

# **Primary Health Care Development Programme in Georgia – a Challenge of Donor Coordination**

**Research Paper**

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## List of Abbreviations

<b>DFID</b>	UK Department for International Development
<b>EU</b>	European Union
<b>FSU</b>	Former Soviet Union
<b>GoG</b>	Government of Georgia
<b>HMIS</b>	Health Management Information System
<b>LFA</b>	Logical Framework Approach
<b>MoLHSA</b>	Ministry of Labour, Health and Social Affairs
<b>MTEF</b>	Medium Term Expenditure Framework
<b>OECD DAC</b>	Organization for Economic Cooperation and Development, Development Assistance Committee
<b>OPM</b>	Oxford Policy Management
<b>PHC</b>	Primary Health Care
<b>PHC CB</b>	Primary Health Care Coordination Board
<b>PHC MC</b>	Primary Health Care Management Committee
<b>SWAp</b>	Sector Wide Approach
<b>ToR</b>	Terms of Reference
<b>WB</b>	World Bank
<b>WHO</b>	World Health Organization

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# 1. Background and Problem Definition

## *1.1 Purpose of the paper*

The purpose of this paper is to assess donor coordination arrangements over the lifespan of the present phase of primary health care (PHC) reform in Georgia (2003-2008). The research identifies existing problems within donor coordination mechanisms deployed on various stages of the process, defines external forces having impact on the implementation and proposes effective coordination arrangements among local stakeholders and international partners for the future.

Assessments in the paper are mostly based on the extensive interviews with reform stakeholders, review of the key national documents and international evidence, as well as internal and external observations of the reform process. Evaluation of the quality of outputs and deliverables produced by implementers across the various workstreams is not the aim of the paper.

## *1.2 Introduction*

One of the major risks to long-term growth of Georgian economy is the deteriorating human capital stock as a result of inequitable access to health care services, low coverage of social services. Extremely poor quality of health care services adds up to it. Empirical evidence proves that health of the population has to be considered as a basic prerequisite to the economic growth of the country<sup>1</sup>.

According to the recently conducted study in the eight countries of Former Soviet Union (FSU), in Georgia of those reporting an episode of illness during 2001 only 24.4% visited medical professional and 49 % did not consult although they felt they should have done so. The main obstacle for not seeking professional medical care when needed named was unaffordability (70%). 65% of those who had consulted paid out of pocket for provided services.<sup>2</sup> Another study revealed that as high as 87% of health care expenditures are financed through out-of-pocket payments.<sup>3</sup>

Since restoring its independence in 1991 Georgia underwent through a number of reform processes in all the spheres of life. So was the health care system. During the Soviet times the health system was too costly and inefficient to be maintained within the newly emerged economic environment where the economic output was over 3 times less than that of the pre-transition period. Primary health care was not a very strong concept and

the majority of the population tended to bypass PHC and seek medical care directly from the hospitals and/or specialists.

First Georgian Health Care Reform Project has been designed during 1993-1995 by the Georgian government with participation of the World Bank experts. The World Health Organization (WHO) also provided technical assistance to the government. Presidential Decree #400 from 1994 was the official initial point in the Health Care System Reform in Georgia.<sup>4</sup> Supported by the World Bank loan, actual reforms started in 1995 were aiming to:

- (a) Concentrate scarce public resources on a basic package of public health (immunization, healthy children and safe motherhood, prevention of socially dangerous diseases, epidemiological surveillance, and health promotion) and essential clinical services (deliveries, treatment of children under the age of 14, treatment of TB, inpatient psychiatric care, provision of drugs for terminally ill patients, and emergency services). The scope of the package to be expandable based on the economic growth.
- (b) Reduce the size and improve the quality of health sector personnel.
- (c) Reduce the number and improve the quality and efficiency of health care facilities.
- (d) Separate the provision of health care services from their financing by moving service provision to the private sector.
- (e) Limit the Ministry of Health's role to one of formulating policy, strategic planning, monitoring and regulation, and quality assurance.
- (f) Develop human resources to support the reform in areas such as modern public health, family practice, health services administration, and management.<sup>5</sup>

To achieve stated objectives reform implied following activities: creation of the legal base for the new healthcare system, decentralization of healthcare management, innovation in financial and economic foundations of the healthcare system, including instituting programme-based funding, prioritizing primary health care, dismantling of the Sanitary-Epidemiological Department and creation of the Public Health Department with expanded functions and capacities, transition from the state-funded health care to the principles of medical insurance coverage, establishment of regulations for accreditation and licensing of all medical institutions and personnel, privatization of health care facilities, establishment of the State Health Fund, reforming the pharmaceutical sector regulation and licensing, restructuring medical education, medical science, health information system and drug policy, elaboration of the basic health care package, and in general, transforming the functions of the Ministry of Health from the centralized administration of the entire system to policy making, strategy development and regulatory functions. In parallel DFID was also actively involved in supporting training of doctors in family medicine and implementation of family medicine pilot sites (clinics) in Tbilisi.

Although there were number of drawbacks in the implementation of the project (weak link between research and policy-making, lack of social dialogue, unmatched expectations from donors, governments and beneficiaries sides, etc) and the tangible impact of the reform is still questionable by some, nevertheless, this was the first step the country has made towards the establishment of effective, efficient and equitable health care system. Some of the most important achievements of the reform are listed below:<sup>6</sup>

- Reforms have contributed to the changing the people's attitude towards their health towards assuming personal responsibility for their health status;
- Competition among health care providers has contributed to continuous improvement in the quality of care.
- Standardization of clinical care was considered to be another successful development of health care reform.
- Health reform has successfully established and developed new institutional arrangements in the health care sector.

Continuous discussion through the reform process has resulted in the development of National Health Policy and Strategy and created grounds for the second phase of the reform, focused on reforming / developing the primary health care system defined as an utmost priority.

In 2000 the Government of Georgia (GoG) with the assistance of the World Bank adopted the PHC Strategy that envisaged the formation of a health care model that effectively and reliably provides high quality, cost-effective and equitable medical services and is physically available and affordable for the entire population. Problems outlined in the PHC strategy, and ultimately to be addressed by the reform process were weak health care infrastructure, inappropriate institutional framework, imbalances in health human resources in terms of unequal distribution and technical competence, health care financing constraints, inadequate legal framework, unhealthy life-style, inappropriate health seeking behavior and poor quality of health care services to name a few.<sup>7</sup> The strategy envisaged conversion of the existing multi-layer ambulatory/policlinic system into the unitary Family Medicine/General Practice centers.

The PHC system development program has become an integral part of the GoG's Poverty Reduction Strategy, illustrating the government's commitment towards the PHC sector. In the long run, strengthening of PHC services in Georgia was expected to have a beneficial impact on the health status of the population. It was envisaged that the reforms would increase the degree of satisfaction that health care produces among the citizens, and would protect the individuals against the serious financial burden and impoverishment caused by illness.

WHO defines primary health care as the principal vehicle for the delivery of health care at the most local level of a country's health system. It is essential health care made accessible at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Besides providing appropriate treatment for common diseases and injuries, essential drugs, maternal and child health services, immunization and preventing the local endemic diseases, it should also include community education on the methods for preventing the prevalent health problems and promotion of healthy life-style. Modern PHC should not be considered as an isolated island in the sea, it should also acknowledge the importance of integrated service provision from primary to tertiary levels of care within a coherent health system.

In response to the Government's adopted strategy number of multi- and bi-lateral international development agencies (donors) expressed interest in supporting the PHC reform process in the country. Major donors that ultimately became involved in the countrywide reform process were the World Bank (WB), European Union (EU), UK Department for International Development (DFID), and USAID.

In 2003 a Memorandum of Understanding has been signed by the Ministry of Labour, Health and Social Affairs (MoLHSA), representing the Government of Georgia and three major donor (WB, EU and DFID) representatives. Parties agreed to act under the leadership of the Ministry and committed themselves to co-operate and coordinate PHC reform activities via the newly established PHC Coordination Board (PHC CB) and the PHC Management Committee (PHC MC).<sup>8</sup> It was also stated in the Memorandum that more detailed enabling coordination framework would be developed at the later stage. .

### 1.3 Donor Commitment

Donor agencies, acting through the contracted implementing institutions (private for-profit, non-governmental, governmental agencies) committed substantial funding for the PHC reform programme (Table 1).

**Table 1. Donor involvement**<sup>9</sup>

<b>Funding Sources</b>	<b>Implementing Organization</b>	<b>Target Geographical Areas</b>	<b>Principal Activity Domains</b>	<b>USD Amount and Timing</b>
<b>World Bank</b>	Georgian Health and Social Projects Implementation Center	Countrywide	~25% for Technical Assistance and 75% for infrastructure rehabilitation	<b>\$24,802,604</b> June 2003-2008
<b>DFID</b>	Oxford Policy Management	National level	100% for Technical Assistance	<b>\$7,166,876</b> Sep 2003-2008
<b>EU</b>	Various	Kakheti Region (infrastructure) and nationwide (technical assistance)	~ 42% for Technical Assistance and 58% for infrastructure rehabilitation	<b>\$8,300,000</b> March 2003-2006

**Georgian Health and Social Projects Implementation Centre (GHSPIC)** – a public law juridical entity under the management of MoLHSA has been the implementing agency assigned to implement and coordinate the **World Bank** supported project. Amount of the loan constituted US \$ 20.3 Million. The government committed additional US\$ 4.46 to this project. The main project development objective, stated in the World Bank Project Appraisal Document (PAD) was to improve the coverage and utilization of quality PHC based on the model of family medicine/general practice, with an emphasis on reaching poor and disadvantaged.<sup>10</sup> Project was broken down to two major components and several sub-components:

1. Service delivery:
  - a. establishing PHC clinics and referral laboratories,
  - b. PHC referral pilot,
  - c. community based information, education and communication campaign
2. Institutional development:
  - a. capacity building for PHC training,
  - b. capacity building in management of PHC services,
  - c. strengthening Health Management Information Systems (HMIS) for PHC,
  - d. support for the PHC financing reforms.

From the total amount of US\$ 24.8 Million about 25% was thought to be allocated for technical assistance (services), and the rest for the infrastructure rehabilitation (works and goods). Credit agreement was ratified by Georgian Parliament. Project was launched in June 2003.

**DFID** has contracted a private consulting company - **Oxford Policy Management (OPM)** for the implementation of the *Supporting PHC reform in Georgia* project. According to the mandate of DFID, total grant amount allocated for the project (US\$ 7.167 Million) was intended to be used solely for technical assistance. Project was launched in September 2003 and aimed to establish a sustainable and affordable system of primary health care in Georgia. Activities were broken down to the following four workstreams:

1. Human resources for PHC,
2. Health financing,
3. HMIS,
4. Health promotion and PR campaign.

**EU** has also contracted various implementing agencies on different stages of the program to implement specific technical tasks within its *Support to PHC Development Project* contracted various companies (ECOTEC, Basnet Consortium, GVG & EPOS). Unlike the WB and DFID programs planned to be implemented nation-wide, the EU program has been specifically focused on a pilot region (Kakheti in eastern part of the country). However, some nationwide activities were also planned with the EU funding. About 58

% of the total EU grant amount of US\$ 8.3 million was intended to be allocated for the infrastructure rehabilitation (in Kakheti), and the rest 42% for the technical assistance (consultancy services). Activities have been initiated in March 2003. GVG&EPOS, contracted from June 2004 for implementation of the 2 years long *Reform of Health Care Financing System in Georgia* Project, is focusing its activities to the following components:

1. Technical Assistance,
2. Pilot activities in Kakheti Region,
3. Capacity Building/Training,
4. Information, Education and Communication,
5. Coordination of Activities.

The **USAID**, not being a formal part signed the Memorandum of Understanding, has awarded **Abt Associates Inc.**, in collaboration with Curatio International Foundation, Care International and Emerging Markets Group, the *Georgia CoReform Project*. This project is not limited in its scope with PHC only. Project is intended to provide technical assistance to the Government of Georgia to build its capacity to transform the country's health system into one that is more efficient, accountable, and transparent. With overarching ownership from the Ministry of Labor, Health and Social Affairs along with the CoReform team, the project is designed to help the Government of Georgia improve its health care financing system, support reproductive health and family planning, and strengthen its health institutions at the national level. This project was launched in 2005.

In addition to these major initiatives, there are also number of other smaller-scale completed and ongoing PHC programs and pilot projects implemented by various local and international agencies such as OXFAM GB, CARE Caucasus, Mercy Corps, IRD, NOVIB, Welfare Foundation, CIF, Genesis and others, ultimately aimed at supporting countrywide PHC reforms.

### **3. Problem Statement**

Series of key informant interviews were conducted during December 2004 - January 2005 (after more than 1.5 year from project launching) with the major stakeholders of the PHC reform programme (including donor agency representatives, implementers, professional associations and prospective beneficiaries) to explore their views about successes and/or failures of the programme and opinions about the reasons behind these achievements or shortfalls.

Most of the respondents rated progress of the programme to date unsatisfactory. Tangible, visible outputs are still to be seen. The following major reasons behind the lack of tangible progress of the programme have been named by respondents:

- Failed donor coordination;
- Duplication of activities;
- Overall political environment (context) in the country alongside the programme development;
- Inexistence of the joint implementation plan to be followed by stakeholders, with performance monitoring and evaluation system;
- Improper sequencing of activities and division of responsibilities leading to vicious cycles in implementation and blaming each other for delays;
- Lack of ministerial will and capacity to properly exercise the leadership of entire process at various stages, institutional weaknesses;
- Lack of understanding of PHC by national stakeholders and MoLHSA Top level;
- Lack of consensus among different stakeholders/experts and consultants;
- Fragmentation of activities leading to high transaction costs.

All the above listed causes are very much interlinked and dependent on the existing political environment.

### **3. Overall Political Context**

One of the major events in Georgian new history – Rose Revolution took place in November 2003. Having dramatic impact on all spheres of the country life, the Rose Revolution had its consequences in health sector also. Although after the Rose Revolution situation concerning public financing of health care services significantly

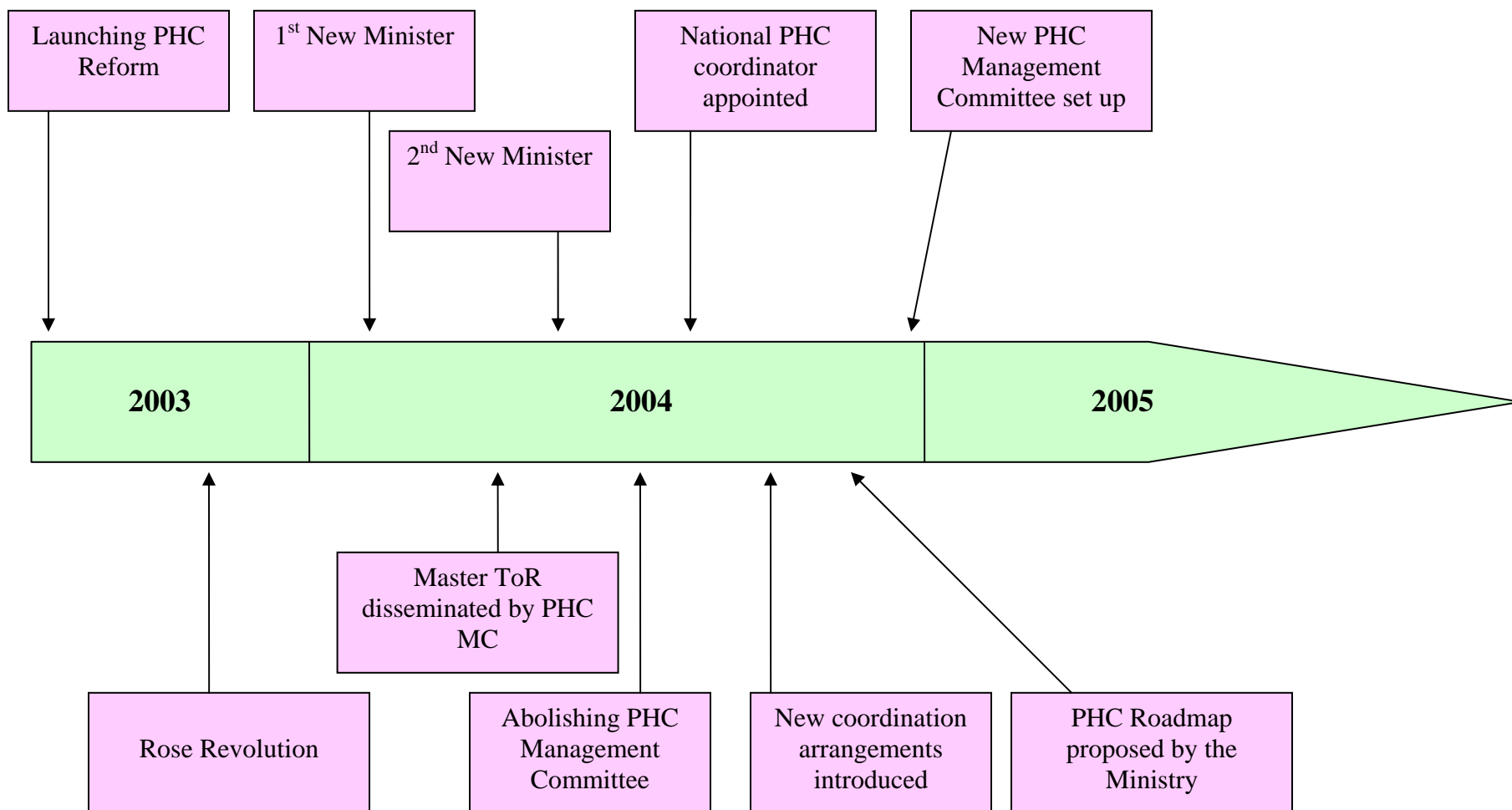
improved and a big share of the accumulated over the years debt has been repaid, still much has to be done to ensure universal and equitable coverage and access of Georgian population to basic health care services and efficient use of existing, still scarce resources.

Also, frequent changes of the MoLHSA and other government Ministries' leadership and staff turnover following the revolution, has also contributed to preventing the continuity of the reforms.

In order to explore the impact of the overall political setting on the development over time of the PHC reform programme let us break down the elapsed time starting from June 2003 to following periods:

- Pre-election (June – November 2003)
- Pre-revolution (October – November 2003)
- Early post-revolution (December 2003 – March 2004)
- Late post-revolution (April 2004 – to present)

**Figure 1. Political context and important milestones of the PHC reform programme in Georgia**



Characteristic features of the government before the parliamentary elections of 2<sup>nd</sup> November 2003 (results of which later on annulled by the Supreme Court of Georgia) were widespread corruption, symbolic official salaries in public sector, lack of interest and motivation of civil servants. Staff uncertainty in the future added to it after October elections and before November revolution. Situation was very similar in health sector too, contributing to the limited attention of the ministerial staff to the reform processes. Very weak links existed between reform implementing agencies from one side and the middle and lower level operational ministerial staff from another. All these were leading to disruption of implementer – government accountability line, demotivation and passive, “follow the current” attitude towards the process from the donors and implementers side also.

Several reforms were launched by the new government in all sectors and strong anti-corruption measures were introduced. Some of these were substantial raise of the civil servants salaries, increasing salary differentials, sentencing for corruption former high level officials, etc. In health sector old ministerial leadership was retained until February 2005. Highest ministerial leadership, as well as lower level civil servants from MoLHSA, uncertain in the future and working in the “awaiting replacement” state, were lacking will and motivation to actively participate in the stakeholder meetings and discussions dedicated to the joint planning of future activities concerning PHC reform process.

A new Minister of Labor, Health and Social Affairs has been appointed in February 2004. However, after couple of months in office without having time to acquaint himself with ongoing processes he resigned and moved to parliament where he became a chair of the parliamentary health and social issues committee. New minister was appointed in May 2004 (formerly the chair of the parliamentary health committee). Changes in the top ministerial level (including all the deputy ministers) were followed by dramatic changes in middle and lower management levels (from heads and deputy heads of ministerial departments down to specialists). Newly appointed staff at all levels in most cases was lacking capacity and experience, needed orientation time to get acquainted with the ongoing processes in the sector, population health needs, donor involvement in the reform and existing implementation systems, as well as to shift personal priorities. The entire instability and frequent staff turnover substantially hindered continuity of the PHC reform, caused long delays and questioned existing reform implementation plans.

Although the will of the new ministerial administration to be actively involved and lead the reform process was evident from the beginning, due to the lack of capacity (both technical and administrative/managerial) and information some months were needed to become able to fully exercise the leadership. It should be also mentioned here, that new ministerial leadership, not being involved in the planning of PHC reforms that has taken place couple of years ago lacked sense of ownership and even resisted to accept the plans approved by previous government. Although in the time being ministerial administration capacity substantially improved and increased control over the reform processes, ongoing civil service reform and expected restructuring of the ministry still leads to uncertainty of the staff and again, problems with continuity.

## **4. Donor coordination arrangements at various stages of PHC reform**

As stated in the Memorandum of Understanding signed by three major donors and the Minister of Health, to achieve reform objectives in a co-operative manner the MoLHSA with aid of donor organizations sets up Primary Health Care Co-ordination Board (PHC CB) and Management Committee (PHC MC). The Parties agreed to work through CB and MC.

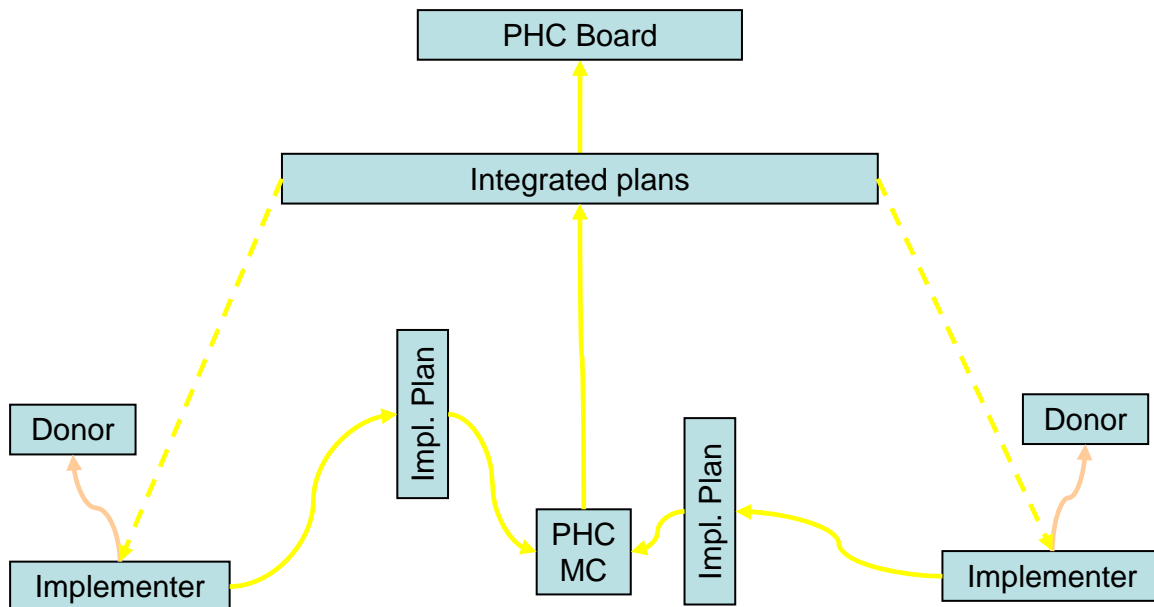
The PHC CB consisted of the MoLHSA, donor (on a rolling basis), parliamentary and Ministry of finance representatives, as well as selected regional health administrators. PHC CB was intended to:

- Lead the PHC Program of Work;
- Act as the overall governing body of the PHC Program and the PHC Management Committee;
- Define, evaluate and/or approve the Mission, Goals, Strategy, Global Project Design, Overall Resource Requirements, Concurrent & Final Program Performance;

The PHC MC was an operational structure under the direction of the Board and was charged with day to day implementation of the PHC program. Entire PHC development programme was broken down to 5 work streams:

- PHC infrastructure rehabilitation;
- PHC Human resources development;
- PHC financing;
- Health Management Information System (HMIS) development;
- IEC campaign (later on renamed to Health Promotion and PR).

**Figure 2. Interrelationship between PHC CB, PHC MC, donor and implementers**



At the early stages of the reform implementation, the roles and functions of PHC CB, and especially PHC MC were not defined and communicated properly among the parties involved in the implementation, often causing controversies and leading to delays. Moreover, there was no clarity with regards to this issue even within the PHC MC.

First attempt to develop joint plan and monitoring & evaluation system for the PHC development programme in August 2003 due to flaws in proposed by international consultant methodology, as well as low preparedness of stakeholders to joint planning exercise, were not successful.

Following this, series of thematic 1-2 day stakeholder workshops have been called by PHC MC during January-February 2004 in order to fine-tune the implementation plans, ensure proper sequencing of activities, avoid duplication of efforts and wastage of scarce resources, and identify gaps. As a result, consolidated process charts have been developed for each work stream, outlining the scope of work of each stakeholder and timing of respective activities. Nevertheless, the workshops were focused on stand-alone workstreams and lacked holistic vision of entire process. Thorough and systematic means-ends analysis was not carried out.

Ministerial participation in the workshops was extremely passive (in some cases none). Decisions to be made on by the ministry on policy options to be followed where only vaguely addressed. Lack of motivation and interest from the Ministry was transferred to other stakeholders (donors and implementers) also – participation over time (during a work day) was clearly decreasing.

There were shortcomings in methodology and facilitation of the workshops too. Objectives were not clearly stated, workshops were sometimes perceived to be just an academic exercise for participants, not having implications for the future planning of activities. Problem definition exercise as an initial part of the workshops was not systematic and comprehensive and resulted in merely disjointed and superficial lists of problems without exploring their cause-effect relationships. This later on had a negative implication on logical sequencing of activities in produced implementation plans. Moreover, approach on the last stage of the workshops was to mechanically aggregate separate activity plans proposed by donors and implementers. Fragmentation of activities between implementers on a sub-component and even lower level led to diffusion and blurring of responsibility.

As an output of the workshops, draft Master Terms of Reference (consolidated plan) has been produced and disseminated by PHC MC to all the stakeholders in May 2004. The document remained by large unrequested by stakeholders, was not approved by the PHC CB and ultimately by government and finally has been forgotten.

In July 2005 the Minister abolished PHC MC and appointed Director of the National Institute of Health (NIH) as a National PHC Coordinator. A Road map of PHC Reform (*Essential Elements of a Road Map for Primary Health Care Reform in Georgia – a Statement of Policy*) was released by the Ministry (signed by the Minister and the National PHC Coordinator) in end November 2004. In the document it was acknowledged, that some months in office were needed for situation analysis and orientation. Situation with regards to donor coordination and PHC reform progress was characterized as follows:

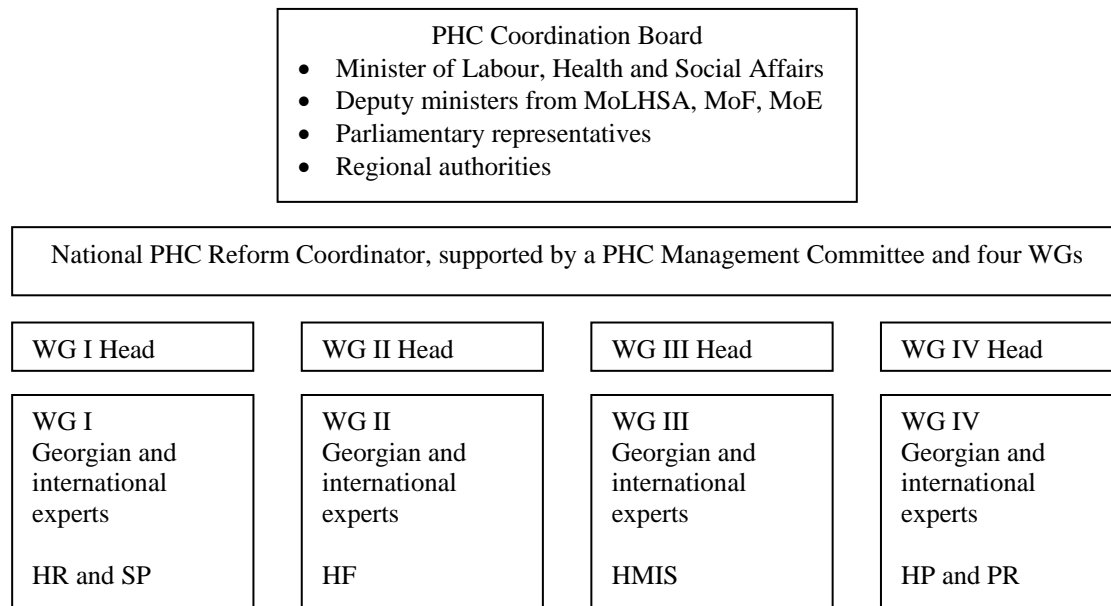
- a complex combination of high public expectations with severe economic difficulties,
- an unstable situation with frequent changes in government,
- a context in which the main stakeholders (doctors, citizens, universities, etc.) have not been properly involved in the process of reform,
- a series of well meant reform initiatives which have been either not properly implemented and/or not necessarily compatible with each other,
- a severe institutional weakness by which the MoLHSA has found it difficult to play a proper leadership in the process so far.

The document highlighted need for visible progress and immediate tangible achievements. According to the Road Map, four working groups (one for each work streams) were to be established in the NIH under guidance of the National PHC Coordinator. Working Groups were expected to prepare:

- o A proposal regarding the immediate action to be commenced, with specific mention of the following items:

- Selection of 100 precise pilot facilities for refurbishment, in which one doctor and one nurse will work,
  - Standards for reconstruction and equipment of those facilities,
  - List of services to be provided / that those facilities should be able to provide in the short term and which will be funded from the state budget,
  - Curriculum for re-training the staff concerned in line with the services that will be provided,
  - Organizational structure and management of those PHC centers, including the HMIS needed to make them work properly,
  - Financial aspects of the proposed arrangements, including sources of funds and methods as well as levels of staff payment, be it time-based, service based, or a combination of both, and how payments will be managed,
  - Public relations and health promotion-related activities, with emphasis on a public information campaign to inform the population and the political forces about the meaning and implications of the proposed changes.
- A proposal of the critical steps needed to achieve substantive progress in PHC reform in the months and years ahead, with a scope of two to five years.
- The areas in which decisions are needed, with mention of the key stakeholders and institutions involved,
  - The measures to be adopted as well as their sequence,
  - The policy alliances needed to make the above feasible, and
  - The recommended mechanisms and institutions to govern those steps.

**Figure 3. PHC coordination approach**



Nevertheless, proposed approach as yet did not result in the development of joint activity plan for the PHC reform programme and duplications of activities and overlaps by different implementers still occur when in the meantime available resources are barely sufficient for the infrastructure rehabilitation. As an example of the overlap the health financing work stream can be brought – different sub-activities within the work stream are artificially split between OPM, GVG, Abt Associates and GHSPIC, while separately all of these stakeholders are acknowledging that task perfectly can be accomplished by one implementer organization only.

In parallel to above described developments, GHSPIC after lengthy discussions approved respective ToR and is in the process of recruiting a short term expert-consultant for facilitating the joint stakeholder workshop aimed at developing a PHC programme LogFrame and implementation plan.

To sum up, the reform process at initial planning stage and along the implementation was not viewed as a significant, purposeful action to improve the performance of the health care system and did not involve a set of interdependent and mutually supporting interventions

In opinion of stakeholders, the following factors substantially hindered the progress of the reforms on various stages:

1. Failed donor coordination
2. Lack of ministerial leadership of the reform process
3. Political context
4. Inexistence of the joint programme implementation plan and performance monitoring and evaluation systems

## 5. Proposed coordination arrangement

### 5.1 International experience

Coordination of international donor assistance on a country level is a challenge and widely discussed issue in international development circles. Development aid differs in important ways from domestically financed services. There is a geographical and political separation between beneficiaries in the recipient country and tax-payers in the donor country, breaking the loop of performance feedback. Beneficiaries in recipient country are not in power to reward or punish the policymakers responsible for the performance in donor countries.

Increasing aid effectiveness rests on three pillars: **harmonizing** donor practices, **aligning these practices** with national development strategies taking account of the specificities of each southern country and, finally, ensuring these countries have **full ownership** of these strategies.<sup>12</sup>

Sector Wide Approach (SWAp) is generally accepted as a credible and effective framework for undertaking health sector reforms. SWAp implies that all significant funding for the sector supports a single sector policy and expenditure program, under government leadership, adopting common approaches across the sector and progressing towards relying on Government procedures for all funds. It ensures adequate attention to local capacity building.

On the operational level there are several options for donor coordination on a country level proposed in the literature:

- Common basket funds;
- Project aid using government services;
- Project aid using parallel services;
- Geographical zoning;
- Sub-sector specialization;
- Aligning lead agency (when the government is weak)

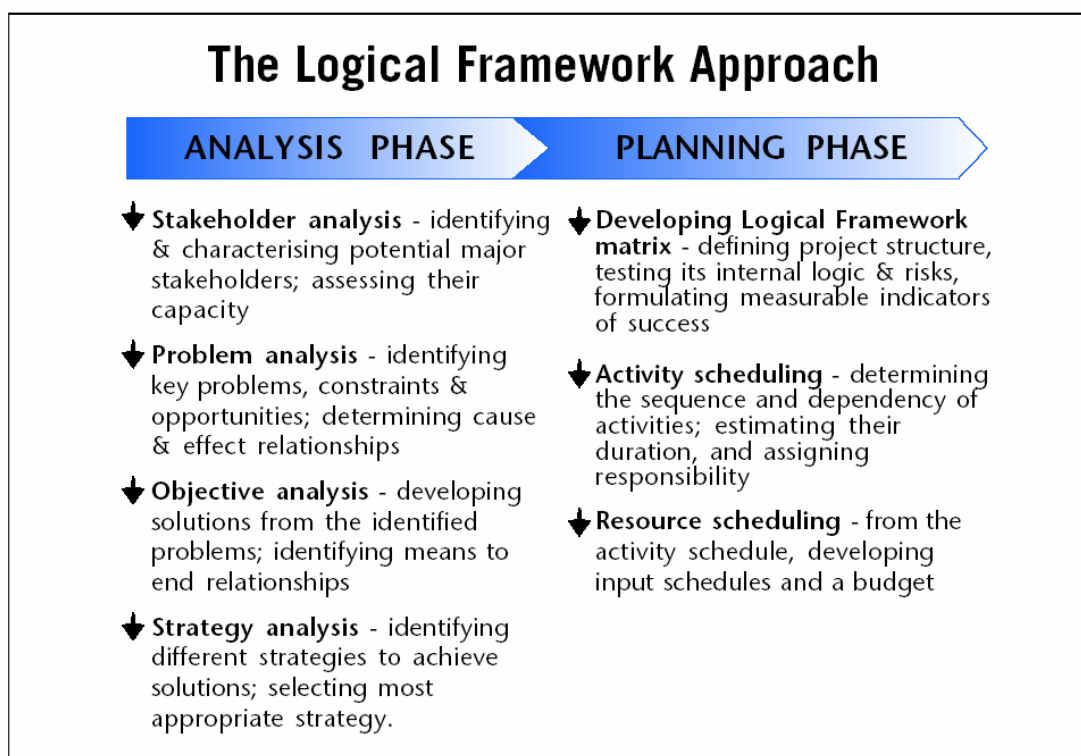
As it is defined in the *OECD DAC guideline on Harmonization*, aid co-ordination should, whenever possible, be led by partner governments. Partner countries and donors should have a shared interest in ensuring that public funds are used appropriately. Donors should decentralize decision making to country based staff, harmonizing procedures. Different donors should use common performance indicators (*common monitoring and evaluation framework*) while funding same activity (sector). Country Medium Term Expenditure Framework (MTEF) projections should be taken into account on an activity planning stage.<sup>13</sup>

SWAp has proved its value in number of countries, especially in terms of reducing transaction costs by means of common procedures for planning, disbursement, accounting, audit and review.<sup>14</sup>

## 5.2 Logical Framework – Proposed approach for joint planning and better coordination

Based on the analysis of the problems identified, hindering PHC programme timely and efficient implementation, the Logical Framework Approach (LFA) is proposed as an option for development of joint implementation plan, as well as system for performance monitoring and evaluation. There is a plenty of literature available online and describing LFA approach in details and interested reader can easily approach it. Just the key steps of the process will be mentioned here: situational analysis (including stakeholders analysis), problem analysis, objectives analysis, strategy analysis, developing Logical Framework Matrix (LogFrame), activity scheduling and resource scheduling.

**Figure 4. LFA steps** <sup>15</sup>



Helping to keep the goal of program in mind all the time over implementation, the LFA is a very effective analytical and management tool when understood and intelligently applied.

Method is well tested over decades and familiar to PHC programme stakeholders - multi and bi-lateral donor agencies, as well as all the implementers that have experience of being involved in various development projects in the past.

As long as method requires active participation of key stakeholders (including ministry) in the process of constructing LogFrame, LFA will lead to better ministerial ownership of the produced plans and though improved leadership over the entire process.

LFA by means of systematic analysis of existing situation allows for proper identification of problems and objectives in their logical hierarchy, followed by identification of exact and logically sequenced activities to be carried out in order to achieve stated objectives. This creates excellent basis for re-distributing activities among stakeholders, clearly defining responsibilities, timing of implementation and avoiding “blaming each other” practices in the future for flaws in implementation.

LFA enables to avoid duplication and overlapping of activities, as well as to identify gaps in activity plans and can serve as a basis for the ministry to approach other donors or request additional funding from the government. Moreover, it allows for identification of important external factors (risks and assumptions) that might have an impact (positive or negative) on programme implementation.

LFA with its common framework system of objectively verifiable indicators corresponding to hierarchy of goal, objectives and activities is a good tool for government and donors to monitor and evaluate performance of implementers.

Contrary to the argument, that the PHC programme has been started already almost 2 years ago, lot has been done in the meantime and it is not proper time to go back for planning at this stage, it should be articulated that LFA situational analysis will be based on already achieved results, existing status and will fully take advantage of deliverables already produced by stakeholders.

LFA process is as important as it’s product – LogFrame matrix for building consensus and finding common ground.

Practicalities of implementation matter a lot - without strictly following the LFA methodology and considering all the details good idea can be discredited and abandoned due to flaws in implementation.

And finally, planning is inherently iterative process, LogFrame is a lively document which allows for updates, adjustments and changes if necessary during the process of implementation without loosing the sight of ultimate goal.

### ***5.3 Recommendations and future steps***

- Utilize potential of LFA for the joint planning of PHC reform activities.
- Take into account government mid-term expenditure framework (MTEF) projections with regards to PHC development in the country.

- Ensure commitment of implementers to amend & review their plans based on the result of planning exercise;
- Ensure commitment of donors to revise the contracts with implementers accordingly;
- Parties involved should assume full responsibility over the output - Logframe planning exercise should not be perceived as a training or merely academic one.
- Prior to the planning exercise provide 1-2 day training to relevant government (National PHC coordinator, Working Groups, etc.) and implementers key staff in planning LFA to fully acknowledge it's potential and prepare them for active participation in the planning workshops.
- Long term investment in government (MoLHSA) technical and managerial capacity building should be intensified.

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