

GEORGIA HEALTH CARE SYSTEM TRANSFORMATION (HCST) SCOPE OF WORK

I. INTRODUCTION

The purpose of this scope of work is to provide Technical Assistance to the Ministry of Labor, Health and Social Affairs (MoLHSA) to: (a) identify gaps in health care policy with particular emphasis on reforming health care financing (HCF) and reproductive health and family planning policy; (b) support to effective reforming of (public and private) health finance policy and models of health care delivery and financing; and (c) improving transparency and accountability in health care costs and management.

II. BACKGROUND

Adequate financing in the health sector of Georgia is a major challenge and stems in large measure from the collapse of Soviet-style health systems. Before the 1990s, central budgeting had dominated the policy and practice of provider reimbursement in the health care sector of Georgia. Under the old system, production capacity (e.g., hospital beds, staff) and utilization of services (e.g., number of inpatient days or outpatient visits) drove the financing of health care providers. The financing system did not contain incentives for higher workloads, better management, or clinical and technological innovation. The supply of health care resources (physicians and hospital beds) continued to grow and reached an excessive level in the economy. Total health care system productivity has been on the decline since the mid-1960s and, to make matters worse, scarce budgetary resources have been diverted to redundant capital investment in defense programs.

After the dissolution of the Soviet Union, the rapid disintegration of the old centrally controlled economy and a civil war left Georgia with a collapsed economy. The system underwent enormous upheaval and was no longer uniform or as highly regulated. In 1995, in response to this economic crisis that brought public expenditures on health to a level of less than US\$1 per capita, the Government of Georgia (GOG) launched an ambitious health sector reform program. The vision of the future health system was a social insurance model, maintaining the principles of solidarity and equity. However, the reality was that scarcity of state financing shifted the financial burden to the population. Underdeveloped private insurance is not yet able to meet existing "needs", to pool available private resources and to increase the volume of prepaid funds for health care funding. That's why, seeking alternative solutions becomes of prime importance for Georgia.

In the Georgian health sector, the problems posed by lack of adequate resources are compounded by lack of knowledge about the optimal pattern for reallocating existing resources or applying new resources. There have been significant, recent advances in the state of knowledge in this area. However, several special considerations still prevail: the confluence of multiple and conflicting goals; the multifaceted nature of constraints faced by the GOG; and market failure in health care delivery and health insurance.

III. DEVELOPMENT CHALLENGE

As in the majority of post-communist countries, health care financing in Georgia is a mix of government, employer, and private financing. Unfortunately, no model has been effectively implemented in Georgia, and the management of health care funds and the level of funding actually reaching service delivery providers has fallen short of expectations. A primary reliance on payroll tax proved to be ineffective. The volume of resources generated from the payroll tax generated only 3% of total health expenditures due to widespread tax avoidance. This seemingly intractable problem in public financing of health care shifted the major part of health care costs directly onto patients. There continues to be an excess supply of physicians and health facilities. Georgian citizens continue to have a low awareness of their health care entitlements. All these factors have impaired the full implementation of changes and have

hampered progress towards the achievement of reform objectives. In short, the GOG failed to effectively implement alternative ways to finance health services and ensure adequate coverage for the most vulnerable.

Public spending is on a par with the poorest countries, yet the population expects a level of service delivery closer to Western Europe standards. Health care costs are becoming increasingly burdensome for the population, as these expectations are met with higher shares of private spending. Patients are paying more out of pocket to obtain essential health services. In 1998, private spending on health amounted to 83% of total national health expenditures estimated at USD 290 million¹, paid mainly from household incomes. Due to the recent political changes and the expectation of improved GOG's fiscal performance, there is a new "window of opportunity" to make the current system more efficient by instituting health policy/financing reforms -- in collaboration with government, citizens, and communities -- to pilot community health funds, to pool risks, and to formalize individual health care expenditures.

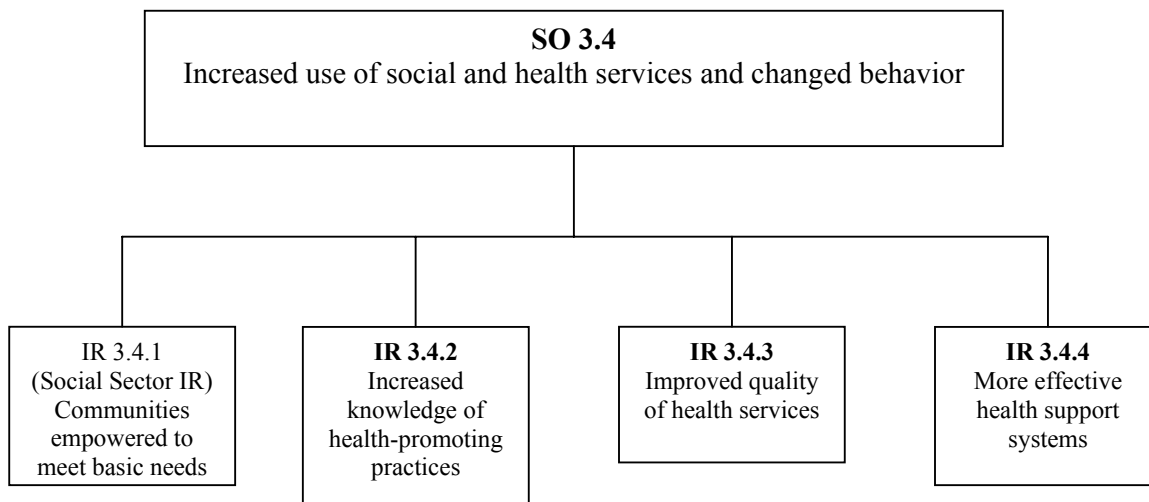
During this period of governmental and donor flux, HCST activity will have to consider all manner of conflicting advice, analyze its rationale, and try to synthesize inconsistent information/data. Thus, an important task is to build skills in the analysis of institutional risk and to bring together the diverse views of the many actors who influence health policy in Georgia. The key challenge is to find ways to link the management of the sector to the achievement of the desired results. Training of local professionals in various aspects of health finance, health economics and health policy analysis -- as well as direct financial aid to the new government committed to health finance reform -- should yield positive results. Health financing policy reform is as much a political, as it is a technical, process. It requires politically and culturally sensitive assistance from USAID. There will be no universal formulas.

IV. USAID/CAUCASUS APPROACH

Throughout the previous strategy, USAID has maintained its focus on supporting disease-specific programs. Such programs proved vital to Georgia at the hardest stage of socio-economic transition. Now USAID stands at an important crossroads. The new health Results Framework dedicates more resources to systemic reforms. In this context, health system strengthening supports all health-related Intermediate Results (IR), including IRs which target specific health risks and population groups.

Health Care System Transformation (HCST) activity will contribute to the Mission's re-formulated Strategic Objective (SO) 3.4 -- "Increased use of social and health services and changed behavior", specifically Intermediate Result (IR) 3.4.4 -- "More effective health support systems".

¹ Jim Mays, Molly Shiefer, "Analysis of Alternative Health Financing Reform Options for Georgia". February 1999.



Support to other IRs: The logic of this Results Framework is that people will increase their use of services and change their behaviors when they *know* about such services and behaviors, when the *quality* of services is improved, and when *systems* provide more effective support of the interaction between patients and providers. In other words, to increased knowledge and improved quality, health services must be supported by effective *systems* in order for people to use them more. Similar to how the interaction between buyers and sellers would be constrained by the lack of an effective market-place, so is the interaction between patients and health care providers in Georgia currently being hindered by ineffective health support systems. If key systems—including evidence-based health management, disease surveillance, adequate health financing, and others—are strengthened, the use of health services will increase.

Health Care System Transformation (HCST) activity will engage the GOG at the national level and help transform the health system to one that is more efficient, accountable and transparent. Increasing resources and improving the management of the health sector system will have a direct impact on the access to, quality of and utilization of services which all lead to improved health. Sub-activities will target three priority areas: health care financing (HCF), reproductive health/family planning (RH/FP), and institutional strengthening at the national level. Assistance to national level health entities will enhance the Ministry of Labor, Health and Social Affairs (MoLHSA) ability to strategically manage health care financing and improve the regulatory environment to assure a sustainable reformed health care system. This technical assistance “package” is expected to yield sizeable results with a modest investment of resources. Technical sub-agendas are more thoroughly discussed below.

V. EXPECTED RESULTS

HCST activity will: (1) improve transparency in health care costs, address the existing financial barriers to access, and stimulate improvements in efficiency and quality of health care services; (2) identify gaps in health care policies with particular emphasis on reforming Health Care Financing (HCF) and reproductive health/family planning policy (RH/FP).

Program outcomes can be grouped into two categories:

Institutional Strengthening of Health Policy and Financing Reforms:

- Improved MoLHSA’s organizational structure and function that is supportive of the new HCF reform environment.

- Improved resource allocation within the health sector that is consistent with GOG goals and objectives for poverty alleviation and the application of subsidies.
- Redesigned Basic Benefits Package (BBP) for secondary care based on Georgia-specific evidence from benefit-cost and demand assessments of health services and programs.
- Improved resources allocation (including financial, technical and human) for family planning programs at the national as well as the district level as decentralization evolves.
- Increased analytic capability of individuals at the national level to find appropriate solutions to contribute to the policy formulation process.
- Endorsed policy options that support the development of private health care insurance plans.

Health Care Financing Innovation:

- A system of targeted subsidies to low-income patients designed, tested in pilot regions, and modified for national roll-out.
- Georgian communities able to define feasible Community-Based Health Financing (CBHF) strategies, test them, and roll-out workable CBHF programs.
- Given sound regulatory environment, the hospital ownership is democratized, and hospital management improves its contribution to hospital performance and hospital worker motivation.

These programmatic outcomes should be supported by interrelated HCF policy and implementation interventions, focused on the Ministry and health system stakeholders, to build capacity, evaluate interventions, define best health policy and financing practices, and support an accountable and transparent health financing system.

Potential Benefits:

- Providing critical skills to Ministry of Labor, Health and Social Affairs (MoLHSA) to evaluate the demand for health care financing and policy reforms will assure sustainability of new programs and improved quality of care.
- A transparent and responsive process for Basic Benefits Package (BBP) optimization and a set of rules for regular review and revision of the BBP will assure a more participatory approach to health system design as well as more efficient and effective resource allocation to priority services and populations.
- A rationalized hospital sector will allow MoLHSA, and the broader donor community to more effectively target scarce health resources so as to assure adequate health services at all levels of the system.
- Community-based health insurance will work as part of a national financing strategy to subsidize health coverage for targeted poor and vulnerable groups at the community level and to facilitate a gradual and selective reliance on household incomes in order to achieve Georgia's ambitious goal of extending health coverage to the entire population by 2010.

VI. IMPLEMENTATION STRATEGY

The implementation of the Georgia Health Care System Strengthening (HCST) activity is envisioned as a two stage process. The first stage will include: (1) Initiation of National Health Accounts (NHA); (2) Placement of a full-time specialist for a two year period on reproductive health/family planning (RH/FP) policy in the MoLHSA; (3) Placement of a full time three year period expert on HCF policy within the Health Policy Unit (HPU); and (4) Placement of a full time expert on Organizational development/implementation within the MoLHSA for two-three years.

The Stage One assistance will support international and local consultants, logistical requirements for local staff (the procurement of limited computer and office equipment for the MoLHSA), meetings, conferences and training and other support required to fulfill the activities described below.

USAID will consider joint proposals from multiple TASC2 IQC holders as long as working arrangements are clearly defined in the joint proposal. However, it is anticipated that one prime contractor will be responsible for coordinating all aspects of the HCST project. Collaboration with indigenous NGO's is also encouraged.

TECHNICAL PROGRAMMATIC AREAS (STAGE ONE)

1. National Health Accounts (NHA)

Goal: The goal of this component is to institutionalize GOG's capacity to produce and analyze National Health Accounts data to better understand the structure of the health sector and where it needs reform.

Need: An important prerequisite for health sector planning is an understanding of the organization and financing of the health sector as a whole. NHA identifies and tracks health sector funding sources, and uses both public and private to develop and monitor policy interventions. It estimates total national health expenditure, links sources of funds to uses of funds, identifies important components of health care financing, and examines efficiency and equity.

Background: In Georgia reliable health expenditure data is scarce. While some data is available on financing and expenditures for health care, it has not been disaggregated by population groups particularly for vulnerable and groups with health access deficiencies. To be able to effectively manage the sector, State as well as wider Donor community must first know where health funding is coming from and how it is being spent. Better information is needed to answer questions such as: How much does a country spend on health care? Who is paying and for what services? How much is spent out-of-pocket for health care? Who are the key players, funding sources, providers and care recipients? At present, there is little if any capacity to produce this data.

Discussion: The absence of NHA affects the understanding and the management of the health financial flows and inhibits the efficiency and effectiveness of attempts to rationalize the health care sector, area of priority to the GOG. The project must develop the sustained capability to implement periodically NHA, analyze its results as contribution to HCF policy and health program allocations and system reforms. The NHA initiative should produce information that will be used to raise the discussion of 'informal' payments from the current prejudiced discourse to a level of objectivity required for sound strategic as well as programmatic solutions.

The NHA will inform health policy and resource allocation dialogue with important evidence on stakeholders' contributions to health financing and derived benefits for nation's health. Conducting NHA in Georgia will focus on institutional strengthening of the MoLHSA, the Unified Social Insurance

Fund, municipal governments, and other Georgian health sector institutions, to act as more effective reform management, resource allocation, and regulatory centers within a strengthened decentralized health care system that will benefit all existing programs, and increase the capacity of the GOG to engage productively with the donor community. NHA should also be tailored to analyze the flow of funds within priority program areas such as HIV/AIDS and Tuberculosis, which is particularly important for Georgia in light of the recently launched GFATM² projects. Also, National Health Accounts will help improve the transparency of health expenditures in the health system and can play an important role in Mission anti-corruption initiatives.

USAID's Comparative Advantage: NHA programs have been initiated in over 80 countries, of which over 20 have been supported by USAID including the development of a standardized protocol in conjunction with WHO. Therefore, the Agency has the unique capability to develop the NHA in Georgia.

Objectives: The program objective is to start up activities to develop a set of estimates of National Health Accounts (NHA). The approach is to assist the GOG with developing NHA emphasizing enhancing existing local capacity in estimating and analyzing health accounts, assisting with the long-term institutionalization of NHA and establishing a local NHA team. Specific objectives include, but are not limited:

- The demonstration of NHA capabilities to inform health financing and resource allocation decisions through a policy/technical dialogue with the central and local governments;
- Strengthening of survey-based methods of data collection to enable accurate accounting of household expenditures;
- Institutional strengthening of major stakeholders to implement NHA and use NHA information on a sustainable basis.

Illustrative Activities: Contractor(s) will assist establishment of the NHA team to attain goals/objectives outlined above. The NHA team will consist of a head of planning (to coordinate all the NHA activities), a local consultant(s) with whom the Contractor will work closely, representatives from the Private Sector (Insurance, manufacturing, service industry), as well as representatives of the relevant GOG ministries.

Gathering and analyzing health specific data to support policy decisions can include: unmet need for services; the allocation of services to various income groups; expenditures for various kinds of services; and other data that are needed to inform effective policymaking. *User-friendly tools* for data collection, analysis and policy dialogue are required. These can include: models, efficacy guides, training materials, and other tools to strengthen advocacy efforts, to help policymakers understand the impact of various policies and plans, to guide resource allocation activities, and to improve multi-sectoral coordination. Under this initiative, the NHA process will *prepare materials and presentations* in order to make information available to policymakers and program planners.

Progress Milestones/Benchmarks:

1st – 2nd Year

- ◆ As part of the MoLHSA reorganization, a locus for NHA within the MoLHSA is defined³.

² The Global Fund to Fight AIDS, Tuberculosis and Malaria

³ The Health Policy Unit (HPU) which will be supported by the World Bank may be the ideal location to implement NHA. Funding the local cost development of the HPU is anticipated within the next 3 to 4 months.

- ◆ The NHA team is organized, roles and working relationships are defined, and key issues are identified that NHA will help address.
- ◆ NHA team is trained and first-round data collection begins.
- ◆ Data collection and production of the first set of tables takes place in order to establish a baseline.

3rd – 4th years

- ◆ NHA data collection policies and operational strategies are recommended for adoption.
- ◆ NHA team completes the first round and issues report.
- ◆ Key government stakeholders review the report and policy applications are discussed.
- ◆ Indicators relevant to policy applications are developed from NHA data together with other operational data.
- ◆ Linkages between NHA data and MoLHSA budget and resource allocation decisions discussed.
- ◆ Frequency of indicator monitoring and flow of NHA information is operationalized and a dissemination and distribution plan is agreed.
- ◆ NHA team facilitates ongoing policy dialogue within the MoLHSA and between the MoLHSA and GOG based on NHA findings and indicators.
- ◆ NHA data and indicators are collected on a routine basis and used in combination with other information to monitor health sector financing and resource allocation.

Results: The project must develop the sustained capability to implement periodically NHA, analyze its results as contribution to HCF policy and health program allocations and system reforms. The measures of successful results attributable to NHA include the collection of relevant data on a continuing periodic basis, the analysis of the data to provide information for policy and program development and improvement at the local, regional and national levels. The resultant data and information should be used by multiple government and private entities as a basis for identifying health care needs in population subgroups and geographical areas, forecasting requirements and allocating resources.

Coordination: This initiative must be coordinated with potentially proposed DFID/OPM⁴ activities which have expressed interest in developing a review of public expenditures for primary health care. However, standardized protocol used by USAID includes both, public and private finance flows and expenditures and in case of Georgia the private sector provides an estimated 87 percent of the health care support. *Coordination with the intended DIFD/OPM activities is essential.*

Illustrative Indicator(s):

- NHA adopted, used in next-year budget planning, and published in the Statistical Yearbook of Georgia;
- Changes policy, program and projects attributable to the analysis and information gathered through the NHA activity;
- Institutionalization of the NHA process within the GOG.
- Health Information Systems that better inform policy-makers and facility managers on health status and trends.⁵

⁴ Oxford Policy Management

⁵ This Indicator is part of the Mission's Performance Monitoring Plan (PMP), thus its mandatory for reporting. This indicator measures quality and use of information systems services within various parts of the health care system where USAID implements its activities. Improved health information systems will become a direct outcome of programs sponsored by USAID at the national level, namely: subject Health Care Systems Transformation activity, and Immunization Health Information and Vaccine Preventable Disease Surveillance activity funded through PHR+.

2. Placement of a full-time specialists on reproductive health/family planning (RH/FP) policy in the MoLHSA for two-three years

Background: The need for such activity derives from the current alarming situation in reproductive health in Georgia. An inadequate service delivery infrastructure for reproductive health, limited capacity, and an inadequate legal, regulatory, and policy framework for reproductive health result in poor access to services. The total induced abortion rate is 3.7, more than twice the total fertility rate of 1.7. 1999 CDC reproductive health survey in Georgia revealed that only 40% of women report using contraception and only one-half of those use modern methods. This is one of the lowest utilization rates reported in any of the former Soviet republics for which CDC survey data is available.

Project: Placement of a one expatriate full time RH/FP policy development advisor and one full time local specialist in the Mother and Child Care Department of the MoLHSA to provide Technical Assistance (TA) to the GoG in developing RH/FP policy. TA will focus on developing improved legislative, regulatory, and policy framework that will create conducive environment for reducing reliance on abortions as a main means of birth control in Georgia. Together with the locally hired specialist, advisor will work with the MoLHSA and other relevant public and private stakeholders on regulatory mechanisms and guidelines for FP/RH.

Activities: Family planning programs in Georgia will not be sustainable unless the government takes steps to ensure the appropriate policy and regulatory environment is in place. The RH/FP Advisor Position is to be filled by a highly qualified expatriate, supported by a full time local specialist and short term international advisors and locally recruited professionals as needed. The RH/FP Advisor will work on a broad spectrum of reproductive health issues such as strengthening political commitment and developing policy and legal environment for family planning and providing advocacy to legislators and government officials for change; Introducing policy changes to support public/private partnerships to advance the goal of increased acceptability and utilization of family planning services and increasing availability and use of modern contraceptives as an alternative to present high rates of abortion.

Specific Tasks:

- 1) Provide short-term expertise in Georgia's legal system and legislative history related to reproductive health;
- 2) Provide a Georgian expert team in reproductive health legal and regulatory issues, and equip and train them;
- 3) Develop a Ministry-wide reproductive health management information system and produce a monthly report of contraceptive supply and use, abortion statistics;
- 4) Prepare issue papers and background documents for the Ministry on critical and timely issues in the sector;
- 5) Prepare sectoral assessments and surveys to inform policy makers on the situation in RH/FP;
- 6) Improve Logistics Management Information Systems for contraceptive procurement, distribution and service health data;
- 7) Enhance changes in licensing requirements for health care providers to enable provision of reproductive health in ambulatories by primary care providers and nurses;
- 8) Help create a public relations, public awareness and public participation strategy and program(s), as appropriate, for the Ministry/National level Government, identify funds for its implementation and assist in preparing the GOG for its implementation using best practices for communicating public policy decision-making processes and decisions, influencing consumer behavior. Detailed program plans, design and implementation, as well as funding for implementation, may be provided under a separate activity to be funded by USAID and/or other donors;

- 9) Help organize multi-stakeholder sector meetings and serve as a clearinghouse for information on all the domestic and international aid programs provided in the area of RH/FP;
- 10) Provide training for Ministry staff as outlined in a training implementation plan to be developed after an initial training needs assessment to be conducted by the Contractor. All training opportunities meeting the requirements for participant training under USAID's operating procedures shall be subcontracted to USAID's training partner in Georgia, World Learning, or their designated successor.

Results:

- Supportive political will from state authorities is increased at national and district levels, for the national family planning program goals of women's health, choice and quality;
- Allocation of resources (including financial, technical and human) for family planning programs is increased at the national as well as the district level as decentralization evolves;
- Access to family planning information and services is increased and improved;
- Increased analytic capability of individuals at the national and district levels to find appropriate solutions to contribute to the policy development process.

3. HEALTH CARE FINANCING (HCF) and POLICY DEVELOPMENT

Background: It would be counterproductive to move to the design of a new health policy development program in Georgia without attempting to overcome the reasons why reforms have not achieved their stated goals despite continued support from lender/donor institutions. Possible causes reside both with the donors and GOG. Referencing conclusions derived from the "Situation analysis for a New Strategy of Technical assistance for Health Care Financing", the following causes are cited:

On the donor side:

- ❖ The donors propose bold reforms that frequently represent political risk to health system leaders;
- ❖ Programs are not always accountable to the national government;
- ❖ Program objectives and designs represent an extraneous policy framework that is sometimes incomprehensible to the national leadership and lacks close coordination with societal goals and national policy agendas;
- ❖ Progress and outcome indicators that donors usually design for their programs are sometimes unrealistic.

On the government side:

- ❖ The MoLHSA's has had a secondary role in the design, management, and evaluation of international health programs;
- ❖ Lack of 'legitimacy' behind health sector reforms. Supportive stakeholders are critically important for leveraging donors in their current role of main reform champions;
- ❖ The MoLHSA capacity to institutionalize innovation is limited;
- ❖ Absence of inter-agency collaboration that would enable a necessary cross-sectoral support of major health sector initiatives.

Project: The placement of a full time specialist in the newly established Health Policy Unit (HPU) to assist GOG in developing HCF policy focusing on select functions particularly secondary health care, Community Based Health Financing, and with selected groups particularly women of reproductive age, children, and perhaps pensioners or other vulnerable populations.

Activities:

- Support the HPU institutional strengthening in overall health policy development;
- Integrate primary HCF (in conjunction with DIFD⁶) and secondary HCF policy;
- Augment/improve the absorption capacity of the counterparts;
- Promote the dedication of resources to systemic HCF reforms and provide the design for the structural linkages to relevant stakeholders while retaining the necessary policy objectivity and insuring its feasibility and effectiveness particularly to the ultimate consumer.
- Legislative and policy support to the development of private insurance.

This position would be within the Health Policy Unit (HPU) of the MoLHSA in conjunction, collaboration and integration with the World Bank's current plan.

Results:

- ◆ MoLHSA core functions and organizational structure are revised and mandated at the legislative or regulatory level;
- ◆ Health Policy Unit for Social and Health policy reforms is operational;
- ◆ National Health Strategy and policy priorities matched to the Ministry's functions.

The **Outcomes** of the proposed program strategy would include:

- ❖ Increased capacity within the GOG/MoLHSA to design, implement, and evaluate health financing policies that are responsive to the financing and policy requirements defined by health system constituents.
- ❖ Demonstrated ability to test and evaluate structural adjustment and regulatory strategies to assure more responsive and accountable health system financing and regulation.
- ❖ Improve MoLHSA consultation, collaboration, and constituency building that assure an accountable and transparent health-financing environment.
- ❖ Improve resource allocation within the health sector that is consistent with GOG goals and objectives for poverty alleviation and the application of subsidies.
- ❖ Integration of hospitals in health financing and structural reforms.
- ❖ Community financing including reinsurance of the Community Based Health Financing (CBHF) schemes becomes part of the National Policy.

These interventions should be carefully coordinated with existing donor programs and would supplement such programs so that the Ministry and other system stakeholders could leverage the considerable investment of all donors and improve overall health policy and financing in Georgia.

Illustrative Indicator(s):

- Specific policy developed for Secondary Health Care financing and incorporated in the national strategy;
- An evaluation system to assess responsiveness and accountability of the HCF policy implementation in place;
- Organization of training programs to improve the planning capabilities of local staff;
- Demonstrated evidence of coordination of health policy with other relevant sectors.

⁶ DIFD will provide short term consultancy to the HPU in the area of primary care financing but will not address secondary health care policy

4. ORGANIZATION DEVELOPMENT AND AGENCY HARMONIZATION

Background: Too often, health sector issues are viewed by both health and non-health sector specific response. This overlooks the fact that the context within which government planners as well as individuals view health issues and needed program responses is complex and not solely health-specific; a person's health status, and elements of policy and program solutions to health challenges are dependent on non-health sector involvement. Years of development in health have proven that health issues are not adequately addressed except through a response that is grounded in a multi-sector approach. Health policy and programs will only be as strong as the strength of the collaboration of health and non-health sectors in strategizing and implementing policy and program responses.

Currently, improvement is needed for effective and efficient (i.e., rationalized) implementation of health care policy into actual projects. Multiple GOG agencies and multiple donors require cooperation, coordination, integration to rationalize HCF and reduce duplication. Harmonizing policy development both between donors and GOG and within the donors themselves will greatly improve rationalization of HCF. USAID has the opportunity now to be a leader in rationalizing HCF and improving coordination if not indeed integration among relevant stakeholders. Furthermore, the MoLHSA has recognized the need for donor integration in the development of primary health care (PHC) and has organized a PHC Board with a management committee to coordinate, integrate and to reduce duplication among donors. Missing in the implementation of these plans is the linkage to relevant stakeholders. Specifically, the process of effective flow of information and understanding between the policy makers, program implementers and consumers of health services, in a manner which insures objectivity, feasibility, and effectiveness of efforts particularly to the ultimate health consumer.

Project: The placement of a full time organizational development specialist to assist GOG/MoLHSA in rationalizing health care implementation and integrating and rationalizing the multiple Government and particularly multiple donor activities in the HCF area focusing on select functions particularly secondary health and select groups particularly women of reproductive age, children, and perhaps pensioners or other vulnerable populations. Activity will build MoLHSA's capacity to manage health system policy and reforms by strengthening the Ministry's focus on priority issues, improving its organizational structure and process to implement reforms, enhancing stakeholder communication and constituency building skills, and improving skills to mobilize resources and actions to effect policy change.

Activities: Within year one (perhaps in the fall after the MoLHSA has "settled down, reorganization and is actually implementing programs) recruit a short term organizational development and health program implementation specialist to assess the feasibility and if appropriate to design the program within the MoLHSA, identifying specific institutional needs, structural requirement, level of MoLHSA support required, tasks and characteristics of a long term consultant.

If the short term specialist's assessment is optimistic and GOG/MoLHSA support commitment is assured, including staff and functional responsibilities, then Contractor will provide a full time organizational development implementation expert for a three year period. The functions would include the support of the integrating and rationalizing the multiple Government and particularly multiple donor activities in the HCF area. This individual with local counterparts shall provide a coherent agenda including: assurance of funding; the integration of complex donor programs and other stakeholder support, focusing on augment/improve the absorption capacity of the counterparts; improving the effectiveness and efficiency of health reform management, resource allocation and regulatory centers within a strengthened decentralized health care system leveraging all donors' investment; build MoLHSA's capacity to manage health system policy and reforms by strengthening the Ministry's focus on priority issues, improving its organizational structure and process to implement reforms; enhance stakeholder communication and constituency building skills and ability to mobilize resources and actions to effect policy change.

One of the objectives would be the establishment of an Inter-agency Coordination Center (ICC), thus bringing sector-wide coordination to a level higher than what multiple donors can normally achieve without a central arbitrator. MoLHSA should regain the leadership over health policy and financing reforms – a role that in recent years gradually shifted to a conglomerate of lending and donor institutions.

Results:

- ◆ Return health policy and reform designs under the national mandate – an important condition of legitimacy and sustainability of future reforms;
- ◆ Establishment of the single coordination center;
- ◆ Improve the GOG organizational structure and function that is supportive of the new HCF reform environment and enables more efficient and effective financing and resource allocation within the health sector.

Providing critical skills to MoLHSA to respond to the demand for legal and regulatory reforms will assure sustainability of new programs and improved quality of care.

Illustrative indicator(s):

- Translation of HCF policy into implementation plans which include goals, objectives, milestone activities, time frame for activities and tasks and the identification of responsible units to carry out the named functions activities and tasks.
- Inter-agency coordination Council for Social and Health Policy and Reforms is operational and steers international collaborative programs.

Budget Estimates: Initial needs assessment/project design up to \$20,000 plus \$780,000 for a consequent three year period.

The linkage between policy planning and project implementation must be structured in a manner which retains policy objectivity simultaneous to insuring its feasibility and effectiveness to all stakeholders, but particularly to the ultimate health consumer with special focus on the poor and vulnerable populations.

Stage One activities, to be sustainable must incorporate to the maximum possible local contingency staff through training, information sharing and logistical support. The assistance should support international and local consultants, logistical requirements for local staff, meetings, conferences, training, and other support required to fulfill the activities described above.

A decision to progress from Stage One activities to Stage Two will be made by the SO 3.4 Team subject to: (a) documented progress during Stage One; (b) a strong, continuing political will on behalf of the GOG to further transformation efforts; and (c) Mission priorities. Stage Two will include short-, medium-, and long-term assistance tentatively to begun in the second year but running through the balance of the project up to 2009. A mid-term assessment will be conducted after **24 months** to assess progress, contractor performance and make any mid-course corrections.

The minimum set of milestones/benchmarks absolutely necessary for USAID to proceed with Stage Two follow:

NHA	1) As part of the MoLHSA reorganization, a locus for NHA within the MoLHSA is defined. 2) The NHA team is organized, roles and working relationships are defined,
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	and key issues are identified that NHA will help address.
RH/FP Advisor	NA
Policy Advisor	<ul style="list-style-type: none"> ❖ Health Policy Unit is operational. ❖ National Health Strategy and policy priorities matched to the Ministry's functions.
Org. Development Advisor	<ul style="list-style-type: none"> ▪ Recommended organizational structure of the Ministry completed and reviewed and approved within the MoLHSA. ▪ Inter-agency Coordination Center established.

Stage Two envisions targeted, both geographically as well sectorally pilot activities to demonstrate/test/refine the practicality of policy proposals to Georgian stakeholders on the following topics:

STAGE TWO

5. SECONDARY HEALTH CARE FINANCING (SHCF)

Background: In Georgia there is a persistent need for structural adjustment in the hospital sector. Secondary care is particularly needed for clinical training of the Primary Health Care (PHC) providers and secondary care physicians and health personnel. For that reason, health financing in hospital settings should be strengthened and viewed as integral to PHC reforms. Support for secondary health care particularly in hospitals is currently omitted within planned DFID, the WB and EU PHC reform project in Georgia. Integration of hospitals in the health care financing reform agenda is an opportunity for direct USAID intervention unattended by other donors and needed by the GOG, because successful PHC model must consider relationships with other levels of care. Without continuity of care from the primary health center to the hospital, PHC reforms will not take root or bring about the expected health gains. Hospitals are a viable pivot for vertical integration of services -- an important strategy to improve quality of care.

Additionally, addressing secondary care financing in conjunction with NHA development will create important synergies: The NHA component will produce information that will be used to raise the discussion of 'informal' payments from the current prejudiced discourse to a level of objectivity required for sound policy solutions.

Program: Identify and cost the feasible secondary health care Basic Benefits Package (BBP) and alternative feasible financial mechanisms to support delivery of those services generally or focusing on select groups particularly women of reproductive age, children, and perhaps pensioners or other vulnerable populations. *This initiative must be related to the Basis Benefit Package for primary health care planned to be developed with WB, DFID and EU support.* USAID support will help design a set of bylaws and management policies and procedures that will motivate secondary health providers such as hospital directors and clinical staff to engage in a productive collaboration around jointly established performance goals and to meet contractual requirements in an increasingly competitive environment.

Activities will be targeted to identify: new mechanisms of budgeting and reimbursement for hospitals; performance incentives for physicians and health professionals; competitive hiring process; drug pricing system at the facility level; incentives for rational drug prescription; plans to rehabilitate provider facilities; a model for medical malpractice protection; patient advocacy strategies, including the role of ombudsmen in protecting health care consumer rights. Additionally, activity should identify and cost the feasible secondary health care benefits package and alternative feasible financial mechanisms including assessing the institution of formal user fees generally incorporating current use of informal out-of-pocket

payment.

Hospital agenda can be piloted focused on the Integrated Delivery Systems (IDS), otherwise termed “Integrated Health Systems”. Such systems usually include several facilities that represent two or three levels of services. IDS can integrate public and private providers into one contractual scheme and will seek to improve quality and continuity of care, accountability of providers, patient satisfaction, and efficiency. Notably, NHA and IDS will mutually benefit, since the IDS agenda implies strengthening financial reporting in all types of provider institutions – also, a key prerequisite of accurate national health accounting.

Illustrative interventions include, but are not limited to:

- Consider a sliding scale to favor select vulnerable populations;
- Review/revise hospital restructuring master plan originally designed under the WB SRS⁷ credit but never implemented on a sustainable basis;
- Public information campaigns on services included in the re-designed BBP;
- Pilot the implementation design;
- Develop new contracting and reimbursement mechanisms to: (a) alleviate the problem of adequate financing to medical staff; (b) eliminate present fragmentation in purchasing; (c) pool all public resources and channel them to providers through one single purchaser.

Activity should help the facilities to design and implement a new medical records system, develop clinical practice guidelines and quick reference sheets, and introduce continuous quality improvement processes. The Contractor shall introduce modern protocols and standards of care in the selected sites. In order to ensure the feasibility of adoption of such protocols and standards, and adherence to them, they shall be commensurate with the Country’s current technological infrastructure, and should be adapted to such a level of technical capacity that can be potentially achieved in Georgia with available resources in the short-term.

Results: A rationalized hospital sector will allow MoLHSA, United Social Insurance Fund and other financing parties to more effectively target scarce health resources to assure adequate health services at all levels of the system. If provided with adequate incentives, hospitals should play an active role in PHC reforms by making their teaching and technology bases available to general practices; and joining in vertically integrated delivery systems, aligned by the goals and values of a patient-centered Primary Health Care. Some of the most tangible outcomes should be:

- **Quality Assurance systems** to ensure responsive quality secondary health care services;
- **Health information systems** that provide the necessary data for decision-making and evaluation of secondary care reforms;
- **Finance, planning and budgeting capacity** to increase and allocate resources more effectively to support secondary health care delivery;
- **BBP** for secondary public health care financing is redesigned based on Georgia-specific evidence from benefit-cost and demand assessments of health services and programs;
- Given sound regulatory environment, the **hospital ownership** is democratized, and hospital management improves its contribution to hospital performance and hospital worker motivation.

Illustrative Indicator(s):

- Identify and cost secondary health care BBP

⁷ Structural Reform Support

6. COMMUNITY BASED HEALTH FINANCE (CBHF)

Background: Funding for health care in Georgia is very limited particularly in rural regions. If the policies are adopted, the use of CBHF schemes to fund medical services directly or above a basic health package through establishment and development of private, voluntary and community health funds can be an interesting alternative to the existing health financing mechanisms and worth exploration and expansion given the limitations of existing public financing. International and domestic NGOs⁸ have engaged in guiding Georgian communities through setting up and managing CBHF plans. Georgia's Unified Social Insurance Fund is looking to CBHF schemes to facilitate collection of premiums, supplement provider income or purchase non-labor inputs.

Project: Contractor will promote the incorporation of CBHF initiatives to be included within the GOG national HCF strategy particularly in conjunction to the planned long term advisor to the planned Health Policy Unit (HPU). The Contractor will scale-up and reform CBHF schemes in a phased manner beginning with the possibilities identified within already graduated Georgia Community Mobilization Initiative (GCMi) supported communities, and eventually proceeding to additional communities. Additionally, through new community development initiatives USAID is considering the development of viable number of community development sites. Some of these projects can be health related, if desired by the individual community and could include CBHF schemes.

CBHF schemes should be used to fund medical services directly or above the basic benefits package (BBP), and expand the definition of community beyond a geographical entity to include affinity groups in particular teachers, labor unions, employee groups, etc. World-wide experience shows that community-based health insurance can work as part of a national financing strategy. While it is particularly effective in mobilizing rural and informal sector populations who may not otherwise use health services, it is also applicable to other "communities" who have inadequate access to care. Schemes should be structured according to the buying power of the communities in order to give a vast majority of family's access to health care or to improved or more comprehensive care to those who might otherwise be excluded. Also, such schemes should have the potential to serve as mechanisms for governments to subsidize health coverage for certain poor and vulnerable groups at the community level. But, because CBHF schemes may themselves run the risk of insolvency, advocacy of CBHF plan development has brought parallel concerns that the plans themselves need protection from the various kinds of financial risks that could jeopardize their survival. One potentially helpful mechanism is re-insurance to cover the risks of bankruptcy in return for their payment of relatively small premiums.

The CBHF component should be supported with efforts such as social marketing at the local, regional and national levels to increase awareness of the potential benefits and to link CBHF with existing and planned primary and secondary care efforts within both, the public and private sectors and the other donor efforts. Multilevel TA support is needed for the CBHF effort to succeed. The concept of CBHF reinsurance program perhaps generally or for specific targeted groups or for occasions of natural disasters might be considered. In addition, consideration should also be given to the introduction of formal user fees on a sliding scale re income or vulnerability and the possibility of "ear-marking" community contributions to fund a reinsurance or subsidy program for select individuals.

The recommended approach will be to use scant evidence on the successful and failed Community Based Health Financing plans in Georgia to develop evidence to better target future support to potentially viable plans. Communities should be empowered to develop feasible community-based financing strategies within a sound regulatory environment as part of a national and/or regional effort.

Illustrative Activities:

⁸ CARE, International Medical Corps, Curatio International Foundation – through USAID funding; Welfare Foundation – through OXFAM funding

- Analyze the varied threats to financial stability that CBHF schemes face in the Georgian context;
- Provide TA to local counterpart agency to develop and test a pre and post-grant assessment methodology/tool to produce evidence on successful and failed CBHF for all types of communities (this TA should be disaggregated between rural communities and selected affinity groups which may be urban);
- Provide TA to use the many technical resources and tools USAID and other donors has developed in E&E Region which are easily downloaded for use in Georgia;
- Sponsor a forum (workshop/conference) to bring together stakeholders to discuss Georgia's CBHF experience, identify and provide needed information and TA and coordinate future activities;
- Explore what role reinsurance might play in helping to preserve their schemes;
- Describe the terms and conditions under which the reinsurance program could be designed to provide reinsurance coverage of the simplest type including the requirements for designing and implementing such a program, a general rule for determining a fair premium.

Results: Improved knowledge of direct payments will help explain the Georgians' potential preference for community-level risk/fund pooling schemes. Potential outcomes include:

- Communities are empowered to develop feasible community-based financing strategies within a sound regulatory environment;
- Community-based health insurance works as part of a national financing strategy, particularly in rural areas;
- Community-based health insurance serves as a mechanism for MoLHSA to subsidize health coverage for certain poor and vulnerable groups at the community level;
- All applications from CBHF plan initiators are assessed for feasibility, using a toolkit designed for the purpose;
- Reduced financial instability in many small health schemes by pooling their risks of excessive losses.

Illustrative Indicator(s):

- ◆ Preparation and application of community evaluation methodology;
- ◆ Preparation and application of pre-grant assessment tool;
- ◆ Adoption of established CBHF tools and resources to Georgia;

Additionally, measurement can be in terms of the numbers and types of communities and individuals impacted, health care delivered and evidence of changes in health outcomes.

7. PUBLIC/PRIVATE PARTNERSHIP IN HCF

Background: The need for health services and commodities already outstrips available resources all around the globe. The current focus of the international debate is on the need to move away from excessive reliance on informal out-of-pocket payment as a source of health financing towards a system which incorporates a greater element of risk pooling (for example, through health insurance) and thus affords greater protection for the poor.

As population increase and as the demand for services grows (e.g., for emergency obstetric care, for contraceptives), the imbalance between supply and demand will only get worse. In Georgia, the gap can be somehow addressed by marshalling new resources from donors, from the private sector, and from customers themselves. But again, both new and existing resources are limited and must be used

effectively. The allocation of public resources to their most efficient and effective use is not just a mathematical exercise. To be done properly, it presupposes participation in the policy process by a wide variety of stakeholders to develop a broad consensus on a society's health needs and how to best meet those needs. Private health insurance may be a feasible option to protect the access of certain parts of the population to health care services.

In Georgia there is pre-paid private scheme offered to the population by the private medical insurance companies, but their share and capitalization is very low and miserable. Coverage is restricted, thus limiting the risk to companies and benefits, which are closely associated with ease of access to care and the quality of the environment in which care is received. Distrust in private insurance companies is mainly determined by recent experience of the population with the fall of pyramid financial schemes, state's default on bank deposits, and early '90s hyperinflation, which dissolved population's savings accumulated over decades. Nevertheless, the share of private insurance in the funding of healthcare service provision is growing from year to year e.g. in 1999 total mobilized premiums amounted to 234,000 USD, increasing to 3 million USD in 2001⁹. Private insurance is likely to become increasingly important as consumers experience co-payments and user fees.

This process may be facilitated (preferably w/o direct subsidy but with some regulatory or other technique) to expand beyond their current one percent market into the employed middle class economic cohorts. The intention is to constructively expand existing successful health financing entities to pool health risks in a direction of currently non-or-under attended populations. Regulatory action could be introduced in conjunction with their licensing to promote their reaching other than their current clients market. If such market expansion could be assessed as profitable and constructive for the nation it may warrant further inquiry. Means should be explored to promote public-private partnerships including provider based schemes, although they are not so common in Georgia. Currently, health care is characterized by a plurality of private providers, registered as well as unregistered, and supplying mainly ambulatory and outpatient care services. The private sector can and should be supported to grow and to become a real compliment or at some point alternative to the public sector and should be part of the national policy.

Limitation: While private health insurance may be a feasible option to protect the access of certain parts of the population to health care services, due to low level of trust in the population this option should be accompanied with a strong IEC campaign and public advocacy. Though population prefers to trust their funds to polyclinics almost all of them admit that in theory private insurance companies are the best-suited institutions for medical insurance coverage¹⁰. However, lack of an appropriate regulatory environment and tax incentive for employer sponsored health care severely limits the ability of private insurance to make any meaningful impacts on overall health care.

Program: Use or expand existing private insurance (which today only addresses the top 1% of the population) to other infinity groups or communities such as teachers, small business owners, etc. Activities should include an assessment to plan if and how the private sector partnered with the public sector could be supported to become a real compliment or alternative to improve national health. Consideration can be given to a reinsurance scheme constructed to partially reduce risks associated with selected groups.

By grouping large numbers of citizens in insurance policies the financial risk for any one participant is greatly reduced. To achieve this, health insurance will need to be introduced on a wide basis, including as many Citizens as possible. There should be a combination of public insurance (to cover a basic level of care) and private insurance (to cover a higher level of care) and participation should be encouraged if not mandated.

⁹ Aldagi Annual Report; 2001, Tbilisi, and Insurance State Supervision Services; 2001

¹⁰ Qualitative Study on OOP Payments in Health in Georgia - WB, 2002

Illustrative Activities:

Short-term:

- Survey current public and private sector programs to address these needs, and determine the capacity and interest of implementing organizations to contribute to a HCST program;
- Determine Government's attitude towards using the private sector to achieve preventive care goals. Solicit their views on the prospects of social marketing to contribute towards achieving public health goals;
- Examine the possibility of funding of medical services above basic health package through establishment and development of private, voluntary and community health funds for the population of Georgia;
- Analysis of cost recovery pilot programs to determine appropriate risk pooling and combinations of public and private financing mechanisms;
- Consider ways to increase private insurance as a supplementary or complementary source of funding.

Long-term:

- ❖ Design and implement federal, municipal and private insurance programs.
- ❖ Introduce private insurance for enhanced services.

Illustrative Indicators:

- Percent of insured enrolled in plans which use co-payments and deductibles, managed care plans, or plans subject to global budgeting

VII. DONOR COORDINATION

HCST interventions shall be carefully coordinated with the existing Donor Programs and will supplement such programs so that the Ministry and other system stakeholders could leverage the considerable investment of all donors and improve overall health policy and financing in Georgia.

In 2003, the GoG together with local and foreign experts developed a Primary Health Care (PHC) program commonly known as the "Health Care II" initiative. This effort will be implemented over five years (2003-2008) with the support of a World Bank loan. Other donors, like DFID and EU/TACIS, are also supporting this initiative in a multi-lateral fashion. Thus, it is important to link HCST with the ongoing PHC initiative and other donor projects in the health and public finance sectors. To avoid overlap with other donors, USAID will not directly participate in the PHC development project. However, since the other donor projects have been or are being designed to focus on multifaceted support to PHC, it is doubtful that the cross-cutting and complex issues of national HCF will be addressed in-depth or very effectively. One such gap occurs in reference to the secondary care and interventions that would crucially depend on the vertical integration of care. Such health programs remain without substantial external support, because other donors deliberately limit their involvement to the PHC agenda, while hospital strengthening should be viewed as integral to PHC reforms. All stakeholders highlighted structural reforms and hospital strengthening as a gap in the current donor support agenda in Georgia. Also, through integration of hospitals in the HCST agenda, USAID will minimize tensions with other donors by touching upon PHC via the hospital management agenda rather than directly.

VIII. SPECIAL CONSIDERATIONS

Link to the National Health Strategy: 2000-2009 (NHS): The GoG produced a NHS in 1995, but it was a broad policy document with few plans for implementation. Assessments concluded that to garner strong support from national constituents, HCST should best link its approach to the NHS as much as possible, rather than relegate it to secondary sources as other donors have done in the past. Contractor will help the Ministry to understand its role and to build new capacity and attitudes required for the critical evaluation of the NHS. Not surprisingly, most of NHS strategy directions fit in the commensurately diverse range of the officially defined MoLHSA functions. However, the Ministry will need to scale up its administrative, technical, and financial resources significantly and to strengthen coordination with other agencies, if it intends to address all NHS topics.

Contractor will facilitate the Ministry to internalize the content of the NHS, to promote the reform agenda through robust inter-agency collaboration, to collaborate with donors over the design and implementation of health programs, to create an evidence-based set of priorities, and to select and disseminate the best health policies and financing practices via a variety of past and current interventions.

Gender: Gender integration is an important part of HCST, focusing on the participation of and benefits to each gender. The focus of the planned health program on expanding health service coverage through strengthening health systems and service quality requires that activity planning must take into account the influence of gender on the demand for, access to and utilization of services, and on health behaviors. USAID will require the Contractor to include both men and women in all aspects of this program including participation and leadership in meetings, associations, working groups, training and counseling activities, exchanges and delegations. USAID will have the Contractor collect, analyze, and submit to USAID sex-disaggregated data and propose actions which will address any identified gender-related issues. In developing the initial program implementation plan the Contractor shall ensure that it incorporates gender issues as appropriate.

Mexico City Policy: All contracts and grants funded by USAID shall incorporate clauses that implement the President's directive reinstating the Mexico City Policy.¹¹ USAID/Caucasus places high priority on preventing abortions through the use of family planning, saving the lives of women who suffer complications arising from unsafe abortion, and introducing women to voluntary family planning and other reproductive health services that will help prevent subsequent abortions.

Anti-Corruption: Health sector corruption impedes social transition by reducing equitable access to health care, distorting efforts to more efficiently allocate health resources, and eroding public confidence in the health system. The inability to purchase health care often translates into death, disease, pain, and disability resulting in reduced productivity of the labor force and erosion of citizens' faith in democratic processes and ideals. The E&E Bureau's anti-corruption methodology known by its acronym of TAPEE (Transparency, Accountability, Prevention, Enforcement, and Education) requires a thorough assessment, diagnosis and possible strategies for mitigation of corruption. USAID will require the successful applicant to include an assessment of corruption issues in the health sector to better understand the problem and recommend how health programs might more effectively confront it. Based on the findings of this sector specific assessment, the Contractor will seek guidance from SO 3.4 and the

¹¹ On January 22, 2001, President Bush restored the Mexico City Policy that had been in place from 1985-1993. The Mexico City Policy requires foreign non-governmental organizations to certify that they will not perform or actively promote abortion as a method of family planning as a condition for receiving USAID assistance for family planning. (http://www.usaid.gov/procurement_bus_opp/procurement/cib/cib0108r.pdf)

Mission’s anti-corruption Special Initiative team to design and incorporate anti-corruption sub-activities into HCST.

Illustrative activities include, but are not limited to: a case-based cost reimbursement system to improve the transparency of hospital financing; posting of health services fees in health facilities so the pricing structure is transparent; informing the public through training, media or community based programs about how financing of health systems occur, their entitlements to health care, functions of an insurance system, and the range of possibilities of payment sources in a fee-for-service system.

National Health Accounts can increase the transparency of health expenditures and can play an important role in Georgia’s anti-corruption campaign. These accounts are particularly useful in revealing the extent of out-of-pocket expenditures, which are often much more than government officials realize and can underscore the need to consider the policy implications.

IX. STAFF REQUIREMENTS

Stage One long-term technical assistance team will be composed of three highly experienced and qualified advisers; HCF/Policy Development Advisor will act as a Team Leader.

Adviser	Number of Months
HCF Policy/Team Leader	60
RH/FP	24 - 36
Organizational Development	36

HCF Policy Advisor/Team Leader of the Technical Assistance Team will be present in Georgia for the entire length of the Task Order. Reproductive Health/Family Planning (RH/FP) Adviser will be present for 24-36 months, and the Organizational Development Adviser who will not start work until preliminary needs assessment conducted and work for 36 months. With the approval of USAID, number of months may be increased at the request of the Contractor, if necessary, and offset by fewer months of Short-Term Technical Assistance.

The long-term Technical Assistance Team is intended to be highly integrated, with each adviser responsible for a specific area, but providing support to other project components. The Team Leader will work with all TA Team members to insure the quality of their work and support them in their efforts to link effectively with their counterparts. S/he helps them set priorities, resolve problems, and generally facilitates their work. The advisers are not expected themselves to do all of the work required in their assigned areas, but are responsible for coordinating all activities related to their areas. They will draw support as necessary from Short-Term technical assistance, and local support staff, both technical and administrative.

In all cases, the following minimum qualifications will apply:

- Demonstrated exceptional expertise in their particular fields;
- A minimum of 5 years of experience in a technical assistance role in a developing country, preferably in their assigned subject area;
- The ability to speak and write English fluently is essential;
- Experience in NIS, with experience in Caucasus preferred;
- Demonstrated ability to work well with other team members and host government counterparts.

All the above mentioned three positions are key personnel. The MoLHSA plans to provide space at the Ministry for the long term advisors.

For Stage Two (if funded) USAID/Caucasus envisions HCF Policy Advisor to fully assume the Chief Of Party (COP) responsibilities. The COP will be responsible for overall planning and management of all technical, administrative and financial elements of the program during the whole length of the Task Order (TO). S/he shall serve as the MoLHSA key counterpart for the program and accordingly will work very closely with the ministerial officials appointed to the program. S/he is the principal representative of the program on all formal occasions and meetings with USAID, counterparts, and related groups. S/he is responsible for the budget execution, accounting, sub-contracting (should this need arise), and reporting on all project activities.

In addition to the requirements above, the Chief-Of-Party should have the following characteristics:

- Formal education in management, public health or an equivalent field at the Masters level (or higher);
- At least three years experience as COP in health related projects;
- Demonstrated ability to manage health support programs at central and community levels;
- Demonstrated ability to create and maintain effective working relations with senior Government personnel, NGO partners, host country citizens, U.S. and foreign government organizations, donor partners, and the private sector;
- Demonstrated ability to manage multiple partner collaborative projects.

It is anticipated that short-term technical assistance will be used to complement a small in-country team. Using the program description, the contractor shall include in its proposal to USAID a roster of short-term technical specialists to implement activities outlined in this Task Order. Short-term technical assistance plans will be finalized during the implementation planning process. In finalizing these plans, the contractor shall, where feasible, make maximum use of local consultants.

During the initial detailed program implementation planning process, the contractor will review local support staffing needs and submit, along with the implementation plan a proposed staffing plan for a limited number of local professional and administrative/support staff. They may include office assistants, drivers, local technical staff, trainers, etc. Once USAID/Caucasus approves this plan, the contractor shall recruit local staff.

Home Office Support: Contractor shall include a discussion of proposed corporate headquarters supervision, support, and quality control efforts under the contract. Given provisions for designation of a fully authorized COP, and provision for activity-funded full-time staff at the local office, any direct Home Office support is expected to be focused primarily on that required for sourcing information and technical expertise to support the field team.

The contractor may execute sub-contracts and/or sub-agreement as necessary to meet the requirements of this Task Order.

IX. PERIOD OF PERFORMANCE

The period of performance of this Task Order is approximately 60 months through September 30, 2009 with option to extend for an additional six months subject to availability of funds.

X. TOTAL ESTIMATED COST

Projected total FY 2005-2006 funding is approximately \$2.8 million covering the initial two-year contract period¹². A projected \$4.2 million will be made available in FY 2006-2009, the three-year option period.

XI. MONITORING AND EVALUATION

Contractor will be responsible for developing and executing a Monitoring and Evaluation (M&E) Plan, which, at a minimum, includes the relevant standard indicators found in USAID/Caucasus Performance Monitoring Plans (PMP). Expected program results with illustrative indicators, mid-term milestones/benchmarks, end-of-project results partially provided in this document, should be further elaborated in the M&E plan. During the initial program planning period, the contractor shall work closely with the MoLHSA and USAID to select final indicators, establish baseline data, and performance targets for each indicator. The M&E should be submitted to the USAID CTO for approval within 90 days of the award of the Task Order. To the extent possible, performance monitoring systems will be integrated into, and will enhance, existing MoLHSA management information systems. USAID/Caucasus, the MoLHSA and contractor will conduct periodic performance reviews to monitor the progress of work and the achievement of results based on the targets specified in the M&E Plan. The M&E Plan shall be updated and revised as appropriate on an annual basis in collaboration with USAID.

A mid-term assessment will be conducted after 18-24 months to ascertain the results of Stage One against mid-term milestones established in the SOW, assess progress, contractor performance and make any mid-course corrections. A decision to progress from Stage One activities to Stage Two will be based on the outcomes of this assessment.

XII. REPORTING

Annual Work Plan: Within 60 days after the award of the Task Order, the Contractor will submit to the USAID Cognizant Technical Officer (CTO) a work plan for the HCST that encompasses all relevant activities for the development and implementation of tasks outlined above. The first year work plan should cover the time period from receipt of award to the end of the 1st year.

The work plan should include, at a minimum:

- Proposed accomplishments and expected progress towards achieving Task Order Tangible Results, Performance Measures, and Benchmarks, tied to the Monitoring and Evaluation Plan;
- A timeline for implementation of the year's proposed activities, including target completion dates;
- Information on how activities will be implemented;
- Personnel required for achieving proposed targets;
- An analysis of possible obstacles hindering achievement of objectives;
- Major commodities to be procured;
- Details of collaboration with MoLHSA and other USAID-funded partners.

The work plan will be developed in close collaboration with the MoLHSA (and to the certain extent with other Donors) to ensure it meets their needs and to coordinate all activities. This will enhance the

¹² Please note, amount of \$900,000 is earmarked only for RH/FP activities, thus shall be entirely spend to cover RH/FP Advisor component, and tracked and reported separately.

likelihood that the HCST will sustain program interventions beyond the life of the Task Order. In the event of changes in funding during the award period, the Contractor will be requested by USAID/Caucasus to modify its implementation plan in accordance with directives associated with those changes.

Quarterly Financial Status Reports shall be submitted quarterly and should contain, at a minimum:

- Total funds committed to date by USAID into the Task Order;
- Total funds expended by the Contractor to date including accrued expenditures broken by main line items;
- Pipeline;
- Funds remaining.

Quarterly progress reports: The Contractor is expected to prepare and submit to the Mission a quarterly report within 30 days of the end of the Contractor's first full quarter, and quarterly thereafter. The report should contain at a minimum:

- Progress (activities completed; benchmarks achieved; performance standards completed) since the last report;
- Problems encountered and whether they were solved or are still outstanding;
- Proposed solutions to new or ongoing problems;
- Compelling success stories (if appropriate);
- Documentation of best practices that can be taken to scale;
- List of upcoming events with dates.

Short-Term Consultants Reports: All short-term consultants will prepare reports at the end of their consultancies detailing their activities and making recommendations as may be appropriate. Before leaving Georgia, the short-term consultant will leave copies of either a final or a draft copy of their report with the Contractor. The Final Report is to be submitted to USAID within 30 days after the consultant's departure from Georgia, unless extended by the CTO.

Special Reports: From time to time, the Contractor will be required to prepare and submit to USAID special reports concerning specific activities and topics.

Completion Report: At the end of the TO, the contract shall prepare a completion report which highlights accomplishments against work plans, gives the final status of the Benchmarks and Tangible Results, addresses lessons learned during implementation and suggests ways to resolve constraints identified. The report may provide recommendations for follow-on work that might complement the completed work.

Miscellaneous Reporting Requirement:

- ❖ **Ownership:** All plans, reports and other documentation under this Task Order shall become the property of USAID/Caucasus and may not be used by the Contractor for any other purpose than to satisfy the requirements of this Task Order.
- ❖ **Report of USAID-funded property.** In accordance with USAID acquisition regulations, the Contractor is required to submit annual inventory reports of all non-expendable, USAID-funded property in the Contractor's custody (based on the calendar year).
- ❖ **Document Specifications:** All reports and other documentation prepared under this Task Order shall be provided in English as a finished document, both in hard copy and electronically. Documents will be prepared in Microsoft Word, Microsoft Excel and/or Microsoft PowerPoint.

XII. ADMINISTRATIVE REQUIREMENTS

- While the MoLHSA will provide office space and equipment to allow technical advisors to co-locate with counterparts to the extent possible, the Contractor will need to rent, equip and staff a modest office in Tbilisi, especially for the Second Stage activities. The office will house the COP and project staff, and will provide space for use by short term consultants fielded by the contractor.
- Recruit and field local and international consultants and experts as needed. Where feasible, the contractor shall make maximum use of available local expertise for short-term assignments. In fielding all short-term experts but particularly with expatriate short-term expertise, the contractor shall ensure continuity of technical assistance by utilizing a limited pool of specialists who make repeated visits to work on continuing activities.
- Manage subcontracts/grants to local groups and other implementing agencies/partners as needed;
- Organize in country logistics and travel for meetings, site visits, conferences and other activities outlined in the approved program implementation plan.

XIII. METHOD OF AWARD AND EVALUATION CRITERIA

Proposals must clearly demonstrate how limited USAID funds can be applied for maximum impact. The criteria for evaluating proposals are listed below.

<p>1. Technical Approach – In evaluating the different components of the technical proposal, USAID will examine:</p> <ul style="list-style-type: none"> ➤ The overall merit and feasibility of the proposals, as well as specific criteria relevant to each of the tasks outlined earlier; ➤ Proposals should outline how the various tasks listed earlier will be undertaken; ➤ The technical components of the proposal will be evaluated based on the overall understanding and approach, and the specific design of the program; ➤ Concept of sustainability should be adequately discussed and clearly defined; ➤ Proposal should demonstrate an understanding of health sector issues in Georgia. 	<p>30 pts</p>
<p>2. Personnel – Proposals should outline:</p> <ul style="list-style-type: none"> ➤ List of the personnel and provide the CVs for the individuals that your firm proposes to manage this task order. These individuals will be “key personnel” for this work order; ➤ Qualification and relevant experience of proposed “key personnel”, including quality of experience in developing country settings and demonstrated exceptional expertise in their particular fields; ➤ Demonstrated success in delivering technical assistance and in working in partnership with local counterparts; ➤ Which subcontractors will conduct the various tasks listed earlier; ➤ Qualifications and experience of proposed home office support or management personnel and explanation or justification for the use of these classifications. 	<p>40 pts</p>

<p>3. Institutional Capacity and Past Performance –</p> <ul style="list-style-type: none">• Past performance on an demonstrated capability to plan, implement and monitor similar programs;• Capability and past performance in starting program activities rapidly and providing timely and extensive TA;• Capability to support personnel and field operations;• Past performance in meeting USAID reporting and accountability requirements;• Success in forming alliances with other organizations.	<p>30 pts</p>
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