PROJECT FICHE

Title	Support to ongoing Primary Health Care reform		
Indicative cost	€7 million		
Aid Method	Centralised management		
DAC-code	12100	Sector	Health

1. RATIONALE

1.1. Strategic framework

The Country Strategy Paper (CSP) 2002-2006 and Indicative Programme 2004-2006 for Georgia foresee support for addressing the social consequences of transition, with a focus on reducing poverty by targeting assistance to the poor and most vulnerable. One of the main areas of assistance concerns the health sector, in particular support to Primary Health Care (PHC), to improve overall health status and distribution of health gain in the population, in line with the priorities identified in the Strategic Health Plan and the Economic Development and Poverty Reduction Programme[1] (EDPRP) of the Georgian Government[2]. The EDPRP represents a long-term strategy of socio-economic development of the country and identifies the development of human capital, in particular improving the health condition of the population as crucial in terms of sustainable economic development and overcoming chronic poverty of individuals and families. The CSP is in line with the Statement on Development Policy, adopted by the Commission and the Council in November 2000 which, for countries like Georgia, identifies poverty reduction as the primary focus of the EC's development assistance. As in Georgia ill health is both a dimension of poverty and an important factor in generating poverty, the proposed intervention under AP 2006 is very relevant to the country context.

Primary Health Care was identified as a priority for reform in Georgia in 2000 in order to address the main health problems and burden of disease, improve the efficiency, quality, and cost-effectiveness of the health system, and contribute to poverty reduction. The Georgian government secured a US$20 million loan from the World Bank in 2003 to develop over a period of five years (2003-8) a new PHC model based on Family Medicine (FM), which effectively and reliably provides the entire population with high quality yet cost effective medical services. Three pilot regions were identified to start the reform- Kakheti region supported by the EC, and Adjara and Imereti regions supported by the World Bank.

The proposed project is a continuation of and builds on EC assistance provided under earlier Action Programmes 2002/3 and 2004/5 in support of the development and implementation of the new model of PHC. In response to the government's request, investments shall focus on a new region where the model will be introduced, Kvemo Kartli. Assistance will continue to be closely coordinated with other international donors across and within the PHC sub-sector to support the capacity of the government to implement and manage a comprehensive health sector strategy and reform efficiently and effectively. This is in accordance with the EC general policy on cooperation with third countries, as outlined in the Guidelines on EC Support to Sector Programmes (the project should be seen as a preparation project in perspective of Sector Support possible under European Neighbourhood Programme (ENP).

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[1] The EDPRP sets out two overarching strategic objectives:
a) Fast and sustainable economic development with an average growth rate of real GDP at 5-8% per year, which should ensure two-threefold growth of real GDP by 2015 in comparison to 2001.
b)Reduction of extreme poverty from 14% to 4-5% of the population and reduction of less severe poverty (defined as the official subsistence minimum) from 52% to 20-25% of the population by 2015.

[2] The EDPRP was adopted by the former Government in June 2003 and re-confirmed by the current Government.

1.2. Lessons learnt

- With many donors participating in various areas of health reform (EC, World Bank, DFID, USAID and WHO), both donors and contractors need to work more effectively together to ensure that key messages are delivered in a clear and effective manner to the government and coordination takes place. Project experts will work through the government led working groups on health financing, health service delivery and human resources, HMIS and IEC reform issues. Donors will hold monthly partner's meetings and support the government in developing a donor coordination mechanism, which is linked to a general health sector reform implementation plan, and clearly specifies donor project contributions. This mechanism will allow the MoLHSA to better manage donor contributions and limit the expansion of activities beyond scopes of work that have been agreed upon by each stakeholder/donor/contractor.

- The EC will continue to rely on government structures where possible to support ownership and sustainability e.g. in the case of re-training of medical workforce, the EC project supports the capacity of the supervisory body, the National Institute of Health and Social Affairs and the Government licensed Family Medicine Training Centres (FMTCs) in managing the training programmes, which ensures that all re-training is meeting national standards and recognition.

- On request of the Government, the EC targeted its main investments under AP 2002/3 to one selected region Kakheti. Although the EC project promotes consultation with all stakeholders and participation of the region in the reform process, the government so far has not adopted a wider consultation and participation strategy with stakeholders and beneficiaries, which poses a risk to successful implementation of the reform as the population at large remains uninformed about the changes. The development of a systematic consultation mechanism by the MoLHSA at the level of health policy design and implementation of the reforms is an important element of a Sector Programme and will be supported under AP 2006.

- The EC will follow a clear Sector Approach to support the government's decision making capacity and ownership over its health sector reforms and health policy directions, to contribute to developing coherence between health policy and expenditure, to monitor impact and to minimise transaction costs for the government by following government procedures as much as possible. The EC and World Bank projects will follow a more or less identical approach. Under AP 2006, the conditions of a Sector Programme will be worked on by the Government and partners to allow for a possible Sector Policy Support Programme (SPSP) under ENP.

1.3. Complementary actions

The EC provided support to Primary Health Care reform with 7.5 million Euro under Tacis Action Programme (AP) 2002/3 and 2 million Euro under Tacis AP 2004/5. The Tacis assistance consists of several components complementing each other with the objective to address the main problems in the financing of Primary Health Care and improve the access and quality of basic health care service delivery:

a) Health care finance system reform, focusing on the implementation of sustainable PHC financing mechanisms (AP 2002/3 - 2.5 million Euro, Service Contract).
b) Strengthening the capacity of the public health purchasing organisation (SISUF). (AP 2004 - 1 million Euro Service Contract)
c) Investments in terms of refurbishment of selected PHC infrastructure and provision of essential medical equipment in Kakheti region - a total of 57 medical facilities and laboratories. (AP 2002/3 - 4 million Euro, Grant Contract).
d) Re-training of selected number of doctors, nurses and practice managers according to the Family Medicine approach. (AP 2002/3 and AP 2004/5 - 2 million Euro, Service Contract).
e) Support to the establishment of a HMIS system in Kakheti Region –equipment and software (AP 2002/3 - 200.000 Euro Supply Contract),

f) Information and health promotion activities in communities in Kakheti region, included in above mentioned Grant Contract of 4 million Euro.

The combination of technical assistance and capacity building support at national and regional level with investment in human resources and health infrastructure at regional level through different types of assistance instruments (service, supply, grant) has allowed the EC to concretely contribute to visible reform initiatives in the short-term while at the same time supporting the long-term reform process. The EC was able to respond to urgent requests for technical advice on the transformation of the State United Social Insurance Fund (SUSIF) and re-design of the health and social sector legislation in support of the reforms undertaken through additional policy advice projects. The EC Delegation has put a strong focus on design of the separate activities into one comprehensive program of complementary actions, complementary also to other donor's interventions.

Under the EC Programme of Aid for Policies and Actions on Reproductive and Sexual Health Rights in Developing Countries, a 2.3 million grant has been awarded to UNFPA to support reproductive health activities targeted to youth in the Caucasus in 2006-7.

Other main donors active in the health sector are the World Bank, DFID, USAID, WHO and UNFPA. The World Bank has supported the ongoing hospital restructuring reform undertaken by the Government (Health Loan I) and provided a Health Loan II of 20 million US dollar for the reform of Primary health Care. DFID supports the Primary Health Care reform with a 7 million Euro technical assistance grant focussing on health service delivery and human resources development, organisation and development of the MoLHSA, health management and information system development, licensing and accreditation, and health information and education aspects of the reform. USAID focuses on the reform of the secondary care financing system and assists the government with the establishment of National Health Accounts. USAID also assist the MoHLSA with the organisational development of the Ministry. WHO is mostly active in hospital management development and contributes to health policy and health financing dialogue. UNFPA is supporting reproductive health policy development and promotion.

1.4. Donor coordination

The EU, World Bank and DFID, the major contributors to the primary health care reform signed a Memorandum of Understanding with the MoLHSA in January 2003 to ensure cooperation and coordination in PHC reform, in order to optimize the benefit of international assistance. The three donors committed themselves to work through a PHC Coordination Board and PHC Management Committee through which the various assistance projects are managed. Areas of reform and donor project contributions and foreseen expertise in those areas were identified. This allowed the government to identify gaps and potential overlap, which the donors took into account preparing their assistance. In 2004, a PHC National Coordinator was appointed to lead the PHC reform activities on a day-to-day basis and working groups led by the PHC management coordinators on the main reform topics were established at the Health Policy Unit at the National Institute of Health and Social Affairs. The coordinators of those working groups constitute the PHC management committee. In regular donor information sharing meetings in Tbilisi, chaired by donors on a rotational basis (EC, World Bank, DFID, USAID, WHO), the programmes and approaches of different donors are discussed. For the second part of the donor meeting, the National PHC Coordinator is normally invited to participate to have an opportunity to put common messages across to the government. Important policy decisions are taken forward to the PHC Coordination Board, which consist of representatives of the Ministry of Health, Finance, regional health administrations, civil society and donors and is chaired by the Minister of LHSA. Support to the government to improve its donor coordination mechanisms are currently being considered as part of the government's ongoing re-organisation efforts. Duplication of functions (e.g. policy and budgetary functions are conducted by MoLHSA departments and units under the National Institute of Health and Social Affairs, an agency subordinate to the MoLHSA), unclear lines of responsibility and accountability, inefficient information sharing and consultation mechanisms, and significant staff reductions, have not contributed to reform implementation efforts

and affected donor-government relations. It is generally agreed that the current structure with the PHC Board headed by the Minister as a top level decision body and with the Health Policy Unit as analytic and research body have to be complemented with a PHC Implementation Unit that will be responsible for fulfilment and coordination of all implementation activities. Such unit should act directly under the Minister or a Deputy Minister and should report to the PHC Board.

The World Bank and EC share a similar intention in terms of supporting the government in developing a sector approach. Although DFID does not foresee new assistance beyond 2008, the agency is committed to support this direction during its ongoing programme. Improvement of donor-government coordination mechanisms is an important condition to move towards a Sector Programme.

2. COUNTRY CONTEXT

2.1. Cooperation related policy of beneficiary country

Following the Rose Revolution in November 2003 and the elections in January 2004 that brought a new government under President Mikhail Saakashvili to power, the initiated reforms in the health sector slowed down, but regained new momentum in November 2004, when a Road Map for PHC reform with short-term goals as part of a long term reform process was adopted and milestones set. New international organisations joined to support the process of reform in the health sector with the aim to enhance access to quality primary health services, rationalize secondary and tertiary care, and improve the budgetary and resource allocation processes in the health sector.

In the Government Programme – Basic Data and Directions for 2006-2009 – the main reform activities in the health sector are stated to be aimed at increasing the per capita expenditure for health purposes in the state budget, formulating a cost effective health sector budget, introduce structural re-organisation and institutional changes in the sector that will promote an efficient utilization of resources, introducing a relevant policy for licensing, accrediting and certifying (both public and private) providers of medical services and staff, the establishment of a sustainable financing strategy, and definition of new basic benefit package based on health priorities for the whole population. The main directions for PHC reform are identified as a) the rehabilitation and equipping of state owned primary health-care clinics, b) optimization of human resources by downsizing the number of narrow specialists and increasing the number of family doctors and nurses, c) gradual increase of the share of primary care service in total of budget of health care sector, and d) formalization of “paid from pocket” practice, ensuring systematic and efficient utilization of this resource.

The government has acknowledged the need for an updated comprehensive health sector policy and medium term strategy with coherent budget framework, which is envisaged to set the main directions in the health sector. The validity of the Government Programme Directions on health is therefore not very clear.

The government has initiated several steps to improve access to quality primary health care. In the short-term, the Primary Health Care reform is to be pursued through the introduction of a new model of PHC based on Family Medicine in three regions - Kakheti, Adjara and Imereti- , where a selected number of key medical facilities based on a plan of optimisation, will be refurbished and equipped with re-trained family physicians and nurses and essential medical equipment with the support of the EC (Kakheti) and the World Bank (Adjara and Imereti). Emphasis is put on providing access to services in rural and mountainous areas. The next regions on the reform agenda are Shida Kartli (financed by World Bank) and Kvemo Kartli (EC).

Studies regarding the content of a revised BBP for primary health care are undertaken by the EC and DFID in line with the government’s intention to have a BBP provided to the entire population, which is simple and clear in structure of services. New financing, payment and contract mechanisms are being introduced in the three pilot regions, developed with EC assistance under AP 2002/3, to create incentives for efficiency and quality and to promote competition and choice. As drugs are the single

most important out-of-pocket expenditure (more than 50% in Georgia) and cost of prescribed drugs deters patients from early diagnosis and treatment in PHC, the rational use and financing of essential medicines is essential. Both USAID and EC contractors are currently working on recommendations for PHC financing policy and essential medicines. In 2006, the Ministry has decided that a universal Basic Benefit Package of services is provided to the population. This package will cover: public health activities, prevention and treatment for (socially hazardous) priority diseases (such as tuberculosis, HIV/AIDS, mental health), and Primary Health Care. The comprehensive BBP for PHC is defined with five components- preventive, curative, laboratory, drug and administration components. Different modifications of the remuneration mechanism for PHC practices were developed and corresponding tariffs calculated. The calculations are based on a comprehensive cost model with normative cost data. Total public expenditures were estimated for the reformed PHC in Kakheti region and projected to the whole of Georgia. The principal result of the calculations is per capita expenditures for PHC. The BBP and the planned network in Kakheti require around 10 Gel per capita annually including all depreciations. If the drug component is added some 5-7 Gel per capita would be required in addition to ensure both protection and attraction of the reform PHC for the population. The task remains to bridge the gap between current 4 Gel capita and desirable 10-15 Gel in the long perspective. Different bridging scenarios that combine further optimization of the current network, increase of public funding and potential official co-payments are currently assessed and calculated.

The final draft health budget for 2006, submitted to the Parliament in December 2005, reflects a 30 % percent increase in overall health care spending in comparison with the year 2005 which is in line with the government policy documents. However, the budget of the Inpatient Care State Programme for 2006 has increased with 55%, while under the State Ambulatory Programme, a 10% increase for the implementation of a new model of PHC based on Family Medicine is foreseen, which comes down to a 2 million GEL increase. According to the MoLHSA this amount is allocated to finance the first number of new Family Medicine practices which will become operational in Kakheti, Imereti and Adjara in 2006, which are only 95 medical units in 2006 in addition to the ambulatory care programme (One unit consists of one FM doctor and one FM nurse). According to the government the share of primary care health care in the total budget will increase over the coming years with the incremental operationalisation of new family medicine (FM) practices.

The First Deputy -Minister of Health and the Health Policy Unit (HPU) within the National Institute of Health and Social Affairs (NIHSA) have very recently started to elaborate the first directions in the health sphere. Due to ongoing human resources re-organisation and revision of the functions of the various departments and institutes under the MoLHSA this process is expected to be taking time, but the initial process has been started. The re-organisation of the Ministry has also not facilitated the development of a sector MTEF which was initiated with the support of DFID in 2005, but is stated to be only addressed over a longer timeframe. The overall support required in this field is to be taken forward by the WB-DFID-Dutch government funded Public Sector Reform Programme in 2006.

2.2. Sector context

The health sector in Georgia faces significant challenges. Health outcomes are stagnant or worsening: Georgia is one of the few countries in the CIS where important Millennium Development Goals in health—early childhood mortality and maternal mortality—do not exhibit a positive trend. Also, non-communicable diseases causing premature adult mortality are increasing. Georgia has the lowest health service utilization in the Europe and Central Asia Region with less than 2 outpatient visits per capita and less than 5 inpatient visits per 100 people. Being ill increases the probability of becoming poor, as 10% more individuals fall below the poverty line after incurring hospitalization expenditure. As a result, only 43 percent of the poorest quintile seeks care for chronic illnesses compared to 62 percent of the richest one. As out-of-pocket expenditures are required for receiving care, 73 percent of chronically ill cite lack of resources as the principal reason for not utilizing health services. Poor people have to pay for health services more than rich ones, not only in relative, but also in absolute terms.

A number of reasons are to blame for the deteriorating health outcomes, the low utilization rates and the high out-of-pocket payments, of which more than 50% are spent on drugs. Public spending on health is less than 1% of the GDP or GEL$18.8 (around US$10) per capita annually. Under-financing of the health sector is coupled by inefficiencies in the management of public resources (e.g. allocation of funding based on historical budgets, contracts with all public health providers, etc). There are a high number of health care providers both at the primary and the hospital level, thus spreading the limited budget thinly and leading to high fixed costs for health care delivery.

3. DESCRIPTION

3.1. Objectives

- Overall objective: Addressing the social consequences of transition in Georgia: improve overall health status and distribution of health gains in the population.

- Specific objective: Contribute to improve the access, quality and utilisation of primary health care services to the Georgian population, in particular for the poor and vulnerable, in Kakheti and Kvemo Kartli regions.

3.2. Expected results and main activities

a. Expected results

1. Institutional capacity and responsibility of MoLHSA over health care system reform enhanced
2. Capacity to implement reform and manage health care system at the regional level improved.
3. New financing mechanisms for PHC facilities further developed and implemented
4. Facilities refurbished and equipped
5. Human resources development and HR management strengthened
6. IEC and health promotion strategies implemented
7. HMIS established and functional

b. Main Activities

Result 1: Activities

- Support the development and implementation of a coherent mid-term health sector strategy and action plan with milestones, reflecting the Government's reform priorities.
- Support the MoLHSA institutional capacity in specific areas, such as donor coordination, monitoring and evaluation, client consultation mechanisms.
- Support a feasibility study assessing the conditions in place for future health SPSP and recommendations for the type of aid modality and possible related conditionalities.
- Assistance to the further re-design/reform of health and related social sector legislation in support of the overall health sector reform.
- Organise regular exchange on implementation between pilot regions and central level of MoHLSA
- Support closer link between policy making and budgeting (i.e. between MoHLSA and MoF)

Result 2: Activities

- Build capacity at local level in terms of implementation and management of the reformed system, based on needs assessment.
- Assist the national and regional structures with definition of the relationship, roles and responsibilities at the different levels.

- Support the implementation of sustainable stakeholder consultation mechanisms (e.g. MoLHSA should inform the regional PHDs, providers and patients about new regulations and norms, while the regional departments should provide feed back to the national level in terms of functioning of the PHC system, identified problems which should be solved, health needs of the population and local developments).
- Train regional bodies (Regional Health Department, regional SUSIF, and Regional Public Health Department in the new Family Medicine model and financial management of new PHC, building on the training programme developed by GVG-EPOS under AP 2002/3 for Kakheti region.
- Provide IT hard and software and practical application training to the regional bodies for Health financing and health management information services, building on GVG-Epos IT training programme under AP 2002/3 for Kakheti region.

Result 3: Activities

- Support an evaluation of the implementation of the Health Financing Master Plan developed towards sustainable financing of the PHC services in Kakheti and the 2 other pilot regions, developed by the EC funded project GVG-EPOS under AP 2002/3.
- Agree with MoHLSA and international partners on evaluation results and consequences for model design and on best modalities of rolling out.
- Training in Financial Management to PHC providers, building on the training programme developed by EC Contractor GVG-Epos under AP 2002/3 and applied in the 3 pilot regions.
- Support the development of an effective referral system, integrating primary health care with other levels of care.
- Support the implementation of an effective drug financing policy for PHC.
- Monitor regularly financial accessibility

Result 4: Activities

- Identify and address remaining refurbishment needs in Kakheti Region, in particular in the high mountainous areas.
- Refurbish/construct selected medical facilities in Kvemo Kartli, starting with the smallest rural and mountainous ambulatory units according to national set standards. Based on a review of the Kvemo Kartli health masterplan, the refurbishment will be conducted in close cooperation with Kvemo Kartli local authorities and population. Water and energy requirements of the facilities will also be taken into account.
- Provide essential medical equipment in line with the standard medical equipment requirements identified by the MoLHSA with support of the EC under AP 2002/3.

Result 5: Activities

- Identify and address remaining re-training needs in Kakheti Region, in particular for the high-mountainous areas.
- Re-train physicians and nurses from selected facilities from Kvemo Kartli.
- Assess and address local training capacity and HR management requirements.

The re-training activities will build on the support provided by the EC under AP 2002/4 in this field and shall take into account the evaluation to be undertaken by EC Contractor HLSP and DFID Contractor OPM in 2006 of the re-training programme conducted by the FMTCs and the management of the re-training process by the NIHSA and regional health departments. DFID and WB support the overall development and institutionalisation of Family Medicine continuous education and training at national level.

Result 6: Activities

- Support the regional (health) administrations in communicating the Primary Health Care reforms among the public and professionals at regional level.

- Build capacity of regional public health department, health care providers and communities to promote health awareness and healthy lifestyle in Kvemo Kartli.
The IEC and Health Promotion Strategy activities which were developed and implemented in Kakheti Region with the support of the EC under AP 2002/3 will be introduced in Kvemo Kartli, taken into account best practices and lessons learnt derived from the KAP surveys and evaluation activities to be undertaken by EU Contractor Merlin in 2007 in Kakheti region.

Result 7: Activities

- Introduce the HMIS model for PHC in Kvemo Kartli, which was developed and tested in Kakheti Region with funding from the EC and DFID to streamline administration and improve the efficiency of primary health service delivery.
- Train regional bodies in Kvemo Kartli in using the HMIS system, building on the training programme developed by OPM, tested in Tbilisi and implemented in Kakheti Region. The HMIS is designed to meet the management information requirements of the various support activities within the PHC reform programme with the aim of providing a mechanism for collecting, processing and disseminating information on health care resources, activities and outcomes in a standardised format to enable effective management and delivery of PHC. Currently existing information will be examined to assess health care utilisation by the poorer segments of the population; if needed the establishment of regular survey mechanisms for obtaining such information will be supported.

3.3. Stakeholders

Ministry of Labour, Health and Social Affairs (MoLHSA)	Project main partner. The Ministry is in charge of the PHC reform and takes main responsibility over implementation.
Regional (health) administrations in Kakheti and Kvemo Kartli regions	Project partners and key stakeholders. Capacity and resources at regional level are limited and will be strengthened under AP 2006
The National Institute of Health and Social Affairs (NIHSA) – Health Policy Unit.	Project partner. The Director of the NIHSA assumes the function of Primary Health Care National Coordinator and reports directly to the Minister. NIHSA – Health Policy Unit supervises the PHC management committee and PHC working groups.
Ministry of Finance	Member of the PHC Board. Plays an important role in terms of decisions on health financing reform issues and the budget.
Parliament.	Key stakeholder in the reform process and re-design of the legislation in support of the reform
PHC Board	Chaired by Minister of LHSA. Consists of representatives of Ministry of Health, Finance, Parliament, Civil Society, Professional Associations, Donors. Makes important reform policy decisions.
The Association of Family Medicine Training Centres and the State Medical Academy	Main providers of Family Medicine mini-residency training and continuous medical education. The only bodies licensed for FM education the moment.
State United Social Insurance Fund	The Fund's department in Kvemo Kartli contracts the health care providers. Recipient of training and IT to conduct new administration, contract and payment processes.
Center of Medical Statistics and Public Health Departments	Main role in the HMIS establishment. PH department in region is regional hub for HMIS and key partner in the health promotion and disease prevention activities in the region
Health Care Providers	Key stakeholders mostly affected by the reform in the short-

	term. Incentives to improve their performance are key to the success of the reform. Participation in the reform process of health providers is crucial. Selected no of doctors and nurses will be re-trained in Family Medicine and selection of those will become ToT in the regions.
Civil Society	Civil society – NGOs and media are to be actively involved in the IEC component of the project. Currently a NGO representative is member of the PHC Board on a rotating basis. DFID supports the development of an NGO platform under its Public Relations support component.
Population	End beneficiaries are directly targeted through IEC and health promotion activities in their communities.

3.4. Risks and assumptions

Establishing an effective system of PHC requires optimisation of the current system and significant spending on staff training and remuneration, equipment, buildings and running costs. Inevitably levels of funding determine the extent of primary health care. Continued political commitment by the Georgian Government, in particular the MoLHSA and the Ministry of Finance is critical to the development of PHC and the health sector reform process and a condition for further EC assistance. This commitment should be reflected in an incremental increase in public expenditure for health in particular in primary health care in the next years and a shift in priority of funding to Primary Health Care in the health sector budget conform the government's declarations in its national strategic policy documents.

Particular challenges for the government include the implementation of a pro-poor health policy making the health system more equitable (fair financing, equal access and more equal utilisation).

RISKS	CONSEQUENCES	COUNTER MEASURES
The Government does not proceed to reform the health sector and the health care financing system in a global way.	The reforms cannot be implemented properly. Results will be unsustainable.	Key focus of the expertise should be on the promotion of a holistic sector approach and strengthening of the linkage of secondary and tertiary care reforms (hospital restructuring) and primary care reforms.
The MoLHSA delays its organizational restructuring and does not take effective leadership and ownership over the reform	The reform cannot be implemented properly. TA absorption capacity and decision-making capacity remains limited at MoLHSA.	Necessity to have key focus on institutional strengthening and capacity building of MoHLSA
The Government delays the modification of the legal framework.	The reform takes more time than initially planned	The expertise needs to be reoriented to the reform activities that can be done without modification(s) of the legal framework
National consensus- on a reform programme based on national priorities and objectives is not achieved	The reform cannot be implemented properly due to resistance of stakeholders.	The expertise needs to be focused on the implementation of a country wide reform information strategy

3.5. Conditionalities

- Increase in government health care spending for PHC per capita approaching 15 GEL.
- Pro-poor government policies including monitoring of resource allocation, access and utilisation of health services for the poorer segments of the population.

- The formulation of an updated national health policy and the translation of the policy into a strategy and plan of action with clear milestones, deliverables and corresponding budget.

3.6. Crosscutting issues

Poverty Reduction: The health of the population is a key determinant of economic growth, while ill health is both a cause and effect of poverty.

Gender: Gender dimension of poverty and health should be taken into account. The project should adequately address gender specific health needs. Women play a key role as caretakers of their family's health and are generally the most active members in their communities in terms of information transfer.

4. IMPLEMENTATION ISSUES

4.1. Implementation method

Centralised management.

4.2. Budget and calendar

The technical assistance component of the project is planned to be implemented via service contract(s). In addition, supply contract(s) could be used for procurement of equipment. The implementation of the infrastructure component of the project might consider the use of works contract(s) or grant agreement, as deemed more appropriate and adequate.

The indicative allocation for the project is €7 million. Around €3 million of these funds are planned to be allocated to the technical assistance component of the project. In addition, approximately €0.7 million is earmarked for the supply component and €3.3 million for the infrastructure component. This breakdown might be adjusted in the course of the implementations of the project.

The project duration is estimated at approximately 36 months and the project is planned to be taken forward in 2007.

4.3. Procurement and award of grants procedures

All contracts implementing the financing agreement must be awarded and implemented in accordance with the procedures and standard documents laid down and published by the Commission for the implementation of external operations, in force at the time of the launch of the procedure in question.

All programme estimates must respect the procedures and standard documents laid down by the Commission, in force at the time of the adoption of the programme estimates in question.

4.4. Performance monitoring

The project will be monitored by the Tacis monitors, based in Tbilisi. Evaluation of activities and results monitoring shall be incorporated in the project design.

4.5. Evaluation and audit

An ex – post evaluation should be performed by the Tacis monitors a year after the implementation of the project is ended.