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# GEORGIA REPRODUCTIVE HEALTH AND MATERNAL AND CHILD HEALTH SECTOR ASSESSMENT

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Finally, we extend our thanks to the many health service providers who took the time to share their thoughts, views, and insights about the changing health care environment, and USAID's technical assistance contributions, with the assessment team.

*"I have a Russian medical education; I was trained in St. Petersburg. I was initially skeptical of the [HWG/JSI] training, but now I am so satisfied. As a result of changes implemented, there has been a three- to fourfold reduction in complications, fewer episiotomies, and babies are born healthier. I have my patients and I am coming in every other night even when I am not on call. But before [the changes resulting from training were implemented] I* ***had*** *to come every other night because I was called in for complications. Now, I am called about once a month for complications. I never thought I would change but it is for the good. Now we are embarrassed at what we were doing….before, it was standard to do an ultrasound before the patient was discharged. And we would usually find something that looked abnormal, and would do some medical procedure. We've learned not to bother with the pre-discharge ultrasound because [after delivery] there will always be something that looks abnormal."*

An obstetrician, head doctor of the maternity ward at a privatized clinic, speaking about the impact of HWG training.

# ACRONYMS

| | |
|---|---|
| CoReform | Cooperation in Health Systems Transformation |
| CSMA | Caucasus Social Marketing Association |
| DFID | Department for International Development (United Kingdom) |
| DHS | Demographic and Health Surveys |
| FP | Family Planning |
| GNP | Gross National Product |
| GoG | Government of Georgia |
| HeSPA | Health and Social Programs Agency |
| HWG | Healthy Women in Georgia |
| IUD | Intrauterine Device |
| JSI | John Snow Inc. Research & Training Institute |
| LMIS | Logistics Management Information System |
| LOP | Life of Project |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MIS | Management Information System |
| MMR | Maternal Mortality Ratio |
| MoLHSA | Ministry of Labor, Health and Social Assistance |
| NCDC | Georgian Center for Disease Control |
| NGO | Nongovernmental organization |
| PA/FP | Post-Abortion Family Planning |
| PHC | Primary Health Care |
| PSI | Population Services International |
| RAMOS | Reproductive Age Mortality Survey |
| RH | Reproductive Health |
| RH/MCH | Reproductive health and maternal and child health |
| RHS | Reproductive Health Survey |
| SMO | State Ministry for Economic Reforms |
| STD | Sexually Transmitted Disease |
| TPM | Team Planning Meeting |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| WRA | Women of Reproductive Age |

# EXECUTIVE SUMMARY

The objective of this assessment, implemented through the Global Health Technical Assistance Project, was to lay the foundation for the design of a medium-term reproductive health and maternal and child health (RH/MCH) strategy and prioritized action plan for USAID/Georgia, aimed at improving the policy environment to enhance and sustain these vital health services, particularly in the context of the Government of Georgia's (GoG) fast-paced health reform efforts. The assessment examines the strengths and weaknesses of the current USAID/Georgia RH/MCH portfolio, and documents the steps taken by the GoG to reorganize and reform the health sector. The assessment team analyzed possible consequences of ongoing reform efforts for RH/MCH policies and services, and addressed the GoG's financial commitment to sustaining the achievements of USAID assistance.

The assessment team concludes that the ongoing USAID RH/MCH assistance in Georgia has been highly successful and has yielded significant achievements in a relatively short time. The reproductive health policy component of the Cooperation in Health Systems Transformation (CoReform) program has clarified the legal and policy framework for the provision of RH services. The Healthy Women in Georgia Program (HWG) accelerated the pace of change in adopting evidence-based RH/MCH practices, with broad geographic and population coverage. Health care providers and consumers have embraced these changes. However, despite great improvements, RH/MCH status and programs in Georgia are still immature and deserve further support from USAID in the medium term. Continuation of USAID support with greater strategic focus in RH/MCH will solidify gains and accelerate the pace of change even more. USAID has a strategic opportunity to build on many of the gains achieved so far, given the comparative advantage of USAID's high-quality technical assistance in family planning and MCH policy and services.

The assessment team provides very specific and detailed recommendations for USAID/Georgia's continued support for RH/MCH. The recommendations are presented as short term (over the next 18 months) and medium term. Particularly important in the short term is the need for both HWG and the Reproductive Health Policy Project to focus rather than expand, and to work on institutionalization and sustainability of their accomplishments to date. The medium-term recommendations are for five years (2009–14). The team recommends that USAID support RH/MCH in Georgia for five additional years beginning in mid-2009, to expand priority activities initiated under the current portfolio and ensure that the gains are sustained. The new activity should be designed as a comprehensive albeit focused RH/MCH project encompassing different components such as policy, advocacy, training, services, and contraceptive commodities, under one umbrella.

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# I. INTRODUCTION

## PURPOSE AND RATIONALE FOR THE ASSESSMENT

The objective of this assessment was to lay the foundation for the design of a medium-term reproductive health/maternal and child health (RH/MCH) strategy and a prioritized action plan for USAID/Georgia, aimed at improving the policy environment to enhance and sustain these vital health services in the context of the Government of Georgia's (GoG) fast-paced health reform efforts. The assessment examined the strengths and weaknesses of the current USAID/Georgia RH/MCH portfolio. It documented steps taken by the GoG to reorganize and reform the health sector, analyzed possible consequences of ongoing reform efforts for RH/MCH policies and services, and addressed the GoG's financial commitment to sustaining the achievements of USAID assistance. The scope of work for the assessment is found in Annex A. Major assessment questions included:

- What have been the successes, and the unintended and unexpected outcomes, of the GoG health sector reform efforts?
- Are the Mission's Healthy Women in Georgia Program (HWG) and CoReform aligned with GoG reform efforts?
- What HWG and CoReform efforts should be expanded, replicated, or scaled up? Which should be discontinued? What are the gaps in the effort?
- What strategies should USAID adopt to promote contraceptive security?
- What role should USAID and other external partners play in advising the GoG in the area of family planning and MCH? How can donors assist in creating a legacy of sustained improvements in RH?
- Based on the cost analysis for improved services, and proposed GoG budgets for RH/MCH, what is the likelihood of sustained service delivery over a one-to-two-year time frame?

## METHODOLOGY

The team used both qualitative and quantitative methods in the conduct of the assessment. Quantitative information was derived from existing data sets generated by local organizations, international agencies, and USAID-funded projects. Qualitative information was generated through interviews with key informants and observations at health facilities. The assessment entailed:

- Review of background documents (see Annex B, References)
- Analysis of existing program, financial data sets, and survey results (see Annex B)
- In-depth discussions with USAID/Georgia, HWG, and CoReform Projects' staff
- Structured interviews with key contacts in the GoG; the Ministry of Labor, Health and Social Affairs (MoLHSA); donor organizations; implementing partners; and stakeholders (Annex C)
- Site visits to Imereti, Samegrelo, Adjara, and Kakheti Regions to observe service delivery and interview managers and service providers. (Annex C). Site visits included maternity houses, primary health care centers, training facilities, multidisciplinary hospitals, and rural ambulatories, including some without project support to allow comparison. The team developed standard interview guides for providers (Appendix D) and facility checklists (Appendix E) to collect comparable information.

The Assessment was conducted over three weeks, April 15–May 2, 2008, by two consultants from the Global Health Technical Assistance Project: Paula Bryan, Team Leader/RH/MCH expert, and Pinar Senlet, Health Policy Advisor. The Mission's Health Management Specialist, Tamara Sirbiladze, accompanied the team on all meetings and site visits.

# II. BACKGROUND AND ANALYSIS: REPRODUCTIVE HEALTH AND MATERNAL AND CHILD HEALTH STATUS IN GEORGIA

## MATERNAL, NEONATAL, AND INFANT MORTALITY

Maternal and infant mortality are among the most significant worldwide indicators of a society's health and well-being. In Georgia and other ex-Soviet bloc countries of Eastern Europe, maternal and infant health status reflect not only a shared political and economic history, but also their isolation from Western Europe that stalled the modernization of some reproductive health and MCH care standards and practices for some 30 to 40 years.

Georgia's official 2006 maternal mortality ratio (MMR) is 23 maternal deaths per 100,000 live births; however, the official statistics reflect significant levels of misclassification and underreporting. Actual MMR is most likely 32. Although declining in recent years, it remains more than sixfold higher than the Western Europe rate of 6 per 100,000. Infant mortality declined over the past 15 years, from the official rate of 40.7 per thousand in the 1990s to 18.4 per 1,000 over the past five years. Georgia's early neonatal mortality rate (deaths 0 to 6 days after birth) of 12.1 is comparable to Armenia and triple the US rate. In regions of Georgia where there has been little or no retraining of medical personnel, perinatal care and delivery practices remain 40 years out-of-date, resulting in much avoidable morbidity and mortality among women and infants.

## LOW CONTRACEPTIVE PREVALENCE; HIGH LEVELS OF ABORTION

Georgian women have the lowest contraceptive prevalence rate of women in any former Soviet republic. The 2005 Reproductive Health Survey found that modern contraceptive use among married women age 15 to 44 was 27 percent, an increase from 20 percent in 1999. An additional 21 percent of Georgian women were using traditional methods in 1999 and 2005. Low levels of knowledge about modern contraceptives, and limited access to family planning (FP) counseling and contraceptives, contribute to high abortion rates.

Abortion, which is legal, has traditionally been used as a method of birth control, and its frequency is seriously underreported. Official rates for induced abortion in 1999 and 2005 were 0.6 and 0.5, respectively, but according to the more reliable 1999 and 2005 Reproductive Health Surveys, the Total Induced Abortion Rates were actually more than six times higher, 3.7, and 3.1, respectively. The rate of 3.7 abortions per woman in 1999 was considered the highest documented rate in the world. Although it has declined to 3.1 abortions per woman, it is still extremely high, reflecting a lack of knowledge and use of modern contraception. Most married women in Georgia desire only one or two children. Eighty-eight percent of first pregnancies result in live births, and only 1 percent of first pregnancies are aborted. However, with second pregnancies, 36 percent result in induced abortion, and with third pregnancies, 64 percent are aborted. This trend continues upward for fourth and subsequent pregnancies. There are few, if any, systematic and effective links between abortion and FP services. Service provision at many sites is disjointed, and there are medical and administrative barriers restricting abortion clients' access to FP counseling and contraceptives. Limiting family size and delaying the next pregnancy are the main reasons cited for induced abortion.

## LIMITED PREVENTIVE CARE ORIENTATION

The concepts of preventive health care, such as FP, routine mammograms for breast cancer screening, Pap tests to detect cervical cancers, and annual gynecological examinations have not yet taken hold in the Georgian health system. As of now, 40 percent of breast cancers are detected when they are at stage 4; breast cancer is the leading cause of death for Georgian women.

## HEALTH DATA SOURCES

As of early 2008, the best source of quality baseline data on RH remains the Reproductive Health Survey of 2005, conducted by the Georgian Center for Disease Control (NCDC), the MoLHSA, and the Center for Medical Statistics. Technical assistance was provided by the US Centers for Disease Control. RH/MCH data also come from the National Center for Disease Control and Medical Statistics, and the State Department for Statistics. The latter two institutions are the most current sources of data on maternal and infant mortality, and cancers of the breast and reproductive organs; however, data quality is reportedly less assured (Tefft 2008). In recent interviews, the team learned that, as a possible consequence of health sector reorganization, official statistics may reflect weaker data reporting now than in the past. Trends in health status are assessed through comparison of the 1999 Reproductive Health Survey results with those of 2005, official statistics, and supplemental data collected through systems established by the HWG program.

## REPRODUCTIVE HEALTH AND MATERNAL AND CHILD HEALTH POLICY AND SERVICES

The organization of RH and MCH services in Georgia resembled, until relatively recently, the MCH service structure of other ex-Soviet states. MCH care has been fragmented, with different institutions providing different levels and types of care. A primary health care (PHC) center, known as an ambulatory, would usually be the first point of contact for women in villages and at the *rayon* (district) level. Doctors assigned to such settings usually did not have specific RH/MCH training. At that level, there was likely to be an internist and pediatrician. In more populated areas, women's consultation centers, often part of a polyclinic, provide care during pregnancy and after birth, while maternity houses are responsible for intra-partum (obstetric care, delivery, neonatal) care. This is changing as some facilities at the *rayon* level have both a women's consultation center and a maternity house in the same facility.

There has never been a state-sponsored comprehensive package of RH/MCH care with an emphasis on health promotion and preventive care, such as breast and cervical cancer screening, sexually transmitted disease (STD) testing, and FP services.

A variety of changes that have taken place in the last decade have transformed the legal and financial basis for the provision of all health services. The Law of Medical Insurance (Government of Georgia 1997) changed from direct, state-provided health care to insurance coverage of health care. When nascent insurance companies develop their policies, they will not have appropriate RH/MCH models in the Georgian context, unless, at the start, some of the innovations and lessons of the HWG Program are disseminated.

Under the Government's plan to retrain physicians as "Family Doctors," a wider range of services will be offered at the PHC level, including FP. There is some attention in the new six-month retraining curriculum to RH/MCH, but it is inadequate in that in some remote areas, the family doctor will be the only source of RH/MCH services and counseling.

## USAID REPRODUCTIVE AND MATERNAL AND CHILD HEALTH PORTFOLIO

There are two major programs of USAID assistance in Georgia, the Healthy Women in Georgia Program and the Reproductive Health Policy component of the CoReform Project. The Mission also funds several smaller activities. All are described below.

### Cooperation in Health Systems Transformation (CoReform) Project: Reproductive Health Policy Component

CoReform is implemented by Abt Associates, Inc., Care International, the Curatio International Foundation, and the Emerging Markets Group. The primary Georgian institution with which the project collaborates is the Reproductive Health Policy Working Group of the MoLHSA, a subgroup of the National Reproductive Health Council of the MoLHSA.

The RH component of the CoReform Project provides technical assistance to the RH Working Group of MoLHSA. This group undertook an analysis of Georgian health legislation, civil codes and policy, and Georgia's commitment as a signatory to international treaties and conventions concerning RH and MCH. Their analyses concluded that there is a clear commitment to reproductive rights in Georgian legislation, but there are many areas where additional, more specific legislation or other Government action is needed to clarify and legitimize specific aspects of RH policy, services, and financing. Additional analyses undertaken with technical assistance by the CoReform/RH Policy Component include the following:

- *National Health Accounts: Reproductive Health Sub-Analysis for Georgia 2001–2003 (2005)*
- *Review and Analysis of Reproductive Health Legislation and Policy in Georgia (2005)*
- *Legitimization of Georgia Reproductive Health Policy & Legal Basis for Implementation (2007)*
- *Reform of the Hospital Sector in Georgia—Implications for Perinatal Care (2007)*
- *Implementation of Clinical Practice Guidelines (2008)*
- *Implementation of Clinical Practice Guidelines: Review of International & National Experiences (2008)*
- *Georgia National Reproductive Health Policy [Framework] issued by MoLHSA July 2007*
- *Strategic Plan for Reproductive Health in Georgia issued by MoLHSA February 2008.*

The MoLHSA ministry-level RH Policy Working Group has "a mandate to participate actively in the review and analysis of current RH policies and practices, develop recommendations for enhancement of these policies, and produce documentation required to support these recommendations. The quality, relevance, and feasibility of the recommendations are the primary responsibility of the Working Group members. Responsibility for implementing revised policies rests with MoLHSA, and the various professional associations involved (particularly, the Association of Obstetrics and Gynecology, and the Pediatrics Association) will play a key role in upgrading and monitoring the clinical quality of care in reproductive health service delivery."[1] However, MoLHSA has no legislative authority to implement some key measures, such as ensuring that RH guidelines are up-to-date, developing training systems for providers, and monitoring adherence to protocols.

The MoLHSA "Strategic Plan for Reproductive Health in Georgia," dated February 2008, states that "the National Reproductive Health Council was created as a deliberating body of the Ministry…a coordinating body for government, donor agencies, nongovernmental organizations

(NGOs), religious and private sector organizations in the area of reproductive health…also has a fundraising mandate, and will provide oversight, monitoring and supervision of program activities in areas of identified need, and …advisory body to the Ministry and other GoG structures on RH policy and program issues."

[1] "Review and Analysis of Reproductive Health Legislation and Policy in Georgia," 2005, p. 2.

The technical assistance of the CoReform RH Policy component has been heavily focused on policy analysis and policy development work, which has been outstanding. However, the practicalities of implementation of the Georgian RH policy have yet to be addressed, as can be seen from the wide and unrealistic scope of the National Reproductive Health Council.

### Healthy Women in Georgia (HWG) Program

The HWG Program, a cooperative agreement with the John Snow Inc. Research & Training Institute (JSI), was competitively awarded in September 2003 for three years. Initially, HWG was funded as a pilot effort to implement best practices in FP and MCH. In addition to antenatal and perinatal interventions, HWG obtained a special waiver from MoLHSA to undertake FP activities with providers that were not "reproductologists." This key action enabled the project to expand to a wide range of service delivery sites, scaling-up in a relatively short time.

The HWG program evolved from a three-year to a six-year agreement as unanticipated resources became available on an annual basis. Along the way, the HWG scope expanded in content and geographic coverage. Annex F provides a summary chart of the original scope and amendments.

The uncertainty of funding from one year to the next led to a design that was more focused on short-term goals, defined in terms of population-level impact and with a focus that was strategic in its geographic coverage, but far less strategic in programming for sustainability. This bottom-up approach may have been the most sensible approach, given the fluidity and uncertainties surrounding the health sector reform and privatization processes.

The project is now the primary vehicle for USAID's work in health service delivery, having modernized antenatal and perinatal care, and introduced safe, effective FP methods to reduce abortion. The project has worked to improve MCH services even in the conflict areas of Abkhazia and South Ossetia. Although originally designed as a pilot program in three locations, the project has been able to scale-up in seven regions. It now encompasses 379 family planning sites, 17 maternities that cover 65 percent of all deliveries in the country, 90 youth-friendly pharmacists, 75 schools, and 11 educational resource centers, and now covers more than 56 percent of the Georgian population.

HWG works at multiple levels:

- Training materials were developed for family planning and antenatal care.
- At the service delivery level, HWG is training health providers in evidence-based antenatal and perinatal care and delivering contraceptives.
- Information, education, and communication and behavior-change communication materials were developed; consumers are counseled at service sites and engaged through social marketing.
- Physicians receive in-service training, and curriculum revision in medical schools is reaching medical students; adult learning methodologies were introduced.
- Pharmacists were trained to be "youth-friendly" and provide information/counseling.
- The HWG program provided USAID-donated contraceptives to support training sites.
- Prospective parents were able to attend "Parents' Schools" developed with HWG technical assistance, to help prepare for childbirth and subsequent family planning.

An internal management review of the HWG activity undertaken in September 2007 noted that "The project has exceeded every health benchmark it established and has made important contributions to saving lives by driving down the abortion rate, cesarean sections and other unnecessary and outdated medical procedures in the first wave of assisted areas while improving contraceptive prevalence and

birth outcomes in a record 60 percent of the country's births. The abortion rates have gone down between 9–21 percent depending on the site. Modern contraceptive prevalence has gone from 20 percent to 27 percent in Georgia in five years (1999 RHS and 2005 RHS data). In HWG pilot sites that originally had lower than the national average contraceptive prevalence rates, use of modern contraceptives increased by 3% in one year, from 15.8% to 19.8%." The assessment team was impressed, during site visits, with the high level of unsolicited praise for HWG and its critical role in modernizing RH/MCH care in Georgia. The positive tone of the internal management review was quite deserved.

**Contraceptive Procurement:** USAID/Georgia began contraceptive donations (combined pills, progestin-only pills, condoms, intrauterine devices [IUDs]) in 2005 and has provided US$700,000 worth of contraceptives since then. Currently, there are adequate contraceptives in the pipeline to cover the needs of the facilities supported by USAID projects through the end of 2009.

**Reproductive Age Mortality Survey (RAMOS):** USAID is supporting a RAMOS, a study of deaths among women of reproductive age (WRA; females 15 to 49 years of age, or the span appropriate for the culture, depending on average age at marriage, age at first birth, etc.) to identify the cause of each death and ways to prevent such deaths. Most often, RAMOS are conducted retrospectively, but may also be done prospectively if a population of WRA is monitored and all deaths are reviewed as they occur.

Further analysis of the 1999 and 2005 Reproductive Health Survey data, in conjunction with reviews of death certificates, is providing a more comprehensive picture of the magnitude of maternal mortality and causes of death among WRA. This data can help to inform planners and health care providers of needs for improving health care quality in specific areas, and for improving characterization and reporting of causes of death.

## DONOR SUPPORT FOR REPRODUCTIVE AND MATERNAL AND CHILD HEALTH

### The United Nations Population Fund (UNFPA)

The UNFPA Country Programme for Georgia, 2006–10, has three components: reproductive health, population development, and gender. Key elements follow:

- Supporting RH commodity security through provision of and technical assistance for RH commodity security management: UNFPA has supplied Georgia with contraceptive commodities (orals, condoms, IUDs, and injectables) since 1993. From 2001 to 2003, UNICEF supported Population Services International (PSI) and the Caucasus Social Marketing Association (CSMA) in promoting the "Favorite" condom through pharmacies. UNFPA support continues through 2010 (within the frame of its first Country Programme for Georgia).
- Supporting improving quality of RH services through development of clinical practice guidelines and protocols related to RH, including FP and Emergency Obstetric Care; supporting MoLHSA in training on the guidelines and protocols in Tbilisi and other regions is underway.
- Improving access of population to quality RH services through operation of four mobile units providing free RH services, including FP counseling and contraceptives provision in all regions of Georgia, with special focus on remote areas.
- Supporting RT cancer prevention through breast cancer and cervical cancer screenings being supported in new facilities in Tbilisi, with funding from the UNFPA, and the Tbilisi municipality.

- Improving the access of youth to quality sexual and reproductive health information and services by opening of youth-friendly sexual and reproductive health services and capacity building of sexual and reproductive health service providers in newly opened Youth RH Centres in Tbilisi and regions of Georgia.
- Supporting RH surveys (women's, men's, adolescents', etc.).
- Improving access to RH information and services in Abkhazia (service providers' training, medical equipment and contraceptive supplies, population information, education, and communication).

### The United Nations Children's Fund (UNICEF)

The design of a Quality Assurance/Quality Care model for MCH services at the secondary and tertiary levels has been initiated. This reporting/hospital rating system will provide the end user with access to information on the performance of maternity hospitals. Location: Kvemo-Kartli.

### World Bank, European Commission, and the United Kingdom

World Bank loans support renovation of primary health care (PHC) facilities. The Primary Health Care Development Project (2002–2009) aims to improve the coverage and use of quality PHC based on the model of family medicine/general practice, with an emphasis on reaching the poor and disadvantaged. The project builds on investments in preventive health care supported through earlier Bank funding. The PHC service delivery component supports a two-phased development of PHC services in urban and rural areas through rehabilitation of facilities and provision of basic medical and office equipment.

### UK Department for International Development (DFID)

DFID will close its Georgia bilateral program in 2008 but will remain engaged with multilateral institutions. Assistance through 2008 will focus on improving governance by supporting financial discipline, anticorruption, and institutional reform. DFID is also helping the GoG coordinate and manage donor aid, facilitating better-targeted and focused programs by donors. DFID financed the *Primary Health Care Reform Support Project, 2003–2008*, providing implementation support and technical assistance through the Oxford Policy Management Group for policy advice, capacity strengthening in MoLHSA, health care financing, human resource development, health promotion, and a health management information systems.

### The European Commission

"EU Support to the Health and Social Programmes Agency" (2007–2008) assists the Health and Social Programs Agency (HeSPA) in improving the efficiency of its operations for health systems, monitoring, and the purchase of private sector health services. The expected outcome of the project is transparency in health financing mechanisms. Implementing agencies are Bernard Brunhes International (Paris), Human Dynamics (Austria), and Agence pour le Développement et la Coordination des Relations Internationales (Paris). This effort is important to the financing and management of all health services RH/MCH encompasses.

# III. BACKGROUND: HEALTH SECTOR REORGANIZATION AND REFORM

## REFORM EFFORTS SINCE 1995

Georgia has faced some of the most intractable health sector challenges of any former Soviet republic following independence in 1991. Struggling with recovery from the economic collapse brought about by the breakup of the Soviet Union, the Government initiated major reforms in the health care sector in 1995, with the aim of improving health status through better geographic and financial access, and enhanced quality and efficiency in the provision of services. Major components of reform in 1996–2002 included reduction of redundant infrastructure through facility closure and privatization, introduction of new health financing models, separation of purchasing and service provision functions, new health legislation, and introduction of a family- medicine-based PHC model. Despite improvements led by this ambitious agenda, health sector financing and government programs have lagged behind needs.

The slow pace of reforms in previous years created a gap in access to care by the poor, and led to concerns about the ability of the health delivery system to simultaneously modernize facilities and deliver quality care, while restructuring the mode of financing health care. Thus, lack of visible progress on health care reform became a key political issue for the 2008 elections.

Beginning in 2006, the Government greatly accelerated the pace of health care reforms. The newly established State Ministry for Economic Reforms (SMO) became the primary architect of all reforms in the health sector and assumed all key decision-making power regarding the reforms. This rapid health reform agenda was driven outside of the Ministry of Labor, Health and Social Assistance (MoLHSA), and the donor community had limited interaction with the SMO during the process. The SMO was abolished in early 2008, shifting the locus of control and implementation of the reforms back to the MoLHSA.

At the time of this assessment, the health sector reform process was a fast-moving and unpredictable target. The team was able to find few official statements on the progress, priorities, and directions of the current reform efforts. At a recent meeting with the donor agencies, the MoLHSA laid out its priorities for the next four years (MoLHSA 2008). The information provided was generic and focused on the longer-term goals of the MoLHSA.

To achieve stated objectives in the health sector, the GoG pursues a multipronged strategy including:

- Hospital privatization
- Primary health care reform
- Coverage of health services for the poor through private health insurance
- State-funded provision of essential public health services
- Deregulation
- Restructuring of MoLHSA

### Hospital Privatization

The vast infrastructure of hospital facilities in Georgia, characterized by an oversupply of hospital beds and patient use at only 30 percent of capacity, was neither cost-effective nor sustainable. The majority of the health facilities had been poorly maintained and needed extensive renovation and new

equipment to bring them up to standard. Despite the privatization of over 400 health care institutions by 2003, Georgia still had 285 hospitals. According to the World Bank, rehabilitation of existing facilities, without equipment, would cost the GoG US$100 million (Collins 2003).

A major focus of the GoG's health reform effort is the creation of a new hospital infrastructure. This resource-intensive element of the reforms is described in the January 2007 GoG Master Plan for Restructuring the Hospital Sector. In a departure from previous reform proposals, the plan calls for privatization of all but five secondary and tertiary care facilities in the country, along with rationalization of hospital beds and number, size, and type of facilities. The decree lays out an ambitious plan to optimize physical infrastructure of hospitals through the construction or renovation of 100 hospitals, built and equipped to defined standards, providing 7,800 new hospital beds. It includes the location of each secondary and tertiary care facility, bed capacity, services to be offered, minimum standards of physical infrastructure, and equipment requirements. Under the plan, services will be accessible to 87 percent of the population within a 30-minute drive.

### New emphasis: community hospitals and multi-profile hospitals

In contrast with the wide range of hospital types and specialization existing in the old system, the new plan calls for just two types of facilities: small or community-level hospitals with 15 to 25 beds and larger "multi-profile" hospitals with 50 and 100 beds. Constructing and equipping the new facilities will be financed by the privatization of current hospital facilities, with their land, with purchasers assuming the obligation of building new hospitals or renovating old facilities. In brief, existing hospitals, with their land, are being sold through public tender in exchange for construction, ownership, and operation of new hospitals in other locations. The Ministry of Economic Development, the owner of all government medical facilities, is managing the privatization process. Construction, equipping, staffing, and licensing of the new facilities are the prerequisites for the investors taking possession of facilities (valuable real estate) they have purchased from the Government. Until new facilities are opened and operational, the investors are obligated to maintain the existing facilities at their current level of operation. The investors are required to own and operate hospitals for a minimum of seven years.

At the time of this assessment, 20 tenders had been awarded to five private investors for the construction or renovation of 80 facilities. Construction and renovation efforts are under way and moving forward, with a few new facilities already operational.

### Primary Health Care Reform

The World Bank, European Commission, and DFID have been providing financial and technical support for comprehensive PHC reform in Georgia. The purpose of the reform is to improve coverage and use of PHC based on a model of family medicine/general practice, especially for the poor and disadvantaged. The national PHC master plan calls for 90 percent of the population to have access to a PHC clinic within 15 minutes. The plan envisions rehabilitation of over 700 rural PHC facilities, each covering several villages, and training of over 2,000 PHC teams, consisting of a family doctor and a nurse. The plan intends to transform the existing ambulatory outpatient centers in the rural areas into PHC facilities through renovation of facilities, provision of essential medical equipment/supplies, and retraining of the staff to enable them to provide a comprehensive package of PHC services. Existing physicians, mostly pediatricians and internists, are being retrained as family doctors through a six-month course. Nurses are trained with the physicians to enable them to serve as PHC teams.

To date, the World Bank project has rehabilitated over 100 PHC clinics, provided training to over 300 doctors and nurses in family medicine, and extended the national family medicine training capacity by establishing three regional PHC training centers. A residency program for family medicine is institutionalized at the State Medical University, and 10 clinical guidelines and protocols have been developed to improve the quality of PHC services.

More recently, the GoG initiated another PHC project with support from the World Bank, known as the "Rural Doctors Project." Under this new initiative, the GoG will provide to 800 eligible family doctors a grant of 2,000 GEL to upgrade the working conditions of the family doctors working in the rural areas, and 5,000 GEL to purchase necessary medical equipment. At the time of this assessment, the eligible doctors were informed that they would be receiving the grant within a month. The conditionality of the grant and systems for monitoring remain unclear.

### Coverage of health services for vulnerable populations

As part of the recent health reform efforts, the GoG launched a medical assistance program in 2006 aimed at improving equity and access to essential health care, especially for the poor and the vulnerable. The beneficiaries are selected based on welfare scores, using a tool developed to estimate a household's welfare status. Currently, it is estimated that 750,000 people are living under the poverty line and are the beneficiaries of this program. The Government purchases an insurance package for the poor from private insurance companies. Vouchers issued to the target population enable them to choose among competing insurance companies. Initially, this policy was a highly targeted program for the poor, but recently it was broadened to cover certain working- and middle-class populations such as the military and police workforce, and teachers. The MoLHSA estimates that by the end of 2008, the program will insure 1.2 million people, or about 35 percent of the population, through the private insurance companies.[2] Formerly, the State United Insurance Fund, which was restructured, administered the medical assistance program. Recently, the responsibility was transferred to the new legal entity HeSPA, a branch of the MoLHSA in charge of procuring, contracting, and financing health care services.

### State-funded provision of essential public health services

In addition to the medical assistance program for the poor, several state-funded programs for the entire population will continue to cover selected RH/MCH interventions, tuberculosis, HIV/AIDS, cancer treatment, and diabetes. State-funded RH and MCH programs fall into two groups: for the entire population and for the poor. For the entire population, HeSPA reimburses the health facilities for four antenatal visits, starting from the 12$^{th}$ week of pregnancy, at 65 GEL for each visit. For delivery services, all women are given vouchers of 200 GEL to reimburse the costs of a normal delivery. For the vulnerable populations, the vouchers are given at 400 GEL, intended to cover costs of complications and emergency obstetric care.

### Deregulation

The GoG is committed to eliminating nonessential regulatory burdens from providers, purchasers, and pharmaceutical companies. The current government regards heavy regulatory provisions inherited from the Soviet systems as the "causes of corruption."

### Restructuring of the MoLHSA

In addition to privatization of hospitals and establishment of the PHC structure, several changes took place within the MoLHSA central organization over the past year. The MCH Department was recently abolished; it remains unclear which body has taken over the responsibility and oversight of MCH care services. The National Center for Disease Control and the Department of Public Health were recently merged to form one quasi-governmental body.

[2] Personal communication, Nikoloz Pruidze, Deputy Minister of MoLHSA.

# IV. FINDINGS AND CONCLUSIONS

## CURRENT STATUS AND CONSEQUENCES OF THE REFORM EFFORTS

At the time of this assessment, the health sector in Georgia was undergoing a vast transformation as the reform agenda was being executed. While some of the results are apparent, many of the expected results were not clearly visible. To the extent possible, the team attempted to understand the implications of the ongoing reforms on health care, especially on PHC, with an emphasis on RH/MCH. Transformation of the dysfunctional government-owned hospital network into a new and privately owned health sector infrastructure is an innovative and progressive strategy. However, many elements of this transition, and the consequences for quality of care, remain unclear at this time. Some key contacts expressed deep concern about the involvement of pharmaceutical companies in the hospital privatization process. Two of the five investors currently bidding for hospitals are large pharmaceutical companies. The assessment team was informed that the MoLHSA is in the process of defining the changing role of the government in the transition to market-oriented health care, to address financing, regulating, and quality control of health care provided by the private sector.

The assessment team visited two privatized hospitals during field trips. One small sized maternity house was bought by its staff several years ago during the initial phase of privatization, after the price had been greatly reduced. The facility, which already had a good reputation for quality services, was able to sustain its operations. The maternity house director noted that their success was an exception, not the norm. Many of the public facilities, when first auctioned, were unable to attract outside investors due to their immensely rundown status. The staff of these hospitals was either not interested or unable to afford purchase of the facilities. Another large facility, originally a maternity hospital, was bought by an investor, thoroughly renovated, and transformed into a multispecialty facility. One of the team members had visited the same hospital six years ago and was able to witness the dramatic physical transformation and improvement of the facility.

### Vouchers for Antenatal and Maternity Care

A major concern voiced in both facilities was the level of reimbursement for maternal care, described earlier. The income generated through the voucher system was adequate to cover the costs of normal deliveries, but insufficient to compensate for costs of complicated deliveries, including caesarian sections. The multispecialty hospital subsidizes the costs of the maternity through other, more profitable services. In the case of the small maternity, the management had no choice but to ask patients for additional payments for complicated deliveries or C-sections.

Another key concern of the assessment team is that FP and contraceptives are not included in the current voucher system. To a certain extent, FP counseling is covered under the antenatal visits for pregnant women, but costs of contraceptives are not covered. Currently, contraceptives are procured by USAID and UNFPA and provided free of charge to anyone. The managers and providers think that it is the government's responsibility to provide free contraception for all, without regard to ability to pay.

### Primary Health Care (PHC)

The GoG's strategy to institute a PHC system especially designed to serve the rural areas is laudable. Effective PHC is essential to improve the overall health status in a country. If PHC is ineffective in providing basic services, hospitals will be overwhelmed with routine and chronic illnesses and will eventually become dysfunctional. The PHC system is therefore the underpinning of all health care. During the field trips, the team visited several facilities that were being transformed into PHC centers, and some were functioning. Many of the physicians and nurses had already undergone family medicine training and were certified, and facilities were renovated or newly constructed and

equipped. However, some retrained doctors said they could not change their practice without a new contract from the MoLHSA, and thus they were not yet providing PHC services. The reasons for the delays were not clear to the assessment team.

It is unclear how construction, renovation, and equipping of the remaining PHC facilities will be financed and managed. To date, only a fraction of the facilities have been transformed and physician-nurse teams trained. Reportedly, rehabilitation of these facilities will be managed in the same manner as construction of the new hospitals—that is, in exchange for ownership of properties being privatized by the State. In several interviews, the assessment team was informed that the GoG is determined to privatize the entire PHC infrastructure; however, the plans were on hold until after the elections. Privatization of PHC raises concerns over the sustainability of this newly emerging system, because PHC is not as profitable as the secondary and tertiary health care services.

### Health Financing

Health financing is another area of dramatic change. Under the current thinking, private insurance will play a critical role in health financing. The GoG intends to rely on the insurance companies to regulate the costs and quality of services purchased by the Government. Health insurance for the poor, through private companies, has just begun implementation as of November 2007. This emerging system will require new health insurance companies with strong internal controls and actuarial focus. Currently, the country's private health insurance sector is young and inexperienced. The sector covers a very small proportion of Georgians with largely employment-related coverage, some to corporations. The insurance companies will also need to understand the costs of services covered under the insurance package within the limit stated by the Government. The maximum medical insurance premium of the Government is 11 GEL per person per month, and already some insurance companies have indications that 11 GEL will not be adequate.

Despite the challenges of the turbulent reform environment, and several questions that need to be answered, many of our key contacts were optimistic regarding the future of reform efforts. A key concern of the managers and providers we met during the field trips, and of staff of teaching institutions, was their limited access to information on the directions, details, progress, and timeline of the reforms. Also, in this fast-changing reform agenda, critical decisions are being made at the central level without consultation with relevant institutions, such as the medical university. There is little communication with the field, not to mention even with senior MoLHSA staff at the central level. Lack of information leads to rumors among the staff, and creates undue anxiety and doubt, which could have been avoided if a good communication policy was in place.

In sum, the team believes that the reform efforts are moving in the right direction and the emerging new health system will be more efficient, sustainable, and of higher quality than the old systems. It is very likely though, that the costs of health care will increase. Health reform has opened the door to a broad range of potential new players in health outside of the GoG, in the private sector and civil society. We envision that these new strategies will be field-tested as the reform process moves on. Modifications and fine-tuning will be required along the way. It is also possible that some elements will fail, given their current ambitious pace, the failure to engage senior officials who might contribute to the process, and unanticipated outcomes. Some aspects of the reform agenda and process will need overall rethinking once the elections occur, political tensions are reduced, and more normal governance is in place.

## CONTRIBUTION OF HWG AND COREFORM PROJECTS TO HEALTH REFORMS

HWG and CoReform RH policy activities have resulted in major achievements directly relevant to the GoG's health sector reform ambitions. Many of their achievements can lead the process of health reform forward, despite an atmosphere of uncertainty. Diverse program achievements benefited the vast majority of the population and have the potential to promote tremendous goodwill toward the US if publicized in ways that are sensitive to Georgian sociocultural, religious, political, and economic and health concerns. Aside from compelling data, there are many great "human interest" stories in this work, from doctors who describe the changes in their medical practice to the family members who have experienced birth at a family-centered maternity center.

The projects contributed to the overall health reforms mainly by training managers and providers, mentoring stakeholders, and educating consumers; they improved access to and use of higher- quality services. The new skills enable managers and providers to function in a private sector context. Both projects maintained good relationships with the MoLHSA and the other partners, and have been flexible and adaptable given the fast and changing reform environment.

The HWG project significantly contributed to the health reforms by transforming many elements of RH/MCH at the service delivery level. Their training has changed many aspects of service delivery in positive ways. There is a greater awareness of costs and cost savings. Costs of services were reduced while quality improved at projects sites; these changes were highly appreciated by managers and service providers, and by newly involved private investors.

HWG was not originally designed as a policy intervention to influence the health care reforms in relation to RH/MCH services. The project focused primarily at the service delivery level to expand and improve RH/MCH services and worked directly with providers. This has resulted in key changes, with long-term positive public health impact. Bottom-up interventions implemented at the local levels could lead the policy makers to reform the system if the positive health gains and financial impact are conveyed to policy makers and key decision makers. Not all reform efforts need to be implemented from top to bottom.

### Healthy Women in Georgia: Areas of Strength

***Human Resources Development***

HWG has had a significant impact on developing the human resources required to provide improved RH/MCH services. Training has contributed to professional development, equipping doctors, nurses, and midwives with new technical information and clinical skills that enable them to effectively provide FP counseling and services, and perinatal and maternity care. In some cases, training skills have been developed through training of trainers, eventually reducing overreliance on international consultant trainers.

***Organizational Development***

JSI, as the lead implementing agency, has worked at the central level with MoLHSA, and at the regional and local levels (ambulatory care). The elaboration of a management structure, and the processes and procedures to manage the relationships among different government entities (for example, MoHLSA, Tbilisi Medical University, regional and local health care facilities) concerned with various components of RH/MCH is a challenge, in part due to the ongoing reorganization and reforms in the health sector. In addition, new entities such as private sector insurance companies, and newly privatized clinical service institutions, have added increasing levels of complexity to the challenge of sustaining and financing RH/MCH services.

A policy and legal framework for RH, and a strategic plan, have been developed by the RH Working Group of the National Reproductive Health Council, with documentation issued by MoLHSA. The Council comprises members who are highly placed in various GoG institutions; however, it is "a deliberating body of the Ministry." It has no authority to make policy, budget for, or implement its recommendations. In this context, traditional measures of institutionalization may be less relevant. There is weak governance and insufficient leadership, planning, and administrative resources for RH. It is in this challenging context that the JSI and its partners under the HWG program have become organizing and implementing entities in place of the GoG.

***HWG Monitoring and Evaluation (M&E) Indicators***

The population-level indicators designed thus far to track HWG program achievements are appropriate, and the assessment team found excellent recordkeeping systems in place, giving credence to the stated accomplishments.

***Cost Impact Study Demonstrates Cost-effectiveness***

HWG is currently undertaking a cost impact study to demonstrate that modernized maternity care is highly cost-effective in reducing hospital costs, especially overuse of drugs and unnecessary medical procedures. It is a timely study to demonstrate that modernized maternity care is highly cost-effective in reducing hospitalization, overuse of drugs, and unnecessary invasive medical procedures.

## Healthy Women in Georgia: Areas of Weakness

***Limited Advocacy***

- Current project M&E indicators could be better framed, and some additional indicators added, to tie program activities and accomplishments to national priorities and political concerns.
- Project accomplishments need to be presented in a way that enables planners and policy makers to use its significant program data in decision making.

***Management Information System (MIS) for FP Not Integrated with the National System***

Record keeping is project oriented, not integrated with a national MIS. Components of a national health MIS system are now weak and insufficiently comprehensive; in some critical areas, health data are nonexistent. As the national system is being upgraded with external technical assistance, it needs to include appropriate RH/MCH content and data.

***Institutionalization and Capacity-building Indicators***

The GoG is apparently very focused on numbers of facilities and personnel. While there are many definitions of the terms "institutionalization" and "capacity building," in its remaining 17 months, the HWG program needs to better document its human resource development and its institutional/organizational strengthening accomplishments. The HWG program has made a huge contribution to the quality of services, through direct training and the training of trainers, the provision of equipment and commodities, etc. The appropriate documentation and dissemination of such information could raise the profile of the work of USAID/HWG, and gain more commitment from the GoG to take on more responsibility.

- HWG project documentation must clearly and systematically identify regional and local institutions/staff that have benefited from their HWG collaboration to raise standards of care.
- Documentation of program success is oriented to USAID requirements. Wider dissemination of accomplishments, oriented to the medical community at large, policy makers, other donors, and the public, must be a very high new priority.

- The demonstrated cost savings from perinatal interventions emphasized by HWG needs to be highlighted for key stakeholders while there is an opportunity to influence many aspects of the reform process.

### CoReform Reproductive Health Policy Component

***CoReform: Areas of Strength***

The analytical documents produced are extremely impressive with respect to their depth and breadth of detailed analyses, encompassing international and Georgian law, policy, medical services and clinical standards, and some financial analyses.

***CoReform: Areas of Weakness***

However, a July 2007 Georgia Health Sector Assessment concluded that "the [CoReform] project needs to recognize that they are supporters, not implementers of health reform," and this is probably true in the case of the RH Policy component of CoReform. In its role as Secretariat for the RH Working Group, CoReform staff may be taking on work that is beyond technical assistance, creating an impediment to MoLHSA's "ownership" of the RH reform process.

The project has set up a partnership with the National Reproductive Health Council led by the First Lady, with representation by the private pharmaceutical sector, key donors, and NGO providers. The project has developed a number of important tools including information and education materials, a government-approved training curriculum, and a model simple logistics system. The locus of implementation authority remains unclear and must be clarified and/or determined.

As part of the MoLHSA Strategic Plan for Reproductive Health, CoReform, in consultation with the RH Working Group, developed a chart of activities for 2007–09, which includes time frames for the planned activities, responsible agency, and means of verification. In many instances, this strategic plan document lists individual donors as "Agency Responsible" rather than distinguishing between the funding agency, the technical assistance entity, and the collaborating Georgian institution. This particular document strongly suggests that CoReform staff might be reinforcing MoLHSA's tendency to let donors fill a gap or needs in health training, services, and commodity provision, with insufficient attention to sustainability of activities.

Donors may be at fault for not insisting on written agreements that require some commitment on the part of the GoG and that outline the financial, institutional, and human resource commitments and other specific responsibilities of each party. The restructuring of the MoLHSA, including the elimination of departments such as MCH, is an impediment to donors in engaging with the GoG.

## CROSS-CUTTING ISSUES

### Sustainability

The team paid special attention to the level of institutionalization and internalization of the gains achieved by the HWG and CoReform Projects and the likelihood of sustaining these changes once these projects end. In general, both projects have been very successful in developing local capacities of organizations and individuals through training and mentoring all along the project activities. For example, HWG worked with hundreds of service providers and updated their knowledge and practices to provide higher quality RH/MCH services. RH/MCH services are now being provided differently at project-assisted facilities; there have been significant improvements in service quality, and the managers and staff have internalized these changes. In addition, the project helped formation of a cadre of trainer of trainers, from various local institutions, to build the needed training capacity within the local organizations. Another effort was to build in a supervision system to ensure continuous quality of the services. Similarly, these supervisors are staff of diverse local organizations.

However, there are unsustainable elements of the project design. Training and supervision functions are carried out by contracted local organizations and professionals, with HWG organizing the efforts and providing funding for meetings, trainings, etc. At this point, there is no local entity assuming the responsibility of coordinating these activities, and paying for the additional costs of training and supervision is not integral to routine services. In sum, if the project ends soon, the quality of the services provided at the project sites will be maintained; however, training of additional providers to replicate the services in new sites, and the supervision function to ensure continuous quality, will likely falter.

Similarly, the RH component of CoReform has had impressive results in assisting the development of RH/FP policy and strategy, and also in drafting the RH/FP clinical practice guidelines. A large group of influential stakeholders have been actively involved in the long process and are appreciative of the quality of CoReform assistance. The national RH policy has not been implemented yet. Similarly, the clinical practice guidelines have not been disseminated and implemented nationwide. If the project comes to an end soon, it is questionable whether the local stakeholders will be able to further the processes without the mentoring they have been receiving from the project.

In sum, the assessment team believes that the projects could have been more forward thinking and could have given more attention to sustainability. It is extremely difficult, though, to achieve high levels of sustainability in a country where the entire system has been going through a tremendous transformation. In this transitional period, it is even hard to identify those local partners that will eventually assume the responsibility for ongoing activities, since the old systems are not in place anymore but the new systems are not in place yet.

### Contraceptive Security

Contraceptive security is a broad term encompassing different facets of sound logistics management. It is achieved when a program is able to forecast, finance, procure, and consistently deliver a sufficient supply and choice of quality contraceptives to every person that needs them (JSI 2000). A number of indicators can be used to assess the level of contraceptive security in a country. The following table shows the status of those indicators for Georgia.

| ASSESSMENT OF CONTRACEPTIVE SECURITY LEVEL IN GEORGIA | |
|---|---|
| **Indicators of Contraceptive Security** | **Georgia** |
| Reliance on donors for commodities, logistics management | 100% |
| Government commitment | Weak |
| In-country budget for contraceptives | None |
| Robustness of the commercial sector | Modest but fast growing |
| Local programmatic capacity | Nonexistent/very weak |
| Per capita gross national product (GNP) | Low – US$1,350 (2005) |
| Proportion of population below poverty line | 40% |
| Ability to pay | Very low |
| Demand for contraception | Low but fast growing |

A country's contraceptive security often corresponds with its degree of dependence on international assistance. Georgia is totally dependent on contraceptives donated by UNFPA and USAID. Since 1993 UNFPA has been donating contraceptives (combined pills, progestin-only pills, IUDS, condoms, spermicides, injectables, and implants) and distributing them through its RH mobile teams, RH service delivery points in all regions of the country, and NGOs working with the most-at-risk population. Between 2001 and 2006, UNFPA purchased contraceptives worth more than US$670,000, to be distributed free of charge to the public sector,[3] and the Agency is committed to continue its contraceptive support in the foreseeable future.[4] USAID/Georgia began contraceptive donations (combined pills, progestin-only pills, condoms, IUDs) in 2005, and provided a total of US$700,000 worth of contraceptives since then. Currently, there are adequate contraceptives in the pipeline to cover the needs of the facilities supported by USAID projects through the end of 2009. USAID-funded contraceptives are distributed through the *rayons* with support from the HWG project.

Local logistics management capacity is very weak—if not nonexistent. There has been no logistics management system at the PHC level except for vaccines. HWG has been working with the MoLHSA to develop a flexible Logistics Management Information System (LMIS) for contraceptive provision to operate at the central, regional and facility levels. So far, 24 *rayon* coordinators, who are Public Health Department staff, are trained in LMIS and are in charge of logistics at the facility level, with support from HWG. Currently UNFPA and HWG are in the process of merging their contraceptive databases and establishing a joint reporting system.

The GoG's commitment to FP is still very weak. As of 2005, there was no provision for FP counseling or services in the state health programs except in relation to health promotion activities and counseling for women (CoReform Project 2005). The Georgia National Reproductive Health Policy and Strategic Plan for Reproductive Health (2007 and 2008) states that "as public sources for provision of health care increase, the Government will consider bearing the costs of contraceptives for members of the population who are unable to afford contraceptives." Currently FP service provision is not included in the basic health benefits package. Contraceptives are not on the essential drug list of state health programs, nor is there any provision in the health budget for procurement of contraceptives.

***Private Pharmaceutical Sector***

There is a fast-growing pharmaceutical sector in Georgia, with three commercial chains opening pharmacies in cities and towns. The pharmacies carry a broad variety of types and brands of contraceptives, in a range of prices. While prices appear low by Western standards, Ability to Pay studies conducted in 2004 and 2006 found that even low-priced contraceptives were out of reach for a significant portion of the population. The analysis indicated that the bottom 40 percent of income earners in both years could not afford any contraceptive type or brand except IUDs. Median gross national income has risen substantially in recent years in Georgia, but contraceptive prices have risen even higher. Of greater concern, those in the center of the income scale—the middle class—cannot afford 80 percent of the contraceptives surveyed in 2006.

***Demand***

Demand for contraceptives also has major implications for the level of contraceptive security. If other factors listed in the table above do not change but demand continues to increase, the level of contraceptive security might be even worse in the future. Demand for FP has been significantly increasing over the last several years, as evidenced by contraceptive prevalence rates.

[3] UNFPA in Georgia: Partnership for Progress.
[4] Personal communication, Lela Bakradze, National Programme Officer, UNFPA Georgia.

In light of the above discussion, the level of contraceptive security in Georgia is very low. The major impediment to achieving contraceptive security is the GoG's lack of commitment to FP coupled with low levels of ability to pay. If the poverty rates were lower, Georgians would have had higher access to contraceptives through the commercial sector, and government commitment would have been less critical for the success of the FP program.

# V. RECOMMENDATIONS TO USAID FOR FUTURE PROGRAMMING

The assessment team concludes that the USAID RH/MCH assistance provided in Georgia has been highly successful and has yielded significant achievements in a relatively short time frame. The program accelerated the pace of change in adopting new practices, with broad geographic and population coverage. Providers and consumers have embraced these changes. Despite these improvements, RH/MCH status and programs in Georgia are still immature and deserve further support. Continuation of USAID support with greater strategic focus on RH/MCH will solidify gains and accelerate the pace of change even more. USAID has a strategic advantage to build on many of the gains achieved so far.

In this section we provide specific recommendations for USAID/Georgia's continued support for RH/MCH. The recommendations are presented under two headings: short term and medium term. Short-term recommendations are envisioned for the next 18 months (2008 and 2009) and relate to programming over the remaining life of the HWG and CoReform Projects. Medium-term priorities and recommendations are for the following five years (through 2014) and are provided to assist the Mission in designing an RH/FP strategy and a prioritized action plan.

## SHORT-TERM PRIORITIES AND RECOMMENDATIONS

### Priority No. 1

**HWG needs to invest more effort in the coming months in a broad public relations campaign, to increase public awareness of USAID contributions in RH/MCH.** The projects' significant achievements, particularly in maternal and neonatal care, are highly appreciated by the participating health care managers and providers; they must be widely shared with the broader health sector and the general public, and through mass media (television, newspapers, and magazines) and other channels.

### Priority No.2

**Policy dialogue and advocacy for FP, in particular, and RH/MCH in general, are urgently needed. Family planning is not a priority for the GoG.** The projects should explore and begin implementing strategies to engage a broader array of stakeholders in addition to central GoG officials, such as Members of Parliament in the HWG project areas, local governments, municipalities, NGOs, and the private sector. The highly fluid state of political reforms is absolutely not an obstacle to constituency building, advocacy work, and education for FP at the local and national levels. However, given the widespread concern about Georgia's negative birthrate and out-migration contributing to overall population decrease, and some religious sensitivity about FP, reorienting the rationale for FP to a focus on birth spacing for better maternal and child health is critical. The fluid state of political reforms might be considered an opportunity, rather than obstacle. Examples of types of activities to be pursued at the local level and parliamentary levels might include:

- **Arranging for Members of Parliament to visit improved health faciliti**es in their districts, to learn about USAID support and the positive impact of HWG assistance on services and cost savings. This may help them to become advocates for improved services in all facilities of their district, and at a national level. Invite journalists, as well, to document and report on the visit.
- **Organizing one-day or half-day conferences for senior city officials (mayors and others)** to learn about municipal involvement in supporting health services—for example, Batumi's

reclassification of the "poverty line" to enable more needy people to receive subsidized health services; and the Tbilisi city government's support for breast cancer screening—and also to learn about how improved RH/MCH services have demonstrated better health outcomes for mothers and children while saving money.

- **Organize a working/brainstorming meeting with the members of the National Reproductive Health Council and others about how to raise the profile of FP, RH needs, and MCH issues**—beyond the pages of their excellent policy documents. Get members of the council to commit to one activity each to push the process along.
- **Organize trips for a single influential journalist or groups of journalists** to document the changes in RH/MCH services and interview doctors, nurses, and patients and their families in family-friendly maternity centers and Parents' Schools.

### Priority No. 3

**HWG and the RH Component of the CoReform Project should be required to submit sustainability plans for the remaining life of project (LOP) as soon as possible. Specifically, the projects need to plan to transfer the responsibility and ownership of ongoing activities to local partners.** It is highly advisable that the projects submit a joint sustainability plan. Sustainability of the initiatives supported by these projects is unlikely to be achieved over the next 18 months. A sustainability plan should describe specific long-term sustainability goals, and the activities planned toward achieving these goals over the next 18 months (or LOP). Long-term sustainability goals should cover (but not be limited to):

- Development and institutionalization of in-service training capacity within appropriate local institutions to sustain RH/MCH.
- Development/institutionalization of supportive supervision capacity within RH/MCH clinical settings. Currently, HWG has Georgian consultants who are paid by the project to assist in sustaining supportive supervision. HWG needs to identify and train appropriate individuals who will have a continuing linkage with clinical sites after the project ends. Such individuals might be senior employees (or a director) of the clinical setting, or a *rayon*-level official who has responsibility for the oversight of multiple primary care settings, rather than paid consultants.
- Development, implementation, and institutionalization of preservice education in RH/MCH.
- Dissemination and nationwide use of the Clinical Guidelines and Protocols.
- Internalization and implementation of a revised National Strategic Action Plan.
- Achieving contraceptive security.

### Priority No. 4

**HWG and CoReform should be very focused in the final 18 months:**

- Expansion by HWG to additional areas of RH and MCH, such as breast and cervical cancer screening, should be discouraged during this short time frame.
- HWG should articulate a transition plan for the Healthy Lifestyles for Youth program, describing how the program will be transferred to local partners. Although the program includes HIV/AIDS prevention, it does not include family planning.
- The assessment team has reservations about CoReform initiating work to improve referral systems in this short time frame. It is advisable to wait until the new systems envisioned by the reforms (PHC and hospitals) are in place.

### Priority No. 5

- **Steps toward developing a contraceptive security strategy should begin immediately, and continue in the medium term.** Plans will not work if they are not developed together with, and endorsed by, the Government of Georgia. In some other countries, USAID seeks formal agreements (Memorandums of Understanding) with the host government on the timeline, and the commitment of the host government to purchase increasing amounts of commodities as quantities of USAID commodities are phased downward.

- **Develop, together with the GoG, a five-year plan to phase out USAID contraceptive donations to the public sector, while increasing access to affordable contraceptives through the private sector, for those who are able to pay**. It is vital that the GoG understand that USAID will not provide contraceptives indefinitely and that the Government needs to take over the responsibility of providing contraceptives to the most vulnerable populations (those who cannot pay). It is highly recommended that USAID/Georgia initiate these high-level policy talks with the GoG while the projects intensify advocacy efforts to promote FP and contraceptive security.

- **Dialogue with the GoG can be facilitated with technical assistance from USAID-funded projects.** For example, a cost/benefit study to provide evidence on the impact of family planning could be used as an advocacy tool to convince decision makers of the benefits of providing contraceptives.

- **Phasedown of contraceptive provision based on the contraceptive type.** For example, IUDs could be phased out last since they are more cost-effective (cost per couple-year of protection) than other contraceptives and are not as readily available at the pharmacies as condoms and pills.

- **Market segmentation of the clientele should be initiated to facilitate a smooth phasedown.** Free contraceptives could be limited to those who cannot afford them, while others purchase contraceptives at private pharmacies. All options need to be discussed with the GoG in detail, based on technical assistance/guidance from USAID projects.

- **Expand contraceptive social marketing; it is an effective strategy to promote the private sector's involvement in contraceptive security.** Contraceptive social marketing could be implemented as a general (not contraceptive-specific) promotion of private sector contraceptives. This is the approach currently being used by the HWG project, and could be expanded. Another approach is promotion of a brand-specific contraceptive. CSMA, a local NGO, is implementing social marketing of a low-priced condom (Favorite) with minimal assistance from UNFPA. This NGO reports that it is operating at only 70 percent of capacity, selling 700,000 units per year. When they have more advertising funds, as they have had in the past, they were selling 1,000,000 units per year. CSMA is self-sustaining in procurement and distribution of condoms; however, they currently lack funding for a broader media campaign to promote sales.

- **New advertising themes should be tested, including the theme of child spacing to improve maternal and child health** (see Appendix G, regarding "Three to Five Saves Lives" program strategies).

### Priority No. 6

**A plan for HWG and CoReform assistance to the private insurance companies should be articulated and pursued.** HeSPA will be a common link to all the insurance companies. Also, as relatively new insurance companies grapple with issues of cost and services, Mission support may strengthen HeSPA's hand as regulatory body for improving and maintaining the quality and efficiency of health services. The European Commission's assistance to HeSPA, as described in the "Donor Support" section (pp. 11–12 of this report) should be noted for coordination and to avoid duplication of effort. Possible activities include seminars to present data from HWG activities demonstrating that improved services can go hand in hand with lower costs. This could help insurance companies become advocates for improved services.

### Priority No.7

**HWG and CoReform projects have planned to initiate a Post-Abortion Family Planning (PA/FP) program over the next 18 months; this should be encouraged now and continued in the medium term. A pilot post-abortion program is needed to link abortion clients with FP services to break the cycle of unintended pregnancy and abortion.** Women who have an abortion and risk another unwanted pregnancy are an important group with an unmet need for FP. Providers generally do not offer immediate contraception, and many clients may be told to return for a follow-up visit. Successful PA/FP programs in other countries implemented the following strategies that may be appropriate for the Georgian context:

- A PA/FP pilot program should be launched in a few selected facilities where large numbers of abortions are provided. It is essential that the facility leaders strongly support PA/FP. Based on the lessons learned from pilot sites in 1.5 to 2 years, the model could then be replicated in additional facilities.
- Setting up links between abortion and FP services to improve client flow between the clinics. This is important in Georgia since abortion is provided in inpatient facilities while FP services are provided in outpatient clinics.
- Gaining commitment of decision makers and leaders, and overcoming provider resistance to providing PA/FP services. Often providers have negative attitudes toward PA/FP based on misconceptions. The commitment of decision makers and leaders at the clinical sites is an extremely important criterion in the success of PA/FP interventions.
- An *in-service* PA/FP curriculum can be developed for providers, to include contraceptive technology updates and improving counseling. This is a higher priority than integrating PA/FP into medical education.
- Provision of accurate information regarding use of contraceptives. Abortion clients often lack accurate information regarding use of contraception during the post-abortion period; thus, the integration of a strong counseling component is essential. A successful PA/FP program requires systematic and integrated approaches; there needs to be a strong focus on provider training and educating clients.
- Client information/education materials, specific to post-abortion, need to be developed.
- The program should collect standard and timely data to track and monitor progress.

### Priority No. 8

**HWG and USAID should initiate talks with the local partners and the other donors to integrate the five-day RH in-service training course supported by HWG within the six-month PHC training for the providers.**

### Priority No. 9

**Joint donor support is critical for a national RH/MCH survey for 2010. USAID should initiate talks with the other donors (UNFPA, UNICEF, EU) and local partners. Data provided through these surveys are extremely important for planning and monitoring purposes of all partners and stakeholders in RH/MCH.**

## MEDIUM-TERM PRIORITIES AND RECOMMENDATIONS

The team recommends that USAID support RH/MCH in Georgia for five years beginning in 2009. The support is highly needed to expand priority activities initiated under the current portfolio and ensure that the gains are sustained. We recommend that the Mission consider procuring a new RH/MCH Project in late 2009 for five years. It is highly advisable that the new project begin before the HWG project ends to allow continuity and to avoid loss of momentum gained under the current project. The new activity should be designed as a comprehensive albeit focused RH/MCH project encompassing different components under one leadership. (Documents listed as references in Appendix B of this report will be very useful for the new project design effort, and should be provided to the design team).

The following priorities and directions for a new RH/MCH project are based on the assumption that the Mission future funding will be similar to past/current funding levels for RH/MCH, approximately US$2.5 million annually.

***Strong sustainability focus:*** Elements of sustainability should be an integral part of the project design. The incumbent(s) should be able to define how sustainability of the activities supported by USAID will be achieved in key areas. (See Short-term Recommendation #1 in the previous section). Identification of local partner organizations that will collaborate and eventually assume the ownership and responsibility of the proposed activities, and how and when such transition would occur should be clearly defined.

***Bottom-up approaches*** to influence the health reforms have proven to be effective under the current HWG project and should be continued.

Priority should be given to ***partnering with the private sector***, since private sector institutions will be the main players in the health sector. HeSPA is responsible for purchasing health services from the private sector on behalf of the people of Georgia. Given this critical mandate, the Mission should absolutely reach out to HeSPA. Private insurance companies will need assistance as these companies assume key responsibility for regulating the cost and quality of RH/MCH services in the future. In addition, new private and nongovernmental partnerships should be explored to further RH/MCH services. As health sector reform and privatization move forward in the coming months, some new potential partners may emerge. Seeking support from local governments and municipalities is an area worth exploring, but as a general principle, we recommend that work with the central government, with the exception of HeSPA, be limited to policy dialogue and advocacy efforts.

The extent to which privatized facilities and their investors should receive technical assistance and whether they can be expected to pay for it is, in part, a philosophical and policy question for USAID: whether/how much to subsidize the private sector. The assessment team concluded that the private sector for health—facility owners and investors, service providers, and insurance companies—is generally very inexperienced and unlikely, at this early stage, to pay for technical assistance of unknown value. In the initial stages of privatization, USAID could provide free technical assistance, but over time, companies with continuing interest and the ability to pay might be expected to co-finance technical assistance.

The technical focus of the new project should be on ***two priority areas: FP and maternal and neonatal health.*** The new activity should extend to other areas of RH, such as breast and cervical cancer screening, if USAID ensures adequate funding and that such initiatives could be nationally implemented and institutionalized within the timeline of the project.

The FP component should be designed with a ***strong focus to meet the needs of the younger generations*.** It is more efficient and effective to promote healthier family planning attitudes and practices within the younger generations rather than changing deep-rooted behaviors of the older generation.

***New and more specific themes are needed to promote family planning among policy makers and consumers, such as the health rationale for child spacing*** (see Appendix G for information on "Three to Five Saves Lives," for program and communication information).

***Post-Abortion Family Planning:*** There are indications that a well-planned and implemented post-abortion initiative, probably initiated in the short term by HWG, could have significant impact on lowering abortion rates in Georgia.

***Assisting Georgia to achieve contraceptive security*** should be a centerpiece of USAID's support in the coming years. There are several ways USAID can engage in this important activity:

- Continued provision of contraceptives within a plan of gradual phasedown and eventual phaseout. The assessment team strongly suggests that on completion of the ongoing market segmentation study, USAID should consider provision of free contraceptives only to the poor who could not afford contraceptives from the private sector.
- Policy work/advocacy with MoLHSA and HeSPA for the inclusion of contraceptives in the insured benefits package and creation of a line item for contraceptives in the central budget.
- Support for a media campaign for social marketing of condoms.
- Partnerships with the pharmaceutical companies to expand contraceptive sales, particularly in the rural areas.

### Future Funding Allocation

The assessment team recommends that the proportion of future funding allocated to policy/advocacy/sustainability measures compared to services be a 50/50 split. This is based on an assumption that future funding might continue at the past level of approximately US$2 million to US$S2.5 million annually. If funding availability increases, we would recommend that not less than one-third of the total be allocated for policy/advocacy and sustainability activities. Obviously, something like the social marketing of contraceptives might fall into both the service and sustainability categories, and it is a matter of judgment on the part of the Mission design team to plan for an appropriate mix and balance of activities.

# APPENDIX A. SCOPE OF WORK

## GEORGIA FAMILY PLANNING AND MATERNAL AND CHILD HEALTH SECTOR ASSESSMENT SCOPE OF WORK

**(Mission/GH Tech revised 03–06–08; LOE Table revised 03–31–08)**

## I. BACKGROUND

Georgia continues to struggle with recovery from the economic collapse brought about by the breakup of the Soviet Union. Faced with many challenges, the Government of Georgia (GoG) has embarked on an ambitious health reform agenda that aims to liberalize the economy, improve social services, particularly to the poor, and extend a package of means-tested health services to a percentage of the population that currently has limited access to quality health care. Despite improvements in recent years, and an ambitious reform agenda, health sector financing and government-sponsored programs have lagged behind needs. The slow pace of reforms in previous years has created a gap in access to care by the poor and a high degree of uncertainty about the ability of the health delivery system to simultaneously modernize facilities and deliver quality care while restructuring the mode of financing health care. It is important to note that this approach to health reform is virtually untested within the Europe and Eurasia region.

The lack of visible progress on health care reform has become a key political issue for the January 2008 Presidential elections. In this interim period leading up to the elections, the current government has sought to greatly accelerate the pace of its rollout of health services covered by its means-tested voucher system. It has gone from a highly targeted program for the poor to a broader system that now also covers certain working- and middle-class populations such as teachers, and government employees. A key concern however, is that FP, and to certain degree maternal and child care, remain elusive and ill-defined elements of the current voucher system. Vouchers are being provided to pregnant women that live below the poverty line to cover the cost of normal delivery in the amount of 400 GEL. All other pregnant women may apply for a 200-GEL voucher for normal delivery. In addition, all pregnant women receive four free antenatal visits at 12 weeks and the last visit at 36 weeks.

A 2004 World Bank Study found that both maternal and child mortality remained serious public health threats, and that many of these deaths could be avoided if women had access to adequate care during pregnancy and childbirth. They recommended a service delivery strategy that expanded access to high-quality delivery care, access to emergency obstetric care in case of complications, and a strengthened referral system to ensure that those who experience complications receive life-saving treatment in time.

Since 2001, USAID has been the lead donor in the areas of MCH and FP through its US$10 million, six-year nationwide project designed to modernize maternity and perinatal care and introduce safe, effective FP to avert abortion and improve overall birth outcomes. Healthy Women in Georgia (HWG) and a US$7 million health reform project (Cooperation in Health Systems Transformation, CoReform) that has focused on improving and strengthening the policy and regulatory environment for family planning and reproductive health services, are the two important mission projects that will form the core of this assessment.

HWG is a five-year initiative, launched in 2003, designed to improve RH outcomes in the Imereti, Kakheti, and Kvemo Kartli regions of the country and selected districts of the capital, Tbilisi, and the Guria, Samegrelo, and Shida Kartli regions of Georgia. The goal of the project is to improve women's health, including maternal health, RH, and FP services, through training doctors and pharmacists and conducting community outreach programs aimed at youth and

expecting parents. HWG is being implemented by John Snow Inc. Research & Training Institute (JSI) along with Save the Children and six local nongovernmental organizations: Orthos, Curatio International Foundation, CLARITAS, Caucasus Social Marketing Association, HERA, and McCann Erikson.

The CoReform project provides technical assistance to the Government of Georgia to build its capacity to transform the country's health system into one that is more efficient, accountable, and transparent. The project is designed to assist the Ministry of Labor, Health and Social Affairs (MoLHSA) to improve its health care financing system, support RH and FP services, and strengthen health institutions at the national level. CoReform is being implemented by Abt Associates, Inc., along with Care International and the Curatio International Foundation.

With continuous USAID assistance for commodities and medical equipment and critically needed in-service training, the HWG project has reached 51 percent of the country with its maternal and perinatal care programs, demonstrating that abortion rates can be lowered and maternal and perinatal deaths averted when a number of cost-effective, affordable measures are in place. The key issue, however, is whether these measures will be sustained once the GoG moves from a centrally financed and delivered health care model to an insurance-based reimbursement system of care. CoReform has done extensive analysis of the policy and regulatory environment related to the reproductive health project, and both projects have worked from different angles to advance contraceptive security, and to advocate for a more rationale use of scarce health resources for women and children.

## II. Findings from the USAID/Washington Health Sector Assessment and Mission Internal Management Review

A July 2007 USAID/Washington Health Sector Assessment confirmed the importance of work in the area of health reform while Georgia is undergoing major restructuring. Despite the obvious need to develop appropriate policies in RH, the assessment was less optimistic about the prescriptive of RH policies being high on the GoG's political agenda.

An internal management review of the HWG project carried out in September 2007 documented the project's success in meeting its public health benchmarks, by driving down abortion rates and improving contraceptive prevalence by more than the average 2 percent per year, while improving birth outcomes and reducing the number of cesarean sections. The project has also made some important inroads in educating consumers, private investors, and health insurance companies about the cost savings resulting from FP programs, well-timed births, and reductions in birth complications. The review documented the compelling, continuing need for these services and the local political and provider support for these programs once they have delivered results. The review did not, however, analyze the level of GoG federal financial commitment to these initiatives.

It remains unclear whether USAID-supported services would in fact be incorporated in the GoG health benefits package. Despite improvements in service delivery in USAID-supported regions, there is a need for a clear graduation and transition strategy whereby areas of initial project support would transition to GoG financing for all services and commodities. At the time of both reviews, there were no other donors or partners poised to step into the role to assist the GoG with this transition, and it was unclear how much the GoG's voucher system would reimburse, particularly for family planning services.

## III. Rationale for Assessment

The purpose of this assessment is to lay the foundation for the design of a medium-term RH/MCH strategy and a prioritized action plan aimed at improving the policy environment to sustain FP and MCH services, to improve overall access to FP and MCH services, to enhance equity in use, and to enhance quality of care and improve health outcomes for Georgia's women and children. The assessment will document the steps taken by the GoG and the private sector to finance these vital health services and will analyze the likelihood of sustained funding for these services beyond the scope of existing donor financing. The study will cast a wide net and analyze different tactics to reach service delivery goals that go beyond those already initiated, and help identify a more balanced approach to FP.

The assessment will also inventory the consequences of ongoing GoG health sector reforms and privatization efforts in FP and MCH services, especially documenting successes, and unexpected, unintended, and untoward outcomes. The strengths and weaknesses of the two projects with respect to the fit of their implementation strategies to the intended outcomes of sector reform efforts will also be documented.

The timing of the study, scheduled to begin in mid-March 2008, is also opportune, because the new government has been put in place following the January 2008 Presidential elections. The findings from this assessment will also inform the FY2008 mission operations plan due in April 2008 in advance of Parliamentary elections to be held in May.

## IV. Scope of Work

A two-person team consisting of an internationally recognized RH specialist and a health policy/financing advisor, over approximately a five-week period (three weeks in country, and one week of preparation of, and a week for completion of, the final report), will document the current climate for the operation of privatized maternal and child services in the context of the health reform agenda. The assessment will document changes in demand for FP and MCH services, and the availability of and equitable access to these services.

The assessment should review local health budgets and central subsidies and assess whether continued or additional funding is likely under the new voucher system. Meetings with all key donors should take place. Focus group interviews should take place with health providers who work with USAID and those who do not work with the project to gauge the willingness to adopt modern FP and obstetric measures. Interviews and meetings with the medical establishment (medical schools and key medical associations) should also be held to determine their role in promoting and sustaining the modernization of RH programs.

### Key questions

- What have been the successes, and the unintended and unexpected outcomes of the GoG health sector reform efforts?
- Are the inputs from HWG and CoReform been kept in line with the reform efforts?
- What HWG and CoReform efforts should be expanded, replicated, or scaled-up? Which should be discontinued? What are the gaps in effort?
- What strategies should USAID adopt to promote contraceptive security after USAID and UNFPA support ends?
- What role should USAID and other external partners play in advising the GoG in the area of family planning and maternal and child health?

- Based on the cost analysis for improved services and the proposed GoG budgets for this type of care, what is the likelihood of sustained service delivery over a one-to-two-year time horizon?
- How can donor financing assist in creating a legacy of sustained improvements in reproductive health?

## V. Methodology

The team, in collaboration with USAID/Georgia, will develop an assessment methodology and a work plan during a team planning meeting at the onset of the assessment. The team will conduct interviews and focus group meetings to collect data on provider attitudes and practices, and out-of-pocket expenditures for FP and MCH services including contraceptives, to generate some independent data on financing and consumer demand. Key program documents, GoG health declarations, work plans, and budgets will also be reviewed to determine future funding streams.

## VI. Future Directions for the HSD Portfolio

The team should prepare a list of prioritized strategic measures for USAID consideration in the FY2008 and FY2009 budget cycles that are within USAID's manageable scope and budget and are consistent with GoG plans. Discussions with other donors should also document the future commitments or likely withdrawal from the sector. For each strategic measure proposed, illustrative budgets amounts should be provided, as well as the rationale for the choice and ranking for the intervention.

## VII. Deliverables (timing may change dependent on number of weeks in country and assignment length; will be revised by team in country and shared with Mission)

- **Team Planning Meeting (TPM):** During the two-day TPM, the team will prepare a detailed work plan and data collection instruments to administer to physicians and consumers. The team should also produce in the first week an outline of the final report, and a methodology for assessing the costs of the USAID-financed package of family planning and maternal and child health services.
- At the end of week three, after completion of key informant interviews and site visits, the team will debrief with the senior mission management team on the key findings. The final week in country will be devoted to preparing the draft report prior to departure from country.
- **After departure:** The team leader will submit final unedited content to USAID/Georgia within one week of receiving comments from USAID/Georgia. The report (not including attachments) will be no longer than 30 pages, with an Executive Summary, Introduction, Methodology, Findings, and Recommendations, in English. Upon final approval of the content by USAID/Caucasus (Georgia), GH Tech will have the report edited and formatted. This process takes approximately three to four weeks. The final report will be submitted electronically to the USAID/Caucasus (Georgia) CTO.

## VIII. Team Composition

The two-person team will be led by the population/MCH expert. A minimum of 10 years of field experience is required with both academic expertise in this field and practical senior-level advisory experience for both US government and host country officials. This consultant will serve as the team leader. The team leader will:

- Finalize and negotiate with client the team work plan for the assignment.

- Establish assignment roles, responsibilities, and tasks for each team member.
- Ensure that the logistics arrangements in the field are complete.
- Facilitate the TPM or work with a facilitator to set TPM agenda and other elements.
- Take the lead on preparing, coordinating team member input, submitting, revising, and finalizing the assignment report.
- Manage the process of report writing.
- Manage team coordination meetings in the field.
- Coordinate workflow and tasks; ensure that team members are working to schedule.
- Ensure that team field logistics are arranged (for example, administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.).

The second team member, a health policy advisor, should have strong finance and survey design expertise. Familiarity with review of budgets in Eastern Europe and Eurasia countries is essential. Knowledge of Georgian or Russian is desirable (but not a must). Five to 10 years of field experience in health policy reform is required.

| ESTIMATED LEVEL OF EFFORT, ILLUSTRATIVE | |
|---|---|
| **Activity** | **Total Person-Days (per person)** |
| Make preparations and review documents (to be provided by USAID), to occur out of country and prior to beginning the assessment. | Team Leader/MCH-FP: 3<br>Health Policy : 3 |
| Travel to Georgia. | TL/MCH-FP: 2 days<br>HP: 1 day |
| Plan and conduct a Team Planning Meeting, develop an assessment work plan and timeline, develop interview questions including a list of people to be interviewed, develop report outline. | TL/MCH-FP: 3<br>HP: 3 |
| Conduct key informant interviews and meetings. | TL/MCH-FP: 3<br>HP: 3 |
| Visit field sites. | TL/MCH-FP: 4<br>HP: 4 |
| Finalize outline for the report, team analysis of findings/consensus on conclusions and recommendations, prepare draft report and presentation. | TL/MCH-FP: 5<br>HP: 5 |
| Conduct USAID and/or partner debriefings. | TL/MCH-FP: 1<br>HP: 1 |
| Travel from Georgia. | TL/MCH-FP: 2 days<br>HP: 1 day |
| Report finalization (based on Mission's comments)—to take place out of country for TL. | TL/MCH-FP: 5 |
| **Est. Total LOE: 49 days** | **TL/MCH-FP: 28 days**<br>**HP: 21 days** |

A six-day work week is authorized when working in the field.

## IX. Logistics Support

The mission will provide lodging, but minimal contractor support. GH Tech will be responsible for M&IE and other assessment costs including local travel, translators (if necessary), communications, etc. The team should bring to post laptops to prepare reports. A six-day work week is authorized while working in country.

## X. Point of Contact:

The USAID/Georgia point of contact is:

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Office Phone: +995 32 92 2844 ext 140
Mobile Phone: +995 99 22 8575
Address: 25 Atoneli St, Tbilisi 0105 Georgia

# APPENDIX B. REFERENCES


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# APPENDIX C. SITES VISITED AND PEOPLE CONTACTED

## TBILISI

**USAID**
Robert Wilson, Mission Director
Andrea Yates, Deputy Mission Director
Anne Patterson, Director, Office of Health and Social Development
Tamara Sirbiladze, Health Management Specialist

**Ministry of Health**
Nikoloz Pruidze, Deputy Minister

**Health and Social Fund**
Vato Surguladze, Director

**National Center for Disease Control and Public Health**
Levan Baramidze, Director of Public Health Department

**Tbilisi State Medical University**
Merab Kavtaradze, Chancellor
Nicholas Kintraia, Head of Obstetrics & Gynecology Department

**USAID-funded Health Women in Georgia Program (HWG) JSI R&T Inc.**
Nancy Pendarvis Harris, Chief of Party
Kartlos Kankadze, Deputy Chief of Party
Mariella C. Tefft, Statistical Consultant
Irina Bagrationi, Finance, Administrative and Contracts Officer
Lia Umikashvili, Field Technical Coordinator
Ivane Kumaritashvili, Private Sector Advisor
Darejan Meskshivili, Clinical Supervisor of the Kakheti Region

**USAID-funded CoReform Project**
Lali Beitrishvili, Deputy Chief of Party
Maia Makharashvili, Perinatal Program Manager, CARE International
George Gotsadze, Director, Curatio International Foundation

**UNICEF**
Tako Ugulava, Program Officer
Nino Lordkipanidze, Assistant Program Officer

**UNFPA**
Lela Bakradze, National Program Officer

**World Bank**
Nino Moroshkina

**Caucasus Social Marketing Association**
Irakli Khvedelidze, Director

**Gudushauri Multiprofile Hospital**
Zaza Sinauridze, Senior Executive Officer of the Gudushauri Hospital
Misha Dolidze, Medical Director of the Gudushauri Hospital

**Breast Cancer Diagnostic Center**, **Tbilisi**
Rema Gvamichava, Director, Oncology Center
Levan Jugeli, Director, Diagnostic Center

### People's Insurance Company

Maia Kublashvili, Coordinator of Medical Chain

## WEST GEORGIA, IMERETI REGION:

**Zestafoni Maternity House (MCH site)**
Kote Bochorishvili, Gynecologist

**Maglaki Ambulatory**

**Tskaldubo Maternity House (no-donor assistance site)**

**Healthy Women in Georgia Program (HWG) JSI R&T Inc.**
**Kutaisi Office**
Mary Todadze, Parents' Schools Coordinator, Orthos Fund
Participants in lunch meeting:
Merab Kvitsaridze, Director, Kutaisi Family Medicine Regional Center
Eka Shevieke, Director, Public Health Center, Kharagouli Branch
Kote Gvetadze, Director, NCDC Georgia Imereti Regional Department
David Giongadze, Department Head, Zestafoni Public Health Department
Keti Jugheli, Family Medicine Doctor-Trainer, Insurance Company "Imedi L" Coordinator

**Kutaisi Youth Healthy Lifestyle School Program**
Discussion with peer educators

**Kutaisi Women's Wellness Center (Breast and Cervical Cancer site)**
Lali Gvetadze, Director

**HERA (NGO) based in Kutaisi Women's Wellness Center**
Marine Davituliani, Director

## SAMEGRELO REGION, WEST GEORGIA

**Tsaishi Ambulatory**
David Lolua, Family Doctor

**Zugdidi Polyclinic Hospital, Maternity Ward**
**and Parents' School** (HWG/JSI MCH/ FP site)
Ronald Akhalaia, Executive Director of Hospital
Maternity staff physicians and nurses

**Charity Humanitarian Center Afkhazeti (CHCA) an NGO serving internally displaced persons (IDP)**

**Kortskheli Village Ambulatory** (FP site)
Kvirkvelia Tsira, MD Head

## ADJARA REGION, WEST GEORGIA

**Batumi Primary Health Care Center** (FP site, Training Center)
Tamila – Director, Family Medicine Training Program

**Batumi Maternal and Child Health, Maternity and Women's Consultation Center** (MCH and FP site)
Maya Khukhunaishvili, Deputy Director
Tamar Antelava, JSI Trainer

**Ministry of Health, Batumi, Adjara Region**
Levan Antadze, Minister of Health

**Kutaisi Private Maternity House**
Leri Kronelidze, MD Head Doctor
Irakli Merkviladze, MD Head of Maternity Ward

## KAKHETI REGION, EAST GEORGIA

**Kakabeti Primary Health Care Center** (FP site)
Ketino Gigi Loshvili, Family Doctor

**Kvemo Bodbe Primary Health Care Center** (FP site)
Nino Begiashvili, Family Doctor

# APPENDIX D. PROVIDER INTERVIEW GUIDE

1. What type of reproductive health services do you provide in this facility?

_____
_____

What have you experienced in your clinical practice as a result of the Government's health care reforms, especially in the area of reproductive health care?

_____
_____

2. What changes do you expect in the future as a result of the planned reforms?

_____
_____

3. What type of training have you had in reproductive health services, and who conducted the training?

_____
_____

4. What is the level of demand for family planning services?
NOTE: Probe for attitude toward family planning, e.g., enthusiastic, positive, indifferent, opposed)

_____
_____

5. How many providers are trained in family planning at this facility/clinic?

6. How many staff provides family planning services, e.g, does only one person provide services while others simply refer?

**Working with HWG/JSI: _____Yes _____No**

**If yes, working with the HWG/JSI project:**

7. What are you doing differently in your clinical practice since the project began?

_____
_____

8. What, if any, training did you/others in this facility receive through the project? What was the duration of training, e.g., one week, etc.

_____
_____

9. How would you rank the quality of the training, on a scale of 1–10, with 1 being the lowest quality and 10 being the best quality? _____

10. Are you able to use the skills in which you were trained?
_____Yes _____No

Additional comments, e.g., if "no", what are obstacles to skill use?

_____
_____

If the project ended, what would change with regard to service delivery?

_____

# APPENDIX E. FACILITY CHECK LIST

## CONTRACEPTIVE SUPPLY CHECKLIST

**Location**_____

**Pharmacy Contraceptive Checklist**_____

**Clinic Contraceptive Checklist**_____

What contraceptives are available?

Condoms_____
Price range_____

Oral contraceptives

_____
_____
_____
_____

OC Price range_____
IUDs_____
Injectables_____
Other_____

Have there been stock outs during the last 6 months? ____Yes _____No

If yes, of which commodities? _____

Do you currently have an adequate supply of all types?

_____

Which type(s) of contraceptive(s) is/are in highest demand? Rank order:

_____
_____
_____

# APPENDIX F. HWG Program: Original Agreement, Amendments, Funding Levels

| | PURPOSE<br>Original and Amended | Total Funding (US$) | LOP/End Date Change |
|---|---|---|---|
| Original Cooperative Agreement with John Snow Inc. Research & Training Institute (JSI)<br><br>HEALTHY WOMEN in GEORGIA<br><br>Start: 09/24/03 | Increase access to and quality of women's health services and information. Emphasis on family planning and evidence-based, family-friendly maternity care. Training of providers in family planning, counseling and services, and perinatal care/safe delivery.<br>**JSI subagreement partner activities:**<br>**Save the Children, US:** behavior change communication; **Orthos (Georgian NGO):** development of Parents' Schools in Maternity Hospitals; **Curatio International Foundation (CIF):** health systems improvements, financing, and monitoring and evaluation.<br>Many activities designed as "demonstration efforts" to influence policy and thinking of GoG, reproductive health professionals, and key stakeholders.<br>**Geographic coverage: Imereti: Kutaisi** (regional level), **Zestaphoni, and Chiatura.**<br>(district levels, 10 PHC ambulatories). | $2,999,621 | 3/24/03–<br>3/24/06<br><br>3 years |
| Amendment/Date | Amendment components | | |
| No. 1 4/19/04 | Justification: Exception to competition to add an additional US$2.5 million; **Same activities w/added staff.**<br>**Geographic expansion to city of Tbilisi.** | $5,499,691 | 3/34/06 |
| No. 2 7/02/05 | Addition of funding: US$1,485,250 (ESF and CSH); Extend LOP by 15 months; **New objective:** ensure availability of and access to contraceptives; additional JSI partnerships with local NGOs: **CLARITAS and Caucasus Social Marketing Assoc (CSMA).**<br>**Expanded scope:** Contraceptive access/logistics support (CALI), contraceptive commodity procurement; CDC/PASA to provide health/epidemiological training component. | $6,630,646 | 5 years<br>3months<br>12/31/07 |
| No. 3 6/06/06 | Increase funding by US$1,750,000; extend LOP to 5 years; **Expanded objective:** Scaling-Up Reproductive Health Efforts (SURE). **New activities:** Increase FP/RH services.<br>**Geographic expansion: Imereti and Kakheti.** | $7,589,871 | 5 years<br>9/24/08 |
| No. 4 2006 | **Increase level of funding by US$250,000.**<br>**Geographic expansion to conflict areas of Abkhazia and South Ossetia, and cities of Zugdidi and Gori.** | $7,879,931 | 9/24/08 |
| No.5 7/06/06 | Exception to competition for new funding and expanded scope re previous amendment # 3. | | |
| No. 6 7/05/07 | **Addition of funds by US$2,752,000; extend LOP for 1 year.** | $10,631,931 | 6 years<br>9/24/09 |
| No. 7 7/15/07 | **Approval to authorize exception to competition** for previous amendment Attachment A: HWG and Health Care Reform, a JSI document regarding HWG's current /planned activities related to health care reform. | $10,631,931 | 6 years<br>9/24/09 |

# APPENDIX G

## CONSIDER FP/CHILD SPACING STRATEGY/PROGRAM: *THREE TO FIVE SAVES LIVES*

### Couples who space their births three to five years apart increase their children's chances of survival, and mothers are more likely to survive, too, according to new research.

Over the years, research has consistently demonstrated that, when mothers space births at least twoyears apart, their children are more likely to survive and to be healthy. New studies show that longer intervals are even better for infant survival and health and for maternal survival and health as well. Children born three to five years after a previous birth are about 2.5 times more likely to survive than children born before two years.

**New Evidence** A 2002 study by researchers at the Demographic and Health Surveys (DHS) program finds that children born three years or more after a previous birth are healthier at birth and more likely to survive at all stages of infancy and childhood through age five. The study uses DHS data from 18 countries in four regions and assesses outcomes of more than 430,000 pregnancies.

Among the findings: Compared with children born less than 2 years after a previous birth, children born three to four years after a previous birth are:

- 1.5 times more likely to survive the first week of life;
- 2.2 times more likely to survive the first 28 days of life;
- 2.3 times more likely to survive the first year of life; and
- 2.4 times more likely to survive to age five.

**Mothers Benefit Too** A 2000 study by the Latin American Center for Perinatology and Human Development reinforces the DHS findings about children, using data for over 450,000 women. It provides some of the best evidence yet that spacing births further apart improves mothers' health. Among the findings: Compared with women who give birth at 9-to-14-month intervals, women who have their babies at 27-to-32-month birth intervals are:

- 1.3 times more likely to avoid anemia;
- 1.7 times more likely to avoid third-trimester bleeding; and
- 2.5 times more likely to survive childbirth.

While the biological and behavioral mechanisms that make shorter birth intervals riskier for infants and mothers are little understood, researchers suggest such factors as maternal depletion syndrome, premature delivery, milk diminution, and sibling rivalry. Studies suggest that shorter birth intervals may not allow mothers time to restore nutritional reserves that provide for adequate fetal nutrition and growth. Fetal growth retardation and premature delivery can result in low birth weight and greater risk of death.

For more information, please visit
http://www.ghtechproject.com/resources/

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