration, place and time:

- a) Adequacy of the program duration is evaluated. Is it too long or short? Adequacy of the program should be assessed though the presented schedule (lecture-seminars, practical work, testing and others). At the second stage the volume of the material presented should be determined.
- b) Program implementation in the region is also assessed. It is important that programs be available for the regional doctors and this should not affect program quality.

6. Listener participation documenting methods:

Adequacy of listener participation documenting methods is evaluated – if the presented method gives the possibility to:

- a) Retrospectively assess how many statements were presented; does the statement include detailed information on “applicant” (specialty, work and home address, other contact information and others);
- b) Accurately/objectively fix listener recording form;
- c) Assess if the certificate reflects all necessary information;
- d) Assess the adequacy of the certificate form, which will give the possibility of authentic evaluation of the certificate.

On the basis of the mentioned material, at the end of the program it should be possible to retrospectively assess listener’s participation and in case of necessity their interviewing.

7. How free is CME program from commercial impact and tendency?

It is allowed that the program be financed by medical/pharmaceutical organizations (for

example: pharmaceutical company), but it should not affect program performance and its content. Commercial material should not be revealed and spread during program execution (for example: material should be revealed in the hall, corridor and not teaching room). Company representative might attend CME course, but during CME program execution (before competing) should not be occupied by product advertising or selling.

The financing body should not participate in the program formulation. It might finance material preparation. The teaching material should not encourage the satisfaction of sponsor commercial interests.

8. Participation fee in the CME program and program financing:

Any kind of CME financing, which is not against the legislature, is accepted. Hence, the restrictions indicated in the previous point should be considered, which is necessary for objectivity of the program.

9. CME program implementer evaluation:

The board evaluates if the program complies with the resources of the implementer (technical or human); or can the company implement the program. This evaluation might include site visits.

While assessing technical resources the following should be determined:

- a) If the program implementer has enough space (if there are enough space and rooms for lectures and seminars). In case of necessity – relevant profile and capacity clinic, diagnostic department and others; resources should be assessed together with the schedule and quantity of listeners.
- b) If the supplier of the program has technical equipment (slide-projector, multimedia-projector, diagnostic equipment, computer techniques and others), which is necessary for the successful implementation of the program. This point should be assessed together with the teaching methods (what methods, what demonstration material uses program implementer).

Human resource evaluation:

It should be determined, if the appropriately educated and qualified personnel is employed in the program implementation, is their quantity enough. Hence, teacher/trainer and technical personnel data should be assessed (job description and CV).

- a) Teachers/trainers should have adequate experience in the field of CME program;
- b) If the CME program includes practical skill studies, the teachers/trainers occupied in the program should possess this skills on a high level;
- c) The information on the participants of the program is also evaluated;

While assessing organizational-administration resources it should be determined:

- a) If the program implementer has the experience of program implementation;
- b) If there exists responsible person for the program preparatory and implementer.

Annex 7B: Criteria for awarding credit hours for the participation in the attendance programs of the continuous medical education

The quantity of the credit hours for the participation on the CME programs is calculated on the basis of hours attended. Only time of study is considered as participation in the course, excluding breaks and preliminary and conclusive tests.

Duration of the program	Criteria of granting credit hours	Note
1-10 days	1 hour – 1 credit hour	not more than 50 credit hours can be granted on the participation in one program

Annex 7C: The form of representing continuous medical education attendance programs

Any information that is not included in the application form, might be put on a separate sheet

Name of the program -----

Program implementer (institution/organization):

Name -----

Address: City ----- Zip Code -----

Telephone-----

Fax ----- e-mail -----

Place of program implementation

Address: City ----- Zip Code -----

Program duration (hours) -----

Date of program implementation (dates) -----

For whom is the program determined

1. Indicate doctor's specialty or specialties, in case of necessity – doctor's position and/or institution type
2. How many listeners can participate in one course?

I. Program aim

II. Program aims (what should the listener know or be able to do after the completion of the program?)

III.IV. Program need verification

Indicate which from the listed below fit the program you submit (tick one or more)

- Is the disease/problem discussed in the program related on the basis of epidemiological data of the country of region (concrete below);
- Does the program concern new diagnostic, medicative, prophylactic and rehabilitation recommendations (guidelines), or methods, or technologies or significantly new information doctor's professional activity (concrete below);
- Are the issues envisaged in the program non-traditional for the specialty, but is included in the modern description of the specialty (concrete below);
- Is the improvement of knowledge and skills envisaged by the program periodically necessary (concrete below);
- The priorities of issues were revealed during medical degree evaluation process (concrete below);
- Do the issues considered in the program comply with the recommendations of the board on post graduate and continuous medical education (concrete below);
- Concrete ticked issues; in case of necessity name other arguments, which verify program actuality

V. Teaching methods

1. Program implementation precise schedule (lecture-seminars and other components) in accordance to the days and hours (include separately)

2. What form of information provision is used (tick one or more)

- Lecture/seminars
- Video film
- audio material (class and homework)
- Printed material (including homework)
- Other (concrete)

3. Used demonstration material (tick one or more)

- Hand made mark on the deck, huge format papers
- Placate, printed scheme
- Transparent papers for projector
- Slides for slide-projector
- Slides for compute projector (PowerPoint presentation)
- Different "multimedia" demonstration materials for computer projector
- Other (concrete)

4. What interactive methods are used (tick one or more)
 - Discussion on the preliminary chosen issue
 - Concrete situation discussion
 - Short speeches of the listeners on preliminary agreed issues
 - Other
5. Other (Fill upon necessity)

VI. Existing resources for program implementation

1. Technical resources (space, equipment and others)
2. Human resources (functions of the participants of program implementation, name, specialty, qualification, experience of the program head or teacher/trainers: attach the CV).
3. Organization-administration resources
 - a. Tick how many accredited CME programs has the provider implemented (among them, retrospectively accredited) (indicate details below):
 - none;
 - 1;
 - 2-5;
 - 5-10;
 - >10
 - b. Person/structure responsible for the program implementation and planning (indicate details below):
 - Does not exist;
 - One person;
 - structure;
 - c. Other (fill upon necessity, for example: experience, international relations or other important for you)

VII. Main material characterization, used literature

1. Annotation, main thesis, what information is reflected in the material)
2. Characterization of the material used while interactive work methods (include sample)
3. Demonstration material characterization (include samples)
4. List of handouts (include sample)
5. List of used literature
6. Other additional information (for example is the program prepared on the basis of accredited programs of other countries or international programs or is the already prepared program used).

VIII. Ways of program effectiveness evaluation

1. Listener evaluation by program implementer
 - a. Theoretical knowledge evaluation (tick appropriate boxes, include sample)
 - test evaluation before course commencement;
 - Other kind of assessment before commencement (concrete);
 - Test evaluation after course completion;
 - Other kind of evaluation after course completion.
 - b. Evaluation of practical skills (tick appropriate boxes); is filled in the cases when program aims to improve practical skills
 - Evaluation before course commencement;
 - Evaluation after course completion;
(Specify which method of skill evaluation is used; include the sample of the form)
2. Anonymous evaluation of the program by the listener
 - a. What method is used (include sample)
 - Fill in the questionnaire (program evaluation necessary questions is provided by the board; program implementer might add or change questions)
 - Others (specify)
3. What other methods of program effectiveness evaluation are pursued

IX. Program duration verification

X. Listener participation documentation methods (include sample)

- Listener attendance recording form (main elements of form are provided by the board; program implementer might add other elements)
- The certificate of program successful completion (It should be indicated in the certificate, that the program is accredited by the postgraduate and continuous medical education board, accreditation date, validity and number)
- Registration form of certificate issuance (form main elements are provided by the board; Program implementer might add other elements)
- Other (specify)

XI. Price of the participation for one listener

XII. Program sponsor

- a. Who pays the price for the participation in the program (tick each relevant points)
 - Listener;
 - Employer;
 - Ministry of Labor, health and Social Affairs
 - Pharmaceutical company
 - Other (specify)

XIII. How free the program is from commercial impact?

(Is filled in the case when program has sponsor, who might have interest of medicative substance, equipment or method or medical service or other production or service realization)

- Describe activities, which exclude the sponsor commercial interest impact on program content and professional cost)

Annex 7D: The format of CME programs where the on-site attendance is required

Below you will see CME programme format, which complies with the CME program accreditation criteria. CME program should be presented with the following structural units:

I. Logo

- Program name;
- Name of the program implementer (organization/institution), including the legal form (Ltd, JSC, NGO or other)
- Address;
- Place of program implementation, with the indication of address;
- Program duration;
- Program holding precise probable dates;
- Program preparation and implementation responsible person position and signature;
- Program submission date.

2. For whom is the program designed?

- The name of the specialty (specialties), for whom the program is designed (for example: internal diseases, cardiology, rheumatology, neurology and others)
Or if the implementer will consider it necessary,
- The name of positions (for example: district doctor, pediatrics and others), or the name of the region for whom the program is mainly dedicated (for example: program for diagnostics and cure of malaria, for particular regions where this disease is prevalent)

3. Program purpose:

What is the purpose of the program: to improve contingent professional knowledge and skills, what kind of development and particularly what changes.

4. Program aims:

- What should the listener know after the completion of the course (explain, describe, understand, interpret)
- What should listener do practically after the completion of the course (skills)

5. Program necessity verification

Program necessity can be verified from one or several criteria listed below:

- Selected disease on the basis of epidemiological data, the diseases prevalence, fatality and invalid indicator of which is high in the country, or region, medical institution (for example: mother's and children's disease prevalence, fatality frequent cases, insult, infarct, sepsis, infectious pathology and others);
- New diagnostics, medicative prophylactic and rehabilitation recommendations (guideline), methods or technologies, which then author researched from scientific-professional literature and other sources of information;
- Identification of professional activities of particular specialties, where periodic improvement of knowledge and skills is needed (for example: cardio-pulmonic reanimation algorithm and skills for emergency medical care, critical medicine departments, intensive therapy blocks. development of these skills is recommended once a year or in two years);
- Priorities revealed in assessing knowledge and skills while assessing medical service quality;
- Recommendation of the postgraduate and continuous medical education board on the actuality of the issue;
- Actual issues reflected in the program evaluation of pervious participants;
- Doctor's interviewing results through preliminary worked out questionnaire (institution, region).

6. Teaching methods

- Program implementation exact schedule (lectures, seminars, practical activities, discussions, and other. Their duration and order)
- What source of information provision is used (lecture, audio-video material)
- What kind of interactive methods are used (discussion, concrete case clinical discussions, short speeches and others)
- Types of demonstration materials (improving skills and others)

7. Existing resources for program implementation

- Technical resources (space, equipment, demonstration material)
- Human resources:
 - Teacher's quantity;
 - Teacher's specialties;
 - Teacher's qualification (training, holder of the international or local certificate, scientific degree, experience and others)

- Organization-administration structure (CME program planning, management, quality control)

8. Used literature, material and others

Annotation, main thesis of the information provided to the listener:

- Material used for interactive work (clinical cases and others)
- Material used for evaluation (for example: test-questionnaires, skill assessment criteria)
- Demonstration material samples;
- List of samples and handouts (if exists);
- Used literature;
- Is the program prepared on the basis of international accredited CME program?

9. Ways of program effectiveness evaluation

- Evaluation of the material before course commencement and after completion (among them: test-questionnaires);
- Description of the methodology of practical skill assessment;
- Anonymous evaluation of the program through questionnaire (program actuality, materials, lecturers, equipment and others)

10. Duration, time and place

- Program duration;
- Program holding determined dates;
- Program holding probable dates;

11. Listener participation documentation methods

- Listener list form, which is certified by program head
- Listener attendance recording;
- Preliminary, midterm and final evaluation forms (among them, test evaluation, and midterm – upon desire)

12. How free the CME program is from commercial impact and tendency

- It should be indicated, if any of the companies plan to hold presentation of their products. This is allowed, only if it will not affect program form and content. Commercial material should not be advertised or exhibited in the CME process (for example: material might be exhibited in the hall, corridor and not in the room). Company representative might attend CME course, but should not sell or advertise the product);
- The sponsor of the program should not participate in the formulation of the program. He can only finance material preparation.

13. Price of participation in CME programs and program financing:
- Price for the participation in CME programs;
 - Is the program implementation financed by the third party?

Annex 7E: The anonymous questionnaire for the program assessment by the listener

Program evaluation questionnaire should include questions mentioned below. Hence, each question should be assessed with 5 points, where “1” is minimal and “5” maximum.

1. How do you evaluate program generally (on the whole)?
2. How do you assess program actuality?
3. How do you assess the relevance of the program material to the program purpose and goal?
4. How do you evaluate the relevance of the used methods to the program purpose and goals (lecture, seminar, case discussion, clinical visits, skill demonstration, and others)
5. How do you evaluate teacher/training activities (information supply, description, practical skill demonstration)?
6. How do you evaluate demonstration/illustration material?
7. How do you evaluate technical resources used in the program process (space, equipment)?
8. How the program met your expectations (program purpose, goals)?
9. How the program will improve your activities?
10. Other comments:

Please indicate the issues you would like to participate in the CME programs.

After each question there should be scale 1-5, to tick the appropriate one.

Program implementer might add other questions (or separate questions).

Annex 7F: Main elements of CME programme attendees list

CME program listener’s list should include following:

1. Name, Surname
2. Specialty
3. Work place, institution, position and address
4. Home address (exact address)
5. Detailed contact information (address, telephone, fax, e-mail)

Program implementer might add other points.

Annex 7G: Registration form of the certificate issuance

Registration form of the certificate issuance should include:

1. Certificate owner’s name;
2. Certificate issuance date;
3. Certificate owner’s signature;
4. Certificate issuance signature;
5. Certification date.

Below please see the probable sample of the form.

#	Name, Surname	Certificate issuance date	Certificate signature	owner’s	Certificate issuance signature

Certificate registration form certification data -----

Program head signature -----

Organization seal

Annex 7H: The criteria of issuing credit hours for the providers of the continuous medical education attendance programs; program accreditation and time limits of holding them; assessment criteria of doctor's successful participation in the programs

1. Program authors are granted credit hours upon accreditation.
2. After holding programs authors are repeatedly and implementers first time granted credit hours. In both cases quantity of credit hours are determined during program accreditation process in the quantity of credit hours determined for the participation in the programs.
3. Time of informing on the accreditation and holding of continuous medical education attendance programs:
 - a. Program accreditation process maximum duration – 2 months;
 - b. Notify postgraduate and continuous medical education board on the program execution time and place 10 days before.
4. Doctor's successful participation evaluation criteria in the CME attendance programs are:
 - a. In order to get the certificate of participation in accredited continuous medical education attendance programs and credit hours, doctor should successfully pass conclusive evaluation at the end of the program.
 - b. Program learning conclusive evaluation should include questionnaire. Questionnaire will be assessed as successful if the correct answers exceed 75%.
 - c. Program final evaluation might include other kinds of evaluations as well (for example: some task, practical skill demonstration and others).

Annex 7I: Time limits of keeping records of issuing credit hours related to the program implementation and accreditation of other forms of continuous medical education programs and the list of responsible persons

Document name		
Documents prepared for the accreditation	In case of accreditation, during 5 years after accreditation; In case of rejecting accreditation in 6 months or after certifying appellation results	CME accreditation or appellation sub-commission of the post graduate and continuous medical education board
CME program holding documents	During 5 years after program execution	CME program implementer
CME program participation certificate	Till next certificate	Certificate owner
Others	5 years	-

Annex 8: Programs accredited by the board of post graduate and continuous medical education

Accreditation #	Program Name	Provider	Address, telephone, fax	Representative	specialty (ies)	# of Students	Granted credit hour
2003001	Cardiac Arrhythmias, I. Front heart fibrillation management principles. II. Supraventricular paroxysm taxicardy management	Cardiology institute	Tbilisi, Gudamakris str 2, Tel: 607535, 676047, 893312937, Fax: 955114	G. Abuladze	Internal diseases, cardiology, family medicine	30	15.0
2003002	Non-intravenous radiological method role heart ischemic disease diagnostics and monitoring	SMA, medical radiology cathedra, light and intervention diagnostics institute	Tbilisi, Tevdore Megvdeli 13, 940289, 352049, fax: 344923	Ph. Todua	Radiology, cardiology, internal diseases, cardio surgery	15	40.0
2003003	Heart cronich insufficiency diagnostics, treatment	SMA, internal disease cathedra	Tbilisi, Chavchavadze 33, Tel: 226817, fax: 251712	T. Zakariadze, M. Tsverava	Internal diseases, cardiology, family medicine	30	10.0

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Accreditation #	Program Name	Provider	Address, telephone, fax	Representative	specialty (ies)	# of Students	Granted credit hour
2003004	some modern methods of Onco-immunology and their role in neurological disease diagnostics and monitoring	SMA, clinical-laboratory diagnostics cathedra	Tbilisi, Chavchavadze 33, Tel: 226879,	N. Gogokhia	Laboratory medicine specialist, doctor – laboratory technician	20	15.0
2003005	Neurovizualisation modern methods and their role neurological disease diagnostics and monitoring	SMA, medical radiology cathedra, light and intervention diagnostics institute	Tbilisi, Tevdore Megvdeli 13, 940289, 352049, fax: 344923	Ph. Todua	Radiology, neurology, angelology, neural surgery, psychiatry	20	40.0
2003006	Lever disease ultrasound and computer tomography diagnostics	SMA, medical radiology cathedra, light and intervention diagnostics institute	Tbilisi, Stevedore Marvel 13, 940289, 352049, fax: 344923	Ph. Todua	Radiology, gastroenterology, abdominal surgeon	25	15.0
2003007	Acute disease modern aspects in dermatovenerology (single accreditation)	SMA, dermatovenerology cathedra, Tbilisi dermatovenerology association	Tbilisi, Constitution 4, Tel: 958843, e-mail: devcokobakhidze@yahoo.com	I. Kobakhidze	derma-venerology, gynecology, urology, family medicine	100	5.0

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Accreditation #	Program Name	Provider	Address, telephone, fax	Representative	specialty (ies)	# of Students	Granted credit hour
2003008	Preclampsy, eclampsy, Hellp syndrome, treatment clinical recommendations	SMA, Gynecology cathedra #1	Tbilisi, Chavchavadze 33, Tel: 790111, fax: 941905	P. Kintraia, D. Jincharadze	Gynecology	15	25.0
2003009	Bleeding prevention and intensive therapy clinical recommendations	SMA, Gynecology cathedra #1	Tbilisi, Chavchavadze 33, Tel: 790111, fax: 941906	P. Kintraia, N. Tsintsabadze	Gynecology	50	25.0
2003010	Infant feeding and bowel diseases	SMA, pediatrics and neonatology cathedra	Tbilisi, Chavchavadze 29, Tel: 234203, fax: 230391	I. Pavlenishvili	Neonatology, pediatrics, general profile doctor pediatrics	30	25.0
2003011	Infant critical situation diagnostics and management modern principles	Children central clinical hospital	Tbilisi, Lubliana 2/6	N. Tatishvili	Neonatology, children neurology	50	7.5
2003012	Primary health unit and district pediatrics role in children onco-hematology diseases diagnostics and management process	Children central clinical hospital	Tbilisi, Lubliana 2/6, Tel: 528099, fax: 523805	A. Shengelaia	General profile doctor pediatrics, general profile doctor, pediatrics, internal diseases, family doctor	50	15.0

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Accreditation #	Program Name	Provider	Address, telephone, fax	Representative	specialty (ies)	# of Students	Granted credit hour
2003013	Before cancer and cancer disease prevention and early diagnostics (private part)	National center of oncology; oncological prevention national center	Tbilisi, Lisi lake district, Tel: 261455, 264343	R. Gvamichava	General profile doctor, surgery, internal diseases, dermatology, gynecology, otorinolaringology, family medicine	50	10.0
2003014	Respiratory system acute disease management in children	TSMU pediatrics cathedra	Tbilisi, Vakja-Pshavela 33	Iv. Chkhaidze	Pediatrics, general profile doctor pediatrics	20	15.0
2003015	Ache management in the final stage of non-curable diseases	Classical and traditional medicine academy	Tbilisi, Kavtaradze 16a, Tel: 305575, fax: 307515	D. Kordzaia	Oncology, critical situation medicine, family doctor, district therapeutics	40	10.0
2003016	Diagnostics and management of the main nosologies of stomach ache in children	Children central clinical hospital	Tbilisi, Lubliana 2/6, 530033, fax: 529034, e-mail: info@cch.ge	V. Bokeria	General profile doctor pediatrics, pediatrics, children surgery, G. Tabidzeinfectious diseases, family doctor, N. Ninuaemergency doctor	50	7.5

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Accreditation #	Program Name	Provider	Address, telephone, fax	Representative	specialty (ies)	# of Students	Granted credit hour
2003017	Heart insufficiency diagnostics and therapeutic intervention handbook principles (recommendations of the European cardiology society)	TSU medical faculty	Tbilisi, Gudamakri 2, Tel: 616047, 337556, 877 449151, cardiology institute, fax: 955114	G. Tabidze	Internal diseases, cardiology, general profile doctor, family doctor	40	15.0
2003018	Carpal syndrome diagnostics and management modern principles	TSMU neurology cathedra	Tbilisi, Vaja-Pshavel 271, Tel: 392504	N. Ninua	Neurology, neural surgery, traumatology, orthopedic, family doctor	50	9.0
2003019	Head ischemic insult anticoagulation and desegregation treatment and prevention	TSMU neurology cathedra	Tbilisi, Vaja-Pshavel 271, Tel: 392504	N. Ninua	Neurology, neural surgery	50	18.0
2003020	Discogenic algic and compressive – reflex syndrome diagnostics and management main principles	TSMU neurology cathedra	Tbilisi, Vaja-Pshavel 271, Tel: 392504	N. Ninua	Neurology, neural surgery, medicative physical culture and rehabilitation	40	12.0

Georgia Health Sector Reform Programme - CNTR 02 4201: Primary Health Care - Human Resources Work Stream

Accreditation #	Program Name	Provider	Address, telephone, fax	Representative	specialty (ies)	# of Students	Granted credit hour
2003021	Clinically and anatomically thin hip	SMA, Gynecology cathedra #1	Tbilisi, Chavchavadze 33, Tel: 790111, fax: 941905	P. Kintraia head of department, D. Jincharadze Department professor	Gynecology	15	25.0
2003022	Endoscope in reproduction	Reproduction institute	Tbilisi, Kostava 43, Tel: 996197, 989110, fax: 998108	A. Gvenetadze	Reproduction, gynecology	5	15.0
2003023	Paradontic disease diagnostics and treatment modern aspects	TSMU, Ltd stomatological clinic	Tbilisi, Agmashenebeli 126, Tel: 952569, 952789	Z. Orjonikidze	Stomatology, therapeutics stomatology, surgical stomatology, orthopedic stomatology	50	15.0
2003024	B and C hepatitis problem in the world and Georgia. Epidemiological situation in Georgia, B and C hepatitis laboratory diagnostics	Infectious pathology, HIV and clinical immunology center	Tbilisi, Kazbegi 16, Tel: 393605, 395729, 330809, fax: 941668	E. Botsvadze	Infections, therapeutics, pediatrics, epidemiology	20	15.0
2003025	Combined and simultaneous operations in surgical clinic	Surgery national center	Tbilisi, Chachava 5, Tel: 522079, fax: 521075	B. Mosidze	General surgery	30	12.0

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Accreditation #	Program Name	Provider	Address, telephone, fax	Representative	specialty (ies)	# of Students	Granted credit hour
2003026	Pancreonectrose – diagnostics and treatment	TSMU surgical disease #1 cathedra	Tbilisi, Vaja-Pshavela 29a, Tel: 390990	N. Lomidze	General surgery	30	10.0
2003027	Symptom control in the final stage of non-curable diseases	Classical and traditional medicine academy	Tbilisi, Kavtaradze 16a, Tel: 305575, fax: 307515	D. Kordzaia	Oncology, critical situation medicine, family doctor, general profile doctor	40	10.0
2003028	Photoadaptogene inclusion principles in prevention medicine and treatment schemes, priorities and possibilities for different diseases	Classical and traditional medicine academy	Tbilisi, Kavtaradze 16a, Tel: 305575, fax: 307515	O. Toidze, I. Djordjoliani	Family doctor, general profile doctor, internal diseases, cardiology, gastroenterology, medicative treatment and rehabilitation, physical medicine, district doctor	30	10.0
2003029	New data on narcologic disease pathogenesis diagnostics and treatment	SMA narcology cathedra	Tbilisi, Vaja-Pshavela 39a, Tel: 396158, 397063, fax: 304602	G. Lejava	Narcology	20	15.0

Annex 9: Accreditation guidelines 2001/2007 for higher education institutions in Georgia

**ACCREDITATION OF HIGHER EDUCATION
INSTITUTIONS IN GEORGIA: ACCREDITATION
GUIDELINES 2001/2007**

4 August 2001

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- Akaki Beridze, Minister for Health, Republic of Adjara
- Iago Kalandadze, Head of Department of Standardization, Norming and Licenzing of MoLHSA
- George Khuphenia, Head of Division of Medical Education of Department of Science and Education of MoLHSA
- Vazha Daborjginidze, First Deputy, Department of Public Health
- Tina Didia, Head of Public Relations, Ministry of Health, Batumi

- Zaza Avaliani, Head of Education Department, Tbilisi State Medical University
- Nodar Bakradze, Rector of Medical Institute 'Tbilisi'
- Varlam Borjadze, Chief Doctor of Central Clinical Hospital of State Railway Department
- Bitchiko Diasamidze, Vice-Rector (Paid Sector), Shota Rustaveli Batumi State University
- Irakli Gagoidze, Chairman of the Board of Rectors of Private Higher Medical Schools
- David Gordeladze, Dean of Medical Faculty of Ivane Javakhishvili State University
- Ramaz Khetsuriani, Rector of Tbilisi State Medical University
- Besarion Kilasonia, Pro-rector of Tbilisi State Medical University
- Archil Kobaladze, Director of Health Sciences Centre, Ivane Javakhishvili State University
- Malkhaz Kokichashvili, Vice-Rector of 'Aieti' Medical School
- George Lobzhanidze, President of Georgian Physician's Association
- Irakli Pavlenishvili, Pro-rector of Academy of Postgraduate Medical Education
- Vladimer Sanikidze, Head of War Veterans' Hospital of the State Department of Veterans Affairs
- Otar Toidze, Pro-rector of Academy of Classic and Traditional Medicine
- David Tvildiani, Rector of 'Aieti' Medical School
- Zurab Zgenti, Head of Maternity Hospital, Batumi
- Tsitsino Mchedlishuli, Member of Editorial Board of 'Family Doctor'
- Beso Lukhutashvili, National Health Management Centre, Translator

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SECTION 1 INTRODUCTION

1.1 Aims and objectives of accreditation in higher education

Through the introduction of a system of accreditation, the Government aims to:

- improve the overall quality of higher education, both in the public and private sectors
- improve the knowledge and skills of graduates
- ensure that minimum standards for teaching and learning are set and maintained across the higher education sector
- provide public recognition to those institutions which provide high quality education
- inform the public so that they can select institutions which can be relied on to provide high quality provision
- ensure that the number of graduates in specific educational programmes meets the needs of the labour market and the national economy
- enable Georgian higher education qualifications to be recognised in the global market and thus facilitate mobility of students and the workforce

1.2 Development of the accreditation process

These Guidelines have been developed by the Ministry of Education (MoE) in liaison with the Ministry of Labour, Health and Social Affairs (MoLHSA) and key stakeholders in the higher education sector. Consultants with experience of international accreditation systems have also assisted in the development of the framework and guidelines. The accreditation framework draws on examples of best practice in Europe.

Funding was available from the UK's Department for International Development to support the development of an accreditation framework in undergraduate medicine. The first year of the accreditation process will therefore focus on developing a robust, sustainable accreditation scheme for undergraduate medical education which is able to be extended to include other educational programmes and also postgraduate medical education.

Initial proposals for the accreditation process were drawn up in April 2001 during meetings between the UK consultants and the Chairman of the Parliamentary Committee for Education, Science, Culture and Sport, the Deputy Chairman of the Parliamentary Committee for Health, the Deputy Minister of Education, the First Deputy Minister for Health, representatives from the MoE and MoLHSA, and various Higher Education institutions in the public and private sector. The consultants also visited a number of medical schools in the public and private sector.

In May 2001 two Workshops were held to consider basic principles of quality assurance and accreditation according to international standards and key features of accreditation in medical education. The workshops were attended by the Deputy Minister of Education, the First Deputy Minister for Health, leading members of the Higher Education sector, MoE and MoLHSA representatives, representatives of the National Health Management Centre and the UK

consultants. The most important outcome of the workshops was to agree a framework for accreditation in Georgia.

In July 2001 the guidelines for the accreditation process were further developed and finalised by a small team representing the Parliamentary Committee of Health and Social Affairs, the MoE, the MoLHSA, leading members of the Higher Education sector, the National Health Management Centre in Georgia and the UK consultants. In addition a meeting was held with the Minister of Health for the Republic of Adjara, the Vice-Rector (Paid Sector) for the Shota Rustaveli Bahumi State University and the Head of the Batumi Maternity Hospital and two journalists to disseminate information on the accreditation process and to consult with key representatives from higher education institutions outside Tbilisi.

1.3 Implementation

These Guidelines describe the method and procedures which will be used to carry out the accreditation of higher education institutions in Georgia. The first cycle of the accreditation process will take place between 2001 and 2007 and will cover all educational programmes offered by all higher education institutions.

Undergraduate medicine will be the first educational programme to be accredited and the accreditation process in undergraduate medicine is expected to be completed in 2002. At the end of the first stage of the accreditation process an evaluation of the accreditation process will be carried out and these guidelines will be reviewed in order that the process can be extended to other educational programmes from the 2002-03 academic year.

SECTION 2 THE ACCREDITATION PROCESS

2.1 What will the accreditation process focus on?

The accreditation process will evaluate the quality of provision within an educational programme. It will focus on the institution and its management and resources as well as programme-specific issues relating to teaching and learning. The contribution of research to teaching will also be considered.

All institutions which offer a particular educational programme will be invited to apply for accreditation of that programme according to the schedule for accreditation to be issued by the MoE. As a general rule, the whole accreditation cycle for one educational programme will take place within one academic year. Normally taught programmes at all levels (undergraduate and postgraduate) will be reviewed although in the first year of the accreditation process only undergraduate medicine will be reviewed.

2.2 What methods will be used to accredit institutions?

In line with international developments, the accreditation process will include the following elements:

- Self-evaluation
- Peer review by members of an Accreditation Team
- An Accreditation Visit which will result in an Accreditation Judgement and in publication of an Accreditation Report

Further information on the role of each of these methods is given in further sections of these Guidelines.

These guidelines should help an institution to produce a self-evaluation report which is both analytical and descriptive, as well as to prepare for the visit of the accreditation team. The self-evaluation process aims to encourage openness regarding institution's weaknesses and strengths.

Experience in the international arena demonstrates that open communication with peers - since the peers come from similar academic organisations - can be enlightening and this is also an important component of the accreditation process. This exercise is designed to assist the institution in looking towards its future development in addition to focusing on public accountability and on judging the quality of teaching and learning within the institution.

The formal outcome of the accreditation process is a final report in which the accreditation team details its findings and conclusions in order to provide feedback to the leadership of the institution about its current performance. The accreditation team will commend good practices and indicate problem areas as well as recommending action for improvement and giving an overall judgement of provision. Furthermore, the accreditation process will provide the Government, through an Accreditation Board, with valuable information to address common problems facing higher education institutions.

2.3 What will accreditation mean to those institutions which are successful?

The Government is planning to introduce legislation to bring attestation requirements into line with the new accreditation process. In future attestation requirements will include the requirement to be successfully accredited. Qualifications in the programme being accredited will be recognised by the State for those institutions which successfully achieve accreditation.

2.4 What happens if an institution fails to achieve accreditation?

Once a full schedule of accreditation visits in an educational programme has been completed, qualifications from non-accredited institutions in that programme will not be recognised by the State. New institutions wishing to be licensed to provide a particular educational programme will be required to apply for accreditation after one year of operation following completion of the accreditation visits in that subject.

Failure to achieve accreditation will result in one or more than one of the following:

- negotiation between the Government and the institution on the impact on staff and facilities
- the transfer of students to another institution or to another educational programme within the same institution
- students will be permitted to complete their studies but no new students will be able to be admitted to the institution
- the institution may be given further time to meet specified conditions
- the total number of students in one or more programme/s may be reduced in order to meet the conditions set as a result of an accreditation visit
- funding may be reduced for state-funded institutions and reallocated to those institutions which are successful in achieving accreditation

2.5 What is the role of the Ministry of Education?

The MoE will be responsible for providing financial, logistical and technical assistance to the Accreditation Board and will delegate to the Board the responsibility for managing the accreditation process.

2.6 What is the role of the Accreditation Board?

The Accreditation Board will be responsible for the following, although they will devolve responsibility to the Chairs of Accreditation Teams or to other nominated representatives as indicated:

- deciding on the institutions, faculties or disciplines to be accredited and the timescale
- determining the focus of the accreditation and design of the guidelines
- guiding the institution during the self-evaluation phase (devolved to Chair)
- selecting the accreditation team
- briefing the accreditation team (devolved to Chair)
- defining the responsibilities of each team member (devolved to Chair)

- providing the team with background information and advice (devolved to Chair)
- organising the practical aspects of the site visit in conjunction with the HE institutions (may be devolved to Chair)
- informing the institution of the accreditation judgement (normally devolved to Chair)
- co-ordinating appeals against the accreditation judgement
- finalising and publishing the accreditation report

The Accreditation Board members will be appointed by the President of Georgia according to existing legislation. The Board will appoint a small team of administrative and secretarial staff to support the accreditation process, deal with applications for accreditation and respond to enquiries for advice and guidance from higher education institutions.

2.7 How will accreditation teams be chosen and what is their role?

2.7.1 Composition

Accreditation will be carried out by a team of external accreditors which will normally comprise a Chair and two specialists for each programme. A larger team will be required for visits to large institutions or visits where more than one programme is being accredited. Depending on the educational programme/s being accredited, a team representing several rather than one programme may be used.

The team of accreditors will be drawn from higher education institutions (both public and private) in Georgia. It is desirable that the team includes a representative from a research institution. The team may also include a representative from an employer organisation, professional body and/or an international or educational expert. In future it is envisaged that foreign experts will be included in the team.

Team members should:

- be independent of the institution under review (team members will be required to declare their interests as part of the selection and allocation process)
- be respected by the institution under review
- have skills in all key aspects of the area of accreditation
- be trained as accreditors

In addition, Chairs must:

- not be experts in the programme they are accrediting in order to ensure objectivity and avoid conflict of interest
- have wide experience in higher education and be respected senior members of society. The Chair will typically hold or will have held (eg retired), a senior management position in higher education (eg, Rector, Vice-rector, Dean, Administrative Director)
- not hold government office

2.7.2 Appointment

Higher education institutions (both private and public) will be asked to nominate team members and submit brief biographies of the staff concerned. Team members will then be selected from this list by the MoE in consultation with representatives from the MoLHSA and from the educational programmes being accredited. Programme specialists will be appointed for one academic year and will be expected to participate in 5-6 visits during the year (12-18 days). Chairs will be expected to participate in approximately 10 visits during the year (up to 30 days) and will normally be appointed for the whole 5 year cycle of accreditation. It is important that team membership varies for visits to different institutions and that the same team members and chairs are not working together on more than 2 visits. This will aim to reduce bias and ensure objectivity by bringing a range of different perspectives and experience to each visit. All team members will be expected to participate in training for further teams of accreditors. On occasion some team members will be required for accreditation visits in subsequent years.

2.7.3 Commitment

It is estimated that approximately 100-150 team members will be required in total (including Chairs) to accredit all educational programmes within all institutions in Georgia (both public and private) between 2001 and 2007. It is important that the accreditation process does not rely on too small a pool of accreditors and that the accreditation process involves as many people as possible in order to:

- spread knowledge and expertise of the principles underlying accreditation and quality assurance
- ensure the contribution of people with a wide range of experience and expertise
- ensure that accreditors are not absent from their institution for long periods of time

2.7.4 Training

The accreditation team will be trained in managing and taking part in the accreditation process. Trained accreditors will in turn be required to cascade training to new accreditors. Training will include guidance on:

- the analysis of self-evaluation reports
- conducting meetings as part of the accreditation visit
- preparing a record of meetings and observing teaching and learning
- analysing a sample of student's work and other documentation
- the preparation of accreditation reports
- grading of areas of provision and reaching an accreditation judgement

In addition training for chairs will include guidance on managing the accreditation visit process including:

- conducting preliminary discussions with the institution on the accreditation visit
- managing the accreditation team, allocating tasks and ensuring that there is an appropriate balance of activities

- managing meetings and relations with the institution
- presenting the final judgement
- preparing the final accreditation report

2.7.5 Payment

A daily payment will be made to Chairs and educational programme specialist team members. Accommodation and travel will be paid for by the Accreditation Board although the institution being accredited may be asked to make the necessary arrangements on the Board's behalf.

It is envisaged that participation in the accreditation process will benefit organisations by providing training in what is required of an accredited organisation, promoting a greater awareness of quality issues and good practice and enhancing the organisation's reputation in the higher education sector. As training will take place early in the accreditation cycle, those trained will be able to assist their own higher education institution to complete the self-evaluation report and prepare for the accreditation visit.

2.7.6 Responsibilities

The accreditation team will be responsible for:

- analysing the self-evaluation report and other information provided in advance of the visit
- participating in the accreditation visit to gather, share and test evidence and verify the content of the self-evaluation report
- establishing a dialogue with the institution
- grading each of the areas to be accredited and making an overall judgement which will include recommendations for improvements.
- commenting on the draft report after the visit

The team chair is responsible for co-ordinating and managing the accreditation visit and for ensuring that it is conducted within these guidelines. His/her role includes:

- preparing for the accreditation visit in liaison with the institution
- co-ordinating the work of the accreditation team
- ensuring that evidence is gathered and tested and that the judgements reached are robust
- providing oral feedback to the institution at the end of the visit
- preparing the accreditation report after the visit.

2.7.7 Support

The accreditation team will be supported by a secretary appointed by the Accreditation Board who will take notes during the site visit and assist in drafting the accreditation report.

2.8 What is the role of higher education institutions?

The Accreditation Board will inform the institution of the composition of the proposed accreditation team. If the institution has any concerns and wishes to challenge the composition of the team it must notify the Accreditation Board as soon as possible but no later than one week after it has received this information. Team membership will only be changed in exceptional circumstances.

The institution will be responsible for sending out any additional documentation required by the accreditation team prior to the visit but not less than one week before the visit. All other communications should be channelled through the accreditation team chair.

The institution will provide a schedule of teaching and learning sessions being carried out during the visit. The institution will also be required to make arrangements for the observation of placements and other off-site teaching in advance of the accreditation visit.

2.8.1 Institutional Contact Person:

It is envisaged that the majority of institutions will have a designated institutional expert in quality assurance. All institutions will be required to appoint an institutional contact person for each accreditation visit and this will usually be the expert in quality assurance.

The institutional contact person will liaise with the accreditation team chair to plan and organise the site visit, eg setting up meetings and briefing the participants on the purposes of the accreditation and the site visit. The institutional contact person will receive briefing in all aspects of the accreditation process. By acquiring experience in this field, the institutional contact person will be able to assist the institution to prepare for any future accreditation exercises, disseminate good practice and focus on areas for improvement identified by each accreditation visit.

The institutional contact person's role includes:

- helping the accreditation team come to a clear and accurate understanding of the institution's structures, policies and procedures and the nature of provision
- liaising closely with the accreditation team to ensure that the team obtains accurate and comprehensive information about the educational programme and its institutional context
- helping the institution understand what issues are of concern to the accreditation team
- responding to requests from the team for comments and information
- assisting in providing the team with documentary evidence
- advising the team on institutional policy and context

The institutional contact person is expected to observe objectively, communicate clearly, respect the protocols on confidentiality and establish relationships of trust with the team members. The institutional contact person is not a member of the team and will not be expected to make judgements on the quality of education under review. S/he should not act as an advocate for the programme being accredited but will provide a means whereby both the institution and the team may be confident that all appropriate evidence has been made available to the team.

It is essential that institutional contacts are involved fully in the process of preparing for an accreditation visit and that they are available throughout the duration of the visit. The institutional contact person will also attend all team meetings (except the meeting to determine grades and the overall judgement) and all meetings held between members of the accreditation team and the institution (except the meetings with current and former students or employers). There may be occasions when the institutional contact's institutional function may need to take precedence over facilitation of the visit, eg if s/he is responsible for a particular area which an accreditation meeting is addressing.

The role of the institutional contact at team meetings is essentially that of an observer, although contributions to the discussion may be made within the context of the contact's remit, subject to the discretion of the chair. The team chair will ensure that the role of the institutional contact is clearly established at the first team meeting.

The institutional contact person will assist in ensuring that no information gained in the course of the visit can be used or transmitted if it would allow an individual from the institution or the accreditation team to be identified. S/he will therefore have to exercise caution when reporting back to staff. It is acceptable for institutional contacts to make notes on the team's discussions in order to assist the institution's understanding of the issues that are of concern to the accreditation team. In this way, information relating to the visit can be conveyed to improve the effectiveness of the visit.

The institutional contact person will ensure that the channels of communication between the accreditation team and the institution work effectively. Frequent discussions between the institutional contact person and the accreditation team chair will be normal features of the visit, to ensure that institutions have a clear picture of the issues which concern the team and the nature of the evidence required to clarify them.

In circumstances where there is evidence that the conduct of the institutional contact person is undermining the effective operation of the accreditation visit, the institutional contact may be excluded from the remainder of the visit. Before excluding an institutional contact person the institution will be notified and allowed to appoint a replacement. Similarly a replacement may be nominated in the event of the illness or incapacity of the institutional contact person originally identified.

It is essential that institutional contacts:

- have a thorough knowledge of the structure, policies, priorities, procedures and practices of the institution
- have extensive knowledge and experience of working in higher education at a senior level
- have knowledge of quality assurance procedures in higher education
- are educated to degree level or equivalent
- have qualifications and experience in a programme area other than that being accredited
- are able to maintain confidentiality

SECTION 3 APPLICATION FOR ACCREDITATION

3.1 What is the timescale for the accreditation process?

Undergraduate medicine will be the first programme to be accredited and the accreditation process in undergraduate medicine is expected to be completed in 2002. At the end of the accreditation process in 2002 the accreditation process will be evaluated and the guidelines reviewed in order that the process can be extended to other subject areas from the 2002-03 academic year.

All programmes offered by higher education institutions in Georgia will be accredited for the first time between 2001 and 2007.

3.2 When should institutions apply for accreditation?

The schedule of action will normally be as follows:

Months 1-3 Institutions are asked to nominate accreditation team members

Accreditation guidelines sent to those institutions offering programmes in the subject to be accredited

Institutions submit an application for accreditation together with the accreditation fee

Institutions complete self-evaluation report

Accreditation team members, including team chairs, are selected and trained

Month 4 Final deadline for submission by institutions of accreditation application together with fee and completed self-evaluation report

Self-evaluation forms are analysed by representatives of the Accreditation Board. A schedule for the accreditation visits in the current academic year is then produced and agreement is reached on the composition of the accreditation teams.

Notification is sent by the Accreditation Board to institutions on the proposed date of their accreditation visit, if appropriate, and proposed membership of the accreditation team visiting that institution. Notification is also sent to those institutions required to resubmit their self-evaluation report and those who have failed to meet the minimum threshold standards.

Institutions which wish to challenge composition of accreditation teams or any other decision made by Accreditation Board must do so within one week of notification.

- Months 5 Self-evaluation reports and associated documentation for an institution will be sent to accreditation team members a minimum of 4 weeks before the visit is scheduled to take place.
- Accreditation team member consider the self-evaluation report to determine the aims and goals of the institution, whether and how they are met, whether strengths and weaknesses are clearly stated, and whether there is any missing information.
- A minimum of one week (and not more than 10 days) after the documentation has been sent to accreditation team members, Chairs of accreditation teams will contact team members to discuss arrangements for the visit, agree the responsibilities within the team and agree the activities to be undertaken and the questions which need to be asked during the visit. This will enable the chair to draw up a proposed programme for the visit for discussion with the institution.
- Chairs of accreditation teams will contact institutions to discuss the visit and agree a provisional programme which will be sent to the institution a minimum of 3 weeks prior to the visit taking place.
- Higher education institutions will send additional documentation which has been requested by team members not less than one week before the visit takes place.
- The Accreditation Board will notify team members of the administrative arrangements for the visit (eg accommodation arrangements) a minimum of one week before the visit takes place.
- Months 6-11 Accreditation visits take place.
- Ongoing monitoring and evaluation of accreditation process.
- Accreditation reports will be finalised within six weeks of the visit. Institutions will be given an opportunity to comment on factual accuracy within this time.
- Accreditation reports will be made available to the public within six months of a visit.
- Month 12 Production by the Accreditation Board of a report summarising the results of the accreditation exercise. Evaluation by the Accreditation Board and government representatives of the accreditation process and revision, as appropriate, of the accreditation guidelines.
- Accreditation process commences for further range of programmes.

3.3 How much will it cost to apply for accreditation?

The accreditation process will be self-funding. Fees collected from institutions will be used to fund the costs of the provision of administrative and secretarial support, travel and accommodation costs for the visiting teams, fees for the chairs and members of accreditation teams, training for team members and chairs and publication and dissemination of accreditation

reports. The fee which the institution will pay will vary according to the size of the accreditation team, the length of the accreditation visit and the number of educational programmes being accredited.

It is not envisaged that the overall monetary costs of implementation will be high but the accreditation process will require a high investment in terms of staff time in participating in the process and preparing for accreditation. Higher education institutions (both private and public) will be asked to nominate team members. Team members will then be selected from this list by the Accreditation Board in consultation with representatives from the programmes being accredited.

3.4 How do institutions apply for accreditation?

Those institutions wishing to apply for accreditation for each individual educational programme of study are required to:

- submit an application for accreditation together with the accreditation fee
- complete a self-evaluation report for the programme/s for which they are seeking accreditation. The report must meet the requirements set out in Section 4 and must not exceed the stated word limits
- submit the report and any supplementary information which has been requested by the set deadline in the year in which the programme is to be accredited
- provide an indication of the institution's preferred dates for the visit (the Accreditation Board cannot guarantee that it will be able to arrange the visit on the preferred date but this information will assist the Board in drawing up the programme of visits).

SECTION 4 SELF-EVALUATION REPORT

4.1 Introduction

The self-evaluation report has three purposes:

- to provide background information (eg student numbers, examination results and descriptions of quality assurance processes already in existence) to enable the accreditation team to carry out the accreditation visit
- to allow the institution to inform the accreditation team of its views on its strengths and areas for improvement
- to initiate internal processes of quality improvement

All of the information in the self-evaluation report is essential and non-completion of any section will mean that the application is not acceptable and will be returned to the institution. There are also word limits for some of the sections of the report. Those institutions which exceed the word limit will be required to edit their report. Self-evaluation reports should be submitted in the Georgian language.

Higher education institutions will be given a minimum of two months to carry out the self-evaluation. The time between submission of the self-evaluation report and the visit should not exceed eight months to ensure the relevance of the information at the time of the site visit. Applications for accreditation, together with the self-evaluation report and any supplementary information, should be submitted by the stated deadline in the year in which the programme is to be accredited (see paragraph 3.2). If institutions are required to edit their report in any way after submission they may not be able to be accredited until the next cycle of visits. Institutions are therefore advised to submit their application for accreditation well before the stated deadline.

A printed and an electronic copy of the self-evaluation report must be provided.

4.2 Production of self-evaluation report

It is important that the report includes an analysis of the quality of educational provision and not just a description of provision. The most common complaint of external evaluators internationally is that self-evaluation reports are too descriptive and not sufficiently analytical and self-critical. It is therefore important to identify the strengths and weaknesses of the provision as well as providing factual information.

See Annex 1 for the information which must be provided in the self-evaluation report.

4.3 Roles of institutional staff in preparing the self-evaluation report

The self-evaluation report should be the responsibility of a team which includes representatives of the programme being accredited: management, staff (academic, technical and administrative) and students, to ensure that the self-evaluation report reflects the observations of all those involved. The person leading the team need not necessarily be the head of the faculty, department or division being accredited.

It is important to involve as many staff and student representatives as possible. This will ensure commitment to the process and agreement with the content of the self-evaluation report.

4.4 Analysis of the self-evaluation report

The self-evaluation report provides the accreditation team with the necessary information to set the priorities and the programme for an accreditation visit. It will also form the basis of preparatory discussions held between the accreditation team chair and representatives of the institution.

The self-evaluation report will be assessed by representatives of the Accreditation Board or by a team appointed by the Board. It will ask the following questions:

- does the self-evaluation report keep to the minimum word limits and structure set in the guidelines?
- does the self-evaluation report meet the minimum requirements?

In some cases the Accreditation Board may, on receipt of an institution's self-evaluation report, decide that an accreditation visit is inappropriate at that time because the institution fails to meet the minimum requirements. In these cases, an accreditation visit will not be carried out. The institution will be notified of the decision and a meeting may be held between representative/s of the Accreditation Board and the institution. The outcome of this meeting will be an agreement on action which needs to be taken by the institution in order to reapply for accreditation.

In some cases the institution may be asked to re-submit part or all of its self-evaluation report.

SECTION 5 THE ACCREDITATION VISIT

5.1 Introduction

The main purpose of the visit is to enable the team to get a comprehensive and clear view of the institution through discussions and interviews with the institution's stakeholders and to clarify unclear aspects of the self-evaluation report in order to arrive at a judgement and prepare recommendations.

An accreditation visit will normally last two days although for larger institutions visits may last up to four days. The length of the visit will depend on the size and complexity of the institution or programme under review. A common range of activities is undertaken during visits, although the precise order and balance may be adapted to reflect the nature of the provision.

A successful accreditation visit is of utmost importance as this, together with the self-evaluation report, constitute the two critical phases in the accreditation process. A successful site visit requires that all parties to the accreditation process have prepared thoroughly for the visit and have agreed specific roles and responsibilities.

5.2 Advance planning

Advance planning will be undertaken by the Accreditation Board in conjunction with higher education institutions. The precise timing of accreditation visits will be a matter for discussion and agreement between institutions and the Accreditation Board. Each institution will be asked to submit its preferred dates for the visit together with its self-evaluation report. The information given in the 'Background Information' section of the self-evaluation report shall provide a basis for discussions with institutions on the timing of visits, the length of the visit and the composition of the accreditation team.

5.3 Appointment of the accreditation team

The Accreditation Board will confirm an accreditation team to the institution not less than four weeks before the accreditation visit. The size and composition of the team will reflect the size and range of the educational programme provided and the complexity of operations. The institution must alert the Accreditation Board of any concerns about the suitability of the team as soon as possible but no later than one week after receipt of the team details.

5.4 Preparation by members of the accreditation team

Before the visit, each accreditation team member will consider the self-evaluation report to identify the strengths and weaknesses of the institution and the key issues to be addressed during the visit. The self-evaluation report will determine the questions to be asked and the interviews and discussions to be carried out during the accreditation visit.

The accreditation team chair will contact the individual team members to discuss arrangements for the visit, agree the responsibilities within the team and agree the activities to be undertaken and the questions that need to be asked during the visit. This will enable the chair to draw up a proposed programme for the visit for discussion with the institution.

Prior to the visit, team members prepare a brief written commentary on those aspects of the visit which they will cover, based on the self-evaluation and any other supplementary information provided, using the *Guidance on Reaching an Accreditation Judgement* provided at Annex 2. The commentary will identify matters on which the team member requires further evidence. The team members' commentaries are discussed at the first accreditation visit meeting and inform the team's priorities and the balance of activities undertaken during the visit.

5.5 Preparatory discussions between the accreditation team chair and the higher education institution

The accreditation team chair will discuss arrangements with the institutional contact person approximately three weeks before the accreditation visit. The discussion may take the form of a meeting or telephone conversation and will include the following areas:

- the dates for the visit and the proposed programme
- any necessary clarification of the self-evaluation report
- requirements for the visit including the range of student work which will be required to be examined, the range of teaching and learning sessions to be observed, meetings to be arranged and additional documentation required by the accreditation team prior to and during the visit and the timetable for its receipt
- the practical arrangements for the visit, eg the room to be used for the visit which will store the documentation needed for the visit, its access and security, access to a photocopier and arrangements for travel and meals

Following these discussions, the chair will write to the institution to confirm the arrangements agreed for the accreditation visit and the programme for the visit.

Further information on the range of documentation and information which will be required prior to and during the accreditation visit and guidance on the sample of student work to be provided is given in paragraph 5.8 below. The institution will be responsible for sending out any additional documentation required by the team prior to the visit not less than one week before the visit. All other communications should be channelled through the accreditation team chair.

5.6 Practical arrangements

The institutional contact will assist the Accreditation Board in making arrangements for hotel accommodation and travel and will ensure that arrangements are made to transfer team members and the secretary from and to the terminal or hotel and between sites they will be visiting. The Accreditation Board will arrange for secretarial support to be provided during the visit.

The institutional contact person and the secretary will co-operate to provide name-plates in meeting rooms. The institution contact person will ensure that all those participating in the visit (with the exception of the accreditation team and the secretary) have been briefed on the objectives of the visit and of the particular meeting or activity in which they are involved.

5.7 Preparation by the institution

The institution will provide a schedule of teaching and learning sessions being carried out during the visit and make arrangements for the observation of placements and other off-site teaching in advance of the accreditation visit. The institution will also arrange the meetings requested by the team, including booking the necessary rooms and briefing the participants on the purposes of the evaluation and accreditation visit.

5.8 Documentation for the visit

The following is the normal range of information required for a visit:

5.8.1 General documentation, if available

- the institution's promotional material on the programme being accredited
- location map and site/building plan
- copy of self-evaluation report and updated information as necessary
- information provided to students, eg course handbooks
- external examiners' comments for each programme for the last three years with guidelines issued to external examiners where appropriate
- teaching and learning timetables for each programme
- questionnaires completed by students to evaluate the quality of teaching
- minutes of relevant meetings, eg Scientific and Methodological Committees
- any relevant associated documentation to exemplify and support statements made in the self-assessment.

5.8.2 Student work if available:

Samples of the work of the most recently assessed students, including examinations and scientific research work, if available. Marking and feedback sheets and assessment criteria (where they are in use) should accompany the samples.

5.9 The programme for an accreditation visit

An outline programme is agreed at the preparatory discussions with the institution and will be included in the advance documentation the institution sends to the accreditation team. An indicative schedule will include the following:

Evening	Team members arrive at institution
1 HOUR	Private meeting of accreditation team and institutional contact:

Team members will agree the programme for the visit, including which teaching and learning sessions they will attend and the length of time they will observe each session they select. The institutional contact person will then inform the person responsible for the session. This meeting will also provide an opportunity for

		the institutional contact to brief the team on particular issues concerning the institution which will give them a better understanding of the programme being reviewed.
	1 HOUR	Meeting with the Rector, Head of the Division, senior staff and student representatives: This provides an opportunity for staff representatives to give an introduction to the institution and to make a brief presentation and to inform the accreditation team members of any developments which have taken place since the self-evaluation report was written. This meeting also provides an opportunity for the accreditation team chair to remind staff and students of the purpose of the visit, the proposed programme and how an overall judgement will be reached.
Day One	5 HOURS	Accreditation team gathers evidence by observing a range of teaching and learning activities, sampling student work, attending meetings, examining learning resource facilities and reading documentation provided. Team members share evidence and begin to formulate written summaries.
	2 HOURS	Private meeting of accreditation team: A team meeting will be held towards the end of the first day to review the evidence gathered and determine which issues require further exploration on the second day. The programme for the visit may need to be adjusted at this stage to meet the team's requirements.
	1 HOUR	Clarification Meeting: Following the team meeting, a further meeting will normally be required between the accreditation team and staff to clarify any issues about which the accreditation team is not clear.
Day Two	4 HOURS	Accreditation team continue to gather evidence, share and evaluate evidence and further develop their written summaries
	2 HOURS	Private meeting of accreditation team: A final team meeting is held to agree the final judgement and the grading and strengths and weakness of each of the areas of provision. The institutional contact person does not attend this meeting.
	<i>½ HOUR</i>	<i>Final oral feedback meeting with senior institution representatives:</i> The meeting takes place in the late-afternoon of Day Two and is chaired by the team chair who will give a report on the provisional

findings of the accreditation team and give the judgement on accreditation. A limited amount of clarification may take place but this is not a consultative meeting to challenge the judgement.

Team members leave the institution

The accreditation team will be required to complete its report of the visit as soon as possible after the site visit and not later than six weeks after the visit. Within this period, the institution will be given the opportunity to comment on the report and correct factual errors.

5.10 Activities during accreditation visit

The activities carried out by the accreditation team during the visit will include the following:

- reading institutional and course documentation
- sampling and reading student work (examination scripts and coursework)
- observing teaching and learning activities (eg lectures, seminars, practicals and work experience teaching as appropriate)
- meeting staff, students and other stakeholders, eg employers
- consideration of the learning resources available to support the programme
- producing written summaries
- meeting to consider the evidence, share information and form a judgement

It is essential that the overall range and balance of activities undertaken enable the team to develop a robust evidence base for an accreditation judgement to be made. The accreditation chair maintains an overview of the range and balance of accreditation activities and guides the team members in apportioning their time to achieve an appropriate balance of activities. The team members will normally split up to visit other sites or to observe teaching and learning activities. All team members are expected to share information which is relevant but individual team members may co-ordinate the evidence related to particular aspects of provision, eg learning resources and academic and personal support for students.

Team members are expected to make notes of meetings, of teaching and learning observations and of comments on the assessment and quality of student work. Members of the team are expected to share their findings with other members of the team. These notes will help the team arrive at their grades for each area of provision and the final judgement and will be used in the preparation of the accreditation report. The notes will be retained by the chair once the report has been finalised.

5.11 Judging the quality of student achievement

Judgements about the quality of student achievement are mainly based on the sampling of student work, external examiners' comments and observations of teaching and learning. Team members will also consider the statistical data provided. Team members will record their comments as they sample student work and observe teaching and learning.

5.11.1 Sampling student work:

In sampling student work, where it is available, team members are expected to:

- make judgements about student achievement of learning outcomes
- evaluate the contribution that assessment makes to student learning
- sample student work to evaluate the quality of assessment design and feedback to students

Where the institution provides oral feedback to students instead of, or in addition to, a written commentary on their work, the team members will take this into consideration.

5.11.2 Observing teaching and learning:

The team will try to observe a reasonably representative range of teaching and learning sessions covering each educational programme being accredited. The institution will be required to make arrangements for the observation of work practice and other off-site teaching in advance of the accreditation visit. The team members will select a sample of observations from a schedule provided by the institution.

The team member observing teaching and learning session should always meet the member of staff responsible before the session commences in order to introduce him/herself, discuss the overall objectives of the teaching and learning activity and to find out how the students are intended to learn from it. The team member should not make comments during the session or engage directly in the teaching or learning.

On occasion, students engaged in practical sessions and independent learning may be asked by the accreditation team member to talk about their learning experience and how the activity being observed fits within their wider programme of study.

Notes are made of each teaching and learning session observed. In making their judgements about an individual session, team members will evaluate whether the teaching and learning approaches and the materials used are effective in achieving the intended learning outcomes. This includes consideration of any relevant written or computer-based guidance for students and samples of student work where these are available.

An observation note may include the following:

Institution	Subject	Module/course unit
Name of Team Member	Session Length Hours Minutes	Observation length Hours Minutes
Level/year	Mode, eg FT/PT	Number of students
Type of activity, eg lecture, CAL	Topic	Composition of student group
What are the learning objectives planned for this session, eg knowledge and understanding, key skills, cognitive skills, and subject-specific, including practical/professionals skills?		
Strengths and weaknesses of the session in the relation to the learning objectives:		
Prompts	Strengths	Weaknesses
Clarity of objectives		
Planning and organisation		
Methods/approach		
Delivery and pace		
Content (accuracy, relevance, use of examples, match to student needs)		
Student participation		
Use of accommodation and learning resources		
<i>Please summarise the session's overall quality in relation to the learning objectives</i>		

After attending a session, the team member will offer a brief oral feedback to the member of staff if possible. The feedback is confidential to the member of staff and will be given privately. The

purpose of the feedback is to offer constructive comment on the observations made and not to prescribe preferred practice. The team member must preserve the anonymity of staff in all written reports and in discussions with other members of the institution.

5.12 Judging the quality of learning resources

Evidence will be gathered through direct examination of student learning resources. Team members will normally visit the facilities made available to support the programme and may observe students and staff using specialist resources and equipment. In looking at library provision, team members may undertake catalogue searches. In evaluating the quality of learning resources, team members' direct observations of facilities are considered alongside evidence from student work, written documentation and meetings with staff and students. The emphasis is on access and use of facilities by students in the educational programme.

5.13 Meetings

Meeting notes should include the following:

- a note of those attending the meeting
- the date and time of the meeting
- the purpose of the meeting
- items discussed, key points, evidence presented, further enquiries to be made

It is important to limit the number of participants at each meeting - normally to eight persons. The accreditation team will not report on any individual person's statements as the focus of the accreditation team is on the institution.

The accreditation team will, at a minimum, meet with the rector and senior management, the team who have prepared the self-evaluation report, staff representatives and students. It may also be relevant to interview members of various committees (eg examinations, scientific and pedagogical, finance).

5.13.1 Meetings with staff:

In general the accreditation team focus on the delivery of the programme and on the way in which matters at a central institutional level impact on the learning experience of students in that programme. Meetings will take place with academic staff, library staff, technical staff and administrative staff and will include discussions of learning resources available. A written record is kept of proceedings. Student representatives may also be present at meetings with staff.

5.13.2 Meetings with students:

The accreditation team will meet with students to gather their views about the quality of their learning experience and achievements. This meeting will typically last an hour and is normally chaired by the team chair. At the beginning of the meeting the chair will introduce the team members and outline the accreditation process and aims of the exercise. Comments made are not attributed to individuals and those present will be assured of this fact. The team will also make it clear that the final judgement will be based on a wide range of evidence, of which comments made by students form only one part. Notes will be taken either by a team member or

the secretary supporting the team. The institutional contact person will not be present although s/he may assist the team in clarifying issues which student raise.

Discussion at the meeting will be structured around the areas to be graded and all present will be encouraged to contribute. Discussion will focus on students' awareness of the institution's aims and objectives, their experiences as learners in the programme and their views on the different areas of provision. Students should be given the opportunity to raise points not covered by the accreditation team.

5.13.3 Meetings with former students and employers

The team may also wish to take into account the views of former students who are able to give an overview of the provision or of the quality of graduates and employers and other representatives from the relevant industry or profession.

5.13.4 Role of institutional contact person

The institutional contact will observe most meetings and may provide factual information relevant to the team's discussions. S/he will not, however, attend the meeting with students and the final meeting when the judgement is decided.

5.14 Scrutiny of documentation

The accreditation team will also gather evidence through scrutiny of documentation. Views expressed in meetings by staff or students will be checked and tested against the documentation provided.

5.15 Accreditation judgement

The outcome of the accreditation visit will be a judgement by the accreditation team on the appropriateness of the institution's educational provision. The judgement is given to the institution orally in a meeting with institutional management and other staff at the end of the accreditation visit.

The judgement is based on the evidence gathered and considered by the whole accreditation team. Judgement will be based on the principle of fitness for purpose in relation to the stated aims and objectives and the extent to which these are being met. Annex 2 gives further information on reaching an accreditation judgement and on the type of information which the accreditation team will be looking for. The criteria used for assigning grades is given below. Written summaries of information and evidence gathered including notes of meetings, completed observation and comments relating to student work and examination will assist team members in co-ordinating the evidence. These written summaries should be analytical rather than descriptive and make reference to relevant aims and objectives and summarise the relevant strengths and issues relating to each aspect of provision.

Seven key areas of provision will be graded in order to reach a final overall judgement:

- Aims and intended learning outcomes of the programme
- Curriculum structure and content

- Teaching, learning and assessment
- Admissions and progression
- Learning resources
- Academic and personal support for students
- Internal quality assurance procedures and quality enhancement

The accreditation team will give a grade of 1 to 5 for each area:

- 5: The provision is excellent.
- 4: The provision is very good.
- 3: The student learning experience and student achievement in that area make an acceptable contribution to the attainment of the stated objectives and the aims are being broadly met.
- 2: The student learning experience and student achievement in that area make an inadequate contribution to the attainment of the objectives or the objectives do not provide students with the experiences and achievements that would support a judgement that the aims were being met.
- 1: The provision in that area is not acceptable.

The final judgement will be based on the total points given to all seven areas of provision. All of the areas have equal weight. One of the following four judgements will be given by the accreditation team:

- Accredited as Excellent
28-35 points, with a grade of 4 or above in all areas of provision. The student learning experience and student achievement is to be commended.
- Accredited as Satisfactory
21-27 points, with a grade of 3 or above in all areas of provision. The student learning experience and student achievement is acceptable and the aims are being broadly met.
- Accredited with Conditions
14-20 points with a grade of 2 or more for all areas of provision. Specific action needs to be taken by the institution to improve the learning experience and student support within 10-18 months (see below) when the institution will be able to reapply for accreditation. After this period if the institution does not achieve full accreditation its qualifications will no longer be recognised by the State.
- Not Accredited
7-13 points with a grade of 2 or less for 3 or more areas. The provision is not acceptable.

Institutions which fail to be accredited or those which are awarded with conditional accreditation will be permitted to reapply for accreditation. This will be normally be not less than 10 months and not more than 18 months after the accreditation visit/meeting. The main responsibility for implementing change or meeting the conditions of accreditation rests with the institution.

In cases where serious concerns are expressed by the Chair during a visit, an Accreditation Board representative may be brought in as a mediator prior to a final judgement being made.

In cases where the institution feels there has been a serious error in judgement they may appeal against the judgement to a committee of the Ministry of Education.

5.16 Oral feedback meeting

The oral feedback meeting takes place at the end of the visit and is chaired by the team chair who will give a report on the provisional findings of the accreditation team and give the judgement on accreditation. A limited amount of clarification may take place but this is not a consultative meeting to challenge the judgement.

The meeting normally lasts approximately 30 minutes and includes:

- an overall judgement
- summary of strengths and issues in each area being graded
- conclusions and issues to be addressed
- any points for clarification
- timetable for production of the accreditation report
- thanks to the institution

The conclusions presented will not be changed when the evaluation report is given. It is therefore important for the accreditation team to have sufficient time during the visit to agree the main issues of the final report.

5.17 Accreditation report

An accreditation visit report is published after each visit. The accreditation team will be required to complete its report as soon as possible after the site visit and not later than six weeks after the visit.

The report is the main documented outcome of the accreditation process and provides a permanent record. The final published report is a public document which will be studied carefully by the institution as well as by others and which provides the government, higher education users (for example potential students and employers) and other higher education institutions with valuable information. It must therefore be evaluative and analytical using a succinct, accurate writing style and demonstrating clarity and thoroughness. It is important that a consistent format and style is used for each accreditation report in order that comparisons can be drawn between different higher education institutions. Accreditation team members will receive guidance on the preparation of the accreditation reports as part of their accreditation training.

The report is based on a thorough analysis of the self-evaluation report and the results from the site visit. It is normally between 2,000 and 5,000 words in length and includes:

- an extract from the self-evaluation report on the aims and objectives of the programme being accredited
- the grade given and an evaluation of strengths and areas for improvement for each area of provision and the overall judgement
- the conclusions reached and recommendations for improvement

The accreditation team chair will produce the first draft of the report drawing on the summaries prepared by the team members. The draft is sent to team members who check it to ensure that it is factually accurate and that it represents the views of the team. The report is then amended to reflect the comments received and sent to the institution to comment on the report and correct factual errors before it is finalised by the chair of the accreditation team. Once the report has been checked for factual accuracy by the institution the institution must sign the report as proof that the report has been prepared with the knowledge and under approval of the management which is formally responsible for all activities taking place in the institution. The purpose of the signing procedure is not to make sure that management agrees with the content of the report - this is the responsibility of the accreditation team.

The accreditation process finishes when the final accreditation report is published. This will be within six months of the accreditation visit.

On completion of the accreditation process for one programme, the Accreditation Board will publish a summary of the accreditation process including a list of providers in the subject area and the overall judgements for each institution. Lists of the accreditation team members will also be included.

Both the accreditation report on the individual institution and the summary report should have wide distribution, for example to schools, careers services and libraries as well as other higher education institutions and the media.

5.18 Monitoring and evaluation

Monitoring and evaluation is integral to the development and refinement of the accreditation process. Each accreditation visit will be monitored through questionnaires completed by institutions and accreditation team members and chairs. A copy of the questionnaire is given on the next page. Completed questionnaires should be completed and returned to the Accreditation Board within four weeks of the accreditation visit.

Accreditation Visit Questionnaire

Name of Institution:	
Address:	
Telephone Number:	Email:
Name and position of individual completing questionnaire:	Contact details:
What worked well during the visit:	
What did not work well?	
Suggestions for improvement	

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QUALITY ASSURANCE AND ACCREDITATION

GLOSSARY

Introduction

In order to carry out the effective planning, developing and implementing of QA and accreditation procedures in HE it is essential to define terms in a standardised way and to clarify some of the terms used in the literature. Definition of terms and description of concepts is not an easy task because of a number of reasons:

- Many countries have to cope with the need to translate the terms in English. There are problems with the translation, because the term in ones own language often has a slightly different meaning than the English word;
- The meaning is often fixed by the cultural context. Even in the English speaking parts of the world the same words may have a different meaning.
- Each agency has often its own jargon, originating from its national context.

Glossary of terms

Accreditation

Accreditation is difficult to define as it has many meanings across the world. Although the terminology has been imported into Europe, the meaning differs from the meaning of the term in the US, just as the role accreditation plays differs.

Accreditation is primarily an outcome of evaluation. It is the award of a status and signifies approval, recognition and sometimes a licence to operate. It may focus on professional accreditation (eg. in medicine, law) or on an institution, faculty or programme. As a process, accreditation is generally based on the application of pre-defined standards. The status may have consequences for the institution itself (eg. licence to operate) and/or its students (eg. eligibility for grants) and/or its graduates (eg. qualified for certain employment).

In some HEIs, a distinction is made between accreditation which can only be awarded to existing programmes or units on the basis of achieved results and licensing (see below).

Some characteristics of accreditation are:

- Accreditation can apply to an institution as a whole and to a programme
- Accreditation is a **formal** decision
- Accreditation is based on an **overall assessment** of the HEI or its core activities
- Accreditation is based on the assessment of at least **minimum requirements** (threshold quality)
- Accreditation concerns a **yes/no/conditional** decision
- Accreditation will have consequences, for example

- In the professional field
- Concerning recognition
- Concerning funding
- Concerning student aid

Accreditation might be seen as providing a formal quality certificate to an HEI or a program showing that the HEI or the program meets at least expected minimum requirements.

Assessment

Assessment is the evaluation of the quality itself. Assessment tries to collect data, information and evidence of the quality of the HEI as a whole (*institutional assessment*) or its core activities (education, research and community service) separately (*program assessment*). It goes beyond quality procedures (although it will be included) and tries to judge the quality of input, process and output.

Assessment does not necessary lead to a formal accreditation decision. However, formal accreditation need to be based on assessment

Audit

Audit is the evaluation or review of procedures, processes and mechanism in an HEI or a part of an HEI (e.g. school of Medicine, school of Business & Management). Not quality itself is subject of review, but procedures and mechanism to assure the quality and the processes to achieve the mission and goals. Audit asks the question “are your processes effective in achieving your objectives?”. It is an evaluation of the strengths and weaknesses of the quality mechanisms established by the institution itself to continually monitor and improve the activities and services of the whole institution, faculty or programme.

A distinction is made between a **quality audit** and a **management audit**.

A **quality audit** evaluates especially the procedures and processes for the assurance of the quality. The main assumption is that if QA-procedures are in place, one may expect that HEI will deliver quality.

A **management audit** looks also at general management, general policy and policy- making.

Institutional assessment judges the overall quality of all core activities carried out by the institution (educational activities and research outcomes).

Benchmarking

Benchmarking is becoming more common in HE with countries such as the UK and Netherlands operating reviews in subject areas on a cross-institutional basis. This allows HEIs which offer certain disciplines or professional areas to be measured against one another so that a national benchmark (which signifies agreed and accepted common practice and standards) can be developed.

In terms of organisational performance, a benchmark is a reference point for business excellence against which others can be measured and compared. In practice it is a combination of two elements: firstly it involves quantitative measurement of performance in a range of comparator organisations or departments; secondly it involves studying processes and practices in organisations and departments highlighted by the results of the quantitative analysis and above all learning from them and implementing the lessons learned.

Boxwell highlighted four types of benchmarking:

- competitive - takes place when organisations or their constituent departments do not wish to be studied and do not co-operate with the data collection exercise
- co-operative - organisations targeted by others as examples of good practice willingly supply data but do not participate in the study or share the results
- collaborative or partnership - organisations with common issues and challenges agree joint-objectives for a study and share the results of data collection and analysis. Each of participants will have valuable practices to share which are the currency for the collaboration
- internal - analysis of comparative performance between similar departments within organisations.

Benchmarking is a powerful driver for positive change

Control see Oversight

Criteria

The terms 'standards' and 'criteria' are often confused. In the US there is often no difference made between standards and criteria, while in Europe standards are becoming more and more distinct from criteria. It is helpful to distinguish between the two words.

Criteria are seen as the checkpoints, the benchmark for assessing the quality of the input and process. Auditing or assessing the HEI as a whole it concerns the benchmark to check the quality procedures and the performance of the HEI as a whole. See also **Standards**

Discipline see Program assessment

External Quality Assurance Agency (EQA-agency)

An External Quality Assurance agency can also be referred to as EQA-agency. An EQA-agency meets the following criteria:

- It concerns **external** quality assurance. This means that the agency is acting outside the institutions of Higher Education HEI. Evaluation by an organisation or entity inside an HEI and aiming at quality assurance inside the institution, is not to be seen as an external quality assurance activity.
- It concerns activities like evaluation, review, audit, assessment or accreditation
- Those activities belong to the **main tasks** of the agency

- Are done on a **regular** base
- The agency is **recognised** at national or regional level as being charged with the above mentioned activities.

The definition excludes:

- QA-organisations inside an HEI
- Agencies which supervise EQA-agencies and which are not actively or on a regular basis involved in the above mentioned activities
- Ad hoc validation or assessment e.g. carried out by a university validating programmes in another country.

Evaluation see Review

Evaluation (also called review) is a general term denoting any process leading to judgements and/or recommendations regarding the quality of a unit. 'Unit' refers to an institution, faculty or a programme of study. Evaluation has both an internal dimension (self-evaluation) and an external dimension (conducted by external experts, peers or inspectors). Evaluation describes the activities of collecting data, information and evidence about the quality of an institution, the quality of parts of an institution or the quality of its core activities: education and/or research.

Evaluation method

International experience shows that **self-evaluation** and the **external expert review** are the two methodological cornerstones of any successful evaluation procedure in HE. Both qualitative and quantitative data may be gathered via documentary evidence, meetings, a self-evaluation report and official statistics. Depending on the focus, scope and boundaries of the evaluation, **input factors** (eg. teaching facilities, teachers' formal qualifications, curriculum content), **process factors** (eg. curricula, programme schedules, teaching, learning and assessment methods) or **output criteria** (eg. specific knowledge or skills required from graduates, employment statistics) may all be measured.

External evaluation team

The external evaluation team (also called expert committee, visiting team, peer review team, academic peer review team) is the group of experts, invited by the agency to do the audit or assessment. They are independent experts from academia and/or the professional world, judging the quality. Sometimes the team may include other members (e.g. students, lay people, employers).

HEI Higher Education Institution

Some reviews/evaluations/accreditations involve the whole organisation and this is often shortened as HEI. In some cases it might not concern an HEI as a whole, but a part of it (for example a School or Department)

Indicator see Performance indicator

Licencing

Licencing is the awarding of the permission to operate a new HEI or a new study programme based on an *ex ante* evaluation of appropriate plans. Licencing also generally proceeds from pre-defined standards.

Management audit see Audit

Oversight

Oversight, also called control or meta-evaluation concerns the question who is controlling the agency? Who is evaluating the activities of the agency? Is there an authority which evaluates the evaluations (meta-evaluation)?

Performance indicator

This term is often used synonymously with *indicator*. A performance indicator generally involves selecting indicators of outputs of HEIs in terms of the unit's goals (eg. increasing employability of graduates, minimising drop out) or the educational processes eg. maximising student satisfaction, minimising cancelled lectures. Other indicators, not linked to performance, may look at staff-student ratio, availability of learning resources for students (libraries or computer services) or access to various services.

In developing a set of indicators, the aim is to find a balance between *measurability (reliability)*, which is often the prime consideration in developing indicators, and *relevance (validity)*. It is also difficult to decide how to weight or combine indicators and it is therefore preferable to view indicators as signals which show where strengths and weaknesses may be found, not as quality judgements in themselves.

Program assessment

Many agencies are assessing one of the core-activities of an HEI, the educational activities. The object of the assessment often is a program leading to a certain degree. Such program assessment also might be called the assessment of a subject area or a discipline. The main future is that the assessment is subject specific: e.g. assessment of History, Biology or Economics.

Quality assurance (QA)

QA is used as an all-embracing term to include all the policies, processes and actions through which the quality of HE is maintained and developed. It emphasises the external aim of evaluation: to assure students, society and government that the unit manages its quality well. QA focuses on the accountability goal.

Quality audit see Audit

Review see Evaluation

Review committee see External evaluation team

Standards

Standards are seen as the **expected outcomes** of the educational training. It concerns the knowledge, skills, attitudes (= competencies) that are expected from the graduates. This concerns both general standards (qualifications for a Bachelor and Master) and specific subject standards. (see also under **Criteria**)

Subject area see Program assessment

Annex 9A: Structure of self-evaluation report

ANNEX 1
ACCREDITATION OF HIGHER EDUCATION
INSTITUTIONS IN GEORGIA: STRUCTURE OF
SELF-EVALUATION REPORT

August 2001

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INTRODUCTION

All of the information in the self-evaluation report is essential and non-completion of any section will mean that the application is not acceptable and will be returned to the institution.

The total length of the self-evaluation report **should not exceed 12,000 words** (not including staff resumes and separate annexes). Institutions should not exceed the total word limit or the word limits for individual sections where stated. Those that do exceed the word limits will be returned to the institution for editing.

The time between submission of the self-evaluation report and the visit should not exceed eight months to ensure the relevance of the information at the time of the site visit. Applications for accreditation, together with the self-evaluation report and any supplementary information, should be submitted by the stated deadline in the year in which the programme is to be accredited (see paragraph 3.2).

A printed and an electronic copy of the self-evaluation report must be provided.

SECTION 1 BACKGROUND INFORMATION ABOUT ORGANISATION

(Word limits are given where appropriate)

General Information

- 1.1 Official Name of Institution
- 1.2 Mailing Address
- 1.3 Phone/Fax/Email
- 1.4 Form of ownership
- 1.5 Date of establishment
- 1.6 List of educational units of the institution, research institutes/laboratories, undergraduate and graduate courses
- 1.7 Data about licensing, attestation and accreditation of departments as appropriate
 - 1.8 Programme/s for which institution is seeking accreditation (including title and level, eg undergraduate, master's, postgraduate)
 - 1.9 Sources of funding (including research). Also indicate each source as a percentage of total institution budget
- 1.10 Budget and its distribution (income and expenses)
Conclusion of financial audit information must be attached to the self-evaluation report.
 - 1.11 Name of Rector and/or Head of Department/Faculty/Sub-Division for educational programme under accreditation
- 1.12 Phone/Fax/Email for each person
Please attach brief resume for these persons, including academic degree, academic rank, date of election/appointment as Rector, scientific, pedagogical, practical and administrative experience. (*Resume should not exceed 2 sides of A4 for each person.*)
- 1.13 Name of Institutional Contact Person
- 1.14 Job Title of Institutional Contact Person and brief description of normal duties
- 1.15 Phone/Fax/Email
- 1.16 Brief description of the institution showing its distinguishing characteristics. This section may include the following:
 - what is the mission statement of the institution?
 - what is the vision underlying the mission?
 - are changes foreseen in the mission statement in the next few years?
 - how does the institution adapt the graduates' profile to the new needs of employers?
 - what is the institution's research strategy and how does research support educational provision (including publications, higher degree completion, prizes/awards, contracts/consultancy/provision of services to industry and other institutions)
 - what are the opportunities and threats in the external environment which have a particular impact on what the institution is trying to achieve (political situation, legal constraints, financial and economic environment, geographical position, demographic factors, competition, technological factors)?

- what strengths and weaknesses does the institution see in its organisation and resources and what plans does the institution have for improvement?
- does the institution have a business or strategic plan and any mechanisms for collecting information which may influence long term planning?

(This section should not exceed 1,500 words)

Student Profile

- 1.17 Number of students in institution on undergraduate, graduate and postgraduate programmes (state sector, non-state sector, free of charge, paid, trained by state order, total) for last 3 cohorts
- 1.18 Average completion time for the students on the programme, data on how many students applied for and passed final examinations, drop-outs/withdrawals for the last 3 years
- 1.19 Total number of students on the programme of study being accredited (state sector, non-state sector, free of charge, paid, trained by state order, total) for the last 3 years in order to be able to identify trends
- 1.20 Number of students on each year of the programme being accredited (state sector, non-state sector, free of charge, paid, total) for the last 3 years in order to be able to identify trends

Staff Profile (including Head of Department and academic and support staff who support the subject being reviewed)

- 1.21 Total number of teaching staff in the institution
- 1.22 Average student:staff ratio
- 1.23 Number of academic staff supporting the programme being accredited (full-time, part-time, full-time equivalent), age profile, number of vacant posts, staff appraisal/performance strategy
- 1.24 Number of administrative and technical staff employed to support the programme being accredited (full-time, part-time, full-time equivalent)
- 1.25 List of names and titles of academic staff supporting the subject being reviewed

Please attach a brief resume for each academic staff member for the subject being reviewed, including experience, qualifications/degrees and responsibilities in current post. *(Not more than 2 sides of A4 for each staff member.)*

- 1.26 Average student/staff ratio for programme being accredited
- 1.27 Description of additional teacher resources available on work placements, where appropriate

Learning Resources

- 1.28 Location of library, library staffing, library ownership, total funding, number of publications (books, text-books, journals, electronic resources), study space available
- 1.29 Description of computer and information technology provision

- 1.30 Description of space available for teaching and study, including lecture theatres, seminar rooms and laboratories
- 1.31 Description of equipment available to support teaching
- 1.32 Description of facilities and support provided to teachers, including office accommodation, equipment, information technology, and access to administrative and technical support, health centres, sports facilities
- 1.33 Description of resources available for workplace teaching

Please provide copies of study guides, handbooks and course material for the accreditation team during their visit.

Alumni

- 1.34 Description of alumni activities, if appropriate.
(This section should not exceed 250 words.)

Partnership with the wider community and overseas

- 1.35 A description of the relationship with partner institutions where relevant for the programme being accredited. This may include educational, scientific, research and industrial partnerships with institutions or organisations, industry or other professional bodies or overseas collaborations where they contribute directly to the programme being accredited.
(This section should not normally exceed 500 words. For those institutions which rely on external organisations for work placements the word limit will be 1,000 words)

SECTION 2 QUALITY OF EDUCATION

This section should contain information on the quality of education in each of the areas listed below. The information given for each of the seven areas must not exceed 750 words for each area and must include an analysis of the key strengths and areas for improvement for each area.

Further information on the evidence required under each area is given in Annex 2 - *Guidance on Reaching an Accreditation Judgement*.

2.1 Aims and intended learning outcomes of the programme:

including the reason why the educational programme is provided, how it addresses the interests of stakeholders (students, employers, government, society), what the intended learning outcomes are (subject knowledge and understanding, cognitive skills, practical/professional skills, transferable skills) and how these are achieved (in terms of the learning experiences provided) together with an analysis of the key strengths and areas for improvement.

(This section should not exceed 750 words)

2.2 Curriculum structure and content

including a brief course description and a curriculum map, hours allocated to each subject, ratio between practical and theoretical teaching, ratio between compulsory courses and elective courses, information on how the programme is kept up-to-date, the impact of current research on course content, information on work placements and an analysis of the key strengths and areas for improvement.

(This section should not exceed 750 words)

2.3 Teaching, learning and assessment

including data for the last three years on examination results (including final state examination) for all years of the programme, description of teaching and learning methods, ratio between directed and self-directed study and an analysis of the key strengths and areas for improvement.

(This section should not exceed 750 words)

2.4 Admissions and progression

including the following data, if available, for the last three years and an analysis of the key strengths and areas for improvement.

- Analysis of entry qualifications including ratio of applications to admissions
- Where appropriate, the number of students who graduate from the course, those who apply for professional licensing examination and number of students who pass final state examinations
- Number of students in each year, percentage of withdrawals, percentage of transfers in and out of the programme, percentage completing the programme

- Number and percentage of qualifications awarded, including breakdown of honours degrees

(This section should not exceed 750 words)

2.5 Learning resources

The information given in this section should complement the information given in sections 1.28-1.33 and should include an analysis of the key strengths and areas for improvement.

(This section should not exceed 750 words)

2.6 Academic and personal support for students

including system for academic supervision, system for personal support and an analysis of the key strengths and areas for improvement.

(This section should not exceed 750 words)

2.7 Internal quality assurance procedures and quality enhancement

including information on the management structure and methods for dealing with decision-making, programme management, management information systems, quality monitoring and improvement, procedures for allocation of funding, external examiner reports and action taken, administrative structures including committees, opportunities for staff development, the system for managing student evaluation of teaching and learning, course review by scientific and methodological council and student involvement in these course reviews. This section should also include an analysis of the key strengths and areas for improvement.

(This section should not exceed 750 words)

Annex 9B: Guidance on reaching an accreditation judgement 2001/2002

**ANNEX 2: ACCREDITATION OF HIGHER
EDUCATION INSTITUTIONS IN GEORGIA:
GUIDANCE ON REACHING AN
ACCREDITATION JUDGEMENT 2001/2002**

August 2001

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INTRODUCTION

This guidance consists of questions and prompts to assist accreditors and should be read in conjunction with the *Accreditation Guidelines, 2001/02*. The guidance should be used in collecting evidence and analysing information from:

- The self-evaluation report prior to the accreditation visit
- Documents, observations of teaching sessions and learning resources and meetings with staff and students during the accreditation visit

It should also be used in the preparation and compilation of the final accreditation report.

This guidance will also help institutions to prepare their self-evaluation reports and supported documentation by specifying the questions which accreditors will be asking as they work towards making their judgements. Institutions should consider the lists of questions under each specific area as they write the evaluations and should aim to ensure that each section includes commentary addressing these questions (see *Accreditation Guidelines 2001/7* for further information on preparing the self-evaluation report). Using the questions as a framework will ensure that institutions cover key aspects of the teaching/learning experience in summarising the strengths and areas for improvement relating to their programme.

The aim of producing guidance in this form is to ensure as consistent approach as possible to accreditation across all higher education programmes. The guidance covers the main features of the accreditation process, but it is not prescriptive nor exhaustive. Clearly there will be differences between programmes and institutions which may raise specific issues and the accreditors will be required to use their professional judgement in the application of this guidance.

The self-evaluation will include sets of quantitative data such as enrolment, drop-out rates, average study time, staff numbers, international exchange etc to provide an overview of the size and activity of the institution. It is important that data used is interpreted with care as their meaning is often ambiguous and it can be misleading to believe that indicators necessarily reflect quality. Failure rate is an example of a relevant indicator for the analysis of an institution's effectiveness that, in itself, does not reflect quality. A low failure rate can indicate a low academic level (low quality) or highly effective student support (high quality). Alternatively a high failure rate can indicate that only the most qualified students pass (high quality) or that the institution has not developed sufficient student support (low quality). Therefore, it is necessary to interpret the quantitative data within the context of the institution and specifically its goals and objectives.

The guidance sets out questions and prompts under the following areas:

- Aims and intended learning outcomes of the programme
- Curriculum structure and content
- Teaching, learning and assessment
- Admissions and progression
- Learning resources
- Academic and personal support for students

- Internal quality assurance procedures and quality enhancement

Accreditation of standards and quality

The accreditation process focuses on the setting of aims and objectives (academic standards) by the programme provider, their achievement by students and the learning opportunities offered. Academic standards and educational quality are inter-related and must be considered within the institutional, national and international context.

The accreditation process has been designed to:

- Accommodate a wide diversity of institutional mission and approaches to programme delivery
- Reflect the core academic processes of design, delivery, support, assessment and review of programmes of study
- Articulate with an institution's internal processes for the regulation of academic quality and standards

Key points of reference for accreditors will include the overall aims of the institution and the requirements of professional and educational authorities in respect of programmes that they accredit.

The guidance is divided into seven main areas that help to set the parameters for the review as a whole. Each section comprises:

- A set of questions to enable gathering of information which indicate the key issues for accreditation
- An indication of likely sources of information
- An indication of activities likely to be undertaken during the accreditation visit
- The judgements that should be made about that area

Please note: It should be noted that this guidance provides a framework for the accreditation process and should not restrict accreditation teams from identifying and reporting on additional strengths and issues for improvement.

SECTION1 BACKGROUND INFORMATION

Although the background information provided in self-evaluation report does not formally form part of the accreditation judgement, it is invaluable in setting the programme provision in the institutional context. See main Accreditation Guidelines and Annex 1 for further information.

SECTION 2 AIMS AND INTENDED LEARNING OUTCOMES OF THE PROGRAMME

2.1 Evaluation of the intended learning outcomes in relation to external reference points and to the broad aims of the provision.

Accreditors should ask:

- What are the intended learning outcomes for the programme?
- How do they relate to external reference points including national and international educational experience and any professional body requirements?
- How do they relate to the overall aims of the provision as stated by the programme provider (for example institution, faculty, department)?
- Are they appropriate to the aims?

Sources of information will include the self-evaluation report, course documentation, for example up-to-date course documentation and details of professional body requirements.

Activities may include an analysis of programme content, comparison with external reference points and discussions with teaching staff and external examiners (teachers invited for examining knowledge and skills).

As a result of these activities, accreditors should make a judgement on:

- Whether the intended learning outcomes are clearly stated
- Whether they reflect appropriately relevant external references and the overall aims of the provision

2.2 Evaluation of the means by which the educational programme provider (for example institution, faculty, department) designs curricula that permit achievement of the intended outcomes

Accreditors should ask:

- How does the programme provider ensure that course content enables students to achieve the intended learning outcomes?
- How does the programme provider ensure that the design and organisation of the curriculum is effective in promoting students' learning and the achievement of the intended learning outcomes?

Sources of information will include course documents and accreditation and records of institution approval processes. Accreditors should seek information about:

- study approach/philosophy and method

- breadth and depth of study
- the number of hours allocated to each programme (including study time of students working on their own versus contact time with teachers, projects and scientific research works)
- inter- and multi-disciplinarity
- the balance and integration of different types of teaching (for example, clinical and non-clinical teaching in medicine, dentistry and nursing)
- flexibility and student choice (including balance between compulsory and optional components; opportunities for part-time or in-service education; electives and international exchange programmes)
- the role of professional and/or educational authorities

Activities will include discussions with members of the teaching teams, technical and administrative staff and discussions with students.

As a result of these activities, accreditors should make a judgement on:

- Whether planning, design and approval procedures are adequate in ensuring that programmes enable students to achieve the intended learning outcomes.

2.3 Evaluation of the means by which the intended learning outcomes are communicated to students, staff and external examiners

Accreditors should ask:

- How are the intended outcomes of a programme and its constituent parts communicated to staff, students and external stakeholders (e.g. external examiners, prospective students, professional/educational authorities)?
- Do the students know what is expected of them?

Sources of information will include publicity material and course documentation as well as specific information provided, for example for external examiners.

Activities will include discussions with teaching teams, students, external examiners and other stakeholders.

As a result of these activities, accreditors should make a judgement on:

- Whether arrangements for communicating intended learning outcomes to staff, students and external stakeholders are adequate
- Whether students are aware what is expected of them in terms of learning outcomes

SECTION 3 CURRICULUM STRUCTURE AND CONTENT

Evaluation of the means by which the programme provider (institution, faculty, department) creates the conditions for achievement of the intended learning outcomes

Accreditors should ask:

- Does the design and content of the curriculum encourage achievement of the intended learning outcomes in terms of:
 - knowledge and understanding
 - cognitive skills
 - programme specific skills (including practical/professional skills)
 - transferable skills (including skills in research techniques, communication, foreign language, ethical/environmental concerns, using Information Technology and computers, data handling and numeracy, professional management)
 - progression to employment and/or further study
 - personal development and professional attitudes?
- To what extent does the evidence of actual progression and achievement confirm that the learning opportunities provided are appropriate?
- How does the programme provider encourage inter-disciplinary collaboration in the planning and delivery of the curriculum?
- Is there evidence that the funding allocation and support structures enable integration between departments?

Sources of information will include course documentation and study and employment statistics.

Activities will include evaluation of course documents, observation of teaching/learning and discussions with staff and students.

As a result of these activities, accreditors should make a judgement on:

- Whether the curriculum for each educational programme is designed in such a way as to enable students to achieve the intended learning outcomes
- Whether evidence on progression and achievement confirms that learning opportunities are appropriate
- Whether inter-disciplinary collaboration is encouraged and supported through funding mechanisms and other support structures

3.1 Evaluation of the means by which the educational programme provider (institution, faculty, department) ensures relevancy of content

Accreditors should ask:

- Is there evidence that curricular content and design is informed by recent developments in:
 - teaching and learning techniques
 - current research and scholarship
 - changes in relevant occupational or professional requirements (including changing patterns of healthcare for clinical subjects)
- How are the outcomes of research and development activity fed into curriculum development and the development of new teaching and learning methods and tools?
- Does the curriculum address demonstrable outcomes reflecting a 'leading edge' awareness of the priorities for professionals and service users (eg. in healthcare delivery for clinical subjects) and does the curriculum reflect industry developments (eg. in minimally invasive surgery, anaesthetics and day case surgery for medicine/nursing)?

Sources of information will include course documentation, records of institution approval processes and professional and/or educational authority accreditation reports.

Activities will include discussions with staff and external examiners, discussions with professional and/or educational authorities (where relevant and possible) and discussions with employers (where relevant and possible).

As a result of these activities, accreditors should make a judgement on:

- Whether the curriculum content and design reflects current good practice
- Whether curriculum content and design reflects input from research and scholarship
- Whether the curriculum reflects 'leading edge' priorities of the relevant profession, industry or service

3.2 Evaluation of the means by which the educational programme provider (institution, faculty, department) ensures that work practice learning (including clinical placements) makes an effective and appropriate contribution to the achievement of the intended learning outcomes

Accreditors should ask:

- Does the curriculum incorporate an adequate programme of work practice learning which ensures that all students have the opportunity to cover defined compulsory areas?
- Do opportunities exist for work practice teachers and other stakeholder groups to be involved in course development and how does the institution ensure that stakeholders' needs are met in the course?
- Is work practice learning designed around current service and employment patterns (eg. patient management and hospital stay patterns for clinical subjects)?
- Is there evidence that work practice learning is well organised and managed and that there is clear responsibility for its co-ordination and institution/faculty ownership?

Sources of information will include programme handbooks and other curricular documents, practical or work practice handbooks and study and employment statistics.

Activities will include evaluation of curricular documents, observation of teaching/learning and discussions with staff, students and work practice providers.

As a result of these activities, accreditors should make a judgement on:

- Whether work practice learning (where appropriate) makes an effective and appropriate contribution to the achievement of intended learning outcomes
- Whether opportunities are given for stakeholder involvement and input into the curriculum design and delivery
- Whether work practice learning is well organised and managed and designed around current service and employment patterns

SECTION 4 TEACHING, LEARNING AND ASSESSMENT

4.1 Evaluation of the quality of the learning opportunities offered by the programme provider (institution, faculty, department), the teaching delivered by staff and how it leads to learning by students.

Accreditors should ask:

- What is the strategy for teaching, learning and assessment and does it articulate clearly and appropriately with the aims and intended learning outcomes?
- Are students and staff issued with timetables which clearly state how the teaching and learning is organised?
- Are class sizes (lectures, tutorials, work practice learning) and staff:student ratios appropriate and adequate to support the achievement of intended learning outcomes?
- Are the teaching/learning modes and methods relevant and appropriate to the achievement of the intended learning outcomes?
- How effective is teaching in relation to curriculum content and programme aims and does teaching and learning enhance
 - knowledge and understanding
 - transferable skills
 - analytical skills
 - subject specific (professional) skills
 - active learning
 - lifelong learning?
- How effectively do staff use their research, scholarship or professional activity to inform their teaching?
- How good and appropriate are the materials to support teaching and learning?
- Is there effective engagement with and participation by students in teaching and learning events?
- Is the quality of teaching maintained and enhanced through:
 - effective staff development
 - integration of part-time and visiting staff
 - effective team teaching
 - orientation and mentoring of new staff?
- How effectively is student learning facilitated in terms of student workload, including classroom based, practicals/labs, work practice learning, self-directed learning, directed study, revision time?

And for work practice learning:

- Is there evidence that students and those who supervise them are fully prepared for each work practice placement, having clear understanding of the expected learning outcomes and of their own role in assessing whether these are achieved?
- How does the institution ensure that work practice staff have appropriate and up to date skills and knowledge?
- Are the appointment, roles and responsibilities of work practice staff appropriate and are honorary university titles given if appropriate?
- Does the institution offer work practice staff appropriate and adequate staff development and training?
- Is there provision of an appropriate mix of teaching types, for example practical skills, small group teaching and continuity of teaching (and for clinical teaching, ward rounds, emergency on take)?
- Do students have opportunities to participate in all relevant work practice activities (eg. audit meetings, clinical meetings and case conferences for medicine)?
- Is the status of students whilst on work practice placements clearly understood by all parties and are questions concerning professional suitability dealt with promptly, fairly and effectively?

Sources of information will include student evaluation questionnaires, internal review documents, staff development documents, academic staff appointment documents, external examiner reports, course documentation, practical or work practice placement information.

Activities will include direct observation of teaching/learning (where judged to be necessary by accreditors), evaluation of course documents and discussions with staff, students and work practice providers.

As a result of these activities, accreditors should make a judgement on:

- Whether an appropriate teaching and learning strategy exists and how this articulates with the intended learning outcomes
- The organisation of delivery of teaching in terms of:
 - timetables
 - class sizes
 - learning materials
 - student workload
- The extent to which teaching and learning contributes to the achievement of the intended outcomes. This judgement should be described in terms of:
 - The breadth, depth and challenge of teaching
 - Whether there is suitable variety of teaching and learning methods
 - Whether research input and scholarship are reflected in day to day teaching
 - The effectiveness of the teaching and learning of programme knowledge

- The effectiveness of the acquisition of programme specific, transferable and practical skills
- Whether both full and part time staff are fully engaged in teaching and learning and supported by an effective staff development programme
- Whether the delivery of work practice teaching and learning is effective in terms of:
 - students being prepared for the experience
 - staff training
 - links with the higher education institution
 - mix of teaching/learning events
 - opportunities for students to participate in relevant activities
 - the status of students whilst on work practice placement

4.2 Evaluation of the assessment process and the standard it demonstrates.

Accreditors should ask:

- Does the assessment process enable learners to demonstrate achievement of the intended outcomes?
- Do the assessment methods clearly match teaching and learning methods?
- Are the methods chosen appropriate, valid and reliable?
- What evidence is there that the standards achieved by learners meet minimum expectations for the programme at each level of study?
- Are there criteria that enable internal and external examiners to distinguish between different categories of achievement?
- Are staff and students fully aware of assessment criteria and the contribution of examinations to the learning process?
- Can there be full confidence in the security and integrity of assessment procedures?
- Does the assessment strategy promote learning and have an adequate formative function in developing students' abilities?
- Is there evidence of adequate and appropriate feedback to students?
- Do teachers involved in assessment receive adequate support and training?

And for work practice learning:

- Are students assessed effectively in professional (for example, clinical) knowledge, skills and attitudes and do work practice teachers play an appropriate part in the assessment process?
- Is there effective support for the assessment process and for teachers during work practice learning?

Sources of information include assessment criteria and guidance to markers, external examiners' reports, examination board minutes, samples of student work, qualifications and examination

results at all stages, including degree results (application for and pass rates in state licensing examinations where appropriate) and procedures for monitoring and recording achievement.

Activities will include discussions with teaching teams, students and external examiners and the analysis of methods for recording progress and achievement. Achievement of students in national examinations (where appropriate) will be an important reference point.

As a result of these activities, accreditors should make a judgement on:

- Whether assessment processes can adequately measure achievement of the intended programme outcomes (including professional knowledge skills and attitudes)
- Whether assessment methods match teaching and learning methods
- Whether assessments promote learning, have an adequate formative function and provide appropriate and timely feedback to students
- Whether appropriate standards are being achieved at each level of study
- Whether the standard of student performance in state licensing examinations is adequate
- Whether clear and transparent criteria exist to enable staff, students and external examiners to distinguish between different categories of achievement
- Whether the assessment process is secure
- Whether teachers are adequately trained and supported in the development and delivery of examinations

SECTION 5 ADMISSIONS AND PROGRESSION

5.1 Evaluation of the quality of the learning opportunities offered by the programme provider (institution, faculty, department) in terms of the admissions and orientation process and student progression.

Accreditors should ask:

- Are there effective arrangements for recruitment, selection and admissions which are generally understood by staff and applicants?
- Are students selected fairly and effectively according to merit?
- Does the profile of applications and admissions match the programme aims in terms of :
 - ratio of applications to places
 - entry qualifications
 - range of applicants and entrants (for example age, gender, ethnicity, disability, geographical origin)?
- Are there clear and effective orientation arrangements in place, including work practice orientation as appropriate?

And for professional/vocational programmes:

- Does the institution ensure that an assessment is made of applicants' future potential as a professional in terms of his/her professional attitude and behaviour?

Sources of information include publicity material, admissions policy documents and other records of process, details of applications, offers and admissions, details of orientation processes.

Activities include discussions with admissions and teaching staff, and discussions with students.

As a result of these activities, accreditors should make a judgement on:

- Whether arrangements for recruitment, selection and admission are clear and effective
- Whether students are selected fairly and on merit
- Whether the profile of applicants and admissions matches the programme aims
- The quality and effectiveness of orientation arrangements (including work practice learning)
- Whether selection procedures cover assessment of professional attributes as well as academic sufficiency

5.2 Evaluation of the quality of the learning opportunities offered by the programme provider (institution, faculty, department) in terms of student progression and achievement.

Accreditors should ask:

- Are the rates and trends in student progression and completion satisfactory in terms of:
 - progression and non-progression at each stage of the programme (differentiate failure, withdrawal and transfers in and out)
 - completion of the programme
 - qualifications awarded (certificate, diploma and degree results)
- Do the qualifications awarded indicate an appropriate level of student achievement in relation to the intended learning outcomes?
- What evidence is there of student attainment of the intended learning outcomes, for example:
 - knowledge and understanding
 - transferable skills
 - analytical skills
 - subject-specific skills, including practical/professional skills
- What is the evidence of student achievement, including progression to employment and/or further study?

And for professional/vocational courses:

- Is the progress of students studying away from the institution monitored effectively?
- Does the measurement of student performance and progression satisfy specific information requirements of external stakeholders?

Sources of information include external examiners' reports, reports of professional/approving bodies (where appropriate), satisfaction surveys and employment data.

Activities include discussions with employers/professional practitioners (where appropriate) and discussions with staff, current and former students.

As a result of these activities, accreditors should make a judgement on:

- Whether the rates and trends of student progression and completion (including into employment or further study) are satisfactory
- Whether the qualifications awarded indicate an appropriate level of student achievement in relation to the intended learning outcomes
- Whether the progress of students studying away from the institution is monitored effectively
- Whether the measurement of student performance satisfies external stakeholders

SECTION 6 LEARNING RESOURCES

6.1 Evaluation of the quality and appropriateness of the staff and whether they are contributing effectively to the achievement of the intended outcomes.

Accreditors should ask:

- Are the knowledge and skills of academic staff suitable and available for the effective delivery of the course, for the overall learning, teaching and assessment strategy and for the achievement of the intended learning outcomes?
- Are appropriate staff development opportunities available?
- Is appropriate technical (laboratory and computer staff) and administrative support available?
- Are staff who are involved in teaching or student support at other sites, including work experience, appropriately skilled and qualified?

Sources of information include staff resumes, internal review documents, external examiners' comments and staff development documents.

Activities include direct observation of teaching (where carried out) discussions with teaching teams and discussions with students.

As a result of these activities, accreditors should make a judgement on:

- Whether the expertise of academic, technical and administrative staff (including work practice staff) is suitable and available for the effective delivery of the curriculum and achievement of intended learning outcomes
- Whether staff development opportunities are effective

6.2 Evaluation of the facilities and learning resources available and whether these contribute fully to supporting the achievement of intended learning outcomes.

Accreditors should ask:

- Is there an overall strategy for the deployment of learning resources?
- Is the learning resources strategy effective and consistent with:
 - support for the curriculum
 - the teaching, learning and assessment strategy
 - the intended learning outcomes
 - the needs implied by the student profile
- Can the curriculum as stated be delivered within the resources available?
- Is suitable teaching and learning accommodation available in terms of:

- the number of general and specialist accommodation (lecture, seminar, tutorial, studios, laboratories)
- space for independent study (library, computing and practicals)
- social, dining and recreational facilities
- staff office space, facilities and support
- Are the library services available, accessible and appropriate in terms of:
 - programme-related books, periodical stock, on-line journals, directed-learning materials, study space and other learning resource facilities
 - arrangements for student orientation, opening hours and user support
- Are suitable equipment and appropriate computing facilities available to learners in terms of:
 - general and specialist equipment (including hardware and software, email/World Wide Web access and effective booking systems)
 - open access and independent learning facilities (number of computers per student)
 - student orientation, training and user support
 - computer based learning materials (networked and CD-ROM)
- Is course documentation produced which is appropriate, up-to-date and supports the achievement of intended learning outcomes?
- Are there effective arrangements for maintaining, replacing and updating resources including co-ordination and liaison between technical and administrative staff and teachers where necessary?

And for work practice learning/clinical teaching:

- Are the work practice placements easily accessible by public transport?
- Are the learning resources appropriate and available for workplace teaching, including:
 - opportunities for learning
 - adequacy of facilities such as seminar rooms, lockers, common room, library and computing resources, teaching aids e.g. whiteboards, projection facilities and video equipment
 - access to catering and car parking facilities
 - access to on-call accommodation as required

and for medicine/dentistry:

- access to patients in out-patients, operating theatres, wards and the community, dental surgeries
- range of specialties
- case mix, with a good balance of elective and emergency admissions and to the necessary range of cases to support the achievement of the objectives of the attachment
- access to diagnostic and support services, diagnostic equipment for clinical examination

Sources of information include equipment lists, library stocks and internal review documents.

Activities include direct observation of resources and equipment, discussions with staff and students, discussions with support staff.

As a result of these activities, accreditors should make a judgement on:

- Whether a learning resources strategy (including repair/replacement of resources) exists and whether this is effective in terms of management and co-ordination of resources
- Whether the curriculum as stated can be delivered within existing learning resources
- Whether suitable teaching and learning accommodation is available and deployed effectively
- Whether suitable library services are available and deployed effectively
- Whether suitable computing facilities are available and deployed effectively
- Whether suitable course materials are available for staff and students
- Whether resources necessary for work practice learning are appropriate and effectively managed

SECTION 7 ACADEMIC AND PERSONAL SUPPORT FOR STUDENTS

7.1 Evaluation of the quality of academic support for students and how this supports learning opportunities.

Accreditors should ask:

- Is there an appropriate overall strategy for academic support, including written guidance, which is consistent with the student profile and the overall aims of the provision?
- How effectively is learning facilitated by academic guidance, feedback and supervisory arrangements?
- Are students' individual needs identified and addressed appropriately?
- Are the arrangements for academic tutorial support clear and generally understood by staff and students?
- What is the evidence in terms of student satisfaction of the success of the support and guidance provided?
- Do the services provided cover the needs of students on all sites and on work practice learning /study abroad?
- Is there effective liaison between academic, technical and administrative staff?

Sources of information include course documentation.

Activities include discussions with academic, technical and administrative staff and students.

As a result of these activities, accreditors should make a judgement on:

- Whether a strategy for academic support exists, whether this is effective and clearly communicated to staff and students
- Whether the provision of academic support enables achievement of the intended learning outcomes for individual students as well as the student body as a whole
- Whether the services cover the needs of students on all sites and on work experience
- Whether there is effective co-ordination between administrative and technical staff and academic/work experience staff

7.2 Evaluation of the quality of accessibility, availability and assistance for students personal support.

Accreditors should ask:

- What is the strategy for personal support and how does this support learning?

- Are the arrangements for personal support clear and is the system of personal support effective in terms of provision and uptake by students?
- Does the institution provide study skills support and support for failing students?
- Does the institution provide access to learning support, for example librarians, Information Technology skills training, foreign language training, support for students with disabilities?
- Do the services provided cover the needs of students on all sites and on work practice learning/study abroad?
- Are the arrangements for careers guidance clear and generally understood by staff and students?
- Is the careers information and guidance well matched to the intended learning outcomes, student expectations and the curriculum?
- What is the evidence in terms of graduate destinations of the success of the guidance provided?
- Do students have access to health and safety support structures, including whilst on work practice placement?
- Is there effective liaison between the programme staff and administrative and technical support services?

Sources of information includes course documentation, curricular review and records of institutional approval processes, destinations data, records of meetings.

Activities include discussions with staff and students and discussions with dedicated support staff.

As a result of these activities, accreditors should make a judgement on:

- Whether a strategy for personal support exists, whether this is effective and clearly communicated to staff and students
- Whether the provision of personal support enables achievement of the intended learning outcomes for individual students as well as the student body as a whole
- Whether the services cover the needs of students on all sites and on work practice placements including:
 - Health and safety
 - Study skills
 - Needs of students with disabilities
 - Library and computer support
 - Language training
- Whether there is effective co-ordination between technical and administrative staff and academic/work practice staff
- The effectiveness of careers information and guidance

SECTION 8 INTERNAL QUALITY ASSURANCE PROCEDURES AND QUALITY ENHANCEMENT

8.1 Evaluation of the institution's capacity to review and measure their standards.

Accreditors should ask:

- How does the programme provider review and seek to enhance standards?
- What is the management structure of the department/institution/faculty and what methods are used for decision-making at institution and programme level (including Scientific and Pedagogical committees)?
- How effective are the internal arrangements for monitoring and evaluating the extent to which aims and intended learning outcomes are being met?
- Do these arrangements involve appropriate consideration of:
 - internal monitoring data (for example on quality of teaching and learning, student progression and achievement, support services)
 - external examiners' reports
 - the views of programme and work practice staff (for example through input into course management decisions)
 - the views of former and current students (for example through course evaluation questionnaires)
 - the views of employers, stakeholders and professional bodies where appropriate
 - other internal or external reviews
 - staff development needs?
- Do the methods used to allocate funding support the achievement of the intended learning outcomes?
- At an operational level, are structures and processes in place to manage the programme effectively and ensure involvement of those who are able to make a significant contribution?
- Are relationships between the institution and its work practice providers managed so as to ensure mutual understanding, co-operation and partnership and are effective contractual arrangements in place which define responsibilities for the organisation and delivery of work practice teaching?
- Is the quality of work practice (including clinical) teaching and the provision of facilities to support teaching monitored and evaluated by the work practice provider as well as the educational institution?
- Is central information held concerning work practice providers/sites and facilities to support teaching and is that information regularly updated through management information systems and regular work practice visits by academic staff?

Sources of information include internal and external review documents, evaluation of courses by students, external examiners' reports, reports by professional and/or educational authorities, accreditation reports and examination board minutes.

Activities include analyses of information, practices and procedures, discussions with teaching teams and discussions with external examiners.

As a result of these activities, accreditors should make a judgement on:

- Whether a strategy for monitoring and ensuring quality exists and whether this is clearly communicated to staff and students
- Whether the methods used to allocate funding match the achievement of intended learning outcomes
- Whether the methods used at institution level for monitoring and evaluating the extent to which aims and intended learning outcomes are met are effective and appropriate
- Whether the structures and processes used for monitoring and evaluation at programme level are effective and appropriate
- Whether there is effective management of arrangements between the institution and work practice placement (or other external) providers
- Whether information exists concerning academic and work practice teaching and whether there is regular liaison between the institution and work practice providers to give feedback and improve quality of provision

8.2 Evaluation of the institution's capacity to promote enhancement.

Accreditors should ask:

- What have been the significant outcomes of the quality management process in terms of:
 - revision of the programme aims and objectives
 - identification and implementation of action points required to meet the aims more fully
 - identification of internal indicators/measures of effectiveness
 - plans for further enhancement of the provision
 - dissemination of good practice
- How are opportunities for enhancement identified and considered?
- What evidence is there of quality enhancement in terms of:
 - orientation arrangements for new staff
 - appraisal and review of teaching skills
 - participation in staff development activities relating to teaching, learning, assessment and student support and guidance
 - application of knowledge and skills gained from staff development activities
 - impact on student experience and achievement

- How effective are the processes used for self-evaluation and continuous improvement, including management information and consultative processes?

Sources of information include course handbooks and other documentation, internal and external review documents, external examiners' reports, professional and/or statutory body accreditation reports and minutes of management committees.

Activities include analyses of information, practices and procedures, discussions with teaching teams and discussions with external examiners.

As a result of these activities, accreditors should make a judgement on:

- Whether the quality management process has been effective and has led to significant improvements in teaching, learning and support activities
- Whether quality enhancement includes consideration of staff development and training
- The effectiveness of the institution in identifying opportunities for enhancement and disseminating good practice

Annex 10 List of private high educational institutions in Georgia with medical faculties (by regions) at 1 August 2003 (01.08.03)

I Tbilisi

N ^o	Name	Address	Phone	Rector	Faculties
1	D. Agmashenebeli Georgian University	25, Chavchavadze st.	25 36 77 25 29 66	T. Koridze	Curative (general medicine for adults), pediatrics, dentistry, pharmacology
2	"Gaenati" Tbilisi Public Institute	55, K. Tsamebuli st.	74 21 65	V. Chantladze	Dentistry
3	University of Corporation "Legia and Company"	70, Uznadze st.	95 80 13 95 74 38	L. Nebieridze	Curative, pediatrics, dentistry
4	"Meridiani" Economical-Humanitarian Institute	1, T. Eristavi st.	69 82 90 61 74 65	V. Todua	Dentistry
5	"Georgia" Tbilisi University	2, T. Eristavi st.	69 86 29	G. Beraia	Dentistry
6	"Aieti" High Medical School	2/6, Lubliana st. (Digomi)	52 71 96	D. Tvildiani	General medicine
7	Academy of Classic and Traditional Medicine	16, kavtaradze st.	30 55 75	D. Kordzaia	Curative, dentistry
8	"Skhivi" Private Medical Institute	16, Kavtaradze st.	30 65 30 30 26 49	Z. Sekhniashvili	Curative, dentistry, pediatrics
9	Institute of Critical Medicine	27a, V. Pshavela av.	39 80 46 39 57 63	Sh. Kheladze	Curative
10	University "Sakartvelo"	1, Budapeshti st.	38 40 72 37 72 40	I. Gagoidze	Curative, dentistry
11	Tbilisi Medical Academy	29, Chavchavadze st.	23 15 93 23 03 87	D. Tsverava	Curative, dentistry
12	Tbilisi Institute of Pediatrics	21, Lubliana st.	52 95 35 52 98 80	T. Jvania	Pediatrics
13	Tbilisi Institute of Biological Medicine and Ecology	42, Kazbegi st.	30 36 92	O. Jishkariani	Doctor – lab. technician

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Nº	Name	Address	Phone	Rector	Faculties
14	"Eskulapi" Tbilisi Medical Institute	60, Agmashenebeli st.	95 63 40 95 65 94	I. Mchedishvili	Curative, dentistry
15	Tbilisi Public medical Institute	13, Sagarejo st.	36 37 26	D. Mshvenieradze	Curative, dentistry, pediatrics, pharmacy
16	"Pharmacia 3 N. N. N." Tbilisi 2-Stage medical Institute	39, Al. Kazbegi st.	39 76 74	N. Zambakhidze	Curative, dentistry
17	"Dastaqari" Tbilisi Medical Institute	78, Uznadze st.	96 16 78 96 14 85	I. Pagava	Curative, dentistry
18	Tbilisi Engineering-Medical Institute	7, Anagi st.	35 00 55	B. Ashordia	Dentistry
19	D. Agmashenebeli Tbilisi University	38a, Saburtalo st.	93 78 78 93 22 88	A Sharashenidze	Dentistry
20	University of Grigol Robakidze	6, J. Bagrationi	38 58 49 38 44 06	M. Tavkheldze	Dentistry, clinical psychology
21	Ltd Georgian University of Quality Management	39, Ninoshvili	95 57 66	Sh. Gugeshashvili	Curative, pharmacy, dentistry
22	"Tbilisi" Medical Institute	4, Kostava st.	96 94 46 93 69 40	N. Bakradze	Curative
23	Medical Institute	4, Lubliana st.	52 77 62 52 68 62	N. Kipshidze	Curative, dentistry
24	Independent Medical Institute "Vita"	8, Navtlugi st.	94 32 89 94 14 18	T. Geliashvili	Dentistry, curative
25	N. Kakhiani State Tbilisi Medical Institute	5, Lubliana st.	96 36 24 52 90 99	V. Borjadze	Curative, dentistry, pediatrics
26	Medical Institute "Doctor of Future"	4, Gudamakari st.	61 36 62	G. Tatishvili	Curative, dentistry
27	Independent University "Ajara"	8, Vardisubani st.	61 21 80	O. Sharadze	Pharmacy, curative, dentistry, pediatrics, doctor-lab. technician
28	Medical Institute of Plastic Surgery, Dermatology and Cosmetology	3, Kapanadze	95 08 91	B. Iashvili	Curative
29	Tbilisi State Medical Institute of Academician E. Pipia	6a, V. Phshavela st.	98 53 62	G. Pichkhaia	Curative, dentistry
30	Tbilisi University of	7, Shartava st.	38 89 20	D. Jangulashvili	Pharmacy,

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№	Name	Address	Phone	Rector	Faculties
	Georgian Union of Professionals				dentistry
31	Zaza Panaskerteli Georgian Medical University	68, Uznadze st.	96 41 60 95 69 56	G. Khachapuridze	Curative, dentistry, pharmacy
32	State Independent University "Iveria" of T. Mukhadze	9, Tsinandali st.	61 30 18	J. Mukhadze	Curative, dentistry, pediatrics, pharmacy
33	Medical Institute "Caucasus"	16, Kazbegi st.	39 66 54 39 79 41	G. Ioramashvili	Curative dentistry
34	Humanitarian-Economical Institute	25, Chavchvadze st.	95 37 33	M. Labadze	Dentistry
35	Tbilisi Institute of Dentistry and Medicine	1, Bako st. 4, Gudamakari st.	95 79 11	G. Menabde	Curative, pharmacy, dentistry
36	Institute "Gorgasali"	83/11, V. Phshavela st. 76, Ir. Abashidze st.	96 41 65 22 54 30	M. Katamadze	Dentistry
37	Medical Institute "Panatsea"	41, A. Tsereteli av.	34 58 63	O. Kiknadze	Curative dentistry
38	Independent Institute "Egrisi"	34, Kazbegi st.	39 79 46	M. Keburia	Dentistry
39	Medical Institute of "Interbusiness"	34, Chargali st.	34 79 59	M. Manasheridze M. Shakarashvili	Dentistry
40	Ltd Georgian Institute of International Relations, Finances and law	61, V. Phshavela st.	30 96 36	A. Dumbadze	Dentistry
41	Tbilisi Medical Institute "Medicor"	49, Chavchavadze st. (Georgian Academy of Sport)	23 03 75	J. Moniava	
42	Medical Institute "Klinitsisti"	2, Chiaureli st.	52 09 76	J. Silagadze	
43	"Metekhi"- Tbilisi Public University	23, Bochormi st.	74 05 95	M. Kirtbaia	Pharmacy, dentistry, curative
44	"Orientiri" Tbilisi Public Insitute	28a, Ts. Dadiani st.	69 69 59	A. Macharashvili	Dentistry, pharmacy
45	"Hypocrate" Tbilisi Medical Institute	3, Jikia st.	23 35 85	D. Kiteishvili	Pharmacy, dentistry, curative

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N ^o	Name	Address	Phone	Rector	Faculties
46	"Legia" Institution of High Professional Education	Kazbegi st.	899 559425	L. Nebieridze	Curative, dentistry, pharmacy
47	Eqvtime Takaishvili State Georgian University	60, Chavchvadze st.	76 22 28	D. Oniani	Dentistry
48	University "Martve" of Georgian Sport Society "Martve"	134, Ts. Dadiani st.		V. Balavadze	Dentistry

II Abkhazia

1	Sukhumi Chkhartishvili Economical-Humanitarian University	Zestaponi. 2, Bibilashvili st.	5 66 18	N. Ardashelia	Dentistry
2	Gali Independent Humanitarian-Economical Institute	Zugdidi. 16, Chavchavadze st.	5 13 69	A. Chkhapelia	Pharmacy, dentistry, curative
3	Ltd Sukhumi State University "Tskhumi" of Academician I. Vekua	Poti. 12, Tabidze st. Tbilisi. 1, 1 st turn of T. Eristavi st.	51 58 3	R. Ablotia	Curative, pediatrics, pharmacy, dentistry

III Ajara

N ^o	Name	Address	Phone	Rector	Faculties
1	Batumi Medico – Ecological Institute	16, Asatiani st.	7 36 92	R. Surmanidze	Curative, pharmacy
2	Batumi Institute of Economics and Law	119, Komakhidze st.	7 07 62 7 07 69	O. Gvarishvili	Pharmacy, dentistry
3	M. Abashidze State Independent University	3a, Javakhishvili st.	7 15 94	D. Baladze	Dentistry, pharmacy
4	Batumi Multi Profile Institute	63, Pushkini st.	2 88 50	A. Diasamidze	Dentistry
5	Multi Profile Institute of Batumi Professional Scientific Educational Centre	84, Lermontovi st.	2 03 16 2 31 37 2 09 13	R. Nakashidze	Dentistry, pharmacy
6	Batumi Institute of Dentistry	78/88, Chavchvadze st.		G. Diasamidze	

IV Kakheti

N^o	Name	Address	Phone	Rector	Faculties
1	Gurdjaani Independent University	21, Guramishvili st.	2 03 59	T. Tsivtsivadze	Dentistry, curative, pediatrics
2	Telavi Institute of Dentistry	1, Freedom square	3 12 30	S. Juruli	Dentistry

V Imereti

N^o	Name	Address	Phone	Rector	Faculties
1	Kutaisi Engineering Institute	53, Luxemburgi st.	7 64 62	O. Shautidze	Pharmacy
2	Kutaisi State Private Institute of Petritsi	18, Victory av.	7 39 68	M. Rekhviashvili	Bio-medical ecology
3	Kutaisi medical Institute	13, K. Tsetkini st.	4 57 93 4 57 35	G. Arveladze	Curative, dentistry, pharmacy, pediatrics
4	Kutaisi Multi Profile Institute	2, Otskheli st.	7 48 38	T. Chechelashvili	Curative, dentistry, pharmacy, pediatrics

VI Samegrelo – Zemo Svaneti

N^o	Name	Address	Phone	Rector	Faculties
1	Zugdidi Independent University	1, Kardava st.	2 49 18	G. Khvitia	Curative, pharmacy, dentistry, psychotherapy

VII Shida Kartli

N ^o	Name	Address	Phone	Rector	Faculties
1	Shida Kartli Public University	Gori. 9. Tskhinvali st.	2 68 75 2 59 26	Z. Tetrushvili	Curative, dentistry, pediatrics, pharmacy, prophylactic medicine
2	Gori Multi Profile Minor Academy	Gori. 9, Tskhinvali st.	899 97 27 02	V. Sukhishvili	Pharmacy, doctor-lab. technician

VIII Qvemo Kartli

N ^o	Name	Address	Phone	Rector	Faculties
1	Rustavi State University of Sh. Rustaveli	9, Balanchivadze st.	15 60 97 15 33 34	T. Maisuradze	Curative, dentistry

IX Samtskhe – Javakheti

N ^o	Name	Address	Phone	Rector	Faculties
1	Akhalkalaki Institute of Georgian International Scientific – Cultural Educational Union Society “Tsodna”	36, Freedom st.	99 94 46	J. Karoiani	Curative, dentistry, pharmacy
2	Ltd Independent University “Meskheti”	Akhaltzikhe. 12, ladze st.	2 32 58	Z. Beridze	Dentistry

Annex 11: List of private secondary educational institutions with medical faculties in Georgia (by regions) at April 2004

I Tbilisi

N ^o	Name	Address	Phone	Rector	Specialties
1	Multi Profile College of Tbilisi Humanitarian – Economical Institute	25, Chavchavadze st.	36 34 25 95 17 52	Madlena Labadze	Pharmacy, orthopedic dentistry, nursing
2	Ltd “Legia and Company” College	34/32, Kazbegi st.	64 61 81 39 35 59	Murman Muradashvili	Obstetrics, pharmacy, orthopedic dentistry
3	Tbilisi Juridical - Pedagogic College	3, Kutateli st.	33 43 89 37 22 40	Evgenia Khvedelidze	Obstetrics, orthopedic dentistry, pharmacy
4	Tbilisi Humanitarian-Economical College	4, Kazbegi st.	23 25 65 39 13 32	Dali Jebirashvili	Orthopedic dentistry
5	Multi Profile College of Tbilisi Industrial-Pedagogic Institute “Tsodna”	1, T. Eristavi st.	98 48 45 66 90 81		Orthopedic dentistry
6	Tbilisi Medical College of Ltd “Argo’	10 kv., Temka	68 21 10 60 27 21	Mikhail Abramidze	Obstetrics, nursing , orthopedic dentistry, pharmacy
7	College of Classic and Traditional Medical Academy	16, Kavtaradze	38 81 51 23 40 58 877 42 70 90	Dimitri Kordzaia	Curative, obstetrics, orthopedic dentistry
8	Tbilisi Humanitarian-Economical College “Momavali”	57, Moscow av.	22 35 04 71 33 34	Ekaterine Gogorishvili	Obstetrics, nursing
9	Medical College of Tbilisi Medical Institute “Vita”	3, Chkalovi st.	29 03 25 74 04 00		Curative, orthopedic dentistry, curative physical training, masseur

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№	Name	Address	Phone	Rector	Specialties
10	Tbilisi State Medical College named by Zaza Phanaskerteli	68, Uznadze st.	33 51 99 95 69 56 96 41 60	Guram Khachapuridze	Curative, orthopedic dentistry, curative physical training, masseur, nursing
11	College "Georgia" of Public University "Georgia"	2, T. Eristavi st.	69 86 29	Alexsandr Beraia	Orthopedic dentistry
12	Tbilisi Medical College	34, Paliashvili st.	22 35 85	Avtandil Sigua	Orthopedic dentistry, nursing
13	Tbilisi Medical Special Secondary College	1, Chachava st.	22 52 52	George Popkhadze	Obstetrics, nursing , orthopedic dentistry, pharmacy
14	Medical College of Georgian Society "Tsodna"	47, Kostava st.	38 36 72 99 65 65	Bidzina Chumburidze	Nursing , orthopedic dentistry
15	Tbilisi Medical College	21, Lubliana st.	98 48 79 52 90 80 52 99 84	Ramaz Mamageishvili	Obstetrics, nursing , orthopedic dentistry
16	Tbilisi Multi Profile College	18, Ateni st.	22 47 09	Manana Parkadze	Curative, orthopedic dentistry
17	Tbilisi Medical College	1, Bako st.	37 93 32 95 79 11	Thea Andriadze, Nina Kakauridze	Curative, obstetrics, pharmacy, orthopedic dentistry, nursing
18	Medical College of Tbilisi State Medical Institute named by E. Pipia	6a, V. Phshavela st.	37 75 86 98 53 62		Curative, obstetrics, pharmacy, lab. diagnostics, nursing
19	College of Tbilisi Public Medical Institute	13, Mardjanishvili st.	34 24 49 95 02 96		Obstetrics, nursing , pharmacy, orthopedic dentistry

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№	Name	Address	Phone	Rector	Specialties
20	Tbilisi Medical College of Ltd "Orienti"	28, Ts. Dadiani st.	76 60 49 69 99 94 899 900 992	Ketevan Kashia	Obstetrics, orthopedic dentistry, nursing , pharmacy
21	Multi Profile College of Tbilisi Humanitarian Institute	2, square of May 26	33 01 57 33 11 40	V. Sakvarelidze	Orthopedic dentistry, nursing
22	Tbilisi Medical College "Orbi"	17, Chikobava st.	22 42 65		Obstetrics, orthopedic dentistry, nursing , pharmacy
23	Tbilisi Medical College "Mkurnali" named by M. Kobakhidze	2, Chiaureli st.	52 09 76	J. Silagadze	Curative, obstetrics, orthopedic dentistry
24	Tbilisi Medico- Biological College # 1	61, V. Phshavela st. (school #151)	39 55 01 31 69 75	Tengiz Zangaladze	Obstetrics, pharmacy, orthopedic dentistry, nursing
25	Tbilisi Medical College of Ltd "Interbusiness"	34, Chargali st.	61 69 77 61 54 23	Inga Manasheridze	Curative, orthopedic dentistry, obstetrics
26	Tbilisi Multi Profile Medical College	39, Kazbegi st.	34 28 64 39 67 74	Nodar Zabakhidze	Curative, obstetrics, pharmacy, orthopedic dentistry, lab. diagnostics, nursing
27	Tbilisi Medical College "Tanadgoma"	10, Kalaubani st.	75 65 92	Nana Gudadze	Pharmacy, orthopedic dentistry, nursing
28	Tbilisi Medical College "Heliosi"	16, Tsutsumia st.	75 86 86 74 29 55	Marine Sarjveladze	Obstetrics, orthopedic dentistry, nursing
29	Medical College of Tbilisi Independent University "Ajara"	8, Vardisubani st.	68 08 62 61 21 80	Nato Sharadze	Obstetrics, orthopedic dentistry, nursing , pharmacy, lab. diagnostics

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№	Name	Address	Phone	Rector	Specialties
30	Medical College of Tbilisi Medical Institute "Dastakari"	78, Uznadze st.		Ir. Pagava	Obstetrics, orthopedic dentistry, lab. diagnostics, nursing
31	Multi Profile College of Tbilisi Humanitarian-Economical Institute	61, Gamsakhurdia st.	37 22 40	M. Adamia	Orthopedic dentistry
32	Multi Profile College of Tbilisi Multi Profile Humanitarian Institute	41, George Brtskinvale st.(didi digomi)		Tsitso Japaridze	Curative, orthopedic dentistry
33	Tbilisi Dental College "Delta"	27/9 Zubalashvilebi st.		Zaza Janelidze	Orthopedic dentistry
34	Multi Profile College of Tbilisi Gr. Robakidze University	6, Bagrationi st.	38 44 06 38 58 49	M. Tavkhelidze	Orthopedic dentistry, obstetrics, pharmacy, nursing
35	Tbilisi Multi Profile College "Tsodnis Tskaro"	178, D. Agmashenebeli st.	38 00 83	Otar Gogilashvili	Obstetrics, orthopedic dentistry
36	Medical College of Tbilisi University "Sakartvelo"	11, Budapeshti st.	38 40 72 37 99 37 95 67 36	I. Gagoshidze	Obstetrics, pharmacy, orthopedic dentistry, nursing
37	Tbilisi Multi Profile College "Gorgasali"	76, Ir. Abashidze st.	22 54 30	D.Kadagidze	Obstetrics, orthopedic dentistry, pharmacy, nursing
38	Medical College "Tbilisi" of Tbilisi Medical Institute "Tsodna"	47, Kostava	93 69 40	N. Bakradze	Obstetrics, nursing
39	St. Nino Medical College of Tbilisi Endocrinology Centre	9, Tsinandali st.		N. Gagunashvili	Nursing
40	Humanitarian College of Newspaper "Chiragdani"	7, Javakheti st.	73 03 72	Gari Chapidze	Obstetrics
41	Tbilisi Medical College "Skhivi"	16, Kavtaradze st.	30 01 95 30 26 49 877 44 13 77	Z. Sekhniashvili	Nursing, orthopedic dentistry

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№	Name	Address	Phone	Rector	Specialties
42	College of Tbilisi State University "Iveria" named by T. Mukhadze	9, Tsinandali st.		Julieta Mukhadze	Orthopedic dentistry, lab. diagnostics, nursing , obstetrics, pharmacy
43	College of Tbilisi Medical Academy	29, Chavchavadze st.		D. Tsverava G. Kandelaki	Orthopedic dentistry, nursing
44	College of Georgian Society "Tanadgoma da Amagleba"	25, Chavchavadze st.		T. Koridze	Nursing , orthopedic dentistry
45	Multi Profile College of Tbilisi Public Institute "Gaenati"	57, Ketevan Tsamebuli st.			Orthopedic dentistry, nursing
46	Tbilisi Multi Profile College "Imedi"	11, Shiraki st.	77 54 73 899 95 28 28	Ineza Ioramashvili	Curative, orthopedic dentistry
47	Medical College of High Medical School "Aieti"	2/16, Lubliana st.	51 68 98	D. Tvildiani	Nursing
48	Medical College of Tbilisi Medical Institute "Caucasus"	16, Kazbegi st.	37 59 27	Givi Ioramashvili	Orthopedic dentistry, nursing
49	Tbilisi Multi Profile College	178, Agmashenebeli st.	35 27 00	O. Gogilashvili	Obstetrics, orthopedic dentistry, nursing
50	Multi Profile College "Martve"	134, Ts. Dadiani st.		V. Balavadze	Orthopedic dentistry, nursing
51	College of Tbilisi E. Takaishvili University	20, V. Phshavela av.		Ts. Chkhartishvili D. Oniani	Obstetrics, nursing
52	Medical College of Public Educational Medical centre of Nurses	2, Gudamakari st.		G. Andriadze	Nursing
53	Clinical Hospital College of Javakishvili State University	60, Agmashenebeli st.		G. Nishnianindze	Curative, obstetrics, prophylactic medicine and epidemiology, pharmacy, orthopedic dentistry, curative physical training, masseur

N ^o	Name	Address	Phone	Rector	Specialties
54	Tbilisi Multi Profile College	61, Khmelnitski st.	877 43 83 81	T. Tsiklauri	Obstetrics, pharmacy, orthopedic dentistry, nursing
55	Medical College of Tbilisi Medical Institute "Hypokrate"	198, Agmashenebeli st.		D. Kiteishvili	Curative, pharmacy, orthopedic dentistry

II Abkhazia

N ^o	Name	Address	Phone	Rector	Faculties
1	Gali Medical College	Zugdidi. 36, Chavchavadze st.	2 13 69 877 44 15 51 877 41 72 58	Anzor Chkhapelia	Obstetrics, pharmacy, orthopedic dentistry, nursing

III Samegrelo – Zemo Svaneti

N ^o	Name	Address	Phone	Rector	Faculties
1	Multi Profile College of Zugdidi Independent University	1, Tskalsadeni st.	2 20 10 2 05 17 29 38 29	Grigol Khvitia	Curative, pharmacy, orthopedic dentistry, obstetrics
2	Zugdidi Medical College "Medikosi"	2a, Nachkebia st.	2 21 11	Katusha Nachkebia	Pharmacy, curative, orthopedic dentistry
3	Martvili Medical College of Georgian Society "Tsodna"	Martvili. Central Hospital	2 13 87 2 15 92	Michail Gabisonia	Nursing
4	Abasha Branch of Tbilisi Multi Profile College of Humanitarian University	13, Tavisupleba st.		Paata Bokuchava	Obstetrics, pharmacy, lab. diagnostics, orthopedic dentistry
5	Senaki Medical College "Kolkhi"	Senaki. 23, Chavchavadze st.	2 20 27	Manana Chanturia	Nursing , obstetrics, lab. diagnostics, orthopedic dentistry, pharmacy

IV Imereti

№	Name	Address	Phone	Rector	Faculties
1	Kutaisi Traditional Medicine Special Secondary College	Kutaisi. 20, Pushkini st.	7 83 70	Iza Diakvnishvili	Pharmacy, nursing , orthopedic dentistry
2	Sachkhere Multi Profile College	1, King Tamar st.	5 48 94 (Chiatura)	Meri Gaprindashvili	Obstetrics, pharmacy, orthopedic dentistry
3	Chiatura Multi Profile College	Chiatura. 6, Kazbegi st.	5 49 49 92 23 86 5 12 64	Tengiz Palavandishvili	Curative, nursing , orthopedic dentistry
4	Kutaisi Medical College	Kutaisi. 33, Avtomshenebeli st.	6 53 94	Jemal Kvariani	Nursing
5	Kutaisi Medical College	Kutaisi. 2, Otskheli st.	7 48 38	Teimuraz Chechelashvili	Curative, obstetrics, pharmacy, orthopedic dentistry, lab. diagnostics, nursing
6	Kutaisi Branch of Tbilisi Medical College "Niblia"	Kutaisi. 15, King Tamar st.	77 82 43	Jemal Kamushadze	Obstetrics
7	Zestaponi Branch of Tbilisi Medical College "Niblia"	Zestaponi. 6, Rustaveli st.	77 82 43	Tenguli Khurtsilava	Obstetrics, orthopedic dentistry
8	Kutaisi Medical College "Satnoeba"	Kutaisi. 10, Solomon I st.	7 28 01 4 35 08	Marina Nutsbidze	Curative, obstetrics, prophylactic medicine and epidemiology, orthopedic dentistry, lab. diagnostics, nursing , curative physical training, cosmetology, masseur

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№	Name	Address	Phone	Rector	Faculties
9	Kutaisi Medical College "Medea XXI "	Kutaisi. 13, Malkhaz Dvalishvili st.	4 57 35	Tamar Valiashvili	Curative, obstetrics, pharmacy, orthopedic dentistry, lab. diagnostics
10	Samtredia Medical College "Medea"	Samtredia. 234, D. Agmashenebeli st.	3 42 52 2 41 94	Tamaz Jordania	Nursing
11	Bagdati Medical College	Bagdati. 14, Kakhiani st.		Nino Bazanova	Pharmacy, orthopedic dentistry, nursing
12	Tskaltubo Medical College	Tskaltubo. 62, Aprili 9 st.	2 21 84 2 27 08	Nona Tabidze	Nursing , obstetrics, orthopedic dentistry
13	Samtredia Multi Profile College "Tsodna"	Samtrdia. 1, Kraveishvili st.		Marine Nadiradze	Obstetrics, pharmacy, orthopedic dentistry
14	Samtredia Secondary Professional Medical College Ltd "Medicori"	Samtredia. 86, Republic st.	2 35 14 2 14 00	J. Papava	Orthopedic dentistry, obstetrics
15	Kutaisi Pharmaceutical College "Pharmaconi"	Kutaisi. 61, Gamsakhurdia st.		Nino Abuladze	Obstetrics, pharmacy
16	Multi Profile College of Kutaisi Independent University	Kutaisi. 2, Rodzevichi st.	4 68 13	R. Namicheishvili	Pharmacy, orthopedic dentistry, curative physical training, masseur
17	Khoni Branch of Tbilisi Medical College "Tanadgoma"	Khoni. 16, Shamatava st.		L. Machaidze	Pharmacy, nursing
18	Kutaisi Medical College "Medikosi"	Kutaisi. 5a, Meskhi st.	7 79 90	Guguli Chkhopbadze	Obstetrics, pharmacy, orthopedic dentistry, lab. diagnostics, nursing
19	Kutaisi Medical College "Hypokrate"	Kutaisi. 105, King Tamar st.		N. Nareshelashvili	Pharmacy

№	Name	Address	Phone	Rector	Faculties
20	Kutaisi Medical College "Solidaroba"	Kutaisi. 163, Rustaveli st.	899 14 04 62	G. Sordia	Obstetrics, pharmacy, nursing

V Ajara

№	Name	Address	Phone	Rector	Faculties
1	Khelvachauri Medical College "Surmaneli"	Khelvachauri. 5, D. Agmashenebeli turn	2 49 35 4 10 29	Neli Surmanidze	Obstetrics, nursing
2	Batumi Independent Medical College "Janmrteloba"	Batumi. 35, Griboedovi st.	2 23 53 2 89 51	Memed Gogvadze	Lab. diagnostics, nursing , obstetrics, pharmacy, orthopedic dentistry
3	Multi profile College of Batumi Institute of Law and Economics	Batumi. 119, Komakhidze st.	7 40 00 7 07 62 7 07 69	Osiko Gvarishvili	Curative, pharmacy, orthopedic dentistry
4	Batumi Medical College "Eleqsiri"	Batumi. Angisa st.	2 19 00 7 41 32	Zurab Jgenti	Curative, obstetrics, orthopedic dentistry, lab. diagnostics, nursing
5	Kobuleti Medical College	Kobuleti. 154, Rustaveli st.	6 78 79 899 170 614	David Mchedlishvili	Pharmacy, orthopedic dentistry, obstetrics
6	Batumi Medico – Pedagogical College	Batumi. 30, Abashidze st.	7 18 87 2 26 33	Grigol Gogvadze	Curative, pharmacy, nursing , orthopedic dentistry
7	Batumi Multi Prifile College	Batumi. 63, Pushkini st.	2 88 50	Alexsandr Diasamidze	Orthopedic dentistry, lab. diagnostics, nursing , obstetrics

№	Name	Address	Phone	Rector	Faculties
8	Kobuleti Medical College "Avitsena"	Kobulati. 62, Tbilisi st.		Valerian Inaishvili	Curative, obstetrics, pharmacy, orthopedic dentistry, nursing
9	Multi Profile College of Batumi Independent University	Batumi. 4a, Javakhishvili st.	7 15 94	Amiran Takidze	Pharmacy, nursing, orthopedic dentistry
10	Medical College of Batumi Medico - Ecological Institute	Batumi. 16, Asatiani st.	7 36 92	R. Surmanidze	Curative, obstetrics, pharmacy, orthopedic dentistry, lab. diagnostics

VI Kakheti

№	Name	Address	Phone	Rector	Faculties
1	Sagaredjo Multi Profile College "Gotsi"	Sagaradjo. 5, Kakheti gzatketsili	38 32 00 4 34 03 4 22 72	Gulnara Gotsiridze	Pharmacy, orthopedic dentistry, obstetrics
2	Multi Profile College of Gutdjaani Independent University	Gurjaani. 31, Guramishvili st.	33 99 55	Tengiz Tsivtsivadze, Nana Beriashvili	Obstetrics, pharmacy, orthopedic dentistry, nursing
3	Tsnori Medical College	Tsnori. 115, Rustaveli st.	4 32 38 41 45 08	Anzor Siprashvili	Obstetrics, nursing , orthopedic dentistry
4	Telavi Medical College	Telavi. 8, Alazani av.	3 48 34	Ivane Tikishvili	Curative, obstetrics, pharmacy, orthopedic dentistry, lab. diagnostics, nursing
5	Lagodekhi Medical College "Kvali"	Lagodekhi. 1, Djanelidze	32 67 62 2 27 09	Tamar Jajanidze	Curative
6	Gurjaani Branch of Tbilisi Medical College named by Zaza Panaskerteli	Gurjaani. 11, Takaishvili st.		Nodar Tsiskarishvili	Nursing , orthopedic dentistry

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N ^o	Name	Address	Phone	Rector	Faculties
7	Sagarejo Medical College "Nini"	Sagarejo. 158, D. Agmashenebeli st.		Nino Datunashvili	Obstetrics, nursing , pharmacy, orthopedic dentistry, lab. diagnostics
8	Telavi Dental College	Telavi. 1, Freedom st.	3 12 30	S. Juruli	Orthopedic dentistry
9	Gurjaani Multi profile College "Okroshidze"	Gurjaani. 24, Sekhniashvili st.	2 26 02 899 17 40 24	Tamar Sekhniashvili	Nursing
10	Dedoplistskaro Branch of Tsnori Medical College	Dedoplistskaro. 52, Gamarjveba st.		A. Saprashvili	Obstetrics, orthopedic dentistry
11	Tsnori Medical College	Tsnori. 32, University st.		Nikoloz Bregvadze	Obstetrics, orthopedic dentistry, lab. diagnostics, pharmacy
12	Telavi Bio- Medical College	Telavi. 1, University st.	3 16 88 3 34 40	Ramaz Maisuradze	Obstetrics, pharmacy, nursing

VII Qvemo Kartli

N ^o	Name	Address	Phone	Rector	Faculties
1	Marneuli Medical College	Marneuli. 80, May 26 st.	39 75 73 893 314 394	Irakli Gomelauri	Curative, obstetrics, pharmacy, orthopedic dentistry, Lab. diagnostics
2	Rustavi Medical College	Rustavi. 3, Nikoladze st.	15 27 37 12 88 44	Lali Kurtanidze	Obstetrics, orthopedic dentistry, nursing , pharmacy
3	Rustavi Medical College "Ksenoni"	Rustavi. 6, Guramishvili st.	14 19 42 12 16 15	Malkhaz Kvinikadze	Curative, obstetrics, pharmacy, orthopedic dentistry, nursing
4	Rustavi Multi Profile Independent College "Lampari"	Rustavi. 10, Akhmeteli st.	893 32 36 41 12 87 65 12 63 25	David Menadire	Obstetrics, orthopedic dentistry
5	Gardabani Branch of	Gardabani.	15 01 12	Tamaz	Orthopedic

N^o	Name	Address	Phone	Rector	Faculties
	Tbilisi Medical College named by Zaza Panaskerteli	15, D. Agmashenebeli st.		Karseladze	dentistry, nursing
6	Bolnisi Medical College	Bolnisi. 47, Agmashenebeli st.		Neli Khurtsilava	Pharmacy, nursing , obstetrics
7	Rustavi Medical College	Rustavi. 47a, Megobroba st.		Giuli Gvenetadze	Curative, orthopedic dentistry, lab. diagnostics
8	College of Rustavi Institute "Rvali"	Rustavi. 5, V. Phshavela st.		G. Tsitskhvaia	Obstetrics, lab. diagnostics
9	Rustavi Branch of Tbilisi Medical College named by Zaza Panaskerteli	Rustavi. 3, Machabeli st.		G. Khachapuridze	Orthopedic dentistry, nursing
10	Rustavi College of Complex Management "Skhivi"	Rustavi. 4, Shartava st.	15 02 47	M. Meparishvili	Obstetrics, nursing , pharmacy

VIII Shida Kartli

N^o	Name	Address	Phone	Rector	Faculties
1	College of Shida Kartli Public University	Gori. 9, Tskhinvali Gzatketsili	2 32 95 2 68 75	Maia Tetrushvili	Obstetrics, orthopedic dentistry, pharmacy, curative
2	Kaspi Multi Profile College	Kaspi. 6, Parnavazi st.	2 29 12 2 29 13	Tamar Berishvili	Obstetrics, orthopedic dentistry
3	Gori Multi Profile College "Amagi"	Gori. 9, Tskhinvali Gzatketsili	2 36 60 2 24 08	Rusudan Sukhiashvili	Pharmacy, orthopedic dentistry
4	Kareli Branch of Tbilisi Medical College named by Zaza Panaskerteli	Kareli. 5, Akhlagazrdoba st.	3 19 35 3 14 78	Givi Egnatashvili	Orthopedic dentistry, nursing
5	Shida Kartli Multi Profile College "Tsiartkela"	Gori. 12a, Mshvidoba st.	2 24 18 899 57 78 49	Robert Maglakelidze	Curative

N^o	Name	Address	Phone	Rector	Faculties
6	Multi Profile College of Kaspi Independent Institute	Kaspi. 40, Rustaveli st.		G. Shakarashvili	Obstetrics

IX Samtskhe-Javakheti

N^o	Name	Address	Phone	Rector	Faculties
1	Borjomi Economical-Juridical College "Tori"	Borjomi. 3, Saakadze st.	22 35 04 2 26 01	Manoni Kirtibaia	Orthopedic dentistry
2	Akhalkalaki Medical College of Society "Tsodna"	Akhalkalaki.		Alexsandr Enokiani	Nursing
3	Akhalsikhe Branch of Tbilisi Independent College "Momavali"	4, Kostava st.		V. Gogorishvili	Nursing , obstetrics, pharmacy, orthopedic dentistry
4	Akhalsikhe Medical College	Akhalsikhe. 10, ladze st.	2 23 58 899 53 51 32	Zura Beridze	Obstetrics, pharmacy, orthopedic dentistry, nursing
5	Medical College of Akhalkalaki Insitute	Akhalkalaki. 45, Tavisupleba st.	899 54 52 49	J. Karoiani	Obstetrics, orthopedic dentistry, nursing

X Mtskheta-Mtianeti

N^o	Name	Address	Phone	Rector	Faculties
1	Dusheti Medical College of Society "Tsodna"	Dusheti. 97, Stalini st.		Shalva Tsmaladze	Nursing
2	Tianeti Medical College of Society "Tsodna"	Tianeti. 58, Rustaveli st.	9 15 36 9 11 07	Simon Tsalugelashvili	Nursing
3	Kazbegi Medical College of Society "Tsodna"	Kazbegi.		Dzidzia Gudushauri	Nursing

XI Guria

N^o	Name	Address	Phone	Rector	Faculties
1	Goraberejouli Medical College	Chokhatauri Rayon, Village Goraberejouli	28 18	David Sharashidze	Curative, obstetrics

XII Racha-Lechkhumi

N^o	Name	Address	Phone	Rector	Faculties
1	Oni Medical College of Society "Tsodna"	Oni, 29, Rustaveli st.	2 03 37	Valeri Gurgenidze	Nursing

Annex 12: The legal basis for the establishment and functioning of clinical ethics committees

Paper Presented by G.Javashvili to bilateral conference of Council of Europe and Georgian MoLHSA on Medical Ethics 14-15th July 2003

Ethics Committees in Georgia have hardly existed more than five years.

The table below briefly describes the three types of ethics committees (EC) in Georgia and the legal basis for their establishment and function.

TABLE 1: ETHICS COMMITTEES IN GEORGIA

	Title of Committee	Task of the Committee	Legal bases (Laws, decrees, etc)
Central EC	National Council on Bioethics	To advise Minister on the ethical aspect of health care and biomedicine	Presidents Decree #15 of 12 January 98. Order #57/m of the Minister of Health and Social Affairs. Regulation for the National Council on Bioethics was enacted by the Order #157/0, of 5 July 2000 of the Minister of Labor, Health and Social Affairs
Research EC	Biomedical Research Ethics Committees	Ethical review of research protocols	Law on Health Care (1997) Law n Drug and Pharmacological activity (1996) Law on Biomedical Research involving Human Subjects (before government)
Hospital EC	Medical Ethics Committees	Ethics education and consultation for healthcare professionals, patients and their family members	Law on Health Care (1997) Regulation for the Institutional Medical Ethics committees was enacted by the Order #128/n, of 2 October 2000 of the Minister of Labor, Health and Social Affairs

The first push towards the establishment of medical ethics committees was the enforcement of the Law on Health Care (1997). Article 62 of the law requires that health establishments set up ethics committees (Hospital or Clinical Ethics Committee), to ensure that the right of patients are respected and the principles of medical ethics are considered:

“In order to ensure protection and promotion of the patient’s rights and the norms of medical ethics, medical institutions create medical ethics committees. The basis of creation of the commission is determined by Georgian legislation”.

Soon after the promulgation of the Law on Health Care, special decree from the President was prepared and signed – Presidents Decree #15 of January 12, 1998. This decree, among other tasks aimed to implement patient's rights legislation in Georgia, ordered the Ministry of Health (now the Ministry of Labor, Health and Social Affairs) to prepare model regulations for medical ethics committees.

The next year the Ministry of Health, with the involvement of the Health Legislation working Group at the National Health management Center, prepared the bylaw defining regulation for the establishment and functioning of institutional medical ethics committees. The charter was adopted by Order #128/n the Minister of Labor, Health and Social Affairs on 2 October 2000.

As defined in the document the composition and function of ethics committees vary depending on the role of the medical institution. Each committee must define its own policy in a statement compliant to outlines in the charter.

The charter includes the following major segments:

- General Provisions
- Criteria for creation of the Medical Ethics Committee
- Functions of the Medical Ethics Committee
- Structure and composition of the medical ethics Committee
- Activities of the Medical Ethics Committee
- Organization of activities of the Medical Ethics Committee

The Charter outlines the functions of institutional medical ethics committees as follows:

- a) Education of the medical personnel, patients, patient' families and the community about the ethical dimensions of contemporary medical practice.
- b) Development of policies and guidelines that will help the medical personnel to address the complex ethical problems arising in the process of providing care to the patients (e.g. policy for the cessation of futile cardiopulmonary resuscitation, do not resuscitate orders, guidelines for how to deal with previously expressed wishes of the patient regarding the withholding or withdrawing of life-sustaining procedures if they should have a terminal condition – “living wills, etc).
- c) Counseling medical staff members, patients and their families on the ethical aspects of particular clinical cases.
- d) Retrospective review/analysis of ethical questions, which rose in the decision-making process related to the care if individual patients.

The document “recommends” establishing MECs in every medical institution if possible. It advises the set up of MECs at multi-disciplinary hospitals and clinics, in particular were ethical dilemmas occur frequently (clinics having intensive care units, psychiatric clinics, transplantology centers, medical institutions utilizing IVF technologies, etc) Several institutions/clinics may establish one MEC by consolidating resources.

According to the charter, MEC should have at least 5 members and all major departments of the hospital should be represented. Representative(s) of the administration should sit in the committee. Head of the clinic/hospital is an ex-officio member of MEC. The committee should report to the head (director) of the hospital.

The charter also outlines the procedures for submitting cases to the committee, the organization of committee meetings, the reporting regulations and other organizational issues.

First Clinical Ethics Committees

According to a survey carried out by the National Council on Bioethics and Georgian Health Law and Bioethics Society, only 9 health care institutions run medical ethics committees (in total 22 HC institutions completed the questionnaire). Only 3 of the 9 committees have their own statement developed on the bases of the Charter. The number of members on these committees varies from 5 to 13.

Most of the committees were established in 2003 after the National Council on Bioethics issued its recommendation on the establishment and development of MECs, based on the Charter. Another factor influencing the establishment of MECs as announcement of programs (by non government sector), which would finance the activities aiming at developing MECs at health care institutions.

According to the above mentioned recommendation prepared by National Council of Bioethics concerning MECs, the Ministry of Labor, Health and Social Affairs has to:

- Further support establishment of MECs;
- Organize training for MEC members;
- Organize annual meetings of MECs, which should represent the forum for discussing existing problems and sharing experiences;
- Regularly collect information about the activities of MECs and the problems they face in their work.

Although few members of the Council insisted to make establishment of MECs mandatory pre-condition for the accreditation of MECs, this was not included in the final text of the recommendation.

At present intensity of the MECs work is quite low (each committee would hold 1-4 meetings since their establishment) and the competence (training, experience) of many members of the above committees is still under the question. For some members of the above mentioned committees the cycle of workshops have been designed and carried out. However, it is not definitely enough and more intense training programs should be made available for the members of medical ethics committees.

In conclusion, although there are considerable legal developments related to the establishment and development of MECs in Georgia, very few committees have been established. It is not clear what the views of health care professional and administrations of health care institutions (basically hospitals) are about the value of MECs. Several projects are on their way of implementation aiming at intensifying clinical/medical ethics committee movement in Georgia. It seems to be too early to make any serious conclusions about the fate of MECs in this country.

Annex 13: Residency program in family medicine (family doctor)

Tbilisi 2003

“Agreed” . Kordzaia Head Charge D’Affairs

Department of Education and Medical Science Ministry of Labor, Health and Social Affairs 2002.

Residency Program

Family Doctor

(Specialty)

Program Director: **Guram Kiknadze**

Position and scientific Degree: Dean of the Faculty of Family Medicine of the State Medical Academy of Georgia, Professor of the Cathedra for Family Medicine, PhD.

Medical-education institutions involved in the program (Clinical Base)

1. Clinical Base	JSC “Medical Concern Curatio” Family Medicine Clinic
2. Clinical Base	Clinic of the State Medical Academy of Georgia, Therapeutic and Coronal Departments
3. Clinical Base	Neurology and Ophthalmology National Center
4. Clinical Base	Institute of Pediatrics
5. Clinical Base	Guramishvili Pediatric Clinic
6. Clinical Base	State Medical Academy Gynecology Cathedra II
7. Clinical Base	Gudushauri “National Medical Center” (Surgical, Traumatological-Orthopedical and Critical Medicine Departments)
8. Clinical Base	Clinical Laboratory Cathedra of the State Medical Academy of Georgia
9. Clinical Base	Diagnostic Department of the State Medical Academy of Georgia
10. Clinical Base	Emergency Therapy and Toxicology Cathedra of the State Medical Academy of Georgia and Tbilisi State University Clinic
11. Clinical Base	Urology Institute
12. Clinical Base	Dermatology and Veneric Disease Clinic of the State Medical Academy
13. Clinical Base	Psychiatry Institute
14. Clinical Base	Narcology Institute
15. Clinical Base	Public Health and Epidemiology Cathedra of the State Medical Academy of Georgia

1. GENERAL PROVISIONS

1.1 Program Objective, Specialty Description

Program Objective

The paramount objective of the “Family Doctor” specialty undergraduate education program is to prepare doctor specialist, whose theoretical knowledge and practical skills will comply with the description of the family doctor specialty.

Specialty Description

Family Medicine – Medical discipline oriented to the primary health care and continuous medical care, with the independent and different from other disciplines system of professional training, research and clinical activities.

Family Doctor – Doctor-specialist, with the right to provide primary multi-profile medical care to the patients of any age and sex in accordance to the rules determined by the Georgian legislation.

1.2 Program Duration

Entire Program Duration: 30 months – 130 weeks (2.5 years)

Factual Duration: 121 weeks

Leave: 3 week leave is considered in each year of study (9 week leave from the total 130 weeks)

1.3 Rotation and Clinical Education in the Family Doctor’s Office

In accordance to the prescribed knowledge and practical skills to be studied during the residency program, it is divided into rotations. Rotations are presented in the form of 4 week blocks, though the duration separate rotations might be 1 or 2 weeks.

In parallel to the rotation, during the whole residency program residents study clinical skills in the office of the family doctor. Residents work in the office of the family doctor once, twice or five times a week at different stages of education. Working hours comprise only part of the whole working day, which gives resident the possibility to simultaneously participate in the rotations, which is carried out at the bases of other clinics.

Rotations are carried out at the relevant bases (resident bases). Only several rotations can be carried out at one base. On the other hand, one rotation might cover work at several bases.

Below see the rotation list

1	Adult stationary medical care
2	Perinatal medicine
3	Children stationary medical care
4	Children ambulatory medical care
5	Women health care
6	Elderly medical care
7	Neurological diseases
8	Psychical diseases
9	Blood vessel diseases
10	Respiratory system diseases
11	Digestive system diseases
12	Urine system diseases
13	Articular system: Orthopedic, rheumatology, physiotherapy, sports medicine
14	Dermatological diseases
15	Head and neck diseases
16	Vision diseases
17	Surgical disease treatment in the stationary
18	Ambulatory (small) surgery
19	Emergency medical care
20	Critical medicine

Above mentioned rotations are divided in time in accordance to the duration of the residency program (2.5 years or 30 months or 130 weeks). As it has been already mentioned, rotations are mainly presented in 4 week blocks. Below see the rotation distribution in time:

First year of residency	Second year of residency	Third year of residency
Adult stationary medical care 12 weeks	Adult stationary medical care 8 weeks	Adult stationary medical care 4 weeks
Perinatal medicine 4 weeks	Children stationary medical care 4 weeks	Respiratory system diseases 4 weeks
Children stationary medical care 4 weeks	Children ambulatory medical care 4 weeks	Dermatological diseases 4 weeks
Children ambulatory medical care 4 weeks	Perinatal medicine and Women health care 4 weeks	Emergency medical care 4 weeks
Vision diseases 2 weeks	Blood vessel diseases 4 weeks	Neurological diseases 4 weeks
Trout-ear-nose 2 weeks	Articular system 6 weeks	Psychiatry 4 weeks

First year of residency	Second year of residency	Third year of residency
Surgical disease treatment in the stationary 4 weeks	Digestive system diseases 4 weeks	
Critical medicine 4 weeks	Urine system diseases 2 weeks	
Emergency medical care 4 weeks	Vision diseases 4 weeks	
Elderly medical care 4 weeks	Ambulatory surgery 8 weeks	
Clinical preparation in the office of the family doctor		
1 day a week (4-6 hours per day)	2-3 days a week (4-6 hours per day)	4-5 days a week (4-6 hours per day)

1.4 Program Implementers and residency bases

Main Clinical Base

Program is implemented by the Family Medicine Faculty and Cathedra of the State Medical Academy of Georgia.

The main clinical base used for the preparation of the family doctors is the Family Medicine Clinic of JSC “Medical Concern Curatio”.

Family Medicine Clinic of JSC “Medical Concern Curatio” has the appropriate loading (20-30 visits per working day). Hence, since the remuneration scheme for the patient medical service is based on the insurance principles, it gives the possibility to hold any necessary consultation and examination to the patient, which is necessary for the clinics involved in the residency program.

Below see the short history and description of the family medicine clinic of JSC “Medical Concern Curatio”.

The organization JSC “Medical Concern Curatio” performs its activities as a medical service provider from 1992. Till today it was the only commercial structure in Transcaucasia, which provided multi-profile and integrated medical care, from primary medical care to high technological specialized medical services.

From the day of its establishment the so called “Family Doctor’s service” is operating in our organization. Notwithstanding, that in those times (1992-1993 years) Georgia did not have such kind of specialty we still used the mentioned term to emphasize that the organization tries to embed the principles of family medicine and suggests the service of the family doctor. In parallel, the internal system of doctor preparation and continuous medical education was formed in our organization, which should have gradually contributed to the formation of our family doctors.

In 1995, the so called position of the deputy director in the field of science and education was officially created in our organization (Scientific Director), which was occupied by Givi Javashvili, PhD. His main function was to develop and manage the system of doctor's preparation, continuous medical education and quality control. Followed by, doctor preparatory and continuous medical education courses envisaged by the program are regularly held (lectures, seminars, and practical working cycles). In 1996, with the leadership of the scientific director and for the execution of the same functions, the strategic research and quality department was formed. On the basis of this department the system/program of the Curatio continuous medical education was established.

In 1996-1997 in the frames of the continuous medical education program the intensive process of family doctor preparation was going on. The objective of this program was to teach and improve the knowledge and skills of the Curatio doctors' considered by the competence of the family doctor (e.g. Courses in neurology, rentgenology, small surgery, rational antibiotic therapy and others prepared in the frames of the continuous medical education program). The mentioned courses are executed by the invited specialists/lecturers (L. Glonti, N. Pirmisashvili, D. Khazaradze and others) in accordance to the preliminary prepared program. The system of preparation process effective monitoring and evaluation was developed – weekly/gradual evaluation/tests and conclusive evaluation (materials are reflected in the attached documents).

In 1996, on the basis of coordination between JSC "Medical Concern Curatio" continuous medical education and UNICEF Children Disease Management Programs (Mr. Stefan Johnson, Ms. Ketii Nemsadze) the course on "Children diarrhea disease and acute respiratory disease management" was held, which contributed to the broadening of the competences of our family doctors in the mentioned field (children diseases).

In 1997, American Family Doctor Academy and American Medical Academy, on the basis of the continuous medical education broad program for the family doctors prepared the course adapted into the Georgian language, for the Curatio family doctors. The program was innovative at that time; particularly, the course was prepared into the Georgian language and the demonstration material was presented into two monitors (At that time Georgia did not have any computer projector at all). During each lecture, doctors were given booklets reflecting lecture materials in Georgian language (see the documents provided as annex). The material was submitted by Mr. Robert Klein, American family doctor from Sietle, who cooperated with our organization. The mentioned colleague participated in the preparation and performance of the several seminars.

By 1997, department for strategic research and quality prepared the charter of the family doctor's office (charter is attached), where the family doctor's competence and activity rules are determined together with the different aspects of the family doctor's office functioning. Different components of the document were gradually reviewed. For example, family doctor job description, including the description of the professional competences was reviewed and approved in 1999-2000. In 1999, the medical record keeping rule for family doctor was approved, in 2001 the new form of record keeping – medical map; hence, in 1999 the charter on the evaluation of the medical personnel was enacted, which covered family doctor activity evaluation criteria (see the attached documents).

From 1997 family doctor inter-organizational preparation and continuous medical education process was planned and implemented on the basis of the above-mentioned charter. In 1998-1999 several other cycles were held, which covered related specialty issues (ophthalmology,

otorinolaryngology, neurology, surgery and others). In addition clinical pharmacology wide course was also held.

From 1998 reviewed preventive programs were embedded into the Curatio family doctor service, from which the most important was the preparation and embedment of the asymptomatic disease screening scheme (see the asymptomatic disease screening scheme in the charter of the “family doctor’s office) and patient education program enactment. Curatio family doctors prepared many booklets and leaflets, the objective of which was to educate patients in disease primary prevention issues or to increase patient role in particular disease management (see annexes, patient education literature from the series “How to Maintain Health”).

In 2000-2002 our organization embedded the system of necessary updated information research and analysis and receipt of continuous medical education credit hours from US medical association required for the continuous medical education, through internet resource utilization. Family doctors participate in the mentioned programs not only as listeners, but as “lecturers”. They translate materials, prepare brochures and lecture themselves. In the frames of the mentioned system family doctors get updated information on gastroenterology, cancer screening, cardiology, asthma and allergy issues. In the frames of this program each doctor has received more than 10 US medical association first category CME credit hours (see the attached documents).

During this year one more course from pediatrics was arranged, which was held by active encouragement from the US health international alliance and Guramishvili pediatric clinic. Program was quite wide and covered more than 4 hours of preparation. Program was focused on the management of more frequent diseases in the children up to 5 years (see the attached documents).

It is worth mentioning, that Curatio family doctors participate in the process of professional standard improvement and in the preparation of different clinical recommendations (so called “guidelines”). As an annex see several samples of the recommendations.

1.5 Residency field bases

The list of the residency field clinical bases is provided at the title page.

1.6 Implementers

The following persons will participate in the program realization:

1. Guram Kiknadze – Program Director - Dean of the Faculty of Family Medicine of the State Medical Academy of Georgia, PhD, Professor.

2. Givi Javashvili – Head of the Cathedra of Family Medicine of the State Medical Academy of Georgia, PhD.

3. Tamar Gabunia – Lecturer of the Family Doctor National Center.

4. Nino Kiknadze – Doctor of the JSC “Medical Concern Curatio”, specialty – family doctor.

5. Ia Kipiani - Doctor of the JSC “Medical Concern Curatio”, specialty – family doctor.

6. Baka Tavkheldze - Doctor of the JSC “Medical Concern Curatio”, specialty – family doctor.

2. PRIVATE PART: ISSUES CONSIDERED BY THE PROGRAM

2.1 Approach to the Particular Issues of Professional Activity

The approach of the family doctor to the issues related with the professional activities should be based on the following evidences:

1. Patient psychological and economic impact on the patient itself and family.
2. Importance of the family on patient health status or life.
3. Working out the desire and skills of disease prevention and treatment methods in the patient.
4. Evaluation of the patient readiness and skills for changing life style.
5. Cooperation between patient and doctor.
6. The role of the socio-economic factors in revealing diseases and in their progress.
 - a. Cultural factors (family, society, ethnicity, religion)
 - b. Social-economic factors (Meal buying capacity, life conditions).
 - c. Psychical health role (Depression, anorexia, dimension, life conditions).
 - d. Health and life style (related circumstances, diseases, skills).
7. Besides medical, the role of the family, life style, interpersonal factors, society, profession, social situation and social perspective in the encouragement of the patient health.
8. Evaluation of the patient readiness and skills to change life style.
9. Working out the feeling of responsibility for the own health.
10. Importance of the doctor’s health, doctor working as positive model.
11. Examination and treatment restriction for the patient.
12. Multi-discipline approach to the patient care, evaluation of one’s own professional abilities, provision of the timely referral to the specialist, constant availability of the services and accountability towards patient.
13. Preliminary declared will and utilization of the authority of legal representative and restrictions.
14. Patient care continuousness and availability of medical care.
15. Effective working skills of health team with other members.
16. Environment selection, conversion with the members of the patient and his family, assessment, the skills of asking relevant questions and expressions to the patient and/or his family members while telling “bad information”. Considering the impact of process on patient and family.
17. Specific issues related to the women health care:

- a. Women refer to the medical services more frequently than men;
 - b. Role of the women in family health status in terms of medical service provision, feed selection and family care.
18. Specific issues related to the men health care:
- a. Men's desire to actively participate in the process of decision making.
 - b. Men refer to the health service very seldom and mostly in the extreme situations.
 - c. Men more frequently avoid referral to doctor on psychical health and sex dysfunction issues.
19. Specific issues related to the adult health care:
- a. Adult relation specifications towards one's appearance and dislike of one's appearance.
 - b. Effect of adult impact and encouragement.
 - c. Adult confrontational attitude towards society, parents and other people.
 - d. Adult sexuality, among them physical, psychological, moral, heterosexual, homosexual, bisexual and sex identification issues.
 - e. Adult feeling of safety and relation toward increased risk.
 - f. Confidentiality and relations between patient and doctor.
 - g. Health encouragement and working out prophylactic skills.
20. Specific issues related to the children health care:
- h. Support in children health.
 - i. Encouragement for the healthy life style of children and family members.
 - j. Infant and children care, which might demand special attention and consultation.
 - k. Social, cultural and other factors, which negatively affect children health.
 - l. Society education on environment factors, which might negatively affect children, and children health encouragement on society programs.
21. Problems related to the elderly, existence of chronic diseases, invalidity and death:
- a. Relation towards elderly, invalidity and death.
 - b. Support for patient defense in one's own care and maintaining skills.
 - c. Support for the patients involved in age and professional activity.
 - d. Psycho-social issues and family dynamicity which affects dying person.
 - e. Issues related to the other values while patient terminal situation.
 - f. Expenses.
 - g. Preliminary declared will and authorities of the legal representative.
 - h. Issues associated with the family and patient in terminal situation.
 - i. Exceptional cultural traditions of the family related to the death.
 - j. Personal relationship and experience on death and person in terminal situation and knowledge, how this experience will affect dying person.
 - k. Pain control of the dying.

2.2 Blood – Vessel System Knowledge

- I. Blood-vessel system anatomy and physiology.
- II. Changes of blood-vessel system physiological characteristics related to the age and pregnancy.
- III. Risk factors of blood-vessel system disease development.
 1. Heart ischemic diseases:
 - a. Hyperlipidemy
 - b. Smoking
 - c. Genetics
 - d. Adimania
 - e. Hypertension
 - f. Diabetics
 - g. Obesity
 - h. Feeding
 - i. Hormonal status
 - j. Emotional stress
 2. Heart valve diseases
- IV. Importance of anamnesis;
- V. Blood-vessel system physical examination;
- VI. Examination with non-invasion methods:
 1. Electrocardiography
 2. Breast rentgenography
 3. Loading test, both with treadmill and pharmacological means (testing procedure, result interpretation).
 4. Ecocardiography/doplerography in calm situation and loading both with treadmill and pharmacological means
 5. Radioisotope examination in calm and loading situation both with treadmill and pharmacological means
 6. Electrocardiography – monitoring in hospital and ambulatory conditions
 7. Vessel doplerography and ultrasound examination.
- VII. Examination invasion methods:
 1. Heart diagnostic catheterization and angiography
 2. Carotid and peripheral vessel diagnostic angiography
 3. Intracranial and peripheral vessel invasion examination with relevant equipment
 4. Inter vessel monitoring with appliances:
 - a. Central veneric and peripheral artery catheter
 - b. Monitoring of homodynamic with balloon flotation catheter
 5. Electrophysiological examinations

6. Medicative invasion positive and negative features:
 - a. Aortocoronary operation
 - b. Angioplasties and stent implantation
 - c. Rhythm (pacemaker) implantation
 - d. Valve change/recovery. Balloon valve anatomy
 - e. Electrophysiological ablation

VIII. Interpretation of the results of laboratory examinations, among them Ferment, izoenzyme and lipid determination:

IX. Specific diseases/situations

1. Heart ischemic disease
 - a. Stable/unstable angina
 - b. Myocardial infarction, complex and simple
 - Cardiogenic shock
 - Arrhythmia
 - Myocardial dysfunction
 - Shock
 - Aneurysm
 - c. Sudden death
2. Heart disease
3. Arrhythmia
 - a. Tachycardia
 - Upper
 - In heart
 - Reentrant
 - b. Bradycardia
 - c. Ectopic rhythm:
 - Front heart
 - In heart
4. Hypertensive:
 - a. Essential
 - b. Secondary
 - c. Lung artery
5. Lung heart
6. Heart failure
 - a. Systolic dysfunction
 - b. Diastolic dysfunction
7. Thromboembolic disease
8. Heart valve disease
 - a. Rheumatic
 - b. Congenital

- c. Degeneration
- d. Mitral valve prolapsed syndrome
- 9. Heart diseases from birth
 - a. Shunting mainly from left to right (atsianozic)
 - b. Shunting mainly from right to left (tsianozic)
 - c. Problems caused by obstruction
- 10. Layer aneurism
- 11. Heart pains (functional)
- 12. Peripheral vessel diseases
 - a. Aneurism
 - b. Carotidal atherosclerosis
 - c. Artery diseases
 - d. Maobliteral atherosclerosis
- 13. Cardiomiopathis
 - a. Dilatational
 - b. Restrictional
 - c. Hypertrophial cardiomiopathy
 - d. After birth giving
- 14. Pericardium disease
- 15. Disease caused by infectious
 - a. Virus miocardite
 - b. Acute bacterial endocarditic
 - c. Kawasaki disease
- 16. Heart other damages
 - a. Immune:
 - Acute rheumatic disease
 - Autoimmune diseases
 - b. Psychogenic
 - c. Traumatic
 - d. Feeding
 - e. Mixsom
 - f. Dysfunction
 - g. Marpan syndrome
 - h. Caused by medications, particularly by cocaine, steroid and chemical therapy
- 17. Examination of the cardiological patients during non-cardiological operations:
 - a. Cardiological risk assessment before operation – assessment tests
 - b. Management before and after operations
- 18. Valve disease prophylactic treatment with antibiotics

X. Cardiovascular pharmacology Skills

I. Diagnostic

1. Anamnesis and physical observations

2. Electrocardiography and interpretation
3. Breast roentgenogram interpretation

II. Medicative

1. Risk assessment and management
2. Reanimation activities
3. Rhythm damage treatment
4. Myocardium acute infarct management, care after infarct period and complication management
5. Heart failure
6. Hypertonic crisis
7. Supervision and management during rehabilitation period
8. Psycho-social issues
 - a. Sex life
 - b. Depression
 - c. Family relations
9. Patient management after surgical operations:
 - a. Change of the life style
 - b. Patient management after aorta-coronary shunting
 - c. Patient management after valve operations
 - d. Patient management after surgical operations on heart disease
 - e. Patient management after heart catheterization.

2.3 Infant and children care Knowledge

I. Fetal and neonatal periods

1. Pregnancy period risk-factors
2. Mother's sickness, pregnancy and birth giving impact on infants.
3. Adaptation to the real life
4. Diagnostics and management of the situations listed below:
 - a. Meconium composition amniotic fluid
 - b. Perinatal asphyxia
 - c. Respiratory distress
 - d. Cyanosis
 - e. Apnoea
 - f. Convulsions
 - g. Hypoglycemia
 - h. Sepsis development risk assessment
 - i. Dislocation articular
 - j. Birth giving trauma
 - k. Anemia
 - l. Blood difference (rh factor, according to group)
 - m. Polycythemia
 - n. Icterus

o. Early and late pregnancy

II. Healthy infant and children care

1. Recommended examinations from birth to 12 years and its periods
2. Supervision of age and growing factors
 - a. Cutting
 - b. Feeding
 - Natural feeding
 - Feeding from bottle
 - Adding other meals
 - Allergy prevention
 - c. Temperament and behavior
 - d. Development stages
 - Development screening tests
 - e. Family and social relations

III. Early born infant

1. Characteristics of early born infant care and supervision

IV. Physical development

1. Feeding
2. Development and calorie requirement
3. Normal development and its options
 - a. Tooth development

V. Disease and trauma prevention

1. Automobile catastrophes
2. Sink in water
3. Aspiration
4. Intoxication
5. Gun
6. Falling
7. Safety during riding bicycle
8. Wounded
9. Force against children
10. Pesticide usage
11. Calcium deficit amenity screening
12. Immunization calendar
13. Other negative factors

VI. Infant immediate dying syndrome

VII. Psychological disorder

1. Family identification where there is more risk between parent and child relations or psycho problems
2. Assessment of the below listed situations, treatment and sending to consultation
 - a. Feeding, eating and other problems
 - b. Somatic and sleeping disorders
 - c. Compulsion syndrome
 - d. Mood disorders
 - e. Hyperactive/impulse and inattentive behavior

VIII. Social and ethical issues

1. Adoption
2. Divorce, parents living apart and death
3. Family impact, impact on medication and alcohol
4. Force against children
5. Refusal to carry out activities of life maintenance

IX. Genetics

1. Screening tests
2. Genetic disorder diagnostics and consultation with the specialist

X. Invalidity related to the development disorder

XI. Infant and children medical problems: revealing, management and usage of relevant specialists

1. Allergic disorders
 - a. Asthma
 - b. Atrophy
2. Inflammatory diseases
 - a. Juvenile rheumatoid arthritis
 - b. Vascular syndrome
3. Kidney anomalies
4. Urological problems
 - a. Urine infectious, pielonephrite
 - b. Urine reflux
 - c. Hypospady, urine prolapse and others
 - d. Enurez
 - e. Criptokrizm
5. Endocrine/metabolic and feeding problems
 - a. Hypo and hypertireodizm
 - b. I type diabetics
 - c. Obesity

- d. Development disorder
- e. Anomaly development: big or little body
- 6. Neurological problems
 - a. Convulsions
 - b. Headache
 - c. Heart disease
 - d. Crying
 - e. Psychometric disorders/cerebral disease
 - f. Sensor deficit
 - g. Movement disorders
- 7. Frequent dermatological disorders
 - a. Atopic dermatitis
 - b. Virus exanthemas and enantems
 - c. Bites and wounds
 - d. Bacterial and other infectious
 - e. Infectious diseases
 - f. Redness
 - g. Urinary and multiphorm eritem
 - h. Wounding
- 8. Orthopedic problems
 - a. Articular dispassion
 - b. rotational problems
 - Rotation in and out
 - Metatarsus adducts
 - c. Scoliosis: Idiopathic and gained
 - d. Aseptic necroses
 - e. Epipizeolize
 - f. Braking and other wounds
- 9. Digestive system
 - a. Diarrhea, virus and bacterial gastroenteritis
 - b. Parasite invasion
 - c. Hepatitis
 - d. Colika
 - e. Gastroezophag reflux
 - f. Feeding and malabsorption
 - g. Pilors stenosis
 - h. Invagination
 - i. Apendisite/peritonite
 - j. Chronical aches in stomach
- 10. Heart
 - a. Heart disease from birth
 - b. Asymptotic ache disorder

- c. Ache in heart
- 11. Respiratory system
 - a. Upper respiratory system virus infectious
 - b. Respiratory system reactive disease/asthma
 - c. Phibrose
 - d. Bronchioles
 - e. Aspiration
 - f. Virus and bacterial pneumonia
 - g. Whooping Cough
 - h. Tonzilite/paringite/sinusite/absess
 - i. Epiglottises and other differentiations
- 12. Ear
 - a. Midyear infectious: acute with liquid
 - b. Outer hearing line infectious
 - c. Loss of hearing
 - d. Other ear diseases
- 13. Eye
 - a. Amblyopic
 - b. Strabismus
 - c. Stenosis
 - d. Vision lackage
- 14. Children different infectious
 - a. Bacterial infectious
 - Diphtheria
 - Chickenpox
 - b. Virus infectious
 - Measles
 - Mumps
 - Rubella
 - Chickenpox
- 15. Serious infectious
 - a. Sepsis and sepsis syndrome
 - b. Meningitis, entsepalite
 - c. Streptococcus and stapilokok infectious
 - d. Osteomielite
 - e. Immunodeficit virus
 - f. Ray syndrome
 - g. Etiology

- 16. Neoplasm in children
 - a. Valise cancer
 - b. Retinoblastics
 - c. Neuroblastoma

- 2.4 Emergency medical care
- 2.5 Terminal patient medical service
- 2.6 Surgical patient treatment
- 2.7 Medical genetics
- 2.8 Medicament utilization without prescription
- 2.9 Medical ethics
- 2.10 Health encouragement and disease prophylactics
- 2.11 Office laboratory medicine
- 2.12 Evidence based medicine
- 2.13 Risk management and professional responsibility
- 2.14 Medical informatics and computers
- 2.15 Sport and recovery medicine
- 2.16 Patient education
- 2.17 Management issues
- 2.18 Alergology and immunology
- 2.19 Motherhood and gynecological problem management
- 2.20 Feeding
- 2.21 Dermatological diseases
- 2.22 Women health
- 2.23 Men health
- 2.24 Adult health
- 2.25 Elderly care
- 2.26 Neurology
- 2.27 Ophthalmology
- 2.28 Professional disease
- 2.29 Behavior and psychical health
- 2.30 Aid and HIV infectious
- 2.31 Articular system
- 2.32 Rheumatic diseases

Skills

- I. Anamnesis and physical examinations according to age
 - 1. Height, weight and head radius recording on the paper
- II. Assessment with Apgar scale
- III. Using standard questions for assessing concentration damage and its evaluation
- IV. Screening tests of vision and hearing assessment and also timpanogram interpretation
- V. Scoliosis screening and ventricle roentgenogram assessment

VI. Infant and children reanimation

VII. Venafunction

VIII. Calculating of transfusion liquid and electrolytes

Annex 14: The list of employment positions for medical personnel with relevant education

Is submitted to the Ministry of Justice for expertise

Decree of the Minister of Labor, Health and Social Affairs

On “the list of employment positions for medical personnel with relevant education”

In accordance to the point 3, article 54 of the law of Georgia on “Health Care” and article 17 of the law of Georgian on “Doctor’s Activities”

Declare:

1. Approve the attached list of employment positions for medical personnel with relevant education.
2. Abolish the decree of the Minister of Labor, Health and Social Affairs #421/n, November 29, 2001 on the list of employment positions at the medical institution with relevant education for medical personnel.
3. Enact the law upon publishing.

Amiran Gamkrelidze

Annex

The list of medical personnel with the right of employment in the medical institution and with relevant education

#	Medical education type, faculty	Granted qualification	Position that can be taken on the basis of existing qualification
1.	High medical institution, faculty		
1.	Medicative, pediatrics and military doctor faculty	General profile <ul style="list-style-type: none"> • Curative • Pediatrics • Military doctor (for the graduates including 2002)	Multiprofile medicative-prophylactic institution acceptance department doctor, emergency medical care station non-specialized team doctor, ambulatory-polyclinic association district doctor, medical institution junior doctor, all pedagogical and scientific position in the theoretical fields of medicine – according to the existing legislation
		Doctor specialist after graduating field residency	Medical institution, doctor-specialist (all the positions) in the residency specialty, all scientific and pedagogical positions - according to the existing legislation

#	Medical education type, faculty	Granted qualification	Position that can be taken on the basis of existing qualification
		Doctor (for the graduates of 2003 and later)	Medical institution junior doctor, all scientific and pedagogical positions in the theoretical fields of medicine - according to the existing legislation
2.	Stomatological faculty	General profile doctor-stomatologist, (for the graduates including 2002)	Non-specialized stomatological cabinet, specialized stomatological institution doctor on duty, emergency medical care station stomatological team doctor, stomatological profile medical institution junior doctor, all profile scientific and pedagogical positions in the theoretical fields of medicine - according to the existing legislation
		Doctor-stomatologist (specialist after graduating field residency)	Medical institution, doctor-stomatologist specialist (all positions) in the residency specialists, all profile scientific and pedagogical positions - according to the existing legislation
		Doctor-stomatologist (for the graduates of 2003 and later)	Stomatological profile medical institution junior doctor, all profile scientific and pedagogical positions - according to the existing legislation
3.	Public health, prophylactic medicine faculty	General profile <ul style="list-style-type: none"> • Doctor prophylactic health manager (for the graduates including 2002) 	Public health, sanitary and quarantine supervision service doctor prophylactic (except the head), medical institution ordinary manager, medical institution junior doctor prophylactic, all profile scientific and pedagogical positions - according to the existing legislation
		Specialist (after graduating field residency)	Medical institution doctor-prophylactic health care organizer – manager (all the positions) in the residency specialties; doctor epidemiologist, doctor proppatholog, doctor-laboratory worker, all profile scientific and pedagogical positions - according to the existing legislation
		Doctor-prophylactic, health manager (for the graduates of 2003 and later)	Public health, sanitary and quarantine supervision service junior doctor prophylactic (all the positions), medical institution ordinary manager, all profile scientific and pedagogical positions - according to the existing legislation
4.	Medical biology department	General profile doctor-laboratory worker (for the graduates including 2002)	General profile doctor –laboratory worker, medical institution diagnostic laboratory junior doctor-laboratory worker; all profile scientific and pedagogical positions - according to the existing legislation
		Laboratory worker (after graduating field residency)	Medical profile specialized diagnostic laboratory specialist (all the positions) in the residency specialties, all profile scientific and pedagogical positions - according to the existing legislation

#	Medical education type, faculty	Granted qualification	Position that can be taken on the basis of existing qualification
		Doctor-laboratory worker (for the graduates of 2003 and later)	Medical institution diagnostic laboratory junior doctor-laboratory worker; all profile scientific and pedagogical positions - according to the existing legislation
5.	Psychotherapy and psycho medicine faculty	General profile doctor-psychotherapeutics (for the graduates including 2002) Doctor-psychotherapist – specialist	Medical institution general profile doctor therapeutics, all profile scientific and pedagogical positions - according to the existing legislation Medical institution doctor psychotherapeutics, all profile scientific and pedagogical positions - according to the existing legislation
6.	Pharmaceutical department	General profile pharmaceutics (for the graduates including 2002) Pharmaceutics – specialist (holder of the relevant certificate)	In the pharmaceutical institution general profile pharmacist (all the positions), among them in drugstore, in the pharmaceutical base, pharmaceutical enterprise, all profile scientific and pedagogical positions - according to the existing legislation In the pharmaceutical institution in all the positions in the specialties determined by the certificate; all profile scientific and pedagogical positions - according to the existing legislation
I.	High not medical education		
1.	Biological and biochemical specialties	Laboratory general profile specialist – master Laboratory worker – master (after the special training, holder of the relevant certificate)	General profile laboratory worker position Medical profile specialization laboratory certified specialist all the positions
2.	Medicative physical culture and rehabilitation	Medicative physical culture and rehabilitation specialist	Medicative-prophylactic institution rehabilitation position
II.	Secondary medical institution		
1.	Medicative department	Mid-wife	Secondary medical personnel all the positions, among them head
2.	Gynecology department	Gynecologist	Mid-wife and nurse (mid-wife point and children's room) registration head, sanitary education and medicative physical culture instructor, medical statistician

#	Medical education type, faculty	Granted qualification	Position that can be taken on the basis of existing qualification
3.	Nursing department	Nurse	Nurse (all the positions), sanitary education and medicative physical culture instructor, medical statistician
4.	Laboratory diagnostics department	Mid-wife laboratory worker	Laboratory secondary medical personnel, medical statistician
5.	Orthopedic stomatology department	Dentist technician	Proteases department medical personnel, dentist-technician
6.	Pharmacy department	Assistant pharmacist	Secondary pharmaceutical personnel (all the positions, head among them)

Annex 15: The approval of the list of nurse related specialties and those received after postgraduate professional education

Decree

of the Minister of Labor, Health and Social Affairs

April 15, 2004

Tbilisi

#80/n

On the approval of the list of nurse related specialties and those received after postgraduate professional education

In order to implement sub-point “a” and “c”, point 1 of the article 32 of the law on “Health Care”

Declare:

1. Approve:

- a) The list of nurse specialties received after postgraduate professional education (annex A);
- b) The list of nurse related specialties (annex B);

2. Decree is in force upon publishing.

Giorgi Tsereteli

Annex 15A: The list of nurse specialties received after postgraduate professional education

**Is approved by the
decree #80/n
of the Minister
of Labor, Health and Social Affairs
April 15, 2004**

1. Nurse activity organizer
2. General practitioner nurse
3. Surgeon nurse
4. Anesthesiology nurse
5. Critical situation medicine nurse
6. Pediatric nurse
7. Gynecology
8. Laboratory activity
9. Medicative-diagnostic nurse
10. Hygiene-epidemiology nurse
11. Public health care nurse
12. General practitioner (community) nurse
13. Orthopedic stomatology
14. Transfuziology nurse
15. Psychiatry nurse

Annex 15B: The list of nurse related specialties

Is approved by the
decree #80/n
of the Minister
of Labor, Health and Social Affairs
April 15, 2004

#	Specialties	Related Specialties
1	Nurse activity organizer	
2	General practitioner nurse	<ul style="list-style-type: none"> • General Practitioner (community) nurse • Surgeon nurse
3	Surgeon nurse	<ul style="list-style-type: none"> • General practitioner nurse
4	Anesthesiology nurse	<ul style="list-style-type: none"> • Critical situation medicine nurse
5	Critical situation medicine nurse	<ul style="list-style-type: none"> • Anesthesiology nurse
6	Pediatric nurse	<ul style="list-style-type: none"> • General Practitioner (community) nurse
7	Gynecology	
8	Laboratory activity	
9	Medicative-diagnostic nurse	
10	Hygiene-epidemiology nurse	<ul style="list-style-type: none"> • Public health care nurse
11	Public health care nurse	<ul style="list-style-type: none"> • General Practitioner (community) nurse • Hygiene-epidemiology nurse
12	General practitioner (community) nurse	<ul style="list-style-type: none"> • General practitioner nurse • Pediatric nurse • Public health care nurse
13	Orthopedic stomatology	
14	Transfuziology nurse	
15	Psychiatry nurse	<ul style="list-style-type: none"> • General practitioner nurse • Critical situation medicine nurse

Annex 15C: The list of nurse specialties received after postgraduate professional education

(Is not approved yet)

#	Specialties	Relevant specialties
1	Nurse activity organizer	<ul style="list-style-type: none"> • Medical institution chief nurse; • Department chief nurse
2	General practitioner nurse	<ul style="list-style-type: none"> • Therapy nurse; • Receipt nurse; • Infectious department nurse; • Urology nurse; • Cardiology nurse; • Endocrinology nurse; • Neurology nurse; • Psychiatry nurse; • TB nurse; • Ophthalmology nurse; • Gynecology department nurse; • Surgical department nurse;
3	Surgeon nurse	<ul style="list-style-type: none"> • Operation nurse; • Bond nurse; • Institution nurse working with surgical profile (Traumatology surgery, orthopedic surgery, oncological surgery, angiosurgery, cardio surgery, plastic surgery, neurosurgery, face surgery, transplantology, laparoscopy, Otorhynolaringology, Optalmological surgery, gynecology surgery).
4	Anesthesiology nurse	<ul style="list-style-type: none"> • Department anesthesiology nurse; • Intensive therapy nurse;
5	Critical situation medicine nurse	<ul style="list-style-type: none"> • Critical situation medicine department nurse; • Emergency care department nurse; • Intensive therapy nurse;
6	Pediatric nurse	<ul style="list-style-type: none"> • Nurse neonatology; • Nurse working with pediatric profile;

#	Specialties	Relevant specialties
7	Gynecology	<ul style="list-style-type: none"> • Midwife; • Gynecology department nurse; • Women consultation midwife;
8	Laboratory activity	<ul style="list-style-type: none"> • Clinical; • Bacteriological; • Biochemical; • Hematological; • Serological; • Immunology laboratory secondary nurse;
9	Medicative-diagnostic nurse	<ul style="list-style-type: none"> • Functional diagnostics nurse; • Radiology nurse (Ultra light therapy, radio-oncological diagnostics, computer tomography, magnitude-resonance tomography, X-Ray); • Physiotherapy nurse; • Nurse-masseur; • Medicative physical culture nurse;
10	Hygiene-epidemiology nurse	<ul style="list-style-type: none"> • Nurse-disinfectant; • Nurse-dietologist; • Nurse-hygienist; • Infectious control nurse; • Nurse-epidemiologist; • Nurse-parasitologist;
11	Public health care nurse	<ul style="list-style-type: none"> • School nurse;
12	General practitioner (community) nurse/family nurse	<ul style="list-style-type: none"> • Practice nurse; • District nurse;
13	Orthopedic stomatology	<ul style="list-style-type: none"> • Stomatological cabinet nurse; • Dentist;
14	Transfuziology nurse	<ul style="list-style-type: none"> • Transfusion nurse; • Blood transfusion cabinet nurse;

Annex 16: Paper on proposals for nursing policy in Georgia

Nursing Policy in Georgia

(Concept and main goals)

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Archil Kapanadze

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During the last quarter of 20th century WHO developed strategy "health for all" which, after elaboration, will become foremost point of world health care organization and management in XXI century. Above - mentioned strategy emphasizes the health maintenance of the population, what is undoubtedly progressive achievement. Main principles of WHO strategy were implanted in "Policy of National Health Care Development" in Georgia where we read: "We face a challenge to elaborate and develop national health care policy, the main target of which is not only establishment of perfect health care services, but maintenance of health of whole population." It's known that reforming of health care system is world wide phenomena. Even affluent and welfare communities couldn't evade this process, as it is the demand of life: there is dairy necessity of transforming patient's treatment oriented health care system into health maintenance one. By publishing the Policy of Georgian National Health Care Development, Georgia joints the states that offer their population reforming health care system founded on scientific knowledge and publicity.

Introduction

WHO considers the nursing practice as the main guaranty for implementation its general principle "health for all", that is reflected in several resolution of WHO (WHO 42, 27; 45.5; 48,8; 49,1, etc). WHO reckons that member states couldn't use their potential abilities both in treatment process and especially in disease prevention and management of health care system. Therefore, WHO applies to the member countries to use completely their resources in health care reforming process. So nursing practice, as the part of health care, is undergoing changes, that is worldwide process supported and promoted by WHO.

Importance of problem

In the process of reforming and reorientation of health system in Georgia we encountered the sheer necessity to set up nursing as independent profession. During changing economical relationships we observe drastic decrease in nurses wages. At the same time, nurses are medical professionals discharged in first place on grounds of redundancy. Persons with physician diplomas are employed as nurses instead of them. (Soviet nursing system considered nurse as the beginning step for physician). According to such judgement, it would be beneficial to employ highly-educated specialists for particular job. By our point, the attitude is entirely

unacceptable because of social (unjustified reduction nurse's working places) and professional reasons (particular work performed by nonprofessionals).

The nursing practice is the science and at the same time the art. It demands special education. It's built on the achievements of humanity.

Hence, nursing reform in Georgia has got both professional (setting up nursing as independent profession for performing qualified medical care) and social consequences (employment of about 30 000 nurses in Georgia and assurance of worthy payment for them).

Conception of nursing reforms in Georgia

Nursing practice reforms proceed distinctly in different countries. In Western countries the issue of main importance is training of leader nurses in order to amplify nurses involvement in planning and management of health care processes. In post-soviet countries (which have the similar problems in nursing practice as we have) reforms in nursing practice are characterized by specific traits. Some countries began reforms by changes in educational system expressed only in establishment Nursing faculties at Universities and set-up model colleges. All these initiatives weren't supported with structural changes in nursing practice, Other countries built demonstrative clinics and departments, where the recent achievements in organization of nursing practice were implemented. In the later instance problems of whole network remain unsolved. We consider such attitudes unilateral, as they are deprived of systemic viewing of problem.

5 years experience of work on nursing practice reforms, along with advice of foreign partners and experts consultations, brought out that reforms should be based on holistic approach i.e. reviewing problem as whole entity. Hence, conceptual issues of nursing practice reforms in Georgia can be brought under two categories: 1. Professional tasks (goals); 2. Management tasks (goals).

1. The main goals of development of nursing as independent profession:

- There is necessity to determine a model nurse i.e. the field of nurses activity, their rights and responsibilities, range of specialties;
- There is need to set up the model of nursing as profession, that implies establishment steps of nurses grow-up in their career, determination of profiles spectrum, elaboration of conceptual basis for pedagogical and scientific work;
- There is need to build up such a pre-diploma, post-diploma and continuing educational system, which can satisfy growing demand for qualified nurses, wide range of nurses specialties, performance of pedagogical and scientific work.

Possible strategy for development of nursing as independent profession in Georgia

- Establishment of a nurse model, that implies determination of nurses rights and responsibilities, range of specialties, field of their activity. To fulfill this goal we should base on definition of nursing practice offered in report of a WHO Expert Committee (Nursing Practice Report of a WHO Expert Committee 1996).

Nursing practice helps the person family physical, mental and social potential and to act correspondably in changeable environment, the health care accomplice measures. The nursing practice also means the planning of care and realization during the disease or rehabilitation process. The physical, mental and social aspects have an influence on the health, patient, disease, helplessness, death.

Nursing practice helps person's family or his friend's or social groups or community's active drawing into the health care's all aspects and this will help to rise the personal responsibility and to get personal decision to create the healthy environment.

The definition completely reflects up-to-date scientific achievements in study of nursing practice that, compared with our own experience, let us elaborate recommendations expressing whole nursing practice potential.

- A nurse model: stages of nurses grow-up during their career, profiles spectrum, opportunities of pedagogical and scientific work; To attain above - mentioned goals, we can base on structural outlines elaborated by us (see appendix 1). Such coordination between educational level and professional responsibilities let us build distinct employment policy for nurses.
- Pre-diploma, post-diploma and continuing educational system for nurses. To solve the problem, we can emerge from structural plan of educational system development offered by us (see appendix 2).

This type of education gives opportunity to provide nursing practice with highly-qualified professionals and resolve the problem of employment by changing the specialty or by attaining new professions (for example: care-giver, social worker, family nurse and so on). Introduction of university - based nursing education let us provide (supply) nursing practice with qualified nurse-trainers, capable to extend potential of continuing education system for additional training and speed up resolution of such socially painful problem as additional training is.

2. The main goals for establishment of nursing practice management system in Georgia

- Create legislative foundation for regulation of nursing practice as independent profession;
- Create the mechanisms for social - based regulation;
- Create the mechanisms for state level regulation of nursing practice as independent profession;

Possible strategy for elaboration of nursing practice management system in Georgia:

Create legislative environment in Georgia allow to create law for nursing practice regulation and it's main principles.

Legislative environment includes the Constitution of Georgia (foremost law of Georgia), Georgian laws related to health care, law of the private enterprise, law of professional unions, law of social alliances and so on. We should also mention here orders of the Ministry of Health Care, National Policy of Health Care Development in Georgia.

To take heed of existing legislative environment, we can work out the low, which allow:

- To maintain existing working place for nurses;
- To create new working place by transforming nurses grow-up pattern during their career and profiles spectrum;
- To build a new educational system for nurses with pre-diploma, post-diploma and continuous educational opportunities;
- During transitional period to set up strong state system of social guaranties in case of redundancy, that let the nurses get new profession (for instance: care-giver, social- worker, family nurse, ect);
- To create favorable environment for women (who are the overwhelming majority of nurses) for promotion their social activity and defend their rights.

Create mechanisms for state control of nursing practice as independent profession.

After review of world experience was found two types nursing practice state regulation:

- 1) Nursing component is dispersed among different state programs. Nursing practice isn't coordinated and its problems aren't mandated as whole entity. Nurses don't participate in construction of health care policy of country;
- 2) The main state official in nursing issues is advise (counselor). It's hard to arrange regional problems of nursing practice. Nurses don't take part in formation of health care policy of country.

According to the results of several studies, authors concluded: for complete realization of professional and social capacities of nursing practice, it is indispensable to create executive type official portion of nursing practice. Characteristics of above - mentioned position see in appendix 3.

Nursing reform and development of nursing practice would be state priority. This reform renders 30 000 nurses directly and 120 000 their family members implicitly. So we can imagine social meaning of the reform. Therefore, the state is bounded to regulate, coordinate and fund reforms. To perform such immense work, it's necessary to set up state regulative board. Taking notice of WHO recommendations and scientific conclusions, we think it's necessary to found powerful nursing practice regulative department (board) at Ministry of Health Care of executive type, which can coordinate health reforming process of nursing component.

See the possible pattern of state regulation for nursing practice (appendix 4).

See list of possible directions in work of nursing practice department (appendix 5).

Create the mechanisms for social regulation of nursing practice.

Nowadays there are several non-governmental organizations in Georgia, activity of which includes caring for nurses problems, but they can't substitute Georgian Nurses Association in raising nurses social role, engagement of nurses in social affairs, control of professional standards and plenty of other necessary activities that is performed by Georgian Nurses Association during the last 3 years. Georgian Nurses Association is highly reputable not only for

nurses of Georgia but also by foreign colleges. This respect was gained by prolific work in partnership relations. The result of such cooperative work is different courses of continuous education carried out by nurse - trainers, members of GNA, new educational system containing of the highest level nursing education, policy of nursing practice reform and so on. In spite of special personal interest and involvement of Ministry of Health Care Mr. Avtandil Dgorbenadze in nursing problems and existence of official adviser's position in nursing issues at Ministry of Health Care, we state that with out having powerful executive type board, it will be impossible for GNA fully express its potential capacity.

Obvious example of cooperation between state and social boards will have been transferring particular duties by state organization to the social one. For instance, to make licensing issue prerogative of GNA.

Implementation of nursing practice reforms, by our point view, seems to be impossible if we don't perform first and foremost work: create executive type state board for regulation of nursing practice - special department at Ministry of Health Care.

Ensuing from above - mentioned goals and strategy of their implementation, we offer order project of Minister of Health Care of Georgia (appendix 6).

After foundation nursing issues department, it will be possible to elaborate "National program for development of nursing practice". We offer extended version of the project in appendix 7.

Dealing with management of nursing practice in this way, allows to establish strong basis for implementation and achievement the main principle of national health care policy - to change the stress from treatment of patient to health maintenance.

Career structure of Nursing as an independent profession

1. Clinic

Staff	Main duty	Education
Junior Nurse	Patients nutrition and hygienic care	6-9 month course of care
Chamber Nurse	The life-giving restrictions diagnostic and care according to main disease of patient	College. General practice Nurse
Procedure Nurse	The organization of procedures for patient according to the main disease	College. General practice Nurse
Department Chief Nurse	Organization and inspection of Nursing practice in department	College+qualification or high school education
Hospital Chief Nurse	Organization and inspection of Nursing practice in hospital	College+qualification or high school education

2. Ambulatory – policlinic unit

NATIONAL PROGRAM OF DEVELOPMENT NURSING PRACTICE (PROJECT OF EXTENDED PLAN)

For set-up and development of nursing practice as independent profession, it is indispensable:

1. Estimate current situation:

- Estimate human resources (quantity of nurses, their age distribution, their distribution due to specialties, their educational level);
- Estimate working resources (equipment for work, working condition due to specialties);
- Estimate educational resources (professional educational facilities, their capacities);
- Estimate social and organizational resources inside the profession (state organizational pattern, social alliances).

2. Future model:

Modern nurses model

- **Who is a nurse** (her role in patient care process, right and duties);
- Place of a nurse in clinic (nurse as representative of an independent profession);
- Place of a nurse in health care system (nurse as the indispensable professional in health care and promotion of healthy life).

Model of the nursing as independent profession

- Intra professional spectrum of nursing (specialties)
- Intra professional spectrum of nursing (positions)

Desirable working resources for accomplishment nurse's duties;

For supplement nursing care with highly-qualified professionals, appropriate educational system (pre-diploma /medium and high-level/, post-diploma and continuous education);

- Curriculum for each educational step; .

Desirable organizational and social resources inside the profession organizational pattern, social alliances);

3. Transitional stage from the current to future model:

- Supplementation with human resources for fulfillment all items of I paragraphs;
- General description of transitional stage;
- Description of transitional stage in regard of time and meaning.

PROJECT BRIEF

Nurse education system strategy formulation in Georgia

1. Introduction

1.1 Analysis of the existing situation

Nurse education issue has been acutely revealed during nurse activity reform process. The existing system of basic and continuous education does not satisfy nurse activity requirements, as independent profession. University education requirement, new ideas, which were embedded in the nurse activity concept, caused research in different directions.

The research process, which was not full of united strategic vision, caused education principle and accordingly education program distribution.

1.2 Problem Nature

The existing multi profile nurse education centers (medical colleges, family nurse preparation centers, secondary medical personnel training institutions, continuous medical education center – nurse component, new partner centers – Mother’s and children health care center in Kutaisi, Mtskheta-Mtianeti region, nurse school in Tbilisi) do not unite education programs and teaching methods and do not coordinate education process. State interests are not taken into account through qualification and employment aspects and due to the lack of unified strategic vision.

1.3 Possible ways of problem solution

Formulating unified state strategy for nurse education is necessary. It will be based on new vision of the nurse activity, as independent profession. This approach will give the possibility to educate the specialists of relevant qualification. The problem of 30 000 nurse unemployment should be solved through state interests.

2. Work plan

- 2.1 The detailed analysis of the existing situation in nurse education in Georgia.**
- 2.2 Determine the quality of imbalance between nurse education institutions and programs (analysis of existing programs and teaching methods and its compilation).**
- 2.3 Consultations with the specialists.**
- 2.4 Conference with the participation of the appropriate specialists to discuss the intermediary option of the strategy.**
- 2.5 Create monitoring principles and system for the formulated strategy.**

3. Strategy presentation conference

4. Project implementation possible results:

The implementation of the given project will give the possibility to:

- Work out nurse education unified strategy in Georgia in the frames of “Nurse Policy in Georgia”.
- It will become possible to discuss in one concept the basic, university and continuous medical education problems, which will give the possibility to unite different teaching programs and methods in one strategy.
- And finally continuous medical education strategy in Georgia will give the possibility to execute education process in the nurse activity the way to get nurse of relevant education and qualification and solve social problem in nurse activity.

5. Program possible duration: April 2001-December 2001

6. Program possible cost: 15 000 Laries

7. Program budget

7.1 Office expenses

#	Name	Quantity	Cost in Laries
1	Computer	1	1 200
2	Printer	1	600
3	Technical up-grader	2	800
4	Computer table	1	200
5	Copy Machine	1	1 000
6	Cupboard	2	500
7	Chair	5	177
8	Binder	20	120
9	Paper	10	100
10	Files	10	400
11		Total	5 097

7.2 Salary (monthly)

#	Name	Quantity	Cost in Laries
1	Program manager	1	130
2	Working group member	4	480
3	Consultant	2	160
4	Operator	1	70
	Total:		840

Total Program budget - (April 2001-December 2001)

#	Title	Quantity	Cost in Laries
1	Personnel work remuneration	8	7560
2	Taxes from the employer Among them: - Social state fund 27% - Medical insurance state company 3% - Employment state fund 1%		2343,60 2041,20 226,80 75,60
3	Office expenses		5097.00
	Total:		15 000 Laries

PROJECT BRIEF: NURSE ACTIVITY MODERN SITUATION ASSESSMENT AND CREATING STATE SYSTEM OF RECORDING

1. Introduction

1.1 Analysis of the existing situation

The issue of reforming nurse activity in accordance to the modern requirements became essential in the process of health care system reform and reorientation in Georgia. In the conditions of transferring into new economic relations, the significant decrease in nurse salary and worsening of their professional and social situation is being mentioned. At the same time the recording system existing in the latest years, as a result of transferring from one economic formation into another has been revealed in the nurse activities. Only the tentative numbers reflecting 90-ies do exist.

1.2 Problem nature

As a result of management theory, knowledge of the management system situation is necessary. The more complete is this knowledge the more effective will the management be.

Nowadays, in the nurse activities, due to the lack of recording and statistical monitoring we have only tentative idea on nurse activity as a necessary main parameter for entire system of state management. Hence, implementing state management in the nurse activity is quite difficult.

Proceeding from the above-mentioned, for the effective implementation of the state management in nurse activity the detailed analysis and creating state system of recording is necessary.

1.3 Possible ways of problem solution

The only effective way of problem solution is creating state system of recording in nurse activities.

2. Work Plan

2.1 Assessment of the human resources existing in the nurse activities

- Nurse total quantity
- Nurse age distribution
- Nurse distribution through specialties
- Nurse distribution through education criteria
- Unemployed nurse quantity

2.2 Capacity evaluation

- Existing nurse quantity in the state and private sector
- Assessment of the existing work conditions

2.3 Evaluation of the educational resources

- Recording of the existing education institutions
- Evaluating the capacity of the existing education institutions
- Recording pedagogical personnel

2.4 Creating state system of nurse activity recording

2.5 Formulating the monitoring scheme and technical resources of the working of the recording state system

2.6 Presentation of the state system of nurse activity recording at the board of the Ministry of Labor, Health and Social Affairs

3. Project implementation possible results

Creation of the state system nurse activity recording will give nurse activity the possibility to effectively manage it as an independent profession. The professional and social problems existing in the nurse activities will be solved in accordance to the state interests.

4. Program possible duration:

5. Program possible cost: 9 903, 60 Laries

6. Program budget

6.1 Salary (monthly)

#	Title	Units	Amount in laries
1	Program manager	1	130
2	Member of the working group	4	480
3	Consultant	2	160
4	Operator	1	70
	Total:		840

Program Cost

#	Title	Quantity	Cost in Laries
1	Personnel work remuneration	8	7560
2	Taxes from the employer Among them:		2343,60
	- Social state fund 27%		2041,20
	- Medical insurance state company 3%		226,80
	- Employment state fund 1%		75,60
	Total:		9903,60

Annex 17: List of scientific-research institutes in Georgia

(All of them are located in Tbilisi)

1. Scientific-research institute of human reproduction named by I. Jordania
2. Institute of plastic surgery and cosmetology
3. Scientific-research institute of microbiology and virusology named by G. Eliava
4. Institute of experimental and clinical surgery named by K. Eristavi
5. Institute of experimental morphology named by A. Natishvili
6. Scientific research institution of skin and venereal diseases
7. Scientific institute of clinical and experimental cardiology named by M. Tsinamdzgvrishvili
8. Institute of clinical and experimental neurology
9. Scientific-research institute of physiotherapy and rehabilitation named by I. Koniashvili
10. Scientific-research institute of narcology
11. Scientific-research institute of neurology and neurosurgery named by P. Sarajishvili
12. Scientific-research institute of parasitological and tropical medicine named by S. Virsaladze
13. Scientific-research institute of pediatrics named by I. Pagava
14. Scientific-research institute of X-Ray and intervention diagnostics
15. Scientific-research institute of traumatology and orthopedics named by O. Gudushauri
16. Scientific-research institute of urology named by A. Tsulukidze
17. Institute of pharmaco-chemistry
18. Scientific-research institute of TB and lung diseases
19. Institute of physiology named by I. Beritashvili
20. Scientific-research institute of psychiatry named by M. Asatiani
21. Scientific-research institute of labor, hygiene and professional diseases named by N. Maxviladze
22. Scientific-research institute of haematology and transfusiology named by G. Mukhadze

Annex 18: Organisation of PHC in Gurjaani Rayon a case study

Gurjaani has the highest number and the widest variety of PHC facilities in the Kakheti Region

PHC Facilities Available

There are 31 PHC facilities in Gurjaani classified as follows

The current PHC facilities in Gurjaani include:

- 1 Rayon Polyclinic (includes Children and Adults)
- 2 adult Polyclinics together
- 1 Women's Consultation Centre in Gurjaani Town. 1 Hospital/polyclinic
- 1 Treatment Diagnostic Centre
- 1 Treatment Diagnostic Centre
- 18 Ambulatory Centres in the villages
- 1 Railway Fund subordinate Polyclinic in Gurjaani Town
- 6 medical points in the more remote villages
- 1 Hospital/polyclinic

Managerial Accountability

The polyclinics, womens consultation centre and all the ambulatory centres with the exception of 3 ambulatories in the villages of Velistsikhe, Vazibusani and Gurjaani (village) are operated as one organization. They have a single budget and are all accountable to the Rayon Polyclinic Director.

(It is unclear whether the Railway Clinic also comes under the same direct control)

The three ambulatories above operate as separate managerial arrangements and are organized as joint stock companies, however they deliver the services from buildings that are state owned assets (one assumes therefore they rent them)

Funding Situation

The Gurjaani Primary Care Organisation (ie the single managerial organization headed by Rayon Polyclinic) and been experiencing very difficult financial circumstances for the past 4 years and is now is effectively insolvent. They reported:

- arrears of State funding of GEL 350,000
- accumulated regional funding arrears of GEL 80,000.
- and in terms of time a debtor day period of 35months!

Service Need

Access

PHC services are required to meet the needs of the Gurjaani population in reasonably accessible locations. Gurjaani is a predominantly rural rayon (as is Kakhei Region) with Gurjaani Town as the only major habitation (with a population over 10000)

Gurjaani Rayon Population	Rural Settlements	Urban Gurjaani Town
72,618	61,513	11,105

Source SDS Census Data 2002

Outside the main rayon town of Gurjaani there are 21 principal settlements the main features of current access to PHC facilities are:

- 18 are currently served by a village doctor ambulatory service
- 2 ...Naniani (pop 693) and Mukuzani (pop1700) are served by medical points
- The remaining settlement Katchreti (pop3044) served by an alternative EU described 'Other' facility.
- There are 4 more medical points in the villages of Darcheti, Kitaani, Kodolo and Dzirkoki.
- Of the settlements served by village ambulatory doctors 3 have populations of more than 5000 .
 - Gurjaani Village (pop 5070, 1.5 km from Gurjaani town),
 - Kardanakhi (pop 5843)
 - Velistsikhe (pop 6376, also has an Adult Polyclinic)
- Another larger settlement of Vazisubani (pop3984) has an ambulatory and an adult polyclinic
- Excluding these 4 settlements the average catchment population served by an ambulatory service is 2486
- The geographically very isolated village of Tcheremi only has a catchment population of 89 served by a village ambulatory doctor
- However another relatively isolated village of Kitaani (pop 421) is served only by a medical point.

Gurjaani Rayon Rural Population Catchments			Total Rural Population 61513		
Settlement	Pop	PHC	Settlement	Pop	PHC
1 Arashenda	2543	Amb	12 Kolagi	1400	Amb
araSenda	1467		13 Melaani	1397	Amb
darCeTi	536	Med Pt	14 Mukuzani	1700	Med Pt
ziari	75		mukuzani	1216	
fxoveli	63		zegaani	494	
qodalo	402		15 Naniani	693	Med Pt
2 Axasheni	3188	Amb	16 Shashiani	3146	Amb
3 Bakurtsixe	3245	Amb	17 Chalaubani	1065	Amb
4 Gurjaani	5070	Amb	18 Chumlaki	4900	Amb
5 Vazisubani	3984	Ad Poly + Amb	Cumlayi	4479	
6 Vachnadziani	2283	Amb	yitaani	421	
vaCnaZiani	2060		19 Chandari	3460	Amb
kaxifari	223		Wandari	2097	
7 Velistsixe	6376	Ad Pol + Amb	Zirkoki	1263	Med Pt
8 Vejini	3780	Amb	20 Cheremi	89	Amb
9 Kalauri	2611	Amb	21 Jimiti	1696	Amb
10 Kardanaxi	5843	Amb			
11 Kachreti	3044	Other			
kaWreTi	2203				
maxaraZe	841				

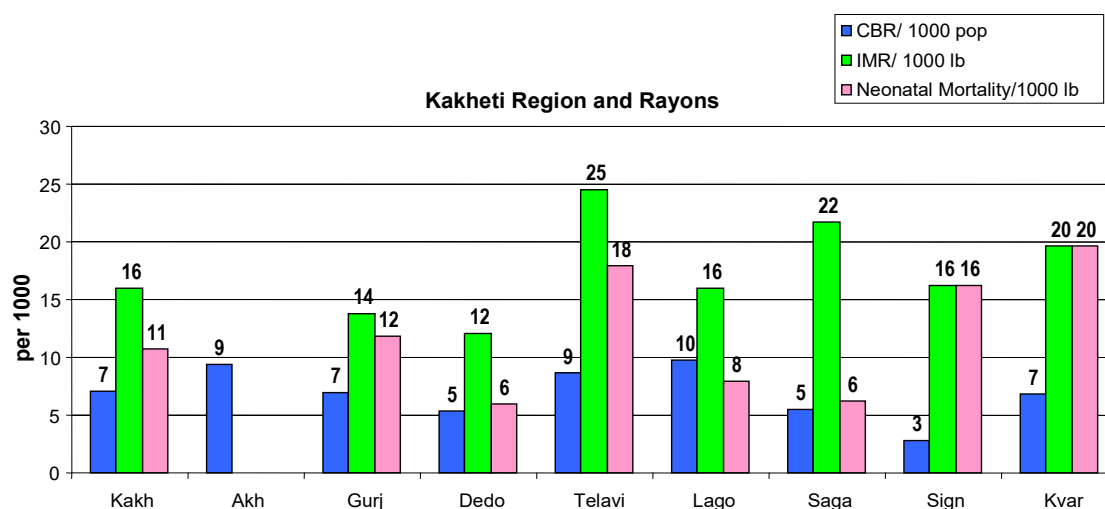
Sources SDS Census Data 2002
EU Survey Report Facility Assessment October 2003

Other demographic indicators of need

Gurjaani appears to have an aging population with an average age of 39.4 years with 20 % of its population 65years or more and only 18.1 % of the population are 14 years or less.

It also has the second lowest proportion of the population in Kakheti under 5 years at only 4.7 %

Officially from the census data it also appears to have a low birth rate of 7 per 1000 population (the average for Kakheti as a whole)



Source EU Survey Report Facility Assessment October 2003

However this data should be treated with caution as the EU Report highlights some of the problems particularly regarding birth registrations. Also our research into the pattern of behaviour of the women in Gurjaani regarding registration of pregnancies and births at the Women's Consultation Centre would also support this sceptical view. (see service demand findings below)

Service Demand

It was reported that in previous (Soviet) periods each doctor employed in the Gurjaani rayon service received consultation visits by patients on average between 15 and 20 times per day and felsher midwives were similarly active in the rural villages of the rayon.

However now **officially** they admit to an average of only 3-5 patient consultation visits per doctor per day an officially recognised reduction of 75-80%.

Our observations in Gurjaani indicate an even lower figure as evidenced by:

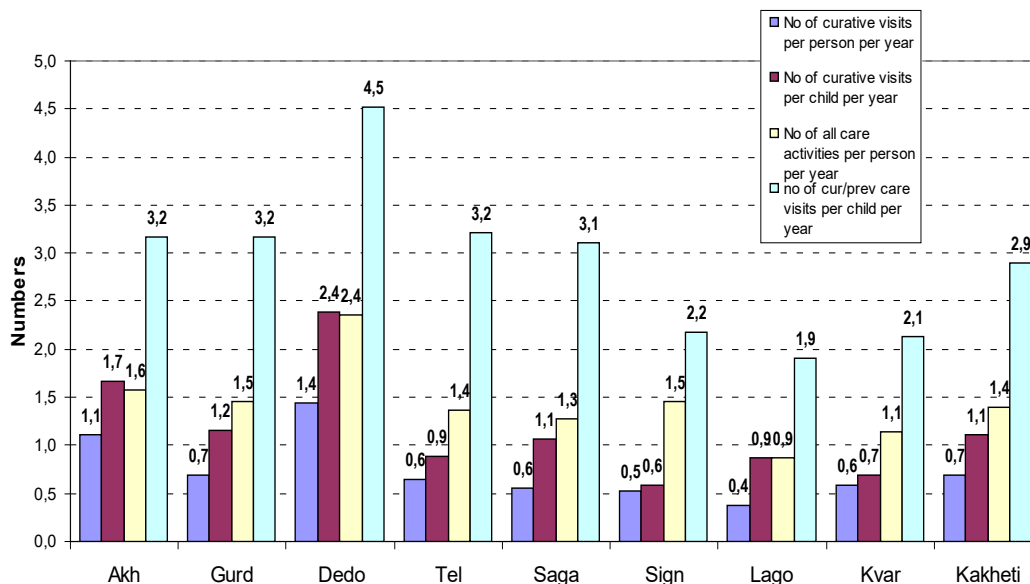
- Visit to a clinic in which there were 8 doctors and 8 nurses in work all of whom were gathered together around a communal heating stove in one consulting room. There were no patients anywhere in the building
- It was reported that visits by patients to 'non State Ambulatory Programme' specialists such as the allergologist and gastroenterologists are virtually zero. Whilst they are officially still on the payroll they admit to receiving no more than 1 or 2 patient visits per month!
- It was also reported that some doctors have even put funds into the PHC to keep themselves on the books even though they have no patients
- The regional managers however are reluctant to declare these staff officially redundant or surplus to their needs. (However several older staff have been retired see staffing supply issues below)

This anecdotal evidence confirms the low workload /lack of demand trend indicated by the EU data for Kakheti as a whole.

a) No of Consultation Activities Officially Recorded in Kakheti for 2002 including home visits, health promotion and vaccinations	559,636
b) Total Number of Clinical Staff in Kakheti in 2003 (Doctors, nurses and midwives)	1148
c) Crude Average Number of patient visits per clinical staff member per annum (a/b)	= 487 per clinician per annum
d) Crude average per day per clinician (officially 225 working days)	2.16 patient consultation visits per clinician per day

(Source EU Survey Report Facility Assessment October 2003 Section 5)

The EU data also indicated very low patient visit numbers per year and that Gurjaani Rayon was fairly representative of the Kakheti region with average curative visits per adult of .7 per year and all care activities of 1.5 visits per person per year. See chart below.



(Source EU Survey Report Facility Assessment October 2003 Section 5)

However even these official records of consultations is likely to be overstated, since the clinics are required to achieve particular minimum levels of activity to receive funding from the 'State Ambulatory Programme' and therefore try to ensure that the data supplied to the Regional Administrators meets these minimum activity requirements.

The lack of funding from the State has exacerbated this over-recording in the desire to at least maintain an official licence to practice for all the staff.

The State Ambulatory Programme lays down the following minimum requirements for **free PHC services**:

- 1 Doctor per 2000 population and they must undertake a minimum patient consultation level of 1.53 visits per person per year.(Adults and excluding pregnant women)
- Pregnant women are expected to receive a minimum of 4 consultations by a doctor and 10 consultations by a nurse (home visits are counted as 2)
- Children under 1 year are expected to receive a minimum of 11 consultations by a doctor (including 1 home visit) and 10 consultation visits by a nurse

State Ambulatory Funding Requirement ...officially doctors will receive their full salary if they achieve 80% of the above requirements i.e. 1.3 visits per person per year . Below 80 % they should receive a reduced salary and below 50% of target they should be considered for redundancy.

There are no adequate validation or audit systems to monitor achievement of these workload norms. It is therefore not surprising that the EU activity data appears to accord more or less with these minimum requirements.

Home Visits officially reported by those staff who completed the questionnaire for the EU survey indicated 65-70% of doctors and nurses in Kakheti spend between 5 and 10 hours a week on home visits:

Main PHC Staff Groups	No Respondents spending 0-5 hours on Home Visits		No Respondents spending 5 – 10 hours on Home Visits	
	Count	Percentage	Count	Percentage
Therapists	56	33%	111	67%
Pediatricians	49	36%	88	64%
Midwives	9	56%	7	44%
Nurses	102	30%	237	70%

(Source EU Survey Report Facility Assessment October 2003 Section 5)

However anecdotal evidence from Gurjaani has indicated that in practice:

- the therapists appear to make very few home visits
- the therapy nurses appear to make no home visits except as assistants to the therapists.

- there appears to be very little health promotion work done with the adult population.
- Pediatricians do make some home visits but not with the frequency indicated by the official data.
- Pediatric nurses are fulfilling their obligations regarding vaccinations and health promotion work with infants.

Other 'Soft Indicators' of low demand for the PHC services in Gurjaani Town include:

- People in Gurjaani Town did not know the location of their rayon polyclinic 10 people asked were unaware of its whereabouts. In fact it is situated in a building adjacent to the Hospital (which also has an out-patient direct referral service) and people assumed they were the same organization.
- Recognition of several 'official' private doctors living in the town..it was reported that there were as many as 15 living in one apartment block and that they were giving free advice to people and referring them directly to specialist secondary care.(see supply issues below)
- The apparent increase in the direct demand for medicines without PHC prescriptions. There has been an increase in the number of outlet selling antibiotics in Gurjaani. The polyclinic manager reported a significant growth and overuse of antibiotics in the population over the last 5 years coupled with a decline in the number of official prescriptions from the PHC services.

Particular issues found in our study affecting demand in the rural villages were :

- a strong desire in some villages to keep the old Soviet trained nurse's first aid points although this system has officially been abolished they still trust in the skills of the older Soviet trained nurses.
- People in the villages tend to refer to someone they regard as a clinically trained person (nurse, doctor, midwife) who lives in their village rather than travel to another village ambulatory clinic
- They appear to refer to the official state ambulatory service or polyclinic only when their condition has become acute.
- Several of the rural villages covered by our research are suffering major population decline with very low birth rates.

Issues found in our study affecting demand for the Women's Consultation centre in Gurjaani:

The reforms of the mid 1990's abolished the felsher midwife system in the villages of Gurjaani and replaced them with the Womens Consultation centre in Gurjaani Town. The Centre has 3 full time gynecologists and they are responsible for all the pregnancy registrations and monitoring visits in the rayon. However our study found the following significant problematic issue regarding the demand for this service and the potential epidemiological problems regarding monitoring of children's health and wellbeing in the rural communities.

- Women from the villages do not wish to travel to the Gurjaani Women's Centre for registration or subsequent birth and resent the removal of the previous local midwife service
- They tend to remain at home and then travel to parents, relatives or into Tbilisi Hospitals for their confinement and child births. There is then no follow up referral service or information flow from the birth place to the home /place of residence.
- Therefore the village ambulatory pediatricians are not informed of the births and are unaware for some time of the children's existence. This perversely leads to
 - no children's services being offered to these new born infants,
 - incorrect registration pregnancies and births
 - delays and possible omissions in vaccinations

Annex 19: On the approval of the additional list of the necessary documents and conditions for licensing private education institutions

DECREE

OF THE PRESIDENT OF GEORGIA

#644

December 6, 1999

Tbilisi

ON THE APPROVAL OF THE ADDITIONAL LIST OF THE NECESSARY DOCUMENTS AND CONDITIONS FOR LICENSING PRIVATE EDUCATION INSTITUTIONS

In accordance with the point 5, article 7 of the law of Georgian on “Licensing entrepreneurial Activities” approve additional list of the necessary documents and conditions for licensing private education institutions”.

E. Shevardnadze

Approved

by the degree

#644, December 6, 1999

of the President of Georgia

The additional list of the necessary documents and conditions for licensing Private education institutions

1. The founder of the institution together with the letter and certificate for the payment of the license fee should additionally provide into the licensing body (points 1 and 2, article 7, law on “licensing entrepreneurial activities”) the following documents in order to get the license of the education institution:
 - a. The registration certifying document determined by the law on education institutions;
 - b. The charter of the education institutions;
 - c. Teaching plan indicating education program (if the education institution executes professional education program then the teaching plans should be provided for each specialty);
 - d. The list of major and invited lecturers, indicating their professional experience and work place (in case of invited lecturers) and subjects considered in the teaching plan;
 - e. Relevant documents on the possession of the building and material-technical base; Building and material-technical base should comply with the active standard norms;

- f. The certificate of the appropriate banking institution for the date of document submittal on the factual quantity of the funds at the institution accounts (charter capital);

Remark: In order to get the license for the new specialty the education institution together with the letter and certificate for the payment of the license fee should provide documents indicated in the sub-points “c” and “d”, point 1 of this list. Upon necessity the requirements of point 5 should also be satisfied.

2. The license researcher should provide certificate of the seismic stability of the building where the education process will be held.
3. The education institution should have:
 - a. Appropriate sport hall or space for the student physical education determined by the relevant construction norms;
 - b. Library with the sufficient fund or the contract with the library;
 - c. Education cabinet-laboratories and bases for practical and theoretical education to successfully implement education programs. Their equipment should comply with the standard requirements. The education institution submits the certificate on the rent of the cabinet-laboratories, clinics or some other spaces.
4. The classes and contingent in the state education institution of the general education programs are created on the basis of the decree of the Ministry of Education #306, June 21, 1996. The student contingent and pedagogical loading of the professional education program of the state education institution should comply with the state education standard norms determined for any programs.
5. The education institution should be staffed with the qualified personnel;
 - a. The kindergarten, general, initial professional and secondary professional education program teachers should have high (secondary special) pedagogical education in accordance to the teaching programs;
 - b. The pedagogical personnel of the high professional education institutions should have high education; hence, the quantity of the professor-teachers with scientific degrees should comprise to 65% of the total number and the PhD - at least 7%.
 - c. The directors of the secondary, initial professional and secondary professional education institutions should have high education and 5 years pedagogical work experience, and the deputy directors – high education and not less then 3 years pedagogical work experience.
 - d. The rector of the high professional education institution should have scientific degree and not less then 5 year work experience at the management position in the scientific-pedagogical institution.

6. The charter and teaching plans of the education institutions who submitted their documents for licensing should comply with the typical active charter of the education institutions and the requirements of the state standards.

Annex 20: About the Georgian medical association

Georgian Medical Association

Background Information

The Georgian Medical Association (GMA) is a national organization representing Georgian physicians. It was founded on October 1989, when physicians from different regions of Georgia were called by initiative group and met at the First Congress of the GMA in Tbilisi. GMA is first independent professional union of Georgian physicians based on principles of democracy, which was formed at the end of Soviet Perestroika period.

The mission statement: **Caring Georgian general population through caring Georgian physicians.**

Aims and objectives

- To promote and defend health-related human rights – the basic rights of patients and physicians
- To help physicians to continuously improve their knowledge and skills through postgraduate and continuing education
- To evaluate national human resources planning for health care services
- To promote medical research activities
- To encourage development of national approved curriculum for medical specialties
- To participate in the elaboration of public health policy for optimal reform of health care system and improvement of public health care
- To facilitate activity of medical NGOs and private sector
- To coordinate health care professional network in close co-operation with Ministry of Health and WHO-Europe
- To find financial support for realization of useful health care initiatives
- To organize forums and discussions of actual professional and organization problems of national health care

The geographical area of activities includes whole Georgia. GMA participates in European and Worldwide structures and projects. GMA is a member of European Forum of Medical Associations and WHO, World Medical Association (an international organization representing physicians from approximately 80 National Medical Associations), Framework Convention Alliance, Essential Action - Global Partnership for Tobacco Control.

COLLABORATION WITH OTHER GEORGIAN MEDICAL SOCIETIES: GMA HAS ORGANIZED THE PRESIDUM OF SPECIALIZED MEDICAL ASSOCIATIONS AND LEADING MEDICAL NGOS WHERE THE POST-GRADUATE TRAINING REGULATIONS ARE REVIEWED AND DISCUSSED. BY THE INITIATIVE OF GMA THE NATIONAL HEALTH PROFESSIONALS ALLIANCE FOR TOBACCO CONTROL WAS ESTABLISHED. GMA IS ONE OF THE FOUNDERS OF HEALTH PROMOTION ALLIANCE AND GEORGIAN SOCIETIES JOINT COMMITTEE ON CARDIOVASCULAR PREVENTION.

Participation in the European Forum of Medical Associations (EFMA) and WHO: GMA has been an official member of EFMA and WHO since 1994 and attends its meetings on a regular basis for review development relevant to the medical profession and to exchange experience. The president of GMA, professor Gia Lobzhanidze, has been a member of EFMA Liaison Committee. GMA translates and disseminates documents and materials (declarations, statements and recommendations) of EFMA and WHO, particularly concerning the problems of tobacco and smoking, continuing medical education, quality of care development, new patterns of tuberculosis, health promotion, development of new health care systems etc.

GMA and WHO CINDI (Countrywide Integrated Noncommunicable Diseases Intervention) program in Georgia: GMA was one of the initiators of implementation WHO CINDI program in Georgia. At the GMA "CINDI-Georgia" group was formed. In 2001 in the framework of Agreement for Performance of Work between WHO European Regional Office and GMA Survey on Health Behaviour among Georgian population was conducted. In 2002-2003 the projects are being implemented in the frames of BCA: "Assessment of policy of prevention and control of noncommunicable diseases" and "The Training Programme for Primary Health Care Doctors on the Prevention of Coronary Heart Disease" (in collaboration with National Family Medicine Training Center). Curently the project in the demonsration area is under the way.

The Training Programme for Primary Health Care Doctors on the Prevention of Coronary Heart Disease (in collaboration with National Family Medicine Training Center): Following actions were carried out: The curriculum for 16 hours training course on the prevention of CHD based on European Societies Joint Recommendations and CINDI approach was developed by the programme consultants; Methodology for course evaluation was developed. This includes (1) Tool for assessment of trainees knowledge (2) Trainees satisfaction questionnaire; Training course for 6 trainers was conducted at 20-21 March; The training course for 120 PHC doctors was conducted in May 2003. Training materials for trainers (in English and in Georgia) and trainees (in Georgia) revised and upgraded according to the recently published new European guidelines on prevention of CVD (including new risk assessment color chart-SCORE and SCORECARD); The schedule for training other 120 PHC doctors developed and the new round of training course was conducted on December 2003.

GMA for Tobacco Control: In May 31, 2001 GMA together with UNESCO Chair "Healthy Life" organized Conference dedicated to the No Tobacco Day in Tbilisi. Georgian Medical Association supported the Framework Convention on Tobacco Control (FCTC) and called on the Georgia government and its representatives to the WHO workgroup on the FCTC to fully implement the convention and related protocols that include binding mechanisms to ensure compliance. GMA established partnership with California Medical Association. Familiarization with the California experience in Tobacco Control is especially useful for GMA, considering the fact that association

learned a lot about the problem of tobacco marketing, promotion and smoking in partner's country, USA. In Georgia, the Georgian Medical Association has organized many signatures to end the use of insidious advertising images such as the Marlboro Man. The Association has translated the petition into Georgian in an effort to organize more people in support of a strong FCTC and against industry influence. In 2002-2003 the project "Georgian medical association for support of a strong framework convention on tobacco control" was conducted. Project was implemented in support of the Framework Convention Process under the WHO "Channeling the Outrage" campaign, in accordance with the Agreement for performance of work between World Health Organization and Georgian Medical Association. Recently in the frame of "Channeling the Outrage" – 2004. GMA together with other relevant Georgian NGOs founded Health Professionals Alliance for Tobacco Control which would act in collaboration with Georgian Parliament and Governmental structures in order to elaborate relevant and proper policy on health promotion and tobacco control issues.

Representation in governmental committees and programmes: Association is represented in relevant government committees (for example, in the: Supervisory Board of Georgian Social Insurance Common State Fund, Special Commission of the Ministry of Labour, Health and Social Affairs of Georgia, responsible for compilation of National Health Report etc.) and is in regular dialogue with state organizations. GMA participated in elaborating State (National) Program of Cardiovascular Diseases Prevention, essential part of which is represented by educational activities,.

Facilitation of Humanitarian Assistance for Georgia: GMA has close collaboration of NGO ACTS Georgia, affiliate of USA charity organization ACTS International. GMA has invited ACTS International the first American NGO in Georgia founded in 1991 by Dr. Patricia J. Blair for provision of assistance. The humanitarian assistance is targeted throughout Georgia with special focus on acute areas of need in the high mountain regions of Georgia. According to official findings ACTS Georgia, led by vice-presidents of GMA (Giorgi Tsilosani and Revaz Tataradze) delivered about half of the total quota of humanitarian medicines delivered in Georgia (National Report on Health Condition of Population of Georgia, 2001, Ministry of Labor, Health, and Social Affairs). GMA participates in other projects of ACTS (for example promotion of family medicine in Georgia), too.

Publishing of Materials: GMA regularly publishes materials for medical professionals and general public. The book "Doctors and Tobacco" is translated. In 1999 the books "Prevention of Cardiovascular Diseases in Primary Care. Recommendations for Improving Quality of Care" and "Strategic Directions of Cardiovascular Diseases Prevention Directives for Action". were prepared and published with participation of GMA. GMA has contributed in the WHO publication: CINDI Health Monitor: A Study of feasibility of a health behaviour monitoring survey across CINDI countries. Data Book. World Health Organization – 2003. Public educational brochures (nutrition, smoking, hypertension etc) in the frame of various projects were published.

Presentations at the National and International Congresses: GMA has regular bi-annual congresses. GMA has organized the Conference: "The Role of Nongovernmental Organization in the Development of Health Care System", Tbilisi, 18-19 December, 1998; supported the conferences: "Epidemiology and Prevention of Chronic Diseases" of Department of Public Health of Ministry of Health of Georgia. Tbilisi, 1998 ; "Physicians for Healthy Lifestyle in New Millennium", dedicated to 70th Anniversary of Tbilisi State Medical University, March, 2000 etc. Three presentations were made on the European Conference on Health and Human Rights. Under the Guidance of European Council. Strasbourg, France, March 15-16, 1999; GMA

presented Georgia in the First European Network Organizations Open Conference WONCA'99. Palma De Mallorca, Spain, 19-22 May 1999; 11th and 12th World Conferences on Tobacco OR Health held in Chicago, Illinois USA, August 6-11, 2000 and in Helsinki, Finland, August 3-8, 2003; European Forum on Prevention of Coronary Heart Disease in Clinical Practice. Regional Follow-up Meeting. Bucharest. Romania. March 23, 2002; 20th annual meeting of the CINDI Programme Directors, Prague, the Czech Republic, May 30-31, 2003. As a delegate from Georgia in European Review Group on Health Promotion and Prevention in Family Medicine and General Practice (EUROPREV) vice-president R.Tataradze presents the relevant materials to EUROPREV.

Annex 21: About the Georgia family medicine association

Georgia Family Medicine Association

Background Information

The association was founded in November of 2003 through a merger of the Georgian Family Medicine Association (1995-2003) and Family Medicine Trainers Association (2001-2003). There are family physicians, general practice nurses and managers and also representatives of State Medical Universities (State Medical University and Faculty of Medicine of the State University), National Institute of Health, Tbilisi Municipality Health Department and regional departments (Imereti, Shida Kartli, Mtskheta-Mtianeti, Adjara, Kakheti) of health and social affairs among 43 founders.

The association is chaired by Irina Karosanidze, MD. An Honorary Overseas GP Tutor at Themes Postgraduate Medical and Dental Education University of London.

The purpose of the association is contribute towards the developing Family Medicine based PHC system in Georgia through

- Setting and maintaining high professional standards for FM human resources: physicians, nurses and managers
- Evaluating functional characteristics of family medicine model
- Contributing towards the professional development and growth of FM HR through participating in developing of postgraduate and undergraduate professional training programmes for FM human resources
- Developing evidence based clinical and practice management guidelines and contribute to it's implementation
- Introducing research methodology at PHC setting which may lead to improved problem identification, setting specific problem solving ways and quality improvement
- Sharing experience of other countries where family medicine is well advanced discipline or on the early stage of it's development
- Collaborating with different governmental and non governmental organizations which may play an important role in the developing of Georgian FM model
- Protecting professional rights of FP HR and ensuring their effective functioning

Association members have actively been involved in developing Family Medicine Institution in Georgia. The first Georgian Family Physicians were trained with the support of British Government (the Know-How fund project "In-service training for general practitioners in Georgia" 1997-1999). They were members of Georgia Family Physician's association at that time. Later they established "Georgia Family Physician Trainers Association" (February 2001). The first steps towards the developing Family Medicine based primary care system was made during the period 1997-1999. The following activities were fulfilled:

- 16 FP trainers have been trained, this created an important capacity for training other Family Physicians;
- Specialty "General Practitioner/Family Physician" was included in the list of physicians and pharmacists (Decree of the Minister of Health # 425/O, 27.10.1997, on "Awarding the State Certificate and License to the High and Middle-level Medical and Pharmaceutical Personnel").
- 47 GP/FP have been re-trained; Thus, together with 8 GP trainers, trained on the initial stage of the Project, 55 GPs were certified;
- Curriculum (930 hours) and appropriate training materials for GP training were developed and approved;
- GP/FP Certification Program has been developed.

British Government continued to support Georgia in strengthening FM specialist training capacity in period 2000-2003. Association members were fully involved in all project activities particularly in training of family medicine professionals, setting professional standards, developing continuous medical education programs for family physicians.

In order to increase Ministry of Labour, Health and Social Affairs capacity to train PHC staff the following activities were implemented (DFID Georgia PHC development project 2000-2003)

Training of Family Physicians

- 43 PHC doctors were retrained at demonstration sites in 2001-2002 by 16 FP trainers (Tbilisi).
- A further 34 PHC doctors enrolled in the GP re-training course in November 2002. 23 of them ended training in November 2003 (Tbilisi).
- A further 18 GPs from Family Medicine demonstration sites were retrained as trainers (There 34 FPs trainers in Tbilisi, in total)
- 14 FPs trainers (2 from Shida Kartli, 5 from Imereti, 7 from Adjara) were trained at National family Medicine Training Center;
- Eight newly trained regional Family Medicine Trainers retrained 32 PHC doctors in regions (13 in Imereti, 13 in Adjara and 6 in Shida Kartli).
- 10 PHC doctors were re-trained by NFMTTC master trainers in Mtskheta PHC center 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. The programme was coordinated by Dr. I. Karosanidze
- FP trainers (at National Family Medicine Training Center) 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.

In total:

- 121 FPs were trained from Tbilisi (34 of them are trainers) (1997-2003);
- 8 (2 of them FPs trainers) from Shida Kartli
- 18 from Imereti (5 of them trainers);
- 19 from Adjara (7 of them are trainers)
- 10 from Mtskheta (4 of them are trainers)

Training of General Practice Nurses

- 14 General Practice Nurse trainers trained
- 24 General Practice Nurses trained at 5 demonstration sites

Training of General Practice Managers

- 5 General Practice Manager trainers trained
- These PHC Manager Trainers trained 10 PHC Managers (6 from Tbilisi, 2 from Shida Kartli, and 1 each from Mskheta and Ajara).

On order to improve the service quality provided at PHC level Evidence-based clinical guidelines in ten areas, were developed by the Association Members with the financial support of Tbilisi Municipality Health Department. 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

Wider implementation of the guidelines has to be supported by training of all FMC staff and introducing tools for performance evaluation. GFMA is seeking for financial assistance to ensure that evidence-based guidelines and performance evaluation tools are implemented.

GFMA members collaboratively with Georgia Nursing Association, National Family Medicine Training Center, DFID Georgia PHC development project consultant developed the legal framework for family Medicine Model in Georgia. The following documents were prepared and approved by the Ministerial Decree (15 April 2002, 103/o):

- 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

Based on its experience and expertise in developing professional and CME training programmes for FM Human Resources GFMA has recently made its application to the Georgian Medical Association which should act as a referee to the Ministry of Labour, Health and Social Affairs for any professional association that intends to resume a responsibility on setting and maintaining professional standards in the country.

The composition of the Association

The GFMA accumulates almost all Family Medicine human resources which have been trained in Georgia since 1997.

The table below shows how many family physicians, general practice nurses and general practice managers who underwent through specific postgraduate training in family medicine are there in Georgia at the moment.

Medical specialty	Total number	Among those association members
Certified Family Physicians	136	122
Fully trained but not certified family physicians	29	-
Medical Practitioners in training to become family physicians	30	25
PHC physicians		12
General practice nurses (trained)	38	18
General Practice Managers	15	6
PHC nurse (without specific training in Family Medicine)		14
Members with academic degrees		10
Health care organizers		15
Other (economist)		2

Association is open for membership and it is highly likely that all certified family physician's will become its full members. The merge of two above mentioned associations and establishing of

new one with a multiprofessional composition was determined by the current political situation and difficulties we are experiencing on the way of developing family medicine model in Georgia. We think that at this stage all family medicine human resources have to work with joint efforts to strengthen FM in Georgia.

Membership of international organizations

GFMA has become a full member of WONCA in May of 2004.

Annex 22: State ambulatory programme

Primary medical care components determined by different curative or preventive programs of the previous years have been integrated in the state program of 2003. Consolidation of the financial resources into one budget program has been carried out, which promoted the efficiency of expenditures and service availability in the primary health care.

Program projected parameters are calculated on the basis of analyzing statistical data and ambulatory service components of the state programs for the latest three years.

Program beneficiaries are the population of the country, except the population of Tbilisi and Batumi (more than 3 years), which comprises 3 261 270 people, among them are 435 thousand citizens of the high mountainous regions.

Visit to the doctor is free of charge for each citizen. Doctor's visit at home is free of charge for the population up to 15 years and more than 65 years, also for the invalids and holders of the "disabled" policy.

According to the program format X-Ray is dedicated to the children from 0-3 years, TB patients, invalids, for the people more than 65 years and for the holders of "disabled" policy.

Number of laboratory examinations is not limited in the frame of the program for the population:

- Up to 15 years;
- More than 65 years;
- For the population of the high mountainous regions;
- For the Invalids;
- For the holders of the "disabled" policy;
- For the diabetic patients holding the policy of "disabled", program envisages glucose measurement in blood 6 times a year.

The annual financial contract volume of the institutions participating in the program is determined on the basis of passport issuance data (considering the data from appropriate rayon local authorities on the quantity of population) in accordance with the estimated volume of population, analyzing the work executed by the institutions and medical teams in the previous years (contract cost is balanced considering the work volume and medical institution resources determined by the program). Institution is paid monthly 1/12 value of the contract cost, in accordance with the accomplished work.

Budget

Program budget is determined in the amount of 15 970.0 thousand laries in accordance to the law of Georgia on “The Budget 2003”.

Population Ambulatory Program	15 970.0
Population ambulatory care component (among them for high mountainous regions)	11 400.0
Immunization sub-component	750.0
Specialized ambulatory care component. Among them: TB, psychiatric, oncological and pregnant patronage	2 880
Invalid ambulatory care sub-component. Among them: expertise and stomatological service	800.0
Medical examination component of the citizens serving in the military forces of Georgia	140.0

Program Components and Activities

I. Population ambulatory care component (among them for high mountainous regions)

Medical service volume is determined by:

- Consultation services;
- Laboratory examinations;
- Supplying with emergency medications;

Component envisages patronage of children up to 1 year.

Provision of the population ambulatory service and prophylactic-curative activity is carried out by medical teams, through the whole territory and by unified format.

Ambulatories with number of population up to 2500 will have only 1 financed team; for 2500-4500 citizen – 2; 4500-6500 citizen – 3; 6500-8000 citizen – 4 and so on. For high mountainous regions method of medical team counting is different, considering the geographical features of the population location.

General profile team composition: 1 doctor and 1 nurse.

(Since medical care of the children is considered in the program format, the functioning of the additional pediatrician is recommended in the team)

Specialized medical teams will provide specialized consultation services for the population at the rayon/region level on the basis of referral. Specialist consultation and laboratory examinations are carried out on the basis of the decision of the doctor of general profile team.

Children care in rayon centers is provided through children specialized teams.

Children specialized team composition: Neurologist, surgeon, ophthalmologist, ENT and 1 nurse, which is at the same time responsible for proper functioning of vaccination cabinet.

Children and adult specialized team functioning is considered at the rayon level.

Adult's specialized team composition: Ophthalmologist, endocrinologist, neurologist, ENT, surgeon, oncologist and psychiatrist, laboratory technician (bacteriological analysis - for TB patients) and X-Ray specialist, also 3 nurses and 1 DOT-nurse among them.

3 years old children ambulatory care financing in the mono-profile institutions (children polyclinics) will be carried out through capitation rule – 1.5 lari per child.

One medical team monthly expenditure review (general profile):

Direct reimbursement, totally	170
Doctor	100
Nurse	70
Taxes from the contractor	52.7
Treatment and other sources	30
Laboratory diagnostic examinations	50
Other expenses	70
totally	373

One medical team monthly expenditure REVIEWS for the high mountainous regions:

Direct reimbursement, totally	229.5
Doctor	135
Nurse	94.5
Taxes from the contractor	71.1
Treatment and other sources	30
Laboratory diagnostic examinations	30
Other expenses	50
totally	410

The doctors' salaries working in the specialized medical teams comprises not less then 80 laries per month and nurses' – 60 laries.

Amount 10% movement between articles in the medical team expenditure is allowed, salary belongs to the defended article.

It is recommended: In the territories where the general profile team quantity exceeds 3 (5 high mountainous rayons), 50% of the amount for laboratory-diagnostic examinations should be used for the medical personnel salaries occupied in this process, hence monthly salary of the doctor-laboratory technician should not be less than 70 lari and nurse less than 60 lari.

II. Immunization Component

Component provides:

- The maximum coverage of the children prophylactic vaccination considered in the national calendar;
- Vaccination holding through epidemiological indicator;
- Holding massive vaccination campaigns for creating defensive immune layers against diseases and for their maintenance.

Vaccination contingent precise and timely determination, safe vaccination and inoculated contingent maximum coverage will be performed at the PHC level. Ambulatory-polyclinic institutions involved in the program realization provide the service. In order to cover children vaccination considered by the national calendar, vaccinations are carried out in the medical institutions (maternity hospital) in accordance to the appendix.

Supply with the routine vaccines for the children up to 2 years, envisaged in the program, except of the mumps vaccination, will be performed by the UNICEF. Mumps, measles vaccines together with the appropriate quantity of auto-destructive syringes – for more than 2 years old children and DT, Td, OPV and B hepatitis vaccine will be purchased in the framework of other vertical program (specific medicines provision). Vaccination material storage – distribution among public health care city/rayon centers will be performed by the Disease Control and Medical Statistics National Center of L. Sakvarelidze. Public health city/rayon services will provide vaccination districts with vaccines and necessary appliances continuously and timely and immunization process monitoring at the rayon level. “Cold Chain” capacity provision will be performed in accordance to the determined rule (Decree of the Ministry of Labor, Health and Social Affairs on the “rules of prophylactic vaccination national calendar and safe immunization”).

III. Specialized ambulatory care component

Component provides specialized ambulatory care at the primary health care level.

Financing of the institutions involved in the realization of the specialized ambulatory care components and also particular mono-profile institutions, is carried out in accordance to the executed work.

- Budget-article principle;
- State standard maximum prices;
- Using average tariff;

- Capitation principle.

TB care sub-component

- Revealing all the suspected cases on lung tuberculosis by the primary health care doctor and nurse in the frames of their work;
- Provide diagnostic examination of the mentioned contingent;
- Execute all the visits considered by state standards (intensive and continuous phase, as well as visits during chemical prophylactics) and strictly follow the standard scheme of the chemical therapy.

Ambulatory care of TB patients

While carrying out diagnostic, medicative and preventive activities at the ambulatory level, considered in the sub-component, DOT principle and its monitoring should be strictly followed - controlled standardized chemical therapy with I-st rank medications against tuberculosis, bacterioscopical monitoring, patient visits to the doctor, nurse home visits to the patient.

Main principles of DOT organizing at the ambulatory

- In order to completely control tuberculosis in the ambulatory conditions and successfully carry out controlled chemical therapy, the crucial importance is given to the effective work of DOT nurses.
- Nurses working in the medical teams will carry out the mentioned function in the component (in accordance to the attached instructions). Nurse work will be coordinated by existing tub-dispensaries at the rayon level or doctor-physiatrists and nurses working at the specialized teams.
- DOT nurses involved in the TB-dispensary work will carry out relevant work at their work sites.

Medical care will be provided to all the population in the frames of the component.

Psychiatric ambulatory care

Medical service considered by the sub-component is carried out through specialized psychiatric dispensary network on the whole territory of the country and with the following volume.

- Providing specialized qualified monitoring to the psychiatric patients;
- Providing patients being at dispensary control with major medications in accordance to the state standards.
- Visit;
- Determining initial patient diagnosis;
- Filling form 88 (special contingent);
- Issuing health certificate

Ambulatory care of oncologic patients

Oncologic disease prevention and revealing at the initial stage by specialized teams and oncologists involved in these teams.

Provision of the service considered in the sub-component will be performed at the primary health care institutions, through specialized teams and oncologists involved in these teams (In Tbilisi and Batumi the mentioned service is provided in the municipal-ambulatory care programs).

- Revealing of early stages of cancer;
- Methodological provision of oncological prevention activities in the country through improving oncological disease recording system.

Pregnant Patronage

Medical service considered by the sub-component will be carried out through specialized consultation network, on the whole territory of the country.

Pregnant patronage:

- Pregnant supervision;
- Providing timely revealing of the drawbacks related to the pregnancy and qualified aid on the basis of referral.

Pregnant supervision upper marginal price for the selected organizations equals to 30 lari in the regions and 25 lari in the rayons.

IV. Invalid ambulatory care sub-component and among them expertise and stomatological service

Invalid ambulatory care at the village level will be performed through population ambulatory state program volume; at the rayon level invalids will be provided with specialized ambulatory services and medical-social expertise. Additionally in three regional centers (Tbilisi, Batumi and Kutaisi), invalids will be provided with the medical care (in terms of enlarged ambulatory package-additional consultations and examinations), stomatological service of the invalids – participants of war will also be carried out in the mentioned regional centers.

Invalid specialized medical-social expertise will be carried out in Tbilisi according to the program format.

- Additional ambulatory treatment of the invalids;
- Stomatological service of the invalids-participants of war.
- Invalid medical-social expertise.

V. Medical examination component of the citizens to serve in the military forces of Georgia

At the medical institutions involved in the program implementation at the rayon level (among them in the cities) adult (15 year old) medical examination and specialist consultation will be performed.

Also adult (from 18 to 27 year) medical examination, specialist consultation and laboratory examinations considered by the program will be executed (except Tbilisi and Batumi).

Adult (to serve in the military forces of Georgia) additional medical examination (among them flurographical) will be carried out in the collecting-distributing points before being sent to serve at the military forces.

Medical aid volume

Medical care main package considered by the program:

I. level

Village ambulatory:

- Consultation of the general practitioner, (among them at home), laboratory examinations (among them using expert diagnostic tests). In case of necessity patient referral to the rayon level specialists for consultation.
- Children prophylactic vaccinations considered by the national calendar.

II. level

1. Rayon/city ambulatory-polyclinic network

- General practitioner consultation, laboratory examination (among them using expert diagnostic tests). In case of necessity patient referral to the rayon level specialists for consultation.
- Children prophylactic vaccinations considered by the national calendar.
 - Ptsiatrical care;
 - Medical examination of those to serve in the military forces;
 - Invalid medical-social expertise;

2. Specialized ambulatory care network

- Pregnant patronage, ambulatory psychiatric care, phtisiatric care.

III. Regional level

Invalid medical care will be provided at the regional centers through extended ambulatory package in terms of additional consultations and laboratory-diagnostic examinations.

List of activities defined by State Ambulatory Program

1. Children under 1 year

- 1.1 Obligatory minimum for patronage: doctor's consultation at centre – 6, doctor's consultation at home – 1, nurse's visit at home – 10, specialist's consultation – 4, common blood test – 1, common urine test – 1, analyses of feces – 1, X-ray – 1(if needed). Remark: all kinds of medical services above obligatory minimum are free of charge;
- 1.2 Ambulatory treatment
 - 1.2.1 According to standards defined by the program;
 - 1.2.2 Assurance with the medicines defined by the program.

2. Children 1 – 15 years old

- 2.1 Obligatory minimum for patronage: doctor's consultation at centre – 4, nurse's visit at home – 2, DOT nurse's visit at home (for TB patients) – 12, specialist's consultation – 4 (if needed), common blood test – 1, common urine test – 1, checking clotting time – 1(if needed), glucose in blood – 1(if needed), analyses of feces – 1(if needed), X-ray – 1(if needed). Remark: all kinds of medical services above obligatory minimum are free of charge;
- 2.2 Ambulatory treatment
 - 2.2.1 According to standards defined by the program;
 - 2.2.2 Assurance with the medicines defined by the program.

3. Population 15 – 65 years old

- 3.1 Obligatory minimum for patronage: doctor's consultation at centre – 4(if needed), nurse's visit at home – 4(if needed), DOT nurse's visit at home – 12 (for TB patients), specialist's consultation – 8(if needed), common blood test – 2, clotting time – 1(if needed), glucose in blood -1(if needed) and 6 for diabetics, E.C.G. – 1(if needed) and 2 for the patients with heart ischemic disease, common urine test – 2(if needed), analyses of feces – 1(if needed), X-ray – 1(if needed). Remarks: patients have to pay for the services exceeding obligatory minimum, consultations with endocrinologist are free of charge for the insulin dependent ensured patients, above defined restrictions do not apply to disabled;
- 3.2 Ambulatory treatment
 - 3.2.1 According to standards defined by the program;
 - 3.2.2 Assurance with the medicines defined by the program (if needed).

4. Population >65 years old

4.1 Obligatory minimum for patronage: doctor's consultation at centre – 4(if needed), nurse's visit at home – 4(if needed), DOT nurse's visit at home – 12(for TB patients), specialist's consultation – 8(if needed), common blood test – 1(if needed), clotting time – 1(if needed), glucose in blood -1(if needed) and 6 for diabetics, E.C.G. – 1(if needed) and 2 for the patients with heart ischemic disease, common urine test – 2(if needed), analyses of feces – 1(if needed), X-ray – 1(if needed). Remarks: all kind of medical services above obligatory minimum are free of charge; consultations with endocrinologist are free of charge for the insulin dependent ensured patients.

4.2 Ambulatory treatment

4.2.1 According to standards defined by the program;

4.2.2 Assurance with the medicines defined by the program (if needed).

5. Special aid for ensured pregnant

5.1 Obligatory minimum for patronage: 1st visit(on 13th week of pregnancy) – doctor's consultation, common blood test, glucose in blood, blood group and rhesus, common urine test, gynecology smear investigation, Wassermann test, specialist's consultation; 2nd visit(on 20-22nd week) – doctor's consultation, hemoglobin test, common urine test; 3rd visit(on 30-32nd week) – doctor's consultation, hemoglobin test, common urine test; 4th visit(on 36th week) – doctor's consultation, common urine test. Remarks: all kind of medical services above obligatory minimum are free of charge.

6. Specialized oncological care

6.1 Obligatory minimum

6.1.1 Consultation of the patients with the suspicious of cancer; monthly quantity-not less than 30 visits;

6.1.2 Follow-up after cancer treatment;

6.1.3 To record all cases of oncologic diseases;

6.1.4 Information submission to the oncology national center with the determined rule and form.

7. Specialized TB care

Obligatory volume-activities considered by the program – visits and supply with medicaments;

8. Specialized psychiatric care

Obligatory volume-activities considered by the program – visits and supply with medicines in accordance to the state standards;

9. Population immunization

Obligatory volume-providing planned and massive vaccinations considered by the prophylactic vaccination national calendar at the working area (The decree of the Minister of Labor, Health and Social Affairs on “determining the rule on providing prophylactic vaccination through national calendar and safe immunization”) and submitting information to the public health care rayon/city centers through the determined rule.

10. Medical examination of the persons to serve in the military forces.

10.1 Obligatory volume-carrying out of the activities considered by the program in accordance to the state standards;

10.1.1 Consultation of the specialist; quantity per case-in case of necessity; note-15 years and 18-27 years old;

Blood analysis; Quantity per case-1;

Urine analysis; quantity per case-1

ESG; quantity per case-1 or in case of necessity;

Note: Only for the 18-27 year old adults to serve at the military forces;

11. Population expertise

Obligatory volume-Invalid expertise for the second time, expertise commission formation and carrying out activities considered in the program.

Annex 23: Municipal ambulatory programme

Objective is to deliver full volume of maximally affordable medical service (curative and preventive) to young (3 -15) and old (>65) population of Tbilisi and to offer special curative/preventive service (it means management of very common chronic diseases) to middle age (15 – 65) population. The last one is so called vertical programme.

List of chronic diseases included in vertical programme:

- Heart ischemic disease (code 120-125; ICD-10);
- Diseases accompanied by hypertension (code 110-115; ICD-10);
- Diabetes (E 10-E14; ICD-10);
- Bronchial asthma (J45; ICD-10);
- Oncologic diseases (D 00-D 09; ICD-10) – 4th grade;
- Parkinson disease (G 20; ICD-10);
- Epilepsy (G 40; ICD-10).

List of laboratory investigations covered by the programme:

1. Common blood test;
2. Hemoglobin, leukocyte count and erythrocytes osmotic fragility test;
3. Glucose in blood;
4. Creatinine;
5. Common urine test;
6. Glucose in urine;
7. Ketone bodies in urine;
8. E. C. G.
9. Cholesterol in blood
10. prothrombin index

Specialist's consultation and laboratory investigation is available free of charge on the basis of district doctor's reference, otherwise patient will be charged according to internal standards of the facility.

List of specialists involved in programme:

- Adult polyclinic –
1. Cardiologist
 2. Endocrinologist
 3. Ophthalmologist
 4. Neurologist
 5. Oncologist (for the patients with IV grade onco disease)
- Children polyclinic –
1. Neurologist
 2. Ophthalmologist

3. Otolaryngologist
4. Cardioreumatologist.

Rule of financial assurance is based on the principle that the most vulnerable group is population from 3 -15 and more than 65 years old. Ambulatory service for them in Tbilisi is free of charge. Tbilisi population aged 15-65 is charged according internal standards for the service which is not included in vertical programme. Home visits (4 times per year) are free of charge only for special group (participants of World War II, patients confined to bed and onco-incurative patients), others have to pay. This was followed by the reduction of home visit numbers and because of this was decided to increase working hours from 9.30 up to 19.30 (two shifts).

Programme budget: total cost of ambulatory aid programme in 2003 was 4500000 L.

Cost of programme components for different age groups:

- For the person more than 65 years old – 15.25L. per year;
- For the middle aged person (15-65) – 1.36 L. per year;
- For the child (3-15) – 7.36 L. per year.

In order to participate in Tbilisi ambulatory programme, the facilities have to meet the minimum coverage requirement:

Facility type	Minimum number of patients for one district doctor	Minimum number of districts per one facility
Children policlinic	660 children	10
Adult policlinic	2400 adults	10
Family medicine centre	2000 children and adults	9

Facility reimbursement is provided on a capitation basis and according volume of performed activities per month. The facility contract volume per year is defined on the basis of population number covered by facility and their age structure. Facility is receiving monthly the 1/12 of year contract cost if the volume of provided medical services is in accordance with the volume defined by programme (see table #1).

Table #1: Maximum volume of patient-visits registered at district level (by one doctor) in different PHC facilities

Facility type	Expected number of visits per day per district	Expected number of visits per month per district	Expected number of visits per year per district
Children policlinic	7,5 visits	159 visits	1908 visits
Adult policlinic	8,16 visits	173 visits	2076 visits
Family medicine centre	8,16 visits	173 visits	2076 visits

- In case the facility provides 80% of activities defined by Municipal programme per month, it receives the total amount of contract cost;

- In case the institution meets 60-79% of requirement from Municipal programme it receives only 80% of contract cost;
- If the institution meets less than 60% of required minimum from Municipal programme it receives 60% of contract cost and issue of contract abolishment with this facility should be discussed.

Facility budget distribution:

Facilities are obliged to allocate 48-50% of programme income for staff salaries, including salary taxes. At the same time gross salary should not be less than 110 L. for district therapist and 80 L. for district pediatrician. Salary for other medical staff is defined by the facility. Only 12-15% of programme income is allocated for the manager's salary and 35% for the indirect costs of facility.