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# **Sustaining Public Health Gains After Donor Transition: What Can We Learn from Georgia?**

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## Abbreviations

CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CIF	Curatio International Foundation
cMYP	Comprehensive Multiyear Plan
CSO	Civil Society Organization
DCFTA	Deep and Comprehensive Free Trade Agreement
DPT	Diphtheria Pertussis Tetanus
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPI	Expanded Program of Immunization
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
EUAA	European Union Association Agreement
Gavi Alliance	Global Alliance for Vaccines and Immunization
GeL	Georgian Lari
GNDP	Georgian National Drug Policy Platform
GoG	Government of Georgia
GPIC	Global Projects Implementation Center
GPS	General Population Survey
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HPV	Human Papilloma Virus
HSS	Health System Strengthening
ICC	Inter-Agency Coordinating Mechanism
ICT	Information and communication technology
IDI	In- Depth Interview
IMEM	Immunization Management Electronic Module
IPV	Inactivated Polio Vaccine
KP	Key Populations
M&E	Monitoring and Evaluation
MMR	Measles Mumps Rubella
MoF	Ministry of Finance
MoH	Ministry of Health
MoJ	Ministry of Justice
MTEF	Mid Term Expenditure Framework
NCDC	National Center for Disease Control and Public Health
NDO	National Drug Observatory
NGO	Non-Governmental Organization

NHA	National Health Agency
NIP	National Immunization Program
NITAG	National Immunization Technical Advisory Group
NSP	National Strategic Plan
OST	Opioid Substitution Therapy
PAAC	Policy and Advocacy Advisory Council
PCV	Pneumococcal Conjugate Vaccine
PHC	Primary Health Care
PIU	The Global Fund Programme Implementation Unit
PLWH	People Living With HIV
PR	Principal Recipient
PTF	HIV and STIs Prevention Task Force
PWID	People Who Inject Drugs
TDI	Treatment Demand Indicator
TGF	The Global Fund to Fight AIDS, TB and Malaria
TSP	Transition and Sustainability Plan
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
UNICEF SD	United Children's Fund Supply Division
UNODC	United Nations Office on Drugs and Crime
USAID	The United States Agency for International Development

## Executive Summary

The purpose of this research is to comprehensively evaluate donor transitions that took place in Georgia in the immunization program (NIP) after introducing new vaccines with Gavi support and the Global Fund-supported opioid substitution treatment (OST) and Tuberculosis (TB) program by focusing on the first-line drug (FLD) supply transition to the government. The objective was to understand better how and why Georgia was (or was not) able to sustain coverage with the selected health interventions after transition and identify the enablers and barriers to this. To achieve this objective following research questions were defined:

1. How does the cessation of external support affect the coverage of interventions previously supported by donor funding?
2. What contextual and health system factors influence whether coverage of the intervention/service was sustained (or not sustained) once donor funding was no longer available?

While answering these questions, the paper tries to understand a) WHAT has (or not) changed in the programs/interventions as they transitioned out of donor support; b) WHY these changes (or no-changes) have happened; and c) WHETHER and HOW we can link these to changes (or lack of it) to attainments in service coverage after donor transition.

Overall, the transition process was successful in Georgia as it has led to significantly improved coverage and access to OST services and uninhibited access to TB treatment with FLD with slightly improved treatment outcomes. Outcomes for NIP were variable, with significantly improved access and coverage with DTP-3-containing and MMR-1 vaccines but suboptimal coverage for Rota-2 and PCV-3, determined mainly by vaccine specificity and health system factors than by the transition process itself.

The study once again confirmed the complexity of the transition process, the time it takes, and the intricate interplay of drivers and facilitators, leading to successful and sustainable coverage following donor transition with tangible public health outcomes. These complex interactions are captured and explained in more detail in the report. Here we summarize the critical factors that facilitated effective transition, and they include:

- **Conducive country context:** country's good economic performance over the past two decades, along with institutional developments driven by

mandates arising from Georgia's Association Agreement with Europe, played an essential role in supporting the donor-transition process, which lasted many years and required numerous, iterative and at times overlapping adjustments not only in the health sector but also beyond. This once again underlines the importance of a context for health system changes-reforms.

- **Well-recognized "health needs"** proved to be an important driver for an effective transition. While significant differences across OST, NIP, and TB were documented in how the "health need" was perceived in Georgia by the country's stakeholders, these perceptions played important roles in all cases. The stronger the need was perceived, the stronger stakeholder engagement in the program, and eventually transition planning and decision-making process were more prominent. Where "health needs" recognition was lower, the stakeholder and community engagement were weaker. Beyond national stakeholders, the "health need" informed and drove donor support throughout the years and for all three interventions inquired in this report.
- **The value of partnership across donors and country government** next, the transition outcomes captured in the study were achieved through joint and complementary efforts of different partners (at times well-coordinated and at times not), and those involved with the health sector and beyond have collectively contributed to the observed outcomes. These findings further emphasize the importance of the partnership approach employed by GAVI and Global Fund and the value such partnerships bring. These findings also point to the need to expand partnerships beyond the health sector players, where possible.
- **External demands on the government** facilitated the developments in both the health and non-health sectors. These demands "pushed" the government to act and be accountable for achievements (or lack thereof). They have also led to (i) development of National Strategies, Comprehensive Multiyear Plans or planning for transition; (ii) setting up multi-sectoral coordination structures (such as Country Coordinating Mechanism or Inter-Agency Coordinating Mechanism), offering inclusive decision-making space to actors, including civil society and key affected communities; (iii) establishing advisory structures for evidence-informed decisions (such as National Immunization Technical Advisory Group or the Policy and Advocacy Advisory Council for HIV/AIDS). These structures played an important role when making decisions, coordinating government and non-government actors, and, most

importantly, keeping implementers accountable for the agreed and planned deliverables. These external demands and structures helped open decision-making space to other players and made governance more participatory and inclusive.

- **Technical assistance** within and outside the health sector and for different technical areas such as developing strategic and transition plans, information systems within and outside the health system, drafting legal and regulatory documents, contributing to educational programs for human capacity development, enhancing public finance management systems, etc. all contributed to effective transition. This technical assistance was not only paid by the Global Fund and GAVI grants and the UN system but also by bi and multi-laterals and not only by those involved with the health sector. The review revealed vivid examples of how evolutionary and multifaced this technical assistance was and how it has contributed to positive developments, not only in the health system. It seems the need for technical assistance would persist going forward to address remaining shortcomings that could put at risk future transitions.
- **Empowered national actors and their advocacy efforts** were essential in achieving transition results. For OST growing need for drug treatment and public pressure led to many decisions taken by the government over the years. For the NIP, it was not as much the need but general preferences for new vaccines, spotted by experts, that led to hexavalent vaccine introduction and eventual state financing. Furthermore, **advocacy efforts organized by different institutional players** were critical in determining program success. For OST, the civil society with community engagement played an essential role in advocating for the government to make OST services available to those in need and sustain them after the transition. However, with NIP, the advocacy role was primarily played with the help of international partners WHO and UNICEF supporting NITAG with needed evidence and engaging in a dialogue with state authorities. All of these played an important role in generating the political will of the government as well as contributed to the development of a conducive legal and regulatory environment that helped transitions.
- **Institutionalizing systems and processes** within the state where national rules and regulations govern daily operations played an important facilitating role. The study showed how much the national public financial management (PFM) system helped during and after the transition. The medium-term budgeting process required responsible state entities to plan their financial resources for the coming years and deliver on the external co-financing promises. Results-based budgeting placed national accountability requirements for providing the intended results and reaching the targets set out in the budget programs. Beyond PFM, national management information systems for OST, NIP, and to a lesser degree for TB, etc., were necessary for the program and transition



planning, management, and monitoring of transition results. Most importantly, information from the system allowed the national actors to use it in their advocacy efforts and decision-making.

- **Enhanced organizational and individual capabilities**, supported through extensive technical assistance, reinforced institutionalization efforts.
- Finally, **fulfilling external and internal accountability requirements** were important facilitators that helped deliver on the transition objectives.

The described facilitators were not operating individually or in a silo mode but were closely interrelated and interdependent, revealing how complex the health system is and how much system thinking is required to move along the transition continuum with proper steps aimed at health system strengthening. In addition to facilitators, the study revealed important processes which helped facilitators materialize, and they include:

- o **Strategic planning** for all three programs in this review was vital for transition planning and execution. These plans served multiple purposes, from analysis of challenges to finding solutions and planning responsive actions with clear timelines and responsibilities.
- o **Continuous advocacy efforts** discussed earlier orchestrated throughout the program planning, and transition process made significant contributions.
- o **Inclusive spaces for decision-making** demanded and actively facilitated by development partners were also important for participatory governance, hearing the needs of those affected, and **holding the government accountable**.
- o **The training and capacity development** activities in various forms and shapes helped beef-up institutional and individual capabilities.
- o And finally, **adaptivity and innovation** in PFM, HMIS, PSM, HR, when developing national regulations, etc., all were essential processes led by national actors but extensively supported by development partners. This adaptivity and innovation led to greater self-reliance of the programs after the transition.

These findings inform our thoughts about donor transition and shape recommendations for a broader donor community and for Georgia to consider. These recommendations are summarized in the last two chapters of this report.



## Introduction and Study Objectives

The World Bank classifies Georgia as an upper-middle-income country with GNI per capita of 4,270 \$US in 2020<sup>1</sup>. Georgia has a small, open economy with a mixed economic system that includes personal freedoms, centralized planning, and government regulations<sup>2</sup>. After the economic shock caused by independence from the Soviet Union, Georgia saw a slow recovery. But since 2003, the Government's comprehensive reforms focused on the liberalization strategy and sustainable economic growth through private sector development, which rendered double-digit GDP growth from 2004 to 2007, expanding the economy by 35%<sup>3</sup>. Therefore, in 2007 Georgia was ranked as the number one reformer globally by the World Bank<sup>4</sup>. However, the 2008 war with Russia, the global financial crisis, and external regional shocks, namely sanctions related to the Russia-Ukraine conflict of 2014, the deteriorating economic performance of Turkey, etc., all negatively affected Georgia's economic performance and annual GDP growth averaged around 5% during the past decade.

Nonetheless, the overall good performance of the economy positively affected Georgia's international standing, and in 2021 the country ranked 12<sup>th</sup> in the Economic Freedom Index<sup>5</sup> and 7<sup>th</sup> in the 2020 World Bank's Ease of Doing Business<sup>6</sup>. Transparency International ranked Georgia 45<sup>th</sup> out of 185 economies on the 2020 Corruption Perception Index.

Within this context, Georgia's healthcare system has undergone significant reforms aiming to expand access to healthcare services for the entire population. In 2013, the Universal Healthcare Program (UHCP) was launched, which significantly increased the number of people able to benefit from state-funded health services, increasing coverage from 40% in 2012 to over 90% of the population in 2014<sup>7</sup>. The introduction of UHCP and removing financial access barriers led to improved service utilization for outpatient and inpatient services. This also increased current

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<sup>1</sup> The World Bank 2021 <https://databank.worldbank.org> Last Accessed January 5, 2022

<sup>2</sup> <https://globaledge.msu.edu/countries/georgia> Last Accessed January 5, 2022

<sup>3</sup> National Statistics Office of Georgia <https://www.geostat.ge> Last Accessed January 6, 2022

<sup>4</sup> The World Bank 2007. Doing Business Survey <https://www.doingbusiness.org/en/reports/global-reports/doing-business-2007> Last Accessed January 5, 2022

<sup>5</sup> <https://www.heritage.org/index/country/georgia> Last Accessed January 5, 2022

<sup>6</sup> <https://www.doingbusiness.org/en/data/exploreconomies/georgia#> Last Accessed January 5, 2022

<sup>7</sup> Fitch Solutions. Georgia pharmaceutical and health care report 2019.

health expenditure (CHE) from 1.1 billion US in 2010 to 1.5 billion in 2018,<sup>8</sup> or 7.2% of GDP, which in per capita terms translates to an increase from 634 \$PPP in 2010 to 970 \$PPP in 2019<sup>9</sup>.

The Government spending levels grew faster than private, which gradually increased the share of government spending in CHE from 22.3% in 2010 to 39% in 2019, albeit with heavy reliance on out-of-pocket payments (OOP) remains – 47% (2019) and places a significant financial burden on the population. Along with these developments, the share of voluntary pre-paid financial resources pulled by private insurance companies also grew, though the percentage in CHE has not exceeded 7% (2019)<sup>9</sup>. While in 2000, external donor funding for health was 7.4% of CHE, along with economic growth and increased public financing, it declined to 0.53% in 2019<sup>8</sup>, revealing lower dependence of healthcare funding on external support and the transition trend from donor assistance.

Along with these reforms, Georgia strengthened purchasing arrangements. It established a single national purchaser – the National Health Agency (NHA), which pays for all services under UHCP, along with the National Center for Disease Control and Public Health (NCDC) which funds public health and infection control programs through uniform purchasing arrangements with public and private providers alike. All contracted providers (private or public) are reimbursed with case-based, fee-for-service, or capitation payments, depending on the program and service type.

**Figure 1 Trends in Healthcare Financing in Georgia<sup>2</sup>**

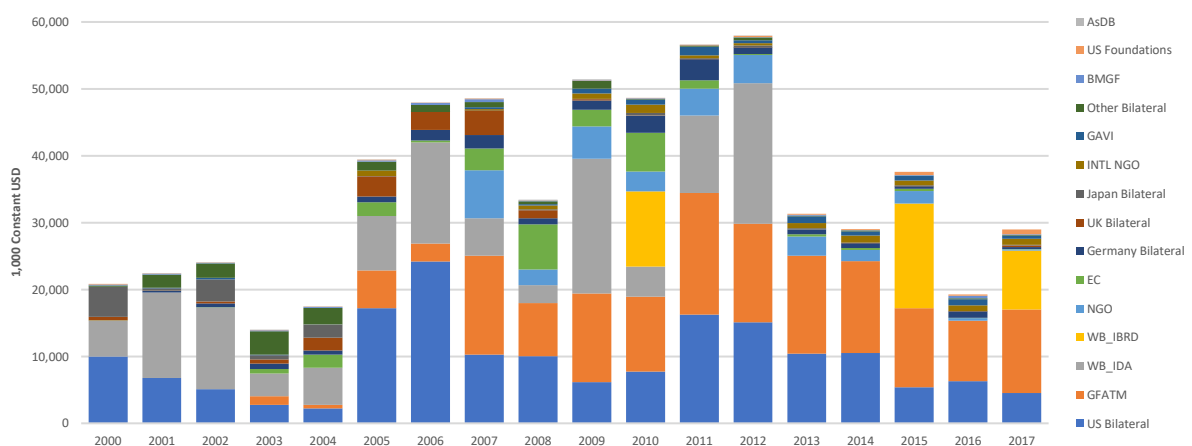


<sup>8</sup> WHO Global Health Expenditure database <https://apps.who.int/nha/database/ViewData/Indicators/en> Accessed August 2, 2022

<sup>9</sup> WHO Global Health Expenditure database <https://apps.who.int/nha/database/ViewData/Indicators/en> Accessed May 23, 2022

Since 2000, economic developments gradually moved Georgia from LMI to UMI, and consequently, donor assistance to the health sector declined. During the early 2000s, the donor landscape featured numerous bilateral players (USAID, UK DFID, Sida, EU, etc.) and UN and multi-lateral agencies (GAVI, Global Fund, etc.) and International Financial Institutions (IFIs). However, over two decades, the external support gradually plunged. Nowadays, the US, UN agencies (handling other bilateral funds), and the Global Fund remain but have significantly reduced share in CHE (see Figure 2).

**Figure 2 Trends in Overseas Development Assistance for Health in Georgia<sup>10</sup>**



The gradual decline in external support led the Georgian Government to assume greater responsibility for programs supported by donors and take the financial burden onto the national budget. Besides, these developments required program managers to play an increased role with reduced external technical assistance. The transition also mobilized a diverse group of national stakeholders to support program implementation, sustain or improve the program coverage and, in that, sustain or expand public health gains achieved with donor help. The transition process required numerous adjustments in the health system and its organizational and governance arrangements; it needed more capable staff to take greater responsibility for the program quality, etc.

Therefore, this research aims to comprehensively evaluate the sample of donor transitions that took place in Georgia to fill the knowledge gap for the country and share the experiences, challenges, and successes with the broader research and policy community within and beyond Georgia.

<sup>10</sup> IHME 2020, Development Assistance for Health <http://ghdx.healthdata.org/record/ihme-data/development-assistance-health-database-1990-2019> Accessed December 28, 2020

Consequently, the study's overall objective is to understand better how and why Georgia was (or was not) able to sustain and increase (or not increase) adequate coverage of health interventions previously supported by the donors and identify the enablers and barriers to this. To achieve the study objective following research questions need to be answered:

1. How does the cessation of external support affect the coverage of interventions previously supported by donor funding (looking separately at each intervention described later)?
2. What contextual and health system factors influence whether coverage of the intervention/service was sustained (or not sustained) once donor funding was no longer available?

While answering these questions, we also set out to understand a) WHAT has (or not) changed in these programs/interventions as they transitioned out of donor support; b) WHY these changes (or no-changes) have happened; and c) WHETHER and HOW we can link these to changes (or lack of it) to attainments in coverage after donor transition.

## Selected Interventions for the Study

For the study, three interventions were selected, and program/intervention transitions were compared using the methodology detailed below. The selection includes:

**The national immunization program (NIP)** with new vaccine introduction through GAVI support. While GAVI was never a significant player among donors in dollar terms<sup>11</sup>, it helped Georgia introduce four new vaccines. Throughout Gavi's support (2002–2021), five new and underutilized vaccines were introduced into the national immunization calendar: Hepatitis B vaccine in 2002, Pentavalent vaccine<sup>12</sup> in 2009, Rotavirus vaccine in 2013, and Pneumococcal Conjugate Vaccine (PCV-10) in 2014. Following the transition, Georgia received final support from Gavi through a post-transition grant. It must be noted that in 2014 Georgia replaced GAVI-funded Pentavalent with Hexavalent<sup>13</sup> vaccine procured with the national funds. Starting from 2015, the country prioritized the inclusion of the *Inactivated Polio Vaccine* (IPV) in the immunization calendar in line with the Polio Eradication and Endgame Strategic Plan 2013–2018 recommendations.<sup>14</sup> Therefore, the study explored the

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<sup>11</sup> Total GAVI investments in Georgia amount to 6.4 million US\$ over 2002–2017, including graduation grant in the amount of 0.62 Mln. \$US.

<sup>12</sup> Contains Diphtheria, Pertussis, Tetanus, Hepatitis B and Hib vaccines

<sup>13</sup> Contains Diphtheria, acellular Pertussis, Tetanus, Hepatitis B, Hib, and Inactivated Polio (IPV) vaccines

<sup>14</sup> A comprehensive, long-term strategy to deliver a polio-free world by 2018. The plan was developed by the Global Polio Eradication Initiative (GPEI) in response to a directive of the World Health Assembly.

<https://polioeradication.org/who-we-are/strategic-plan-2013-2018/>

vaccine coverage with these vaccines during GAVI support and after the transition in 2017, when the Government assumed full responsibility for planning, procuring, delivering, and managing immunization services for these vaccines.

**The transition of first-line TB drug (FLD) supply** under the Global Fund (TGF) support ended five years ago, and since then, procurement has been fully state-funded. While most governments are “willing to take on” the treatment component of the donor-supported program(s), numerous challenges usually emerge, e.g., delay in funding drug purchases out of state budget caused by public finance management shortcomings or capacity limitations in commodity quantification and procurement planning-management; or country may procure low-quality and/or high-priced drugs, and diagnostics<sup>15,16</sup> or challenges could emerge in managing supply logistics. The study explores these issues in-depth to answer research questions.

Finally, we looked at **Opioid Substitution Therapy (OST)**, introduced and fully supported by the Global Fund in Georgia. However, in 2017, the intervention delivery and financing were entirely shifted to the state. In many countries, structural and legislative barriers, national socio-cultural norms, stigma related to drug use, etc., inhibit the introduction and eventual transition of OST services onto the government budget<sup>17,18</sup> and negatively affect the intervention coverage after the transition. Georgia proved the contrary; therefore, the study tries to take stock of how this was achieved.

## Study Methodology

The study uses an analytical case study design with a mix-method approach using an adapted Walt and Gilson<sup>19</sup> policy triangle framework. Because the transition

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<sup>15</sup> Silverman R., Keller JM., Glassman A., Chalkidou K. 2019. Tackling the Triple Transition in Global Health Procurement. <https://www.cgdev.org/better-health-procurement>

<sup>16</sup> Gotsadze G., G Chikovani I., Sulaberidze L., Gotsadze T., Goguadze K., Tavanzhib N. 2019. The Challenges of Transition from Donor-Funded Programs: Results from a Theory-Driven Multi-Country Comparative Case Study of Programs in Eastern Europe and Central Asia Supported by the Global Fund. *Global Health: Science and Practice* 2019 (7) 2:258

<sup>17</sup> Burrows D., Oberth G., Parsons D., McCallum L. 2016. Transitions from donor funding to domestic reliance for HIV responses. Recommendations for transitioning countries.

<sup>18</sup> Otiashvili D. 2015. Situation analysis of sustainability planning and readiness for a responsible transition of harm reduction programs from Global Fund support to national funding in EECA. <https://harmreductioneurasia.org/situation-analysis-of-sustainability-planning-and-readiness-in-eeca/>

<sup>19</sup> Gilson L. Investigating policy and system change over time. In *Health policy and systems research: a methodology reader* / edited by Lucy Gilson. AHPRS. 2012

from donor support occurred over the years, we looked at policy and health system adaptations over the years. Using program-specific historical information, for each intervention, we defined three time periods: pre-transition, the transition from the date of transition commitment until its realization (i.e., complete removal of a program or component from donor funding), and post-transition, and looked at how a range of decisions and/or actions, taken at different periods, have accumulated over time and shaped the performance of the selected programs and interventions after the transition. Therefore, the study was longitudinal with a retrospective analysis of past events and experiences.

Furthermore, to be conclusive about transition outcomes, i.e., sustaining or expanding public health gains (or lack of it) achieved with donor assistance, we first looked at what has changed in each intervention during and post-transition in terms of access and coverage with the services. After that, we qualitatively explored why and how these changes occurred in each health system building block and applied Walt and Gilson's policy triangle framework for describing these developments over time. We extracted data in Excel 16.0® from reviewed documents and used the following coding conventions to classify the qualitative information. Each extract was characterized with five qualifiers/codes (if all applicable). They included **Policy Triangle Codes** to denote the content, the context, the actors who played the role, or the process used for the change to occur.

Furthermore, all process-related **codes** were subdivided into WHAT, WHY, and HOW codes to increase the explanatory power of the quote during analysis. The next set of codes denoted the **Health System** block in which the described change occurred. Where applicable, we coded transition outcomes and outputs based on changes observed in access, coverage, or the program due to the transition. Finally, **barriers** and **enablers** spotted in the document were coded to systematically capture inhibiting or facilitating factors for the program or transition process. Two individuals coded separately to assure robustness. After coding, we applied thematic analysis and reached agreements on the findings through iterative discussions among researchers involved in the study. The findings from the desk review were complemented with secondary quantitative data (where necessary), and in-depth interviews with purposefully selected individuals were used to validate some of the desk review findings or to fill in the information gaps arising from the document review. The study followed all ethical rules spelled out in the



protocol IRB # 2021-055<sup>20</sup>, and in total, 121 documents and 28 individuals informed this report.

Before presenting the study findings, the following study limitations must be noted. Firstly, resource limitations prevented capturing views of the OST, immunization, or TB service providers. Thus, we may have missed some important challenges and/or constraints imposed by the transition process on providers. Indeed, such views could have made the findings richer, but we do not think they would have changed our judgment about the overall transition outcomes. Secondly, the reviewed documents may not have captured all aspects of the transition or changes in health systems. Therefore, we tried to compensate for these documentary shortcomings with in-depth interviews. Thirdly, documentation of FLD transition proved limited and not as comprehensive as for OST and NIP, which imposed limitations as the team could not explore the changes to the comparable extent of the other two interventions. Nonetheless, triangulation of findings across three disease programs/interventions and the divergent sources of information allows us to claim that essentially the study results are robust and depict the changes in the health systems and the facilitating and inhibiting factors of the transition process.

## Country context

Following the Gilson and Walt framework, we have decided to separate the country context into two broad categories (a) the broader developmental context, which certainly created the space for some changes to emerge, and (b) the program/intervention-specific context, which was more relevant to a specific change or lack of it occurring in the health system. Therefore, in this section of the report, we will describe the overall country context, while the latter will be elaborated on later in the document, along with the specific interventions.

Since its independence in 1991, European aspirations have been central to Georgia's political agenda and identity<sup>21</sup>. Since then, Georgia looked Westward and became a member of the Council of Europe in 1999. Furthermore, Georgia's Euro-Atlantic

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<sup>20</sup> Georgia National Center for Disease Control and Public Health. Institutional Review Board Letter # 2021-055 from July 14, 2021, on approving the study protocol for „ Sustaining adequate coverage in the context of the transition from external assistance – Lessons from Georgia. “

<sup>21</sup> Mitchel L. 2020. Georgia: European aspirations, Middle Eastern realities.

<https://www.mei.edu/publications/georgia-european-aspirations-middle-eastern-realities>

aspirations, determined by threats emerging from Russia, became the most important political priority for the nation and shaped the foreign policy agenda for the years to come. This westward drive featured more prominently after the Rose Revolution of 2003<sup>22</sup> and led to closer engagement with Western partners on numerous fronts. Eventually, Georgia signed an Association Agreement with the EU in 2014<sup>23</sup>, setting clear conditionalities for the Government to deliver. The EU routinely monitored progress on Georgia's implementation of its commitments, and reports were made publicly available on the EU's Eastern Partnership website<sup>24</sup>. A transparent and external accountability mechanism, set in motion by the EU, allowed the Georgian public to actively engage and monitor the government's compliance with the agreement promises.

Positive developments were also observed in Georgian civil society and NGO community since the launch of the *European Neighborhood Policy* in 2004, which aimed at stabilization of the EU neighbors in political, economic, and security-related terms<sup>25</sup>. A significant role was played by the *Eastern Partnership Civil Society Forum* (EaP CSF), a multi-layered regional civil society platform aimed at promoting European integration, and facilitating reforms and democratic transformations in the six Eastern Partnership countries, including Georgia<sup>26</sup>. This has led to donor support for building civil society capacity and helping Georgian CSOs and EU stakeholders establish direct linkages. Currently, these organizations promote a pro-Western discourse, monitor the Georgian authorities' efforts to harmonize their policies with EU standards, and pressure their government when it does not fully follow through<sup>23</sup>.

The association agreement elevated the importance of the human rights agenda for Georgia, and active CSO engagement in human rights issues has featured prominently ever since<sup>27</sup>. Also, the government was obliged to adhere to EU values for democracy, respect for human rights and fundamental freedoms, and the rule of law<sup>28</sup>. Annual monitoring of Government commitments to the agreement

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<sup>22</sup> Minesashvili S. 2013, How European Are We? Explaining Georgia's Westward Aspiration. Working Paper. Center for Social Sciences. Foreign Policy & Security Program.

<sup>23</sup> Lejava N. Georgia's Unfinished Search for Its Place in Europe. 2021

<https://carnegieeurope.eu/2021/04/06/georgia-s-unfinished-search-for-its-place-in-europe-pub-84253>

<sup>24</sup> <https://euneighbourseast.eu/>

<sup>25</sup> [https://ec.europa.eu/neighbourhood-enlargement/european-neighbourhood-policy\\_en](https://ec.europa.eu/neighbourhood-enlargement/european-neighbourhood-policy_en)

<sup>26</sup> <https://eap-csf.eu/>

<sup>27</sup> <https://civil.ge/?s=CIVIL+society>

<sup>28</sup> EU-Georgia Association Agreement from August 30, 2014.

provisions by the EU was also crucial for this area. It may have set a conducive environment for civil society engagement, most notably in drug and OST-related issues, described later in the document.

The EU association agreement, and not only, set in motion many structural, policy, legal, and institutional changes which occurred in the country after that. Just to note a few.

With support from the EU and other donors, the public finance management (PFM) system is gradually evolving and developing in Georgia, significantly accelerating since 2007, when the medium-term budgeting framework was first introduced. After that new budget code was approved by the Parliament in 2009, which established basic rules and responsibilities for budget planning, execution and monitoring, and evaluation. Eventually, starting in 2010 with program-based budgeting pilots, this approach was rolled out countrywide and for all programs in the state and municipal budgets and increased transparency of the whole budgeting process. PFM was further enhanced with several electronic management systems such as a fully integrated e-Budget, e-Treasury, e-Customs, etc. As a result of these reforms, in the open budget survey rankings, Georgia moved from 34<sup>th</sup> place in 2010 to 5<sup>th</sup> in 2019 with a high budget transparency score of 81 (out of 100), albeit still scoring low on public participation–28 (out of 100), especially in budget formulation and execution parts<sup>29</sup>. Such developments, as described later in the documents, proved conducive to the financial transition of the programs.

Along with economic developments, Georgia has shown significant progress in all six dimensions of the Worldwide Governance Indicators, especially in fighting corruption. Albeit the country's development has slowed since 2014 as Georgia has been unable to keep up with the high standards shown in 2014.<sup>30</sup> Nonetheless, the 2021 Worldwide Governance Indicators still ranked Georgia among the top 20 European countries regarding the rule of law, control of corruption, government effectiveness, and regulatory quality.

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<sup>29</sup> Open Budget Index <https://www.internationalbudget.org/open-budget-survey/country-results/2019/georgia>  
Accessed April 28, 2022

<sup>30</sup> IDFI 2021: World Governance Indicators – Georgia in the World Bank Ranking 2021  
[https://idfi.ge/en/world\\_governance\\_indicators%E2%80%93georgia\\_in\\_the\\_world\\_bank\\_ranking\\_2021](https://idfi.ge/en/world_governance_indicators%E2%80%93georgia_in_the_world_bank_ranking_2021)  
Accessed April 28, 2022

Finally, Georgia capacitated its state institutions and organizations within and outside the health sector over the years. Developments positively affected individuals and institutions involved in economic performance, in public finance management, allowing for more engaged partnerships with strategic and multi and bilateral donors. Increased budget revenues on the back of improved economic performance allowed the government to prioritize human capital development in the national development policy agenda and invest more in health, education, and improved social protection. Thus, the political commitments for these investments were also important for the transition process described later in the report.

## **What has changed after the transition?**

The transition process has led to significantly improved coverage and access to OST services. Namely, services expanded from eight cities to twelve and 18 to 22 sites, and two prison detox units continued operation. This capacity growth increased the number of annual beneficiaries from 3,968 in 2014 to 12,500 in 2021, over a four-fold rise. And all of this was achieved through state financing.

For TB services, geographical and financial access to services was already in place and sustained during and after the transition. Continuous and uninterrupted supply of FLDs was assured after transition, and treatment outcomes slightly improved.

As for the NIP, the picture is slightly complex. Out of four newly introduced vaccines, coverage levels above 90% were maintained for DTP-3 under one year and MMR-1 under two years of age. The number of districts reporting <90% coverage declined from 37 in 2016 to 12 in 2019, and the share of children affected by <90% coverage was reduced from 38.1% to 10.9% during the same period. However, suboptimal coverage was recorded for Rota-2 and PCV-3. While the target population for DTP-3 containing vaccine and Rota-2 are the same, the coverage between these vaccines differs. The same was observed for MMR-1 and PCV-3, with the same target population – children under two years of age. It seems several factors could explain these differences. Firstly, different international and internal accountability requirements for these vaccines may have affected provider or program manager performance. While the DTP-3 and MMR coverage rates are subjected to greater global and national scrutiny (due to higher disability and mortality risks posed by the diseases), the rotavirus infection and pneumococcal disease might be less severe when patients are treated in the developed health systems like Georgia.

Therefore, these diseases do not pose comparable risks to DPT and MMR and do not attract comparable societal attention to the former.

Secondly, differences in vaccine-specific timing for vaccine administration could be at fault. Namely, the delayed start of vaccination for the Rotavirus determines low coverage. In Georgia, about 70% of infants start vaccination timely within the 8–16<sup>th</sup> week after birth.<sup>31</sup> Contrary to Rotavirus, DPT-1 could be administered without age limitation, and those delaying the first shot catch up with the third dose by 12 months since birth. Contrary, Rota-1 has an age restriction and needs to be administered by the 16<sup>th</sup> week since birth and Rota-2 by the 32<sup>nd</sup> week<sup>32</sup>. Thus, in the case of Rota, due to described vaccine-specific time restrictions, the delayed start (delayed administration of the 1<sup>st</sup> dose) does not allow the timely completion of the vaccination schedule (i.e., administration of the second dose) within the first year of age leading to low coverage.

The next set of factors affecting suboptimal coverage was related to the shortcomings of the primary health care and public health system. Namely, free choice of family doctors and the loss of linkages between maternity and primary care services that existed during Soviet times led to a loss of information exchange about an incoming newborn in the PHC's catchment area<sup>33,34</sup>. As a result, primary care personnel are unaware of a newborn child unless parents show up at the PHC, which could occur with a significant delay after birth. If, for DPT, delayed start does not negatively affect coverage rates within the first year of a child's life for Rotavirus, this undermines target achievements. To remedy the situation, the immunization HMIS was modified to identify infants who are not timely vaccinated and automatically send reminder SMS notifications to mothers. Albeit this capability of the HMIS is not fully exploited currently.

Thus, program transitions in all three focus areas were successful, with some limitations noted for NIP, which primarily relates to vaccine specificity and broader health system issues. Therefore, in the following sections of the report, we will

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<sup>31</sup> There is small difference between DPT-1 and Rota-1 timely vaccination coverage rates (69.2% vs 67.7%).

<sup>32</sup> WHO allows to deviate from strict age restriction of Rota vaccination particularly for countries with high mortality from diarrheal diseases, however Georgia NRA strictly follows the manufacturer's instructions which does not allow this deviation.

<sup>33</sup> Government of Georgia. (2011). Comprehensive Multi-Year Plan of the National Immunization Program of Georgia 2011–2016. May 4, 6. [http://www.who.int/immunization\\_financing/countries/cmyp/Bangladesh\\_cMYP\\_doc.pdf](http://www.who.int/immunization_financing/countries/cmyp/Bangladesh_cMYP_doc.pdf)

<sup>34</sup> Government of Georgia. (2016). Comprehensive Multi-Year Plan of the National Immunization Program of Georgia 2017–2021.

explore changes in each health system building block during the transition to identify the facilitating and limiting factors and explain the results achieved.

## Evolutions in the health system building blocks

This chapter looks at the developments occurring in each health system building block. It draws attention to those factors that have emerged and either facilitated or impeded transition across three program components.

### Governance and Leadership

Firstly, donor demands for improved **national coordination through multisectoral representation** triggered the establishment of the *Country Coordination Mechanism (CCM)* for the Global Fund and *Intersectoral Coordinating Committee (ICC)* for GAVI. Both structures, democratic in design, engaged government representatives from different sectors, leading national institutions, and development partners. Civil society and community inclusion in the CCM were also requirements imposed by the TGF, closely followed by the authorities. Both structures evolved, offered inclusive and participatory decision-making spaces for all involved parties, received technical guidance/inputs from national/international experts and development partners, and most importantly, played a leading role in the national strategic and transition-sustainability planning (TSP) for the disease/vaccination programs as well as in preparing applications for donor funding, which was better aligned with the national needs and policy priorities. **The vital role of enhanced national coordination through well-functioning structures and, most importantly, the inclusion of a broad group of stakeholders in a more “democratic” and “inclusive” decision-making process has featured prominently throughout the years.**

These entities fulfilled the oversight function and ensured that national strategies and programs were implemented as planned and that the challenges and bottlenecks were promptly identified and addressed. Thus, providing a functional mechanism for monitoring the obligations assumed by the state for the program implementation and transition purposes and holding responsible institutions and individuals accountable.

Secondly, both donors required the national strategic plans as a pre-condition for accessing the grants. These demands triggered the national-level planning process through which the *National Strategic Plans (NSPs)* for HIV and TB,

*Comprehensive Multi-Year Plan (cMYP)* for NIP, and eventually *Transition and Sustainability Plans (TSPs)* for the Global Fund were produced with the active participation of the national stakeholders. The latter frequently received external technical assistance and support. These plans helped create a strategic framework for the national programs to evolve, think about, and deal with forthcoming transition issues. The planning process, primarily led by the national coordination bodies, itself was crucial in (a) sensitizing a broad group of national stakeholders about the programmatic needs for OST, TB, and immunization; (b) creating spaces for advocacy efforts mounted by external partners, national technical entities/bodies, civil society, or communities and (c) negotiating necessary steps with the national stakeholders (most notably with the Ministry of Finance) and external partners/donors. These plans helped foresee required financial and other resource needs that informed the medium-term national budget planning process, institutionalized by the Government/MoF.

Independently from donors, Georgia also took steps to gradually absorb and streamline the program management/leadership responsibilities within the state structures and national systems using national processes. Namely, the management responsibility for the HIV/OST and TB response, initially supported by the *Project Implementation Unit (PIU)*, was gradually moved to the *National Center for Disease Control and Public Health (NCDC)* which is a leading state public health institution having implementation capacity to respond to a broad range of public health needs. As for NIP, NCDC was always in charge of the program management, albeit with shared responsibility with MoH for vaccine procurement, which was eventually brought under NCDC, alleviated operational shortcomings related to vaccine supply, and assured uninterrupted vaccine provision throughout the system. The institutionalization of the management responsibility within the state institution helped apply national rules (and, where necessary, develop new or adapt the old ones) and management procedures, including for goods and service procurement, provider contracting, monitoring, reporting, and financing. All these significantly helped the transition process from donor support to the government without significant impediments.

Developing a conducive **legal and regulatory environment** proved critical in determining transition outcomes. However, it is so broad and encompasses so many domains that we decided to reflect on changes in the laws and regulations in the following sections of the document. Where relevant or important throughout the document, we highlight where laws or rules contributed to the

institutionalization or definition of the responsibility for an institution; regulated the process of service provision or data capture-reporting; defined financing rules, volumes, and duties with patient co-payments, etc.

### **Healthcare financing**

Before we describe changes in program financing, it is vital to note reforms in the public finance management (PFM) system occurring in parallel with donor transitions. Namely, in 2004 Georgia introduced the *Medium-Term Expenditure Framework (MTEF)* with pilots in the health sector<sup>35</sup>, which required linking sector/program priorities and expenditures and demanded planning over four years with allowed annual revision. Secondly, since 2008 Results-based budgeting (reporting on program performance indicators) was imposed by the Ministry of Finance, which increased accountability demands from MoH for the funds spent on healthcare. The MoF saw this exercise as an important step in the judgment for next year's funding for health programs if targets set in the annual budget were achieved and results delivered. Thus, these changes facilitated long-term planning for donor-funded programs and set clear programmatic targets to be attained at the end of each year.

Within this context, the Global Fund and GAVI imposed sustainability and co-financing requirements, although at different times. These demands forced the governments to respond, though observed developments differed between the studied program components, which are explained below.

Before GAVI's arrival, the national immunization program in Georgia was 50% donor-dependent<sup>36</sup>. However, eventually, the government assumed responsibility for traditional and then for the new vaccine financing, supported by GAVI. The first mention of the financial transition appeared in 2014 in the State Concept on Universal Health Coverage<sup>37</sup>, where the Government declared its commitment to mobilize national resources and cover traditional and new vaccine costs in the context of economic growth and decreasing donor financing, noted earlier in the document. Co-financing terms and conditions imposed by GAVI were embedded in all formal communication, decision letters, and a binding document between the

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<sup>35</sup> Kraan, D., & Bergvall, D. (2006). Budgeting in Georgia. *OECD Journal on Budgeting*, 5(4).

<sup>36</sup> Government of Georgia. (2001). Proposal for Support Submitted to the Global Alliance for Vaccines and Immunization (GAVI) and The Vaccine Fund.

<sup>37</sup> Government of Georgia. (2014). State Concept 2014-2020 for Universal Health Care and Quality Control for Protection of Patient's Rights. Government of Georgia Ordinance, 724.



Gavi and the country, including a description of co-financing terms. WHO-CO and UNICEF-CO were important immunization advocates, played an intermediary role between Gavi and the government and were copied in all communications. They sent reminders, held regular advocacy meetings with GoG officials, and participated in all ICC discussions. Joint Appraisals (JA) were carried during 2012 to 2017 involving the national stakeholders, and partner organizations assured that the timelines, responsibilities, gaps, and priorities were clear and agreed upon and contributed to reaching a consensus on transition activities between GoG and its international partners and GAVI.

Furthermore, a necessary *process* that played a central role in the awareness-rising of national stakeholders was the WHO European Regional Working Group for Gavi, where Georgia was represented by the mid-level officials from the MoH, the MoF, and the NCDC. They actively participated in annual workshops and presented progress, challenges, and lessons learned, co-financing achievements, and plans towards transition. These workshops provided a platform for effective communication with partners and experience sharing between peer countries during the transition period. Mid-level managers/officers played a crucial role in shaping the decisions of key policymakers. In these gatherings

*“Georgia from year to year was viewed as a model – leader country, and we [Georgia team] always strived to maintain this status” (IDI Respondent).*

Eventually, these efforts led to the NIP budget covering costs for a) routine immunization vaccines and injection supplies; b) vaccines and other pharmaceuticals for the epidemiological indication (rabies, tetanus); c) influenza vaccine and delivery costs (from 2014); d) cold chain maintenance and strengthening (since 2017); and e) public communication and immunization information system support (since 2020).

Besides, the NIP budget is not the only governmental fund spent on immunization because providers' payment for the actual service delivery is part of the primary health care budget under the UHC Program. NIP management cost, such as EPI staff labor and operating cost, is part of the NCDC's institutional budget. In contrast, the respective municipal budgets cover personnel costs for immunization supervision at the municipal level. Thus, NIP financing is multifaceted, receives funds from different budgets, and reveals complementarity, alignment, and complete integration of the program financing within the national public finance management system.

The program financing for TB revealed a completely different picture. While service delivery costs (inpatient and outpatient) on a facility level were fully covered by of state budget program, functions such as management, surveillance, planning for drugs and diagnostics and conduct of procurement, and other relevant costs were paid out of the Global Fund grant. In its first national TB strategy, 2013–2015, Georgia, expected a decline in TGF support. While the *Sustainability, Transition, and Co-Financing Policy* (STC) were not yet in place, CCM decided on the first line-drug (FLD) transition by 2015. However, later TGF made Georgia’s TB program eligible for NFM and eventually introduced STC policy in 2016, which led to the development of the *Transition and Sustainability Plans* (TSP) with external technical assistance in which the country delayed transition.<sup>38</sup> Consequently, Georgia planned to purchase 100% of the FLD with the state budget in 2016, and second-line drug purchases were scheduled as follows 35% in 2017 and 75% in 2018.<sup>39</sup> In reality, Georgia procured FLD buffer stocks for 2017–2018 using the TGF grant money and further delayed the transition to 2019 instead of 2016. Although FLD’s cost within the TB program budget is small (about 5% of the TB budget), the NCTLD and NCDC acted opportunistically and effectively shifted the financial burden on the budget out by two years. Since 2019 the country fully covers the FLD procurement costs out of domestic sources. Still, such important functions as program management, TB surveillance, second-line drugs, some diagnostics, and other program costs are still being paid by TGF as of 2022. They have not yet transitioned onto the national financing. This increases the risks for a smooth transition, more for programmatic parts than for financial ones.

As for OST, presenting a comparable picture to NIP reveals additional peculiarities about how and why financial responsibilities were assumed by the Government. Although Georgia started state investments into the OST long before the Global Fund’s STC agenda was in place, these investments were not huge. The study revealed other important factors facilitating the financial transition. Firstly, The TSP development process ensured meaningful engagement of all stakeholders, including communities. The process entailed consultations with affected communities and civil society stakeholders, the CCM was used as a place for inclusive national dialogue, and *the Policy and Advocacy Advisory Council* (PAAC) was established specifically for the transition planning and elaboration of the TSP

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<sup>38</sup> Curatio International Foundation (2016). TB Transition and Sustainability Plan.

<sup>39</sup> Country Coordinating Mechanism (2013). National Tuberculosis Strategy and Operational Plan for Georgia 2013–2015

with the financial requirements<sup>40</sup>. Albeit PAAC was only focused on Global Fund transition, not considering other transitions simultaneously occurring in other programs. Consequently, the government's commitment to completely take over OST funding was reflected in the TGF funding request for 2016–2018, in National HIV/AIDS Strategic Plan (2016–2019), and the TSP 2016–2020<sup>40</sup>. We think the process itself and the resulting documents were important for the transition.

Secondly, massive advocacy by community activists, civil society, and other stakeholders played an important role. The *Georgian National Drug Policy Platform* (GNDP) unites 40 organizations advocating for a comprehensive four-pillars drug policy introduction, which includes treatment, rehabilitation, and harm reduction interventions. While the GoG wasn't ready to implement comprehensive drug reforms, the public pressure forced the state to compromise and fund and expand OST as a partial response to public demand.

*“There was a very serious pressure from the stakeholders and political actors, including political opposition ... we were demanding expanded support and wide reform [comprehensive drug policy] ... this process prompted government to compromise and led to scale-up of OST” (IDI Respondent)*

Thirdly, most respondents noted that Georgia was praised as a “champion” and a “regional leader” in ensuring access to OST services in the Central and Eastern Europe and Central Asia. This gave decision-makers the opportunity to capitalize on this recognition and motivated them to continuously increase financial support to the program.

*“Georgia turned out to be a pioneer and a leading country in the wide geographical region in terms of OST, having even better coverage than some western European countries. This positively represented the government and created their image as successful reformers, and was an important factor in their decisions” (IDI Respondent)*

Fourthly, Georgia always used its domestic investments in OST as a case for fulfilling two important eligibility criteria imposed by the Global Fund for countries like Georgia. These two criteria include focusing most investments on key and vulnerable populations, including drug users, and meeting the program co-financing targets. In the 2016–2019 TSP<sup>40</sup>, Georgia allocated US\$ 9,263,428 for the

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<sup>40</sup> Curatio International Foundation (2016). HIV/AIDS Transition and Sustainability Plan 2016–2020.

prevention of HIV transmission, for early detection of HIV, and for ensuring timely progression to care and treatment among the key affected populations. And out of this amount, 99% was allocated to OST services, i.e., interventions targeting KAPs. These factors were important in securing stakeholder support for OST allocations and eventually increasing them.

Finally, during the transition, both TGF and the state program co-existed and used different financing and provider reimbursement modalities. But eventually, they were aligned, and uniform financing and provider payment policies were introduced. At the same time, service procurement functions were moved from the *Global Projects Implementation Centre* (GPIC) to a state institution – NCDC. All this institutionalized OST program management and financing responsibility within state entities and subjected funding flow for OST to public finance management rules.

To conclude, we have observed how gradual financial adaptations were made by OST and NIP programs (albeit not to a comparable extent by TB). It is obvious that not only the responsibility of financing was shifted over to the state budget, but most importantly, critical financial management functions such as the payments for service provision, planning, and procurement of drugs and commodities, etc. were domesticized and institutionalized within the national entities, which helped to move external financing into the national public finance management systems (PFM) and subject to the national rules and regulations. These transitions were supported by the PFM context, along with strategic planning and advocacy efforts complemented by international recognition that motivated organizations and individuals to follow the course, deliver on transition objectives, and feel accountable to the stakeholders placing demand on individual and organizational performance.

### **Service delivery**

The transition from donor assistance did not require major efforts to develop the service provision, except for OST, which was created before Global Fund entered the country. Immunization and TB services were rendered through a well-developed network of providers throughout the country, and these services were always paid out of the state budget. As noted earlier, inadequate financial incentives and lack of accountability requirements placed on PHC providers did not facilitate adequate coverage for Rota-2 and PCV-3 vaccines. Still, these shortcomings were not related to a transition process but determined mainly by

broader health systems needs which led to relatively poorly developed PHC in Georgia<sup>41,42</sup>. Furthermore, while service provider networks for NIP and TB services did undergo reforms, they were not driven by donors. Still, they were determined by the local reform agenda for the overall health sector.

As for OST, three critical developments must be noted. First, the role of the Global Fund in piloting OST in 2005, using the model developed with the support of the Open Society Georgia Foundation (OSGF), was critical, albeit established capacity was only limited to one site in the capital city and with an annual patient load of 60 individuals in 2005<sup>43</sup>. But during the following two years, the Global Fund-supported canters expanded to four sites, including two in Tbilisi and two in the regions of Georgia<sup>44</sup>, and two additional sites opened in the penitentiary system in Tbilisi, followed by another one in 2011 in Kutaisi<sup>45</sup>. Nonetheless, demand for OST significantly outpaced the progress in provider capacity development due to the high prevalence of opioid use in Georgia<sup>46</sup>, which triggered community mobilization and advocacy efforts on the part of drug users and their families in 2008. Patient advocacy groups supported by civil society organizations, the medical community, research institutions and international partners influenced the decision-makers and helped eventually expand access to OST.

*“Very powerful and multi-component advocacy was very important in influencing government. It was a collective effort by the community, service providers and their administrations, human rights groups, and international organizations. Everyone was pushing for the same, and it paid off [established and expanded OST sites]” (IDI Respondent).*

Broader advocacy efforts, along with community participation in CCM and other decision-making platforms, helped influence government decisions and hold the

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<sup>41</sup> Chanturidze, T., Ugulava, T., Duran, A., Ensor, T., & Richardson, E. (2009). Georgia: Health System Review. Health Systems in Transition, 11(8), 1–116.

<sup>42</sup> Richardson E, Berdzuli N (2017). Georgia: Health system review. Health Systems in Transition, 2017; 19(4):1–90.

<sup>43</sup> Javakhishvili, J., Kariauli, D., Lejava, G., Stvilia, K., Todadze, K. and Tsintsadze, M., 2006. *Georgia Drug Situation 2005*. Tbilisi, p.42. Available at: [https://altgeorgia.ge/media/uploads/georgia\\_annual\\_rep\\_2005\\_best\\_version.pdf](https://altgeorgia.ge/media/uploads/georgia_annual_rep_2005_best_version.pdf)

<sup>44</sup> Javakhishvili, J., Sturua, L., Todadze, K., Skvitaridze, Z., Kirtadze, I., Zábbranský, T., Connor, G. and Nozadze, P., 2008. *Georgia Drug Situation 2008*. Tbilisi, pp.26,50. Available at: <https://altgeorgia.ge/media/uploads/drug-2008-eng.pdf>

<sup>45</sup> Javakhishvili, D., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D. and Zabransky, T., 2012. *Drug Situation in Georgia 2012*. Tbilisi, p.13. Available at: <https://altgeorgia.ge/media/uploads/drug-2012-geo-eng.pdf>

<sup>46</sup> UNODC, 2021. The World Drug Report 2021. Vienna, Statistical Annex. Available at: <https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html>

government accountable for its own commitments. Consequently, GoG launched the state-funded OST in 2008 with the Order of the Minister of Labour, Health, and Social Affairs of Georgia №111/n May 6, 2008, which established the norms for and requirements for OST service provision and its reimbursement rules. After this, the state-funded OST program rapidly expanded, and by 2009, 11 sites were operating<sup>47</sup>, and by 2021 the number reached 22<sup>48</sup>, with nearly all major cities of the country covered.

Geographical expansion and capacity increase observed in OST sites were not accompanied by a proportional growth in users due to financial access barriers arising from co-payment requirements in the state program. Consequently, by 2017 a total of 4800 patients were included in the OST<sup>49</sup>. After the full transition, access to service was increased, and with the complete removal of co-payment requirements (elimination of the financial access barrier), access to services improved. At the end of 2021, 12,500 patients were enrolled in the OST<sup>50</sup>, leading to a three-fold increase in the number of program beneficiaries over the four-year period.

### **Health Management Information System**

Health Management Information System (HMIS) saw one of the most important transitions, especially for NIP and OST and, to a lesser degree, for TB. The HMIS transition process was multi-faceted, evolutionary, and not only dependent on GAVI/TGF support but significantly determined by contextual developments within the country and outside of donor support. It took almost 15 years, many steps, and involved different national and international players. Highlights of these transitions were as follows:

In the pre-Gavi period, Georgia NIP had significant data quality issues arising mainly from a paper-based HMIS. UNICEF/WHO coverage estimates<sup>51</sup> significantly differed from the administratively reported indicators across all parameters,

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<sup>47</sup> Javakhishvili, J., Sturua, L., Todadze, K., Skvitaridze, Z., Kirtadze, I., Zábanský, T., Connor, G., Nozadze, P. and Zakarashvili, T., 2009. *Georgia Drug Situation 2009*. Tbilisi, p.49. Available at: <https://altgeorgia.ge/media/uploads/drug-situation-in-georgia-2009-eng-2-.pdf>

<sup>48</sup> Georgia HIV/AIDS National Strategic Plan 2023–2025

<sup>49</sup> Beselia, A., Gegenava, V., Kirtadze, I., Mghebrishvili, T., Otiashvili, D., Razmadze, M., Stefanishvili, N., Sturua, L., Kutelia, L. and Javakhishvili, J., 2018. *Drug Situation in Georgia 2016–2017*. Tbilisi, p.8. Available at: [https://altgeorgia.ge/media/uploads/drug-situation-in-georgia-2017-summary\\_finaldocx.pdf](https://altgeorgia.ge/media/uploads/drug-situation-in-georgia-2017-summary_finaldocx.pdf)

<sup>50</sup> Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health, and Social Affairs of Georgia, 2022. *Georgia HIV/AIDS National Strategic Plan 2023–2025*. Tbilisi, p.18.

<sup>51</sup> Based on Multiple Indicator Cluster Survey (MICS) and other survey findings.

negatively affecting NIP planning and management. To address HMIS shortcomings, USAID supported the immunization information system reforms during 2003–2005, in which revised registration, reporting, and monitoring forms were institutionalized by Ministerial decree and implemented countrywide through NCDC and district public health centers. An excel based software – “Geovac,” was developed and deployed to track indicators on a routine basis, improve the accuracy and reliability of data for sub-national and national levels, and strengthen the use of data for program planning and management. However, weakness in civil/birth registration and discrepancies in the number of live-born infants reported by medical establishments and the civil registry continued to challenge the NIP planning, vaccine requirement forecasting, and program implementation.

In 2011 Ministry of Justice implemented online civil registration for births and significantly improved the data quality. It triggered the development of a new *Immunization Management Electronic Module* (IMEM) with UNICEF’s financial and technical support, accomplished in 2014. The IMEM was handed over to NCDC and built around a citizen’s national ID, allowing individual child vaccination profiles to track vaccine administration per child (historical and ongoing) and register adverse vaccine events. IMEM helped generate real-time and reliable coverage rates for each vaccine. Improved birth registration improved data quality on surviving infants (denominator) after the IMEM was fully integrated with the birth registry in 2016. The module that sends SMS reminders to parents was added to increase coverage. IMEM analytical modules were expanded and included vaccine stock management and monitoring allowing adequate vaccine planning and logistics management. Consequently, the quality of administrative immunization data improved, and reported coverage indicators now concur with the WHO/UNICEF estimates.

NIP’s transition to the IMEM platform has not yet been fully accomplished. Data entry and reporting from vaccination sites occurs through IMEM, but its full-scale use for NIP or vaccination management on a PHC level remains weak. For instance, the district public health network still uses the “Geovac” software, which does not produce case-based or real-time data. The main reasons for this shortcoming include weak accountability placed on PHC by the government, weak ownership of the IMEM by district public health centers, and failure to resolve software functionality shortcomings when such a need emerges promptly. However, a further upgrade of the IMEM was planned in 2020 as part of the post-transition GAVI

grant, with capacity-strengthening activities at the national and subnational levels for data analysis and use in real-time decision-making. However, the Covid-19 pandemic required the mobilization of resources to modify the system and respond to COVID-19 vaccination needs (with support from the WHO). Therefore, subnational capacity-strengthening activities were delayed. Although after respective software upgrades, IMEM has been used for COVID-19 vaccination registration and reporting since 2021.

After IMEM development Gavi and international reporting for immunization were fully integrated into the national HMIS, and a joint WHO/UNICEF reporting form was generated from the system. International reporting held EPI accountable for program performance as it required reporting on what has been done, resources spent, and an explanation or justification of actions that were not performed. At the same time, annual reporting helped capacity building: while the first reports were developed with external technical support, subsequent reports were produced with the EPI's resources.

Thus, critical actors in Immunization HMIS development were USAID and UNICEF, but the value of investments was significantly increased only after systemic and regulatory improvements in civil registration, which occurred outside of the health sector and/or donor support. Nonetheless, further IMEM updates and maintenance, along with continuous capacity strengthening activities, are one of the areas that the government should fully take over. The NIP budget for 2021 already includes some, but not all, funds for IMEM technical maintenance. According to the respondents, only 30% of the maintenance costs were covered by domestic sources in 2021.

For OST, several data elements were necessary for adequate intervention planning. Namely, reliable national-level data about drug-use prevalence and patients enrolled in drug treatment was required at a minimum. With the support of the TGF, bio-behavioral surveillance (IBBS) and population size estimation (PSE) surveys have been implemented on a routine basis in Georgia since 2009. These systematic studies provided essential data about PWIDs behavioral patterns, HIV, HCV, and STI prevalence, and PWID population size estimations. The IBBS and PSE generated strategic information for monitoring the need and planning the service provision - drug use interventions. While these studies were TGF funded and carried out by contracted national organizations, attempts were made to institutionalize the responsibility for funding and conduct of IBBS and PSE surveys within NCDC. The



decision was included in the TSP, and by 2019, the Government was to assume complete funding and implementation responsibility for IBBS and PSEs<sup>52</sup> through NCDC.

Consequently, during the 2017 IBBS and PSE implementation, NCDC staff were trained to conduct the survey and data analysis, including necessary laboratory components for HIV, HCV, and STI biomarkers. Despite these attempts, as of 2022, funding still relies on the TGF, and implementation is still outsourced, except for the laboratory testing that NCDC is conducting. Most likely, the lack of IBBS transition onto the government is primarily driven by NCDC's weak institutional/expert capacity to plan and manage the survey implementation and secondly with continued financial support permitted under TGF grants which allows the government to use its financial resources for other purposes.

Another vital piece of information for OST service planning is the *Treatment Demand Indicator* (TDI), which collects data about the number and characteristics of people in need of treatment, the substances used, the types of treatment offered, and the number of patients enrolled. At the time of OST's introduction in 2005, TDI was unavailable. The program planning relied on routine but chaotic provider reports without harmonization and/or data collection and processing standards. Subsequently, in 2013 NCDC designed and legislated a mandatory data collection and reporting form capturing aggregated information by gender, age groups, the number of first-time and repeated visits, the administration route, the type of primary and secondary drugs, polydrug use, and HIV testing/results<sup>53</sup>. However, these forms required further modifications after *EU Association Agreement* (EUAA) was signed by Georgia<sup>54</sup>, imposing external legal demands for improved drug use surveillance. To comply with external requirements Georgia became part of the *European Monitoring Centre for Drugs and Drug Addiction* (EMCDDA) in 2014 and harmonized key indicators for illicit drug supply and demand monitoring. As part of this process and with technical assistance from EMCDDA, the NCDC amended the

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<sup>52</sup> Curatio International Foundation: Georgia Transition Plan, 2016–2020, Tbilisi 2016.

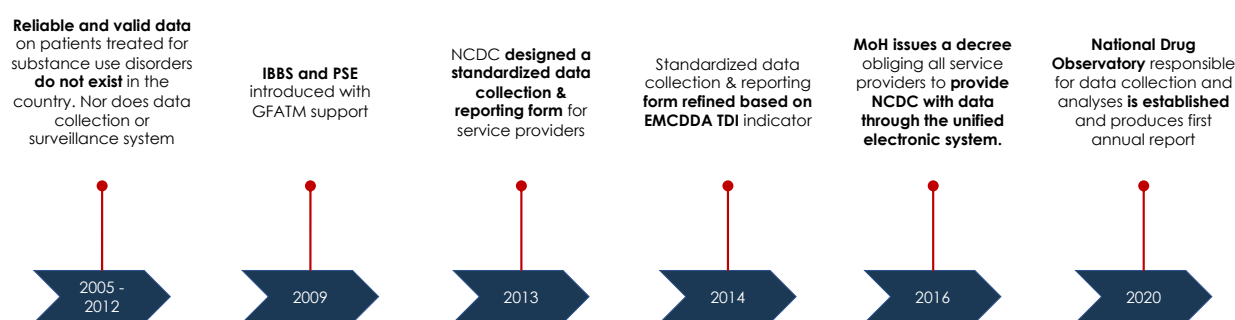
<sup>53</sup> Javakhishvili, J., Otiashvili, D., Mzia, T., Alavidze, S., Balanchivadze, N., Batselashvili, L., Duchidze, N., Kikvidze, T., Kirtadze, I., Razmadze, M., Sturua, L. and Tsertsvadze, V., 2015. The Drug Situation in Georgia 2013. Tbilisi, p.30. Available at: [https://altgeorgia.ge/media/uploads/5\\_drug-report-eng-2013.pdf](https://altgeorgia.ge/media/uploads/5_drug-report-eng-2013.pdf)

<sup>54</sup> 2014. association Agreement between the European Union and the European Atomic Energy Community and their Member States, of the one part, and Georgia, of the other part. Available at: [https://eur-lex.europa.eu/legal-content/en/TXT/PDF/?uri=CELEX:22014A0830\(02\)](https://eur-lex.europa.eu/legal-content/en/TXT/PDF/?uri=CELEX:22014A0830(02))

forms in 2015 by revising the regulations introduced two years earlier<sup>55</sup>. These changes helped align Georgia's routine statistical reports of addiction treatment clinics with international standards.

In addition, for EMCDDA to understand patterns of drug use, risk perceptions, social and health correlates, and the consequences of the use of illicit drugs in countries, it supports *European School Survey Project on Alcohol and Other Drugs (ESPAD)*<sup>56</sup>. Although financial assistance from European Union, Georgia conducted biennial surveys among youth since 1999, they differed from ESPAD in coverage and sampling methods. Therefore, after the NCDC joined the ESPAD in 2015 using national financing and international survey tools and techniques, it conducted studies and produced national reports in 2015<sup>57</sup> and 2019<sup>58</sup>, enhancing drug use surveillance among youth.

**Figure 3 Evolution of OST Health Information Systems**



Finally, to enhance national responses to drug-related health and security threats and the national monitoring and reporting capacity, EMCDDA<sup>59</sup> facilitated the establishment of the *Georgian National Drug Observatory (NDO)* in 2020 (also arising from EUAA and DCFTA<sup>60</sup>). The NDO is chaired by the Ministry of Justice and

<sup>55</sup> Order of the Minister of Labour, Health, and Social Affairs of Georgia № 01-2/n on Maintaining and Delivering Medical Statistical Information. January 18, 2016. Available at: <https://matsne.gov.ge/ka/document/view/3161608?publication=0>

<sup>56</sup> Is a collaborative effort of independent research institutions across European countries and the largest cross-national research project on adolescent substance use in the world.

<sup>57</sup> ESPAD Report 2015: Results from the European School Survey Project on Alcohol and Other Drugs, Publications Office of the European Union, Luxembourg. ESPAD Group (2016). Available at: [https://www.emcdda.europa.eu/system/files/publications/3074/ESPAD\\_report\\_2015.pdf](https://www.emcdda.europa.eu/system/files/publications/3074/ESPAD_report_2015.pdf)

<sup>58</sup> ESPAD Report 2019: Results from the European School Survey Project on Alcohol and Other Drugs, EMCDDA Joint Publications, Publications Office of the European Union, Luxembourg. ESPAD Group (2020). Available at: [http://www.espad.org/sites/espad.org/files/2020.3878\\_EN\\_04.pdf](http://www.espad.org/sites/espad.org/files/2020.3878_EN_04.pdf)

<sup>59</sup> Emcdda.europa.eu. 2021. EMCDDA4GE: supporting Georgia on drug-related health and security threats|www.emcdda.europa.eu. Available at: [https://www.emcdda.europa.eu/activities/emcdda4georgia\\_en](https://www.emcdda.europa.eu/activities/emcdda4georgia_en)

<sup>60</sup> 2014. Deep and Comprehensive Free Trade Areas (DCFTA) of the EU-Georgia Association Agreement. Available at: <https://dcfta.gov.ge/en/agreement>

is accountable to the Interagency Coordinating Council against Drug Addiction. The NDO collects and investigates drug-related information, including the illicit drug market, and produces an annual drug situation report for Georgia that includes information about drug treatment. Previously similar reports were made with bi- and multilateral donor assistance, but after its establishment, the NDO prepared its first annual report for 2019<sup>61</sup>. All of these indicate that beyond TGF support for IBBS and PSE (which has not been yet transitioned), there were numerous other drivers, primarily from other donors, but most importantly arising from EUAA and DCFTA, which facilitated the overall HMIS development and standardization for drug use surveillance and treatment. These drivers emerged from legally binding international agreements, placing demand on national accountability within and outside the health sector that has led to the establishment of the data collection-reporting system adequately supported by the national regulations, institutionalized within the national entities, and funded out of state budget. In the words of one respondent:

*“The progression of information systems [for drug use and treatment] is a large part of the EU association process, in which our [health information] systems should be based on and resemble European systems, ... this process was the main trigger for advancing our systems” (IDI Respondent)*

HMIS development for TB was not as impactful as the ones described for NIP and OST. Under external technical assistance from USAID digital TB module was developed for the national *Electronic Information System* (E-Health). Although the platform was endorsed by the GoG in April 2015 and installed at all TB service delivery sites, the TB module is not being used as no single entity assumed legal responsibility for its ownership, maintenance, upgrade and/or use and neither the use of TB module was appropriately legislated/regulated by the Government. Consequently, the TB program continues using paper and electronic forms. The electronic system works at the regional and central levels. But district level public health centers and facilities still notify the regional level about newly detected TB cases through weekly paper-based forms. Although the system may not be technologically up to date, it generates all necessary indicators for national and international reporting to WHO. The only addition in 2017 was a separate “QuanTB” tool, a separately standing electronic quantification and early warning system designed to improve procurement processes, ordering, and supply planning for

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<sup>61</sup> 2021. Drug Situation in Georgia 2019. Tbilisi: National Drug Observatory.

tuberculosis treatment. Albeit the required data for “QuanTB” is manually fed, without any linkages to existing HMIS and ability to source real-time data, though does deliver on the objective of assuring uninterrupted drug supply without stockouts.

Thus, we note that HMIS development is multifaceted and affected by the health system and program needs as well as by a broader country context. Most likely, the noted evolutions in the HMIS were important facilitators of better program planning, implementation management and outcome monitoring. Continuous technical assistance and donor investments were essential for the observed gradual evolution of the system. However, other factors such as external mandates, accountability requirements imposed via international agreements, UN reporting framework or national budgetary process, demand from national stakeholders and contextual developments have all contributed to observed system adaptations, innovations, and alignment with national and international requirements. While HMIS developments in OST and TB were solely program-specific, the changes in HMIS for NIP certainly played an important role in the COVID-19 pandemic response allowing the country to promptly adjust the information system and use it for COVID-19 vaccination service delivery and vaccine supply planning and management.

Furthermore, on the one hand Georgia is failing to transition IBBS surveys while actively assuming responsibilities for ESPAD surveys and funded the last two rounds out of the state budget. It seems lack of rigorous demand from TGF on the one hand and the remaining institutional weaknesses of NCDC on the other could be at fault. However, if the former is strengthened, the latter may not pose challenges if NCDC maintains to outsource IBBS implementation to capable national organizations as it was done for the past several years.

### **Human Resources for Health**

This section of the report speaks to two broad areas of human resources for health (HRH), the first being approach to capacity strengthening activities and the second funding these inputs for adequate program management and service delivery.

Human resource capacity development proved multifaceted, supported by various donors over many years while using variable modalities and approaches. Firstly, we note that two broad groups of human resources were beneficiaries of capacity strengthening efforts and included (a) service providers involved in clinical service provision and (b) the public health workforce involved in program

leadership and management, surveillance, monitoring, and evaluation, information-communication activities, procurement, and supply chain management, etc. Beyond TGF/GAVI, the capacity strengthening throughout the years was supported by a broad donor base such as WHO/UNICEF, USAID, US CDC, JICA, EU, EMCDDA, Sabin institute, etc. They paid for and provided short-term issue/topic-focused training, which predominated the donor efforts. Activities included traditional and on-the-job training, participation in knowledge-sharing forums (national or regional), and site visits for peer learning, mainly for national-level program staff. For example, under the NIP, each new vaccine introduction was preceded by extensive training of public health and primary care workers on the respective disease burden, vaccine characteristics, eligibility and schedule, vaccine handling, immunization safety, monitoring of *Adverse Effects Following Immunization* (AEFI), and issues related to immunization HMIS and communication technics.

Similarly, through bilateral cooperation with the EMCDDA (project EMCDDA4GE), the capacity of national authorities was enhanced in the planning and implementation management of drug use policy. The EMCDDA equipped authorities with essential prevention knowledge and the most effective evidence-based prevention interventions and approaches and helped train service providers in evidence-based drug treatment approaches. Furthermore, TGF, GAVI, UNICEF, and WHO invested heavily in training program management staff for NIP, HIV/AIDS, and TB that included a cadre of managers, epidemiologists, primary care professionals, cold chain specialists, M&E specialists, staff responsible for procurement and supply management and budgeting, HMIS personnel, CCM, NITAG, MoF and MoH staff, and experts. Most of these pieces of training were “supportive”<sup>62</sup> as they provided immediate help for effective program implementation and significantly aided national capacity strengthening on a provider and public health workforce level.

In rare instances, funders took a more longer-term – “strengthening”<sup>63</sup> approach and invested in developing formal educational programs for necessary human

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<sup>62</sup> Chee G, Pielemeier N, Lion A, Connor C. Why differentiating between health system support and health system strengthening is needed? *Int J Health Plann Manage*. 2013 Jan-Mar;28(1):85-94. DOI: 10.1002/hpm.2122. Epub 2012 Jul 9. PMID: 22777839; PMCID: PMC3617455.

<sup>63</sup> Strengthening the health system is accomplished by more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behavior and/or allow more effective use of resources to improve multiple health services.

resource production to achieve a more durable and sustainable impact. Namely, the EU responded to the lack of addictologists in the country faced by the OST program through the project “*Development of Human Resources, Evidence-Based, and Quality Standards in Addictology in Georgia*” implemented during 2014–2016. The project was implemented with technical assistance from academic and research institutions in the Czech Republic, Poland, and Germany. Georgian civil society and educational institutions were actively engaged as partners. The project established the master's degree program at Ilia State University, with ten students graduating each year. Although a master's degree program has been developed at Ilia State University, specific courses and modules on addictology have been incorporated into study programs of other higher educational institutions<sup>64</sup>. These programs produce highly qualified professionals capable of handling different types of addictions. And graduates are also eligible to work on program planning, undertaking research, and monitoring the existing situation to better deliver addiction services to people in need<sup>65</sup>. Similarly, to institutionalize the immunization training modules for doctors and nurses, under the Gavi post-transition grant, immunization theory and practice modules were developed and incorporated for pre-service, postgraduate, and continuous medical education (CME) curricula. Albeit comparable investments were not made for public health workforce production with the help of under or graduate level educational programs that would have helped achieve long-term durable impact and prepare a cadre of adequately trained healthcare managers for long-term sustainability. Most likely short-term timespan of TGF and GAVI funding schemes (i.e., grant cycles) and narrow focus on diseases and/or immunization is not the suitable funding schemes for long-term investments in educational programs. Instead, they focus on short-term and problem-focused trainings facilitating program implementations. As for the EU using complementary investment vehicles/channels, it was possible to reinforce drug-related investments with educational system investment to achieve better outcomes.

As for funding salaries for HRH inputs, the situation varied across the studied components. For the TB program, essential management functions such as TB surveillance, HMIS, procurement and supply chain management, M&E, etc., are still being performed by the staff/experts paid out of grant funds. While in the OST and

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<sup>64</sup> <https://cbw.ge/culture/addictology-masters-programme-established-in-georgia>

<sup>65</sup> Ilia State University. 2022. Institute of Addiction Studies. Available at: <https://iliauni.edu.ge/en/iliauni/institutebi-451/adiqtologiis-instituti>

NIP, similar functions have been entirely handed over to the government and are financed from the state budget. Consequently, OST and NIP seem to have achieved a high degree of sustainability in staff retention. At the same time, the TB program remains at risk of losing qualified staff unless the transition steps are timely, and a cadre of trained and experienced performers are retained in the program with Government salaries. Factors facilitating such divergent developments across three program areas are primarily related to the government's stake/commitment to program transition. If, for NIP and OST, government commitment featured prominently for TB seems the government acted opportunistically when TGF permitted such opportunities to be exploited.

### **Procurement and Supply Management Systems**

Initially, for all three program areas, procurement of drugs, vaccines, and commodities was supported by TGF/GAVI grants. Commodity quantification was conducted/aided by external technical assistance. For example, TB drugs were procured through the Global Drug Facility (GDF) and were exempted from national registration with one-off waivers; vaccines were purchased through the UNICEF supply division, actively involved in quantification, and imported through UNICEF channels; methadone was procured, paid for, and imported by TGF. However, the government gradually streamlined the procurement, registration, and importation process. First, in 2006 the national legislation was amended and permitted the government to use the state budget on a non-competitive basis and procure vaccines and drugs through the UNICEF supply division or other UN entities. Another step occurred in 2009 when the Law of Georgia on Medicines and Pharmaceutical Activities<sup>66</sup> was amended, introducing a "recognition regime" for foreign-produced pharmaceuticals<sup>67</sup>. Namely, due to the weak capacity of the national regulator (quite common in many developing parts of the world), the Government decided to rely on the ability of the stringent regulators outside of Georgia and recognize their marketing permits as valid for admitting pharmaceutical products to the Georgian market. Therefore, the products having stringent regulatory approval were imported without additional national registration. These amendments reduced administrative hurdles, simplified import procedures, and reduced the time required to bring drugs and vaccines into the country. These amendments

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<sup>66</sup> Law of Georgia on Medicines and Pharmaceutical Activities.

<sup>67</sup> These were general pharmaceutical market reforms not linked or driven by donor assistance.

also covered WHO-prequalified vaccines and drugs<sup>68</sup>. Furthermore, after amending the Law of Georgia on Public Procurement in 2010, public procurement procedures became transparent and helped ensure robust competition while minimizing corruption risk.

The next important developments occurred over the years when the procurement function was gradually moved out of donor-funded programs and consolidated under NCDC – the entity managing all three programs under the review. However, this road was not without pain and mistakes. Initially, procurement responsibilities for drugs, vaccines and commodities were fulfilled by the State Social Service Agency (a single public purchaser of health services in the country)<sup>69</sup> when commodity planning and quantification responsibilities were left with the NCDC. Albeit the functional distribution between these two impeded program implementation and vaccine or drug stockouts were frequent due to a poorly coordinated procurement process and divided accountability for the failure. Gradually in 2011, procurement functions for vaccines were consolidated under NCDC. In 2014 drug procurement for OST and TB drugs was also added. The entity became responsible for the full cycle of drug, vaccine and commodity procurement paid by the state or donor funds but following the national procurement rules/laws.

Nonetheless, up until 2013, vaccine planning, forecasting, procurement, and supply management by NCDC had significant shortcomings, leading to stockouts caused by challenges in stock management, improper planning and/or complete reliance on the UNICEF supply division for procurement planning and/or quantification. Obviously, external technical assistance, along with capacity-strengthening activities described earlier, helped NCDC advance on the procurement and supply management role. The main player in procurement capacity strengthening was the UNICEF-CO and UNICEF-SD. Key NCDC specialists responsible for planning, forecasting, procurement, and supply management (including through cold-chain) participated in numerous workshops, site visits, and joint learning forums, where they gained access to relevant knowledge, skills, and tools.

Finally, HMIS developments, led by NCDC and described in the early part of this report, also contributed to this transition path. A comprehensive assessment of the

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<sup>68</sup> Gavi. (2015). Georgia Joint Appraisal 2015. <https://www.gavi.org/sites/default/files/document/joint-appraisal-georgia-2015pdf.pdf>

<sup>69</sup> The State Social Service Agency was a predecessor of the National Health Agency established in 2020.



vaccine procurement system in 2016 found the system performance was good; the process was open, transparent, and efficient. Customs clearance procedures were simplified. Procurement legislation allowed for multiyear contracting, and other procurement practices such as e-platform for online participation, transparency and increased institutional accountability for the process, international access to the e-procurement platform, and acceptance of international electronic tender documentation prepared in English all played contributing roles and aided transition<sup>70,71</sup>.

While achievements are bold and clear, unfortunately, some risks remain and primarily for the TB program, which is still largely dependent on TGF. Especially individuals involved in TB drug procurement planning, quantification, and supply chain management are paid from TGF grants and have not transitioned to state budget-funded salaries. NCDC faces risks of losing this important cadre after full program transition unless preparatory steps are timely taken, and smooth staff transitions are assured.

To conclude, several factors seem to have played important role in the transition of procurement function onto the national entities. They included: developing a conducive legislative and regulatory environment, external technical assistance, which initially aided program implementation but eventually helped develop institutional and individual capabilities, proper institutionalization/consolidation of a procurement function and streamlined and increased domestic (and probably international) accountability for the achieved results.

## Cross initiative analysis

In this section of the report, we summarize our observations about transition drivers and facilitators that have emerged as important ones across the initiatives. We also reveal those critical processes that helped these drivers and facilitators to materialize.

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<sup>70</sup> UNICEF Georgia, & NCDC. (2016). Assessment of Vaccine Procurement System in Georgia.

<sup>71</sup> LNCT. (2019). Georgia's Introduction of the Hexavalent Vaccine: Lessons on successful procurement and advocacy. <https://lnct.global/blog/georgias-introduction-of-the-hexavalent-vaccine-lessons-on-successful-procurement-and-advocacy/>

## Transition drivers and facilitators

The case study confirms the complexity of the transition process, the time it takes, and the intricate interplay of drivers and facilitators, leading to a successful and sustainable program transition from donor support to tangible public health outcomes. These complex interactions, captured in Georgia, are schematically depicted in Figure 4 (albeit not able to reveal the richness of findings completely) and explained below. While the figure is unidirectional, the process is iterative, evolutionary, and at times repetitive in nature, occurring over a decade, and multiple factors are at play, cross-contributing, mutually reinforcing, or inhibiting. And finally, there is a great deal of interdependence between these factors.

However, before discussing these interactions, we want to highlight that the transition proved to be a long-term and incremental process alongside the country's movement on its developmental path. Namely, economic growth over the past two decades created conducive macroeconomic conditions, the government's political will to increase funding for healthcare, and importantly, countries' drive toward the EU, leading to the signing of the Association Agreement that positively affected institutional developments in Georgia and imposed stringent and legally binding accountability requirements on the government. Therefore, transition outcomes are significantly determined by this context over the past decade(s) and the accompanying changes in the health system. Gradual evolutions across the health system blocks described in the document contributed to a successful transition. However, these developments would have been challenged and/or slowed down without a conducive and evolving country context. **Thus, the context in which transition happens has a significant bearing on outcomes and must always be considered when planning for a transition or adjusting implementation in any given country or program.**

Secondly, the **people's healthcare needs** recognized by national and international stakeholders seem to be one of the most critical determinants in driving described changes in the health system, including transition. The "need" was perceived differently by different stakeholders and population groups and for various programs and manifested itself in different forms. A diverse group of stakeholders elevated an unmet need in the case of OST when services were demanded by the key affected population and their families. Still, the national capacity to deliver such services fell short. In the case of NIP, the need was fully met with routine vaccines and immunization services. However, the emergence of new vaccines triggered the

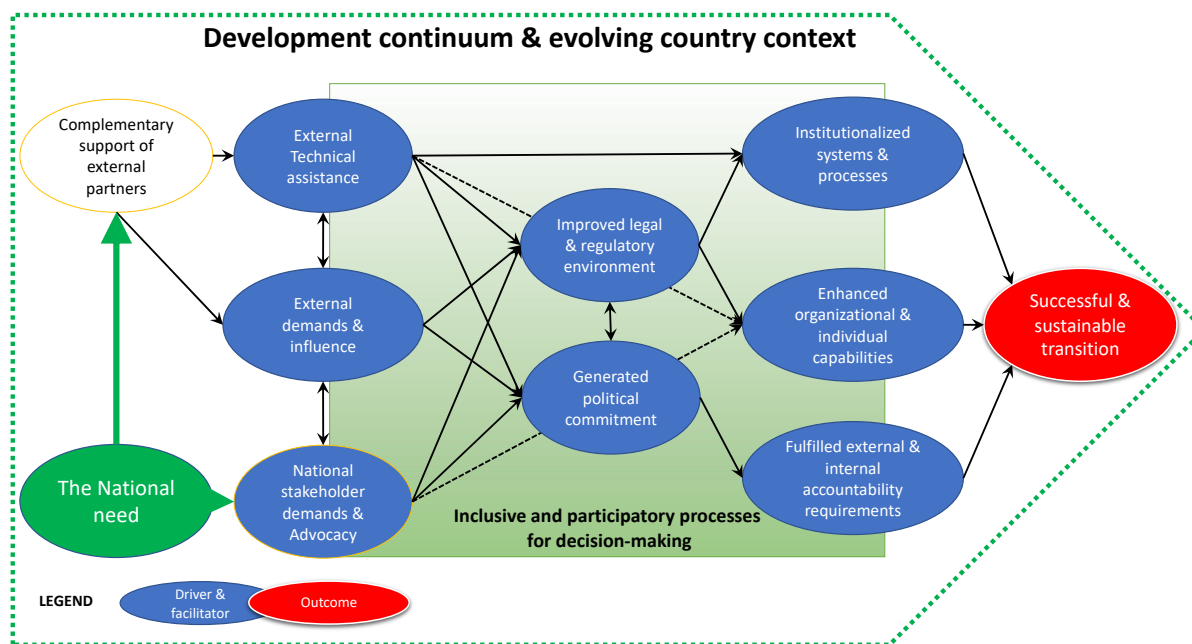
desire to achieve better protection for children, and the need materialized primarily within the expert community. While the public demand for tackling TB challenges was not explicit, general expectation, originating from the Soviet past, for the availability of treatment services for TB was present in society and among policymakers. However, it never translated into a comparable “demand” observed for OST and NIP and therefore allowed the government to place TB transition relatively low on its political agenda for health. **Thus, the level of societal perception of the need significantly influenced the transition path and national dynamics, albeit differently for different programs depending on the gravity of perception.**

While the “need” did not trigger the transition, in our case, it determined two critical pathways (see Figure 4 for schematical depiction as the process and interaction of factors proved to be more complex) through which the developments evolved: (a) the need well perceived by the national stakeholders led to societal demands placed on the government to establish OST services and/or expand vaccine portfolio with new vaccines. In lieu of expected donor graduation, it elevated discussions around transition-related issues in the national policy agenda. (b) Secondly, “the need” also determined the actions and content for donor support. Namely, the challenges of drug use for society were not only confined to HIV response, but for some donors like the EU it landed in a broader security agenda aimed at reduction of drug use in the EU neighborhood. The nation's need for new vaccines (and threat arising from vaccine-preventable diseases) resonated with the Global agenda and drove investments first from USAID and then from GAVI, UNICEF, WHO, and others. Similarly, the resurgence of TB after the fall of the Soviet Union attracted support from numerous donors, including the Global Fund. Thus, while the need was an important factor in shaping donor support, by far, it was not the only one, and broader security or other concerns have also motivated donors and partners to help Georgia throughout, including during the transition.

Next, as we have revealed, the evolutions in the health system blocks cannot be explained by single donor support. Only through joint and complementary efforts of different partners (at times well-coordinated and at times not) and those involved with the health sector have collectively contributed to the observed transition outcomes. These observations further emphasize the importance of the partnership approach employed by GAVI and Global Fund and the value such partnerships could afford. While we have not looked at how country-level “partnerships” themselves were facilitated, operationalized, and/or coordinated,

the outcomes of multi-donor support, revealed in the case studies, allow us to **confirm the value afforded by the partnership and emphasize the importance of well-coordinated efforts that can assure complementarity of donor investments when collectively, the partnership delivers on the country's (not donor's) developmental objectives with tangible results.**

**Figure 4 Drivers and facilitators of the financial and programmatic transition in Georgia**



**While providing financial resources throughout the years, external partners have placed demands** for government action and greater accountability. Some external demands, such as those arising from the EU accession agreement, had more power “to push” governments’ efforts in implementing new policies, respect human rights, establish national institutions and systems in response to legal provisions of the agreement, comply with international reporting requirements and standards, build national capacity, engage civil society in policy debates and/or decision making, etc. Other demands arising from the UN membership and/or accountability framework (for WHO and UNICEF), probably with lesser power than EUAA, still played an essential role in imposing accountability and some transparency demands on the government. Furthermore, when requirements/demands were linked to conditions for funding access (such as for TGF and GAVI) government did take action to comply and even established structures such as CCM and ICC. Although, where permitted, the Government/institutions also acted opportunistically in “the best national interest” financially but not programmatically (e.g., FLD transition case where little money

was saved but the transitions process is full of remaining risks). Most likely, the least forceful mandates were placed (if any) by bilateral donors working with the Georgian government placed the least forceful mandates (if any), but their support was also important. All these demands collectively contributed to the transition and led to government actions described in this report.

Furthermore, the case studies revealed that in response to donor/external demands, Georgia had to (i) develop National Strategies, cMYPs, and plan for transition; (ii) set multi-sectoral coordination structures such as CCM or ICC offering inclusive space for various actors, including civil society and key affected communities; (iii) establish advisory structures for evidence-informed decisions like NITAG and PAAC. These structures were important when making decisions, coordinating government and non-government actors, and, most importantly, keeping implementers accountable for the agreed and planned deliverables. These structures played an important role in offering participatory and inclusive processes for governance. They allowed for the national need to be voiced and discussed and decisions made through national debates, compromises, and/or consensus building. Furthermore, accountability arrangements (for external as well as internal purposes) demanded routine progress monitoring (for EUAA, for Gavi and Global Fund, etc.), and when monitoring results were placed in the public domain, it helped assure transparency, facilitated inclusivity which helped the country move forward and enact required institutional, regulatory, and other changes. While these structures were instrumental, it is not clear if they would remain when donor support completely stops. In the country and society still undergoing democratic transition, it would require time before durability and resilience of the established structures are revealed.

**Next, the external parents funded and provided technical assistance** (see Figure 4) mobilized by donors within and outside the health sector and for different technical areas such as developing strategic and transition plans, information systems within and outside the health system, advancing legal and regulatory environment, contributing to educational programs or short-term training for human capacity development, enhancing public finance management systems, etc. Such technical assistance was not only paid from Global Fund and GAVI grants and the UN system but also by bi and multi-laterals and not only by those involved with the health sector. The case studies revealed vivid examples of how evolutionary and multifaced this technical assistance was, how and where it has contributed to the developments observed in the health system blocks and beyond, the crucial roles the donors played in crafting and funding such technical assistance, and how important it would remain going forward when addressing remaining shortcomings still posing a risk

to future transitions. When delivering technical assistance, a narrow focus on health systems or health program needs was paramount. However, eventual alignment with the evolving country context seems to have delivered more durable outcomes with potential for sustainable impact (e.g., linking the immunization system with a birth registry, aligning statistical reporting about drug treatment within the health sector with broader EMCDDA reporting requirements, and adjusting national regulations, producing multi-year plans with budget forecasts linked with MTEF, establishing programmatic objectives for budget programs to comply with program-based budgeting requirements, establishing the *Georgian National Drug Observatory* and capacitating national planners to deal with drug challenges on a national scale, establishing educational programs with higher educational establishments, etc.).

Ultimately, all donor-supported activities described above step-by-step contributed to the sustainable transition of OST and NIP, yet to a lesser degree for the TB-FLD component. However, it must be noted that the support of the external partners not directly involved with the studied programs was as crucial as the ones affording technical support directly to the health sector. The eventual contribution of this TA gradually generated political commitment of the government, ready to improve the legal and regulatory environment for the transition.

The next step through which “the need” contributed to the achieved outcomes (see Figure 4) relates to **national actors and their advocacy efforts**. How “the need” influenced national processes vividly featured in OST and NIP transitions when the demands from stakeholders through numerous advocacy efforts led to the government’s supportive decisions. For OST growing need for drug treatment and public pressure led to many decisions taken by the government over the years. For the NIP, it was not as much the need but general preferences for new vaccines, spotted by experts, that led to hexavalent vaccine introduction and eventual state financing. It is hard to evaluate the exact level of public interest or measure the pressure they applied on the government. However, described events occurring in both programs and repeating over the years confirm that the government considered public opinion, and the services were not only introduced but eventually scaled up and sustained when donor transition occurred.

Furthermore, the case study reveals that **advocacy efforts organized by different institutional players** were critical in determining program success. For OST, the civil society with community engagement played an essential role in advocating for the government to make OST services available to those in need and sustain them after the Global Fund transition. However, with NIP, the advocacy role for NVI was primarily played by international partners WHO and UNICEF supporting NITAG with needed evidence and engaging in a dialogue with state authorities. International partners produced necessary and credible evidence for vaccine introduction needs. The advocacy events occurred multiple times and in various settings such as meetings (national and international), evidence delivery to decision-makers, organizing workshops with MoF, MoH, and other stakeholder participation nationally and, most importantly, internationally, where international recognition of Georgian accomplishments motivated the national representatives and played on their national pride.

All these elements collectively played an important role in generating the political will of the government as well as contributed to the development of a conducive legal and regulatory environment that helped program transitions.

Finally, three additional important transition facilitators (see Figure 4) emerged and included **institutionalizing systems and processes** within the state where national rules and regulations governed daily operations. The case studies showed how much the national public financial management (PFM) system helped during and after the transition. The medium-term budgeting process required NCDC and MoH to plan their financial resources for the coming years. It created space for medium-term financial planning and delivering on the external co-financing promises within the national budget framework. Secondly, results-based budgeting placed formal accountability requirements on NCDC and MoH to deliver the planned results and reach the targets set out in the budget programs. Thirdly, national regulations supporting these programs followed national procurement rules because budgetary resources were used to procure goods and services. Beyond PFM, national management information systems for OST, NIP, and to a lesser degree for TB, etc., were necessary for the program and transition planning, management, and monitoring of transition results. Most importantly, information arising from the system allowed the national actors to use this information in their advocacy efforts.

Institutionalization efforts were reinforced by **enhanced organizational and individual capabilities** achieved through extensive technical assistance delivered over the years, and individual capacity-building efforts described earlier in the document. Not only building individual capacity but retaining the cadre of trained individuals within the state entities and paying at the national salary scale helped the transition process go smoothly for NIP and OST. At the same time, for TB, these aspects still require resolution.

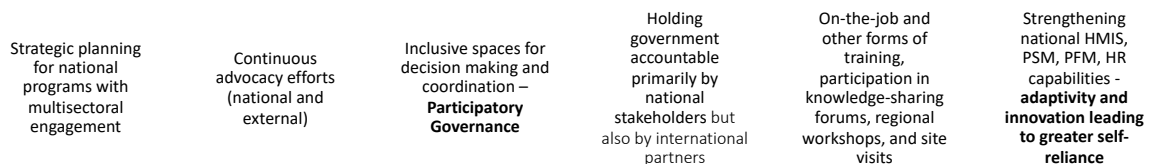
### **Which Processes Proved Important?**

Once again, the described facilitators were not operating individually or in a silo mode but were closely interrelated and interdependent, revealing how complex the health system is, how dependent are these changes on the country context and how much system thinking is required to move along the transition continuum with properly planned steps and execution arrangements. The case studies pointed toward important processes which helped facilitators materialize. These processes are schematically presented in Figure 5.

While readers may feel that these process elements were already explained when describing facilitators above, we thought it was important to highlight those again as they had a significant bearing on transition outcomes. While none of these processes are new, their importance for the transition should not be

underestimated. Therefore, going forward, it seems vital to plan for such processes, fund-support their implementation, and adequately monitor produced outputs.

**Figure 5 Important processes for transition**



**Strategic planning** for all three programs in this review was vital to transition planning and execution. HIV and TB NSPs and cMYP for immunization proved effective tools for inclusive debate and discussion on programmatic matters and transition steps. These plans served multiple purposes, from analysis of challenges to finding solutions and planning responsive actions with clear timelines, responsibilities, and funding allocation, where required. The strategic documents' financial plans also helped determine co-financing needs and contributed to MTEF planning with the MoH and MoF.

**Continuous advocacy efforts** extensively discussed earlier in the document and orchestrated throughout the program planning and transition process made significant contributions.

**Inclusive spaces for decision-making** demanded and actively facilitated by development partners were also important for participatory governance, hearing the needs of those affected, and **holding the government accountable**.

**The training and capacity development** activities in various forms and shapes helped beef-up institutional and individual capabilities.

And finally, **adaptivity and innovation** in PFM, HMIS, PSM, HR, when developing national regulations, etc., all were important processes led by national actors but extensively supported by development partners. This adaptivity and innovation led to greater self-reliance of the programs after the transition.



## Implications for donor transitions

Global health donors are increasingly transitioning funding responsibility to host governments as development assistance for health declines and countries meet development and disease burden goals<sup>72</sup>. At the same time, over the past decade(s), the global thinking about donor transition significantly evolved from talking about the financial transition to broadening the concept and adding considerations for the programmatic transition to the financial one. As a result, donor transition policies became more nuanced. However, they still are more focused on the financial than programmatic aspects of transition, but without much specificity<sup>73,74,75</sup>. Our research has highlighted several important factors that donors may need to consider in the transition policy formulation/modification and/or when planning programmatic activities supporting the transition of donor-funded programs.

Firstly, the overall economic performance of Georgia proved that the financial burden of taking on the program components was not huge for the state budget. But most important was preparing the national systems and capabilities to independently manage the program, which required described evolutions-developments along the health systems blocks and many years. The case study provides vivid examples of how health systems were strengthened step-by-step. Thus, focusing more on health system strengthening in the transition policy documents along with financial transition would be the first obvious thing to consider. However, we do need to note that over the years Global health community, and not only, has become more aware of the importance of Health Systems Strengthening (HSS) in achieving Global targets for HIV, TB, Malaria, immunization, or other Global health problems.

*“Strong health systems are fundamental if we are to improve health outcomes and accelerate progress towards the Millennium Development Goals of reducing maternal and child mortality and combating HIV, malaria,*

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<sup>72</sup> McDonough, A., Rodríguez, D.C. How donors support civil society as government accountability advocates: a review of strategies and implications for the transition of donor funding in global health. *Global Health* 16, 110 (2020). <https://doi.org/10.1186/s12992-020-00628-6>

<sup>73</sup> The Global Fund Sustainability, Transition and Co-financing Policy 2014. GF/B35/04 – Revision 1 <https://www.theglobalfund.org/en/sustainability-transition-and-co-financing/>

<sup>74</sup> Gavi, the Vaccine Alliance Co-Financing Policy 2015. <https://www.gavi.org/programmes-impact/programmatic-policies/co-financing-policy>

<sup>75</sup> CEPA 2019. Evaluation of Gavi’s Eligibility and Transition and Co financing Policies.

*and other diseases. At a time when economic downturn, a new influenza pandemic, and climate change add to the challenges of meeting those goals, the need for robust health systems is more acute than ever.”* WHO DG Dr. Margaret Chan 2009.

*“We will not be successful in our efforts to end deaths from AIDS, malaria, and tuberculosis unless we do more to improve the health systems around the world.”* President Barack Obama 2009.

Therefore, donors have focused on strengthening health systems as an essential objective for sectoral investments. However, even HSS advocates admit that it often seems like a "distant, even abstract aim"<sup>76</sup>, lacking granularity for operationalization<sup>77</sup>. Frequently, it is not clear to country stakeholders how HSS investments are intended to strengthen health systems and support sustainable disease outcomes. Therefore, more clarity on strengthening health systems is required<sup>77,78</sup>. We think our findings could add a penny here.

Secondly, our case reveals the well-known truth – the strong interdependency of developments within the health system blocks. Namely, almost no change in a system block occurred in a silo but was closely linked, reinforced, or required (or challenged) by the changes occurring in the other(s). These findings resonate with field-level observations documented elsewhere that health systems strengthening is a nonlinear process benefitting significantly from holistic systems thinking rather than traditional, vertical analysis<sup>76,79</sup>. Although health system building blocks provide an analytical framework, their utility seems limited for the operationalization of health system strengthening investments. Moving from vertical/silo thinking about the health system blocks to more holistic systems thinking<sup>80</sup> is a paradigm shift requiring attention to how individual components within the overall system and subsystems interact and affect each other. To achieve this paradigm shift and operationalize HSS on a country level, based on our findings, we propose to use the new term “**Block of HSS Intervention,**” which

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<sup>76</sup> USAID New Perspectives in Health Systems Strengthening. <https://www.hfgproject.org/wp-content/uploads/2015/02/New-Perspectives-in-Health-Systems-Strengthening-Executive-Summary.pdf>

<sup>77</sup> Gavi 2016. Meta-Review of Country Evaluations of Gavi’s Health System Strengthening Support

<sup>78</sup> Global Fund. 2019. Technical Evaluation Reference Group: Position Paper – Thematic Review on Resilient and Sustainable Systems for Health (RSSH).

<sup>79</sup> AHPSS. 2009. Systems thinking for health systems strengthening: edited by Don de Savigny and Taghreed Adam

<sup>80</sup> Systems thinking is an approach to problem-solving that views problems as part of a wider dynamic system. It recognizes and prioritizes the understanding of linkages, relationships, interactions, and interdependencies among the components of a system that give rise to the system’s observed behavior.

could denote **a support area** for donor assistance, the meaning of which we try to unpack below.

For example, frequently, donor-funded programs state their support areas using broad statements, **“strengthening HMIS”** [one of the health systems building blocks] which does not resonate with a country stakeholder unless it is more granularly defined, nuanced, and focused on which HMIS of the country is being strengthened and how. Do donor-funded programs want to enhance the management information system for monitoring service delivery on a facility level, or is the focus on information systems for the laboratories or maybe on procurement and supply chain management systems? Thus, a narrower definition of a support area is warranted.

Next, beyond the definition, e.g., **strengthening lab HMIS**, for the proposed **“Block of Intervention”** to acquire operational clarity, it would be necessary to spell out planned activities in support of enhancing lab HMIS. Using systems thinking approach will help be more specific about investment areas that collectively would shape the “Block of Interventions,” and investments could include:

- **Supporting Relevant human resource capacity strengthening** activities, e.g., is it software engineers, big data analysts, epidemiologists, or managers we want to train? Or do we train lab personnel on how best to enter the data in the newly strengthened/updated system? Do we train only individuals within the state sector, or will the training be available for the state, non-state, and private sector players? Which modality will be used for training one of a short course, or a comprehensive certificate course, or do we invest in educational establishment to assure continuous HR production with required competencies, etc?
- **Funding** lab HMIS strengthening may require financing technical assistance (external or local) for software or HMIS architecture development; funding daily operations of the system, managing costs or HMIS software upgrades; and most importantly, thinking about how the government will fund these functions after the transition.
- **Ownership and governance arrangements** must be considered and supported for enhanced HMIS for labs; the data standards, data acquisition, and reporting roles, responsibilities, and frequencies must be adequately reflected in the relevant national regulatory documents.

Thus, for a smooth transition, it would be necessary to clarify what the “**Block of Interventions**” might entail for a given program in a given country. The “**Block of Interventions**” should be comprehensively considered and adjusted to a country’s context (discussed later). Interventions should be well sequenced and implemented across the building blocks to achieve durable outputs that would predetermine sustainable transition. Therefore, when HSS is being discussed and linked to transition, maybe it is necessary to move away from a “**Health System Block**” as a priority area for investment and use “**Intervention Blocks**” as an operational dimension for investment planning which encompasses an array of interlinked required changes in the relevant investment area and across the health systems blocks **linked to the area of focus**? If this proposal is acceptable, its operationalization may need re-writing country guidance for HSS investments and how to identify and select those.

Thirdly, we have noted that much of what has occurred in the health systems over the years was context-dependent. By far, this is not a discovery. The current transition-related policies of TGF and Gavi have become better tailored to the “development continuum.” However, the need for additional granularity and better alignment is still warranted<sup>81,82</sup>. The challenge here might be a country’s or donor’s capacity to fully comprehend the local context, especially developments outside of the health sector that are so important, and plan interventions accordingly. Based on our findings, there is a need to seize the potential of development partners through a better-coordinated partnership model and empowered and engaged country stakeholders. Partnership coordination may need to reach beyond the health sector peers in a country to better grasp the potential for HSS afforded by a broader context. However, without the national stakeholders’ active engagement, expertise, knowledge, and the capacity to contribute context-specific insights, the benefits of such partnerships could be constrained. Thus, we think national planning processes for a strategy or TSP should be used more purposefully and effectively for better tailoring HSS investment to a country’s context and the better elaboration of the “**Block of Interventions.**”

Next, we think it is essential for donors to enforce adopted transition policies rigorously. The case of the delayed start of TB transition and lack of assuming IBBS

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<sup>81</sup> Global Fund. 2019. Technical Evaluation Reference Group: Position Paper – Thematic Review on Resilient and Sustainable Systems for Health (RSSH).

<sup>82</sup> CEPA 2019. Evaluation of Gavi’s Eligibility and Transition and Co financing Policies.

survey responsibilities in Georgia reveals a relatively relaxed approach of funders allows opportunistic behavior of countries. Thus, consistent enforcement of established rules could help improve country compliance and trigger national actions necessary for better planning and implementation of transition.

Finally, the potential afforded by civil society, the expert community, and their advocacy efforts should not be underestimated and further capitalized on. This may require additional grant investments in civil society capacity building (or supporting expert community) and advocacy efforts to use their power in securing political commitments from the government, so much is required for a sustainable transition.<sup>83,84</sup> The Georgian case reveals that the regional approach, such as *Eastern Partnership Civil Society Forum*, supported by the EU, offers a modality to consider other donors and, if appropriate, support through regional and country-level grants could be assured.

## What could countries do?

**Start with planning.** While this is not news, the approach and processes revealed in our work suggest the following. A good strategic plan (which also incorporates transition thinking) tailored to the country's context and accounting for developments occurring within and outside the health sector could be essential if these plans are effectively executed. However, good strategic plans may require organized participatory, inclusive, consultative processes, local needs to be voiced, and local context-specific knowledge to meet international/global expertise to produce solutions better tailored to the country's specifics.

Furthermore, to the extent possible, **retain participatory structures of Governance**, allowing inclusive and transparent governance arrangements. Where necessary, legislate and regulate these structures in a way that affords durability during and after donor transition. Never underestimate the role and value the communities and affected populations bring to these structures and their functionality. And for more robust governance, assure transparent accountability for successes achieved but, more importantly, for challenges faced.

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<sup>83</sup> McDonough, A., Rodríguez, D.C. How donors support civil society as government accountability advocates: a review of strategies and implications for the transition of donor funding in global health. *Global Health* 16, 110 (2020). <https://doi.org/10.1186/s12992-020-00628-6>

<sup>84</sup> Rodríguez DC, Whiteside A, Bennett S. Political commitment for vulnerable populations during donor transition. *Bull World Health Organ.* 2017 Feb 1;95(2):121-127. doi: 10.2471/BLT.16.179861.

**Try to gradually transfer/institutionalize critical program management functions** supported/funded by donors within the responsible state entities. Such functions could include overall program management, monitoring and evaluation, financing, and payment for service delivery (unless inputs for health service production are funded through line-item budgets), procurement and supply management, human resource development through short-term or institutionalized training programs, etc. The institutionalization of functions/responsibilities must be accompanied by updated national rules and management procedures, including goods and service procurement, provider contracting, monitoring, reporting, and financing. All these national regulatory instruments would be necessary to endure the transition from donor assistance to the government without significant impediments.

**Depending on the degree of PFM development** and where opportunities permit, the government should try moving funding to the national PFM system, even before the transition discussions commence in the country. Frequently national PFM systems are rigid and significantly constrain spending flexibility, commonly offered by external funders, but the early transition and gradual adaptations to these restrictions for the staff and institutions eventually deliver better transition results. Financial transitions require awareness raising and advocacy efforts to increase the size of stakeholders aware of transition-related demands and engage and support the financial transition process. Formats, such as regional meetings among peer countries, where responsible individuals from MoF and other structures (administrative or electoral) participate, proved to be helpful for budget advocacy.

**Try to build and/or enhance functioning and purpose-fit information systems** meeting program management and service delivery needs. However, try to unpack the elements of the systems that require strengthening, whether for infrastructure, equipment, software, interoperability, data use for decision-making, etc. Be mindful that digital developments and advances in Information Technology and Communication (ITC) demand re-thinking old approaches and adaptations to new realities. They force to break silos between and within information system elements (such as laboratory HIS, or service delivery HIS, or asset/commodity management HIS or financial and HR management HIS) but also between the health and other sectors, where greater integration could offer significant value add to the health programs. IMEM system integration with the birth registry seems to be a great example of what could be achieved. Try to augment the system

functionality and quality of system outputs with necessary regulatory support helping to standardize the type and frequency of data elements collected, transmitted, compiled, used, and analyzed with the help of numerous digital tools. Finally, greater alignment of the collected information with international standards further facilitates and supports program operations and sovereign responsibilities for global reporting.

**Governments should try to grab the value of partnership.** No one better than the government should be aware of the national needs and priorities and be best placed to secure the assistance it needs for the priority areas. Thus, the governments must assume the driver's seat for partner coordination. Albeit in real life, this is easily said than done, but countries on the right-hand side of the development continuum should strive for their best in seizing the most outstanding value through better partner coordination. The space for such partnership is not only in the health sector; some development occurring outside of health is also essential. Finally, at times looking at and learning from peers who may have delivered on this objective better could be an option to consider, and regional meetings/conferences supported by partners might be the best space for identification and engagement.

## **Policy Recommendations for Georgia to address remaining shortcomings**

The study findings reveal remaining transition shortcomings that Georgia needs to address. Therefore, building on proposals from the previous section and study findings, we think the following areas deserve attention:

It is evident that the TB program transition is not strong-footed compared to OST and NIP and requires timely attention. Namely, the processes used for OST and NIP need to be repeated for the TB program. More rigorous TSP development might be necessary to elaborate better on the “**Block of Interventions**” that may lead to better transition outcomes. To facilitate this process, there seems to be a need to look for opportunities to make a case for higher priority for the TB program on the national agenda. WHO, Global Fund, Stop YB Partnership, and others could play an instrumental role along with empowered national stakeholders. In their advocacy efforts, they could try to raise the importance of TB from a broader health security perspective linked to

MDR and Antimicrobial Resistance (AMR), which could help create pressure for donors and the government for a solid and sustainable transition.

The timely transition of IBBS and PSE would be necessary for the country not to lose the strategic information needed for HIV/AIDS programming. This may require deliberate action on the Global Fund to define the end date for IBBS and PSE funding from the grant and a clear vision on how and when NCDC would assume financial responsibility for funding and commissioning this work, as it has done with ESPAD.

To increase low coverage rates for HPV and Rota, several things would be required. Firstly, the potential afforded by IMEM needs to be fully exploited, which may entail a) completing a full transition of this system to the government with clearly defined ownership and funding responsibilities; b) facilitating or mandating its use on a PHC and district public health center level, making IMEM the only information system throughout the country to manage the NIP and c) tightening the accountability responsibilities for PHC and district level managers, maybe supported with revised PHC provider reimbursement to create an economic incentive for achieving higher coverage targets. Luckily, the latter interventions are already being considered by the Government in its efforts aimed at PHC reforms.