



NATIONAL INSTITUTE OF HEALTH AND SOCIAL AFFAIRS

**THE PROJECT IS IMPLEMENTED UNDER THE FINANCIAL SUPPORT OF  
THE WORLD HEALTH ORGANIZATION**

# **REPORTS**

**ON**

# **PHC SERVICE PRODUCTION IN GEORGIA**

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## Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
CDC	Centre for Disease Control
DFID	Department for International Development
EC	European Commission
FM	Family Medicine
FP	Family Physician
GPM	General Practice Manager
GPN	General Practice Nurse
GvG / EPOS	Contractor team of the Gesellschaft für Versicherungs-wissenschaft und Gestaltung e.V. and EPOS (Health Care Financing Reform Project)
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IDU	Injecting Drug User
IEC	Information, Education and Communications
INGO	International Non-Governmental Organisation
IPC	Interpersonal communications
MoLHSA	Ministry of Labour, Health and Social Affairs
NGO	Non governmental organization
NIHSA	National Institute of Health and Social Affairs
OPM	Oxford Policy Management (Group)
PHC	Primary Health Care
PHD	Public Health Department
RTA	Road traffic accidents
STI	Sexually Transmitted Infections
SW	Sex Workers
TB	Tuberculosis
WB	World Bank
WHO	World Health Organization

## **Introduction**

Government of Georgia has been implementing health care reforms for over the last decade. The development of Primary Health care (PHC) is the main priority of on-going reforms. The Health sector development Strategy envisages the formation of a PHC model that effectively and reliably provides the entire population of the country with high quality yet cost effective medical services and is physically available and affordable. This will contribute to the goal of improving the health status of the Georgian population, with particular emphasis on the most vulnerable and poor. The Strategy calls for major changes in the institutional establishment, functional performance, and financing of the health sector.

In its intention to reform health care system into one based on strong PHC model the Government of Georgia is supported by multiple donor agencies such as the World Bank, British Department for International Development, European commission and USAID. A Memorandum of Understanding (MoU) was signed between these partners with the aim to cooperate in the establishment and further development of a sustainable Primary Health Care system in Georgia.

Donor agencies propose a comprehensive programmes supporting the Primary Health Care development, comprising of technical assistance at national and regional levels as well as investment in a pilot regions (Adjara, Imereti and Kakheti) in terms of refurbishment of existing PHC infrastructure, provision of equipment, health promotion and prevention activities and training of PHC facility staff. The PHC reform programme aims to enhance the capability of the PHC network to meet the health needs of Georgia population through sustainable, accessible and affordable health care services; and to increase the capacity of local communities to make informed health care decisions, promote their active participation in the health care process, and mobilize their resources to create a more sustainable health care infrastructure.

To ensure successful reform implementation, the Ministry of Health, has established a PHC Coordination Board through which all reform activities are managed and coordinated. In November 2004 the MoLHSA issued a policy statement known as the "Road Map" for PHC reform in Georgia. The policy statement was followed by an indication of the specific steps to be taken, including the establishing of four different working groups in which stakeholders should be involved. The MoLHSA viewed this step as a promising opportunity for constructive policy dialog. Professionals and policy makers of different organizations were expected to join, look out for a common assessment of the situation and try to reach consensus while defending their legitimate perspectives and interests. These working groups composed of representatives from all key stakeholders dealing with human resource development, service definition, health management information system development, health financing and health promotion are currently in function in order to adapt the appropriate means to be done in parallel and built up a consistent PHC system. The precise list of working group members is presented in annex 1.

The World Health Organization supported the MoLHSA and National Institute of Health and Social Affairs in setting up necessary arrangements to facilitate this process by ensuring

effective operation and management of working group activities. The working group meetings were prepared and led by the NIHSA consultants:

Mr. Mirian Murjikneli, The working group on health financing  
Mrs. Tamar Gabunia, The working group on PHC services and human resource issues  
Mrs. Khatuna Kuparadze, The working group on health promotion and public relations  
Mr. Givi Nozadze, The working group on Health Management Information Systems

The group discussions were informed by proposals and background papers prepared by OPM<sup>1</sup> and GVG<sup>2</sup> teams. The full list of papers used is allocated in annex 2.

OPM and GVG expert teams provided great support and contribution to the working group activities including preparing final proposals presented herein.

The overall supervision and coordination of the work has been provided by the National PHC reform coordinator (The director of NIHSA).

A total of 52 meetings were held during the period of January-December of 2005. The series of meetings with the Ministerial team were arranged on policy issues associated with the PHC development. The working group facilitators presented summary points, highlighting group recommendations and key issues for a further elaboration and decision making.<sup>3</sup> The joint meeting of representatives of all working groups was conducted in Gudauri in November 2005 where summary proposals were presented and final agreements were reached on key issues related to the implementation of the new PHC service model.<sup>4</sup> Minutes of selected working group meetings are presented in annex 3.

This paper presents a consolidated picture of the key positions that have been taken by the working groups in order to advance PHC in Georgia, specifically through the introduction of the first new village ambulatory clinics. It is intended to serve as a ground for intraministerial discussions and facilitate informed decision making. The document has six sections:

1. List of services to be provided by reformed PHC facilities
2. Organizational structure and Management operations of the PHC facilities
3. Health management information system at PHC facilities
4. Financing of PHC facilities
5. Health promotion activities provided by reform PHC facilities
6. Communication strategy for informing the population, politicians and health professionals of the content and progress of the health sector reform

Each section addresses the main issues as well as some background information where needed. Then identifies the broad options (where appropriate) and finally, offers recommendations on the best options. The format of recommendation at the very least, captures main problem to be addressed. A set of specific activities for preparing implementation phase are also summarized and presented in annex 9.

As the first steps towards the establishment of the new PHC model in Georgia are being made now, the MoLHSA and concerned stakeholders will continue to work on policy preferences for reforming PHC. The proposals generated will draw from and build upon the results from the action steps described in this report and will pave the way for a sustainable PHC system in Georgia.

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<sup>1</sup> Is implementing DFID Georgia PHC development project

<sup>2</sup> GVG/EPOS is implementing EC Georgia PHC development project: To reform the health care financing system in Georgia

<sup>3</sup> The presentations and minutes of these meetings are allocated in annex 3

<sup>4</sup> The event was supported by GVG/EPOS team financed by European Commission

**PART I. SERVICES PROVIDED BY THE  
REFORMED PHC PRACTICES**

## I. SERVICES PROVIDED BY THE REFORMED PHC PRACTICES

### 1. List of services provided by the reformed PHC units<sup>5</sup>

The delivery of PHC services in Georgia must be considered within the context of the overall reform of the health sector. A medium term expenditure framework and a poverty reduction strategy are being developed to provide the pillars on which the future health policy will be articulated. PHC reform is an integral part of this overall process. It can be viewed as the catalyst in changing provider attitudes and patient health seeking behavior.

The key goal of the reform is to improve the health status of the population. This goal will not be achieved if there are no good quality services generated by the renovated PHC clinics which are highly utilized by the population. Naturally, the success of the reform greatly depends on the decision on services provided by the renovated PHC facilities and the way how these services are organized. The list of services to be provided by the reformed clinics has extensively been discussed by the Human Resource Development and Service Provision Working Group.

The roadmap on Georgia PHC reform issued by the MoLHSA made clear the intention of the Government to proceed with the transformation process gradually. Thus to focus on incremental change to developing the existing village ambulatory services without major disruption to the current service provisions from polyclinics or other out patient services at the initial stages of the reform. The working group concentrated accordingly on defining PHC service production model for the immediate future to be introduced at renovated PHC clinics staffed by the re-trained **family physicians** and **general practice nurses**. The working group during discussions has been guided by the basic principle that good PHC system should apply an integrated approach to the health needs and problems of the individuals, the family and the community rather than provide an episodic management of disease. Services to be included into the PHC service package were weighted against a range of clinical and functional criteria including:

- Health need: services should be relevant as per the epidemiological information in terms of morbidity and mortality rates;
- Affordability to users (financial accessibility). Services that can be afforded by the population who need to use them;
- Clinical viability: services should be effectively deliverable in the new rural PHC centres to an acceptable standard within their medical capability in terms of the competencies of the staff and the technology that will be available to them;
- Customer focus: services should meet the demands of local people;
- Sustainability: services should continue to be required to meet local needs beyond the initial “pilot” period and resources should be mobilised for that.

Based on above mentioned criteria working group recommended that the renovated PHC centers should offer comprehensive services within the **limited resources** available and the

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<sup>5</sup> Health Services in the Reformed Village Ambulatory Clinics, Oxford Policy Management/DFID Georgia PHC development project, March 2005



competence of the family medicine teams, including both curative services and some priority preventive and other services. They should be able to address:

- Any health problem presented to them in an undifferentiated manner
- The needs of all segments of the population (regardless of age, gender, income, location, religion or ethnicity)
- The full range of types of services needed at PHC level (prevention, health promotion, diagnosis, treatment, rehabilitation and care).

On the other hand, it has also been fully realized by all involved parties that well equipped PHC model which is able to produce services that are general, available, continuing, context-oriented and co-coordinative may not be possible for Georgia to implement to full extent due to the lack of competence capability in the clinical staff to deliver broad range of services, lack of financial resources to ensure affordability and a demand amongst the local population for these services to be delivered. However, despite to all above mention constrains the working group strongly supported the development of a comprehensive care model targeted according to the priority health needs of the population rather than making some improvements in priority directions selectively.

The next step was to discuss more precisely the scope of services and define ways for incorporating the current vertical programmes into primary health care service package. As the first step on moving to the new system the priority areas such as women's reproductive health, child health and tuberculosis were identified which have to be addressed immediately. The rationale of the working group for selecting these programmes was as follows:

- High Epidemiological evidence that current programmes are ineffective
- Preventative work in monitoring pregnancy, early post natal care, as well TB preventative work and case finding, monitoring DOTS treatment are PHC functions and should be carried out near peoples homes
- All services mentioned above are core functions of family medicine teams all over the world so integration of these activities into PHC service package has to be main objective of the PHC reform in Georgia

The working group, based on conceptual features of the family medicine service model, financial considerations (evaluation of direct and overhead costs of a practice related to the service provision) and the current organizational and legal arrangements, determined the main categories and types of services to be provided by the family medicine practices. The list of services recommended by the working group comprises of:

1. Free consultation for all (despite to age, gender, physical, mental, social status) patients at Family medicine practice or at patient's home where necessary;
2. Antenatal and postnatal care;
3. Family planning (counseling);
4. Children and adolescents health surveillance;
5. Immunization and vaccination (according to the country calendar)
6. Ensuring the treatment under direct observation of TB patients (DOT)
7. Regular check-ups of population in order to identify high-risk people to cardiovascular diseases and diabetes mellitus
8. Management of common chronic conditions
9. Elderly health check (above 65 year )
10. Some lab tests and diagnostics:
  - ECG;
  - Othoscopy;

- Ophthalmoscopy
- Pick flow metry
- Measurement of arterial blood pressure
- Anthropometry

Brief descriptions on the scope of services under each category and factors which may have an impact on their delivery by the reformed PHC clinics, as discussed by the group, are presented below.

### **a. PHC consultation**

A typical PHC consultation will comprise of (i) interviewing and history taking, (ii) physical examination, (iii) patient management and problem solving, (iv) anticipatory care and advice, (v) record keeping and (vi) an awareness of how this consultation process affects the patient's health seeking behaviour. The consultation process will take place in a face to face situation at the FM clinic, but it may in particular circumstance take place in the patient's home. In extreme emergency situations, conversations over the telephone could also include many of the essential elements of a consultation. Every consultation should be treated as a good opportunity to conduct preventive activities e.g. identifying individuals at high risk of coronary heart diseases and diabetes, elderly health check according to the rational and evidence based screening procedures.

It has been emphasized by the working group that each element of the consultation process should be performed according to evidence-based guidelines and protocols, so that good clinical management will be ensured.

### **b. Maternal and reproductive health care at PHC level**

Integration of maternal and reproductive health care into the service package provided by family medicine practices is of particular importance. The significant deterioration in the last 10 years in the key health status indicators of infant and maternal mortality calls for an urgent action for changing current practice in the field of maternal and child care.

In Georgia, Maternal and Reproductive Health outside the hospitals is at present completely provided by the Rayon Women Consultation Centre, staffed by specialists in obstetrics and gynecology and midwives. They are responsible for monitoring the health status of the mother and fetus during the uncomplicated pregnancy. If any difficulty occurs the pregnant should be referred to hospital. Considering the fact that in most countries where family medicine model is well developed reproductive health services are delivered by family physicians, general practice nurses and midwives with highly efficient and effective results the working group strongly supported the idea of moving antenatal service delivery function from "vertical" antenatal care programme into integrated package of health services provided by family medicine teams. Undoubtedly this is rather complex transition and will require considerable time and effort to be implemented. The following issues were identified by the group as having critical impact on shifting of OB/GY responsibilities to family medicine teams and antenatal care delivery itself:

- It will require some time and good patient information campaign to ensure that the family medicine team is perceived as a reproductive health care provider by the population
- Given that the newly trained PHC doctors and nurses will require to develop competency in handling these activities no immediate shift can be in place;

- As number of family medicine teams in the nearest future will not be sufficient to fully cover population needs in antenatal care provision the obstetricians will remain for the moment at Rayon Polyclinic level;
- Temporary co-existence of two different PHC providers delivering antenatal care services may cause some overlapping and inefficient use of resource unless their responsibilities and relationships are clearly defined;
- Initial professional capability of newly retrained family practitioners may not be sufficient for delivering antenatal care at an acceptable level of quality;

In order to minimize the negative impact of above mentioned factors the working group recommended introducing specific measures. In particular,

- To establish special clinics for pregnant women at family medicine practices and ensure provision of ante-natal care services jointly by FM team and a contracted obstetrician/gynecologist. The number of sessions per month will obviously depend on the number of pregnant women in the catchment area of each centre;
- To provide on-job clinical sessions for newly re-trained practitioner. It is highly advisable that sessions are conducted jointly by experienced family physicians and OB/GY specialists;
- To distribute functions between FM provider and OB/GY from women consultation centre according to the circumstances (skills and competences) of each family medicine practice centre, along the guidelines and protocols that will be designed

### **c. Child care**

Child care at PHC level will cover well baby clinic (including neonatal care and child growth and development monitoring) and immunization. Adolescent health is also an area which should be covered by family medicine teams as it is recommended by best practice guidelines and resource availability allows. Some working group members argued that involvement of the pediatrician will be necessary at least at initial stages before family medicine teams gain more confidence in this area. The easiest way for solving this problem proposed by the group is to encourage peer review practice in FM centers staffed by at least two teams with different professional backgrounds: in internal medicine and pediatrics. The re-trained pediatrician may provide support to former internists and vice versa where necessary. However this can't be the case in solo practices and if the lack of competency in children health care will be identified as a problem then other ways for its solution have to be set out. On-job professional training provided by experienced family physicians in collaboration with pediatricians will be particularly helpful under such circumstances.

### **d. Tuberculosis**

The working group intensively discussed the issues of integration of Tuberculosis care into PHC service package. Nobody argued an importance of the action however the need for transitional arrangements has been recognized in this case as well like in all "vertical" programmes. Considering that psychiatrist physician and nurse are key players of TB management vertical programme, it will require complex changes to fully integrated this service into PHC service package to be provided by qualified family practitioners. Two main areas of TB care: (i) treatment of the known TB patients as per the established Directly

Observed Treatment (DOT) Strategy and (ii) preventive work to avoid the spreading of the disease, including early case detection can be implemented by family medicine teams to some extent in the immediate future. Again, main concern is a professional competence of newly trained practitioners. It is highly likely that newly trained physicians and nurses will require support which can be provided by physicians who will remain at the moment at Rayon Polyclinic Level.

Other issue for consideration is implementation of DOT strategy at a community level. This service was included in the PHC service package to be provided by the village ambulatory nurses almost three years ago. It is obvious now that they fail to accomplish this function. The lack of financial incentives has been identified by the group as main reason for this programme to be unsuccessful. In order to ensure an effective DOT implementation and PHC level it is strongly recommended to introduce financial incentives for PHC teams not just at renovated facilities but countrywide.

### **e. Management of chronic conditions and palliative care**

In epidemiological terms non-communicable diseases such as hypertension, diabetes, etc have all the elements to deserve being considered as priorities at PHC level in Georgia. The working group, taking into consideration cost implications related to this services category, discussed two options for chronic disease management process at PHC level.

1. One option is not to identify chronic disease management as a separate service category assuming that family medicine teams will pay specific attention to checking the health status of the population regarding chronic diseases during routine consultation.
2. Other option preferred by most of the group members is to give clear highlight to this area of services and consider it as a specific set of activities family medicine teams should provide rather than to put this function under the heading of the routine consultations and follow up visits. Pros and cons of each option are summarized below:

#### ***Option 1:***

##### **Chronic disease management is identified as a separate service category**

##### ***Pros***

- 1) *Epidemiological importance of Noncommunicable Diseases for Georgia*
- 2) *Well established current practice and physicians perception that this is the cornerstone activity which should take place at PHC level*
- 3) *Resources available will allow introducing many components of chronic disease management e.g. patient education and counseling; health promotion activities supporting life style modification, ongoing care through offering follow up visit, screening via diagnostic tests available and etc.*
- 4) *A performance targets could be set specifically for the service area which will enhance commitment of the providers to generate good quality services*

##### ***Cons***

- 1) *Essential drugs for managing common chronic conditions will not be available*
- 2) *Unrealistic expectations of the population over the service entitlements*

#### ***Option 2:***

## **Family Medicine team still treats chronic patients but this is considered as a part of routine consultation and follow up visits**

### **Pros**

- 1) As drug component is missing chronic disease management model as it is seen per “best practice” standard can’t get operational. However, chronic patients will still receive medical care through physician’s consultations and follow up visits*
- 2) Unrealistic expectations over service entitlements avoided*

### **Cons**

- 1) Needs of chronic patients may not be properly identified and met*
- 2) If not specifically targeted the importance of good clinical care provision for this patient’s group may be underestimated*

Another important issue raised by stakeholders is **palliative care** provision by FM teams: this still will be limited to FM team home visits to terminally ill and provision of narcotics where necessary. According to the current regulations the oncologist working at rayon level PHC facility (Rayon polyclinic, financed under the State Ambulatory care programme) ) is a key person in charge of narcotic drug prescription. As the role of family medicine teams should get central in palliative care provision for terminally ill the responsibilities have to be shifted accordingly. Additional technical work and discussions are required to refine palliative care model further with a clear definition of roles and responsibilities of involved parties. An appropriate regulatory framework should be developed and applied to allow the model to get operational.

## **f. Managing common medical emergencies and minor trauma**

Under the laws of Georgia and according to medical professional standards, all doctors are expected to provide services to a person who has suffered an adverse medical event which requires immediate attention. Any such event, “emergency”, which occurs within normal operating hours of the PHC Centre, will be regarded as a normal PHC consultation. So Family medicine teams have to be capable to deal with the common medical emergencies. There should be appropriate equipment and medicines readily available for FM teams to provide first aid in the case of emergencies occurring at FM practices.

Since the government of Georgia is offering a universal ambulance service for emergency cases, FM teams are no longer directly responsible for this particularly out of the working hours. It should be taken into consideration that in high mountainous areas not reachable in winter ambulance services simple may not operate and family medicine team as only health care provider in the area has to be able to manage all emergencies. The needs of such PHC practices in terms of the (1) medical equipment and drug provision; (2) staff competencies and (3) transportation and communication means should be considered as an area of particular importance and addressed accordingly. Additional responsibilities of PHC teams related to emergency care provision have to be specified and regulated under the contract with the state purchaser.

More technical work also is required to define the role of PHC team in emergency care provision, especially in light of the existing ambulance services.

### **g. Laboratory and other diagnostic services**

The initial point for the working group discussion on laboratory and other diagnostic services to be included in the PHC service package was overview of the the practice of rational use of investigations in Georgia which is quite dramatic. The need for investigation is often defined by the patients themselves as they prefer to secure the money by not attending the physician and be investigated instead. Most of the physicians simply are not familiar with an evidence based guideline on selecting and rational ordering of investigation. Those who are aware of this often find a reason to ignore evidence based recommendations. Fear of patient dissatisfaction or procrastination on the part of the doctor, come into play in daily practice and are difficult to influence.<sup>6</sup>

Other important issue for consideration was the specific nature of the clinical decision making process in family medicine. Normally, this is not based on high technology investigations. The specific probability based decision making process is mainly informed by knowledge of patients and the community. However the family physician ought to make decision on the need of such investigation and ensure referral. Some working group members argued that the limited opportunity for patients to be investigated at primary care setting could bear a certain risk for their health. Particularly if assumption is made that family physician usually sees the patient at an early stage of disease when the predictive value of clinical examination and tests are less certain. Risk management under these circumstances is a key feature of the discipline. Laboratory tests and investigations at a very early stage of disease, even if those are available at PC level, may still not have much value as long as the issue of referral for urgent, severe cases is a concern.

On the other hand, the availability of some basic tests and investigations in PHC service units is very important. As an outcome of above discussions the working group resumed certain criteria for inclusion of lab tests and clinical investigations in the PHC BBP. Investigations should be easily available for PHC physicians and there patients if:

- They are used in evidence based, effective screening programmes e.g. blood pressure measurement, ophthalmoscopy to screen for hypertensive/diabetic retinopathy, sugar in blood or urine, blood cholesterol and etc.
- They are necessary for decision making in chronic disease management e.g. blood sugar monitoring, protein in urine, serum creatinin etc.
- They may be helpful in decision making on referrals to secondary care for non urgent cases e.g. sputum microscopy, ECG, X -ray. However these tests are not necessary to be conducted in all PHC service units. Patients could be referred to PHC diagnostic centres and after test results FP decides if referral to specialists is needed.

The working group considering clinical effectiveness, efficiency and performing capacity at family medicine practice level proposed the following rapid tests to be provided by the re-trained family physicians and nurses:

- Urine analysis (10 parameters dipsticks);
- Glucose in peripheral blood test (reading via glucometer);
- Hemoglobyn;

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<sup>6</sup> EU PHC development project, Options paper on PHC service Model in Georgia, 2004 with contribution of OPM team

- Pregnancy test;
- HIV

The working group recommended also some laboratory tests which are still important for clinical decision making at PHC level but they require laboratory facility to be performed. Since there will be no laboratory facility including lab staff available at family medicine practice level patients will be referred to the appropriate laboratories. The list proposed by the working group is presented below:

- Full blood count;
- Ocult feacal blood;
- Venous blood test on glucose;
- Feacal ocult blood
- Bacterioscopy of vaginal smear;
- Creatinin;
- Total Cholesterol;
- Blood resus and group;
- Serological test on sexually transmitted diseases (Vaserman);
- HIV/AIDS

The costs for above mentioned tests are estimated and included in the cost model for one PHC team (which account 18 852 Gel per team).<sup>7</sup> These tests can be financed by a contract between the PHC facility and the laboratory/diagnostic centre (supported with funding from the Government's purchasing agency). FM Teams will refer patients requiring the above services only to laboratories/ diagnostic centers which have entered into contracts through proper licensing.

The following issues were identified by the working group as having critical importance for laboratory and diagnostic service provision by newly established family medicine practices:

- Driven by the desire to increase patient's satisfaction and generate demand on PHC services family physicians may overuse available rapid tests and other diagnostic capacity (e.g. ECG). So rational use of available laboratory tests has to be encouraged through introducing evidence based clinical guidelines, practice protocols and performance evaluation tools;
- The new PHC model should provide optimum geographic accessibility to all services including lab and diagnostics. Appropriate organizational arrangements have to be set up by pilot practices to ensure easy access for patients to laboratory tests which can't be performed locally and thus the patient has to attend rayon level or any other appropriate laboratory. The expectation of the working group is that such arrangements will be reflected in the Master Plan for developing functional Laboratory Network which will be finalized in due course under the World Bank PHC development project support.

## 2. Pharmaceuticals

Pharmaceuticals of all kinds are an essential component of PHC, and one with a particular bearing on the credibility of the system. They also have enormous implications in terms of costs.

A limited range of essential pharmaceuticals will be available at the PHC centers. They will include:

- pharmaceuticals within some priority services, such as TB care and immunizations

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<sup>7</sup> MODEL, COST AND FINANCING FOR PILOT Report of the Joint Working Group on Health Financing, National Institute of Health and Social Affairs, August 2005.

- insulin for diabetic patients
- narcotics for cancer patients
- drugs to provide the first aid during minor traumas and common medical emergencies (the drug list has been elaborated by the expert teams and approved by the MoLHSA)

However there may be justification for additional pharmaceutical benefits in the BBP. There can be essentially two potential objectives to doing so,

- To generate demand for the health services, and thus increase PHC service utilization and health status of population;
- To act as a financial protection mechanism that protects target groups from catastrophic drug expenditures that can drive individuals and households into poverty.

Both types of scheme require a substantial amount of further work in developing management systems and in providing training. The budgetary constraints under which PHC is operating in Georgia makes impossible to introduce either of the schemes in the nearest future. It should also be taken into consideration that drug benefit schemes if implemented can't be restricted to just pilot regions; countrywide implementation strategy has to be developed and cost calculations made accordingly.

Other important issue is to encourage rational prescribing of pharmaceuticals and to ensure that this is done according to the evidence based clinical guidelines.

### **3. Health promotion activities**

This is fully discussed in the report prepared by the health promotion and public relations working group, however in this section it is worthwhile to emphasize that health promotion should be treated as an integral part of family medicine team activities. In addition to providing direct health care services, the staff of the new PHC centers will undertake health promotion and health education activities with the objective of raising the level of awareness in the catchment population of important health issues and of the services available at the new centers. Considering given importance of this activity for the successful functioning of family medicine model great support is needed to equip FM practices with recourses required (e.g. flip charts, posters and leaflets for patients).

### **4. Supplementary package at PHC level**

Although the primary focus of all PHC facilities in the pilot areas will be to deliver the services in the basic package of benefits, some facilities, if allowed, could choose to offer additional services that are currently outside the PHC BBP.

The issue of provision and financing of supplementary services has extensively been debated by the working group.

It was argued that an additional services may adversely affect a performing capacity of PHC teams contracted under the State financed programs and prudence would advise to give a moratorium of for example 6 months, before allowing premises to choose to deliver a supplementary list of services. It was also taken into consideration that the current legal status of PHC facilities which will not change in the immediate future does not allow any restriction in service provision profile. Even under such circumstances it is vital to ensure that family medicine teams are engaged in PHC BBP service provision with a great commitment and this is strengthened by a relevant contractual arrangements. The contract between family



medicine practice and purchaser should clearly state that during working hours envisaged within the contract no additional services can be provided by FM teams.

The issue of additional service provision appeared to be one of the most important for physicians and nurses involved in re-training schemes. Knowing rural circumstances and realizing needs of the local populations they raised two major issues for clarification such as (i) home visits and (ii) out of hour's services.

1. The working group recommended that home visits due to severe mobility restrictions on the part of the patient should be considered as part of the normal PHC consultation. The need and timing for home visits has to be determined by the family physician, however fear is expressed by the physicians that this entitlement if not well explained may be overused by the population. Home visits in which there is not a practical impossibility for the patient to visit the PHC facilities have to be considered as part of a private agreement between the patient and the health professional and should not take place within regular working hours. Outside exceptionally isolate areas, every non urgent service outside the working hours should also be considered as part of a private agreement between the patient and the health professional.
2. Family medicine teams might have claims from the population within or outside their catchment areas on emergency or non-emergency service provision after normal working hours. In principle, emergency cases are covered by the State Ambulance Programme, but there are mountainous regions in which the ambulances simply cannot operate in wintertime due to weather-related restrictions, so these cases will have to be attended by the Family medicine teams. In this case, the FM Team has to be entitled to charge a fee for such consultation but will not be allowed to refer the patient for free diagnostic services. This policy would not extend to an emergency situation.

## **5. Conclusion and recommendations:**

The process of defining most appropriate PHC service provision model for Georgia will require discussion on each component which would make this model functional. The working group focusing on "immediate" reform objectives came up with some recommendations to the PHC management board on composition and scope of services to be provided by renovated PHC practices staffed by family medicine teams composed of 1 family physician and 1 general practice nurse. Areas where further technical input and consensus building is required before recommendations are made were also identified.

### **It is recommended:**

1. To define list of services in the basic benefit package for new family medicine centers as listed in section I (page 7);
2. To define list of laboratory tests and diagnostics to be included in the basic benefit package for new family medicine centers as listed in section I (page xxx);
3. To ensure gradual integration of priority health programmers into PHC service package via appropriate transitional arrangements which should include:
  - a. *Easy access for family physicians to competent "second opinion" that can be provided by rayon level specialists (e.g. OB/GY and physiatrist);*
  - b. *Encouraging joint clinical sessions of family physicians and selected specialists;*
  - c. *On-job training and clinical supervision provided jointly by experienced family physicians and specialists as needed.*

4. To elaborate and set up an appropriate organizational, regulatory and financial arrangements for emergency care provision by family medicine teams located in remote areas where ambulance service can't operate;
5. To promote good clinical practice via introducing evidence based clinical guidelines and protocols which has to be developed with a broad participation of professional bodies (physician and nursing professional associations);

The group has been mainly focused on determining features of PHC service model which will be feasible to introduce in the nearest future. However vision on mid to long term arrangements has not yet been discussed. The working group identified areas where additional technical input of the local experts and implementing partners is required to prepare proposals which will help to lead a policy dialogue with the Ministry and reach a consensus among all stakeholders. **The priority issues** for a further elaboration are listed below:

1. Linkage between primary and secondary care and modalities of referral;
2. Long term plan for absorption of all vertical programmes into the PHC and specialist based secondary care sector;
3. A policy on emergency services in PHC with attention to the issues of transport and secondary (specialist or hospital) care has to be developed;
4. A policy on supplementary service provision by renovated PHC facilities has to be developed.

**PART II. ORGANIZATIONAL STRUCTURE  
AND MANAGEMENT OPERATIONS AT  
PHC FACILITIES**

## **PART II. ORGANIZATIONAL STRUCTURE AND MANAGEMENT OPERATIONS AT PHC FACILITIES**

### **2.1. Human Resources in PHC**

This section discusses (1) the workforce and (2) organisational arrangements that will be needed to deliver those PHC services that Georgia will offer to its population. The following aspects are considered:

- 1.a. numbers and categories of PHC staff
- 1.b. eligibility, roles and responsibilities of PHC staff
- 1.c. competencies and training
- 1.d. deployment of staff resources
- 1.e. professional performance monitoring and quality
- 2.a. customer enrolment
- 2.b. guidelines for the continuity of care: visits and referrals
- 2.c. patient's satisfaction and participation
- 2.d. practice management and organisation of PHC Facilities (including information and financing system)

#### **2.1.a. Numbers and categories of PHC staff**

##### *i. Clinical personnel*

The approximate rule-of-thumb to calculate PHC staff in the pilot regions is 1 doctor and 1 nurse per 2000 inhabitants. This decision was made by the PHC management board in June of 2004 based on initial financial analysis of different options proposed.<sup>8</sup> The 15<sup>th</sup> August 2005 financing paper has refined this figure and suggests different criteria will be used. E.g.

- Remote areas: 1 doctor and 1 nurse per 1000 inhabitants
- In villages: 1 doctor and 1 nurse per 1500 inhabitants
- In rayon centers: 1 doctor and 1 nurse per 2000 inhabitants
- In big cities: 1 doctor and 1 nurse per 2200 inhabitants

The option of increasing the number of nurses can also be the case. E.g. if village population is 2000 then it would be reasonable to compose PHC team of 1 doctor and 2 nurses.

Such variations will have obvious implications in terms of expected workload per professional and professional incomes. It will also lead to higher per capita costs. Full financial analysis of these options considering countrywide implications needs to be made before any amendment in ratio of 1 physician: 1 nurse: 2000 population is recommended. Other issue is universal applicability of any above mentioned variations in the country. The master planning exercise conducted in three region of Georgia identified many remote villages where geographic accessibility dictates to keep PHC facility for very small populations (less than 1000 or even smaller). Due to such geographic specificities it will be unavoidable to allow exceptions or to think on different arrangements for such places.

It is obvious that the needs of small, remote population centres will not provide sufficient work for a full FM Team of one FP and one GPN and provision of such a level of service would be a waste of scarce resources. Therefore, it is reasonable to staff centers serving population less

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<sup>8</sup> EU PHC development project with support of OPM team, "Options on PHC service model in Georgia", June 2004

than 500 only by a general practice nurse who will be notionally attached to a GP at the closest possible larger centre. The “nurse only” centers will not have separate legal status; they will be part of the larger centre. Naturally, such arrangement will have some implications on services provided by the PHC facility. Since there will be physician from the closest PHC facility involved in service provision no specific restrictions will be in place. However availability of services would greatly depend on availability of physician’s time and frequency of visits to “nurse only” clinic. General practice nurse should be able to recognize the need of urgent referral to mentor family physician or, in exceptional cases, directly to the specialists.

***ii. Non-clinical personnel***

Different proposals prepared by expert teams suggest discussion of the role of administrative staff alongside with other medical personnel. It is important to identify the additional categories of non-medical staff for larger centers, particularly receptionists, laboratory technical staff, assistants, IT specialists, accountants, etc. It is recommended to determine exact number and categories of such non-medical staff only after carrying out organizational procedures and volume of work at each pilot unit, though for preliminary evaluation and based on the Georgian experience and PHC facilities need assessment the following option of staffing the facilities with non-medical personnel is proposed (see table). This option assumes one full time person to fulfill a management function and one full staff to fulfill a reception function for 5 PHC teams, one full time staff dealing with statistics and accounting for 10 PHC teams. As for the watchman, it will be necessary for each facility.

Staff	Recommended staff members for different number of PHC teams				
	1 PHC team	2-3 PHC teams	4-5 PHC teams	6-7 PHC teams	8 >PHC teams
Physician	1	2-3	4-5	6-7	8 >
Nurse	1	2-3	4-5	6-7	8 >
Manager (1 for each 5 PHC team)	0.2	0.4-0.6	0.8-1	1.2-1.4	1.6
Med. receptionist	0.2	0.4-0.6	0.8-1	1.2-1.4	1.6
Watchman/Fireman	0.2	0.4-0.6	0.8-1	1.2-1.4	1.6
Lab. technician	0,2	0.4-0.6	0.8-1	1.2-1.4	1.6
Other	0.2	0.4-0.6	0.8-1	1.2-1.4	1.6

***Principle for staff unit determination***

Based on the number of the population the following principle for determination the staff unit is proposed: according to the number of the population staff unit above 0.25 and including 0.75 is equaled to the 0.5 staff unit and from 0.76 to 1.25 is equaled to 1 staff unit.

***iii. Importance of the staffing the PHC facilities with appropriately qualified personnel***

The issue of licensing and eligibility for employment in PHC has a major impact on the numbers and categories of PHC staff and thus requires attention. The current system in Georgia has produced an insufficient number of PHC staff and therefore they will need to be taken from other clinical professional profiles in order to develop PHC in the country.

The critical issue (particularly for doctors) is how to align Georgia with the EU requirement that PHC staff require *specific* qualifications for delivering PHC as a specialty (that is, not any doctor can perform PHC activities either at the end of his/her licensing process or because “similar” specialties have been studied).

### **2.1.b. Eligibility, roles and responsibilities of PHC staff<sup>9</sup>**

Clear description of functions and responsibilities of PHC staff is essential for effective performance of PHC team. This is considered in licensing requirements, issued for any professional (the same relates to the standard job descriptions of each staff member, including supplementary personnel).

Functions and responsibilities of family physicians and practice nurses in Georgia are described in the statutes approved by the Decree of the Minister of Labour, Health and Social Affairs N103/o from April 15, 2002 (developed in frames of DFID funded PHC development Project 2000-2003). In 2005 arose the question of delegating to the practice nurses the administrative functions, which were reflected in new training programme (Decree of the Minister of Labour, Health and Social Affairs of Georgia N128/O from May 13, 2006). These documents will need to be reviewed as part of the ongoing development and evaluation of the pilot project.

As mentioned above, there is a need of administrative personnel along with physicians and nurses. The working group extensively discussed the concept of functions and responsibilities of managers in PHC system. It has been generally accepted that a task as large as the reform of PHC in Georgia requires enhanced management resources. The need of strengthening management capacity at each level of the system has been recognized by all involved parties. However final proposal on the scale and form of enhanced management requirements and organization is not prepared yet.

### **2.1.c. Competencies and training**

The performance of health systems depends mainly on the knowledge, skills and motivation of their personnel. However, Georgia has not adapted its medical education and training to match the shift in strategic emphasis towards primary and preventative services. Despite some specific initiatives, and a very large number of legally accredited institutions offering competing PHC curricula, the health workforce continues to be dominated by networks of specialists with very narrowly prescribed skills. Georgia’s PHC skills base remains amongst the lowest of the countries of the former Soviet Union (in turn the lowest in Europe).

It is critical that the skills of the doctor and nurse teams working in the reformed village PHC clinics are upgraded, so that they are competent to deal with the range of health problems presented to them by any person in their locality regardless of age or gender. It is proposed that this should be achieved through a programme of retraining and continuous skills development of practicing village doctors and nurses, so that they can adopt a patient-centered approach to dealing with a broad spectrum of health issues. The retraining programme should also cover the skills needed by the proposed rayon manager/developers. The list of existing training programmes for PHC staff is presented in annex 2.

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<sup>9</sup> Retraining for Staff in the Reformed Village Ambulatory Clinics., OPM-DFID PHC Reform Support Programme, March 2005

A professional developmental curriculum must start from the underpinning knowledge included in the educational syllabus, and then build required skills and competencies through training; clinical supervision (provided by the experienced family physicians and other specialists where necessary) and continuous medical education programs. The evidence shows that doctors and nurses undergoing retraining want to learn new practical problem-solving skills through applying them in clinical settings with appropriate tutoring and support. Clinical supervision is thus vital to the retraining process.

To address these issues a two-stage retraining process is suggested as follows:

### **STAGE 1**

- Small groups of doctors, nurses and managers from the three pilot regions undergo an intensive 6-month program of tuition in new PHC skills (940 hours for doctors and 816 hours for nurses).
- The syllabus is divided into modules, each of which comprises input of new knowledge, practical demonstrations, and a clinical application session.
- After satisfactory completion of this stage, including passing an examination and practical tests, doctors. After satisfactory completion of this stage doctors will be allowed to take the Unified State Examination, leading to a license to practice as a Family Medicine Specialist.

### **STAGE 2**

- Staff return to their villages to apply their new skills for up to 18 months to prove their competence.
- Doctors will work under clinical supervision and record evidence of their clinical practice in learning portfolios.

The issue of re-training process quality assurance is an area of a particular importance. Since there is no well established and functional PHC workforce training quality assurance structure in Georgia, but there is an urgent need of delivering training programs for preparing the new cadre of family medicine practitioners, some transitional arrangements have to be in place before the system develops. In regard to training for staff of the pilot centers the working group discussed three options. The first is to leave the issue of quality to each donor organization. A variation on this option is to assign responsibility for Quality Assurance of the training process to each training organization in charge of delivering the training. In either case the quality of emerging FMS doctors will be variable and largely uncontrollable. The preferred option is to assign responsibility for Quality Assurance of the training process to the PHC Board or its equivalent structure in the future (which should set up an independent body with participation of all concerned academic institutions as soon as possible).

#### **2.1. d. Deployment of staff resources**

International experience has shown that PHC involves a process of professional and institutional development which not only requires training the workforce but also motivating it (through financial and other means) and keeping its skills updated. The actual delivery of services also requires the efficient deployment of the workforce in line with clear policy objectives. Flexibly deploying human resources in primary care in order to achieve desired policy outcomes is a fundamental step to achieving improvements in services for the population of Georgia. The pilot schemes should be used to measure and learn about different

arrangements. It would be advisable to give the pilot exercises some specific space and safeguards for variations on existing methods of working and monitoring. An initial period of 2 years is seen as appropriate. A clear decision is needed about all this so that the pilot experiences can be prepared accordingly.

Also some transitional arrangements will be needed between the selection of appropriate staff for retraining and their actual deployment as fully qualified PHC staff at the end of the training period.

### **2.1. e. Professional performance monitoring and quality**

The development of a sustainable, well-managed PHC system in Georgia requires a continuous monitoring and evaluation of the services provided. When the services which are to be included in the basic benefits package for the pilot centers have been determined, provisions for engaging with the professional associations and other stakeholders will be needed to develop an appropriate Quality Assurance monitoring system for the PHC pilot. The expert teams will continue to work on this direction and prepare proposals for further discussions by the spring of 2006.

## **2.2. Organization of PHC facilities**

### **2.2.a Customer enrolment**

The conditions under which a person gets enrolled in PHC (e.g. based on the territory where the person lives or by his/her choice, individually or because of enrolment of the head of the family, etc) have a direct influence on many aspects of PHC. Which type of organisational arrangement would be most appropriate for Georgian PHC system needs to be decided. To assign patients to service delivery points according to the geographic accessibility might be the best option as it is close to the current situation. However, it does not respect the patient's freedom of choice; although in group practices patients still have a choice. In remote areas (single practice) there was and will be no choice.

As part of the implementation planning stage the patient enrolment system will need to be developed including the design of forms, flow of forms, checking procedures, patient renewal and so forth.

### **2.2.b Guidelines for the continuity of care: visits and referrals**

The way in which visits to PHC are organised needs to be explicitly defined from two points of view: (i) the path of the patient through the surgery and (ii) the guidelines and protocols for addressing specific conditions.

The first patient visit is particularly crucial and procedures will need to be designed to open a medical record and everything related to the patient information system as a preliminary step before the history taking ("anamnesis"). The procedures for dealing with patients and visitors need to respect the rights of patients and accord with the guidelines and standards that will be developed in the implementation plan



At the present time there is little insight into the referral system in Georgia as referrals are not required to be reported about. No information management system for referrals exists. Two dimensions therefore need to be addressed in designing the new PHC pilots:

- (i) policies and procedures (what and when to refer and where to refer, gate-keeping, etc) and
- (ii) guidelines for referral (how exactly to refer?)

Policies and procedures for referral systems will need to be prepared prior to the commencement of the pilots. This will include flow diagrams and decision charts for use in the PHC pilot practices

### **2.2.c. Patient's satisfaction and participation**

Effective customer (patient) feedback is an essential element of any service organization. The advantages of such a system are that it will:

1. Generate effective managerial information. (see 2.2.d Practice management below)
2. Help ensure that the services provided by the state address the genuine needs and concerns of the local population.
3. Will encourage active community involvement
4. Will foster professional accountability to patients

This system should be developed through consultation with the local community but as a minimum it would include procedures for patient complaints and customer satisfaction surveys. These procedures and relevant forms together with the associated legal implications can be addressed in the implementation planning.

### **2.2.d. Practice management and organisation of the workload in the PHC facilities**

The reform of the PHC system is rightly focused on the services to be offered, the quality of the physical and human resources and the financing arrangements. However, it must be recognised that these are only components of a total system and, at the PHC Centre level, components of a total organisation which, in turn, are also parts of the total system. The point is that if the overall system and each of the PHC Centres are not well managed the reform will fail. This section of the document describes proposals for both: overall system management during the reform period and PHC facility management.

As legal status of practices and health care providers have significant impact on the process of the practice management, this is also described in the chapter.

#### ***2.2.d.1. Central (MoLHSA) Level Management***

The establishment of a truly reformed PHC system involves complex changes and requires development of good management capacity at Ministry level to ensure implementation of proposed actions leading to a system development. Naturally, key responsibility of PHC reform management lays on MoLHSA which fulfills this function through its central office and regional departments.

Goal of the PHC reform management is to develop, implement and based on the evaluation data analysis, improve family medicine led PHC programme.

The implementation of the Government's PHC Reform system should have a single coordinating point to provide focus and leadership for the process of the reform. The coordination body has to have clear and direct access to the First Deputy Minister and be referred to as the PHC Reform Implementation Unit, (the Unit).

The role of the Unit is to "make things happen" rather than undertake the tasks itself. It is a co-ordination, evaluation and planning unit, which must liaise closely with the line functions of MoHLSA and its regional offices to ensure that their activities are consistent with the needs of the PHC reform process. It **does not** replace the functions of the health department of MoHLSA which ensures that the many new and complex activities are carried out according to an implementation plan and in accordance with the policy directions from the Minister and First Deputy Minister.

The principal statements of PHC reform management unit proposed by HPU team are as follows:

1. Development and approval of PHC reform implementation programme;
2. Development of the draft version of contract on state purchasing process for purchaser and provider;
3. Development of the draft version of contract between PHC legal entity of private law and its branch;
4. Development and approval of rules regulating receiving of information from PHC facilities, their reimbursement and accountability procedures;
5. Elaboration and adoption of regulations for collecting of information about PHC program progress; information movement and identification of responsible units/managers;
6. Identification of quantitative and qualitative indicators for assessment and monitoring of PHC reform and program implementation process;
7. Establishment of PHC laboratory network, development and approval of its functioning, financing and management plans;
8. Monitoring and evaluation of PHC laboratory network based on preliminarily determined indicators. Submission of the recommendations developed on the data analysis to the MOLHSA, in order to improve performance of the PHC laboratory network;
9. Development and approval of monitoring and evaluation plan for implementation of PHC reform
10. Monitoring and evaluation of PHC reform implementation process according to preliminarily identified indicators;
11. Obtaining from regional departments and Funds information about the results of PHC facility performance for the first three and six months periods (2006) and its analysis. Development of proposals based on this data and monitoring results and their submission to the MOLHSA;
12. Discussion of the first 6-months results at the MOLHSA and development of proposals for improvements;
13. Development of short- and long-term strategic plans for PHC reform countrywide roll out;
14. Inclusion of PHC reform costs into mid-term expenditure plans.

Staff of the reform implementation central unit or its regional focal points should satisfy the following criteria:

1. Having Special training on PHC reform management;

2. Having good knowledge of PHC structure, functioning and financial arrangement and its role in the health care system of the country;
3. Being familiar with the Fund's structure, aspects of its operation and details of contracts made between the Fund and PHC facility;
4. Having good skills in monitoring and evaluation technologies and knowing specificities of their use in health system.

### ***2.2.d.2. Practice management***

For the purposes of this paper Practice Management is defined as the way in which the workload (derived from the PHC service requirements specified in 1 above) is organised at each PHC centre in order to actually deliver the services to the local population. It includes organising all the direct delivery and support functions of the each centre in properly planned and efficient manner but it does not include the domain of managing professional competence and quality assurance of PHC.

Each PHC centre in the pilot premise will require a clear statement, possibly in the form of a practice manual, of how the different functions are performed in that facility. This includes the provision of services i.e. issues such as services available, schedule of activities including opening times, etc. and the conditions under which the user is entitled to receive services. Relevant parts of these functions will need to be communicated with the local population as customers through proper signals, posters, leaflets and the like. In addition financial and management information will need to be generated and communicated to the relevant organizations to ensure sound governance of the centers.

It is obvious that the role of the new PHC centers is more than the application of new technical/ clinical skills. The teams running the centers are expected to:

- take an active role in improving the health status of the population it serves;
- consult and be influenced by local communities in developing the style and quality of services as well as the conditions for improving access;
- collect data and use information to review effectiveness and improve services;
- respond to an active purchasing organization, setting targets for service delivery expressed through contracts;
- actively promote the model of family medicine;
- engage with specialist care providers to develop acceptable, cost-effective health care arrangements;
- improve quality of services by extensively using clinical guidelines and protocols, peer reviews and continuous training;
- ensure that the delivery of services is satisfactory for the local community by allowing complaints and suggestions to be freely expressed by service users.

The management of all above mentioned areas involves much more than the management of premises, ordering of supplies and routine administration. Therefore the issue of providing some **support** to PHC teams to accomplish these complex tasks arises. Considering the legal status of PHC facilities (*chapter 2.2.d.3*) no external involvement (even with a purpose “to support”) in the process of operational management of legal entity of private law can be a subject for discussion. According to the Georgian “Law on Law on Entrepreneurs” the director of LLC ensures the management of rehabilitated centers, as private legal entities. In small practices it may be a family doctor. In the bigger centers – the independent manager, who will fulfill only this function. The PHC cost model foresees 1 full time manager per 5 FM teams. In case the rehabilitated unit functions as filiation in ambulatory- polyclinic union, the management will be performed by the filiation's manager. Ambulatory-polyclinic union is

allowed to spend the funds received within the framework of the programme only according to the manager's application; detailed description of functions of PHC facility managers was developed by HPU team which will be submitted to the MoLHSA for approval early 2006 (annex 4). So the best way (considering its feasibility) for strengthening managerial capacity at local level is training of directors/heads of pilot PHC facilities by specifically designed programmes.

### ***2.2.d.3. Legal status of practitioners and the new PHC facilities***

The legal status of professionals needs to be unequivocally defined in terms of their legal status to trade as "medical entities". The MoLHSA will need to decide what it wants the staff to be and then what changes this requires in the current law

Options proposed<sup>10</sup> are as follows:

1. Employed FD teams
  - ✓ Directly by an owner
  - ✓ By administration of the facility (director, or management appointed by the owner-partner). Both in case of solo or group practice the FP or, one of the FPs respectively may serve this role;
  - ✓ By the purchasing agency (SUSIF or any public purchaser designated for financing of PHC programme by the state)
  - ✓ By local community based Organization (CBOs) in areas where such organizations function.
  
2. Self employed:
  - ✓ Incorporated into entrepreneurial legal entity
  - ✓ Registered as non entrepreneurial legal entity
  - ✓ Registered as non-entrepreneurial legal entity\_ "Legal person of Public Law"

The working group came up with the conclusion that option I (FD teams Employed by the owner) is most appropriate option for the time being. Any of the sub options or combination of two or three of them depending on the size of the facility and specific local conditions is feasible.

Different options on legal status of PHC facilities were also discussed. Currently Basic Primary care organizations-Polyclinics and ambulatories are "Medical Organizations" established as LLCs. They belong to a legal person of private law and their everyday business activities are regulated by the "law on Entrepreneurs". In most regions of Georgia (Exempt Imereti) the polyclinics and ambulatories function as Polyclinic-ambulatory Unities. In this case polyclinics and ambulatories operate as one legal person, i.e. the head unit is responsible for obtaining license for PAU, contracting and financial operations. Agreement has been achieved on the legal status of rehabilitated centers during Gudauri meeting in November 2005. The working group recommended to keep the status of rehabilitated PHC facilities as private legal entities. No radical changes in legal status of pilot facilities has to be undertaken unless there is no completed picture on PHC service model in Georgia. Immediate reform targets just small village ambulatories while city polyclinics (which actually could be viewed as hubs for small ambulatories) will remain unaffected for the nearest future. However, it is significant to ensure financial independence of new entities and detach those

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<sup>10</sup> Detailed description of each option, its advantages and disadvantages are presented in "Working paper Legal and organizational Issues for Primary Care Pilot Programme in Kakheti, A. Zoidze et al. "

from old ambulatory-polyclinic unions financially as well as organizationally, though taking into account the technical and procedural difficulties, it would be acceptable to establish the rehabilitated centered as organizationally independent filiations of polyclinic-ambulatory unions, which also provides opportunity of financial independence.

The work needs to be continued on how to change legal status of new PHC facilities in mid to long term future. Options for further elaboration and discussions are:

- PHC facilities as non-profit organizations
- The founder of these facilities be not the central, but local authorities

Ownership status of assets and capital of the new facilities will largely determine the choice of options for legal form of FM practices.

### **2.3. Action plans for the next stage of development**

For the necessary services to be delivered in a managed clinical network, a number of actions will need to be taken. In developing this action plan it is vital that there is a common target of when the first of the new, pilot centres will be available to be “operationalised”. The actions that have been so far identified are shown in annex with the time frames shown being based on an assumption that the first centres will be available on May 2006.

## **RECOMMENDATIONS**

1. To allow exceptions from the defined ratio 1 family physician: 1 general practice nurse to 2000 population where necessary considering local circumstances;
2. To staff centers serving population less than 500 only by a general practice nurse who will be attached to a family physician at the closest possible larger center;
3. To assign population to PHC facilities according to the geographic accessibility criteria at an initial stage of the reform;
4. To introduce appropriate mechanisms to implement a patient satisfaction system for the new pilot PHC centres;
5. To strengthen managerial capacity at local level through specifically designed training programmes for directors/heads of pilot facilities;
6. To ensure full financial and organizational separation of rehabilitated facilities from existing ambulatory-polyclinic unions or establish new units as filiations or branches of APU's where such separation is impossible;
7. To make new arrangements for the assessment and certification of retrained nurses and managers, for whom there is currently no professional recognition;
8. Assign responsibility for Quality Assurance of the training process to the PHC Board or its equivalent structure in the future.

**PART III: THE HEALTH MANAGEMENT  
INFORMATION SYSTEMS AT PHC  
FACILITIES-PLANS AND ISSUES**

## **III. PHC HEALTH MANAGEMENT INFORMATION SYSTEM PLANS AND ISSUES**

### **3.1. Purpose<sup>11</sup>**

The main objective of the PHC HMIS developments is to introduce an appropriate and sustainable Management Information System to support Primary Health Care in Georgia, that will assist in the provision of quality PHC services that are reliable and cost effective, and also assist in streamlining PHC administration and in improving the efficiency of primary health service delivery to the people of Georgia.

To achieve this objective, the following goals need to be met:

- To establish an information system that balances the requirement for management information from both a policy and operational level with the resources available;
- To take into consideration the immediate needs for quality and verified information within operational and resource constraints, while reflecting the potential for increasing demand for management information in the future;
- To provide appropriate information to managers and staff within the Georgian PHC system and to obtain the data necessary to plan for the systematic development of health information;
- To provide users with the necessary skills to carry out their functions effectively utilising the appropriate technology and resources available;
- To develop and manage the HMIS Policy, Information, Security and Procurement Standards and Training.

### **3.2. Agreements so far**

An HMIS Technical Strategy for Primary Health Care has been prepared and has been presented to the PHC HMIS Working Group, and also to meetings of key stakeholders. This Strategy was accepted by the PHC Working Group and by the PHC National Coordinator, although it has not received formal MoLHSA approval.

The intention of the PHC HMIS Strategy was to:

- i) Propose an HMIS Framework which provides a structure within which all PHC HMIS maintenance and developments should fit. If all developments and projects work to a commonly agreed structure this will allow all HMIS work to proceed in the most effective way.
- ii) Present some specific HMIS developments designed to support the PHC pilots that are due to start at the beginning of 2006.

In many areas affecting management information systems, further discussions and formal approval are needed before the suggested recommendations can be agreed and adopted. One of the recommendations within the Strategy relates to agreeing and setting up the mechanisms that will allow these detailed discussions, and also the necessary approval process, to proceed.

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<sup>11</sup> Briefing Paper on Proposals for HMIS Development, DFID / OPM Georgia Primary Health Care Development Project - Proposals for HMIS Development

However, although some issues require longer term action, there are some clear good practice principles have emerged from the discussions so far, and which were endorsed by the HMIS Working Group. It is therefore recommended that these principles should form the foundation for future HMIS work. These principles are outlined below.

It also needs to be recognised that there are several information systems activities that are currently ongoing, or that need to start immediately in order to meet deadlines. It is important that, so long as the immediate work conforms to the good practice principles below, this work is allowed to proceed, at the same time as more detailed discussions are held about longer term agreements,. The proposed HMIS developments to support Primary Health Care are one of these immediate activities that need to proceed as quickly as possible in order to be available in time to meet the information needs of the planned PHC pilots.

The main principles that have been discussed and agreed by the PHC HMIS Working Group.

<b>Principle</b>	<b>Rationale</b>
a) The HMIS Framework or structure should be defined mainly in terms of data definitions and information flows	Any current or proposed information systems can then be assessed against their ability to conform to data definition and information exchange standards This also allows different, but compatible, technical solutions to be developed and tested.
b). The formally approved existing recording and reporting forms should be used as the basis for the data collection and for the transfer of data, whether these are carried out manually or electronically, unless a clear case can be made for amendments or additions to meet a specific information need	This approach: <ul style="list-style-type: none"> <li>○ Ensures consistency between different systems</li> <li>○ Builds on the knowledge and expertise relating to the existing data</li> <li>○ Reduces the burden on data collectors</li> <li>○ Reduces the cost of data collection</li> <li>○ Allows comparisons to be made with data for previous years</li> </ul>
c) Designing the HMIS does not imply creating new systems for collecting information. Instead it means setting up mechanisms for obtaining selected summary data from existing information collection systems and putting in place an infrastructure for processing these data into Management Information	This avoids the development of new separate systems, which will be more expensive and can lead to inconsistencies in data This also ensures that management information is drawn from data that are collected and used for health care activities, which is more cost effective and reliable
d) All the current flows of health information, and of information relevant to health e.g population data, should be considered as potential sources of PHC HMIS data. Discussions on developments therefore need to include all those responsible for all these information systems so that a common approach to data and information flows can be agreed and common standards applied	Management information for PHC needs to draw on not only data collected at primary health care level, but also other data to make comparisons and put the information in context. If a common approach is not agreed to data and information standards then it is likely to be difficulty to bring together data from different systems to provide the management information required
e) HMIS developments should build on existing systems (both manual and computerised) wherever possible, but amended where necessary to meet new requirements.	This approach ensures consistency, and reduces possibility for confusion This also makes best use of the investment already made and the knowledge that staff have in running and using these systems
f) Use of manual systems need to be continued at the levels where the infrastructure and resources are not sufficient to support the running of computerised systems.	Computerised systems require suitable environment, including availability of reliable and affordable power supply, and also resources for purchase of consumables.



In addition to agreements on basic principles, some agreements have also been reached on the main components of the PHC Health Management Information System in relation to Georgia.

<b>PHC HMIS Component</b>	<b>Rationale</b>
At this stage of development within Georgia, computerisation for PHC HMIS should initially be focused at regional and national level, although where computerisation already exists at rayon level this can be used to assist data transmission.	Data collection at most clinics and ambulatories will need to be in a paper format, at least in the short term, because of the general lack of resources currently available to support an electronic system at that level
Initially the data collection will be based on the existing recording and reporting forms in use in Primary Health Care.	The data items on these forms are required by legislation, and so at this stage no additional actions are needed in order to instruct the clinics to collect the data required. An initial set of standard indicators can be produced from these data items which provides information that is relevant for PHC, and that can also be used for comparative purposes.
A database will be developed, for use primarily at regional and national level, using Microsoft Access. The database is designed to collect and process the data from the standard forms. The flow of the data to this database will make use of existing collection and transfer systems.	Microsoft Access is being used as the software for this application because it provides easy links to other commonly used software. Management of, and support for, the system require only limited skills and resources. It has facilities to develop user friendly access to the information, and it provides a good foundation for migration to alternative more sophisticated systems as and when these are considered to be appropriate.
The regional data processing hubs will allow rapid feedback of relevant information to the PHC clinic level, in pre-defined formats, as well as passing required data aggregations to national level	PHC clinic staff and managers need access to up to date and relevant information for management purposes. Increased use of information will improve the quality of management decisions, and also increased use of information by staff at the data collection level will improve the quality of the data collected

### **3.3. Outstanding issues for the development of an HMIS for the Georgian PHC system**

Outstanding Issues for the development of an HMIS for the Georgian PHC System. This section considers the main issues that are still “open”, together with possible options and recommendations. For each issue it is noted whether it:

- i. Requires formal approval now, to allow progress with actions that need to be carried out immediately. These are actions needed in order to meet the planned timetable for the pilot phase.
- ii. Requires longer term actions.

#### **3.3.1. PHC HMIS Policy**

##### ***3.3.1.a. PHC HMIS Strategy***

Draft Technical PHC HMIS Strategy and Briefing Paper have been prepared by OPM team. An agreement is needed on the basic principles and immediate plans outlined within the

Strategy and Briefing Paper. This is required in order to proceed with developing systems for PHC pilot. Approval of Technical Strategy, and of recommended immediate actions, is needed as a matter of urgency, to allow progress with the HMIS to continue.

### ***3.3.1.b. Strategy Approval Process***

A PHC HMIS Working Group has considered proposals for HMIS developments, but the strategy has not yet been approved by the Government. Proposals on appropriate mechanisms for discussing and approving HMIS developments should be submitted for discussion and approval to the MoLHSA early 2006.

### ***3.3.1.c. Strategy Review and Updating***

The process of development of health management information system should be dynamic and requires both evaluation and consultation on an ongoing basis to ensure that the direction and effectiveness of the stated aims and objectives are maintained. Process for regular review and updating needs to be agreed. This needs to be within the responsibilities of the focal point mentioned above. It also needs to be driven by the information needs of the ongoing development of the health care system. Proposals for review and updating process should be submitted to the MoLHSA for discussion and approval.

### ***3.3.1.d. Links to other PHC activities***

The development of management information systems should be driven by the management requirements of the PHC system. However a mechanism for submitting information requirements as they arise from policy developments or Government decisions does not currently exist.

Specification of the information requirements should be an integral part of any policy development or implementation activities - both for pilot ambulatories now and on an ongoing basis for PHC developments as a whole. A mechanism is needed to ensure that these information requirements can be assessed on a regular and structured basis, in order to:

- i) Make arrangement to produce information (or proxies) from existing systems
- ii) Ensure that any new requirements are considered in the annual HMIS review

Proposals for mechanism for submitting and approving information requirements as they arise should be submitted to the Ministry for approval.

## **3.3.2. Information Technology Issues**

### ***3.3.2.a Hardware***

Specifications for the hardware required for the data processing hubs for pre-testing and for the pilot regions have been completed. Standard hardware has been specified to allow for commonality with other information systems within PHC.

Hardware requirements for national rollout will be considered during the evaluation of the pilot, and will take account of hardware already purchased and available through other initiatives. EU procurement is underway but WB procurement has not yet commenced. Procurement and delivery timetable need to be progressed urgently by EU and WB, in order for the hardware to be available in time for PHC pilot. No budget has yet been allocated for national rollout, and this will need to be considered during the evaluation phase. The working group recommended that specified hardware for the pilot phase should be procured and installed as a matter of urgency.

### ***3.3.2.b. Software***

Options considered for software were discussed in the HMIS Technical Strategy. Microsoft Access was chosen since this is a standard application that is easily programmable using local resources, and provides a good platform for migration to more sophisticated software at a later stage if this is considered appropriate. It also links easily to other software, for example Excel which has been used as the basis for the public health system.

The data files are based on standard forms and so are compatible with other data collection systems currently in operation.

The database is being developed to run at regional and national level. It could also be used at rayon level if appropriate computing resources are already available at that level.

Access is being used for the database for the pilot phase and this is currently under development.

The evaluation of the pilot will consider whether this is appropriate for continued use and for national rollout, or whether migration to a more sophisticated system is needed, taking into account the resources likely to be available. All the data collected and also the database structures and definitions developed within the Access application will be suitable for use, if migration is recommended.

The software development takes account of the need to link with other systems, by using standard software and by ensuring that data and documentation standards are followed. This includes, for example, the hospital system developed by CSIH, public health information system and any developments in relation to contracting and patient registration.

The group recommended to continue with development and implementation of Access database, ensuring that it links to, and enhances existing information systems such as the public health system.

### **3.3.3. Data and Information Issues**

#### ***3.3.3.a. Levels of responsibility for data collection and data processing***

Levels currently involved in data collection and processing are:

Facility – data recording

Rayon – data recording & data transfer

Region – data collation, aggregation, analysis, reporting

National – data collation, aggregation, analysis, reporting

At present there is only limited feedback of data to the lower levels. There are parallel data flows, and different organizations involved at rayon, regional and national level.

The database being developed is intended to provide facilities for data processing, at regional and national level, and for feedback to lower levels, in particular to facility managers.

The database is intended to be run using existing levels of responsibility, but it also provides the opportunity for bring data together from different systems, to provide a wider range of analyses.

The working group recommended to use existing levels of responsibility during the pilot phase for data collection, but opportunities for streamlining information flows and processing should be considered as part of the evaluation of the pilot.

### ***3.3.3.b. Data Collection***

The HMIS database is based on standard recording and reporting forms. The data collection process is being facilitated by:

- Improved documentation of these forms with guidance notes,
- Provision of copies of forms to pilot facilities
- Provision of templates for journals and recording forms

Availability of improved documentation, together with training and support for relevant staff at facilities during the pilot phase, is needed to improve the quality of the data collected. This support should also cover methods for the use of these data at a facility level.

### ***3.3.3.c. Data Processing***

It is planned that data will be entered on to computer, and processed at regional and national “data processing” hubs. Where computerization exists at rayon level this can be used for data entry and transfer, but not for processing in the initial stages. The immediate focus of the regional data processing "hubs" is on helping to provide some basic data for primary care. However it is also intended that this will provide an opportunity for more general information exchange and information sharing.

There are a number of options for housing the proposed Regional Primary Health Care HMIS “Data Processing” Hubs. They could be housed at Public Health Centers, which already collect statistical data on paper and computers, or they could be set up at Regional Health Departments, which represent the Ministry of Health in regions or a combination of both. A third, but less likely solution, is that they could be placed in SUSIF regional offices, who collect and digitize a subset of healthcare data for financial purposes.

Each location has advantages and disadvantages. Thus, the possibility of creating mirrored hubs at more than one location is also considered.

**Option 1 Sharing of the data collection and entry, and also the data processing, analysis and reporting of the information by both the Public Health Center & the Regional Health Office.** The Regional HMIS Hub (excluding SUSIF) would be split into two mirrored hubs with facility in both the Regional Health Department and Public Health Center. Data entry would also be split between the two organizations – with each being responsible for collecting and entering their own specified data. The forms that are already collected and computerized by Public Health Centers (immunization and notifiable diseases), will continue to be processed by this organization. The additional forms would be collected by either the PH Centers of the Regional Health Department, whichever was considered more appropriate in terms of the data content and potential use of the information. Data would be shared either in full or in summary form between the two hubs, depending on the requirements for each of the forms..

This option will require the following:

- One room in each Regional Health Department is refurbished and equipped with hardware to house a mirror hub
- Provisions are made for allowing HMIS software (developed by OPM) to support mirrored hubs – the PH Centers is using software developed using MS Excel spreadsheets and the data would need to be converted to a format accessible by MS Access
- HMIS software is installed at both locations

- Responsibilities between Regional Health Department and Public Health Centers are delineated (which forms go where, how and when electronic data exchange happens between the two organizations, back-up plans for data exchange, if necessary)

Observations:

- The Public Health Centers are already established and would not require additional refurbishment or investment in equipment/software etc.

*Option 1* is feasible technically, and has advantages in sharing the workload for data entry and processing between the two departments. It is also possible that participating in these shared arrangements will lead to improved exchange and use of information across the two organizations. However, setting up and maintaining the procedures for the shared working arrangements may cause some problems, unless there is a good working relationship between the two departments. In organizational terms, the simplest approach for sharing the regional hubs would be to have data entry through only one route and this is considered in *Options 2* and *3* below. In these options the Public Health Centers would be solely responsible for data entry. In *Option 2*, the Public Health Centers would be responsible for the straight through flow i.e. passing on up to national level, but the Regional Health Departments would be responsible for further data processing i.e. bringing the data together from different sources, and producing information for feedback to lower levels. In *Option 3* all the work on data processing, reporting and feedback would be carried out by the Public Health Centers and the Regional Health Department would be a key user and function as a specialist analytical centre.

There is also a 4<sup>th</sup> Option of all data entry for the PHC HMIS being only via the Regional Health Departments, but this is not considered further in this paper. This is because, as mentioned in the discussion on PH Centers above, it is understood that computerized systems are already in place at the PH Centers for some of the data collection. It is important to build on these existing functioning systems at the PH Centers, and therefore continue to use this as the route for data collection for the data already covered by the immunization and communicable diseases system, even if it is agreed that the Regional Health Departments will play a role in the data collection or data processing process..

***Option 2. Data entry and data transfer by the Public Health Center, with further data processing, analysis and dissemination at the Regional Health Department.***

The Regional Health Department would not be involved in any of the collection and entry of data. The Public Health Center would be responsible for entering all data and providing initial reports. The data would be copied to the Regional Health Department for further data processing and dissemination, including bringing data together from different sources.

This option will require the following:

- One room in each Regional Health Department is refurbished and equipped with hardware to house a mirror hub for data processing, analysis and dissemination purposes
- HMIS software is installed at both locations
- Responsibilities between Regional Health Department and Public Health Centers Delineate are delineated (which forms go where, how and when electronic data exchange happens between the two organizations, back-up plans for data exchange, if necessary)

Observations:

- The Public Health Centers are already established and should not require additional refurbishment or investment in equipment/software etc. Any extra investment required

could be facilitated by the new hardware being purchased for the regional HMIS by the EU/WB.

**Option 3. Data collection and entry, and also the data processing, analysis and reporting of the information to be carried out by the Public Health Center only, including bringing together data from different sources. The Regional Health Office would be an analytical centre for the use of management information.** The Regional Health Department would not share responsibility with Public Health Center for entering data or providing reports. The Regional Health Department would be equipped to electronically access the information provided through PHC for analysis purposes only.

This option will require the following:

- One room in each Regional Health Department is refurbished and equipped with hardware to house an analytical centre
- Provisions are made for allowing HMIS software (developed by OPM) to run at PHC Centers, including accessing data from the existing systems. The PH Centers are using software developed using MS Excel spreadsheets and the data would need to be converted to a format accessible by MS Access
- Provisions are made for allowing HMIS software (developed by OPM) to enable “read-only” access by Regional Health Departments. This can be done in various forms
  - Online access by limiting permissions of some users to read-only
  - By assuming that Regional Health Department will receive regular copies of the database files on Compact Discs (recommended)

Observations:

- The Public Health Centers are already established and should not require additional refurbishment or investment in equipment/software etc. Any extra investment required could be facilitated by the new hardware being purchased for the regional HMIS by the EU/WB.

It should be noted that each of the three organizations mentioned above are, or should be, users of management information and so need facilities for accessing and analyzing the information. Such analytical centers do not necessarily need to be sited in the same places as the data processing hubs, but the way these analytical centers function may affect the siting and running of the data processing hubs.

As already mentioned, it is expected that the financial information will be collected separately from the Regional HMIS Hub (SUSIF/GVG project). All options therefore need to include technical requirement to enable linking or integration between the system being discussed and the financial information system being developed for SUSIF under European Union project. It should be noted that the development of this financial system has not yet started, and so this may not be available during the early testing phases of the HMIS development.

Also, regardless of the option chosen, the existing computerized system for immunization data and data on notifiable diseases, developed by Curatio International Foundation and PHR*plus*, will need to be integrated with the new system. This can be done by either developing export-import interface between two systems, or re-programming the capabilities of immunization and notifiable disease software into the new system. Both should be done via close coordination of consultants and technical staff of both projects. It is also important that any new arrangements ensure that the reports currently available from the current software can be easily produced.

At this initial stage, linkages to data collected through other parallel systems, for example the TB system, are not being covered. However, once the initial version of the HMIS has been piloted, it is intended to consider how best to incorporate, or link to, other relevant information systems

Having the functions of the regional hubs shared between Regional Health Department and the Regional Public Health Centers, at least during the pilot phase, allows both Regional level organizations to be involved, and hence increases the use of the information, and introduces some resilience and flexibility in the system. It is suggested that the arrangements could vary slightly from pilot region to pilot region, including elements of all three of the workable options outlined above, to allow for local circumstances. This will allow for a wider range of options to be evaluated during the pilot phase.

This approach also takes account of the fact that there are ongoing discussions about the roles at regional level and the future relationship between the regional centers. The pilot evaluation for the HMIS should therefore take account not only of technical and information issues, but also any decisions made about the functions at regional level which it is expected will have become clearer during the pilot phase

It should be noted that the databases that will be set up in both places will be designed to allow for changes in the data entry arrangements if it appears, following the pilot evaluation, that some amendments in the procedures are needed. Also both the hardware and software that have been specified for the regional hubs are general purpose, and so will be of use even if there are some minor changes in functions and arrangements following the pilot evaluation.

#### ***3.3.3.d. Specification of Information requirements***

Users at all levels, and their requirements for PHC management information should, ideally, drive the development of the PHC HMIS. However, immediate developments are constrained by the data that are currently being collected. Also the evolving nature of the PHC system means that management functions and responsibilities are not yet clear and so management information requirements can not be fully defined at this stage.

Improving availability of PHC management information in the short term can be achieved by making use of indicators based on current data that provide information of value for PHC policy makers and PHC managers at national, regional, rayon and facility levels

In the longer term approaches to improved management information need to include:

- Stimulating the demand for better quality data and use of information
- Ensuring that management information requirements arising from policy developments are clearly specified and fed into the ongoing process of HMIS design.

Standard indicators, derived from data currently being collected, should be prioritized according to their appropriateness for use in PHC management

#### ***3.3.3.e. Analysis and provision of information***

Routine reports will be produced from both the regional and national HMIS data processing hubs. There will also be a facility for ad hoc enquiries, but this will be limited by the time available from appropriately skilled staff. The national and regional HMIS database needs to include routine reporting and ad hoc reporting facilities.

It is also planned that information provision and interpretation will be carried out at analytical hubs. These will be situated at departments where analytical work is already being carried and where appropriate skills currently exist, for example Health Policy Unit. Access to data will depend on requirements and on facilities available at analytical hubs, and is likely to include transfer of appropriate data extracts.

The design of the national and regional HMIS database needs to include routine reporting, based on the prioritized set of indicators mentioned in 3.4 above, and also ad hoc reporting facilities

### **3.4. Implementation**

#### **3.4.1. Implementation in pilot regions**

OPM have started developing the application software, in advance of the hardware and software procurements so that this can be tested and ready in time for the start of the pilot phase. Arrangements have been made to pre-test the regional HMIS database in Shida Kartli, using EU funded hardware and software, but also making use of system staff trained as part of the South Caucasus Health Information Project, and testing linkages with other computerised systems currently in operation.

The HMIS database will then be piloted in Kakheti, utilising EU funded hardware that is currently being procured, and in Imereti and Adjara utilizing World Bank funded hardware.

Technical support will be provided by OPM.

Initial pre-testing activities can proceed in advance of the arrival of the hardware and software, but full testing cannot be completed until the hardware and software have been installed.

The HMIS database, and also data collection and transfer procedures will be refined following pre-testing prior to pilot implementation.

Data collection can start as soon as the forms are made available, but full implementation at the pilot regions depends on the installation of hardware and software. It is planned that the use of the forms will be tested during March 2006, prior to going “live” on 1 April 2006.

#### **3.4.2. National roll out**

Plans for national rollout depend on results of evaluation of pilot. No funding has yet been allocated for the national rollout. Options for national rollout will be considered as part of the evaluation of the pilot. Evaluation of the pilot should include consideration of options for national rollout.



## **RECOMMENDATIONS:**

- Approval of Technical Strategy, and of recommended immediate actions, is needed as a matter of urgency, to allow progress with the HMIS to continue
- Software and hardware procurement should be expedited, so that this can be installed and tested prior to 1 April 2006.
- Existing levels of responsibility should be used during the pilot phase for data collection
- Availability of improved documentation, together with training and support for relevant staff at facilities during the pilot phase, is needed to improve the quality of the data collected. This support should also cover methods for the use of these data at a facility level.
- Data processing of the standard recording and reporting forms will be handled at regional and national data processing “hubs”.
- Pre-testing on Shida Kartli should start as soon as the Beta version of the regional HMIS database is available. Data collection should be tested during March 2006 and go live from 1 April 2006.
- Proposals on appropriate mechanisms for discussing and approving HMIS developments should be submitted for discussion and approval by end of December 2006.

## **PART IV. THE FINANCING OF PHC FACILITIES**

## PART IV. THE FINANCING OF PHC FACILITIES

The objective of this part is to present the model and costs for a PHC team, the Imereti and Adjara/Kakheti pilots and national roll-out. It has 4 sections:

1. The model and costs of a PHC team
2. The total costs of the Imereti and Adjara/ Kakheti pilot schemes
3. Cost of national roll-out
4. Key financial issues

### 4.1. The model and costs of a PHC team

Cost estimates have been calculated using a “bottom-up” costing methodology. This assesses the volume and value of the inputs that are required for each PHC team. The results are shown in Table 1:

**Table 1: Costs of PHC team and facilities**

<b>Annual costs in GEL</b>	Type I facility (assuming 1 team)	Type II facility (assuming 2 teams)	Type III facility (assuming 5 teams)	Average per team across pilot <sup>12</sup>
<b>Salary costs</b>	<b>6,270</b>	<b>12,540</b>	<b>31,350</b>	<b>6,270</b>
Facility depreciation costs	4170	7437	14562	
Maintenance	1068	1926	3870	
Office supplies	768	1371	4043	
Medical supplies	989	1933	4666	
Generators, fuel consumption <sup>13</sup>	370	581	1056	
Communications costs	479	675	2034	
Utilities costs	1326	2150	6038	
Services	983	1325	2341	
<b>Total non-salary costs</b>	<b>10,153</b>	<b>17,398</b>	<b>38,610</b>	
<b>Lab costs<sup>14</sup></b>	<b>2,454</b>	<b>4,908</b>	<b>12,270</b>	<b>2,454</b>
<b>TB, antenatal care and immunizations</b>	<b>2,764</b>	<b>5,528</b>	<b>13,820</b>	<b>2,764</b>
<b>TOTAL</b>	<b>21,641</b>	<b>38,513</b>	<b>91,399</b>	<b>18,852</b>

These cost estimates are based on a desired set of inputs, in other words they are “need-based”. It should be noted though that the salary costs are based on remuneration levels (250 GEL for the doctor, 150 GEL for nurses, 200 GEL for practise managers) that some experts consider insufficient to avoid informal charges or informal private practise. The proportion of costs allocated to salaries (around one-third) is also very low by international standards.

<sup>12</sup> Based on actual mix of facilities in pilot – some type II facilities have 3 teams and some type III facilities more than 5 teams. The average cost per team is slightly lower than the cost of single practise with 1 team due to economies of scale.

<sup>13</sup> The standard equipment list does not include vehicles.

<sup>14</sup> The laboratory costs include the depreciation costs for the laboratory building and equipment

**Table 2: Number of PHC Teams in 2005**

	<b>Total</b>	<b>0-15 years old</b>	<b>15 + years old</b>
Population number (thousand)	4328.9	845.5	3483.4
Rural 47.8%	2069.2	404.1	16665.1
Urban 52.2%	2259.7	441.4	1818.3
Work load per one doctor	1725	800	2400
Total number of PHC teams	2509	1057	1452
# of PHC teams in villages	1199	505	694
# of PHC teams in towns	1310	552	758

Asymmetry of the population density among urban and rural areas as well as very low population density in mountainous areas should be accounted while projecting the number of coverage population per PHC team in different regions and districts. Optional number of coverage population per one PHC team is summarised below:

**Table 3: Population coverage per one PHC team in different settlement areas**

<b>Area</b>	<b>Proposed number of covered population per one PHC team</b>	<b>Average number of covered population per one PHC team (except cities)</b>
High mountainous regions	1000	1580
Village	1500	
District centres	2000	
Cities	2200	

Calculations suggest that proposed number of PHC Teams in towns and villages will be 1027 and 1310 respectively (total of 2337 PHC clinics).

## 4.2. The total costs of the Imereti and Ajara/ Kakheti pilot schemes

The number and type of the 60 PHC facilities to be included in the pilot for 2006 are shown below<sup>15</sup>:

**Table 4: Number of facilities in 2006 pilot**

	<b>Type I</b>	<b>Type II</b>	<b>Type III</b>	<b>Total</b>
Imereti	5	12	3	20 (50 teams)
Adjara	11	9		20 (31 teams)
Kakheti	5	14	1	20 (47 teams)
<b>Total</b>	<b>21</b>	<b>35</b>	<b>4</b>	<b>60 (128 teams)</b>

**Table 5: Summary of PHC pilot expenditures for 2006**

1	Number of PHC teams	128
2	Average cost per one PHC team	18.9 thousand GEL
3	Average cost per one PHC team without capital costs	13.8 thousand GEL
4	Average cost per one PHC team in the village in 2005	5 thousand GEL
5	Additional costs over 2005 budget for one PHC team	Including cap. costs 13.9 thousand GEL
		Without cap. costs 8.8 thousand GEL
6	Additional Cost (over 2005 budget ) of 128 PHC teams in 2006	Including cap. costs 1,779.0 thous. GEL
		Without cap. costs 1,126.0 Thous. GEL

<sup>15</sup> This is based on an estimation of the mix of facilities to be included in the 2006 pilot – a final list of the individual renovated facilities to be included in the pilot was not available at the time of writing.

In Imereti the pilot will finance a supplementary package of hospital services for the extreme poor and the poor throughout the region. It is expected to have 3500 such hospital cases that will require 2,8mil. GEL. Share of government subsidy per case is proposed to be 65 percent or 800 GEL. In addition, it is proposed to increase subsidy on maternity care from 165 up to 300 GEL in Imerety Pilot (6412 deliveries were registered in Imereti region in 2004). Cost of prescription drug benefit package for age groups of 0-15 and pensioners over 65 is calculated to be 3,650 thousand GEL.

Using the information on the cost of the Imereti supplementary package, and the cost and number of PHC teams in the pilot, the total costs for the pilot in 2006 can then be calculated:

**Table 6: Total 2006 pilot costs**

Annual costs in Thousand GEL	Total	2005 year	Additional Costs in 2006	
			Total	without capital costs
Imereti – PHC	945	250	-695	- 440
Imereti - Prescription drug benefit	3,650	-	-3,650	-3,650
Imereti - Maternity Care	1,920	1,060	-860	- 860
Imereti – supplementary package (hospital sector)	2,800	-	-2,800	-2,800
<b>Total Imereti</b>	<b>9,315</b>	<b>1,310</b>	<b>-8,005</b>	<b>-7,750</b>
Ajara - PHC	585	155	-431	-273
Kakheti - PHC	888	235	-653	-414
<b>Total Ajara/Kakheti</b>	<b>1,473</b>	<b>390</b>	<b>-1,084</b>	<b>-687</b>
<b>Grand total</b>	<b>10,789</b>	<b>1,700</b>	<b>-9,089</b>	<b>-8,437</b>

It should be noted that ‘facilitation’ costs such as: the design of the pilot; technical support to the purchaser and providers (e.g. contracts, regulations, installation and use of systems such as information systems, drug prescription etc.); and pilot monitoring and evaluation costs are not included in these cost estimates.

### 4.3. Cost of national roll-out

The cost implications of rolling out the pilot model shown above across the whole population of Georgia are shown below, and compared to the 2005 budget:

**Table 7: Roll-out costs versus 2005 budget (in Thousand GEL)**

GEL	National roll-out costs		2005 budget		Resource gap	
	Total GEL	Per capita	Total GEL	Per capita	Total GEL	Per capita
PHC	44,057	10,18	21,463	5,0	-22,594	-5,2
Secondary care/ Universal package*	57,080	13,2	48,330	11,2	- 8,750	- 2
Maternity Care	17,750	4,1	9,000	2,1	- 8,750	- 2
Drug benefit scheme (see paper 2)	22,800	5,2	4,592,	1,1	- 18,208	- 4,1
Ambulance service	13,850	3,2	8,543	2	-5,307	-1,2
Other budgetary items	64,621	14,5	64,621,	14,5		0,0
<b>Total cost</b>	<b>202,408</b>	<b>46,8</b>	<b>147,557</b>	<b>33,8</b>	<b>-54,851</b>	<b>-13</b>

It is of critical importance to note three costs that are not included in Table 7:

- Secondary level specialty care (surgery, cardiology, oto-rhino-laryngology etc.) cost, which had approximately 4 mil. GEL allocation in 2005 Health Budget;
- 17.6mil. GEL cost estimate of supplementary package (hospital level urgent care) for extremely poor and poor population is based on an extrapolation of the 2006 Imereti supplementary package which itself does not include any provision for general hospital care. It is estimated that 22 thousand patients will receive these services. The share of government subsidy per case is proposed to be 65 percent of total cost or 800 GEL.
- The table shows the annual, recurrent costs only and do not cover the capital injection required to renovate PHC facilities and re-train doctors and nurses in family medicine. Very crude estimates reveal this cost to be around 134mil. GEL or approximately USD \$ 67mil. at today's prices<sup>16</sup>. If rolled out between 2006 and 2016 – in other words over a period of ten years – there would be a capital financing requirement of around USD\$ 6-7mil. a year (approximately 12 mil. GEL).<sup>17</sup>

Adding additional hospital coverage for the extreme poor *and* annual capital injection would increase the national roll-out costs to approximately 236mil. GEL a year or about 54 GEL per capita.

**\* Hospital care subsidy according to 2005 budget structure**

<b>title</b>	<b>National Cost</b>	<b>2005 year budget</b>	<b>Resource gap</b>
<b>Total:</b>	<b>57,080</b>	<b>48,330</b>	<b>-8,750</b>
Psychiatry	3,062	3,062	
TB	3,100	3,100	
Infectious Disease	2,186	2,186	
0-3 years old subsidy	6,000	6,000	
Maternity	17,750	9,000	-8,750
Oncology	4,500	4,500	
Referral	3,800	3,800	
Urgent care	12,260	12,260	
All the rest	4,422	4,422	

<sup>16</sup> This estimate is based on the capital value of the building and equipment items in Table 1 and also a training costs of 3,140 GEL per doctor and 2,694 GEL per nurse.

<sup>17</sup> Whilst development partners are one obvious source of this finance, it is unlikely they can provide all the required funds. It may therefore be necessary to attract private sector investment to build and equip facilities and train staff (possibly in partnership with public funds) in order to roll out the PHC model nationally. The legal status of PHC facilities then becomes of critical importance in order to attract this investment.

#### 4.4. Affordability and sustainability issues

There are a number of issues arising out of the estimation and projection of PHC team costs, total pilot costs and national roll-out costs:

##### Is the pilot affordable?

Without the full financing of 10,8 mil. GEL for the costs of the pilot scheme, certain inputs will not be affordable. The table below shows cumulative unit costs for a single practise and illustrates what inputs will be foregone with any budget shortages:

**Table 8: Cumulative annual unit costs**

GEL	Unit costs <sup>18</sup> for a single practise	Cumulative unit costs
Salary costs <sup>19</sup>	6,270	6,270
Medical supplies	989	7,259
Lab costs (including lab depreciation, 1 lab per 5 teams)	2,454	9,713
Services	983	10,696
Costs of TB, ANC and immunization supplies	2,764	13,460
Communications costs	479	13,939
Utilities costs	1,326	15,265
Office supplies	768	16,033
Generators, fuel consumption <sup>20</sup>	370	16,403
Maintenance	1,068	17,471
Facility depreciation costs	4,170	21,641

The omission of any of these inputs would compromise the quality of the service that can be offered and thus the validity and value of pilot outcome data.

##### Are the recurrent costs sustainable with national roll-out?

**Roll-out costs versus resource availability:** As mentioned in the previous section there is at least a 13 GEL per capita resource gap between resources needed to replicate the pilot nationwide and the levels of financing in the 2005 budget.

Figure 1 below summarizes the cost and resource projections for the PHC sector. There are two resource projection scenarios. The first scenario is based on the share of the 2005 health budget that was allocated to PHC, of around 20%<sup>21</sup>. The second, more ‘optimistic’, scenario assumes a rise in the budget share to PHC to 30%.<sup>22</sup> There are also two cost levels shown on Figure 1: PHC roll-out costs and PHC roll-out costs with a drug benefit scheme added:

<sup>18</sup> These unit costs are for a type I (single practise) facility.

<sup>19</sup> Calculated with the following wage rates: 250 GEL for the doctor, 150 GEL for nurses, 200 GEL for practise managers.

<sup>20</sup> The standard equipment list does not include vehicles.

<sup>21</sup> This is relatively low by international standards: PHC often represents 30-40 % of total healthcare financing.

<sup>22</sup> For both scenarios the resource projections are made with MoF forecasts of average GDP growth 2005-2009 is 5% and tax revenues growth of 1% of GPD a year. MoLHSA share of government budget is assumed to remain constant at 2005 share.

Figure 1: Sustainability analysis: PHC costs and resources

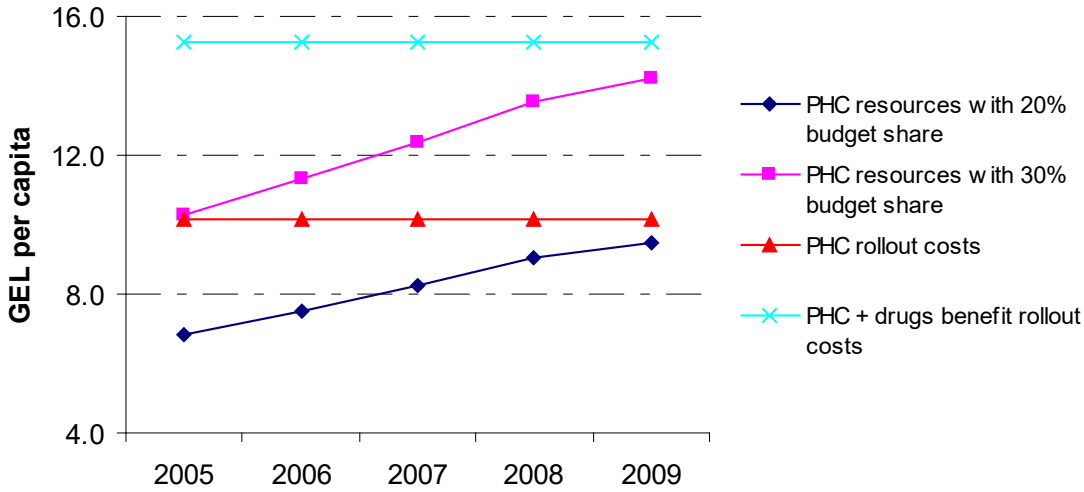


Figure 1 implies that a 20% budget share to PHC will be just short of financing PHC costs *alone* by 2009. With a 30% budget share to PHC, PHC roll-out costs *and* most of the drug benefit scheme could be financed.

This type of analysis can be repeated for the total roll-out costs (e.g. including supplementary package), as shown in table 7. In Figure 2 the resource projections are based on different proportions of the government budget allocated to the health. The conservative estimate (dark blue line) assumes constant government budget share to health. The ‘optimistic’ estimate (pink line) is based on the MoF’s assumption of a gradual increase in government share to health<sup>23</sup>. There are again two cost estimates: national roll-out costs (red line) and a higher cost estimate (light blue line) to include a provision for capital costs and coverage for general hospitalization services for the extreme poor:

Figure 2: Sustainability analysis: total costs and resources

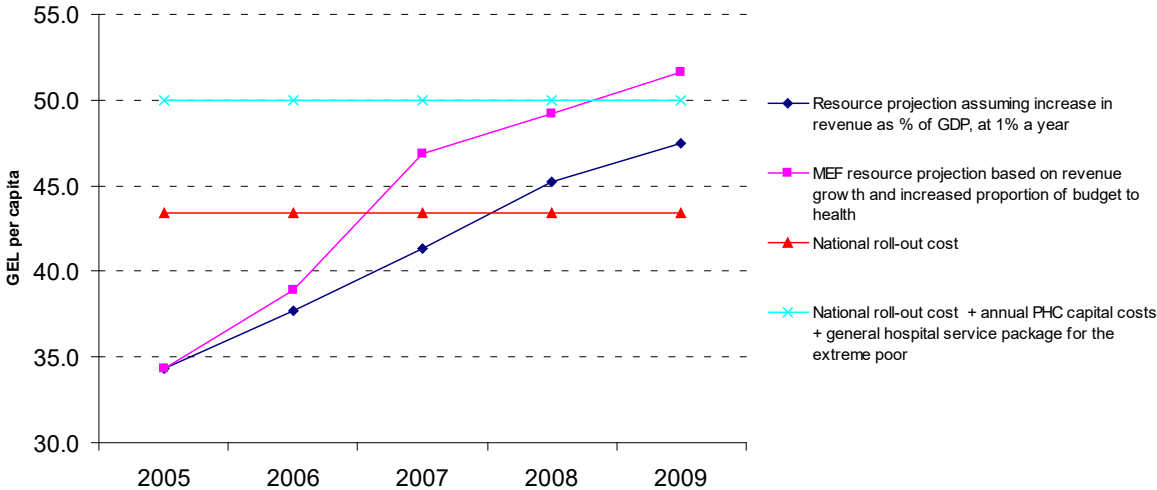


Figure 2 demonstrates that for the higher cost level to be financed there will need to be an increase in the GoG budget share allocated to health.

<sup>23</sup> The GDP growth projections and baseline revenue share of GDP are the same as in Figure 1



The conclusion of these analyses is that potentially both the overall government budget share to health *and* the share within the health budget that is allocated to PHC may need to increase to make the national roll-out sustainable. One important tool for ‘winning’ budget reallocation is the medium-term expenditure framework (MTEF), which allows ministries to demonstrate what activities and outputs they expect to yield from budgetary inputs.

It is also worth mentioning that until roll-out is complete, there are likely to be equity concerns around the level of financing in the pilot regions. The national roll-out cost is around 53 GEL per capita whereas current financing levels in the 2005 budget were only around 34 GEL per capita. Whilst resource discrepancies between pilot and non-pilot areas may be acceptable in the short-term, they could create tensions between communities over longer periods if not carefully managed.

**Other options for improving sustainability:** If public resources remain insufficient to cover all costs, there are still ways to make the roll-out sustainable. A major option is to harness private sources of finance to jointly contribute to health service costs. Private sources of finance already account for the majority of health expenditure in Georgia.

The simplest way to do this is to levy co-payments or user fees for health services<sup>24</sup>, although this has been ruled out for the 2006 pilot. Table 10 demonstrates the approximate effect on national roll-out finances with different levels co-payment/user fees for adult visits<sup>25</sup>:

**Table 10: Contribution of co-payments to PHC financing gaps**

All figures GEL per capita	Adult (15-65) user fee/ co-payment per curative visit GEL				
	None	2.5 GEL	5 GEL	7.5 GEL	10 GEL
Cost	10.18	10.18	10.18	10.18	10.18
Public subsidy	5	5	5	5	5
Co-payment revenue	0	1.0	2.0	3.0	4.0
Resource gap	-5.18	-4.18	-3.18	-2.48	-1.18

The results show that quite high levels of user fees/co-payments are needed to significantly contribute to PHC financing and if anything these contributions may be overstated<sup>26</sup>. User fees/co-payments will work best if linked to the salary levels of providers and revenues are not returned to the purchaser, as this provides incentives to collect revenue effectively.

Simple user-fee / co-payments do not allow any risk-sharing between ill people and healthy people. This risk-sharing can be facilitated by harnessing private sector finance through an insurance scheme. An example of this would be for a community-run scheme to collect pre-paid premiums into a fund which then finances the user fees/co-payments levied by the facility. If the insurance scheme is run on a national basis, it also allows risk-sharing between regions and (if membership is compulsory) between rich people and poor people.

<sup>24</sup> A second option is permit public practitioners to devote less than 100% of a normal working day to public practice and allow them to earn income from private practice at other times ('dual practise'). The problem here is that monitoring to ensure that sufficient hours are devoted to public practice would be required and to prevent doctors exploiting their relationship with public patients by referring them to their own private practices for 'improved' treatment.

<sup>25</sup> This analysis is based on an annual adult utilization rate of 0.6 per adult (SISUF, 2005, all regions except Tbilisi).

<sup>26</sup> This is for a number of reasons: First, demand for health services is assumed to stay constant as co-payments are introduced. In practise, as with almost any other good or service, demand will fall as the price of the product rises. Second, there is also no provision in this model to exempt vulnerable groups from fees, which would be a desirable feature of any final scheme.

A final option for making the pilot scheme more sustainable is to trim some costs. It is not obvious where this is possible but an option would be to use a less expensive mix of health workers, such as to use more nurse-clinicians and fewer doctors. Another option would be a systematic review of the technology, equipment and building inputs required for the PHC facilities and laboratories to identify whether any cost savings can be made. A final option would be to carry out a functional review of the MoLHSA budget not directly financing PHC or the supplementary package (estimated at around 66m GEL in 2005, see table 6) and see if any savings can be identified.

## **Summary of the key findings, recommendations and required decisions:**

- The average cost for a PHC team is 18,852GEL including salary, running and depreciation costs, and including TB, antenatal care and immunization services.
- The total cost for the comprehensive Imereti pilot in 2006 will be 9,315 thousand GEL. The total cost for the overall pilot in 2006 (including Adjara and Kakheti PHC services) will be around 10,789 thousand GEL, not including any 'facilitation' costs.
- If the model of the pilot schemes was replicated nationally, to also include a prescription drug benefit scheme, there would be a 54,8m. GEL shortfall (13 GEL per capita) in the health budget based on current resource availability.
- Both the share of the government budget to health, and the share of the health budget to PHC, will need to increase to make up this short fall. Alternatively private sources of finance will need to be harnessed through user-fees/co-payments or insurance, and/or health services costs will need to be reduced.
- There remains a need to consider the capital injection required to build, equip and train staff for the national roll-out. This capital injection is likely to be in the order of USD\$ 67m for PHC buildings and staff training alone.

## **PART V: HEALTH PROMOTION**

## V. HEALTH PROMOTION

### 5.1. Background

In Georgia at present there is no systematic and co-ordinated Health Promotion. The Public Health Department acts largely as a purchaser of services from NGOs and there is a small Health Promotion unit within the CDC. There appears to be little attempt to co-ordinate inputs and there is no evident strategy related to behaviour change. There are no clear policies related to creating an enabling environment conducive to health (for example enforcing the wearing of seat belts to reduce the high number of deaths and injuries on the road or the creation of policies to reduce smoking in public places). Some donor-funded NGOs have produced HP materials but its use and availability is *ad hoc* and not related to policy or co-ordinated. Health staff are involved in providing curative services and preventative activities and systematic Health Promotion interventions have been neglected.

A national strategy for Health Promotion in Georgia was produced in December 2004 through a workshop process involving Government, Staff from MoLHSA, PHD and representatives from NGOs active in Health Promotion and behavior change. Behavior change strategy is described in annex 5.

### 5.2. Priority Health Issues in Georgia

There are a number of important health challenges facing Georgia. Epidemiological evidence provided by the Centre for Disease Control (CDC) and evidence provided by workshop participants produced the following list of health issues.

Health Issue	Comments
Alcohol abuse	<ul style="list-style-type: none"> <li>• Leads to violence, liver cancer, work loss, dysfunction in family.</li> <li>• High level of social acceptability of alcohol use from an early age.</li> </ul>
Breast cancer	<ul style="list-style-type: none"> <li>• Multifactorial causes easily treated in early stages. Needs education for self examination and screening facilities.</li> </ul>
Cardio-Vascular disease	<ul style="list-style-type: none"> <li>• Major cause of death.</li> <li>• Main causes; tobacco, poor diet and lack of exercise.</li> </ul>
Cervical cancer	<ul style="list-style-type: none"> <li>• Multifactorial causes. Detected by regular screening for women over 50.</li> </ul>
Childhood illnesses	<ul style="list-style-type: none"> <li>• Including measles, diarrhoea, diphtheria, ARI.</li> <li>• Six fold increase in cases of measles from 2001 to 2002.</li> </ul>
Diabetes	<ul style="list-style-type: none"> <li>• Multifactorial but closely linked to family history.</li> </ul>
Drugs (injecting drug use)	<ul style="list-style-type: none"> <li>• Currently major cause of HIV transmission in Georgia. Needs needle exchange and work with law enforcement agencies.</li> </ul>
HIV/AIDS and STIs	<ul style="list-style-type: none"> <li>• Gonorrhoea cases have doubled during the two year period 2000 to 2002.</li> <li>• Among pregnant women the number of cases of syphilis doubled during 2001 to 2002.</li> <li>• Ten percent increase in syphilis cases between 2000 and 2002.</li> <li>• Official figurers of PLWHA doubled from 314 in 2002 to 614 in 2004.</li> </ul>
Immunisation	<ul style="list-style-type: none"> <li>• Six fold increase in cases of measles from 2001 to 2002.</li> <li>• Previously high rates of immunisation, but system deficiencies have lead to drop in uptake.</li> </ul>

<b>Health Issue</b>	<b>Comments</b>
Mental Health	<ul style="list-style-type: none"> <li>• Socioeconomic changes contribute to an increased level mental health concerns.</li> </ul>
Nutrition	<ul style="list-style-type: none"> <li>• Poor dietary practices and traditional eating patterns lead both malnutrition and obesity.</li> <li>• High level of iodine deficiency in some regions—easily treatable using iodised salt.</li> </ul>
Reproductive Health	<ul style="list-style-type: none"> <li>• Including maternal health (ante- and post-natal care), fertility, high maternal mortality, contraception, abortion, miscarriage, menopause, etc.</li> </ul>
Road Traffic Accidents	<ul style="list-style-type: none"> <li>• RTA linked with use of alcohol.</li> <li>• Low enforcement of traffic laws.</li> </ul>
Tobacco use	<ul style="list-style-type: none"> <li>• One third of male cancers are lung cancer.</li> <li>• High level of social acceptability of tobacco use from an early age.</li> </ul>
Tuberculosis (TB)	<ul style="list-style-type: none"> <li>• Highest rates in Europe.</li> <li>• New cases increase by 12% in 2002.</li> <li>• High regional variations.</li> </ul>

This list of health issues represents the main causes of mortality and morbidity in Georgia. However, not all of these are amenable to measurable changes through health promotion activities. Although health promotion activities can raise awareness, for example women can be taught and encouraged to examine their breasts regularly, unless services are in place to screen and treat there will not be measurable changes in numbers of women treated for and dying from breast cancer.

<b>Health Issue</b>	<b>What expect to change</b>
Alcohol abuse	<ul style="list-style-type: none"> <li>• Decrease number of alcohol use people through significant change in social attitudes.</li> </ul>
Breast cancer	<ul style="list-style-type: none"> <li>• Decrease number of women with breast cancer through education for self examination and screening facilities, distribution promo materials.</li> </ul>
Cardio-Vascular disease	<ul style="list-style-type: none"> <li>• Decrease number of acute cardiovascular disease with promotion of lifestyle changes</li> </ul>
Cervical cancer	<ul style="list-style-type: none"> <li>• Decrease women with cervical cancer providing by regular screening for women over 50.</li> </ul>
Childhood illnesses	<ul style="list-style-type: none"> <li>• Increase immunization rate through HP</li> </ul>
Diabetes	<ul style="list-style-type: none"> <li>• Awareness raising programs facilitate to decrease consequences of diabetes, especially in children</li> </ul>
Drugs (injecting drug use)	<ul style="list-style-type: none"> <li>• Decrease number of drug users supporting needle exchange programs, involve religious aspects</li> </ul>
HIV/AIDS and STIs	<ul style="list-style-type: none"> <li>• Decrease number of HIV/AIDS and STI consequences through screening programs among pregnant women and high risk groups.</li> </ul>
Immunisation	<ul style="list-style-type: none"> <li>• Increase immunisation rate actively involving HP strategy through mass media.</li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>• Socioeconomic changes contribute to an increased level mental health concerns.</li> </ul>
Nutrition	<ul style="list-style-type: none"> <li>• Behaviour change strategy for traditional eating patterns leads both malnutrition and obesity.</li> </ul>

Health Issue	What expect to change
	<ul style="list-style-type: none"> <li>• Decrease number of cases associated with high level of iodine deficiency in some regions— treating by using iodised salt.</li> </ul>
Reproductive Health	<ul style="list-style-type: none"> <li>• Decrease maternal mortality through increasing of screening programs among pregnant women and improving ante- and post - natal care</li> <li>• Increasing prevalence of contraception and decreasing abortion rate through HP strategy</li> </ul>
Road Traffic Accidents	<ul style="list-style-type: none"> <li>• Decrease number of RTA by introduction of seat belt law</li> </ul>
Tobacco use	<ul style="list-style-type: none"> <li>• Decrease tobacco use through anti – tobacco advocacy programs</li> </ul>
Tuberculosis (TB)	<ul style="list-style-type: none"> <li>• Increase TB immunization rate</li> <li>• Increase preventive measures</li> </ul>

### 5.2.1. Recommended communication interventions

Health promotion messages should be delivered through a packaged campaign approach utilising a variety of reinforcing and interrelated interpersonal and mass media channels. It is recommended that communication interventions to be developed are based on the “triangle (Δ) approach”<sup>27</sup> as shown in Figure 1.

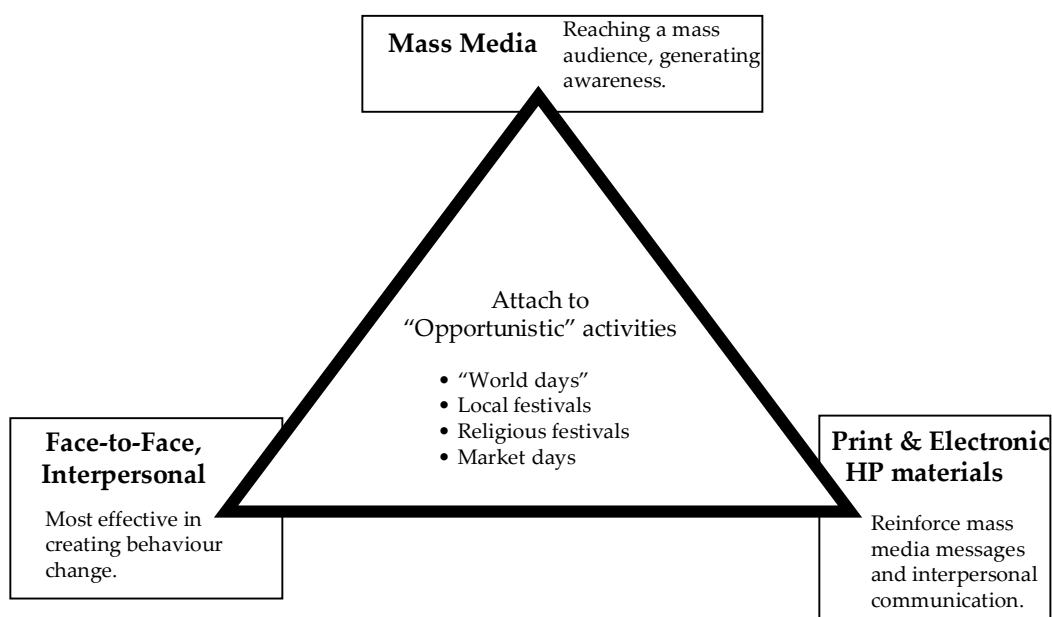


Figure 1— Triangle Approach for Health Promotion

The Δ approach suggests that the delivery of health promotion messages is more effective when a combination of three key methods are used as a part of the same intervention. These three key methods include:

- mass media such as radio or television broadcasts
- face-to-face communication by a community influential, health worker, peer educators, family member, friend

<sup>27</sup> UNICEF/Vietnam, Effective Information, Education and Communication in Mountainous Populations of Viet Nam, 2002

- print or electronic health promotion material such as a leaflet, poster, flipcharts, teaching cards, booklets or audio cassettes and video

As an example of applying this formula, health promotion messages on reducing tobacco consumption could be delivered, simultaneously, through:

- radio and television (national and regional broadcasts)
- scheduled workplace peer education using print and electronic materials such as a flipchart an accompanying audio cassette for training, and leaflets for distribution to workers
- display of posters or billboards in target communities

An intensive, packaged campaign approach to delivery of information should be scheduled to run over an extended period of time (one to two months for example). Campaign interventions developed along this framework can also be attached to “opportunistic activities” such as “world days” (e.g. World Health Day, World No Tobacco Day, World AIDS Day), local festivals, religious festivals, market days, etc. However, continuous and sustained delivery of information must continue following a formal campaign period.

### **5.2.2. Illustrative communication activities/interventions**

The following tables show a variety of potential communication interventions that the MoLHSA may choose to implement. Interventions are linked to health “problems” — statements demonstrating unhealthy behaviours or beliefs. Frequency of activities is also recommended. This information is presented as an illustrative proposal, individual parts or activities can be applied and modified as desired by stakeholders.



**Health Problem Statement:** HIV/AIDS is increasing in Georgia; official figures of PLWHA doubled from 314 in 2002 to 614 in 2004. It is likely that this is a five fold underestimate.

**Target group:** Taxi/lorry drivers (clients of sex workers).

Contributing Factors	Communication Objectives	Potential Communication Interventions	Location/Delivery	Frequency/ Intensity	Notes
Lack of adequate and appropriately delivered information on HIV transmission.  Lack of “culture of use” of condoms.	Raise awareness of drivers regarding transmission and prevention of HIV.	Peer education among drivers supported by use of quality HP materials.	Gathering points for drivers — bus terminals, truck stops, petrol stations, transport companies, etc.	Each peer educator to meet with an agreed number of peers each month. Monthly report to be submitted to supervisor.	Peer educators should be selected from each sub-group of drivers; taxi, truck, bus.  Refresher training for peer educators should be provided as needed.
	Counter misconceptions and misinformation.	Strategic placement of posters and printed information targeting drivers, describing methods of HIV transmission.	Gathering points for drivers — bus terminals, truck stops, petrol stations, transport companies, etc.	Continuously — new messages and images should be developed on a regular basis (every six months) to avoid information becoming “stale”.	Materials to be placed in public areas should be designed to be non-offensive to social and religious norms.  Use a variety of spokespersons: target group members, community and religious leaders, medical authorities
	Increase safe behaviours (use of condoms).				

**Health Problem Statement:** While previously there has been a high rate of immunisation of children, system deficiencies have lead to a dramatic drop in uptake.

**Target group:** Mothers and other care givers of children.

<b>Contributing Factors</b>	<b>Communication Objectives</b>	<b>Potential Communication Interventions</b>	<b>Location/Delivery</b>	<b>Frequency/ Intensity</b>	<b>Notes</b>
Lack of adequate and appropriately delivered information on the importance of childhood immunisation.  Lack of accessible immunisation centres/facilities.	Raise awareness of mothers and care givers regarding the importance of immunisation of children.	Health worker outreach among mothers and care givers supported by use of quality HP materials.  Peer education activities with “satisfied customers” — mothers whose children have completed immunisation regimes.	Gathering points for mothers/care givers — markets, clinics, workplaces, etc.	Each peer educator to meet with an agreed number of peers each month. Monthly report to be submitted to supervisor.	Peer educators should be selected from each sub-group of drivers; taxi, truck, bus.  Refresher training for peer educators should be provided as needed.
	Counter any misconceptions and misinformation regarding side effects of immunisation.	Placement of posters and printed information targeting mothers describing the importance and benefit of immunisation.	Gathering points for mothers/care givers — markets, clinics, workplaces, etc.	Continuously — new messages and images should be developed on a regular basis (every six months) to avoid information becoming “stale”.	Use a variety of spokespersons: target group members, community and religious leaders, medical authorities.
	Increase the uptake and completion of immunisation regimes.		TV spots		

**Health Problem Statement:** There is a high level of disabilities and mortality as a result of road traffic accidents.

- Target groups:**
- Drivers.
  - Law enforcement officials.

Contributing Factors	Communication Objectives	Potential Communication Interventions	Location/Delivery	Frequency/ Intensity	Notes
<p>Lack of understanding of road traffic laws/rules by drivers.</p> <p>High levels of drink driving.</p> <p>Lack of adequate enforcement of road traffic laws/rules by police.</p>	<p>Raise awareness among drivers of road traffic laws/rules.</p> <p>Decrease the level of drink driving.</p>	<p>Workplace interventions targeting men.</p>	<p>Workplaces.</p>	<p>Weekly.</p>	<p>Use a variety of spokespersons: target group members, community and religious leaders, medical authorities.</p>
		<p>Mass communication campaigns (national and regional TV and radio) using influential people to educate and <b>warn</b> drivers of the implications of drink driving. Promotion of careful driving.</p>	<p>Newspapers, magazines, other printed materials targeting men.</p>	<p>Continuously — new messages and images should be developed on a regular basis (every six months) to avoid information becoming “stale”.</p>	
	<p>Increase the enforcement of road traffic laws/rules by police.</p>	<p>Placement of posters and printed information targeting drivers describing the dangers of drink driving. Promotion of careful driving.</p>			
	<p>Advocacy activities targeting police to insist on the active enforcement of traffic laws/rules.</p>	<p>Police stations.</p>			

Health Problem Statement: A high rate of disabilities and fatalities among Georgian men and women are attributed to lung cancer and the use of tobacco.

Target group: School and university youth, and young adults.

Contributing Factors	Communication Objectives	Potential Communication Interventions	Location/Delivery	Frequency/ Intensity	Notes
<p>Cheap tobacco products.</p> <p>Cultural approval of smoking (smoking is considered normal behaviour).</p> <p>Lack of understanding of the consequences of smoking.</p> <p>Lack of “non-smoking” legislation.</p>	<p>Increase the awareness of the consequences of smoking.</p>	<p>Peer education among young people.</p>	<p>Schools, universities clubs and other locations frequented by youth.</p>	<p>Each peer educator to meet with an agreed number of peers each month. Monthly report to be submitted to supervisor.</p>	<p>Interventions should target young people before beginning smoking and before smoking becomes an engrained habit.</p> <p>Peer educators should be selected from each age group of youth.</p> <p>Refresher training for peer educators should be provided as needed.</p>
		<p>Include tobacco education in school curriculum.</p>			
	<p>Increase taxes on tobacco products.</p>	<p>Mass media campaigns targeting young people.</p>	<p>Newspapers, magazines, other printed materials targeting youth.</p> <p>During TV and radio programming most likely to be watched by youth.</p> <p>Outreach in youth oriented places of entertainment (discos, cinemas, bars, etc.)</p>	<p>Continuously — new messages and images should be developed on a regular basis (every six months) to avoid information becoming “stale”.</p>	
	<p>Change social norms/acceptance of smoking.</p> <p>Enact legislation prohibiting the sale of tobacco to minors.</p>	<p>Advocacy — Lobbying within parliament to insist on the enactment of regulatory tobacco laws.</p>	<p>Within government.</p>	<p>Regularly.</p>	

**Health Problem Statement:** Georgia suffers from the highest rate of pulmonary TB in Europe.

**Target group:**

Contributing Factors	Communication Objectives	Potential Communication Interventions	Location/Delivery	Frequency/ Intensity	Notes
Lack of information on symptoms, treatment and the need to complete lengthy drug treatment.  Cost of treatment.  Difficulty in visiting screening centres.  People do not seek treatment because of the stigma of TB.  Myths and misconceptions regard the cause and transmission of TB.	Raise awareness and provide information on symptoms, cause and transmission of TB.	Mass media campaigns in areas where pulmonary TB is endemic.	Newspapers, magazines, other printed materials.  TV and radio programming.	Continuously — new messages and images should be developed on a regular basis (every six months) to avoid information becoming “stale”.	Use a variety of spokespersons: target group members, community and religious leaders, medical authorities.  Health workers to be on the alert for potential TB cases during clinical consultations.
	Inform on importance of completing treatment regime.	Workplace awareness building campaigns.	Workplace		
		Health worker training.	Health facilities.	Annually.	
	Inform on screening locations.	Journalist competition for human interest stories around TB.	Print and electronic media.	Annually.	
Reduce the stigma associated with TB.	Increase case finding.				

### **5.3. Training Requirements to Implement the Health Promotion Strategy**

Capacity building of staff is an important outcome for the MoLHSA. Limited skills and experience with principles of adult learning, facilitation techniques or participatory training techniques are evident. Currently health staff teams focus primarily on treating patients, with little or no attention paid to preventive activities including systematic health promotion interventions.

Health promotion activities supported by the MoLHSA should be planned, implemented and evaluated in partnership with stakeholders and counterparts. In order to carry out the planning, implementation, management and assessment of health promotion initiatives outlined in this Strategy, focused training will be required for staff at all levels.

Training is vital to ensure that personnel at all levels have the ability to design and carry out programme activities as required. Long-term measures which the MoLHSA could initiate include the incorporation of a health promotion component into the curricula of basic training programmes for health workers.

Training should include:

- Health promotion planning
- Health promotion material design and production (including formative research and pretesting techniques of both print and electronic materials)
- Health promotion material use
- Supervision and monitoring

#### **5.3.1. Training content**

Health service staff — in particular those who come in direct contact with clients — should be provided with training in interpersonal communication and simple counselling skills, health promotion material use, and design and implementation of simple health promotion activities for use in the community. The skills to design and carry out formative research and Knowledge, Attitude and Practice (KAP) surveys, leading to the design and implementation of health promotion campaigns in the future will need to be introduced for an appropriate group within the MoLHSA.

A programme of training to ensure that the basic skill set for the design and implementation of a health promotion programme (including research, campaigns, peer education etc) is required. Indicative training should include:

- Health promotion theory: principles and methodologies, international best practice, planning and objective setting, target group identification, social assessment, message development
- Media workshop: designing effective print, TV, radio materials; radio, television and print design and production for health promotion
- Advocacy training; influencing skills, gaining political support, working with the commercial sector
- Interpersonal skills development; positive client centred consultation, peer education, outreach, participatory methods

- Basic formative research/survey and pretesting techniques
- Health promotion programme monitoring and evaluation
- Health promotion campaign design skills; contracting out, activity sequencing; coordinating and ensuring message continuity

Recommendations for HP/BCC inclusion in the current Family Physician (FP) and general practice nurse training curriculum in allocated in annex 6.

### **5.3.2 . Health promotion theory training**

This training will introduce participants to some of the theory behind health promotion. It will look at the guiding principles (such as the importance of working at both the individual and structural levels), theories of behaviour change and social and cultural issues. Project planning, beginning with how to set objectives, timing interventions and measuring their success, will be introduced and practical examples used throughout. The course will ensure maximum participation. It will not be lecture-based. Most importantly time will be spent by each participant on planning what they will do next (next week, next month and during the next three to six months) so that the course is of the maximum possible practical use back in their work place.

### **5.3.3. Media workshop**

This training will enhance the skills of selected radio, television and print material designers/producers. The outcome of the training will be a highly skilled cadre of enthusiastic media professionals who will contribute to the development of effective health promotion campaigns designed to motivate target groups to change behaviour.

### **5.3.4. Advocacy training**

Learning how to influence important institutions and individuals in order to gain their support is the fundamental goal of advocacy training. The successful advocate has a range of methods and messages that are targeted at specific audiences for a specific purpose. For example, enlisting the support of political champions for diseases such as TB and HIV/AIDS can have an impact upon both the public funds that are made available to provide health care services and upon the development of sound government policy. Similarly, the private sector represents a potential source of funding for activities such as media or print –based health promotion work. With advocacy work it is important that clear messages about health issues are used when engaging with stakeholders who do not have specialist knowledge of the issue. Therefore, advocacy training will address the methods and the messages that can be used to create better connections to a range of institutions that are potentially important to improving health outcomes. Audiences for advocacy include decision makers and politicians, donors, journalists, corporations and industry.

### **5.3.5. Interpersonal skills development training**

Training for health workers (both government and NGO) will equip them with the skills to conduct better consultations with clients. The training will include opportunities for role-play

situations so that participants can practice asking and answering questions, putting clients at ease, respecting confidentiality, dealing with anxious patients and relatives.

Training for peer educators and their supervisors will equip them with the skills to organise, deploy and supervise peer educator teams, and assess the impact of peer education for specific target groups such as, sex workers (SW), young mothers, students, and injecting drug users (IDU).

### **5.3.6. Formative Research/Pretesting**

This training will:

- Increase competence in the social dimension of health research (for example, investigating the indigenous knowledge, commonly held beliefs and behaviours) to improve the appropriateness of the content of health promotion campaigns.
- Train staff in the theory and practice of the pretesting process of health promotion materials so that all materials are revised using feedback from members of the target group for which they are intended.

### **5.3.7. Monitoring and evaluation**

The training will provide staff with a sound basis for both the monitoring of the implementation of health promotion activities and the assessment of impact of campaigns. Using evidence and experience from across the world, suitable indicators will be designed that allow both qualitative and quantitative measures to indicate success.

## **5.4. Key decisions that need to be made**

**a) Key Question:** Who will be responsible for the strategic direction of HP within the new structure of the MoHLSA

### **Recommendation:**

Coordination of HP is a government function and the government must decide quickly on its coordination mechanism:

### **Implications of not doing this:**

HP will be uncoordinated leading to potentially dangerous and confusing messages to the public

### **Action:**

Clear statement of intent by the MoHLSA that the PHD (or another department) is the lead department to coordinate HP

TA to support the PHD (or another department) in its role through training and mentoring (for coordination, planning, purchasing, monitoring)

An approved budget for HP to start to implement the HP strategy Government coordination of donor funding to provide start-up funds for HP resources

**b)Key Question:** How will HP be funded?



## **Recommendation**

If the MoHLSA is unable to provide adequate funding for HP it must leverage funds from Donors and the Private Sector for the first years of the new PHC programme.

### **Implications of not doing this:**

It is unlikely that real changes in health status will be achieved without a major effort in targeted HP

### **Action:**

- An approved budget for HP to start to implement the HP strategy
- Government coordination of donor funding to provide start-up funds for HP resources
- Provide TA to assist Government to apply for funds (business plans, budgeting etc)

c) **Key Question:** How will the special needs of users of the 100 ambulatories be reconciled with the special needs of major target groups across Georgia?

## **Recommendation**

Vulnerable groups across Georgia will need targeted HP activities and the local HP needs of the ambulatories must be met.

### **Implications of not doing this:**

- If HP is directed only at the small scale ambulatories no changes will be seen in health status
- Ensuring that targeted HP is directed at, for example, sex workers, intravenous drug users, will bring about noticeable changes in health status.

### **Action:**

- Training for staff of the ambulatories
- Rapid research at local level to determine HP priorities
- Resources for the above produced
- HP strategy targeting needs across Georgia implemented

d) **Key Question:** How can training for HP for service deliverers be made sustainable by institutionalising training in a suitable medical/nursing school?

## **Recommendation**

Training on client centred consultations and basic HP is institutionalised within one or more medical/nursing schools

### **Implications of not doing this:**

- Relying on TA to improve doctor's skills is not sustainable.
- Increasing doctor's skills likely to increase clinic attendance and patient compliance

**Action:**

- Training of Trainers course as soon as first batches of those who will staff the 100 ambulatories is completed

e) **Key Question:** In order to ensure best practice in HP, how can training for HP for the growing number of NGOs be made sustainable by institutionalising training with a major NGO?

**Recommendation:**

Most of the HP activities and resource production is likely to be undertaken by NGOs. It is necessary for the government to ensure that the NGOs working in Georgia adhere to international best practice. Regular (annual) training for NGOs should take place and one NGO designated to provide it.

Implications of not doing this:

- NGOs not providing the best possible HP
- NGOs providing conflicting HP

**Action:**

- NGO chosen
- NGO to receive TA and Training of Trainers
- Funding for regular NGO training and updating secured

## **PART VI: PUBLIC RELATIONS**

## VI. PUBLIC RELATIONS

### 6.1. Background

At present the MoLHSA has a low level of capacity for preparing and implementing an overall Public Relations strategy.

The Minister wishes to present, both to the public and the medical/health personnel, a clear understanding of a clear understanding of primary health care policy, what services are to be provided free and those to be paid for, as policy evolves. The aim of the public relations campaign is, therefore, to help create a climate of acceptance for the policy, so that all its constituent parts can succeed.

The medical profession has the responsibility for ensuring the quality of services delivered to the population and their own legitimate professional aspirations must be taken into account within the context of the resources available.

The mass media should be supported in the task of informing and educating by a programme of training and mentoring. The media is likely to watch, most carefully and critically, both the new approaches to PHC and the work of the pilot 100 walk-in clinics. Proactive work with journalists may help to mitigate against negative reporting.

It will be necessary to work directly with the public, through outreach work (by the staff of the ambulatories and through NGOs) so that everyone is aware and informed about the changes to PHC in Georgia. For example, public meetings can be held, to which representatives of the local public and interested persons are invited, This allows for questions and answers and if trust and credibility in the policy is to be built then face to face contact is most effective.

Public authorities need to provide support to the proposed changes within their respective areas. They must work hand in hand with the MoLHSA to find solutions to the complex challenges that currently precludes people in Georgia from having access to quality PHC services.

There has so far been little systematic communication of the overall policy to the medical profession and as a result the reforms have a “bad image”. It would seem that some, but not all of the medical profession, have some knowledge of some of the reforms, but whether they have a full picture or have been helped to develop a clear understanding is uncertain.

There is a need to develop and implement a systematic and sustained effort to communicate the nature of the reforms and the primary healthcare element in particular. The new policy represents a major cultural change and a well organised communication campaign is necessary to gain support for it. The timing of this will need to be tied in with policy development - communication must not run ahead of agreed policy - but there are a number of basic tasks that can easily be carried out and which would make an impact.

By developing a clear and agreed brief on primary health care - what it is, how citizens will be affected, why it is necessary, how it will be introduced - and making sure that all those involved in the policy, particularly those explaining and promoting it, the reform process can gain critical support.

There are two reasons for preparing a brief:

1. There appears to be no consistent definition at present, and this may be giving rise to some confusion.
2. It is important in a programme of major change that the messages the public receives are agreed, consistent, understandable and well coordinated. Everybody must speak from the same brief. The alternative - mixed messages delivered in a random way - potentially spells disaster.

The brief would be regularly updated. Similar briefs on other aspects of the policy would be prepared in time.

As a starting point in support of Public Relations, the following initiatives are suggested:

- Establishing a calendar of events, announcements, statements and speeches, openings, and Ministerial visits to the regions. Initially it will be important to explain the overall policy and the meaning and potential significance of primary health care in a very clear yet detailed way. As the programme rolls forward, messages and their form of delivery may change.
- Carrying out an assessment of communication options among medical professional and ensuring there are interventions to communicate the Government's messages direct to the entire professional body.
- Producing a regular newsletter for distribution to Ministry staff, other interested government departments, medical professionals, and members of Parliament and the media, reporting on the latest developments, activities, and forthcoming events.
- Closely monitoring the media to ensure that inaccurate information, rumours and innuendos are challenged and corrected.
- Conducting desk research to gain an understanding of public attitudes and concerns. This will help to give an idea of the scale of the Public Relations strategy needed and offer assistance in shaping messages to meet concerns, answer questions, etc.

## **6.2. Objectives and target groups**

The principal objective of the Information, Education and Communication (IEC) component of PHC reform is to assist the Ministry of Labour, Health and Social Affairs (MoHLSA) in building a supportive environment for the introduction of the new health insurance policy and practices.

This is to be achieved at both national and regional level (in the Project’s pilot region of Kakheti in Eastern Georgia).

There is, moreover, a widespread lack of knowledge, among health professionals, administrators and the wider public, about the nature and purpose of health reform and Primary Health Care (PHC) in general. MoLHSA therefore requires assistance in communicating a broader vision of PHC reform.

The activities envisaged under the IEC component are:

- Inventory of already existing public information and PR activities and products
- Definition of the “IEC content needs”
- Based on research results, definition of a strategy for Information, Education and Communication
- Preparation of materials for seminars/workshops to introduce the new health insurance policy
- Selection of participants for seminars/workshops in pilot region Kakheti, including health administrations, municipalities, health care providers and the population
- Implementation of seminars/workshops and round tables to introduce the new health insurance policy at national and regional levels
- Evaluation of seminars/workshops for replication nationwide
- Final conferences to present project results
- Regular press conferences (including a press conference at end of the project)
- Communications support and advice to other project components

There is thus (a) at least as much emphasis placed on direct communication with key groups, such as health administrators and professionals, as on communication with the general public; and (b) an equal stress on activities at national and Kakheti Regional levels.

The objective of the IEC strategy is therefore defined as:

**To assist MoLHSA in building a supportive environment for the introduction of Primary Health Care and health insurance reforms among the public and professionals at both national and regional level.**

The IEC Strategy sets out three target groups for IEC activities:

- The “internal” public, including the main health policy-makers and administrators (MoLHSA, SUSIF, Public Health Departments, other departments and public offices at national, regional and municipal level) and others directly involved in implementing the information campaign, such as project staff.
- The professional public: health professionals (doctors, nurses, midwives, pharmacists etc), decision-makers and opinion-formers at national, regional and municipal level such as politicians (especially members of the Parliamentary Health Committee), Government and civil servants, regional governors, mayors, international organisations, the media, professional bodies, NGOs and interest groups.

- The general public, including users and current non-users of the health service, vulnerable groups and ethnic minorities.

At national level, IEC activities will focus on policy-makers, health care administrators, health professionals' associations and opinion-formers (including politicians, NGOs and the media as communication channels to the public).

In Kakheti Region, activities will cover all target groups, including direct contact with health administrators, health professionals and local opinion-formers and information for the general public to improve understanding and acceptance of the reforms.

### **6.3. Implementation**

The Implementation Plan for public relations sets out a detailed framework for implementation of the activities contained in the IEC Strategy. It builds on the analysis contained in the Strategy and should be read in conjunction with that document.

Since the IEC Strategy was originally prepared and submitted to the Working Group on Health Promotion and Public Relations – which was established in accordance with the Ministry's Road Map for PHC Reform – in December 2004, a number of developments have arisen which affect implementation of the Strategy:

- While the Health Promotion and Public Relations Working Group produced and agreed working papers which incorporated the recommendations of the IEC Strategy, neither these nor the overall PHC reform strategy were formally approved, as envisaged in the Road Map, by the PHC Co-ordination Board by 30 March 2005.
- This Implementation Plan is based on the assumption that the key decisions on the main features of the PHC reform and the funding mechanisms to be piloted – i.e. those items which will provide the content for IEC materials and activities – will be agreed no later than the end of December 2005 – since information materials have to be prepared for activities starting in February 2006.
- The key features of PHC reform and funding mechanisms which require to be clear in order for IEC activities to convey useful information to the target groups include:
  - Registration: patient registration system, how it will operate, maximum / minimum size of lists
  - Access: location of PHC facilities, hours of service, appointments
  - Services: services to be included in Basic Benefit Package
  - Drugs: which drugs, if any, to be included in BHP, prescription and issuing of drugs
  - Co-payments: existence and size of official co-payments for services, visit fees, exemptions
  - Visits: home/school visits by PHC staff
  - Patients' rights: information, confidentiality, changing doctors, complaints mechanism

- Referrals: PHC “gatekeeper” role, penalties for by-passing PHC, rights of direct access to emergency care / certain specialists
- PHC staff: staffing levels for PHC teams, administration system, training / retraining, remuneration / salaries of staff
- Facilities and equipment: ownership / rent / maintenance of facilities, minimum equipment list, refurbishment programme under new EU project
- Payment: invoicing and payment mechanisms for staff costs, reimbursement of expenses, etc

A number of the above features do now appear to have been agreed, but formal decisions by MoLHSA are awaited.

- Close co-operation with other PHC reform projects has been ongoing to ensure that activities envisaged in the IEC Strategy complement, rather than conflict with or duplicate, other activities. Two developments in particular should be noted:
  - The DFID / OPM PHC Reform Project has appointed, as part of its overall PR technical assistance to the Ministry, a full-time Communications Manager for MoLHSA. The Manager has prepared an overall health reform communications strategy for the Ministry, which incorporates the activities relating to PHC reform set out in the IEC Strategy. The overall strategy also envisages producing a new visual identity, either for MoLHSA as a whole or for health reform activities in particular.
  - The World Bank / GHSPIC PHC Development Project has launched a tender for implementation of the IEC activities required under that project at national level and in the WB pilot regions of Imereti and Adjara. Appointment of a contractor for this work is imminent.
- This Implementation Plan assumes close co-operation with the MoLHSA Communications Manager and regular, ongoing co-ordination on communications matters between GVG’s IEC experts, OPM, the implementers of the WB project’s PR activities and other relevant projects (e.g. USAID CoReform), through the formation of a PR Co-ordinating group bringing together communications experts from all relevant projects and staff of the MoLHSA Press & PR Office.
- As part of this co-operation, the contents of research activities, information materials etc will be co-ordinated. Information events and media activities at a national level will wherever possible be held jointly. The GVG IEC experts will also give advice on the development of IEC activities in Imereti and Adjara regions, similar to those planned for Kakheti.
- This Plan also assumes close co-operation with the implementers of the two other EU health projects in Kakheti – HLSP (retraining of FM teams) and Merlin (refurbishment and re-equipment of PHC facilities and health promotion). Input from HLSP and Merlin will be sought for research, development of information materials and participation in information events and media activities in Kakheti. This is particularly important since these projects do not have their own IEC components.



- GVG's IEC activities at national level will be closely co-ordinated with the MoLHSA Communications Manager and, through her with other PHC reform projects and with the press/PR departments of MoLHSA and SUSIF.
- GVG's IEC experts will further feed into joint activities (i.e. a website and newsletter regarding health reform) being planned by the Communications Manager with funding from the WB project. If a common visual identity – e.g. a health reform logo and slogan – for MoLHSA is produced in time, it will be incorporated into Project materials, subject of course to EU visibility guidelines.

The list of specific activities set out in the IEC Strategy is presented in annex 7.