

Georgia Global Health Initiative Strategy



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Background Statistics

Geography

Area: 69,700 square kilometers; slightly smaller than South Carolina; approximately 20% of its total territory is not under Georgian Government control.

Cities: *Capital*--Tbilisi (population 1.1 million, 2010).

Terrain: Mostly rugged and mountainous.

Climate: Generally moderate; mild on the Black Sea coast with cold winters in the mountains.

People

Nationality: *Noun and adjective*--Georgian(s).

Population (2010 est.): 4.6 million.

Population growth rate (2009): -0.3%.

Ethnic groups (2002 census): Georgian 83.8%, Azeri 6.5%, Armenian 5.7%, Russian 1.5%, other 2.5%.

Religion (2002 census): Orthodox Christian 83.9%, Muslim 9.9%, Armenian Apostolic 3.9%, Catholic 0.8%; other 0.8%; none 0.7%.

Language: Georgian 71% (official), Russian 9%, Armenian 7%, Azeri 6%, other 7%. Abkhaz also "official language" in Autonomous Republic of Abkhazia.

Education: *Years compulsory*--9. *Literacy* (2004 est.) 100%.

See <http://dashboard.healthsystemsdatabase.org/> for more Georgia health statistics.



Rationale and Vision for the Global Health Initiative (GHI) in Georgia

The U.S. Government's (USG) vision for Georgia under the Foreign Assistance Framework for "Investing in People" is to contribute to the improved health and well-being of all Georgians, but especially the poor and disadvantaged, with the overall goal of achieving a peaceful, prosperous and democratic Georgia. The Global Health Initiative (GHI) in Georgia is part of the U.S. Mission in Georgia's "whole-of-government" plan using development, diplomacy and defense, and represents in itself a whole-of-government health strategy. The GHI Georgia Strategy will assist the Government of Georgia (GOG) in managing sustainable, high-quality, equitable health services for the Georgian people. USG health assistance will augment GOG efforts to reach its Millennium Development Goals (MDG) for health as articulated in GOG Health Sector Plan II (2010-2015), particularly to reduce maternal and child mortality – MDG 4 and 5. USG assistance will also contribute to MDG 6 – to halt and begin to reverse the spread of HIV among most at risk populations, and halt and begin to reverse other major diseases, such as Tuberculosis (TB).

Progress in the health program area is critical to U.S. foreign assistance priorities, as a healthy population, besides being a goal in itself, is also required for an economically and politically stable society. In 2007 the GOG embarked on a new health sector reform strategy by turning to market mechanisms to improve access to health care, upgrade infrastructure, improve the quality of health care services, and increase the efficiency of service provision. They pursued a three-pronged strategy that has evolved to respond to the impacts of the 2008 war with Russia and the global economic recession: better means-tested targeting of public resources to address the health needs of the poor and disadvantaged; increased privatization of health care providers (including hospitals and primary health care facilities); and an enhanced role for private health insurers. The USG supports the GOG's health reform efforts to improve the health status of the population and increase the quality of, access to, and satisfaction with health services. U.S. assistance fills the development need to maximize effectiveness of limited government funds for health and develops a regulatory framework ensuring health sector privatization initiatives positively impact access to and quality of services for target populations.

Among the continued health care challenges in Georgia are high infant mortality, lack of adequate family planning (FP) and reproductive health (RH) services, high abortion rates, high prevalence of tuberculosis (TB), an emerging HIV/AIDS epidemic, limited access to and un-affordability of essential health services, low quality of clinical care, and low public expenditures on health. There are problems associated with water supply, utility management and financial solvency, institutional capacity, chronic under-financing and the resultant deterioration of potable water supply system infrastructure. Georgia's rate of 3.1 abortions per woman is among the highest in the world. 26% of married women use modern contraception. At the rate of 1.6 children per woman, fertility is well below replacement level. Low fertility and a high infant mortality rate in Georgia, 21 per 1000 according to various sources, makes support for improved maternal and child health (MCH) of vital importance.

The TB treatment success rate of 70% still falls short of the WHO recommended target of 85%. This gives rise to multi-drug resistant TB (MDR-TB). The limited capacity of national health services, the emergence of MDR-TB, and the link with HIV/AIDS pose a threat to the success of economic and democratic reforms and require further assistance. While Georgia remains a low HIV prevalence country, the existence of risk factors including widespread injecting drug use and sustained conflict areas within the country, place Georgia at risk for a growing HIV/AIDS epidemic. A rapid increase in HIV infection rates would

increase health care costs with direct and damaging impacts on economic progress and stability in the country.

More than 60% of the population lacks insurance coverage and is destined to pay out of pocket for health services. Those older than 60 years of age are provided with a limited health service package, not protecting them from catastrophic health expenditures. Essential medicines are only partially covered through the publicly paid private health insurance policies. Many of the beneficiaries of public health care programs are not aware of their entitlements, ultimately not benefiting from the available services. The health information system is not available to provide timely and accurate data to support evidence based decision making.

Recognizing that Georgia is in a position to initiate development of a graduation/phase-out plan for its health programs, implementation of the GHI strategy over the next five years will be critical to maximizing sustainability of current and past USG program investments. *The vision for the GHI strategy is therefore to improve the health status of the population through strengthened stewardship and responsiveness of the health sector, by supporting the twin pillars of increasing demand for quality services, and improving the local capacity to supply those services.* In this vision, GHI/Georgia will work to build the management and technical capacity of both the public sector health care system as well as the private health care sector and insurance providers. In doing so, the USG will support the GOG goals of reducing maternal and infant mortality and reducing the incidence of critical infectious diseases such as TB and HIV/AIDS.

The USG health program in Georgia also serves as a model for other USG country programs to learn how to ensure sustainability through private sector engagement and leveraging of non-USG resources. Innovative approaches such as development credit authority (DCA) loan guarantees for private sector investment in the health sector, US-Georgia university partnerships in health management and nursing education, and partnering with private hospitals for the implementation and sustainability of approaches such as effective perinatal care (EPC), all serve as models that could be replicated around the world.

In the spectrum of GHI countries, Georgia stands out as three-quarters of the way on the trajectory of having had demonstrable success in graduating USG programs. One example of successful graduation of a USG health program is the support to the National Immunization Program (NIP). USAID awarded UNICEF three consecutive agreements from 2000- 2008 with total funding of \$2,336,124 in support of routine immunization services in Georgia. The long-standing partnership included supply assistance (vaccine/injection safety supplies), advocacy and policy development, institutional and human capacity building (cold-chain, IT equipment, NIP staff training), logistics support for outreach services, Information Education and Communication (IEC), and monitoring and evaluation.

USAID assistance extended and maintained the overall immunization coverage for six major antigens: DPT3, OPV3, Measles and BCG vaccination. As a result of this assistance, Georgia received Polio Free Certification in July 2002. Incidence rates of Diphtheria were reduced from 7.9 per 100,000 in 1995 to 0.49 per 100,000 in 2001 and went down to 0 cases in 2010. Measles incidence rates reduced from 13.27 per 100,000 in 1994 to 0.79 per 100,000 in 2001 and 0.5 per 100,000 in 2010.

Most notably this collaboration achieved visible progress in country ownership and sustainability. Georgia started replacement of 20% share of traditional vaccines in 2003, ensured procurement of 30% in 2004, covered 40% of the vaccine costs for the 2005 program, 70% in 2007 and completely took over

funding the program in 2008. The evidence of the successful graduation of the NIP program in Georgia is sustained immunization coverage rates (over 80%), decreasing trends of vaccine preventable diseases (VPDs) and polio-free certification.

In order to successfully graduate all areas of USG health assistance in Georgia and ensure sustainability of USG achievements, it is vitally important that the USG finish the good work started. The USG program in Georgia is on track to achieve sustainable change in the health sector, which will be the foundation for further economic development and sustained democracy in the country.

Background on the Georgia Context and Challenges Affecting Health

The independent Republic of Georgia was established on May 26, 1918, in the wake of the Russian Revolution. Pro-Menshevik Prime Minister Noe Zhordania and a social-democratic government led the country until March 1921, when it was occupied by the Bolshevik Red Army. Georgia became a Soviet Socialist Republic the following year. On April 9, 1991, shortly before the collapse of the Soviet Union, the Supreme Council of the Republic of Georgia declared independence from the U.S.S.R. Like other former Soviet Republics, Georgia's newly declared independence was followed by ethnic and civil strife. Secessionists took control of parts of South Ossetia and most of Abkhazia prior to cease-fire agreements brokered in 1992 and 1994, respectively. Georgia began to stabilize in 1995. However, the separatist conflicts in Georgia's regions of Abkhazia and South Ossetia remain unresolved. Periodic flare-ups in tension and violence culminated in a short war in August 2008 between Russia and Georgia. French President Nicolas Sarkozy negotiated a cease-fire between Presidents Mikheil Saakashvili and Dmitry Medvedev on August 12, 2008 which remains in effect. As part of the Saakashvili-Medvedev cease-fire agreement, the European Union established the EU Monitoring Mission (EUMM), which patrols the Georgian side of the administrative boundary lines with Abkhazia and South Ossetia but does not have access into those regions of Georgia. The cease-fire also called for international peace talks on the situation, which have taken place regularly in Geneva since October 2008 among the EU, United Nations (UN), Organization for Security and Cooperation in Europe (OSCE), Georgia, Russia, and the United States, with the participation of representatives from Abkhazia and South Ossetia.

Health situation in Georgia

Family Planning (FP): Georgia continues to have low modern contraceptive prevalence rates and high rates of abortion. Only 26% of married women use modern contraception. The 2005 Reproductive Health Survey found Georgia to have a rate of 3.1 abortions per woman, which is amongst the highest in the world. A key feature of Georgia's abortion pattern is that decisions to abort increase significantly with each new pregnancy. Only 1% of first pregnancies end in abortions, while 28% of second pregnancies and 58% of third pregnancies end in abortion.

Maternal and Child Health (MCH): Georgia faces the possibility of steep demographic decline, which could upset long-term economic growth and threaten the provision of government services. In addition to steady out-migration, low fertility and lingering, preventable infant and maternal mortality contribute to population decline. At 1.6 children per woman, fertility is well below replacement level. Maternal, infant, and under-5 mortality rates are high with 49 per 100,000; 21 per 1,000; and 32.7 per 1,000 deaths respectively. Georgia's early neo-natal mortality rate of 12.1 is triple the U.S. rate. The combination of low fertility and high infant and maternal mortality makes support for improved maternal and child health (MCH) a matter of national security in Georgia.

HIV/AIDS: Since 2006, the number of registered HIV cases has tripled, and, as of the end of April 2011, it has reached 2,819. There is a high potential for a rapid rise of HIV infection due to widespread use of injecting drugs and migration between Georgia and neighboring high-prevalence countries. HIV is currently detected more commonly among the most at-risk persons (MARPs) groups, such as injecting drug users (IDUs); commercial sex workers (CSW); men who have sex with men (MSM); and “bridge” populations - clients of CSW, partners of IDUs, military, and youth. As of April 2011, injecting drug use accounts for 56% of all cases with a known route of transmission. In addition, the Behavior Surveillance Survey (BSS) conducted among MSM in Tbilisi in 2010 has shown that HIV prevalence among MSM reached 6.4%, meaning that the MSM sub-group has reached a concentrated epidemic stage. An analysis of the total expenditures on HIV/AIDS in Georgia revealed that the share of funds spent on treatment and surveillance is increasing at the cost of a declining share for prevention. According to the National AIDS and Clinical Immunology Research Center, the number of patients on anti-retroviral treatment (ART) is anticipated to triple in 2013 compared to 2010. In addition, WHO issued new treatment guidelines in 2009. These changes in treatment regimen will increase treatment cost per patient. All the above will lead to the inevitable increase in the amount of funds needed from the Global Fund to cover AIDS treatment. This will further deepen the already existing funding gap in HIV prevention services in Georgia. Furthermore, due to the global financial crisis, the Global Fund recently introduced new prioritization rules that are expected to adversely affect lower-middle income concentrated HIV epidemic countries like Georgia. Georgia is at risk of losing future Global Fund resources for HIV/AIDS. Ongoing technical assistance is necessary to help Georgia to plan for this major change.

Tuberculosis (TB): The TB epidemic in Georgia is characterized by high rates of multi-drug resistant TB (MDR-TB), including extensively-drug resistant forms of TB (XDR-TB), and HIV/AIDS-TB co-infection. Successful control of TB in Georgia, as elsewhere, requires: (1) rapid identification (case detection) and successful treatment of those with active TB; and (2) stringent infection control procedures to prevent the spread of TB and the development of drug-resistant strains and co-infection with HIV. The GOG’s National TB Program (NTP) has made good progress in TB case detection. However, the treatment success rate of 70% is still lower than the WHO target of 85%.

Neglected Tropical Diseases: Surveillance for visceral leishmaniasis shows resurgence of this disease in Georgia. Over 600 new cases were diagnosed between 2006 and 2009. West Georgia is reporting this disease for the first time since surveillance was initiated in the 1920s. Brucellosis in cattle, sheep and goats remains a problem in Georgia. This is an important animal disease worldwide and results in millions of dollars of loss to regional economies.

Health Systems: Since 2003, there has been a dramatic increase in public spending on health care, although this increase has not kept pace with overall public spending or GDP growth. Market mechanisms have been introduced to enhance competition, efficiency, quality, and customer satisfaction. Hospitals are being privatized countrywide, with insurance companies and other private sector investors building or renovating outdated and dilapidated hospitals in almost every district of the country. Although Georgia has an excessive number of physicians, there has been little or no re-training of skills over the past forty years. Georgia’s current health management information system does not allow for monitoring of the population health status, tracking the value of money spent by GOG on health services, or using data for informed decisions.

Vulnerable Populations:

Poor: The Ministry of Labor, Health, and Social Affairs (MoLHSA) defines poverty based on a special methodology of valuating assets and income of the applicant household. Those households that are given a score of 70,000 or less, are entitled to health insurance vouchers. In addition, households with a score of less than 57,000 receive a monthly monetary subsidy. Vulnerable groups also include those families with a poverty score of 70,000 to 100,000. These families are not much different from those with less than 70,000 points, but are not eligible for state health insurance coverage.

IDPs: There are about 260,000 Internally Displaced Persons (IDP) in Georgia, expelled from their homes as a result of conflicts in Abkhazia and Tskhinvali Region. Some IDPs, residing in the newly built IDP settlements (~16,000), are entitled to government paid health insurance, while others remain uninsured.

Ethnic Minorities: Despite integration efforts by the GOG, many of the Armenian and Azeri ethnic minorities residing in Kvemo Kartli and Samtskhe-Javakheti regions, mostly due to language barriers, do not fully benefit from governmental social services.

Persons with Disabilities: About 140,000 persons with disabilities are registered and receive state disability pensions. Many of these people cannot afford access to health services.

Table 1: Key Health and Population Indicators in Georgia

Indicator		Source
Population	4.436 million	http://www.geostat.ge/
Per Capita Income	\$2,840 (2010)	http://www.geostat.ge/
Life expectancy at birth	Men: 69.2 Women: 77.7	http://www.geostat.ge/
Fertility rate	1.6	Reproductive Health Survey, 2005
Contraceptive Prevalence Rate (CPR)	27% modern contraceptive prevalence rate	Reproductive Health Survey, 2005
Unmet need for family planning	44%	Reproductive Health Survey, 2005
Abortion Rate	3.1	Reproductive Health Survey, 2005
Maternal Mortality Rate	49 per 100,000 live births	Georgia National Center for Disease Control (NCDC), 2009
Neonatal Mortality Rate	12.5 per 1000 live birth	Georgia National Center for Disease Control (NCDC), 2009
Infant Mortality Rate	14.1 per 1000 live birth	Georgia National Center for Disease Control (NCDC), 2009
Under 5 Mortality Rate	15.4	Georgia National Center for Disease Control (NCDC), 2009
TB Incidence	MDR and XDR detected in 11.6% of the new cases and in 40.3% in previously treated cases in 2008	National TB Program, 2010
HIV Prevalence	0.1%, with Injecting Drug Users (IDU) as the main transmission risk group. The latest trend is that prevalence is slightly decreasing through injecting drug use 59.8%, and is increasing via unprotected heterosexual intercourse 32% (majority of these cases are among partners of IDUs).	National AIDS Center, 2011
# of people with health insurance coverage	1.6 million	http://www.nbg.gov.ge/

Country-led Five Year USG/GHI Strategy, Priorities and Targets

While Georgia has made significant achievements through ongoing reform efforts, significant institutional and systemic challenges remain in the health sector. Georgia's HIV/AIDS prevalence rate has grown at a slow but steady pace, its abortion rate is among the highest in the world, and the emergence of MDR and XDR-TB is alarming. Infectious diseases and poor health care services undermine economic growth, drain the GOG's resources, and threaten to weaken public confidence in the democratic process. Although the GOG has made progress in rebuilding the healthcare system, more needs to be done. Continued improvement of the sector is needed to provide the social stability and the rising standards of living necessary for the GOG to maintain its path of democratic reform.

GHI Goal: *Improved health outcomes & decreased incidence of communicable disease*

Intermediate Goal: *Strengthened stewardship and responsiveness of the health system*

The Georgian government plays a very active and strong role in setting priorities and providing services in collaboration with other donors and the private sector. In recent years, the GOG has initiated a privatization program in the health sector aimed at reducing costs and providing services across the range of programmatic needs in the country. During this time of transition, it is critical that the government remain a strong 'steward' of the health sector – that is, continuing to actively manage the transition process to ensure that a privatized health sector continues to provide comprehensive, quality health care in an equitable fashion. The privatized system must be responsive to the changing needs of the Georgian people across a range of health care issues from quality maternal services, to complex regimens for HIV/AIDS and MDR/XDR TB. Similarly, the private sector needs to be managed so that it finds ways to provide these services equitably to all Georgians, regardless of socio-economic status and ethnic origin. The stewardship role of the Georgian government will be critical to ensure these features and to remain vigilant so that the new private health sector can grow in a flexible, equitable, and comprehensive way to meet the future needs of the Georgian population.

Results Framework Focal Areas

Focal Area 1: Equitable Utilization of Quality Health Care Services

Improvement of health outcomes in Georgia remains a continuing challenge, especially for the most vulnerable populations. Appropriate, equitable and timely utilization of quality health services is a key proximate determinant of health status. Health services utilization rates are the lowest in the World Bank European and Central Asian (ECA) region with less than two outpatient visits per capita and less than five inpatient visits per 100 people. Out-of-pocket payments for treatment are still a major barrier to seeking care. Illness is one of the causes of falling into poverty, as 10 percent more individuals fall below the poverty line after incurring hospitalization expenditures.

The first objective of the GHI strategy is to increase the equitable utilization of quality health services to reduce maternal and neonatal mortality, increase the use of reproductive health and family planning services, and decrease the burden of infectious diseases in Georgia. Increased utilization of quality health services will also help protect against catastrophic out-of-pocket expenses to individuals due to illness and reduce costs to the entire healthcare system. As USG assistance moves towards phase-out, we will focus our efforts on the most vulnerable populations throughout the country. This objective will be achieved by:

Improved health infrastructure to increase demand. Currently, many health services in Georgia are outdated and ineffective. If the quality of such services is improved, people will utilize them more. Health workers will learn and adhere to evidence-based clinical protocols with better managed services and quality assurance systems in place. Quality improvement activities will include changing provider attitudes and norms and partnering with the private sector to upgrade infrastructure throughout the country.

Increased health promotion practices in public and private sectors by assisting health insurance companies to include health promotion incentives in insurance plans and by disseminating evidence-based clinical practice **guidelines** and drug prescribing practices to healthcare providers. The USG will also continue to support national communication campaigns in the areas of HIV/AIDS, family planning and reproductive health, and tuberculosis. The USG will continue to build the capacity of the National Centers for Disease Control (NCDC) to plan and manage these campaigns independently in the future.

Improved use of insurance schemes to cover health care costs by strengthening the capacity of private insurers and health care providers to provide quality health insurance and health care services; strengthening the capacity of the government to guide and monitor the health reform process; and educating insurance and health care consumers on their rights and responsibilities.

Focal Area 2: Individual, Institutional and Systems Capacity Building

Despite the efforts by MOLHSA and international donors, major gaps remain in the capacity of individuals, institutions, and systems to deliver high quality services in Georgia. Malpractice results in high case-fatalities, sub-optimal health outcomes, and high costs to the healthcare system. The public health disease surveillance and laboratory systems have been enhanced with new facilities, but development of human capacity in evidenced-based approaches to disease investigation and control is still substantially below where it needs to be to achieve efficiency and sustainability.

The MOLHSA discontinued its specialist physician licensing program due to weak and inappropriate management practices. Physicians could too easily obtain certification without being properly tested. Similar to the licensing program, the continuing professional development program is weak and not effective in ensuring provider skills keep pace with medical advancements. The MOLHSA has established procedures for approving and updating clinical protocols and drug prescribing practices, but the number approved is far short of the number needed. The ministry has approved clinical practice guidelines (CPG) for 60 cases, most developed with the assistance of donor organizations. Many of those already need to be updated, and many more new ones are needed.

Georgia lacks an effective national health information system to provide timely, reliable demographic, epidemiological, clinical, service use and financial information needed to monitor the health reforms, inform decision making, ensure continuity of patient care and permit the efficient management of the privatized health system.

To date, the USG has addressed gaps in the capacity of individuals, institutions and systems through strengthening the provision of quality perinatal health services, building family planning/reproductive health modules and practicums into medical and nursing school curricula, creating modern training opportunities for emergency physicians and nurses, providing technical assistance and supportive supervision to infectious disease healthcare providers, and strengthening the capacity of professional medical and hospital associations to play a more active role in setting up health care standards and ensuring higher quality services. The USG assists insurance companies and health service providers to

standardize their relationships; set up payment and reporting schedules; develop and introduce standardized disease classification, coding systems and treatment guidelines; and incorporate health promotion and preventive examinations into insurance policies. All of these interventions have demonstrated that evidence-based, optimized care, can significantly improve health outcomes and reduce costs. For example, through implementation of effective perinatal care (EPC) practice methodologies at several maternity hospitals across Georgia, birth complication rates decreased dramatically and costs were reduced by 25%. In another example, training of emergency physicians from Kipshidze Central University Hospital (KCUH) has led to significant reduction of hospital-acquired infections in KCUH's emergency wards.

Recognizing that building capacity must happen not only at the level of the individual health care worker, but also within the systems and institutions in which they work, the USG will work in partnership with the following groups to achieve this GHI objective:

Individual: Healthcare professionals, nurses, epidemiologists, laboratory managers, and veterinarians

Institutional: MOLHSA, NCDC, private sector insurance providers, laboratories, academic institutions, professional associations, and civil society organizations

Systems: HMIS, EIDSS; and Integrated Disease Surveillance & Response

The second objective of the GHI strategy is to build the capacity of individuals, institutions, and systems in Georgia. This objective will be achieved by:

Strengthened human resources for health by providing training to healthcare providers to learn and adhere to evidence-based clinical guidelines; improve access to clinical equipment; and better managed physical facilities. Training of nurses will ensure better and more efficient patient care, including reduction in hospital-acquired infections and complications. Training of public health and veterinary health specialists will develop technical capacity in scientific approaches to disease surveillance and response. By using a classroom curriculum in epidemiologic methods, biostatistics, disease surveillance and outbreak investigation, public health communication (writing, oral presentations), health economics, rapid survey methods, geographic information systems, teaching skills, and mentoring by senior advisors from CDC, the capacity of MOLHSA and MOA/SVS to address practical problems will be developed.

Strengthened strategic information for evidence-based decision making by training of laboratory professionals to diagnose infectious diseases reliably. Supporting the full implementation of the electronic integrated disease surveillance system (EIDSS) for rapid reporting of disease and analysis of disease patterns and risks, helping to inform and evaluate disease control strategies and improve decision making. Supporting national surveys such as the RHS and the BSS; improving the infectious disease surveillance system through DTRA investments to improve the detection and response capabilities of the national authorities.



Strengthened healthcare management in public and private sectors by implementing more transparent and accountable medical intervention classification systems and more efficient provider payment systems; strengthening the management skills of health insurance and healthcare providers; creating a database of insurance clients and strengthening the capacity of insurance companies to detect and prevent fraud; developing and implementing the essential drug lists; and developing a national Health Management Information System (HMIS) to better inform policy-makers and facility managers on health status and trends. The USG will support institutionalization of systems to support service provision at national and local levels. At the national level, there will be improved policies, standards, and quality assurance programs for FP/RH, infectious diseases (including STI/HIV/TB), and maternal health, as well as nationwide information/education activities that promote behavior change and healthy lifestyles. The capacity of MOLHSA and other Georgian health sector institutions will be strengthened to take a leadership role in policy development and analysis, management, health economics and planning in order to implement the reform process.

Expected results of Global Health Initiative in Georgia

Health Systems Strengthening

- Increase in utilization of essential health care services by lowest income quintile population group by 50%;
- Development and implementation of the essential drug list (EDL) ;
- Development and operationalization of the national Health Management Information System (HMIS);
- Sustain number of persons covered by government insurance at the current level;
- Increase the number of people with voluntary health insurance coverage by 50%;
- At least 10 medical facilities renovated/constructed with the funds leveraged through USAID credit guarantees

HIV/AIDS

- Increase coverage of interventions aimed at IDUs to 60% (from the current 20%) to impact group-level behavior change;
- Increase access to VCT by 30% among all risk groups by expanding access to services;
- Preserve prevalence in each risk group (IDUs, MSM, and FSWs) under 5% to maintain low prevalence status in the country;
- 80 % of general population seeing stigma reduction campaign messages;
- 60% of health providers reached with HIV/AIDS stigma reduction messages;
- Healthy Lifestyle course is incorporated in national education plan and is institutionalized;
- Awareness about HIV increases by 40% across baseline in all risk groups;
- Safe sex and injecting practices improved by 30% across baseline in all groups;
- Key legislation or national policies affecting HIV/AIDS revised

TB

- Achieve the WHO goal of 85% treatment success rate (from the current 70%);
- Reduce the nationwide patient default rate to less than 10%;
- Increase National TB Program patient referrals from general practitioners to 40%;
- Reduce incidence of TB to 70 cases per 100,000 persons (from the current 134 new pulmonary cases per 100,000 population);
- Sustain high accuracy in laboratory diagnostic services;
- Reduce the number of MDR and XDR cases that must be treated with expensive 2nd line drugs;
- Reduce the spread of TB in the general population by increasing early case detection;
- Reduce stigma of TB in the general population and raise awareness of early symptoms of TB;
- Incorporate TB detection modules and practicum into medical and nursing school curriculum;
- Guide financing policy decisions to assure long-term sustainability of TB prevention

Family Planning

- Increase modern method contraceptive prevalence to 40% by expanding access to services and contraceptives (current modern method prevalence is 27%);
- Major nationwide communications campaigns launched with focused messages for married couples and youth on: 1) the benefits of child spacing, 2) two parent families with strong male involvement and the dangers and consequences of domestic violence; and 3) family planning saves lives campaign;
- New contraceptive products introduced through commercial pharmacies and other retailers. May include new oral contraceptives, implants, IUDs, the vaginal ring, and the Patch, a high quality commercial condom;
- Three major commercial pharmaceutical suppliers lower prices of key contraceptives products in return for product and category specific market research and advertising;
- At least one pharmaceutical supplier develops local production of a contraceptive product.

Maternal and Child Health

- Decreased Maternal Mortality from 49/100,000 to 15/100,000¹;
- Decreased Infant Mortality from 14.1/1000 to 8.1/1000²;
- 85% of births covered with EPC practices; at least 55 facilities (which currently constitutes 55% of maternal facilities) implementing EPC practices;
- Sustained support of maternal facilities by the GoG and private sector.

Neglected Tropical Diseases

- Specific recommendations for improving surveillance of visceral leishmaniasis related to: collection of samples, use of diagnostic methods, flow of surveillance information, and plans for routine analysis;
- Analysis of factors associated with increased reports of visceral leishmaniasis in the last 10 years
- Identified geographic areas or groups of persons at increased risk;
- Control strategies identified and implemented.

Government of Georgia Response and Health Sector Reform

Starting from 2004 the Government of Georgia (GOG) has dramatically increased its budget allocation for the health sector. In 2003 public spending on health constituted 0.6% of GDP. While still very low as compared to developed nations, in 2010 the figure reached 1.8%. Starting in 2007, the GOG initiated a new round of bold reforms in the health care sector, relying on market mechanisms to increase the population's access to health care; improve the quality of care; and increase the efficiency of service provision. The reforms consist of privatization of health care infrastructure, targeting of the most vulnerable population groups with comprehensive health insurance coverage, channeling of public funding to targeted vulnerable groups through private insurance companies, reducing health sector regulation to an essential minimum, and retaining the most essential public health functions as governmental responsibility.

Four years after the initiation of reforms, 1.2 million people (out of approximately 4.6 million total country population) are covered by health insurance by private insurance companies through public funding. In addition, more than 400,000 Georgians now have private voluntary (corporate or individual) health insurance, as compared to 40,000 in 2005. The hospital privatization process that was stalled in 2008 due to the Russia-Georgia conflict and financial crisis has now been redesigned by the GOG and is underway. Largely due to limited insurance literacy of beneficiaries and their inability to differentiate between offerings of various insurance companies, the GOG last year decided to replace the voucher mechanism with a new tender mechanism. The entire country was divided into 27 health care districts, and insurance companies were invited in March 2010 to compete for the opportunity to provide health insurance to the eligible poor for a period of three years in each of the country's health care districts. Along with the obligation to provide the state-defined health insurance package, the bidders were also requested to build small hospitals in designated districts by September 2011.

Despite these major achievements, several challenges still remain in the system. About two thirds of the country population lack insurance coverage and are destined to pay out of pocket for health services. Serious illness in an uninsured family often leads to impoverishment. Those older than 60 years

¹ Reducing by three-quarters the maternal mortality ratio is the Georgia's national MDG Goal 5 target (http://undp.org.ge/index.php?sec_id=65&lang_id=ENG).

² Reducing by two-thirds, by 2015, the under-five mortality rate is the Georgia's national MDG Goal 6 target (http://undp.org.ge/index.php?sec_id=65&lang_id=ENG).

of age are provided with a limited health service package, not protecting them from catastrophic health expenditures. Essential medicines are only partially covered through the publicly paid private health insurance policies. Many of the beneficiaries of public health care programs are not aware of their entitlements and are not benefiting from the available services. The existing Health Management Information System (HMIS) is not available to provide timely and accurate data to support evidence based decision making.

Health insurers, health care providers, and the government face challenges in building their capacities to function in the newly privatized health sector market. Health insurers' constraints include weak management skills of executives, actuaries, underwriters and claims managers; inefficient medical coding and provider payment systems; and limited capacity to prevent fraud. Professional medical associations are weak and are unable to assume greater responsibility in promoting higher health service quality and evidence based care.

The MOLHSA is finalizing a health sector strategy expected to be completed by September 2011. The strategy will set priorities of the MOLHSA over the next five years, including development of health human resources, protecting the population from catastrophic health care expenditures, ensuring quality, access and affordability of health services, and retaining GOG responsibility over provision of public health services.

USG Health Program in Georgia

USAID response: The USG's long-term goal of improving the health status of the population will be achieved through improving access to quality health care services, building the management and technical capacity of the health care system, improving legislation, enhancing public awareness and demand for higher quality health services, strengthening capacity of health insurers and service providers, and reinforcing the stewardship role of the MOLHSA to set and enforce public/private relationship rules.

The USG's short-term objectives are to improve health system management capacity and financing, improve infectious disease prevention and treatment, and expand access to MCH and FP services. These objectives will be achieved through: improving quality of diagnosis and treatment of TB; strengthening the National Tuberculosis Program's capacity to improve TB control efforts; improving HIV surveillance; increasing HIV prevention efforts targeting most at risk groups and youth; launching new private sector led service delivery models for MCH services; implementing evidence-based maternity/newborn care; increasing awareness of the modern methods of contraception; catalyzing the health insurance sector to become the vanguards of FP/RH services; and incorporating FP/RH modules and practicum into medical and nursing schools curriculum.

USAID supports maternal and child health by assisting the GOG to ensure that health services are affordable, accessible and of high quality for women and children throughout Georgia, with a special focus on the poor. USG assistance particularly aims to improve women's reproductive health in Georgia by developing evidence-based, women-friendly, client-focused, safe delivery services and creating informed health consumers. MCH services are part of the insurance benefits package for over one million poor covered by the GOG. USAID activities help to strengthen these insurance programs, to improve quality of the delivered services, and to increase population awareness of and use of covered services.



USAID launched new private sector-led service delivery, health insurance and product-specific social marketing models for FP services. With USG funding, a broad range of activities is planned with the goal of improving both knowledge and health-seeking behavior of reproductive age women and their families. The underlying philosophy of all activities is to empower women with information and confidence to improve their health and welfare through healthy lifestyles and proactive prevention. These activities help to advance the acceptance and use of modern contraception through provision of evidence-based FP services and counseling across the country. USAID also helps the GOG develop evidence-based clinical protocols to improve RH services.

To prevent further spread of HIV among the most at-risk population and the general population, the USG-supported HIV Prevention Project provides confidential and anonymous Volunteer Counseling and Testing (VCT) services. Supporting free-of-charge, user-friendly, anonymous and confidential HIV testing services significantly contributes to HIV early case detection, thus serving as a prerequisite to increasing anti-retroviral (ARV) treatment success and, ultimately, the survival rate of patients on ART. USG efforts have a positive impact on containing the growth of the new HIV infections among MARPs and bridging population groups, which in turn, will prevent the spread of HIV infection in the general population. USAID works on strengthening the national TB response in Georgia to sustain high case detection and achieve 85% treatment success rates by further strengthening DOTS and DOTS plus implementation. TB treatment default rates in USAID pilot sites have decreased from 28% to 6%. As part of a new program to be awarded in 2011, USAID will promote the integration of TB services into the Primary Health Care (PHC) system and examine ways to work with newly-privatized facilities on appropriate TB responses. The overall goal of the new Tuberculosis (TB) Prevention Program will be to reduce the number of TB cases in Georgia. The new TB Prevention project will improve clinical services and strengthen the National TB Program's capacity to address current critical challenges in the treatment of all forms of TB, including MDR-TB.

USAID is assisting the GOG to develop a new integrated Health Management Information System (HMIS). Once developed and operational, the system will allow for greater efficiency, transparency and accountability in the health care sector, support evidence-based decision making, and ensure better continuity of patient care across different levels of the system.

Defense Threat Reduction Agency (DTRA) response: Through the Cooperative Threat Reduction program, Georgia has consolidated its collections of especially dangerous pathogens, advanced its ability to safely detect these diseases through modern techniques that do not propagate the pathogens and expanded its understanding of the disease baseline through collaborative research. DTRA is enhancing

the existing disease surveillance system capacity by updating infrastructure, including a tiered network of modern laboratories across the country. The network will consist of seven Public Health Centers/Laboratory Support Stations that facilitate population-based surveillance for diseases/pathogens within a region. Five of these facilities in Western Georgia were constructed by the European Union. There are also three zonal diagnostic laboratories – one each in Tbilisi, Kutaisi and Batumi. These laboratories are larger and have more diagnostic and investigative capability. The final tier is the Central Public Health Reference Laboratory, located just outside of Tbilisi, which will provide a centralized, secure location where all pathogens of interest to Georgian Public Health, including especially dangerous pathogens, can be safely housed and studied. The CPHRL will also perform confirmatory diagnostics, serve as a national and regional reference laboratory, serve as a national and regional scientific training center and perform research of public health importance.

CDC response: CDC is working with the Georgia MOLHSA, Ministry of Agriculture/State Veterinary Service (MOA/SVS), Georgia National Center for Disease Control and Public Health (NCDC), and analogous agencies in Armenia and Azerbaijan to develop the South Caucasus Field Epidemiology and Laboratory Training Program (SC/FELTP). The SC/FELTP is a regional program, based within the Georgia NCDC which strengthens the governments' institutional capacity to detect, investigate and prevent disease through a combination of mentored practical work and classroom training. This two-year program develops technical competencies of host country specialists in disease surveillance, outbreak investigation and prevention.

Begun in 2009, the SC/FELTP is similar to over 35 programs worldwide, most of which were started by CDC and have since matured into country-led programs of ongoing service and capacity development. Georgian participants in the SC/FELTP have been working on surveillance or outbreaks of the following diseases: visceral leishmaniasis, TB and MDR-TB, HIV, enteric diseases (including hemolytic uremic syndrome), brucellosis (in animals and in humans), anthrax, motor vehicle injury deaths, tularemia, and others. CDC is working with host country partners so that over the next six years, Georgia will be able to assume technical leadership of the FELTP and continue developing the technical capacity of its personnel. To date the SC/FELTP has graduated the first cohort of 11 specialists (7 from Georgia, 4 from Azerbaijan), and has another 34 in either the first or second year of their training (17 from Georgia, 9 from Azerbaijan, and 8 from Armenia).

As evidence of GoG contribution, the SC/FELTP offices (5), reception area, and 18-person classroom are provided in-kind by the Georgian National Center for Disease Control and Public Health. All SC/FELTP participants continue to receive their salary during the course of training, and one of the Deputy Directors of the NCDC also serves as the Director of the SC/FELTP.

SC/FELTP builds capacity of the government sector in public health, animal health and food safety. Graduation from the SC/FELTP is based on completion of both classroom and applied disease control and prevention activities in the context of the participants' work responsibilities. Thus, SC/FELTP participants and graduates are in good positions to participate in other USG and donor-supported activities related to health including: disease outbreak detection and control, identification of disease risk factors, evaluation of health promotion and disease control activities (including TB, HIV/AIDS, childhood immunization), monitor infection control in clinical settings, detection and control of animal diseases, and improvement of food safety.

The SC/FELTP and other specialists from CDC Atlanta are collaborating with DTRA to develop the laboratory network for diseases of humans and animals through the development of a laboratory quality management system (QMS) with the Central Public Health Research Laboratory (CPHRL) at the center.

Development of skilled laboratory managers is essential in order to take full advantage of the laboratory infrastructure built with DTRA support. By developing cross-cutting capacity in disease surveillance, investigation, control, and the evaluation of disease prevention programs, the SC/FELTP is well poised to assist Georgia to address the full range of GHI goals in both infectious and noninfectious diseases and disease risk factors.

Peace Corps response: Peace Corps (PC) Georgia focuses HIV/AIDS prevention initiatives on awareness raising and early education. Taking into account the cultural sensitivities of openly discussing HIV/AIDS in Georgia, Peace Corps found the most valuable approach to this conversation is via basic life skills. With the support of PEPFAR funds, Peace Corps Georgia’s volunteers and partners engage over 60 communities in awareness raising and early education, of more than 1075 Georgians in the benefits of abstinence, being faithful, and other prevention interventions.

Peace Corps Georgia currently has two projects, Secondary English Education and Business & Social Entrepreneurship. Both projects have objectives that focus on promotion of basic life skills including communication skills, decision making, and problem solving through clubs, camps and other events. Volunteers in both projects are actively involved in developing and implementing projects targeting youth education on healthy lifestyles, communication, and behavior change.

In February 2011, Peace Corps designed and facilitated the 2011 Healthy Messages training-of-trainers (TOT) that engaged 18 Volunteers and 18 counterparts. The TOT was based on the Behavior Change Communication (BCC) framework, identifying behaviors such as smoking, drug and alcohol use, early marriage, lack of personal healthcare, safe sex, target groups, and BCC model action planning. Future PEPFAR funds will support participants of the 2011 Healthy Lifestyles TOT in implementing their action plans by creating updated and translated materials concerning healthy lifestyles and HIV/AIDS-related topics.

USG Costing Data

Cost Description	Amount per Unit	Total	Results of Investment
USG cost per one DCA guarantee covered new hospital (DCA subsidy cost)	\$65,000	Cost per eight new hospitals \$520,000	Provide access to modern evidence based medical care for 700,000 people including 107,000 IDPs
USG cost per one retrained nurse (one month long retraining course)	\$800	2,500 nurses to be trained	Higher quality and more efficient health services for patients

USG cost per one rehabilitated TB outpatient clinic (standard four rooms: DOTS, DOTS plus, Lab, and a room for a doctor, a nurse, and a lab technician)	\$10,000	50 facilities to be rehabilitated \$500,000	Improved treatment adherence and reduced treatment defaults (in pilots defaults dropped from 26% to 8% of patients failing to complete the full 7 to 24 month course of treatment). Key public health result - preventing the emergence of drug resistant TB.
USG cost per Effective Perinatal Care per maternity facility	\$24,000 Including: EPC Training (1) - \$15,000 Birthing Bed (1) - \$3,000 Infant Warmer (1) - \$3,000 Supportive Supervision and on-job training (3 per year) - \$3,000	Current cost 26 pilots, out of 100 maternity facilities in Georgia \$624,000	Decrease in postpartum hemorrhage to less than 1% from up to 10%. Drop of newborn hypothermia to zero from initial 40% to up to 90% in different facilities. Birth trauma and neonatal asphyxia also reduced significantly. EPC led to 45% reduction in cost per delivery.

Key Considerations

Graduation/Phase-out Markers

Planning for program graduation/phase-out will begin during the implementation of the GHI strategy. The following graduation triggers are proposed for smart phase-out planning:

- **Effective Perinatal Care (EPC)** –graduation indicator: % of births covered with EPC practices; # and % of facilities implementing EPC practices; sustained support by the GOG and private sector.
- **Infrastructure investments**– graduation indicator: % of population with geographic access (in accordance to the WHO standards) to modern facilities.
- **Capacity building of private insurers and private providers**–graduation indicator: established relationships geared to sustain quality and efficiency between insurance companies and healthcare providers.
- **TB DOTS – spots and support to vertical TB system**–graduation indicator: achievement of WHO indicator of treatment success rate of 85%.
- **Youth HIV/AIDS prevention activities** – graduation indicator: incorporation and institutionalization of the Healthy Lifestyle course in Georgia’s national education plan.

The USG will conduct a broad health sector assessment in 2013 to measure progress and define future assistance priorities. As with all sector-wide assessments, the USG will coordinate efforts so that the results of the assessment are useful across all agencies.

Ongoing USG investments

DTRA's transition planning and execution with the Government of Georgia has begun and will continue over the next several years. DTRA has committed to supporting the laboratory network, including the CPHRL, up until December 2015. The CPHRL will have a US Government long-term presence, as both the CDC and US Army Walter Reed Army Institute for Research will perform research and disease surveillance activities there.

One of the first activities of transition planning and execution is capacity building at the Public Health Centers/Laboratory Support Stations throughout Georgia. These sentinel labs, which are spread out in each region of Georgia, are receiving additional equipment and training that will enable them to perform testing and quality control for each of the public/private hospitals in their region. In addition to strengthening the network and disease surveillance capability, the revenue generated from performing these services will allow the sustainment costs to fall within the ministry's budget constraints.

The SC/FELTP is a CDC-modeled, two-year, training program, similar to about 40 programs worldwide; the first was in Thailand, starting in 1980. Of these 40, about 25 have "graduated" from CDC and major USG support, and are now functioning independently under local country leadership. This graduation is based on the achievement of a functioning level of proficiency which takes between 5 and 10 years to achieve. SC/FELTP began enrolling participants in June 2009 and has graduated one cohort of 11 specialists; two additional cohorts are currently enrolled, an additional 34 specialists from the region, half of whom are from Georgia.

CDC is the beginning stages of developing another program for Georgia and the region called a Global Disease Detection (GDD) Center, which has an indefinite time frame for CDC leadership. A Georgia GDD Center will work with laboratory and disease surveillance infrastructure developed largely by US-DoD/DTRA—including the Central Public Health Reference Laboratory—which serves the Georgian human health and animal disease control agencies. The Georgia GDD Center extends the activities of other CDC GDD Centers in Egypt, Kenya, Guatemala, Thailand, India, South Africa, and Central Asia as a network of disease surveillance and pathogen discovery. These centers serve as a means of early warning of global disease and health security threats.

Alignment with GHI Principles

Focus on Women, Girls and Gender Equality

The underlying philosophy of all USG activities in Georgia is to empower women and girls with information to improve their health and welfare through healthy lifestyles and proactive prevention. Family planning programs help to advance the acceptance and use of modern contraception through provision of evidence-based, women-friendly services, creating informed consumers across the country. MCH services are part of the insurance benefits package for over one million people of the most vulnerable groups covered by GOG. MCH services improve the health of women and their babies and also promote male engagement in healthy family lifestyles. USG activities help to strengthen these insurance programs, to improve quality of the delivered services, and to increase awareness of and use of covered services.

Examples of the USG's ongoing work with a focus on women, girls and gender equality includes protecting women's privacy through providing individual delivery rooms and eliminating the old practice

of having common “labor block” and “delivery hall” areas where often times two, three, or even four simultaneously laboring women were delivering with the old Soviet-style delivery chairs with virtually no privacy; introducing family inclusive and laboring women supportive practices, such as companion deliveries, as opposed to the old practice of prohibiting family members from entering a maternity facility; and, finally, allowing for free choice of positions by the woman in labor instead of a doctor, nurse, or midwife – all have proven to not only optimize care and make it more women-centered, these new practices eventually lead to empowerment of women in decision-making in other important aspects of their lives.

The USG’s investments in human capacity development also focus on women and gender equality. SC/FELTP builds capacity of government epidemiologists, veterinarians, and laboratory specialists. In Georgia, approximately 80% of the specialists participating in the SC/FELTP are women. Additionally, USAID, through its Nursing Education Project, is significantly upgrading knowledge and skills of Georgian nurses countrywide. Nursing is almost exclusively a profession of women in Georgia. Through training, the program empowers women to seek better positions in the workplace and improves their job opportunities and remuneration.

Peace Corps Georgia has contributed to gender empowerment in a number of ways. Since launching the Women in Development/Gender and Development (WID/GAD) Volunteer Committee in 2006, the Peace Corps Volunteers have been actively engaged in developing and implementing activities and projects aimed at girls and women’s empowerment. Contributions include implementation of projects like gender seminars, gender development training modules, girls’ leadership promotion, boys’ leadership, and distribution of the WID/GAD newsletter.

Over the last six years Peace Corps Volunteers have promoted Life Skills and Healthy Lifestyles, which included youth skills development in the areas of teamwork, relationship building and management, leadership, communication, self-esteem, resisting peer-pressure, initiating behavior change and establishing positive behavior patterns. Aside from working with youth, Volunteers have worked with adult women facilitating their interaction with health professionals and organizations who provided women with health information that they otherwise lacked.

Country Ownership

The GOG has strong ownership of its health program, assuming responsibility and accountability for addressing the country’s public health challenges. The USG’s close relationship with the GOG provides an exemplary technical assistance (TA) model for GHI to strengthen the management and delivery of health services - providing only strategically focused technical assistance to the health sector – not providing health services or commodities. In Georgia, country ownership includes a strong relationship with the private and civil society sectors.

Using private sector market mechanisms to improve access to health care, the USG’s technical assistance provides: better means testing, targeting state resources to address the health needs of the poor and disadvantaged; increased privatization of health care providers (including hospitals and primary health care facilities); and an enhanced role for private health insurers. Through GHI, USG assistance will continue to maximize effectiveness of limited government funds for health and support a regulatory framework for ensuring health sector privatization initiatives that positively impact access to and quality of services for target populations.

Examples of USG's work with the private sector include introducing Effective Perinatal Care (EPC) practices in pilot maternities throughout the country. Along with obvious improvements in clinical care areas, and the resulting reductions in maternal and infant morbidity due to hemorrhage, birth trauma and newborn hypothermia, the EPC practices also led to a 45% cost reduction, mainly due to decreases in unnecessary medications use during labor. Costs also went down because there were fewer complications and shorter hospital stays. The documented cost savings, combined with improvements in quality of care, became an important advocacy factor for EPC with private investors. Georgia's biggest hospital investors now insist that EPC be implemented in every new hospital. Increasing competition for maternity clients in Georgia encourages health professionals to provide client-oriented, evidence-based services. Hospitals which use EPC are experiencing more rapid increases in client loads than non-modernized facilities.

With USAID support, the Georgian Insurance Association set up a new Insurance Professional Education and Consultation Center. The center is already independently delivering professional training courses for Georgian insurance professionals, aimed at improving health insurance customer services, diversifying insurance products, attracting new clients to be covered, and enhancing efficiency in the operations. Ultimately this all will lead to higher quality health services, satisfied patients, and better health outcomes. USAID is also assisting private hospital managers in getting acquainted with hospital environmental regulations and setting up the internal environmental policies to comply with those regulations. Private hospital managers countrywide are also sending nurses from their medical facilities to the USAID funded nurse retraining courses.

USAID's DCA guarantee in Georgia, with only \$515,000 paid as a subsidy cost, has leveraged \$8 million in private financing intended for construction, rehabilitation and equipping of the eight remotely located small and medium sized hospitals, predominantly serving poor and disadvantaged population groups in West Georgia.

In addition to working with zoonotic diseases that pass from animals to humans, Ministry of Agriculture specialists have responsibility for ensuring the safety of food (animals and plants). These specialists also work with private sector veterinarians and laboratory infrastructure. By improving the investigative and disease controlling skills of those specialists, SC/FELTP has an impact on improving safe and economic production of food products.

In the human health sector, hospital-acquired infections (HAI) are a major source of morbidity and health care expense. SC/FELTP is currently working with Georgian health authorities to estimate the burden of HAIs, the first step towards developing strategies for reducing the occurrence and impact of these infections.

Similarly, the development of accurate laboratory diagnosis of disease requires implementation of laboratory quality management systems (QMS). While developing skills in QMS, SC/FELTP laboratory specialists will work as trainers with public and private sector labs to develop the Georgia laboratory network, incorporate standard operating procedures, external quality control using reference laboratories, including the Georgia Central Public Health Reference Lab. The Georgia National Center for Disease Control and Public Health has requested CDC's help to strengthen their laboratory network so it may serve as a fee-for-service service provider for small, private sector hospitals.

Working with local partners, the USG is **building civil society capacity** to work with the GOG on HIV/AIDS legislative reforms and improved prevention and treatment of HIV/AIDS within high risk populations.

Georgian partners include HIV/AIDS NGOs, universities, and professional associations – all of which are now leading partners in the country for preventing the spread of HIV/AIDS to the general population.

Through the GHI, direct support to NGOs will continue to achieve efficiencies, lower administrative costs, and position local partners to leverage USG funds with those of other development partners and the GOG's own funds.

Strengthen and Leverage Other Efforts

In Georgia, the USG recognizes that the ability of the GOG to provide health care to its citizens is a critical attribute of a stable, democratic society. The USG democracy and governance sector recognizes this essential contribution to national stability in addition to the importance of civil society groups as advocates for improved health of citizens and providers of health services to vulnerable populations. Health is also considered a key element of building an economically viable population.

GHI will fully leverage DTRA's global health security investment in Georgia. The tiered laboratory network, including the Central Public Health Reference Laboratory and the institutional development of NCDC will increase Georgia's capabilities in detecting infectious diseases, epidemiological surveillance and research for the public health benefit of Georgia – and more broadly for the Caucasus region. The network that was designed to detect and respond to especially dangerous pathogens (EDPs) can be utilized to perform testing and research on TB and support overall syndromic surveillance.

Under GHI, the USG will continue to strengthen its direct technical engagement in relevant national level committees and will promote greater private sector involvement in improving health outcomes in Georgia.

Strategic Coordination and Integration

Strong coordination exists between the GOG, private sector partners in the health sector, civil society, and local and international implementing partners. The whole-of-government approach in Georgia means that the USG team avoids duplication of activities and staff, ensuring that our work remains cost effective and efficient. The USG team has a long established framework for interagency collaboration and communication. Interagency coordination in the health sector is included in the 'Investing in People' (IIP) USG working group. The working group is a sub-group under the Assistance Coordination Committee which is chaired by the Deputy Chief of Mission. The IIP group also coordinates activities in the education and social sectors, and includes members from six USG agencies. USAID's Health and Social Development Office Chief chairs the working group. The GHI framework will provide further opportunities for the USG to engage government and partners as one USG.

An illustrative example of USG interagency coordination includes coordination of national Reproductive Health Surveys (RHS) in 1999, 2005, and 2010. Funding for all three surveys was provided by USAID, which supported technical assistance from the US Centers for Disease Control and Prevention Division of Reproductive Health (CDC/DRH) for survey design, implementation, data processing, analyses and dissemination, and UNFPA, which covered all costs related to field work, translation, and dissemination seminars.

For all three surveys, CDC/DRH provided technical assistance to the National Centers for Disease Control and Health Statistics (NCDC) and MoLHSA, the implementing agencies and key stakeholders. SC/FELTP Georgia participants collaborated as data collectors, managers, analysts, and writers on the 2010 USAID/CDC Reproductive Health Survey. This survey measured key demographic factors and program impacts related to reproductive health over the last 10 years. Similarly, the survey will help set benchmarks for future USG funded programmatic activities. Similarly, several SC/FELTP participants

worked on other surveys such as the 2009 UNICEF-sponsored nutritional survey of women and children, and on the USAID-sponsored survey of mortality among reproductive age women. In 2008-2009, USAID in collaboration with MoLHSA and CDC also conducted the first mortality study among women of reproductive age (RAMOS).

Sustainability through Health Systems Strengthening

The USG will continue as the lead donor in helping the GOG to develop capacity and implement innovative approaches through a technical assistance model. The USG's long-term goal of improving the health status of the population will be achieved through improving access to quality health care services, building the management and technical capacity of the health care system, improving legislation, enhancing public awareness and demand for higher quality health services, strengthening capacity of health insurers and service providers, and reinforcing the stewardship role of the MOLHSA to set and enforce public/private relationship rules.



Donor Coordination

USAID is represented on the National Reproductive Health Council (NRHC), a coordination body of the GOG in the area of RH and MCH. It is co-chaired by the First Lady of Georgia and the Minister of Health and includes representatives of GOG, USG, other donors, and NGOs. USAID is also a member of the Country Coordination Mechanism (CCM), a large and representative forum of all involved stakeholders, including international donors in the areas of TB, HIV, and malaria. The CCM is also chaired by the First Lady. USAID also remains an active member of the Interagency Coordination Committee on Immunization.

DTRA works with a number of local and international donor organizations to maximize the impact of the Cooperative Threat Reduction program in an effort to enhance Georgia's public health system and expand its integrated disease surveillance capacity. In particular in June of 2009, DTRA hosted the Roundtable Meeting on Public and Animal Health Projects in Georgia, where around 30 agencies representing the diverse donor community, project staff and the Georgian Government were brought together to discuss prospects and plans for collaborating in the development of Georgia's public health system and its future global integration into the international public health system. During the two-days sessions over 60 participants brainstormed on key barriers to an effective health care system and quality service in the country and generated possible solutions for these barriers as well as developed recommendations on how to establish and maintain efficient donor coordination mechanisms.

As a result of DTRA's engagement with donor organizations and their health programs, collective efforts to optimize donor support and resources are in place and partnerships in specific programmatic areas are underway. The European Union has invested into the construction of five Public Health Centers/Laboratory Support Stations as part of the DTRA supported network of laboratories across the

country. The European Union designated an additional grant for the Central Public Health Reference Laboratory to complement development of its training capacity and establishment of a regional training center for infectious disease detection and research. UNICEF has successfully cooperated with the upgraded Zonal Diagnostic Laboratory of the NCDCPH Imereti Branch and nominated it as a regional center for external quality control for UNICEF countries throughout the region. DTRA is pursuing partnerships with the World Health Organization (WHO), the Food and Agriculture Organization of the United Nations (FAO) and the World Organization for Animal Health (OIE) to assist Georgia in complying with their recommendations and guidance, and strengthen Georgia's WHO and OIE disease reporting capabilities.

Monitoring and Evaluation

One of the legacies of GHI will be to create a critical mass of Georgian public health officials who generate and use appropriate data to drive decision making at the national, regional, and district levels both in the public and private sectors. The USG is a lead partner in supporting the MOH to create a public health workforce including: 1) a cadre of nurses who are well trained to operate with advanced technical and data for decision-making skills; and 2) physicians, lab technicians and researchers who will also have the ability to utilize epidemiological data, creating a new generation of public health professionals with skills in using data for key decisions. The USG is also working to improve the surveillance systems to respond to epidemics and public health threats as they emerge. The DTRA-supported electronic integrated disease surveillance system (EIDSS) collects all infectious disease information in one system electronically. The GOG will begin fully utilizing this system by the end of 2011. In addition, with the ongoing expert technical assistance the USG will strengthen the HMIS system for improved health information to monitor activities nationwide. These systems will be enhanced to monitor progress in achieving GHI goals.

Research and Innovation

In an ongoing activity, the USG is supporting GOG colleagues to develop a national health research agenda and supporting research at referral sites and training institutions to improve the quality of services. Georgia is in a position to serve as a learning laboratory for the rest of the world in areas such as privatization and health care reform; neglected tropical diseases; and HIV prevention activities for injecting drug users (IDUs).



Links to Democracy and Governance (D&G) and Economic Growth

Strong cross-cutting linkages exist among health, democracy, governance, and economic growth programming. Successful democratic processes, good governance, and economic growth efforts require healthy, productive, and engaged citizens. In the absence of effective healthcare systems that mitigate the spread of disease, produce quality health care interventions, and result in desirable healthcare outcomes, macro level progress on democratic, governance, and economic development objectives is constrained and development potential diminished.

Despite notable success in fighting corruption in recent years, the country still faces constraints in building a strong and responsive civil society, and struggles with a lack of effectiveness in administrative and delivery institutions such as the healthcare system. A highly receptive environment for US involvement at the policy reform level presents an opportunity for the USG to support the kinds of systemic changes that will lead to greatly strengthened institutions and irreversibly establish Georgia as a strong and representative democracy.

Health care delivery is a major governance concern, given the state of the sector, limited access to services of almost two thirds of the population, and the extent to which systemic weaknesses impact citizens every day. There is a need for enforcement of the legal framework to support the health care system and ensure equal access to care for citizens. The price-listed out-of-pocket payments vastly increase the cost and limit access to care without providing any guarantee of quality of services for the average patient.

USG assistance in promoting greater accountability and transparency includes widening the use of E-Systems for better and more transparent service delivery. USG's work in assisting GoG to develop a national Health Management Information System (HMIS) is one of the examples of improving governance in the public and private sectors. Once functional, HMIS will ensure transparency and accountability of every GEL of governmental spending on health. Moreover, the system will enable Georgian citizens to be fully informed about their health care rights and empowered to use the services they are entitled to.

Following the recent health reforms adopted in 2006, total government expenditures on health increased from 55 million GEL in 2003 to 350 million in 2010. There is a continued need to provide assistance to the government and private sector in optimizing budgets, improving overall planning, rationalizing resource generation and expenditure, bolstering implementation capabilities, and improving transparency. In efforts to strengthen governance in health, there will be emphasis on institutionalizing steps to ensure more responsible management and use of resources. Throughout the process of strengthening planning and resource management capabilities, European Union (EU) standards will provide the criteria to be achieved.

At the same time, attention is given to strengthening those civil society entities that can serve as public overseers to help promote greater transparency, improve public access to information, and assure that interests of vulnerable groups are protected and their access to the health care services is not limited. The USG is the only donor in the country that in addition to funding direct prevention also emphasizes organizational capacity building among NGOs working in HIV prevention. Although still limited, enhanced oversight and involvement of NGOs in HIV/AIDS prevention and care has helped to more effectively reach out to most at risk populations (MARPs). In Georgia, MARPs avoid interaction with governmental entities, including health providers, out of fear of being reported to authorities for drug use or prostitution, while NGOs are perceived as non-judgmental and have more success in establishing trust. Thus, the role of NGOs in HIV prevention among MARPS is vital in Georgia.

Democratic processes, civil society advocacy groups, political parties, and professional associations can and do play an influential role in shaping public healthcare policy at national and local levels and seek to protect the interests of healthcare consumers. In Georgia, both civil society organizations and independent media are active in raising awareness on health sector issues and organizing stakeholders to be heard in their efforts to lobby decision makers. While advocacy campaigns have demonstrated

considerable success in Georgia, much remains to be done to more fully utilize this important and influential medium to advance reform and promote socially responsible governance. Advocacy is a particularly potent tool during elections, and the run up to the 2012 parliamentary elections and the 2013 presidential elections represents an ideal opportunity to bring healthcare issues to the fore in political campaigns and candidate debates that will shape national policy and priorities for years to come.

Clearly a healthy workforce is a major contributor to overall economic development. Moreover, the health care sector is a significant employer and contributor to economic growth in Georgia, estimated at 6.57 percent of the GDP in 2010. As a result of the health reforms since 2003, only 25% of the \$1.1 billion total health care expenditures come from government budgetary allocations; the remaining 75% of total health care costs come from individuals or private sector insurance.

Of the GOG portion, the preponderance consists of financing the health care insurance costs for Georgia's poorest people, most of whom live outside of Tbilisi. This portion of government expenditure has continually increased over recent years. Consequently, private insurance plays a major, and increasingly, important role in financing health care costs at private health care providers across a range of economic groups in Georgia.

The healthcare sector is also a major employer in the country. The health and social work sector grew at about five percent per annum in the three years preceding 2009. In 2009 it employed 53,600 persons or 13.8 percent of the total number of employees engaged in economic activity in Georgia.

Georgia has about 70 firms that manufacture pharmaceuticals, which employ about 2,400 people. Domestic distribution of pharmaceutical products is dominated by three firms that are horizontally and vertically integrated into hospitals, pharmacies, clinics, manufacturing and insurance companies. Georgia exported about \$24 million in pharmaceuticals in 2008, one half of which went to Azerbaijan. Furthermore, pharmaceutical exports have increased nearly five times over the last decade. USAID funding in the health sector dovetails with USG economic growth (EG) funding to achieve improved private sector competitiveness by supporting the GOG policies to utilize private sector solutions for health care service provision and to achieve improved economic security for targeted vulnerable populations and sectors by supporting the GOG policy to use private sector health care insurance for the country's poorest people.

Links to engagement activities

Health and humanitarian assistance are a legitimate and non-threatening vehicle for outreach to the separatist regions of Abkhazia and South Ossetia, and the very nature of these programs can prove effective in restoring trust and confidence. For example, both GOG and de-facto representatives in Abkhazia are open to a range of planned and possible healthcare-related programming that could be used to promote engagement among parties to the conflict, should funding be made available. Support for Georgia's territorial integrity remains central to USG policy in Georgia, and USG assistance efforts will seek to exploit opportunities for constructive engagement.

Communication Plan

The USG Public Affairs Office and USAID's Communication Team lead outreach and media activities which showcase the USG's role in assisting Georgia to reach its health sector goals. Activities include outreach with civil society, non-governmental groups, and the GOG to raise awareness of the USG's commitments to health in Georgia. The Embassy uses its relationships with a broad range of Georgian television, print, and radio outlets to ensure that information about USG health projects and activities

reaches a wide public audience. Media events are routinely conducted by the Ambassador, as well as outreach efforts using social media. All USG representatives will have up-to-date talking points on GHI goals and accomplishments to refer to in interactions with host government counterparts and the media.

Monitoring and Evaluation (M&E)

The monitoring and evaluation plan for the Georgia GHI Strategy will closely follow the goals, objectives, and results detailed in the results framework (Appendix One). The M&E plan will be grounded in solid data on morbidity, mortality, and demography coming from high quality surveys and focused surveillance efforts. These data systems will generate the baselines for the GHI Strategy and will be used to evaluate the impact at the end of the five year period. Routine monitoring of the GHI strategy will be done through a mix of surveillance data, project monitoring reports, and information from the health information system. The Georgia GHI M&E plan will also incorporate indicators on the GHI cross-cutting principles when they have been identified by headquarters.

The USG supports the Reproductive Health Survey in Georgia as the principle source of nationally-representative demographic data as well as data on family planning and reproductive health outcomes. The most recent survey was conducted in 2010 and will serve as a baseline for many of the GHI indicators; however the final report was not released in time for this strategy document so indicators from the 2005 survey are included as placeholders. A subsequent RHS will be conducted in 2015 to measure progress against these indicators and to provide data for the impact evaluation of the GHI strategy.

The HIV/AIDS program also uses behavioral surveillance surveys as a means to collect data on prevalence of HIV, as well as knowledge and behaviors, among various risk groups in the country. These data will be an important source of information for the program as Georgia redoubles its efforts to control a burgeoning AIDS epidemic among high-risk groups. The most recent round of BSS data was collected in 2010 and serves as the baseline for prevalence in high risk groups.

Other critical morbidity and mortality indicators will be obtained through the Georgia National Center for Disease Control, which manages the national health information system and vital registrations systems for the country. Data on incidence and prevalence of HIV, TB, and other infectious diseases will be obtained from the national program's surveillance database.

The development and expansion of health insurance schemes is an important part of the GOG's plan to build a sustainable and equitable health system. The USG will work closely with the GOG and the private insurance companies to develop and maintain information on the coverage of the insurance programs, including coverage in vulnerable population groups. In addition, USG staff will work with the insurance companies to monitor the quality of the insurance schemes and ensure that individuals are covered for basic packages of services for maternal and child health as well as other health issues.

It is important to note that the success or failure of the Georgia GHI strategy hinges on the critical assumption of continued USG funding through a defined phase-out period. To that end, we have identified a number of 'phase-out' benchmarks as part of this strategy. These indicators will be used to determine when the GOG health system has obtained a level of self-sufficiency where it can be "graduated" from USG assistance.

The GHI Learning Agenda

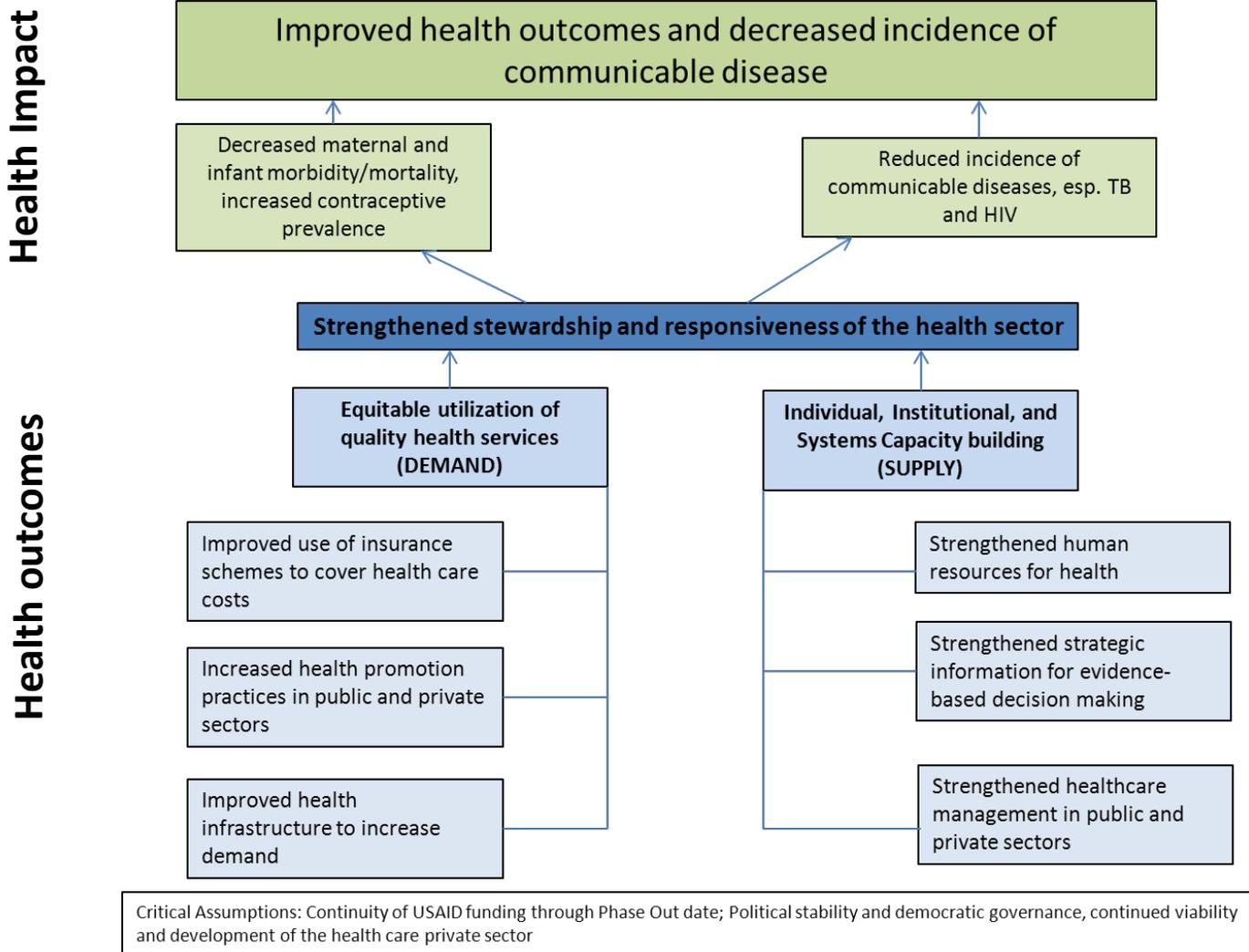
Table 2: GHI Assessments Conducted

	Sector
2007	HIV/TB Assessment
2008	Reproductive Health Assessment
2009	Health Sector Assessment, HIV/AIDS Assessment
2010	Non-Communicable Disease Assessment, TB Assessment, Reproductive Health Survey (RHS)
2011	Maternal and Newborn Health (MNH) Assessment, 2011 Quality of Clinical Skills Assessment

Planned 2013 Broad Health Sector Assessment

- Status, trends and dynamics of the health reform
- Where does public health fall under this reform?
- Most vulnerable populations: which specific groups of population in Georgia are most vulnerable and underserved?
- Human and institutional gaps?
- Where is USG's comparative advantage in addressing the identified needs?

Appendix 1: Strategy Results Framework



HEALTH IMPACT

Decreased maternal and infant morbidity/mortality; increased contraceptive prevalence



Decreased Maternal Mortality from 49/100,000 to 15/100,000

Decreased Infant Mortality from 14.1/1000 to 8.1/1000

Increase modern method contraceptive prevalence to 40% from current 27%

Reduced incidences of communicable diseases, esp. TB and HIV



Reduce incidence of TB to 70 cases per 100,000 persons (from the current 134 new

Preserve HIV prevalence in each risk group (IDUs, MSM, and FSWs) under 5% to

More timely response and investigation of disease outbreaks, leading to disease

More accurate identification of disease risk factors, leading to more efficient and rapid

More accurate estimation of burden of disease leading to more appropriate targeting of

Outcomes

Health outputs

Improved use of insurance schemes to cover health costs



Increase the number of people with voluntary health insurance coverage by 50%

Sustain number of persons covered by government insurance at the current level

Government paid insurance covered persons are informed and benefiting from their entitlements.

Increased health promotion practices in public and private



Increase coverage of interventions aimed at IDUs to 60% (from the current 20%)

Awareness about HIV increases by 40% across baseline in all risk groups

Safe sex and injecting practices improved by 30% across baseline in all groups

Evidence-based preventive health examinations and effective screening practices are included in insurance packages

Equip 380 Georgians and community advocates to facilitate life skills development using the Behavior Change Communication model

Support 1500 girls and boys in selecting health life choices via leadership camps

Improved health infrastructure to increase demand



At least 10 medical facilities renovated/constructed with the funds leveraged through USAID credit guarantees

Achieve the WHO goal of 85% TB treatment success rate (from the current 70%)

Reduce the nationwide TB patient default rate to less than 10%;

85% of births covered with EPC practices; at least 55 facilities implementing EPC practices

Improved disease surveillance

Improved response to and control of disease outbreaks

Consolidate and secure EDPs into CPHRL and utilize BSL-2 & 3 lab capacity to achieve more advanced research objectives

7 new Laboratory Support Stations/Public Health Centers

Outcomes

Health outputs

Strengthened human resources for health



Increase National TB Program patient referrals from general practitioners to 40%

More accurate detection of tuberculosis through lab diagnosis

Reduce the spread of TB in the general population by increasing early case detection

2,500 practicing nurses are retrained and providing higher quality care to patients

18 persons graduate from FELTP per year (3 human health lab technical managers; 3 animal health lab technical managers; 3 to 4 veterinary epidemiologists; 8 to 9 epidemiologists), from 3 South Caucasus countries

60 laboratory scientists per year receive one-week laboratory quality systems management course

Strengthened strategic information for evidence-based



Development and operationalization of the national Health Management Information System (HMIS)

Strengthened scientific evidence as basis for policy formulation

Full operationalization of the electronic integrated disease surveillance system (EIDSS)

Strengthened healthcare management in public and



Development and implementation of the essential drug list (EDL)

Hospital and health insurance managers are trained

Strengthened intersectoral communication and collaboration in human and animal health

GoG developed solutions to long-term sustainment of laboratory network and disease surveillance research

Appendix 2: Success Stories

EPC: Hospital Helps Spread Modern Birth Practices in Georgia

Zugdidi Hospital in western Georgia is at two frontlines: the boundary with a secessionist region that was a battleground only two years ago and as Georgia's leading edge of the movement to modernize birth practices. The story of Lela Bulia-Tikanadze dramatically illustrates how support from USAID has enabled Zugdidi Hospital to become a leader in that modernization. This past March, Lela delivered her second child at Zugdidi Hospital. The maternity ward was warm and clean, her husband was by her side, and her doctor delivered the new baby boy using effective modern medical practices.

Not long ago, women often delivered alone in hospitals lacking heat. Babies were immediately separated from their mothers and given formula or donor's milk instead of breastfeeding. Group delivery rooms, antiquated delivery tables, and excessive, medically unjustified interventions and overmedication were common. Cows occasionally wandered the hospital's first floor. Lela delivered her first child in such conditions. A comparison of the experiences, she says, "is like night and day. Everything has improved dramatically, from the care I received from my doctors and nurses to the facilities. I even had the opportunity to choose a birth position this time."

The Zugdidi Hospital is one of the pilot sites of the USAID-funded SUSTAIN project to improve the effectiveness of maternal and infant health services. The project promotes evidence-based medical practices, family-centered maternity and newborn care, and family planning services using World Health Organization recommendations. At Zugdidi Hospital and other SUSTAIN pilot sites in Georgia, the maternal care practitioners use a family-oriented approach to delivery, allowing spouses, friends, or family members to attend the birth for support. Midwives attentively care for patients as part of the team, women are given a choice of labor and delivery positions, and mothers are encouraged to stay with their babies after birth and breastfeed. As a result, hypothermia among newborns has been eliminated, and the risks of hemorrhage and preventable infection have been significantly reduced. By many accounts, maternity care in Georgia is many years out of date, but Georgian medical professionals are keen to utilize evidence-based programs such as USAID's.

At first, many Zugdidi doctors did not believe a change in maternity care was necessary or possible. "After 30 years of delivering babies, I did not believe it would be possible to transform the way we do things," remembers Dr. Alla Gridasova, head of the Zugdidi Hospital maternal department. "But now I have seen the change, and the improvements are clear. I am a firm believer."

The group immediately began implementing all the principles they learned, and the Zugdidi hospital quickly became an outstanding site. The dramatic improvements required only a modest investment for training and support through SUSTAIN, due to cost sharing by the Government of Georgia and the private sector. This largely self-motivated transformation in Zugdidi was remarkable, given the initial impression; on their first visit USAID staff found the hospital to be "one of the most badly damaged by armed conflicts and out-of-date facilities ever seen in Georgia."

Today, conditions have improved dramatically in many other SUSTAIN hospitals throughout Georgia thanks to USAID-supported, family-friendly, evidence-based perinatal care. Modern practices for managing the third stage of labor have decreased postpartum hemorrhage – the leading cause of death of delivering mothers – to less than 1 percent. An additional benefit was that medical costs went down due to fewer complications and shorter hospital stays. The improved health of mothers and proven financial savings helped Dr. Alla Gridasova and her Zugdidi team to negotiate much-needed salary increases.

Georgia's biggest hospital investor, Block Georgia, was so impressed with the results in Zugdidi that it now insists the same methods be implemented in every new hospital it runs. "We have seen the palpable benefits of promotion of effective perinatal care principles at Zugdidi Maternity Department through reduced medical interventions during the delivery. The observed benefits – both in terms of improved health outcomes and reduced hospital expenditures – suggest that we adopt these practices in other medical facilities," said the director of Block Georgia Gela Gogishvili. The Zugdidi Hospital maternity department serves as a showcase for other hospitals in Georgia. Dr. Gridasova and her team now help train others in effective perinatal care techniques.

USAID currently assists 18 pilot maternities across Georgia. But with 51 licensed maternity departments in Georgia, there is much more work to be done to transform maternity care and promote newborn health across the country. For mothers like Lela Bulia-Tikanadze, the modern care interventions have greatly improved patient and family satisfaction. The experience was "unforgettable—the most precious in life!" she says.

Donor Coordination, Capacity Building, Women and Children, Transition

During the Donor Roundtable Meeting hosted by DTRA in June 2009, UNICEF identified that it planned to perform a national survey of women and children's nutrition. They were going to collect samples and send them to a laboratory in Indonesia for testing. The director of NCDCPH Imereti Branch Zonal Diagnostic Laboratory (ZDL) who was in attendance, mentioned that his renovated lab had the capability and capacity to do the testing within Georgia. As a result of the Roundtable Meeting, UNICEF toured the Kutaisi ZDL and identified as a full-capacity laboratory that could perform the testing of biologic specimens for the UNICEF's 'Georgia National Nutrition Survey' project. Shortly following the Roundtable Meeting, the contract was awarded and Kutaisi ZDL successfully conducted the multi-indicator testing of samples from a total of 4,043 households across Georgia. The target population of the survey included children 0-59 months of age, non-pregnant women of child-bearing age, and pregnant women. With the results of the National Nutrition Survey, published in June 2010, the Georgian government can make more informed policy decisions since it has a better baseline understanding of the nutritional issues that may impact women and children's health.

Quality: As part of the survey, quality control measures were put in place to validate the capability of the Kutaisi laboratory. The validity of the ferritin and CRP laboratory results from Kutaisi Zonal Diagnostic Laboratory has been confirmed by blinded duplicate testing by HUMAN GmbH in Wiesbaden, Germany (an aliquot of a random selection of 400 serum specimens obtained from children and women during survey data collection were sent to the German laboratory). In addition, a subsample of 30 salt specimens obtained from households during the survey data collections were re-tested in a salt iodine reference laboratory in Ukraine. The coefficient of correlation between the Georgian and Ukrainian laboratories' was quite high demonstrating that the results were very similar¹.

Transition: Since then, the Kutaisi laboratory has undertaken three externally funded projects, which provided additional financial support to this institution, increased its linkages with international partners and expanded their ability to become self-sustainable in the near future.

USAID Guaranteed Private Financing Ensures Access to Modern Healthcare in West Georgia

USAID Development Credit Authority (DCA) is used to encourage financial institutions to lend to underserved borrowers and sectors in developing countries. For the first time in its history since 1999,

DCA guarantee has been used in Georgia to stimulate private lending to the health sector for construction and renovation of remotely located hospitals serving vulnerable and disadvantaged population groups, including women and girls.

At the end of 2006, the Government of Georgia embarked on a health reform strategy by turning to market mechanisms to enhance access to health care, upgrade dilapidated health care infrastructure, improve the quality of health care services, and increase the efficiency of service provision. The Government pursued a three-pronged strategy: better means-tested targeting of state resources to address the health needs of the poor and disadvantaged; increased privatization of health care providers (including hospitals and primary health care facilities); and, an enhanced role for private health insurers. As a key component of the privatization effort, in 2007 the GoG announced the launch of the *100 New Hospitals Initiative*. According to the plan, new modern hospitals were to be built by private investors over the next few years to replace 250 existing obsolete ones.

The subsequent war in August 2008 and the repercussions of the global economic downturn in Georgia placed great strains on the investors. The collateral value of the hospital real estate controlled by the winning bidders had substantially declined, reducing their ability to mobilize financing. In the light of these developments USAID/Georgia negotiated with the major Georgian banks about the possibility of a USAID partially guaranteed loan to hospital investors. In parallel, USAID conducted risk analysis of the possible loan. Several months of negotiations resulted in approval of the loan guarantee by the USAID Credit Review Board and signing the loan guarantee agreement with TBC Bank, one of the leading commercial banks in Georgia. According to the loan guarantee agreement, TBC Bank issued an eight million U.S. Dollar loan to one of the biggest hospital investors, Block Georgia, to renovate and build eight medium and small hospitals in West Georgia. Only \$515,000 was paid as a subsidy cost to the special DCA account for leveraging eight million in private capital intended for construction of hospitals. In less than one year from signing the loan guarantee agreement, Khobi and Abasha district residents are already served by modern hospital facilities in close vicinity of their homes. Moreover, USAID, through its grant, assisted Block Georgia in renovating a geothermal well located next to Khobi hospital. The hospital now has access to hot water and a heating system using this renewable and sustainable energy source.

Darejan Kikvadze, a school teacher from Abasha, is covered through the government paid health insurance for public school teachers. Before, she had to travel to Kutaisi or Zugdidi to receive elementary medical services. Today she can walk down to the new Abasha hospital for a regular check-up and blood tests. Nini, an 8 year old girl with pneumonia from Khobi, will soon be discharged from the newly renovated hospital healthy and fit. Her mother is extremely satisfied with the hospital environment, quality of patient care and is expressing gratitude to the medical personnel caring for Nini.

By the end of this year Block Georgia through the USAID guaranteed loan will complete renovations of another six hospitals. From January 2012 residents of Kutaisi, Poti, Tskhaltubo, Martvili, Chkhorotskhu and Tsalendjikha will also be served by modern, newly renovated and equipped hospitals, now forming First Georgia Hospital Network. Altogether, the modernized hospitals will serve more than 700,000 persons, including 107,000 internally displaced persons living in the covered districts.

ⁱ Report of the Georgia National Nutrition Survey 2009 (UNICEF, 11 June 2010)