Information about PHC reform implementation in Georgia

The priority for ongoing reform of the Health Care system in Georgia is the establishment and further development of Primary Health Care (PHC). The Government of Georgia developed and approved a PHC Strategy in 2000, which serves as a guiding document for the development of PHC and General Practice/Family Medicine in the country. The PHC Strategy envisages the formation of a PHC model that effectively and reliably provides the entire population of the country with high quality yet cost effective medical services and is physically available and affordable. This will contribute to the goal of improving the health status of the Georgian population, with particular emphasis on the most vulnerable and poor. The PHC Strategy calls for major changes in the institutional establishment, functional performance, and financing of the health sector.

The EU TACIS 2002 Action Programme for Georgia foresees a support for addressing the social consequences of transition. The activities in this sphere will concentrate on the health sector reform, in line with the Strategic Health Plan of Georgia and the priorities identified in the Economic Development and Poverty Reduction Programme of the Georgian Government.

TACIS proposes a comprehensive programme (7.5 million Euro grant) supporting the Primary Health Care development, comprising of technical assistance at national and regional levels as well as investment in a pilot region (Kakheti Region, Eastern Georgia) in terms of refurbishment of existing PHC infrastructure, provision of equipment, health promotion and prevention activities and training of PHC facility staff. The European Commission aims to enhance the capability of the PHC network to meet the health needs in Kakheti Region through sustainable, accessible and affordable health care services; and to increase the capacity of local communities to make informed health care decisions, promote their active participation in the health care process, and mobilize their resources to create a more sustainable health care infrastructure.

The programme is part of a multi-donor collaboration (EU, World Bank and DFID) with the Ministry of Labour, Health and Social Affairs. A Memorandum of Understanding (MoU) was signed between these partners with the aim to co-operate in the establishment and further development of a sustainable Primary Health Care system in Georgia (see Annex 1**).** To achieve these objectives, the Ministry of Health, has established a PHC Coordination Board and a PHC Management Committee in the National Institute of Health and Social Affairs through which all assistance is managed and coordinated. Several Working Groups composed of representatives from all key stakeholders dealing with human resource development, service definition, health management information system development, health financing and health promotion are currently in function in order to adapt the appropriate means to be done in parallel and built up a consistent PHC system.

One of the priorities for the development of Primary Health Care is the reform of the health care training for family physicians, nurses and managers in PHC. In order to prepare valuable and coherent assistance to the Ministry of Health, Labour and Social Affairs in this field, the EC financed a study and prepared a regional master plan in Kakheti which has been completed under the preparation of these ToRs on health care needs related to existing providers, equipment, services and staff. Following the Kakheti master plan, that was based on Kakheti PHC system survey data conducted in 2003 and an intensive period of consultation and consensus building with all stakeholders (see Annex 2).

1.1. Beneficiary country

Georgia

1.2. Contracting Authority

The European Commission.

1.3. Relevant country background

Georgia became independent in 1991. Two major crises marked the beginning of the transition period: the break-up of the former Soviet Union (FSU), which disrupted traditional trade and payments links and increased the price of imports, particularly energy, and the civil conflicts in Abkhazia and South Ossetia, which generated a large movement of refugees. As a result, Georgia suffered one of the sharpest economic declines of the FSU. After the signing of cease-fire agreements with South Ossetia (1992) and Abkhazia (1994) the government launched a successful and important structural reform programme, including fiscal and monetary reforms. However, in 1998, economic performance declined again with the onset of the Russian crisis. Economic development restarted at the beginning of 2000, but remains largely dependent on external factors.

GDP	1996	1997	1998	1999	2000	2001	2002
GDP at market price *(Million GEL)*	3 846	4 639	5 041	5 666	6 015	6 638	7 427
Index/volume of the GDP *(Previous year = 100)*		110,6	102,9	103,0	101,9	104,7	105,3

Source: World Bank / State Statistic Department of Georgia

The main consequences of these developments were:

- An important decline of the economic activities and a modification of their repartition between the various sectors.

GDP	1996	1997	1998	1999	2000	2001	2002
Agriculture	33,2 %	29,0 %	26,7 %	24,7 %	20,2 %	20,7 %	19,3 %
Industry	22,9 %	21,7 %	21,6 %	21,2 %	21,0 %	20,6 %	21,3 %
Services	43,9 %	49,3 %	51,7 %	54,1 %	58,8 %	58,7 %	59,4 %

Source: World Bank data / State Statistic Department of Georgia

- A stagnation of household incomes.

Monthly household incomes	1996	1997	1998	1999	2000	2001
Total (Average/in GEL)	153,5	134,7	162,2	168,8	174,8	192,2
Urban	126,9	126,3	154,4	152,8	174,4	189,9
Rural	186,7	144,3	171,3	186,9	175,2	194,7

Source: State Statistic Department of Georgia

- An important discrepancy of the repartition of incomes between the various groups of the population.
- An important increase in the number of the poorest part of the population[1].

[1] The estimation of the poverty line depends for a large part on the methodology used. For this reason, at the moment, there are 3 levels of poverty in Georgia (sources: UNDP "Human Development Report – Georgia 2001-2002"; World Bank "Georgia poverty update" January 2002):

- High level: from 41,55 (summer) to 50,71 % (winter) of the total population

The direct consequence of this situation is that an average of 33 % of the population (up to 50, 7 % in some regions) does not seek medical care mainly for financial reasons. The cost of medical services (42, 4 %) and the cost of pharmaceuticals (32, 8 %) are reported to be the main problem for the population in the district health care system.

Demography

The initial first results of the census of 2000 estimate the current population at 4,355 million inhabitants (1, 1 million households) not including Abkhazia and Tzkhinvali regions. The available demographic estimates portray a pronounced fertility rate drop from 2,14 births per 1000 in 1989 to 1,4 births in 2001 and a growing number of elderly (percentage of population over 65 years: 1991: 15,3 / 2001: 18,9). During the same period, due to the bad conditions, the infant mortality rate increased dramatically from 13, 1 (per 1000 live births) in 1995 to 24 in 2000, and the average life expectancy dropped from 72, 5 years in 1995 to 68, 9 in 2001.

1.4. Current state of affairs in the relevant sector

1.4.1. Overview

The health care service system is divided into three levels:

- Primary health care network, uniting different ambulatory clinics, polyclinics and women's health centres,
- Second level network, including village, city hospitals and central regional hospitals
- Third level health care, including special level hospitals, diagnostic and scientific centres.

Main medical facilities	1999	2000	2001	2002
Hospitals	287	280	278	279
Outpatient facilities in hospitals	94	87	93	96
Dispensaries	79	75	79	78
Independent outpatient facilities	977	963	181[2]	191
Independent dentist polyclinics	62	63	68	83
Medical posts	33	22	39	17
Midwife posts	438	345	305	306

Source: Ministry of labour, health and social affairs-Department of statistics

During the 90s, the reorganisation of medical facilities was mostly oriented towards the decrease of the number of hospital beds (22 491 in 1999; 18 290 in 2002). Due to important financial difficulties, the authorities were also obliged to close some medical and midwife posts. During the same period the number of nurses was decreased while the number of physicians remained more or less stable.

Number	1988	1994	1995	1996	1997	1998	1999	2000	2001	2002
Physicians	26179	22578	21252	19062	21706	20824	21520	21062	19513	20225
Nurses & Midwives	56961	43321	38541	29978	29775	28642	28638	26179	23360	23356

Source: Ministry of labour, health and social affairs-Department of statistics

- Medium level: from 24,62 to 30,85 % of the total population
- Low level: from 8,41 to 12,68 % of the total population

[2] The difference between 2000 and 2001 figures concerning the number of independent outpatient facilities derives from the fact that some of these facilities were"absorbed" by the polyclinics in their regions.

1.4.2. Health care financing structure

Due to the economic situation (recession of the GDP, stagnation of the household incomes) which caused a quasi-stagnation of the revenues coming from taxation, the government health expenditure remained low throughout the 1990s.

Health expenditures in % of the GDP

1996	1997	1998	1999	2000	2001	2002
2,1 %	3,5 %	4,5 %	4,3 %	5,2 %	4,8 %	4,5 %

Source: WHO, World Bank, MLHSA

But due to the difficult economic situation a serious gap exists between the planned allocations and the actual receipts.
The majority (90 %) of these public sector funds for health care are allocated for the financing of a basic benefit package. In 2000, this BBP included 16 programmes managed by the SMIC, 3 programmes managed by the Public Health Department and 8 programmes managed by the municipalities.

1.4.3. National Strategy

a) Municipalities

The municipalities are involved with the health care budget at two levels:
- Identification of the poor *(See § 1.4.2.b)*
- Payment of some of the health care services.

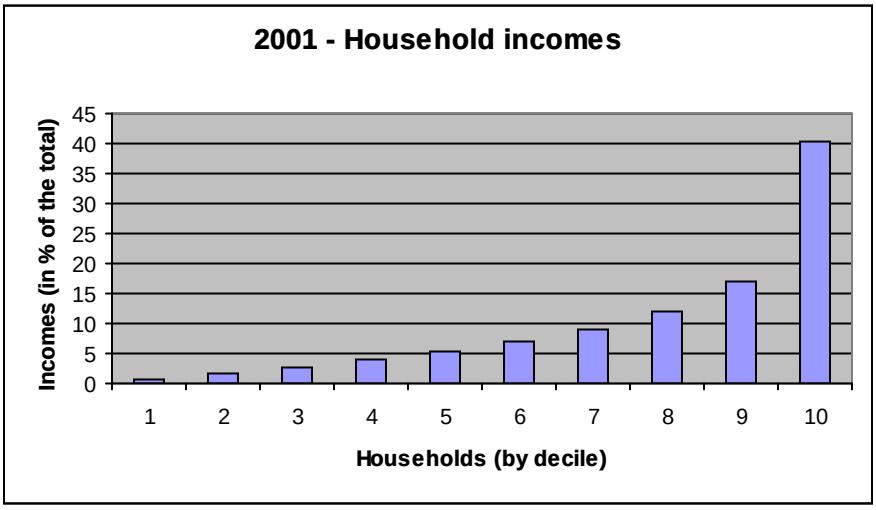
A compulsory minimum of 10 % of the municipal budget[3] must be allocated for local health care expenditures with a repartition between (i) 5 municipal programmes included in the BBP (7 % of the municipal budget) and (ii) three categories of health expenditures (3 % of the municipal budget):
- Medical examination before military service
- Sanitary supervision department
- Public health programmes (monitoring of epidemics, malaria, etc).

Due to the low level of taxes collected, most municipalities are not able to pay for the full amount of their planned health budget (Average: 60 %). This situation[4] affects the functioning of the polyclinics and other local medical units and is often compensated by the implementation of a fee-per-visit paid by the patients. Municipalities have the possibility to invest in the refurbishment of polyclinics and other medical units from other resources than the previously indicated 10%.

b) The Basic Benefit Package (BBP)

The initial concept of solidarity (based on the BBP) has been transformed (and is gradually disappearing) due to the lack of financial resources in MoF and the SISUF to finance the permanent increase of the BBP (new benefits). In addition, the existence of a "universal" BBP, taking into consideration the person and not the income of this person, has increased the total cost of the BBP. The current solidarity mechanisms are thus "disconnected" from the structure of the income of the population. However, the current structure of the income of the population[5] points out that 10% of the population receives approximately 40 % of the total income. One of the key aspects of the health care financing reform is to re-consider whether this group must benefit or not of the health care services of the BBP.

[3] The municipalities' financial sources constitute of local taxes and taxes shared between the central level and the municipalities (85 % of the Income Tax, Corporate Tax, and a part of the financial flows derived from privatisation).
[4] The lack of cash flow causing delays in payments is also significant.
[5] Source: Statistic Department of Georgia



Source: Household expenditures / State Statistic Department/2001-2002

1.4.4. Country Strategy

The PHC Financing Reform is required to be coordinated with the Economic Development and Poverty Reduction Programme of Georgia and should be in line with the Strategic Health Plan adopted by the Georgian Government.

Economic Development and Poverty Reduction Programme (EDPRP)

In June 2003, the Government of Georgia adopted the Economic Development and Poverty Reduction Programme (EDPRP). The programme aims to achieve sustainable economic development and substantial reduction of poverty in the country by 2015. Main goal is to raise the welfare of the population of Georgia, which implies improvement of the quality of life of each person. In order to achieve this goal, two strategic objectives have been defined: a). fast and sustainable economic development; b) reduction of poverty. In order to achieve these strategic objectives, various priorities have been defined, including (i) development of human capital and (ii) social risks management and improvement of social security through improvement of standard of living of individuals below the poverty line and reduction of vulnerability level through improved management of social risks.
The EDPRP is promoting the establishment of fundamental principles in the country, including: a) rule of law; b) effective governance; c) public participation; d) human development; e) incorporation of the interests of future generations; f) creation of favourable entrepreneurial climate; g) expansion of the legality in all spheres: h) formation of information society and i) equality of opportunity.

Strategic Health Plan

At the end of 2000, the Government of Georgia adopted a concept of PHC development that envisages the formation of a health care model that effectively and reliably provides the entire population of the country with high quality yet cost effective medical services and is physically available and affordable. This reform will be implemented over a five year period (2003-2008) with the support of a World Bank loan, EU and DFID grants, and other donor assistance programmes (for example, USAID, CIDA).

In this programme the clear priority of the health care training is to serve the short and medium term priorities of the PHC development by making it sustainable from a country wide implementation perspective.

The implementation strategy for improving the health care training process should include:

- Focusing on desired PHC results and priorities
- Creation of a momentum by building and maintaining a consensus
- Balancing and communicating measurable results with the rate at which capacity can be built
- Improving the PHC culture.

PHC Training

A key issue for discussion is the issue of human resource planning in the health care sector. In developing appropriate human resource capacity for primary care it is important to ensure that an optimal number of health professionals of appropriate competence base are trained, including specialists in Family Medicine.

The following could be viewed as key challenges in human resource planning and management:

- An imbalance of doctors, other primary health care professionals such as family/ primary health care nurses and workers that support the actions of the Family Medicine team, often called the Family Medicine manager.
- Recruiting and retaining health care staff in family medicine, in rural or unpopular areas
- Developing the cadre of practice managers and giving them credibility within the health system
- Are professionals (doctors and nurses) adequately regulated in both public and private sectors to ensure the quality of their practice and protection of the vulnerable public?
- Ensuring that the training of doctors and nurses in Family Medicine is undertaken to international standards and that training institutions are providing learning experiences to this standard.

As the process of developing PHC system moves forward and key emphasis is made on high quality care provision by PHC service providers, it is essential to develop a suitable system with appropriate infrastructure and regulations for the training of PHC cadre. Such system should cover:

- Postgraduate training of FM specialists
  a) Retraining of existing physicians as FM specialists
  b) Continues medical education for all PHC staff (doctors, nurses, managers)
- Undergraduate training
- Residency programme
- Manpower planning

The re-training is viewed as a postgraduate training and has to be legally recognized by the MoLHSA according to the existing regulations for that level training interventions. The current problem with this retraining programme is, at the moment, it does not have full legal status and operates under a temporary statute. Due to the lack of regulations for short term residence schemes (or Minimum Residence Training) it was impossible to approve so called “Temporary training programme for family physicians” and “Temporary training programme for nurses” as a minor residency training scheme.

In a mid and long term perspective Georgia must be prepared for PHC staff training, implemented through the State Medical Academy. This process is part of the WB programme dealing with training issues in the entire country. It is still unclear what the role of FM faculty at the academy will be. The WB is supporting development of Family Medicine Faculty at the SMA but that may

not necessarily mean “PHC staff training to be implemented through the State Medical Academy”. In the mid- and long-term perspective Georgia should develop sustainable institutional infrastructure for PHC staff training that will generate human resources with appropriate skills and competencies.

The main emphases is made on developing a medical personnel for the new PHC systems but since the number of PHC service unit staff increases the need of complex administrative/organisational arrangements is obvious. This will require an input of practice managers, receptionists and other administrative staff. Numerical and qualitative requirements for administrative staff are yet to be defined.

As the EU/TACIS project will comprise re-training of PHC staff in Kakheti Region, the Minimum Residency Training and its follow-up after the completion of the re-training will become the pivotal actions for the contractor.

The contractor should be ready to adopt changes that may appear in the delivery of the re-training by the time of the project implementation.

Training Institutions

In-service training for family medicine human resources was first introduced in Georgia in 1997. This has been closely linked with the establishment of functional FM practices that are considered as an ideal environment for training of family physicians, general practice nurses and practice managers. All newly established family medicine practices were licensed as a family medicine training centres and were eligible to provide post-graduate education. Due to the new licensing requirements issued by the MoLHSA in summer of 2003 FMTCs resubmitted applications on renewal of the license to implement family medicine residency and CME programmes for physicians, serve as a clinical placement for medical and nursing schools. The applications have not yet been approved by the MoLHSA.

FMTCs are equipped and furnished, for creating comfortable and effective training environment. The following organizations have been involved in re-training of FM human resources during the period of 1997-2003

- National Institute of Health
- National Family Medicine Training Centre and Four Family Medicine Training Centres in Tbilisi established within DFID Georgia PHC development project (2000-2003)[6]
- Mtskheta-Mtianeti Regional training centre (USAID/AIHA)

The State Medical Academy had developed the full residency programme in family medicine. The programme has been operational since 2002.

The Tbilisi State Medical University, in partnership with Missouri, Columbia University faculty of Family Medicine, is currently been working on developing the FM full residency programme.
Other training institutions have also been providing some training activities for PHC staff and family physicians through continuous medical education courses.

Training Curricula

Retraining programme for family physicians was designed in 1997-1999[7] by the team of the Deanery of postgraduate general practice education of the University of London. Retraining

[6] National Family Medicine training center, Family Medicine Practices at Tbilisi Family Medicine Training Center (Former Children’s polyclinic 9), Adult’s Polyclinic 28, JSC “VERE-21”, Medical Preventive Center 1

programmes for general practice nurses and practice managers were developed in 2000-2001[8]. After the broad discussion and consultations with experts from major educational institutions and professional associations all training programmes were approved as temporary programmes by the MoLHSA in April 2002[9]. The duration of re-training programme for FP is 940 hours.

The existing temporary training programme for general practice nurses composes of 704 hours out of which 548 is for small group teaching, 156 for clinical practice. Duration of GPN retraining programme is 4 months.

The position of the Family Medicine Practice Manager as understood in the West is rather new for Georgia. The first group of practice managers were trained within the DFID Georgia PHC development project 2002-2003. Based upon a training needs assessment, a training programme was developed and implemented. The duration of the practice managers training programme is 650 hours that may last for 6 months.

Staff trained in PHC

There are number of PHC staff already retrained in family medicine in Georgia: 198 primary care physicians, 40 general practice nurses and 15 practice managers were re-trained during the period of 1997-2003 at family medicine training centres under the supervision and coordination of National Health Management Centre (Currently, the National Institute of Health and Social Affairs). The National Institute of Health has been acting as a Supervisory organisation by providing the monitoring and evaluation of the training programmes all over the country.

Most of the staff re-trained is currently working at family medicine practice sites in Tbilisi and Mtskheta, 35 PHC physicians were re-trained from Imereti, Adjara and Shida Kartli. There are no re-trained physicians and nurses in Kakheti.

Family Medicine Trainers of Physicians / Nurses/Practice managers

The training programmes for family medicine staff have been established for the family physician, general practice nurse and practice manager trainers. The roles and functions of trainers were determined under the temporary statutes approved by a Ministerial decree in April 2002. The specific training course “Pedagogic Skills-Teaching and Learning in General Practice” for trainers was developed and implemented by the National Institute of Health and Social Affairs. The duration of the course is 68 hours. A family physician desiring to be certified as an FM trainer must complete the course. Potential trainers were identified on the basis of a competitive selection either before the completion of the full re-training scheme or after being successful at a summative assessment (post-training). The number of FP, GP nurse and practice manager trainers working at each FMTC are as follows:

Number of FP trainers at each FM training practices

Family Medicine Training Practice	N of FP trainers	N of GP Nurse trainers	N of GP manager Trainers
National Family Medicine Training Centre	11	6	1
Tbilisi Adult’s polyclinic 28	8	2	1
Tbilisi Children’s polyclinic 9	5	2	1
Tbilisi JSC "Vere-21"	5	2	1
Tbilisi Medical-Preventive Centre 1	4	2	1
Mtskheta Family Health and Regional Training Centre	4	2	-
Kutaisi	5	-	-

[7] Know-How fund Georgia Health Project "In -service training for General Practitioners in Georgia" 1997-1999
[8] DFID Georgia PHC development project 2000-2003
[9] Ministry of LHSA, Ministerial decree 103/O 15. 04. 2002

Batumi	7	-	-
Gori	2	-	-
TOTAL	51	16	5

Primary Health Care Board and Management Committee

A Memorandum of Understanding was signed between the Government of Georgia/Ministry of Labour, Health and Social Affairs, World Bank, European Union and DFID in January 2003 in order to co-operate in the establishment and further development of a sustainable Primary Health Care system in Georgia (see Annex 1). The cooperation is aimed at strengthening the coordination of state and international initiatives in the sector, so as to optimise the benefit for all stakeholders, particularly the poorest sectors of the Georgian population. To achieve this objective the parties have agreed to work through a PHC Co-ordination Board and Management Committee. The Board acts as the overall governing body of the PHC Programme and Management Committee. It defines and communicates the ongoing vision and mission of the PHC Programme and it co-ordinates activity between the MoLHSA, the external community and strategically related GoG initiatives. The PHC Management Committee is under the direction of the Board implementing the PHC work programme with a focus on donor coordination and the sequencing of activities.

In order to improve the coordination and facilitate future implementation of PHC programme activities the MoLHSA and the PHC board decided in October 2003 to reorganize the existing PHC committee in a way that functional responsibilities of its members are directly linked to the specific domains of PHC programme work. The composition of PHC management committee has been determined according to the major work streams and includes the following:

- Human Resources and Service Provision Work Stream National Coordinator
- PHC financing Work Stream National Coordinator
- HMIS Work Stream National Coordinator
- IEC Work Stream National Coordinator

The staff of the PHC committee is expected to coordinate, monitor and evaluate the implementation of the activities of each work stream. PHC committee staff works under the direct supervision and is accountable to the PHC Programme National Coordinator that is the director of National Institute if Health and Social Affairs. PHC committee staff members are expected to facilitate the functioning of the stakeholders working groups that have been established for each work stream. The role of the working groups is coordination, providing advice to the PHC board and advocacy with both decision makers and stakeholders.

In November 2003 the MoLHSA issued a policy statement known as the "Road Map" for PHC reform in Georgia. The policy statement was followed by an indication of the specific steps to be taken, including the setting up of 4 different working groups in which stakeholders should be involved. The road map envisaged two sets of interlinked measures, namely:

- Tangible immediate achievements and
- Carefully prepared mid and long-term solutions and strategies

The first set of measures should aim, as stated in the document, to establish 100 renovated PHC service production units in the regions of Imereti, Adjara and Kakheti. This will include retraining health workers for the selected PHC facilities and then refurbishing and equipping the units that would have an impact on the health status and the satisfaction of the population concerned. As the first steps towards the establishment of the new PHC model in Georgia are being made now, the MoLHSA and concerned stakeholders will continue to work on policy preferences for reforming PHC. The proposals generated will draw from and build upon the results from the action steps described above and will pave the way for a sustainable PHC system in Georgia.

1.5. Related programmes and other donor activities

1.5.1 International donor programmes supporting the health sector reform

During the previous years, various health sector reform initiatives and projects have been implemented with the assistance of international donors. The Contractor must take into consideration the achievements, results and lessons learnt from those past efforts.

World Bank

The World Bank is the key donor supporting health sector reform in Georgia. The World Bank (IDA) provided the Georgian Government with a first loan (commonly known as Health I Project) of approximately US $ 14 million. It became effective in 1996 and terminated in December 2002. The objective of this loan was to achieve the following developments:

- Reorient the health system towards cost-effective public health interventions like preventive and primary health care, assuring, in particular, better quality care for women and children, and focusing the MoLHSA activities on regulation of public and private providers;
- Rehabilitate selected facilities and equipment that were down-sized and dedicated to cost-effective provision of maternal, prenatal, and paediatric care;
- Develop human resources to support health reform, through continuing education for public health doctors, family practitioners, nurses, health administrators, and other personnel; and
- Support the development of an independent health fund with regional branches, in order to finance a package of basic clinical services in a cost-effective and equitable manner.

The Government of Georgia secured a second loan (20.3 million US$) from the World Bank in July 2003 to help finance the development of its PHC sector over a period of 5 years. The main objective of the PHC Development (commonly known as Health II) Project is to improve the coverage and utilisation of the quality PHC based on the model of the family medicine/general practice, with an emphasis on reaching the poor and disadvantage. The project consists of three components: (i) PHC service delivery; (ii) institutional development; (iii) project management.

Key components of the Project include: (a) priority reconstruction, development and rationalisation of PHC facilities in selected parts of the nation; (b) the provision of essential PHC equipment to support those facilities, (c) the development of national policies to support the initiative, (d) the development of an improved national health care financing system that will provide sustainability for the PHC function, (e) the establishment of an Health Management Information System (HMIS) capacity that will meet the prioritised needs of the evolving PHC function while playing into the long term information needs of the entire sector, and (f) a supportive but highly targeted Information Education and Communication (IEC) initiative that will support the requirements of all of the above efforts.

UK Department for International Development (DFID)

DFID has provided assistance to the reorganisation of the health care system in Georgia since 1996. A first DFID project (1996-1999) supported the World Bank Health I project and piloted mechanisms for training doctors in Family Medicine.

A second DFID financed project on Primary Care development was designed in 1999 with input from the GoG, Tbilisi Municipality Health Department, the WB and WHO. The purpose of this project was to develop and implement a sustainable new model of Primary Health Care through Family Medicine to improve the quality of and access to services. The Project was designed to assist the Georgian Primary Health Care development through three key outputs.

- Establishment of functional Family Medicine demonstration sites in urban areas to provide a platform for the national roll-out of the FM model.
- Strengthening of the human resource capacity by training staff to work in primary health care facilities based on the family medicine model.
- Promote access to basic services through population-based risk pooling schemes to cover the costs of essential primary care drugs, developed and implemented in the FM demonstration sites.

A third DFID project which commenced in October 2003 with a duration of 5 years, supports the Primary Health Care Development Project (Health Loan II) with a grant of 8 million US$ (technical assistance only) executed by Oxford Policy Management (OPM) structured according to the following work streams:

1. Direct support to the PHC Board and Management Committee.
2. Support to Finance and Policy management. This component will be oriented towards:
- Identification (National Health Accounts) of the financial flows.
- Reform of the financial processes, including the repartition mechanisms of the allocations between the various regions of Georgia.
- Development of new Secondary Health Care financing mechanisms linked to the PHC development, including a Basic Benefit Package concerning hospital care services.
3. Support to Human Resources development.
4. Support to Health Management Information System development.
5. Support to Information, Education and Communication development.

EU / TACIS

The EU TACIS Action Programme 2002 foresaw support for addressing the social consequences of the transition in Georgia with a focus on support to the health sector reform in line with the Strategic Health Plan and the Economic Development and Poverty Reduction Programme of Georgia. EU assistance to the Primary Health Care Development Project (technical assistance at national and regional level and investment in Kakheti Region) comprises of a 7.5 million Euro grant for a period of 3 years (2004/5/6). EU assistance includes:

1. Support to Health Care Finance reform and policy development, an ongoing project.
2. Investment in Kakheti Region to implement new services delivery by supporting PHC facility refurbishment, equipment procurement and health promotion and disease prevention activities,
3. Human Resources Development (re-training of PHC medical and facility staff in Kakheti region).

In order to develop a sustainable and coherent support to the reform, the European Commission was and is implementing a range of preparatory activities:

a) *Assessment of the health care financing system and health care management in Georgia*
The assessment was completed in June 2003.

b) *Poverty Mapping Kakheti region: Statistical data on living conditions for poverty measurement.*
The objectives of this project are to: a) improve the availability of statistical data on living conditions
in Kakheti Region for poverty measurement; b) enlarge the range of poverty indicators and therefore the scope of poverty analysis. The project started in June 2003 with a total duration of 12 months.

c) *Development of a Regional Master Plan for the Primary Health Care system in Kakheti Region (A brief summary of the Master Plan appears in Annex 2).*The Regional Master Plan answers what, where, when and how the current and future PHC project resources and interventions

should be sequenced and allocated to best meet the needs for workforce training, infrastructure improvement, FM equipment and health promotion in Kakheti region. This is one of the initial steps within the initiative led by the MoLHSA to develop and take forward the implementation of the National Master Plan for the PHC sector in Georgia. The National Health Master Plan objective is to help define a health care model that reliably provides the population of Georgia with high quality yet cost effective primary care services and is physically accessible and affordable. The national planning process, considering the Kakheti exercise as one pilot, will begin in Imereti and Adjara regions and includes an inventory and evaluation of the current resources. This will lead to a similar assessment in all regions of Georgia and eventually define the number of PHC facilities, health personnel, resources and activities required countrywide.

The Kakheti Regional PHC Master Planning tasks were initiated in July 2003. Analysis of results and proposed actions were considered throughout 2004 in a linked series of consultations involving health decision-makers at national level and from Kakheti region, key donors and civil society stakeholders. Linked to this exercise, DFID/OPM conducted a financial analysis of the implications of implementing the Kakheti Master Plan and then developed a human resources supply and demand model based upon master plan needs. The general objective of this activity has been to develop a financing strategy for a smooth transition from the current staffing and skill levels to those required in a more efficient system. The specific objective dealt with a review of the proposed PHC staffing in the Kakheti region based upon effectiveness and affordability considerations. The PHC management board approved on 8th February 2005 the actions proposed for the present EC projects during 2005 and 2006 that will be the first steps of the PHC development plan in Kakheti. Long-range implementation of the Regional PHC Master Plan will be a function of the resourcefulness of the Georgian authorities to leverage further investment in the reorganisation of the health sector in Kakheti Region.

USAID

USAID is implementing a range of health care assistance programmes and projects with the aim to catalyse improvement of social and health services in targeted areas. USAID's assistance includes:

Support to Mtskheta Family Medicine Centre
The overall goal of this project has been the design, development and implementation of a family- and community-oriented Primary Health Care (PHC) system in the Mtskheta-Mtianeti region and the development of a Healthy Communities initiative. Among the key objectives were:

- The establishment of a PHC centre in Mtskheta that consolidates family and community oriented adult and child curative and preventive services in a renovated facility.
- The establishment of a Family Health Training and Demonstration Centre in Mtskheta.
- The training of a core group of 10 Mtskheta-based certified and licensed family physicians.
- The training of a core group of trainers for family physicians and general practice nurses.

CIDA (Canada)

Information Technologies and Information Management Strategies (IMS) oriented to the Health Sector
The objective of CIDA's assistance (2001-2005) is to accelerate the reform of the health care system(s) in the South Caucasus countries with the implementation of Information Technologies and Information Management Strategies oriented to the health sector. The assistance includes: (i) the development of network(s) between the main health care providers, (ii) the development of partnership between the various actors involved in the health care sectors and (iii) training for the development of IMS in the health sector.