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Abbreviations

CME	Continuing Medical Education
DFID	Department for International development (UK government)
EU	European Union
FMCs	Family Medicine Centres
FMTC	Family Medicine Training Centre
GFMA	Georgia Family Medical Association
HLSP	HLSP Limited
HR	Human Resources
MoHLSA	Ministry of Health, Labour, and Social Affairs
PHC	Primary Health Care
PHCCB	Primary Health Care Coordination Board
PHCMC	Primary Health Care Management Committee
QA	Quality Assurance
TORs	Terms of Reference
WB	World Bank

1. Rationale

HLSP welcomes this opportunity to return to Georgia and to support the Government in further developing Primary Health Care Services through the re-training of Doctors, Nurses, and Managers for Family Medicine Practices in Kakheti Region. In this submission we will demonstrate how we propose to fulfil the terms of reference (TORs).

The TORs are clear and comprehensive, and provide helpful background information. HLSP fully supports the overall project objective to support the reform of health care human resources development and quality of services in primary care.

1.1 Our understanding of the background

Since gaining independence in 1990, the Government of Georgia has committed to the development of comprehensive, effective, affordable primary health care services. This represents a significant move away from the traditional Soviet, centrally planned, “Semashco” medical model based on the paradigm of curative treatments, principally provided by specialists working in narrowly defined areas of medicine. The Government recognised the importance of providing effective preventive and promotive services, most effectively delivered in the primary care setting. The initial healthcare reforms (1995) outlined a move towards a primary care driven service that would meet the needs of the population through the development of a cadre of medical staff with a broad range of skills, and competent to deliver them in the community. Attendance rates in primary care at this time were the lowest in Europe; the reasons include inability to pay – due to the economic decline following independence, lack of confidence in the services provided, and self-referral to secondary care. However, because the licensing system of MoHLSA continued to define doctors’ activities within their specialist spheres, primary care services continued to be provided by teams of narrow specialists, and training was directed at ensuring that these specialist services were maintained.

1997 saw the recognition of family physicians as independent medical practitioners and the introduction of a retraining programme for this specialty (supported by DFID and implemented by HLSP). This represented a major shift in thinking; for the first time, family physicians were equipped to deal with most of the conditions that had previously required specialist input. The first cohort of trainees received additional training and qualified as family medicine trainers; they have been retraining family medicine doctors since that time. In 2000 the programme was extended to provide training for family medicine nurses and practice managers (again, through training-the-trainer programmes). At the same time, five family medicine centres (FMCs) – and a sixth in Mtskheka - were established in Tbilisi. Now retrained doctors and nurses were able to provide curative, promotive and preventive family-centred services for the community they served, in addition to delivering the nurse and family physician retraining programmes (the medical staff include family physician and nurse trainers). The training programmes were approved as temporary programmes by MoHLSA decree in 2002; to date 198 doctors, 40 nurses and 15 practice managers (most from urban areas) have been retrained. We understand that the family physicians re-training programme has now been formally recognised by the MoHLSA Licensing and Accreditation Board (13 May, 2005). The curriculum was introduced by the Georgia Family Medicine Association (GFMA), our project partner. We understand that the nurse training programme has also been revised recently. Based on recommendations by the current DFID project (managed by Oxford Policy Management) the number of hours in management training

and clinical practice has increased to 816 hours, in consultation with the GFMA, and the Nursing Association.

However, the resource base of competent family medicine practitioners remains weak, as most primary care services continue to be provided by specialist, or inadequately trained medical staff. The MoHLSA strategic health plan for Georgia (2000 -2009) wisely places greater emphasis on primary care services, and the need to deploy resources to primary care from secondary care. Extending re-training in family medicine is the cornerstone of the plan, together with refurbishment of the existing primary health care infrastructure, and ensuring sustainable financing to ensure equitable access for all. EU TACIS, World Bank, DFID, and other donors are collaborating with MoHLSA to support this programme. The MoHLSA "Roadmap for Primary Health Care Reform" (November 2004) detailed short, medium and long-term activities for developing PHC. MoLHSA has established a Primary Health Care Co-ordination Board (PHCCB) to oversee its implementation (members include representation from MoHLSA, Ministries of Finance and Justice, and donors) and the Primary Health Care Management Committee (PHCMC) is responsible for operationalising the roadmap.

An immediate measure is the improvement of primary care services in rural areas. 100 family medicine centres providing comprehensive services in selected locations in Kakheti, Imereti and Adjara regions will be established by the end of 2006.

EU TACIS is supporting primary care development in Kakheti Region (the World Bank is providing parallel support in Imereti and Adjara). This project supports the re-training component; EU funds also provide for refurbishment and equipping of primary health care facilities, health promotion and prevention activities. Staff from 85 primary health care teams comprising one physician and one nurse from around 57 rural facilities (as recommended by the Kakheti PHC Master Plan) will be re-trained from Kakheti region (in three six-month cohorts), and at the same time their facilities will be refurbished and equipped. EU TACIS is also supporting the reform of the health care financing systems (2004-6), and the reforms will be piloted in Kakheti in 2006.

1.2 Key issues for the successful implementation of the project

The project comprises three components: technical assistance for the re-training implementation; evaluation of the re-training programme: and coordination of the pilot activities in the region. The methodology for implementing the project has been worked out in considerable detail, and much of the preparatory work has been completed which provides a good basis for the delivery of this project.

In our opinion there are several key issues which must be taken into account in order to ensure successful implementation of the project:

a) Ensuring that project timing supports the achievement of objectives

We note that the three six-month re-training cohorts are to take place sequentially, and the TORs state that the project will not extend beyond 18 months. We suggest that a one-month inception period prior to the start of training would provide added value. Our proposal therefore outlines two options:

Option 1: an inception period that precedes the re-training; (see Gantt chart Section 3.2)

Option 2: an inception period that runs in parallel to the training programme – on the assumption that the re-training contracts will have been drawn up prior to the project start. (See Gantt chart Section 3.2)

Option 1 would enable us to undertake valuable groundwork which will be an investment for the implementation of the project and ensure that relationships are built, coordination is established right from the start, and that the training institutions can be properly prepared before training begins. If this option is acceptable, then

Either:
The third cohort would not have completed their re-training at the project end, but we believe all the other elements of the project will have been finalised by that stage, and that this should not pose a problem

Or:
Provided there was the capacity, there could be an overlap of re-training, thereby ensuring all re-training was completed by the project end. We are concerned, however, that this could result in significant disruption to primary care delivery in Kakheti

Or
We could negotiate a one-month extension with the client in order to ensure that project activities are supported right up until the end of training. We recommend this as the preferred way forward.

b) Working closely with the PHC Coordination Board and PHC Management Committee

We welcome the establishment of the PHC Coordination Board and the PHC Management Committee in the National Institute of Health. This should ensure that the findings and lessons learned from the project are institutionalised. The project must be regarded as a pilot for rolling out a national PHC training programme, so all aspects should be detailed and documented carefully in order to build capacity and sustainability after the end of the project. For this reason close working with the PHC Management Committee will also be crucial to the success of the project.

c) Ensuring that existing training is relevant to new trainees

HLSP had a major involvement in the design of the training programmes for doctors, nurses, and practice managers from 1997; the curriculum was targeted at health workers working primarily in urban settings. However this project is targeted at workers from a largely rural part of the country where the knowledge, skills and attitudes of health workers in these rural areas - as well as the health needs of their patients - may differ significantly from those of their urban counterparts. It is important that the training programme is significantly flexible to accommodate these differences, and that the programme is regularly monitored.

One of the weaknesses of the current re-training programme has been the lack of follow-up and ongoing support after the formal training course is completed. Although the TORs recognise the importance of follow-up, particularly as the course is implemented through an intensive six-month scheme, we consider it important that workplace follow-up and additional training is built into the programme. This is supported by our experiences both in the region and worldwide. Our proposals to address this are detailed in the section that follows.

Our recommendations to address this key issue are discussed in section 2.3.2.

d) Ensuring appropriate criteria for the selection of trainees

We understand that MoLHSA has already identified the selection criteria for potential trainees for the first cohort. This will be of major assistance in ensuring that the project is able to start on time. However, if MoLHSA is in agreement, we would recommend that these criteria be reviewed for the selection of the two remaining cohorts; the experience of the first batch, and the lessons learned by the training institutions will be a useful tool for considering whether these criteria should be modified. We should also remember that the criteria set could be used nationally for training personnel from other regions.

Our recommendations to address this key issue are discussed in section 2.3.2 page 18.

e) Ensuring that training and training facilities are up to standard

There are a limited number of trainers and training facilities in Georgia (there are only 12 nurse trainers in the six FMTCs); all will be needed if the proposed training is to be completed within the 18-month timeframe. However we do agree with the TORs that it is still important to establish clear criteria for qualification as a trainer or training centre because this will form the basis of future training contracts.

Moreover it is likely that many trainers will need a refresher course before commencing training; this is partly due to the length of time and opportunities for practice since the last training that these institutions have received, but also because of the need to ensure that the curriculum and skills of the trainers is relevant to the needs of rural health providers. We therefore propose that provision for one-week refresher courses should be included in the project plan.

Our recommendations to address this key issue are discussed in section 2.3.2 page 18.

f) Ensuring that the training evaluation methodology is appropriate

The evaluation methodology should not be limited to the current normative and summative assessments as this will only assess performance after the intensive training programme. More important is follow-up assessment – measuring performance in the workplace; has the training really resulted in improved health care delivery? Unsupported, there is a risk that PHC staff may revert to their previous clinical practice. Post-training workplace evaluation (including direct observation of clinical practice, process indicators, and clinical outcomes) is a vital component in order to ensure there has been a real change. This should be accompanied by ongoing training support/mentoring. This provision of Continuing Medical Education (CME) is essential: there is otherwise a risk that unsupported, isolated health workers will revert to their old practices and the investment made by the project will be lost.

Our recommendations to address this key issue are discussed in section 2.3.2 page 17

g) Ensuring continuity of primary care provision in Kakheti

This will pose a major challenge, as it is our experience that refurbishment and re-equipment of health facilities is rarely completed on schedule – whereas planned training programmes generally have a good record of completion on time. We will work closely with the Kakheti Health Authorities in order to keep updated on refurbishment programmes and will prepare contingency plans at an early stage of the project.

Provision must be made to ensure continuous PHC provision throughout the training and refurbishment process.

Our recommendations to address this key issue are discussed in section 2.3.2 page 19.

h) Ensuring that external co-ordination facilitates project work, and vice versa

As discussed above, the PHC Coordination Board and PHC Management Committee have a key role, and liaison with these organisations (and the donors) will be a major component of the project activities. It will also be important that the project team, in particular the team leader works to support the development of sector coordination and to promote synergies between this and other projects.

Our recommendations to address this key issue are discussed in section 2.3.2 p23

i) Maximising the potential impact of the project in Kakheti region (appendix 2 in the TORs)

Fifty-seven of the 159 ambulatories will be equipped to provide comprehensive services by the end of the project. It is clear that most facilities are in a state of disrepair, and lack very basic medical equipment – a significant deterrent to accessing PHC at present. Hence the importance of the refurbishment and equipment component of the EU TACIS support. This must contribute to the low consultation rate of 0.7 consultations per person per year, which is a matter for concern (see section 1.3, page 7). Unless this improves, doctors and nurses will not have the opportunity to use their newly acquired knowledge and skills which will mean that they will not retain them, but unless the rate increases significantly, the intervention will have little impact on the health of the community. There simply will not be enough patients receiving care.

Therefore patients must be encouraged to use the services. This will require close working with the Regional and District health authorities in Kakheti, and will be dependent on new financing mechanisms. We see this problem as a major challenge to the project.

Our recommendations to address this key issue are discussed in section 2.3.2 page 21

1.3 Risks and assumptions

Based on our earlier experience in developing the PHC through the DFID projects 1997-2003, and a recent visit to Georgia, we have reviewed the risks and assumptions outlined in the TORs (sections 3.1, 3.2). Our comments on the specific issues listed are presented in tabular form below.

In addition to those identified in the TORs we identify three other risks (also included in the table):

a) Low attendance rates at primary care facilities

We are concerned by the low attendance rates (0.7 / year) for primary care in Kakheti region, and see this as a significant risk to the impact of the project. Uptake would have to increase ten-fold in order to achieve the average attendance figures for Europe. If they remain unchanged, the project will make little difference to the health of the poor. Although newly refurbished and equipped facilities and more competent PHC staff will attract patients, the lack of confidence in PHC by the public, and the current financial

barriers to access must be addressed. Furthermore, PHC staff will have little opportunity to practice their new skills.

b) Attrition of PHC specialists

There is a risk that once re-trained, PHC specialists may seek more lucrative work either in urban areas or with the private sector. This has been our experience in similar projects in the region. This may (to some extent) be addressed through contractual arrangements committing re-trained specialists to work in their designated FMC for a fixed period; breaking the contract could result in financial penalties (i.e., repaying the re-training fees). Nevertheless, provided they continue to work in the health sector in Georgia, it could be argued that the overall human resource capacity of the health sector will have been improved through the project.

c) One or more current FMTCs lose their license to train.

At present, there are only six FMTCs, and training capacity is already strained. Should one or more of the FMTCs fail to meet the licensing standards, the project will be in jeopardy. We recommend that should the situation arise, rather than take the training license away, MoHLSA provides the resources to enable the FMTC to address their failings as quickly as possible. Inputs could include additional training for trainers, provision of necessary teaching materials, or increasing access to clinical cases.

Assumptions

Assumptions	Our comments	Our Actions
Political stability in the country	Georgia is enjoying greater stability since the Rose Revolution	Whilst we cannot directly influence political stability through this project, we can endeavour to ensure that the need to improve access to services is kept at the forefront of project planning and implementation activities which will build citizen satisfaction with government service delivery.
Resolve of health sector leadership to pursue PHC modular approach and implement mechanisms to ensure access to the poor	MoLHSA appear committed to developing PHC – November 2004 roadmap sets out a clear strategy. Financial constraints may continue to limit access to the poor	We will endeavour to promote best value for money approaches in PHC delivery and will focus on capacity building to ensure sustained delivery, and will disseminate project lesson learning to contribute to MoLHSA ownership.
Consensus among stakeholders on PHC services, staffing and location	It appears that there is agreement between donors and MoLHSA and its regional subdivision, the regional department of health and social affairs.	We will work at all levels of the MoLHSA and alongside donors and other stakeholders to build and maintain commitment to PHC delivery.
Application of unified curricula for PHC physicians, nurses and managers re-training	There is consensus that the DFID training syllabuses will be used for this project. Key issues centre around licensing of the training, and whether the current syllabuses are appropriate for the Kakheti health workers	We will work closely with the PHC Coordination Board and PHC Management Committee to ensure the ongoing review of the training curricula. See section 2.3.2.
MoLHSA has a specific, resourced centre in order to ensure PHC training and follow-up meets international standards for QA in place when the training commences	This will be dependent on MoLHSA Dependent on MoLHSA, PHCCB / PHCMC	If this is not in place when training commences we will work with MoHLSA to help them establish such a centre.
Availability of well-qualified Georgian staff and advisors throughout project implementation	Based on our experience in Georgia we believe there are well-qualified Georgian staff and advisors who have the technical knowledge to support the project	We will work to ensure that the Georgian staff and advisers are motivated and engaged by ensuring they have ownership of the project, and are actively engaged in all project activities and reviews

Risks

Risks	Our assessment of the risk	Our Actions	New Likelihood once action has been taken
Lack of consensus on defining constituent elements of the PHC programmes, and/or failure to gain support from constituents, including regional and local authorities and public	Low Risk: Clearly much work has been done to prepare for the project and build consensus and understanding	We will work closely with the PHCCB and PHCMC and the regional and local authorities in Kakheti so that consensus is maintained and support is generated from all stakeholders. We will emphasise consultation, participation, and cooperative working throughout the project.	Low risk
Gaps or shortcoming of donor and stakeholder co-ordination	Low Risk: There has been considerable investment in stakeholder and donor coordination.	We will work closely with the PHCCB and PHCMC, the donors, and all stakeholders, including the regional and local authorities in Kakheti, in order to contribute to the coordination efforts.	Low Risk
Shortage of training capacities, both institutional and trainers	Medium Risk: There are only 6 training centres; capacity will be stretched as they are also providing the training for Imereti and Adjara regions. There are only 12 nurse trainers, but they expected to train 85 nurses in 18 months. Many trainers may not be up to date, have limited clinical experience	We will work with the PHCCB and PHCMC to help them expand network of training centres, and recruit and train additional PHC trainers. We will introduce a refresher course for trainers, and will work with MoHLSA to address the need for additional nurse trainers. However the impact of this will not be seen until after the project.	Short term: Medium risk Longer term: Medium/low risk
Lack of motivated trainers	Low : On the basis of our experience in Georgia we have found the trainers to be enthusiastic and committed	We will continue to motivate trainers by providing refresher courses, adequate and timely reimbursement. We will also work with the PHCCB and PHCMC on strategies to establish the status of trainers.	Low
Limited choice in selection of trainees	Medium: At the moment there are limited incentives for trainees to improve their skills beyond promoting their employment options outside the state sector.	Work with all levels of MoHLSA and in particular the PHCCB and PHCMC to establish incentives to attract able trainees. It will also be important to establish clear selection criteria to attract the most able staff. .	Low
Local authorities fail to implement incentives for PHC teams to settle in	Medium: This is in part dependent on availability of funds	We will closely with regional and local authorities to promote understanding of the need for appropriate	Medium / Low

Risks	Our assessment of the risk	Our Actions	New Likelihood once action has been taken
rural areas		incentives. We will work with them to promote creative and innovative ideas which are not entirely dependent on funding.	
Delays in putting in place prerequisites for defining PHC system: BBP Appropriate reimbursement Modifying legislation	Medium: The necessary work to be done is complex and faces significant challenge in terms of capacity and funding	We will work closely with the PHCCB and PHCMC and other stakeholders to promote commitment and capacity for undertaking these tasks. We will also endeavour to ensure that the project implementation goes on regardless of progress on these issues.	Medium
Refurbishment and equipment of PHC's inadequately implemented	Low / medium: The main risk is that the timing will not coincide with that of the project	We will work closely with Kakheti Health Authorities and EU TACIS to ensure a co-ordinated workplan is developed and implemented, along with contingency plans for places where there is a mismatch of timing.	Low

Additional risks identified by HLSP	Our assessment of the risk	Our Actions	New Likelihood once action has been taken
Low attendance at primary care facilities (0.7 per year) threatens impact of new primary care services	Medium-high: This is currently in part caused by financial barriers and perceptions of service quality.	We will work closely with Kakheti Health Authority to ensure an effective media programme is introduced to inform the public about new improved services in order to promote usage. We will also promote awareness amongst other stakeholders of the need to promote service usage and address access issues. We will also work closely with the EU financing project / Kakheti HA and the PHCCB / PHCMC to ensure the mechanisms are developed and implemented.	Medium
Attrition of PHC specialists after re-training	Low – Medium: Our experience shows that the training such as this may be a passport to other employment	We will work with Kakheti Health Authority to ensure PHC staff are contracted to return to their ambulatories or pay a penalty.	Low
One or more of the current FMTCs lose their license to train	Medium: At this time, if any of the current FMTCs lost their	In developing selection criteria for FMTC there should be an opportunity (and financial support) for any	Low

Additional risks identified by HLSP	Our assessment of the risk	Our Actions	New Likelihood once action has been taken
	license to train, the project would be jeopardised.	FMTC failing to meet the criteria to address the deficit immediately.	

2. Strategy

This section details our strategies for achieving the objectives as described in the TORs, including our overall approach, specific activities related to achieving the outputs, an outline of the main inputs required to achieve project outputs and our organisational and backstopping arrangements for delivering the project.

5. Overall Approach

HLSP is committed to undertaking this project, and welcomes the opportunity to return to Georgia to contribute further to primary health care development. Based on our previous experience in Georgia and our knowledge of the country and sector we will adopt the following principles in our approach:

- A focus on ensuring long-term sustainability of the re-training programme though capacity building and developing approaches and inputs which can be replicated after the project has finished
- Consistency with wider health sector reform including government policy, planning and financing frameworks
- Contributing to donor harmonisation and coordination initiatives, by emphasising consultation and consensus building in all aspects of our work.
- Responsiveness to national counterparts needs whilst bringing appropriate international best practice and wider European perspectives.
- Reinforcement of principles of transparency, accountability, quality assurance and effectiveness
- A focus on achieving benefits for poor and vulnerable groups who are in most need of access to effective primary health care.

6. Key strategies

Based on the principles outlined above:

a) We will adopt a consultative and flexible implementation process

We recognise that the primary health care reform programme in Georgia is operating in a complex environment with multiple stakeholders and sources of funding. The implementation of the programme is challenging, as success is dependent on a number of inputs (finance, refurbishment, equipment, public acceptance) – not all of which are within the remit of this particular project. Moreover conditions for project implementation may change throughout the implementation period. Our approach will therefore be flexible and consultative in order to avoid an over prescriptive style: we will help identify key milestones within the project in order to monitor and evaluate progress; we will regularly consult with national counterparts to ensure we are providing appropriate support in responding to the changing environment; we will work closely with all stakeholders to ensure consensus in decision making.

b) We will promote national ownership

Political commitment and leadership from Georgian counterparts is fundamental to the success of this project and we will focus on a constructive and integrated partnership with the PHC Coordination Board and the PHC Management Committee in MoLHSA, and in particular with the Human Resource and Service Provision working group co-

ordinated by the PHC Management Committee. The focus of the project is on supporting primary health care reform through the delivery of family medicine training, with an emphasis on institutional and human resource capacity building. A consultative approach involving key stakeholders with whom we will determine project policy, activities and timescale will be an integral part of the project culture. It is essential that consensus is built and that all parties have ownership to ensure integration and complementary approaches.

We have significant experience of working with stakeholders using this methodology, both in Georgia and in the Region. We feel it is essential to incorporate a dissemination workshop at the end of the inception phase to ensure that our team and all stakeholders have common expectations and have agreed their appropriate roles and responsibilities to ensure:

- high level input and ownership of policy decisions
- simple monitoring mechanisms based on the agreed log frame
- Appropriate operational authority to reduce unnecessary transaction costs.

c) We will emphasise capacity building

The focus of the project is on strengthening primary health care through the delivery of an appropriate retraining programme capacity in Kakheti, but it is important that the entire project is seen to act as a model for national rollout in the future. The project team (and international experts) will therefore be expected to:

- Share their skills and knowledge
- Act as coaches and mentors
- Identify key counterparts who can be provided with the skills to support the ongoing development of family medicine training programmes
- Ensure national capacity to effect national roll-out, including effective evaluation of the programmes

d) We will promote a focus on measuring and maximising long term project impact

The log frame will of course act as the basic tool for managing the project performance. The ToRs define the outputs in terms of numbers of health workers receiving PHC training, but it will be important to measure the impact of the project in terms of improved health care provision and increased access and acceptability for the community. This will require detailed design, planning and implementation and ongoing consultation in order to understand stakeholders expectations and to set realistic deliverable targets.

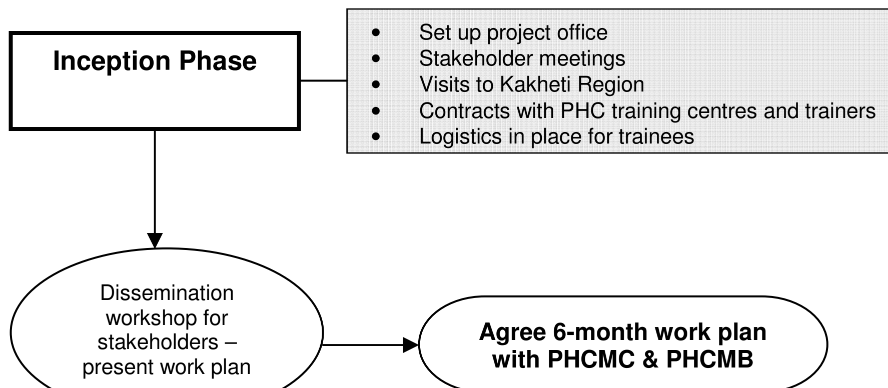
7. Proposed Activities

This section focuses on the main activities outlined in the TORs. The specific activities outlined below are indicative. A detailed activity plan will be developed and agreed with the PHC Management Committee, the EU Task manager, and the project steering committee during the inception phase. We propose that the project activities be divided into three phases:

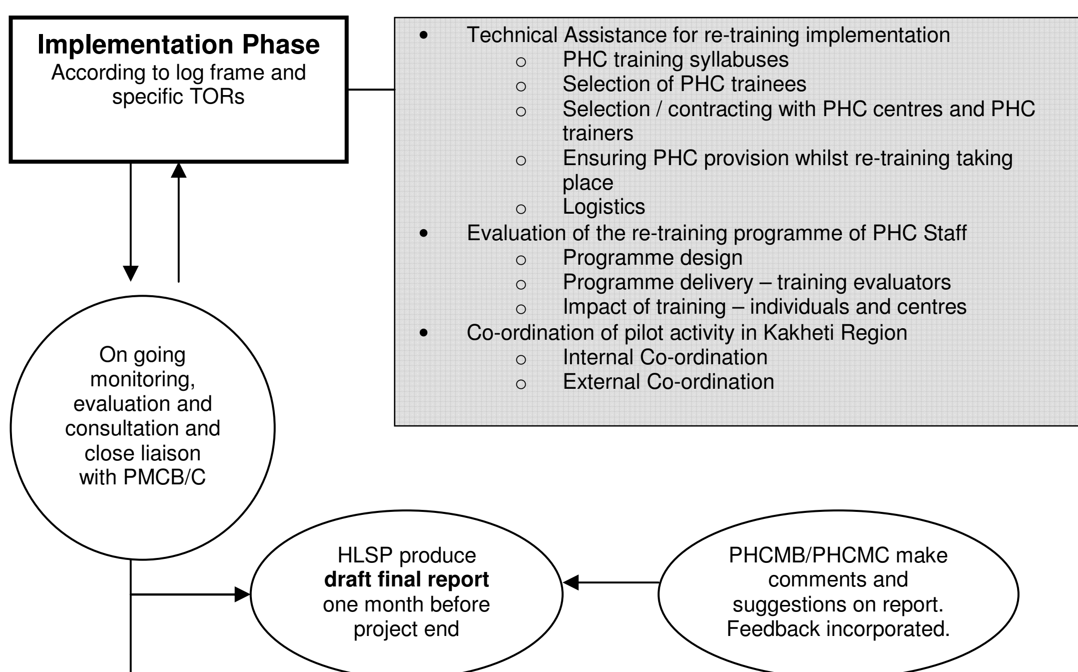
- **Inception phase** (1 month)
- **Implementation Phase** (17 months: option 1)
  (18 months: option 2)
    a. Technical assistance for retraining implementation
    b. Evaluation of the re-training programme of PHC staff
    c. Co-ordination of activities in Kakheti Region
- **External evaluation and exit phase** (final month of the project)

Chart to Demonstrate Proposed Activities

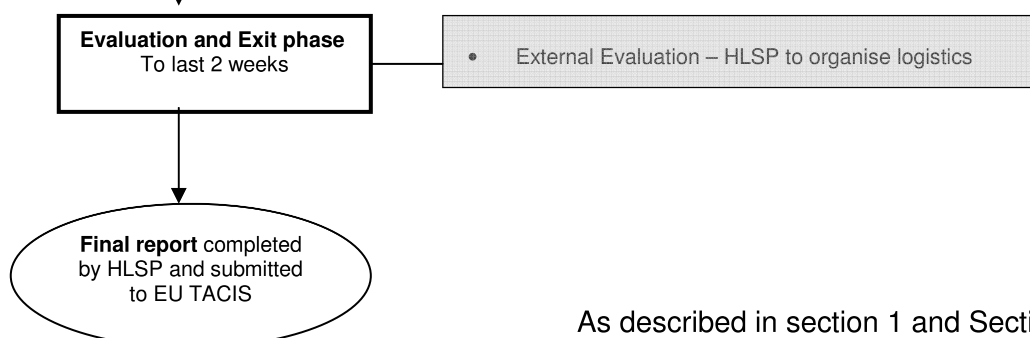
Month 1



Months 2 – 18 option 1
Or 1 - 18 option 2



Month 18



As described in section 1 and Section 3

Option 1: A one-month inception period, followed by the implementation phase. This would entail ending the project one month before the third cohort complete their training. As there would be no opportunity to evaluate the impact of the training (which would take an additional two months, thereby extending the project by a further two months), we consider this approach, far from prejudicing the project, would add value.

Option 2: To run the inception phase in parallel with the start of the first training course.

2.3.1 The inception phase (1 month)

As described earlier, we believe an inception period prior to the start of the re-training would provide added value (option 1). However, we recognise this may not be possible, and that the inception period may run in parallel, should the re-training start immediately (option 2). We would wish to discus the options with the contracting authority and would comply with their wishes, and focus on the logistical and operational elements of establishing the re-training.

The main objectives of this phase will be to:

- Establish relationships between the HLSP team, the PHC Management Committee, and key counterparts;
- Clarify roles and responsibilities of the HLSP team and counterparts;
- Establish the operational aspects of the project (office setup, logistics);
- Undertake a review of current training activities – syllabus, PHC trainers, PHC training centres;
- Gain further understanding of the situation in Kakheti region;
- Gain further understanding of other donor activities, their findings, and impact on this project;
- Agree a detailed work plan with PHCMC;
- Start to build close linkages to policy discussion in the country;
- Contract FMTCs to deliver the training.

Our activities will include

- Establishing the project office (equipment, facilities, necessary refurbishment)
- Individual meetings with key stakeholders:
    - PHC Coordination Board, MoLHSA
    - PHC Management Committee, HR and Service Provision working group
    - EU, WB and DFID/ Oxford Policy Management team
    - Family medicine training centre chiefs (Tbilisi and Mtskheta)
    - Georgia Family Medicine Association
    - Kakheti Regional Health authority
- Visit to Kakheti Region
    - Field visits to ambulatories to observe clinical practice of doctors and nurses
    - Meetings with Regional and District health authorities
    - Ensure alternative arrangements for covering primary care services are in place
- Drawing up contracts with PHC training centres and PHC trainers
- Starting to put in place a one-week teaching refresher course for trainers who have no recent training experience

- Holding a dissemination workshop for all stakeholders to present the workplan.

See project implementation schedule Section 3.

2.3.2 Implementation phase (17 months (option 1); 18 months (option 2))

We see this project as providing an opportunity to enable MoLHSA and PHCCB / PHCMC to deliver, develop, and refine both an effective PHC retraining programme and a mechanism to monitor, evaluate, and improve the delivery of primary care that can be adopted nationwide. Adopting an iterative approach will allow us to modify each successive training programme based on constant review of experiences and evaluation of the three training cohorts.

1.3.1 Component 1: Technical assistance for re-training implementation

We identify the following key elements in this component:

1. Ensuring that the PHC re-training syllabuses are appropriate
2. Selection of PHC trainees
3. Selection/ contracting with PHC training centres and PHC trainers
4. Ensuring continuity of primary care provision in Kakheti whilst re-training is taking place
5. Logistical management

a) Ensuring that the PHC re-training syllabuses are appropriate

The re-training syllabuses were designed between 1997 – 2003, and to date have been adopted for all training activities. The content was based on the principles of family medicine – promotive, preventive, and curative services – as well as the health needs of a predominantly urban population, and delivered to trainees who met strict selection criteria. We think it likely that rural PHC staff may be dealing with different health needs, and may have less knowledge and skills as many will be working in isolation (unlike urban practitioners who work in polyclinics alongside other colleagues and narrow specialists). It will be important to ensure that the training syllabus addresses trainees' needs, as well as those of the rural population of Kakheti. Whilst the first training cohort will be trained using the current syllabuses, we would seek agreement from PHCCB / PHCMC and other stakeholders that the syllabuses should be the subject of constant review, and that they could be modified for successive training cohorts. Finally, we will ensure that the re-training programme meets international standards.

We will ensure that the training modules in the field of financial and administrative management under development by the EU "Reform of Health Care Financing System" are incorporated into the re-training programme. This will have particular relevance for the training for practice managers.

We would develop, during the first three months, a template for assessing potential trainees' and population health needs. This would comprise:

- Trainees' diary of clinical contacts for one month; identified clinical problem, action taken (treatment, referral etc.)
- Self-completion checklist of competencies to identify trainees' knowledge and skills
- Focus group activities during the re-training programme to enable trainees to discuss / identify problems they encounter in their clinical practice in Kakheti.

Focus group activities could be introduced during the first re-training cohort. The clinical contact diary and the self-completion competency checklists would be completed by potential trainees selected for the second (and third) re-training cohorts just before they started their training.

We would also (and see output 2 below) develop templates to record trainees' clinical activities after completion of their re-training to re-assess their skills.

Based on the analysis of the data, the re-training programmes may need revision. Any changes would require prior approval of the PHCMC HR and Service Provision working group. The analysis would be carried out by the Georgian Family Medicine Association, supported by the national HLSP expert.

b) Selection of PHC trainees

MoLHSA has already identified criteria for selection of the first cohort of trainees which will facilitate a swift start for the project. We anticipate that the criteria may require modification based on evaluation of the first re-training course. We would support PHCCB/ PHCMC in revising the criteria in the light of the evaluation. If required, we would work closely with Kakheti Regional Health Authority in determining the criteria for selecting PHC teams for training, using our regional and international experiences.
Aspects of selection that may be considered could include:

- Previous experience / relevant specialist training?
- Age limit?
- Need to recruit from other areas of the region?

.

c) Selection / contracting with PHC training centres and PHC trainers

At present there are only 6 FMTCs in Tbilisi and Mtskheta, and training capacity is severely limited. At this stage competitive tendering is unlikely to be a viable option. We believe it may be necessary to establish additional training centres – ideally within the timeframe of this project (although we understand that financing their establishment would not be within the remit of this project). At this time, if any of the current FMTCs lost their license to train, the project would be jeopardised. Thus we propose that in developing selection criteria for FMTC there will be an opportunity (and financial support) for any FMTC failing to meet the criteria to address the deficit immediately, e.g. through additional training.

At this stage we propose that selection criteria would include:

- Trainers meet trainer requirements (see below)
- Adequate teaching facilities – equipment, consultation rooms, tutorial rooms, teaching materials in Georgian / Russian
- Clinical workload of FMTC adequate to provide comprehensive range and number of clinical cases
- Protected time for teaching and training.

Trainers must be able to demonstrate a high level of clinical skills and knowledge of all aspects of primary health care. They must also demonstrate the ability to teach effectively through the use of modern teaching methods. It is likely that some trainers may have completed their training a few years ago, and may not have been working as trainers for some time. We propose that provided they can demonstrate adequate clinical knowledge and skills, they undertake a short, one-week trainer refresher course – focusing on modern teaching methods. Satisfactory completion of the course would

lead to re-appointment as a PHC trainer. This would apply to doctors, nurse and practice manager trainers. We would ensure that trainers' performance is monitored – both by direct observation as well as feedback from the trainees themselves. We would involve the Georgian Family Medicine Association in this exercise.

Ideally, additional trainers for Kakheti Region could be identified from the Kakheti retraining cohorts. They could play an important role as evaluators of the impact of the re-training (see Section 2.3.2, page 22), and providing ongoing workplace training / continuing medical education once the new PHC teams are established in the Region (as described below).

If this was possible, criteria could include:

- Excellent performance throughout the re-training programme
- Commitment to part-time training activities in Kakheti region
- Under 45 years of age
- English language – requirement to study English language textbooks and other materials.

We will review the current contracts MoLHSA holds with FMTCs and PHC trainers, and make recommendations for any additions / changes required. This work would be conducted in close association with PHCMC.

d) Ensuring continuity of primary care provision in Kakheti

It will be the responsibility of the Kakheti health authorities to ensure that existing primary care services are maintained during the project, and that the inevitable disruption is minimised. We anticipate that the FMC refurbishments will take time, and that it is likely that many affected ambulatories will be unable to provide any services during the process. We will support the authorities in ensuring that the work is done in a timely manner, and that it is completed on schedule – to ensure that the re-trained PHC teams have a workplace to practice from. We will support the Kakheti health authorities in deciding whether to reallocate staff to work in the refurbished FMCs catchments during the retraining; this will be dependent on location (are there alternative ambulatories accessible to the affected community?) and workload (could health workers in alternative ambulatories absorb the additional workload? Analysis of the workload in Kakheti presented in the TORs would suggest that doubling the workload would not stretch capacity at present).

The public will need to be informed of the changes and possible disruptions – we would support the Kakheti authorities in preparing an effective media programme. This would be one component of an overall **public awareness programme on new primary care services** outlining how the new services will benefit them, and emphasising the enhanced skills of the PHC team that they can expect. This will be essential, if primary care attendances are to increase. The programme would be developed in the third month, and disseminated two months before the first cohort returns to the Kakheti.

e) Logistical management

We will ensure that all the components are managed effectively:

- Contracts prepared for FMTCs and the trainers, and ensuring that all payments are made on time
- Trainees will be provided with accommodation and per diems during their six-month training

- Regular meetings with the project steering committee (monthly, if required): agendas and minutes of meetings circulated
- Regular visits to Kakheti Region to:
    - Meet with health authorities
    - Field visits to FMCs.

1.3.2 Component 2: evaluation of the re-training programme of PHC staff

This is a key component, as it is essential to ensure that the programme has an impact that extends beyond providing re-training. The project must demonstrate that clinical practice and service delivery is changed. Effective evaluation should provide the basis for continuing professional development programmes to suit the needs of Kakheti region.

The following table summarises the range of evaluation that needs to take place within the project.

Table 1: Areas for evaluation

What is being evaluating?	How?
a) Delivery of the 6 month re-training programme	• Enrolment, attendance and pass rates • Trainee satisfaction • Trainers' performance
b) Clinical and management skills of professionals	• Workplace evaluation of progress in ability to manage caseload (by Kakheti - based evaluators)
c) Patient satisfaction	• Evaluation of the perceived changes (exit polls) • PHC attendance rates
d) Impact of new PHC delivery	• Develop process indicators to monitor delivery of service • Data collection and analysis

a) Assessing the delivery of the 6 month re-training programme

We propose that the programme be evaluated based on the following criteria:
- Performance of FMTCs
- Performance of individual trainers
- Structure of the course – balance between classroom and clinical training etc
- Enrolment, attendance and pass rates of doctors, nurses and practice managers
- Trainees' own assessment
- Assessment of individuals' performance in the re-training programme(normative and summative assessment).

b) Patient satisfaction

We propose to evaluate patient satisfaction by:
- Attendance rates at the new PHC centres will be a strong proxy measure for patient satisfaction. It is important that any increase in attendance is maintained over time.

In addition we would:
- Conduct exit PHC Centre exit surveys: we would develop a simple questionnaire to be completed by patients leaving the PHC centre

- Focus group discussions: these could be conducted in the community (and would have the added value of involving a broader cross-section of the community (some of whom may not be visiting the PHC Centre).

c) Clinical and management skills of professionals

A key element of assessing clinical and management skills involves direct observation in the workplace. Evaluators should spend time (at least half a day) observing re-trained doctors and nurses conducting clinical consultations in their refurbished PHC Centres. They will be able to assess:
- Rapport/ communication with the patient
- History taking
- Clinical skills
- Diagnosis
- Case management
- Incorporating preventive/promotive practice in the consultation
- Team working.

d) Impact of the re-training and new PHC delivery

The longer-term impact of the retraining may be measured by looking at the following:
- Assessment of PHC practice after re-training *section c, above*
- Impact of new delivery of PHC practice
- Feedback of findings to inform:
  - Review of the PHC training syllabus
  - Development of individual workplace training and continuing medical education for PHC teams.

The first step in assessing PHC practice is to establish the clinical activities that are to be provided after re-training. The table below illustrates activities that could be considered:

Table 2: Clinical activities expected of PHC teams

Health promotion: o Smoking cessation o Prevention of coronary artery disease o Healthy nutrition o Safe sexual practice o Community based activities Health prevention o Immunisation o Screening for hypertension, diabetes o Contraception services o TB screening o Screening for thyroid disease Management of chronic disease o Diabetes o Hypertension o Asthma

- Coronary artery disease

Curative services
- Adherence to evidence based protocols for up to 10 common conditions

We would first work with the stakeholders (through the HR and Service Provision group) to agree a list of activities. Based on this list it would then be possible to determine process indicators to demonstrate how they are being delivered. The table illustrates indicators that could be considered.

Table 3: Activity data that PHC teams could provide

Baseline:
- Number of patients in catchment area: age / sex distribution
- Consultation rates

Health prevention:
- Immunisation rates for children under 5 years
- Patients screened for hypertension / diabetes (% target group)
- Patients offered contraceptive advice (% target group)

Management of chronic disease
- Diabetes: number of patients / number managed in FMC
- Hypertension: number of patients / number managed in FMC

Financial data
- Indicators identified by the EU health financing project

This is illustrative only; experience would suggest that the indicators are limited to a small number only; the list can be extended as the PHC teams' skills and confidence improve.

It is our experience that evaluation is most effective when carried out in the workplace by a **trained evaluator**. We would recommend that they are based in Kakheti Region; they could be selected from doctors or nurses who successfully completed the re-training course (and, ideally, trained as trainers). Ideally, the assessment would take place after the PHC teams have completed their clinical diaries (see section 2.3.2 page 17), and when they have collected the basic activity data, so the PHC team can be given feedback on their activities. The workplace assessment would provide evaluation of the PHC teams' clinical skills, ability to work as a team, and identification of any weaknesses. Based on the assessment, it will be possible to determine any additional training needs for the team, and design an individual training plan for the PHC team. The findings should also inform any changes that may be required.

It is our experience that direct feedback on activity data is regarded positively by PHC teams, provided it is made clear that the exercise is to support the PHC teams to find ways of developing their skills – focusing on the positive, and not just the negative, data – and not as a punitive procedure. This will further be dependent on the Region providing additional training / support to meet any training needs that are identified.

International expert support to evaluation of the training

We propose that we provide additional international support to the HLSP team in devising the evaluation methodology, training for the evaluators, ensuring that any changes in the re-training programmes are licensed and accredited by MoLHSA, and that they meet international standard. It is important that the methodology meets international standards. We have already identified two international experts; both have

had significant involvement in the previous DFID family medicine programmes in Georgia 1997 - 2003, and played a key role in designing and evaluating the training syllabuses. Each has over 10 years international experience of developing family medicine in the region, and worldwide (family physicians, nursing, practice management); They have significant experience in licensing and accreditation of medical practitioners, trainers, training facilities and training syllabuses. At the same time they continue to be involved in the UK National Health Service, working in primary care, and involved in senior management. They would provide back-up support to the team from their UK base, and as well as two in-country visits between the first and second re-training cohorts.

1.3.3 Component 3: Co-ordination of pilot activities in Kakheti Region

We will ensure that activities are co-ordinated both internally and externally by directing all activities through the PHCMC.

a) Internal co-ordination

We have described earlier the need for close co-operation with the Kakheti health authorities in ensuring the refurbishment is completed on time, and that the training programmes for doctors, nurses, and practice managers are conducted simultaneously. The training modules developed by the EU health financing project will be incorporated into the re-training programme, and findings and recommendations will be incorporated into the re-training programme the FMC activity reporting dataset. We will work to ensure that Kakheti health authority ensures continuity of PHC services during the project, and that the public is made aware of the new services they can expect.

b) External co-ordination

There is a strong emphasis in the terms of reference on the importance of working closely with other projects. This is not just to ensure that the timing of facility rehabilitation and training is correct, but also to build greater capacity in government to activity manage its aid programme. The commitment by EU, DFID and other donors to support this is encouraging. The project needs to contribute to this actively by:

- ensuring that the EU programme manager is kept well informed about project progress and coordination issues as they occur in the field
- Building relationships between the team leader and national coordinator on this project and their counterparts on other projects
- Taking a wide view of how the improvement of medical training can improve PHC as a whole in Georgia. Liaison on issues such as HR, service financing and efforts to improve population access to services must be considered in the course of this project and similarly the team leader will work to build technical linkages between his project and others dealing with relevant issues
- Welcoming any developments in reporting requirements proposed by the EU and other donors in order to facilitate harmonisation of reporting, monitoring, procurement and planning.

HLSP will ensure that the project activities, findings and recommendations are co-ordinated with the DFID Primary Health Care Development project, the World Bank PHC project (including the Adjara and Imareti training project), in line with MoHLSA policy.

Our activities would be circulated through the minutes of the monthly project meetings with PHCMC, and through one-to-one meeting with the stakeholders.

c) Evaluation and exit phase

We agree that it is important that the project is subject to an external evaluation. We would ensure that the evaluation team is provided with all relevant project background, including project reports prior to their visit to Georgia. HLSP would meet with the team, address any queries, and agree a two-week programme. HLSP will be responsible for arranging their itinerary, and proving logistical support, including use of the HLSP office and access to all its facilities. The HLSP National Co-ordinator and Team Leader will be available to the evaluation team throughout their visit.

HLSP will produce a draft final report one month before the project end. The report will be circulated to PHCCB / PHCMC for comments and suggestions. Their feedback will be incorporated in the final report which will be submitted to EU TACIS at the end of the project.

2.4 Related inputs and outputs

This section outlines the main inputs and outputs provided by HLSP and the Georgia Family Medicine Association.

The table below summaries the key areas of expertise we bring to the project.

HLSP

- 5 years experience of primary care development in Georgia
- 10 years experience of primary care development in the Region Uzbekistan, Kazakhstan, Kyrgyzstan, Russia, Ukraine, Romania, Albania, Kosovo, Bosnia Herzegovina
- Project management (with EU, DFID, World Bank and other donors)
- Health policy and health systems analysis
- Development and implementation of training for health professionals
- Human resource planning and management
- Institutional building, capacity building
- Quality assurance
- Licensing and accreditation of health professionals
- Monitoring and evaluation
- Development of clinical protocols

Georgia Family Medicine Association (GFMA)

- Membership includes Doctors, Nurses and Practice managers working in Family medicine
- Involved in design and co-ordination of training activities: presented the revised training family medicine specialist training programme to MoHLSA Licensing and Accreditation Department, which was formally recognised on 13 May 2005.
- Close affiliation with family medicine training centres and high medical schools (Universities
- Clinical protocols
- Clinical practice quality evaluation
- Full membership of World Organisation of Family Physicians (WONCA)

Technical inputs

HLSP Team leader:	David Simpson
HLSP National Coordinator	Tamar Shanidze
HLSP Internationals	Two international consultants
National implementation	Georgia Family Medicine Association

Project backstopping

HLSP London staff

<u>Team leader: **David Simpson**</u>

Key qualifications and skills he brings to the project:

- Senior health service manager with extensive international and UK experience
- 12 years experience in health sector reform in Eastern Europe, Russia, Africa, Asia and the Far East
- Primary care development projects in Kosovo, Bosnia Herzegovina and Mongolia
- Introduction of primary care training in Kosovo; monitoring and evaluation, quality assurance, licensing, continuous medical education
- Project management (team leader) in European Union, DFID, World Bank and Asian Development Bank development projects
- Health financing expert: advising ministries in Kosovo, Russia, Mongolia, China, and Bosnia Herzegovina.

Role of the team leader:

- Overall management and responsibility for all the components of this re-training project
- Overall supervision of all elements of the retraining programmes
    - Delivery
    - Evaluation
    - Follow-up evaluation
- Co-ordinating project activities with EU refurbishment/ equipment project
- Co-ordinating activities with EU financing project
- Co-ordination of activities through the MoLHSA PHCCB / PHCMC, EU Delegation and other donors.

He will spend 10 months in Georgia; we propose two three-month, and two two-month visits, although the times may be altered to meet with project demands should they arise. He will be based in Tbilisi, but will visit Kakheti region on a regular basis and hold meetings with Kakheti health authorities, visit family medicine centres, and contribute to the workplace training evaluation.

<u>National co-ordinator: **Dr Tamar Shanidze**</u>

Key qualifications and skills she brings to the project:

- 7+ years of experience in the field of Primary Health Care since the very first steps of its implementation in Georgia
- Excellent knowledge/understanding of the development of Primary Health Care in Georgia
- Experience in developing the first Georgian family medicine training curriculum and understanding the needs for its further development
- GP trainer with special knowledge of adult learning methodologies
- Extensive managerial and administrative experience in governmental and non-governmental organizations

- Experience in PR/ communications
- Outstanding language skills necessary to produce good narrative forms of a project/ organization.

Roles and responsibilities

- Support to the team leader in delivering all the project outputs
- Day-to-day management of the project office
- Responsibility for logistics of all project activities
- Regular liaison with PHCCB / PHCMC, EU and donors.

She will be permanently based in Tbilisi, and work full time for the project throughout its 18-month duration

Georgia Family Medicine Association

Roles and responsibilities:

- Support to the evaluation of the re-training programme
- Support to the evaluation training for Kakheti trainees/trainers
- Supervision of the evaluation process in Kakheti

International Experts (two one-week visits to Georgia)

Their role is to ensure that all elements of the re-training programme meet international standards. They will provide additional support to GFMA and the HLSP team:

- Support to the development of the re-training evaluation methodology to ensure
    - Methodology is robust and replicable
    - External evaluation of the re-training evaluation process
- Support to the design and delivery of the evaluation training for Kakheti trainees/trainers
- Ensuring the re-training syllabus/delivery meets international standards
    - Working with GFMA/HLSP team in reviewing the re-training syllabus, and introducing necessary modifications.

2.5 Backstopping to HLSP team

HLSP will provide a full range of organisational support, systems, and operational services. This will ensure a broad range of quality expertise and efficient problem solving in order to execute the project to the highest professional standard. A team will be assigned to specifically support this project, based at the HLSP offices in London. The team will comprise:

- HLSP Regional Director for East and Central Asia
- Dedicated Project Officer
- Contracts and Finance manager
- In-House Specialist in Primary Care (with extensive experience in developing primary health care in Georgia and the Region).

All the staff have experience of supporting the delivery of technical assistance programmes in Europe and elsewhere, including programmes on behalf of the EC, EAR, the World Bank, UNAIDS and the UK Department for International Development (DFID).

3 Timetable of activities

This section outlines the timing and sequence of activities as well a major milestones anticipated during the life of the project. These are indicative and will be adjusted during the inception phase and throughout the project in conjunction with the EU Task Manager and national stakeholders.

3.1 Timing, Sequence, Duration of Proposed Activities

As described above we propose that the project activities be divided into three phases. We will regularly consult with national counterparts (PHCCB/PHCMC) to ensure we are providing appropriate support in responding to the challenges of the project, as well as working closely with all stakeholders to ensure consensus in decision making. The project ends after 18 months; we believe that an inception period (one month) – Option 1 - should precede the first re-training course to ensure that contracting and logistical arrangements are in place before the start. On the assumption that it will not be possible to retrain more than one cohort at a time (lack of training capacity, increased disruption to primary care services in Kakheti) the project will end (one month) before the third cohort has completed the re-training. At that stage, all the other elements of the project should have been finalised, so we do not think this should pose a problem.

The table below summarises the timing, milestones and reporting for the project**.** Detailed scheduling can be found in section 3.2. We have presented our timetables for both options.

Phase	Timing Option 1	Timing Option 2	Milestones	Report
Inception	Month 1	Month 1	Project operational set up Contracts with FMTCs Project workplan agreed	Inception report Month 2
Implementation	Months 2-18	Months 1-18		Report Month 7 Report Month 8 Report Month 18
Training cohort 1	Months 2-7	Months 1-6	Training report	
Training cohort 2	Months 8 -13	Months 7-12	Training report	
Training cohort 3	Months 14-18	Months 13-18	Training report	
Evaluation methodology	By Month 7	By Month 6	Evaluation tool developed	
Workplace training/ evaluation	Months 7-18	Months 7-18	Evaluation reports from M9	
Exit and evaluation	Month 18	Month 18		Final report Month 18

3.2 Project Implementation Schedule (Indicative)

Option 1

Month	week				month																	
	1	2	3	4	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
Activity																						
Inception phase																						
Establish office																						
Meetings with stakeholders																						
Kakheti field visit																						
Agreement for DFID training syllabus																						
Trainer re-training course																						
Contract FMTCs and trainers																						
Logistics in place for retraining to start																						
Stakeholder workshop																						
Agree detailed workplan																						
Project reports																						
Implementation phase																						
FM retraining																						
FM retraining cohort 1																						
FM retraining cohort 2																						
FM retraining cohort 3																						
Selection criteria for FMTCs																						
Selection criteria for FM teams																						
Identify FM teams for retraining																						
Monitoring of training programmes																						
Develop Kakhetei Media campaign																						
Informing public about new PHC																						
Workplace follow-up training																						
Monthly visits to Kakheti Region																						
Evaluation of re-training programme																						
Develop methodology and indicators																						
Service delivery recording mechanisms																						
Design recording templates																						
Design monitoring training for PHC teams																						
Training for evaluators																						
Evaluate re-training programme																						
Review FM team indicators																						
Workplace evaluation post-training																						
Revise training programmes																						
Co-ordination activities in Kakheti																						
Co-ordination refurbishment, equipment																						
Co-ordination of nurse, GP, PM training																						
Incorporate finance inputs into training																						
Liaison with WB, DFID (OPM)																						
Liaison with PHCMC																						
Evaluation and exit phase																						
External evaluation of project																						
Prepare draft report																						
Final stakeholder workshop																						
Inputs																						
Team leader: David Simpson																						
Local coordinator: Tamar Shanidze																						
Georgia Family Medicine Association																						
International experts:																						
Family physician training																						
Nurse, practice manager training																						

Option 2

Month	month																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Activity																		
Inception phase																		
Establish office																		
Meetings with stakeholders																		
Kakheti field visit																		
Agreement for DFID training syllabus																		
Trainer re-training course																		
Contract FMTCs and trainers																		
Logistics in place for retraining to start																		
Stakeholder workshop																		
Agree detailed workplan																		
Project reports																		
Implementation phase																		
FM retraining																		
FM retraining cohort 1																		
FM retraining cohort 2																		
FM retraining cohort 3																		
Selection criteria for FMTCs																		
Selection criteria for FM teams																		
Identify FM teams for retraining																		
Monitoring of training programmes																		
Develop Kakheti Media Campaign																		
Informing public about new PHC																		
Workplace follow-up training																		
Monthly visits to Kakheti Region																		
Evaluation of re-training programme																		
Develop methodology and indicators																		
Service delivery recording mechanisms																		
Design recording templates																		
Design monitoring training for PHC teams																		
Training for evaluators																		
Evaluate re-training programme																		
Review FM team indicators																		
Workplace evaluation post-training																		
Revise training programmes																		
Co-ordination activities in Kakheti																		
Co-ordination refurbishment, equipment																		
Co-ordination of nurse, GP, PM training																		
Incorporate finance inputs into training																		
Liaison with WB, DFID (OPM)																		
Liaison with PHCMC																		
Evaluation and exit phase																		
External evaluation of project																		
Prepare draft report																		
Final stakeholder workshop																		
Inputs																		
Team leader: David Simpson																		
Local coordinator: Tamar Shanidze																		
Georgia Family Medicine Association																		
International experts:																		
Family physician training																		
Nurse, practice manager training																		

3.3 Expected number of Working Days of the Experts

The expected number of working days of the key experts is contained within the standard budget template utilised for EC programmes and included within our financial offer, both as a hard copy and an electronic version. One section is copied here as per the requirement of the Tender Dossier.

Option 1

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	**Year 1**	Cumulative total
Long-term international experts														
- Team leader	22	22	22			11	22	22	11				132	132
- Senior experts													0	0
- Junior experts													0	0
Long-term local experts														
- Senior experts													0	0
- Junior experts	22	22	22	22	22	22	22	22	22	22	22	22	264	264
Short-term international experts														
- Senior experts						12					12		24	24
- Junior experts													0	0
Short-term local experts														
- Senior experts					10	10	10						30	30
- Junior experts													0	0

	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	**Year 2**	Cumulative total
Long-term international experts														
- Team leader	22	22			22	22							88	220
- Senior experts													0	0
- Junior experts													0	0
Long-term local experts														
- Senior experts													0	0
- Junior experts	22	22	22	22	22	22							132	396
Short-term international experts														
- Senior experts													0	24
- Junior experts													0	0
Short-term local experts														
- Senior experts													0	30
- Junior experts													0	0

Option 2

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	**Year 1**	Cumulative total
Long-term international experts														
- Team leader	22	22	22		11	22	22	11				22	154	154
- Senior experts													0	0
- Junior experts													0	0
Long-term local experts														
- Senior experts													0	0
- Junior experts	22	22	22	22	22	22	22	22	22	22	22	22	264	264
Short-term international experts														
- Senior experts					12					12			24	24
- Junior experts													0	0
Short-term local experts														
- Senior experts				10	10	10							30	30
- Junior experts													0	0

	Month 13	Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 20	Month 21	Month 22	Month 23	Month 24	**Year 2**	Cumulative total
Long-term international experts														
- Team leader	22				22	22							66	220
- Senior experts													0	0
- Junior experts													0	0
Long-term local experts														
- Senior experts													0	0
- Junior experts	22	22	22	22	22	22							132	396
Short-term international experts														
- Senior experts													0	24
- Junior experts													0	0
Short-term local experts														
- Senior experts													0	30
- Junior experts													0	0

4 Log frame

The log frame for the project will be revised with stakeholders during the inception phase of the project. Changes have been made to input level only at this stage.

Intervention Logic	Objectively Verifiable Indicators	Sources of Verification	Assumptions
Overall Objective			
To introduce a model of PHC in Georgia that provides comprehensive, effective, affordable health care services available and accessible to all, including the poor			Continued support from MoHLSA, World Bank, and other donors
Project Purpose			
To provide the rural population of Kakheti access to improved comprehensive primary care services provided by re-trained family medicine teams			Continued support from Kakheti Health Authorities, MoHLSA
Results			
1 Re-training in family medicine delivered to 85 family medicine teams in Kakheti Region 2 85 family medicine teams providing high quality comprehensive primary care services 3 Training activities are co-ordinated with the parallel EU refurbishment and PHC financing programmes in Kakheti, and the overall health reform strategy supported by WB and DFID 4 A methodology to ensure the training	1. Number of doctors, nurses and practice managers trained 2. Number of teams providing primary care Number of teams meeting evaluation criteria Number of teams working in refurbished PHC Centres 3. New financing mechanisms introduced in Kakheti 4 Training programme evaluation mechanism	1-4: Project reports PHCCB / PHCMC reports Kakheti HA reports	1.1 Training capacity FMTCs 1.2 Kakheti HA co-ordinates activities 2.1 PHC Centres are refurbished and equipped 2.2 Increased attendance PHC Centres – effective medial campaign 3.1 Effective co-ordination of all elements EU-TACIS project 3.2 Support from Kakheti HA 3.3 MoHLSA supports new financing initiatives 4 Continued support from

Intervention Logic	Objectively Verifiable Indicators	Sources of Verification	Assumptions
programmes meet international standards is established; training programmes are licensed by MoLHSA	introduced Modification to training programmes licensed by MoLHSA		MoHLSA

Activities	Specification of inputs
1.1 Contract training institutions and trainers to deliver training 1.2 Provide refresher training for trainers 1.3 Identify doctor, nurse and PM trainees 1.4 Deliver six-month training programmes 1.5 Training syllabuses/ programme modified based on feedback/ local health needs assessment 1.6 Develop ongoing workplace training for PHC teams	1.1 Develop contracting criteria 1.2 Deliver 1 week training refresher course 1.3 Selection criteria developed, and modified 1.4 FMTCs provide the training 1.5 HLSP work with PHCMC / FMTCs in reviewing the training, and recommending changes 1.6Kakheti trainers/ evaluators trained to provide ongoing workplace training/ CME
2.1 Ensure training activities co-ordinated with refurbishment and PHC financing activities 2.2 IEC programme to inform public of new PHC services introduced in Kakheti 2.3 Develop indicators to monitor and evaluate primary care delivery by retrained PHC teams with Kakheti health authorities	2.1 HLSP liaises closely with Kakheti HA and EU financing 2.2 HLSP and Kakheti develop IEC 2.3 HLSP agrees indicators with PHCMC and Kakheti HA
3.1 Develop close working with stakeholders and donors involved in the Kakheti pilot (EU finance, refurbishment and equipment) 3.2 Co-ordinate training activities with stakeholder activities	3.1 Frequent meetings with all stakeholders, especially Kakheti HA and EU 3.2 Close liaison with Kakheti HA/ EU/ FMTCs
4.1 Develop Training programme evaluation methodology 4.2 Training programmes licensed by MoLHSA	4.1 HLSP/ GFMA develops an evaluation methodology 4.2 Kakheti evaluators identified and trained 4.3 Kakheti evaluators evaluate training programme 4.4 Evaluation findings fed back to PHCMC and programme modified

5 Key Experts

Proposed Technical Assistance Team

The key experts proposed provide the expertise and knowledge requested from the TORs. We have agreed their involvement on the basis of this contract being awarded to the consortium.

Letters of exclusivity and copies of relevant diplomas are with the Tender Submission Form.

5.1 Key Expert Summary

Name of expert	Proposed position	Years of experience	Age	Nationality	Educational background	Specialist areas of knowledge	Experience in beneficiary country	Languages and degree of fluency (VG, G, W)
David Simpson	International Team Leader	31	60	British	1977, Open University, BA 1972, Diploma in Management Services	Management and implementation of Primary Health Care reform projects PHC policy development and reform Health sector reform HR development, capacity building and reform PHC training and quality assurance Monitoring and evaluation Strategy development and planning Health sector reform in central and eastern Europe, and former soviet union Team management and leadership Donor liaison and coordination Sector wide working.	No	English VG

Name of expert	Proposed position	Years of experience	Age	Nationality	Educational background	Specialist areas of knowledge	Experience in beneficiary country	Languages and degree of fluency (VG, G, W)
Tamar Shanidze	**National Coordinator**	25	48	Georgian	Tbilisi State Medical Institute, Faculty of General Medicine, 1981, MD	GP Training Project management and administration PHC delivery and reform Primary clinical practice	Yes	Georgian VG English VG Russian VG

KEY EXPERT 1: INTERNATIONAL TEAM LEADER

1. **Family name:** **Simpson**
2. **First names:** **David**
3. **Date of birth:** 1945
4. **Nationality:** British
5. **Civil status:** Married
6. **Education:**

Institution [Date from - Date to]	Degree(s) or Diploma(s) obtained:
Open University, 1977	BA
1972	Diploma in Management Services

7. **Language skills:** Indicate competence on a scale of 1 to 5 (1 - excellent; 5 - basic)

Language	Reading	Speaking	Writing
English	1	1	1

8. **Membership of professional bodies:**
9. **Other skills:** (e.g. Computer literacy, etc.)
10. **Present position:** HLSP In-House Specialist
11. **Years within the firm:** 3 Years
12. **Key qualifications:** (Relevant to the project)

- Senior health service manager with extensive UK and international experience
- 12 years experience in health sector reform in Eastern Europe, Russia, Africa, Asia and the Far East
- Extensive experience in the implementation of primary care development projects in Kosovo, Bosnia Hetrzegovina and Mongolia
- Introduction of primary care training in Kosovo including leading on monitoring and evaluation, quality assurance, licensing, and continuous medical education.
- Project management (team leader) in European Union, DFID, World Bank and Asian Development Bank development projects (including HR recruitment and development activities, evaluation and monitoring of primary health reform projects and programmes)
- Health financing consultancy in Kosovo, Russia, Mongolia, China and Bosnia Hertzegovina
- Wide experience in the management and provision of health services at local, district and national level. Worked at hospital level as well as developing strategies at a national level and advising Ministers.
- Experience of working in complex aid management environments, ensuring coordination between projects and donor inputs, and promoting sector wide leadership by national governments.

13. **Specific experience in the region:**

Country	Date from - Date to
Russia	1999-2000

14. **Professional experience**

Date from - Date to	Location	Company	Position	Description
2001 - to date	UK	HLSP Consulting	In-House Specialist	Providing consulting services to Ministries of Health, with emphasis on transformation of health systems. (see Consultancy Experience)
1996 – 2000	E Europe and Asia	Various	Freelance Consultant	Team leader and consultant working in Eastern Europe and Asia. (see Consultancy Experience)
1994 – 1996	UK	WHCSA	Director Business and Planning	Responsible for providing support services to the NHS in Wales including; Estates matters, Procurement of goods, Organisational Development, Information/ Information Technology, Blood Transfusion, Breast Test Wales etc. Responsible for overall business planning for the organisation, introduced significant level of privatisation and out-sourcing into the organisation so that it focused more clearly on its core business.

Date from - Date to	Location	Company	Position	Description
1989 – 1994	UK	WHCSA	Director Value For Money Unit	The task of the Director was to lead the organisation's mission to add value to the use of resources and enterprise in the delivery of health services to achieve genuine health gain. The Unit provided internal management consultancy support to the National Health Service in Wales and through its overseas trading arm provided consultancy services abroad. Simpson successfully led projects addressing strategic initiatives, including Benchmarking, Estates review, Supplies review, Ambulance review, Pathology review, R&D review, Review of Breast Test Wales. Also involved in providing operational support to managers in the following areas: cost improvements, income generation, Marketing, Innovation, In-house consultancy, Quality in contracting, Contracting currency, Contracting for health gain, Annual Review, developing high level indicators for monitoring and evaluation, Clinical resource utilisation, Waiting times review for primary health care, Waiting list management, Treatment centre evaluation, 'Patients first' information.
1984 - 1989	UK	Welsh Office	Principal Executive Officer	Set up a Division with responsibility for allocating the revenue and capital resources between the nine District Health Authorities in Wales, monitored expenditure and provided financial advice on strategic and operational planning matters. He was responsible for the option appraisal of new developments, the provision of key statistical indicators and the financial review of District Health Authorities. During this period he was also responsible for the development of policy and advice to Ministers on local authority involvement in competitive tendering, companies, economic development, members' responsibilities, sport and recreation and Home Office liaison. Spent 6 months seconded to Swansea City Council as Assistant Director of Housing.
1974 – 1989	UK	Welsh Office	Senior Executive Officer	Working with management consultants seconded to the Civil Service on various organisational development assignments. Provided administrative support to a number of major capital road developments and managed the complaints and litigation section. Responsible for the public expenditure survey and allocation of resources to the Welsh Water Authority, the Sports Council, local authority environmental service and road improvements.
1962 - 1974	UK	NHS	Various Managerial Positions	Worked throughout the UK in a number of managerial positions within the health service, including capital and service planning, hospital management and management services.
Consultancy Experience:				
2004 – to date	Kosovo	EAR	Long Term Team Leader	Supported the development of: quality assurance, licensing and registration, an integrated information system for monitoring and evaluation at primary and secondary levels, and support to family medicine development and PHC policy development. Responsibilities included managing all aspects of the project and providing technical leadership, supervising local support and professional staff, leading on liaison with all stakeholders, and ensuring good communication and close working with other donor funded projects, and contributing to the development of sector wide coordination in a complex multi donor environment .
2003 - 2004	Kosovo	EAR and World Bank	Long Term Team Leader	Supported the development of family medicine through the provision of an extensive training programme and institutionalisation of the concepts. The project also helped modernise medical education through reforming undergraduate, postgraduate and continuing professional development. Technical inputs included developing methods and practices for assessing quality assurance in re-training programmes, advising on the development of an enabling HR environment, and supporting the development of systems and indicators for monitoring and evaluating the delivery and impact of training and the performance of trainers and training institutions. As team leader he was also responsible for ensuring management of all project inputs, compliance with all donor procedures, maintaining close working relationships with the project steering committee and all other stakeholders, and ensuring close synergy between this project and other donor funded activities. Project manager on World Bank extension project to help introduce the concept of the purchaser provider split and the development contracting methodologies.
2002 & 2003	Sri Lanka	World Bank	Short Term Consultant	Advised the Ministry of Health on the development of health policies and strategies with a particular focus on promoting access to Primary health care.

Date from - Date to	Location	Company	Position	Description
2002	Mongolia	Asian Development bank	Short Term Team Leader	Team leader responsible for an ADB project to develop the second health sector development programme. Technical areas to be addressed by the project included HR recruitment, retention and posting to rural areas, professional support and training for medical staff working remotely in rural areas, and developing an investment programme to rehabilitate rural primary health facilities. As team leader he was responsible for ensuring stakeholder participation through a participatory assessment exercise, holding stakeholder workshops, liasing closely with MoH, and managing project financial and reporting requirements. Specific technical inputs focussed on a high level policy review plus evaluation of financing arrangements for primary and secondary health care.
2002	Kosovo	DFID	Short Term Consultant	Reviewed the Ministry of Health organisation and structures, including advising on HR policies
2002	China	EU	Short Term Consultant	Health insurance expert of the project team that undertook an evaluation of social protection issues in China and the possibility for an EU support project. Focused and advised on pension arrangements in China.
2001	Albania	DFID	Short Term Consultant	Consultancy for policy seminar.
2001	Egypt	World Bank	Long Term Team Leader	Helped develop health plans for two Governorates in Egypt. The work involved the management of a team of twelve consultants and the transfer of knowledge and techniques to Egyptian counterpart staff.
1999 – 2000	Russia	EU	Long Term Team Leader	Helped the Russian Ministry of Health reform its health financing systems. The project focused on collection, distribution, payment, contracting, pricing and costing, accounting and audit of health resources. The project determined the key areas in which support could be provided to help support the Russian Government's policy of health reform. The team leader responsibilities also included supervising and coordinating the work of all other national and international consultants, and support staff.
1999 – 2001	Bangladesh	DFID	Short Term Consultant	Five separate assignments that supported health planning, organisational development, stakeholder participation, patients charter.
1999	China	DFID	Short Term Consultant	Designed and ran a project-planning workshop.
1998 – 1999	Bosnia and Herzegovina	EU	Long Term Team Leader	Helped reform the health finance and information systems. A series of sub projects were undertaken to: improve the management and financing of the Health Insurance Fund organisations; develop hospital costing; develop information systems throughout the country; establish Health Information Centres. Development of a health strategy and legislative framework for Brocko District.
1996 – 1998	Slovak Republic	EU	Long Term Team Leader	Supported the development and implementation of an 8 million ECU change programme by working within MoH to support programme planning, setting indicators for monitoring performance and assisting with longer term project evaluation, and setting up project management and technical assistance procurement procedures.
1994	Kenya	EU	Short Term Consultant	Evaluated investment possibilities for the EU
1994	Poland	EU	Short Term Consultant	Designed and ran a health planning workshop
1994	Bulgaria	EU	Short Term Consultant	Evaluated tenders and set up a project on health management training.
1994	Hungary	EU	Short Term Consultant	Preparing primary health care project terms of reference for the EU.
1993–4	Bahrain	Bahrain Gov	Long Term Team Leader	Developed a health plan, working directly for the Bahrain Government

KEY EXPERT 2: NATIONAL COORDINATOR

1. **Family name:** **Shanidze**
2. **First names:** **Tamar**
3. **Nationality:** Georgian
4. **Education:**

Institution [Date from - Date to]	Degree(s) or Diploma(s) obtained:
Tbilisi State Medical Institute, Faculty of General Medicine, 1981	MD

5. **Language skills:** Indicate competence on a scale of 1 to 5 (1 - excellent; 5 - basic)

Language	Reading	Speaking	Writing
Russian	1	1	1
Georgian	1	1	1
English	1	1	1

6. **Membership of professional bodies:**

- Honorary Overseas GP Tutor at Thames Postgraduate Medical and Dental Education, University of London;
- Founder/member of the Trade Union of Georgian Family Medicine Professionals;

7. **Other skills:** MS Office, internet, email
8. **Present position:** Independent Consultant
9. **Years within the firm:**
10. **Key qualifications:** (Relevant to the project)

- More than 7 years of experience in Primary Health Care since early in its implementation in Georgia
- Excellent knowledge / understanding of the Primary Health Care development in Georgia
- Experience in developing the first Georgian family medicine training curriculum and involved in its further development
- Extensive experience in donor funded projects involving expatriate and international consultants
- GP trainer with special knowledge of adult learning methodologies
- Extensive managerial and administrative experience in governmental and NG organizations
- Experience in PR/ communications, project administration, financial management
- Outstanding language and project report writing skills

11. **Specific experience in the region:**

Country	Date from - Date to
Georgia	1980 - date

12. **Professional experience**

Date from - Date to	Location	Company	Position	Description
2001 To date	Georgia		Independent consulting as PHC Expert / GP Trainer	Research, formulate, develop and implement training modules / seminars on health issues, including the development of questionnaires and survey materials. Training of PHC doctors and nurses in Tbilisi and different regions of Georgia (Mtskheta, Imereti, Guria, Batumi, etc). Tailor the general training curriculum according to the immediate local health / epidemiological needs and requirements
Aug 1998– Mar 2001	Georgia	National Health Management Centre	Family Medicine Program Coordinator	Co-ordinate and manage all activities of the project, including training and field activities providing logistical and administrative support; coordination of the production of project technical reports; preparation of all performance/financial components in project reports; liaise, collaborate and consult with all project partners and beneficiaries including basic FM training centres; arrange and attend meetings, producing reports of meetings as necessary; reporting to donors in compliance with contract management requirements, procuring equipment for the office in accordance with donor procedures. Active participation in training activities as a GP trainer
Mar-Dec 2001	Georgia	WomenAID International – Caucasus	Project Manager / Trainer	Coordination and supervision of project activities: providing all necessary educational materials/means for the trainings, implementation of informational/educational activities at community level, liaison with relevant governmental and NGOs, partners; drafting monthly, mid-term and final reports to be submitted to the donor agency UNHCR.
1999 - to date	Georgia	PR Agency Action Global Communications	PR Manager (part time)	
1999 - to date	Georgia	American International Health Alliance	Freelance Translator / Interpreter	
1980 – 1998	Georgia		Clinical neurologist	Internship in Neurology, Central Clinical Hospital 1980–1981; Doctor of Neurological Department, Tbilisi Physiotherapeutic Hospital 1982–1984; Clinical Residency, Board of Neurology, Tbilisi State Medical Institute 1984–1985; Neurologist, Department of Neurology, Tbilisi Railway Hospital 1985–1998

13. **Other relevant information** (eg, Publications)

Courses and Seminars Attended:

- Long term participation as a trainee on DFID Health Project for the Development of Family Medicine / Primary Health Care in Georgia, 1997 – 1998, (Training course covered: General family practice clinical curriculum; Health management; EBM; Training of trainers)
- "Aspects of Holistic Infant Development for Doctors and Psychologists", MASHAV course; Haifa, Israel, 31 May – 24 June 2004.
- Continuous Medical Education courses (EBM, pediatrics in FM, EB Guidelines), NHMC, 2000-2001.
- Salzburg Seminar "Social and Economic Determinants of the Public's Health". Salzburg, Austria. April 2000.
- Clinical Attachment to an approved UK training practice; Chelmsford, UK, August 1999
- Basic Trainers' Course for GPs organized by the Deanery of North Thames Postgraduate Medical and Dental Education, University of London. Cambridge, UK, June 1998.
- Seminar "Evidence-based Health Care Program", Imperial College of Medicine, Science and Technology, London, November 1997.
- Seminar in European Studies, Euro-Caucasian University for Interdisciplinary Study, Tbilisi, July 2004.
- TACIS Public Administration College (General Management, Financial Management, Market Economics, IT,) 1996, Tbilisi.
- Seminar in Public Relations", PR Development Institute. Tbilisi, Georgia. February 2002

Community Activities:

- Initiation and participation in the design/implementation of the OSI Geriatric / Gerontology 1998/1999 regional grant for the project on community and home care for the elderly.
- Implementation of the project of an NGO WomenAid International "Empowerment of IDP Women through Awareness Raising Seminars in Areas of Women's Rights and Health" at community level for IDPs from Abkhasia in Zugdidi and Tbilisi. March-December 2001