Health System Strengthening in Georgia

Proposal

Submitted to Global Alliance for Vaccines and Immunization (GAVI)

Government of Georgia

This document is accompanied by an electronic copy on CD for your convenience. Please return a copy of the CD with the original, signed hard-copy of the document to:
GAVI Secretariat; c/o UNICEF, Palais des Nations, 1211 Geneva 10, Switzerland.

Enquiries to: Dr Julian Lob-Levyt, jloblevyt@unicef.org or representatives of a GAVI partner agency. All documents and attachments must be in English or French.

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Executive Summary

A national task force composed of local experts and representatives of the MoLHSA was guided by the major trends in health care system reform and findings of system assessments conducted by development partners for the formulation of HSS options**.**

Description

The overall goal of the program is to contribute to the increase in immunization coverage and its sustainability through the provision of support to ongoing health reforms at the national and rayon levels.
The following specific objectives (outcomes) are proposed:

1. Motivation of the medical personnel (necessary to ensure planned (desired) immunization coverage rates) is institutionalized
2. Increased professional skills of public health specialists at the rayon level
3. Supportive supervision introduced at the rayon and health facility levels
4. Increased skills of PHC medical personnel (doctors and nurses) related to immunization
5. Improve capacity of Public Health institutions to deliver services

Justification

In total 9 criteria were used to assess the following options that were formulated based on the situational analysis:

- Increase motivation of PHC staff to achieve immunization coverage targets
- Increase capacity for outreach services
- Increase professional skills of public health specialists (at the district level)
- Increase managerial capacity of district public/health authorities for supportive supervision
- Increase PHC medical teams' professional skills related to immunization
- Improve epidemiologic statistical systems performance
- Improve capacity of Public Health institutions to deliver services

Program interventions represent an investment in human resources and service infrastructure ensuring long term sustainability and effectiveness. The proposed components supplement existing health system reform interventions with focus on preventive care.

HSS Support Program budget

The total budget of the program is $**1,010,906** for 4 years (2007-2010) out of which $ 576,324 will be financed by the Government of Georgia and the remaining $434,622 is supposed to be financed through the GAVI HSS support.

Management and Accountability

The program will be implemented by a state agency that will be established (by April 2007) after the merger of the alone standing Public Health Department and the National Center for Disease Control.
An overall program management will be carried out by the Sectoral Policy Planning Division of the Ministry of Labor, Health and Social Affairs.
The Sectoral Policy Planning Division will be accountable to the Health Sector Coordination Committee that was established in January 2007 for the purpose of the present application.

In addition to the abovementioned accountability scheme the implementing agency and the MoLHSA will be audited by the Chamber of Control of Georgia ensuring proper allocation of the state and donated funds.

Signatures of the Government and National Coordinating Bodies

Government and the Health Sector Strategy Committee (for HSS only)

The Government of...Georgia ...commits itself to developing national immunization services on a sustainable basis in accordance with the multi-year plan presented with this document.

Districts' performance on immunization will be reviewed annually through a transparent monitoring system. The Government requests that the Alliance and its partners contribute financial and technical assistance to support immunization of children as outlined in this application.

Ministry of Labour, Health and Social Affairs:

Signature: .....

Title: Acting Minister
Irakli Giorgobiani.....

Date: .....

Ministry of Finance:

Signature: .....

Title:Minister
Aleksi Aleksishvili.....

Date: 27.02.07

National Coordinating Body: Health Sector Strategy Committee:

We, the members of the National Co-ordinating Body Health Sector Coordination Committee (HSCC) met on the 30.01.2007 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

- The endorsed minutes of **this meeting and signatures** are attached as DOCUMENT NUMBER: **#1.**

Agency/Organisation	Name/Title
MoLHSA	TaTa Chanturidze/ Deputy Minister
MoLHSA	Nikoloz Pruidze/ Deputy Minister/HSCC Chair
MoLHSA	Tamar Gabunia/Head of the Sectoral Policy Departmant
MoLHSA	Sophia Lebanidze/Head of the Health department
MoLHSA	Shalva Goduadze/ Head of the Finance and Budget Department
SUSIF	Vakhtang Surguladze/Deputy Director
PHD	Levan Baramidze/Dead of the Department
NCDC	Paata Imnadze/Director
MoLHSA	Ketevan Ghambashidze/ main specialist of the Sectoral Policy Departmant /HSCC Secretary

WB	Tamar Gotsadze
EU	Colette Selman
DFID	Lali Meskhi
UNICEF	Mariam Jashi /Health Program Officer
USAID/Caucasus Humanitarian Response Office	Tamar Sirbiladze / Medical Project Officer
WHO	Rusudan KlimiaShvili/ Liaison Officer
Curatio International Foundation	Ketevan Goguadze/ Assistant Program Manager
VRF	Tamar Dolakidze / Country Director

In case the GAVI Secretariat has queries on this submission, please contact:

Name: Tamar Gabunia.....

Title:Head of the Sectoral Policy Department

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The GAVI Secretariat is unable to return submitted documents and attachments to individual countries. Unless otherwise specified, documents may be shared with the GAVI partners and collaborators.

Government and the Inter-Agency Coordinating Committee for Immunization

The Government of Georgia commits itself to developing national immunization services on a sustainable basis in accordance with the multi-year plan presented with this document.

Districts' performance on immunization will be reviewed annually through a transparent monitoring system. The Government requests that the Alliance and its partners contribute financial and technical assistance to support immunization of children as outlined in this application.

Ministry of Labour, Health and Social Affairs:

Signature: .....

Title: Acting Minister : Irakli Giorgobiani .....

Date: .....

Ministry of Finance:

Signature: .....

Title:Minister Aleksi Aleksishvili.....

Date: 27.02.07

National Coordinating Body: Inter-Agency Coordinating Committee for Immunization:

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We, the members of the ICC met on the …11.01.2007 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

Ø The endorsed minutes of this meeting are attached as DOCUMENT NUMBER: **#2**

Agency/Organisation	**Name/Title**
MoLHSA	Nikoloz Phruidze/ Deputy Minister/ICC Chair
NCDC	Lia Jabidze?head of the Immunization Department / ICC Secretary
NCDC	Paata Imnadze/Director
NCDC	Levan Baidoshvil/ Deputy Director
SUSIF	Vakhtang Surguladze/Deputy Director
MoLHSA	Levan Jugel/ Deputy Minister
PHD	Levan Baramidze/Dead of the Department
UNICEF	Mariam Jashi /Health Program Officer
USAID/Caucasus Humanitarian Response Office	Tamar Sirbiladze / Medical Project Officer
WHO	Rusudan KlimiaShvili/ Liaison Officer
Curatio International Foundation	Mamuka Jibuti/ HIS Programme Officer
VRF	Tamar Dolakidze / Country Director

In case the GAVI Secretariat has queries on this submission, please contact:

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The Inter-Agency Coordinating Committee for Immunization

Agencies and partners (including development partners, NGOs and Research Institutions) that are supporting immunization services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC). The ICC are responsible for coordinating and guiding the use of the GAVI ISS support. Please provide information about the ICC in your country in the spaces below.

Profile of the ICC

Name of the ICC: Interagency Coordination Committee
……

Date of constitution of the current ICC:…26.09.2000……..

Organisational structure (e.g., sub-committee, stand-alone):…
Interagency committee……

Frequency of meetings:…Once a month……..

Composition:

Function	**Title / Organization**	**Name**
Chair	Deputy Minister/ MoLHSA	Nikoloz pruidze _
Secretary	Head of the Immunization Division/ NCDC	Lia Jabidze _
Members	• Deputy Minister/f MoLHSA • Director/ NCDC • Deputy Director/NCDC • Head of the Deoartment/PHD • Deputy Director / SUSIF • Head of the Pectoral Policy and Planning Division/ MoLHSA • Health Program Officer/UNICEF • Country Director/ VRF • Liaison Officer/ WHO • HIS Programme Officer/Curatio International Foundation • Caucasus, Medical Project Officer, Humanitarian Response Office/USAID • Head of the Finance and Budget Department/ MoLHSA • Head of the Health department/ MoLHSA	• Levan Jugeli _ • Paata Imnadse • Levan Baidoshvili • Levan Baramidze • Vakhtang Surguladze • David Kvirkvelidze • Mariam Jashi • Tamar Dolakidze • Rusudan KlimiaShvili • Mamuka Jibuti • Tamar Sirbiladze • Giorgi Kirvalishvili • Tamta Demurishvili ……

Major functions and responsibilities of the ICC:

Establish powerful partnership by means of coordination of input and existing resources (both internal and external funds).

- Ø mobilization and multiplying resources (national and international)
- Ø assess the effectiveness using resources
- Ø revision of needs for additional financing and technical assistance
- Ø stimulating agencies to provide financial support to NIP
- Ø Promoting implementation of strategies and goals of the program;
- Ø Identify needs of the program and provide necessary technical assistance
- Ø Support MoLHSA in implementation, monitoring and evaluation of immunization service;
- Ø Establish transparent and responsible program of immunization
- Ø Provide with information and sufficient feedback at national and sub-national levels.
- Ø Provide help in preparing immunization plans
- Ø monitor and evaluate indices of activity

Major strategies to enhance the ICC's role and functions in the next 12 months:
1. Coordination and monitoring of donor assistance in the field of Immunization; 2. Coordination and supervision of the Immunization Program and cMYP implementation. 3. Reviewing results of implementation annually and propose necessary amendments and recommendations.

Immunization Programme Data

Please complete the immunization fact sheet below, using data from available sources.

Immunization Fact Sheet

Table 1: Basic facts for the year 2005… (most recent; specify dates of data provided)

Population	approximately 4,32 million	GNI per capita	1483.4 $US
Surviving Infants*	46171	Infant mortality rate	19.7/1000
Percentage of GDP allocated to Health	5.4%	Percentage of Government expenditure on Health	33.3%

* Surviving infants = Infants surviving the first 12 months of life

Table 2: Trends of immunization coverage and disease burden
(as per last two annual WHO/UNICEF Joint Reporting Form on Vaccine Preventable Diseases)

WHO/UNICEF Joint Reporting Form is attached as DOCUMENT NUMBER: **#3**

Trends of immunization coverage (in percentage)						**Vaccine preventable disease burden**		
Vaccine		**Reported**		**Survey**		**Disease**	**Number of reported cases**	
		2004…	**2005…**	**2004…**	**2005…**		**2004…**	**2005…**
BCG		90.8	95	NR	ND	Tuberculosis*	6543	6696
DTP	DTP1	88.1	92.1	NR	ND	Diphtheria	12	5
	DTP3	78	82,2	NR	ND	Pertussis	207	165
Polio 3		65.7	81.7	NR	ND	Poilo	0	0
Measles (first dose)		86.5	91.2	NR	ND	Measles		1356
TT2+ (Pregnant women)		NR	NR	NR	ND	NN Tetanus	0	0
Hib3		NR	NR	NR	ND	Hib **	ND	0
Yellow Fever		NR	NR	NR	ND	Yellow fever	1	0
HepB3		63.7	72	NR	ND	hepB sero-prevalence*	279	308
Vit A supplement	Mothers (<6 weeks post-delivery)	NR	NR	NR	ND			
	Infants (>6 months)	NR	NR	NR	ND			

* If available ** Note: JRF asks for Hin meningitis

If survey data is included in the table above, please indicate the years the surveys were conducted, the full title and if available, the age groups the data refers to:
MICS2 Multiple Indicator Cluster Survey 2 were conducted in 2005.
the data refers to <5 years old children

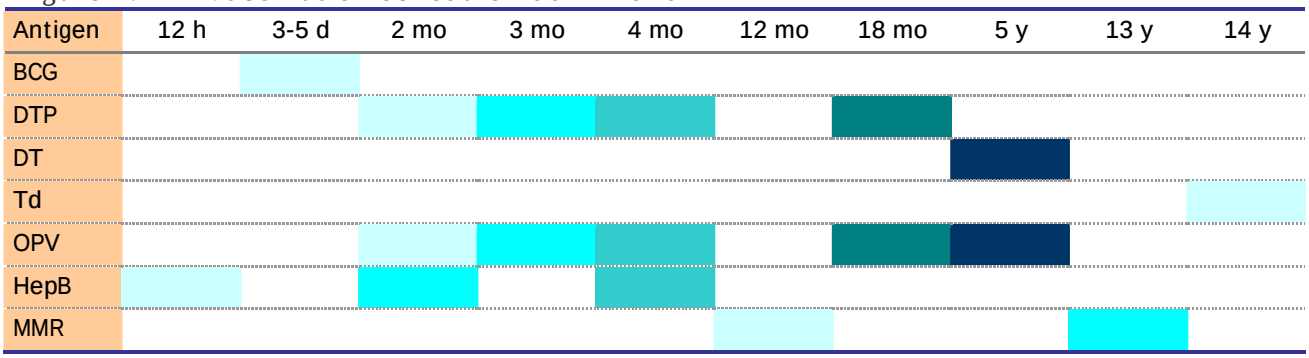
Comprehensive Multi-Year Immunization Plann

Ø A complete copy (with an executive summary) of the Comprehensive Multi-Year Plan for Immunization is attached, as DOCUMENT NUMBER #4.

The following tables record the relevant data contained in the cMYP, indicating the relevant pages.

Table 3: Current Vaccination Schedule: Traditional, New Vaccines and Vitamin A Supplement *(cMYP pages14)*

Figure 1: Vaccination schedule 2007 - 2010



Vaccine *(do not use trade name)*	Ages of administration *(by routine immunization services)*	Indicate by an "x" if given in:		Comments
		Entire country	Only part of the countr y	
BCG(Bacille Calmette-Guérin vaccine)	D 3-5	X		
DPT(Diphtheria and tetanus toxoid with pertussis vaccine)	Mo 2-3-4-18	X		
Hepatitis B vaccine	12 H- Mo2-Mo 4	X		
Oral polio vaccine	Mo 2-3-4-18 -Y5	X		
Measles mumps rubella vaccine	Mo 12-Y 5	X		
DT(Tetanus and diphtheria toxoid children's dose)	Y 5	X		
Td(Tetanus and diphtheria toxoid for older children/adults)	Y14 – every 10 years up to 55	X		
Vitamin A	NR			

Summary of major action points and timeframe for improving immunization coverage identified in the cMYP

Major Action Points (cMYP pages*40-46, Figure 13****)*** and Timeframe

Timeline for the key activies

Key Activities				
	2007	2008	2009	2010

Key Activities				
Service Delivery				
1. District health managers conducting routine and accelerated immunization activities will be trained every year from 2008 to 2010. In turn, they will conduct training of immunization teams in their districts				
2. Reproduce guidelines for planning, implementation, monitoring, evaluation and supervision of immunization activities in first level health institutions.				
3. Prepare and implement macro and micro plans for routine and accelerated immunization activities at each level				
4. Supervisory visits will be conducted by the central or/and district Epidemiologist to high-risk areas and throughout the routine and accelerated immunization activities. Supervision activities will be training focused and on-site feedback will be provided				
5. Training modules for all level EPI managers to conduct standardized district trainings will be provided to each district.				
6. Results of routine and accelerated immunization activities will be analyzed to identify high risk and low performing areas at each level (regional and district). Analysis will cover financial components together with resources utilized.				
7. Evaluation meetings will be held with districts at least 3 times per year				
8. Feedback to districts and related sectors will be provided by the end of each activity				
9. Accelerated immunization activities are planned in the high-risk, out reach area for the period 2008-2010 at least four times per year by the mobilizing team (for OPV)				
10. Conducting training, printing and distributing training materials and forms prior to the activity				
11. Accelerated immunization activities are planned in the high-risk, out reach area for the period 2008-2010 at least four times per year (for measles)				
12. Macro and micro plans for routine immunization activities at each level will be prepared and implemented				
13. Measles and Rubella Elimination and Congenital Rubella Infection Prevention Field Guide will be prepared, printed and distributed to all health care providers.				
14. To prepare and distribute operational guidelines to the regional and districts health managers prior to the campaign,				
15. To train health care staff on objectives of supplemental vaccination, strategies of the elimination program, planning, implementation and evaluation of the campaign, injection safety, and AEFI surveillance,				
16. Training materials and forms will be printed and distributed prior to the activity				
17. Vaccine for supplementary immunization activities will be received at least 2 months prior of activities				
18. Cold chain equipment, vaccine carriers and injection safety equipment will be provided to districts with shortages				
19. Supervisory visits will be conducted by the central or district EPI team to high-risk areas and throughout the supplementary immunization activities. Supervision activities will be training focused and on-site feedback will be provided				
20. To supervise the activity by house to house visits in high-risk areas				
21. To establish AEFI surveillance and monitor AEFI via surveillance				
22. Evaluation meetings will be held with districts and mop-up vaccination will be conducted where needed.				
23. Macro and micro plans for routine and accelerated immunization activities at each level will be prepared and implemented				
24. Through micro planning at the district or local level, map (geographically, socially, culturally) the entire population in order to identify and reach the unreached target populations at least four times a year.				
25. Forms and cards for routine and supplementary immunization activities will be printed and distributed				

Key Activities				
26. Scheduled outreach services will be provided at regular intervals based on the plans provided by the districts				
Advocacy and communications				
27. To conduct a large meeting to obtain support of the Ministries of Education and Finance, the Military, universities, private sector, NGOs, UN organizations and other international organizations and to continue strengthening social mobilization through collaboration with them				
28. Special materials will be developed for parents, teachers and community leaders				
29. To prepare and distribute posters, brochures and TV spots				
30. Surveillance system guidelines for clinicians will be developed and distributed.				
31. Clinicians' knowledge will be updated on the improvements of the program through newsletters to be issued twice a year				
32. Posters and stickers for identification of AFP/polio cases will be developed, printed and distributed in all hospitals and policlinics				
33. Meetings will be held to inform clinicians (pediatricians, neurologists, infectious disease specialists and epidemiologists) and representatives from hospitals, NGO's and Medical associations on AFP surveillance in each region or districts				
34. Produce quality and timely information on the benefits immunization and associated risks, and develop key messages to promote immunization according to national needs and priorities				
35. Develop new ways of using media, including the internet, to build public awareness of the benefits of immunization				
36. To prepare and publicize commercial programs to advocate for MMR vaccination				
37. To prepare and distribute posters and brochures				
38. To prepare educational material for teachers and parents				
39. Mass media will be involved to educate the population				
40. Taking advantage of community structures with regular, consultative meetings with community leaders and representatives				
41. Special materials will be developed for school children, teachers and community leaders				
42. Material development and production for social mobilization: Videotapes 3 spots(3-5 minutes); Posters 5000; Brochures 50000; will be produced, printed and distributed for the public				
43. Training of health personnel from each primary health care unit (approximately 2 day training) by training teams (based on WHO guidelines “Immunization in practice”).				
Surveillance				
44. High risk areas will be identified according to the risk of wild poliovirus circulation and/or AFP surveillance performance				
45. Annual refreshment trainings will be conducted by central training team for regional and/or districts AFP surveillance officers				
46. Criteria for identification of high risk AFP cases (Hot cases) will be highlighted and distributed and AFP cases will be analyzed according to those criteria to take timely action				
47. National Polio Laboratory will be strengthened through training of personnel and procurement of equipment				
48. Supervising surveillance activities on district level by central level				
49. Relevant training material for district EPI managers in charge of AFP surveillance will be developed by central level for each districts				
50. To provide training to health care personnel to improve quantity and quality of measles-rubella surveillance data gathered from hospitals				
51. To gather information on a regular basis at the central level				

Key Activities				
52. To monitor active surveillance performance				
53. To investigate outbreaks and use data to control and prevent outbreaks				
54. To improve case-based surveillance following MR Vaccination Days (Catch up). To report, investigate, confirm (laboratory based) all suspected cases, and to identify imported and indigenous measles viruses based on genetic sequencing.				
55. To update standardized case-investigation forms and use these forms when case-based surveillance is established.				
56. To improve criteria for the selection of cases for laboratory confirmation				
57. To train health care personnel regarding laboratory support				
58. To continue evaluating routine vaccination coverage rates.				
59. To conduct periodic follow-up vaccination campaigns in the identified high risk and low performing areas among children born after the catch-up campaign				
60. EPI field guide will be upgrated, printed and will be provided for each health center				
61. Monitor the quality and performance of coverage and surveillance systems through surveys, monitoring of performance indicators, data quality assessments, and supportive supervision				
62. Routine feedback mechanism will be improved: A newsletter/epidemiological bulletin will be published by the MOH/NCDC and sent to the district level every three months, including latest data and technical information on EPI disease and vaccine				
63. Collaborate with civil authorities in advocating for increased registration of births and deaths				
64. Disease trends in certain areas, and groups will be analyzed every month by each level that are at high risk of illness or death				
65. Demonstrate the impact of immunization services on the clinic, district, regional and national level				
66. AEFI surveillance and management mechanisms will be strengthened, including training workshops and the development of training materials supported for all areas of immunization safety				
67. Revise and update the AEFI guidelines				
Vaccine supply, quality and Logistics				
68. To assess problems in vaccine logistics and injection safety.				
69. Based on the results and recommendations of the logistics assessment and prior to the catch-up campaign, to provide guidelines for waste management and injection safety				
70. Prior to the catch-up campaign, to train health care personnel on safe injection practices				
71. Procure vaccines through UNICEF and/or from WHO pre-qualified manufacturers				
72. Follow policy developed by WHO to ensure quality of vaccines procured - Procedures for assessing the acceptability, in principle, of vaccines for purchase by United Nations agencies				
73. Ensure that vaccine forecasting system accounts for usual inventory, usage patterns, and anticipated needs at central, district and health center level				
74. Provide training on vaccine forecasting, storage, and handling at district and health center levels				
75. Provide training on reducing vaccine wastage at health center level consistent with WHO open vial policy				
76. Conduct post training evaluation of level of understanding of open vial policy and wastage reduction practices				
77. provide additional training as needed and at least annually				

Key Activities				
78. Undertake a review and provide necessary equipment at national, regional, district, and health center level to maintain cold chain: refrigerators, freezers, generators and spare parts				
79. Obtain donor support to purchase equipment and supplies to maintain cold chain for republic, central, districts, and health centers				
80. Conduct training at district and clinic level on appropriate procedures for storing vaccines and monitoring cold chain				
81. Conduct post-training evaluation of level of understanding of vaccine storage and cold chain policies				
82. Supervision by cold chain managers at each level periodically				
83. Sub-national level cold stores will be monitored and required equipment will be provided to regions lacking identified standards				
84. Replacement of old and broken cold chain equipment at regional and health center level will take place in stages during a period of four years.				
85. Refreshment training for cold chain managers will be conducted once a year				
86. Cold chain stickers, booklets, posters for administration of vaccine and cold chain and a poster showing various stages of VVMs will be developed, printed and distributed to each health center				
87. To conduct a survey to assess of the quality of injection for evidence of risks to patient, provider & community				
88. Advocacy and communication activities for the sustained use of Disposable and AD syringes and safety boxes				
89. Develop training materials/guidelines and train health personnel for increased awareness/knowledge about injection safety				
90. Monitor injection safety through AEFI surveillance				
91. Safety boxes will be used for collection and destruction of used injectables will be monitored				
Program management				
92. Steering committee (ICC) will assess the program outcomes and submit annual progress reports and plans to the Minister to obtain his support and endorsement				
93. Coordination meeting for the regional and district directors (governors and mayors) will be conducted for routine and accelerated immunization activities				
94. Training material for health care staff will be produced,				
95. Reduce the drop-outs rate through improved management, defaulter tracing, and social mobilization and communication during immunization contacts, and avoid missed opportunities to vaccinate				
96. National plan of action for measles and rubella elimination will be prepared by the end of 2008-9				
97. To conduct a meeting Measles and Rubella elimination plan will introduce to all level health managers and obtain consensus on the plan				
98. With the leadership of the Minister of Health, to introduce measles and rubella elimination plan to the President and Prime Minister and to obtain their full support.				
99. Coordination meeting for the regional and district directors (governors and mayors) will be conducted for Measles and Rubella elimination supplementary immunization activities				
100. To introduce the plan of action for measles and obtain support of different sectors, to conduct a meeting for the Ministries of Education and Finance, the Military, private sector, NGO's, UN and other international organizations				
101. To print the measles plan of action and distribute to a large group of audience				
102. Coordination meeting with the leadership of governors, to obtain intersectoral support at the regional and district level.				

Key Activities				
103. To conduct a large meeting to obtain support of the Ministries of Education and Finance, the Military, universities, private sector, non-governmental organizations, UN organizations and other international organizations and to continue strengthening social mobilization through collaboration with them				
104. Steering committee (ICC) will assess the program outcomes and submit annual progress reports and plans to the President and Prime Minister to obtain their support and endorsement				
105. National cMYP will be printed and widely disseminated to the parliamentarians, governors, other related government members and organizations, health managers, international and non-governmental organizations (NGOs)				
106. A workshop will be held to introduce the cMYP to all level health managers and EPI managers. In turn, they are expected to prepare their level plans of actions				
107. Workshop with regional governors will be held every year: There will be one day workshop with governors to improve the political support and intersectoral coordination at the regional level on EPI.				
108. A training team will be established in each district and central level. Each training team will be composed of approximately 2 persons (to be defined according to the number of health personnel in the districts).				
109. Training team will be responsible for the development of yearly plans, implementation, monitoring, evaluation and supervision of EPI activities including public relations, training, intersectoral coordination etc.				
110. A manual and checklist will be developed for training teams for supervision and standardization of training				
111. Central and district level EPI team staff will provide on-site support to district Health centers for planning and supervision of routine vaccination services.				
112. Strengthen the managerial skills of national and district immunization providers and managers and develop and update supervisory mechanisms and tools.				
113. New manpower will be recruited at the each level for the EPI team and required equipment will be provided for their effective performance				
114. Improve coverage monitoring of vaccines and other linked health interventions and the use of information at district and local levels through strengthening human resource capacity, monitoring the quality of data, improved tools for data compilation, feedback and supervision.				
115. Regularly review indicators of performance in district level, including risk status for vaccine-preventable diseases and use surveillance and monitoring data to advocate for improved access to, and quality of immunization.				
116. Training for to encourage the analysis and use of data collected by health workers at delivery level				
117. Steering committee (ICC) will meet quarterly every year and meetings will be held every six months for the rest of the planned period				
118. Duties, powers and responsibilities at each level EPI team will be redefined in accordance with Health Sector Reforms				
119. Participate actively in collective efforts to shape sector wide policies and programs, while preserving the central role of immunization in the context of sector wide policies and programs				
120. Through regular analysis of district-wide data, document key factors for the success and failure of immunization activities and share these findings with others involved in health systems development.				
121. Provide timely funding, logistic support and supplies for program implementation in every district				
122. Reduce the number of immunization drop-outs (incomplete vaccination) through improved management, defaulter tracing, and social mobilization and communication during immunization contacts, and avoid missed opportunities to vaccinate.				

Key Activities				
123. Existing guidelines for micro planning, reaching the unreached and reducing drop-outs (improving utilization) at health facility and district level will be revised by central team				
124. Relevant training materials for clinicians and health staff will be developed to reducing risks of non-vaccination due to false contraindications and missed opportunities				
125. To hold working meeting with the policy makers and technical decision makers				
126. Amount of vaccine, injectables, safety boxes and equipment required will be calculated annually and all expendables will be procured and distributed based on plan developed				
127. Training of cold chain managers on vaccine logistics, safe immunization and cold chain				
128. Revision/development of guidelines and training manuals				
129. To prepare technical documents and training materials (Preparation, adaptation, translation, printing and distribution of technical documents and training materials, based on related WHO documents)				
130. To train managers (conduct EPI Mid-Level Management (MLM) training course for district immunization managers)				
131. To translate and adopt the WHO-UNICEF Effective Vaccine Store Management (EVSM) Initiative				
132. To conduct vaccine store management and immunization safety training course in 66 districts for 2-3 days				
133. To calculate the future resource requirements for vaccines and injection supplies				
134. Establishment of the new system (Logistic Management Information System for EPI): The system to be established has to include the flow of logistics at central, as well as the regional cold stores. Software will to be adopted and translated in 2008 and system users at central and regional level will be trained				

Table 4: Baseline and annual targets *(cMYP pages 25-40)*

Number	**Baseline and targets**							
	Base-year	Year of GAVI application	Year 1 of Program	Year 2 of Program	Year 3 of Program	Year 4 of Program	Year 5 of Program	Year 6 of Program
	2005…	2007…	2008	2009…	2010…	2011…	20…	20…
Births	47022	47500	48000	48000	48000	48000		
Infants' deaths	851	851	851	851	851	851		
Surviving infants	46171*	46649	47149	47149	47149	47149		
Pregnant women	47246	48200	48200	48200	48200	48200		
Infants vaccinated with BCG	46388	46400	46400	46400	46400	46400		
BCG coverage*	98,6	99	99	99	99	99		
Infants vaccinated with OPV3	36528	39275	40147	41460	41460	41460		
OPV3 coverage**	83.7	90	92	95	95	95		
Infants vaccinated with DTP3***	36725	39275	40147	41460	41460	41460		
DTP3 coverage**	84	90	92	95	95	95		
Infants vaccinated with DTP1***	40865	42660	42660	42660	42660	42660		

Wastage[1] rate in base-year and planned thereafter		1,28	1,18	1,18	1.18	1,18	1,18		
Infants vaccinated with **3rd dose** of …HEPB……..		31957	36970	39150	41325	41325	41325		
…HEPB……. Coverage**		73,1	85%	90%	95%	95%	95%		
Infants vaccinated with **1st dose** of ……HepB……..		45237 92	97.0	46470	46470	46470	46470		
Wastage[1] rate in base-year and planned thereafter		1,21	1,18	1,18	1,18	1,18	1,18		
Infants vaccinated with Measles		39870	41135	41135	41135	41135	41135		
Measles coverage**		90,7	95	95	95	95	95		
Pregnant women vaccinated with TT+		NR	NR	NR	NR	NR	NR		
TT+ coverage****		NR	NR	NR	NR	NR	NR		
Vit A supplement	Mothers (<6 weeks from delivery)	NR	NR	NR	NR	NR	NR		
	Infants (>6 months)	NR	NR	NR	NR	NR	NR		

* The official rate of surviving infants is 44326 (based on annual (2005) statistical reports), additional 1843 infants, which where born in 2005, were registered later (in 2006). So the real number of surviving infants is 46171.

** JRF, and consequently the data in Table 2, was prepared in April, 2005. By this time these data were not fully accurate. The accurate data is shown in Table 4. This accounts for the difference between immunization coverage rates shown in Table 2 and Table 4.

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants
*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women

Please indicate the method used for calculating TT and coverage:N/A

Table 5: Estimate of annual DTP drop out rates

Number	**Actual rates and targets**							
	2005 …	**2007 …**	**2008 …**	**2009 …**	**2010 …**	**2011 …**	**20…**	**20…**
Drop out rate [(DTP1 - DTP3) / DTP1] x 100	10,1%	8%	6%	5%	5%	5%		

[1] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check **table** a after Table 7.1.

Table 6: Summary of current and future immunization programme budget *(cMYP pages 67…….)*

Cost Category		Expenditures	Future Resource Requirements				
		2005	2007	2008	2009	2010	Total 2007 - 2010
Routine Recurrent Cost		**US$**	**US$**	**US$**	**US$**	**US$**	**US$**
	Vaccines (routine vaccines only)	$822,000	$517,621	$519,942	$521,177	$526,898	$2,085,639
	Traditional vaccines	$225,647	$165,958	$164,132	$161,214	$161,595	$652,899
	New and underused vaccines	$596,353	$351,663	$355,810	$359,963	$365,303	$1,432,739
	Injection supplies	$52,119	$76,021	$77,133	$78,175	$79,219	$310,549
	Personnel	$96,275	$105,903	$116,493	$128,143	$140,957	$491,496
	Salaries of full-time NIP health workers (immunization specific)	$66,177	$72,795	$80,074	$88,082	$96,890	$337,840
	Per-diems for outreach vaccinators/mobile teams	$0	$0	$0	$0	$0	$0
	Per-diems for supervision and monitoring	$30,098	$33,108	$36,419	$40,061	$44,067	$153,655
	Transportation	$51,210	$38,436	$24,925	$25,423	$25,932	$114,715
	Fixed site and vaccine delivery	$44,883	$24,436	$24,918	$25,416	$25,924	$100,694
	Outreach activities	$6,327	$14,000	$7	$7	$7	$14,022
	Maintenance and overhead	$183,891	$185,479	$189,189	$193,418	$195,493	$763,579
	Cold chain maintenance and overheads	$96,432	$96,272	$98,197	$100,161	$106,062	$400,692
	Maintenance of other capital equipment	$5,258	$5,364	$5,471	$6,026	$455	$17,315
	Building overheads (electricity, water…)	$82,200	$83,844	$85,521	$87,231	$88,976	$345,572
	Short-term training	$77,330	$141,796	$116,561	$62,998	$58,737	$380,092
	IEC/social mobilization	$30,729	$215,200	$85,404	$87,112	$88,854	$476,570
	Disease surveillance	$111,927	$4,080	$4,162	$37,937	$4,330	$50,508
	Programme management	$177,714	$62,659	$135,538	$115,072	$124,301	$437,571
	Other routine recurrent costs	$21,810	$28,169	$24,970	$12,734	$12,989	$78,863
	Subtotal Recurrent Costs	**$1,625,006**	**$1,375,366**	**$1,294,316**	**$1,262,190**	**$1,257,710**	**$5,189,582**
Routine Capital Cost							**$0**
	Vehicles	$35,180	$0	$0	$0	$0	$0
	Cold chain equipment	$186,190	$68,834	$0	$0	$44,185	$113,019
	Other capital equipment	$1,914	$0	$0	$8,914	$0	$8,914
	Subtotal Capital Costs	**$223,284**	**$68,834**	**$0**	**$8,914**	**$44,185**	**$121,933**
Campaigns							**$0**
	MMR	$0	$0	$4,109,353	$0	$0	$4,109,353
	Vaccines and supplies	$0	$0	$2,594,653	$0	$0	$2,594,653
	Other operational costs	$0	$0	$1,514,700	$0	$0	$1,514,700
	Subtotal Campaign Costs	**$0**	**$0**	**$4,109,353**	**$0**	**$0**	**$4,109,353**
Other Costs							**$0**
	Shared personnel costs	$939,297	$1,033,746	$1,137,120	$1,250,832	$1,375,915	$4,797,614
	Shared transportation costs	$0	$0	$0	$0	$0	$0
	Construction of new buildings	$0	$0	$0	$0	$0	$0
	Subtotal Optional	**$939,297**	**$1,033,746**	**$1,137,120**	**$1,250,832**	**$1,375,915**	**$4,797,614**
GRAND TOTAL		**$2,787,586**	**$2,477,945**	**$6,540,789**	**$2,521,936**	**$2,677,810**	**$14,218,480**
	Routine (Fixed Delivery)	**$2,781,259**	**$2,463,945**	**$2,431,062**	**$2,521,571**	**$2,677,446**	**$10,094,024**
	Routine (Outreach Activities)	**$6,327**	**$14,000**	**$374**	**$365**	**$364**	**$15,104**
	Campaigns	**$0**	**$0**	**$4,109,353**	**$0**	**$0**	**$4,109,353**

Table 7: Summary of current and future financing and sources of funds *(cMYP page 54.)*

Funding gaps by type and source of financing and years (*without* shared cost and financing)

	2007	2008	2009	2010	Total
Total resource requirement	1,488,680	5,519,249	1,378,568	1,358,067	9,744,564
Total Secured Financing	1,372,033	1,140,675	1,021,379	1,052,295	4,586,381
Government	515,285	625,340	1,021,379	968,036	3,130,039
Others	856,749	515,335	0	84,258	1,456,342
Funding gap	116,646	4,378,574	357,190	305,772	5,158,182
	7.8%	79.3%	25.9%	22.5%	52.9%
Total Secured and Probable Financing	1,405,799	5,302,282	1,261,456	1,340,525	9,310,062
Government	515,285	4,584,692	1,079,264	1,074,875	7,254,116

Immunization Services Support (ISS)_ N/A

Please indicate below the total amount of funds you expect to receive through ISS:

Table 8: Estimate of fund expected from ISS

	Baseline Year	Current Year *	Year 1**	Year 2**	Year 3**	Year 4**	Year 5**
DTP3 Coverage rate							
Number of infants reported / planned to be vaccinated with DTP3 (as per table 4)							
Number of *additional* infants that annually are reported / planned to be vaccinated with DTP3							
Funds expected ($20 per additional infant)							

* Projected figures
** As per duration of the cMYP

If you have received ISS support from GAVI in the past, please describe below any major lessons learned, and how these will affect the use of ISS funds in future.

Please state what the funds were used for, at what level, and if this was the best use of the flexible funds; mention the management and monitoring arrangements; who had responsibility for authorising payments and approving plans for expenditure; and if you will continue this in future.

Major Lessons Learned from Phase 1	Implications for Phase 2
1.	
2.	
3.	

4.	
5.	
6.	

If you have not received ISS support before, please indicate:

a) When you would like the support to begin:

b) When you would like the first DQA to occur:

c) how you propose to channel the funds from GAVI into the country:

d) how you propose to manage the funds in-country:

e) who will be responsible for authorising and approving expenditures:

- Please complete the banking form (annex 1) if required

Health Systems Strengthening Support (HSS)

Please provide details of the most recent assessments of the health system in your country (or significant parts of the system) that have been undertaken and attach the documents that have a relevance to immunization (completed within three years prior to the submission of this proposal).

Ø Please also attach a complete copy (with an executive summary) of the Comprehensive Multi-Year Plan for Immunization, as DOCUMENT NUMBER # 4.

Recent assessments, reviews and studies of the health system (or part of the system):

Title of the assessment	Participating agencies	Areas / Themes covered	Dates	DOCUMENT NUMBER
1. Georgia: Review of the Health Sector Report No. 29413 -GE	Human Development Sector Unit Europe and Central Asia Region (WB); EU Ministry of Labour, Health and Social Affairs, Government of Georgia	1.Status and Trends in Health Indicators; 2. Demand for Health Services; 3. Supply of health care services; 4. Human Resources in Health; 5. Organization and Management in the Health Sector; 6. Health Care Financing.	June 2004	#5
[1] Immunization Program Management Review, Georgia.	WHO Regional Office for Europe; UNICEF Georgia, US Centres for Disease Control and Prevention (Atlanta, USA) and World Bank together with counterparts (from the PHD and NCDC)	1. Management, Coordination and Service Delivery; 2. Immunization Strategies, Policies and Schedules; 3. Immunization Coverage and Monitoring; 4. Disease surveillance; 5. Immunization Quality and Safety; 6. Advocacy and Communication; 7. Financing and Sustainability (together with health system issues).	17-27 July 2006	#6

The major strengths identified in the assessments:

	Strengths
1.	Vaccine Security - ensuring continuous and non-interrupted provision of vaccine/syringe supplies for routine EPI and SIAs (NIDs, sub-NIDs, mop-ups);
2.	Improvement and maintenance of the overall immunization coverage for the six major antigens. HepB vaccine coverage remains modest due to recent introduction of the new antigen;
3.	Polio Free Certification achieved - In July 2002 Georgia among the other countries of the European region has been declared as the Polio Free zone;
4.	Diphtheria incidence reduced from 7.9 per 100,000 population in 1995 to 0.6 in 2001;
5.	Measles incidence rates reduced from 13.27 in 1994 to 4.6 per 100,000 in 2001;
6.	GoG starting implementation of Vaccine Independent Initiative – 20 percent Share for 2003 NIP;
7.	Formation of strong policy framework for improving quality performance in NIP implementation;
8.	Launching HIS initiative for immunization project management (GoG/USAID/Curatio/UNICEF

The major problems with relevance to immunization services identified in the assessments:

	Problems (obstacles / barriers)
1.	Lack of medical professionals and their low motivation in districts with low immunization coverage
2.	Low coverage of population in hard to reach (usually remote mountainous areas) with public health services including immunization
3.	Inadequate (low) level of analysis of immunization related information at the health care provider and public health management levels
4.	Knowledge and skills of medical professionals at the PHC level is not enough to ensure high immunization coverage
5.	The guidelines on post-vaccination complications has not been finished and corresponding trainings of physicians in medical organizations has not been conducted
6.	Low capacity of public health services necessary to ensure efficient and effective delivery of public health services including immunization

The major recommendations in the assessments:

	Recommendations
1.	**Management, Coordination and Service Delivery** 1. Re-emphasise high priority to Communicable Diseases and Immunization by MoLHSA, in the context of health sector reform 2. Use new multi-year plan exercise to focus on priority activities, using this review recommendations 3. Maintain Interagency Coordination Committee (ICC) as a pro-active body, to lead implementation of the review recommendations 4. Advocate for and support proper staff allocations, especially in low performing districts 5. Strengthen training of nurses and physicians on immunization practices through local courses and supportive supervision
2.	**Immunization Strategies, Policies and Schedules** 6. Start and gradually increase the planning and implementation of outreach sessions in low performing districts and for underserved population

	7. Conduct assessment/analysis in the low performing districts to find out the main determinants for the lack of performance and motivation, and further adjust immunization delivery strategies 8. Move forward the Reach Every District (RED) main strategies, especially supportive supervision, linking services with communities and planning and management of resources 9. Conduct special work with neuropathologists, to drastically reduce false contraindications 10. Strengthen surveillance for measles, rubella, CRS, diphtheria and AFP and start macro-planning for measles/rubella supplementary activities 11. Conduct disease burden studies to assess the need for new vaccine introduction (Rotavirus)
3.	**Immunization Coverage and Monitoring** 12. Give priority focus on regions with districts reporting less than 80% DPT3 - Priority review by ICC and meetings with identified regions/districts - Develop district specific plans of action with regular monitoring arrangements 13. Include priority actions for targeted districts/localities in new "Costed Multi Year Plan", with specific focus on first 12 months activity (2007) 14. Improve analysis of coverage at health facility and rayon level - Use "left out", "dropped out" and "late" for consistent target group analysis 15. Improve timeliness of immunization: e.g. better tracking of newborn from birth at maternity house to first contact at local health facility 16. Improve "Geovac" MIS e.g. further develop software to permit comparison with previous years data 17. Improve documentation of immunization
4.	**Disease Surveillance** 18. Refine overall surveillance management 19. Strengthen the surveillance infrastructure 20. Ensure analysis and use of surveillance data for programmatic purposes 21. Provide additional training for staff on surveillance issues
5.	**Immunization Quality and Safety** 22. Reinforce and monitor Safe Immunization Practices and AEFI 23. Strengthen vaccine management 24. Address equipment issues
6.	**Advocacy and Communication** 25. Ensure that the communication-for-behaviour-impact (COMBI) plan for 2006-07 is launched as early as possible, with a detailed action plan 26. Ensure that communication components are included in: 27. Prioritize improving staff motivation in relation to communication efforts and in the context of discussions on performance-based incentives
7.	**Advocacy and Communication** 28. Ensure that the communication-for-behaviour-impact (COMBI) plan for 2006-07 is launched as early as possible, with a detailed action plan 29. Ensure that communication components are included in: 30. Prioritize improving staff motivation in relation to communication efforts and in the context of discussions on performance-based incentives
8.	**Financing and Sustainability** 31. Maintain the same level of commitment and partnership in advocating legislative and budgetary changes for the NIP

	32. Develop legislative mechanisms to ensure that necessary funds are earmarked at the sub-national levels for the immunization services (outreach sessions, incentives, equipment, maintenance) 33. Forecast national immunization budget increases in the FSP, and reflect in relevant budget planning tools–MTEF, annual state programme budgets- as vaccine prices are expected to grow and combination vaccines to be introduced

Progress with implementation of the recommendations of the assessment reports:

Recommendations	Progress
1. **Management, Coordination and Service Delivery:** 1.1. Health prioritization: Re-emphasise high priority to Communicable Diseases and Immunization by MoLHSA, in the context of health sector reform	1.1. These priorities are icluded in the National Policy and strategy (including Primary Health Care Development Masterplan);
1.2. Strategic planning: Use new multi-year plan exercise to focus on priority activities, using this review recommendations	1.2. cMYP is developed, priority activities are integrated into the MTEF.
1.3. Coordination and Partnership: Maintain Interagency Coordination Committee (ICC) as a pro-active body, to lead implementation of the review recommendations	1.3. Interagency Coordination Committee (ICC) is maintained, the annual action plan of ICC is prepared.
1.4. Human resources: Advocate for and support proper staff allocations, especially in low performing districts	1.4. The motivation mechanisms are integrated into the state ambulatory program 2007 and the state budget.
1.5. Capacity building and training: Strengthen training of nurses and physicians on immunization practices through local courses and supportive supervision	1.5. In 2007 UNICEF-VRF will provide Capacity building and training support, from 2008 until 2010 GAVI-HSS will support the development of immunization specific refresh training.
2.Immunization Strategies, Policies and Schedules: 2.1. Immunization delivery strategy: Move forward the Reach Every District (RED) main strategies, especially supportive supervision, linking services with communities and planning and management of resources	2.1. In 2007 support for Supportive supervizion will be provided by UNICEF-VRF, in 2008 - 2010 by GAVI HSS. Gradulally the government will take over this function.

2.2. Disease control strategy: Strengthen surveillance for measles, rubella, CRS, diphtheria and AFP and start macro-planning for measles/rubella supplementary activities	2.2. In February 2007 Implementation plan for mass MR vaccination campaign (2008) was prepared by the WHO and local experts with the support of the UNICEF and VRF.
2.3. New vaccines introduction: Conduct disease burden studies to assess the need for new vaccine introduction (Rotavirus)	2.3. From November 2006 with WHO support, the government started a 2-year pilot project (in Tbilisi) _ `Epidemic Surveillance on the Rota Viral Diarrhoea ", to assess the need for introducing a new vaccine (Rotavirus).
3. Immunization Coverage and Monitoring Give priority focus on regions with districts reporting less than 80% DPT3 Priority review by ICC and meetings with identified regions/districts; Develop district specific plans of action with regular monitoring arrangements; Include priority actions for targeted districts/localities in new "Costed Multi Year Plan", with specific focus on first 12 months activity (2007); Improve analysis of coverage at health facility and rayon level; Use "left out", "dropped out" and "late" for consistent target group analysis; Improve timeliness of immunization: e.g. better tracking of newborn from birth at maternity house to first contact at local health facility; Improve "Geovac" MIS e.g. further develop software to permit comparison with previous years data; improve documentation of immunization	3.In 2007-2008 paralel to the reorganization of public health entities (at disctrict/rayon level) installation and training in using of « Geovac » software is planned. The software will be used to obtain and assess the results of MR mass vaccination campaign (2008).
4. Disease Surveillance -Refine overall surveillance management; -Strengthen the surveillance infrastructure; -Ensure analysis and use of surveillance data for programmatic purposes; -Provide additional training for staff on surveillance issues.	4.In 2007-2008 paralel to the reorganization of public health entities (at disctrict/rayon level) installation and training in using of « Geovac » and « Geoepid » software is planned. In addition to routine immunization the software will be used to obtain and assess the results of MR mass vaccination campaign (2008).
5. Immunization Quality and Safety -Reinforce and monitor Safe Immunization Practices and AEFI; -Strengthen vaccine management- -Address equipment issues.	5._The government's health policy implies purchase and import of only WHO pre-qualified vaccines. In 2006 the rule of importing humanitarian vaccines was made more liberal. The license for importing humanitarian vaccines is given by an ad-hoc commission of the MoLHSA;

	-In 2005 the VRF provided Georgia with 144 refrigerators together with MK 144 voltage stabilisers and 256 cold boxes. In 2007 the UNICEF provided Georgia with 100 refrigerators. At present these equipments are being distributed among primary health care centres.
6. Advocacy and Communication -Ensure that the communication-for-behaviour-impact (COMBI) plan for 2006-07 is launched as early as possible, with a detailed action plan -Ensure that communication components are included in: Ministerial Decree (#122/n) In-service training, particularly at service delivery level PHC protocols/guidelines under development Pre-service university curricula - Prioritize improving staff motivation in relation to communication efforts and in the context of discussions on performance-based incentives	6. The preparatory activities of COMBI plan began in November 2006. Submission of the plan is planned on 27 February. The plan includes immunization propaganda issues as well as incentives for medical personnel (gifts, diplomas, etc). The plan will be finished by October 2007.
7. Financing and Sustainability -Maintain the same level of commitment and partnership in advocating legislative and budgetary changes for the NIP -Develop legislative mechanisms to ensure that necessary funds are earmarked at the sub-national levels for the immunization services (outreach sessions, incentives, equipment, maintenance) -Forecast national immunization budget increases in the FSP, and reflect in relevant budget planning tools–MTEF, annual state programme budgets- as vaccine prices are expected to grow and combination vaccines to be introduced	7. The increase of the NIP's budget and the share of the government's responsibilities in it is reflected in the budgets of relevant state programs 2007 and MTEF 2007- 2010.

Components or areas of health systems that are yet to be reviewed (with dates if planned):

	Component or area to be reviewed (with review month / year if planned)
1.	**Review of the Health Sector of Georgia. WB ,** will finished by 1st quarter of 2007
2.	**Assessment of the Health sector of Georgia. EU, will finished by 1st of March**, 2007**.**

Proposed GAVI Health Systems Strengthening Support

In the two boxes below, please give:

(i) a description of the HSS proposal for your country including the objective, the main areas that GAVI HSS will support, how your proposal links to the core themes identified by GAVI, the major action points and activities, and the expected timeframe for success; and

(ii) a justification for why these areas and activities are a priority for strengthening capacity, and how the proposed activities will achieve sustained or increased immunization coverage.

Ø Please give a summary below, and attach the full document outlining the proposed programme of activities and justification for support (stand-alone document or the relevant parts of existing documents or strategies, e.g. Health Sector Strategic Plan).

The proposed program is attached as Document #7

Description

Program Objectives

The overall goal of the program is to contribute to the increase in immunization coverage and its sustainability through the provision of support to ongoing health reforms at the national and rayon levels.
The following specific objectives (outcomes) are proposed:
1. Motivation of the medical personnel (necessary to ensure planned (desired) immunization coverage rates) is institutionalized
2. Increased professional skills of public health specialists at the rayon level
3. Supportive supervision introduced at the rayon and health facility levels
4. Increased skills of PHC medical personnel (doctors and nurses) related to immunization
5. Improve capacity of Public Health institutions to deliver services

Key health system functions to be supported

The proposed program supposes to support the following key health system functions:

1 Human resources – increased performance of professionals through improving knowledge and skills of:
   - local (district) level public health specialists on issues such as management and training, vaccination techniques, planning immunization sessions, reporting, vaccine preventable infections, vaccines, vaccination safety, post-vaccination complications (their surveillance and reporting), vaccination contraindications, medical waste management, logistics, medical/health statistics and data collection/registration/reporting, etc.
   - immunization service providers on issues such as vaccine characteristics, vaccination techniques, contraindications to vaccination, vaccination session planning, detection and management of adverse reaction of vaccination, injection safety, medical waste management, surveillance and reporting

2 Service delivery – increased performance and quality of health care providers through increasing performance of medical personnel/health care organizations in charge of vaccination

3 Management – improved effectiveness and efficiency through:
   - introducing supportive supervision

- strengthening managerial capacity
- streamlining the supply of vaccines and injection materials and ensuring smooth operation of cold chain

Major action points and activities

The following activities are proposed to achieve the aforementioned objectives:

1.	Increase the motivation of medical personnel:
•	Integrate the motivation mechanisms into the state health programs (and ultimately into the MTEF related policy instruments such as the state budget, contracts between the state purchaser and health care providers)
•	Assess an impact of the motivation mechanisms on the effectiveness and efficiency of immunization services through qualitative and quantitative surveys
•	Provide recommendations to the policy maker on scaling up immunization related motivation mechanisms covering other public health interventions
•	Motivation mechanisms for the delivery of public health services are integrated in PHC state health programs
2.	Increase knowledge and skills of public health specialist at the local (district) level:
•	Adapt, formalize and reflect in the public health specialist curriculum WHO recommendations ("Increasing Immunization Coverage at the Health Facility Level", WHO/V&B/02.27)
•	Develop, endorse and integrate guidelines on post-vaccination reactions and complications in the training curriculum
•	Develop, endorse and integrate guidelines on supportive supervision into the training curriculum
•	Develop, endorse and integrate guidelines on essential management and training skills into the training curriculum
•	Plan and organize the trainings
•	Develop a package of training materials
•	Public the training materials
•	Carry out the trainings
3.	Introduce supportive supervision at the district level public health departments and primary health care providers:
•	Develop an implementation plan and organize the supportive supervision with reporting formats and submission (communication) schedule
•	Develop a state health program (or a module to be integrated in existing one) with clear contracting/financing mechanisms
•	Provide co-financing of the supportive supervision with gradual take over by the government
4.	Increase knowledge and skills of medical personnel of primary health care providers:
•	Develop an immunization specific training curricula for PHC medical personnel and integrate into the overall PHC training program
•	Integrate WHO recommendations (WHO/V&B/02.27) and guidelines for AEFI and essential managerial skills into the training curriculum
•	Develop guidelines for waste management, endorse and integrate into the training curriculum
•	Plan and organize the trainings
•	Develop a package of training materials
•	Public the training materials
•	Carry out the trainings
5.	Improve capacity of Public Health institutions to deliver services
•	Develop district level vaccine supply and stock management plans
•	Purchase a track with cross-country capacity and ensure timely delivery of vaccines to remote (mountainous) areas

Justification

Program rationale

A national task force composed of local experts and representatives of the MoLHSA was guided by the major trends in health care system reform and findings of system assessments conducted by development partners for the formulation of HSS options. Major weaknesses had been identified that affect an overall performance of the health system and have direct or indirect impact on sustainability and level of the immunization coverage in the country. These weaknesses/challenges were mostly related either to inadequately developed physical infrastructure or human resources (including organization/management issues). Considering the ongoing health care system reform initiatives and expected excessive investments in physical infrastructure (by the GoG and development partners such as the World Bank, EU, DfID) it was decided to focus on and analyze human resource related challenges. The task force also favored the investment of GAVI HSS support funds in human resources at the local (district) and primary health care provider levels because it could significantly improve the performance and sustainability of the system.
HSS support options developed by the task force and presented to decision makers. They conducted a thorough assessment of these options against 9 major criteria. Results of the assessment are summarized in Figure 3, page 22 of GAVI HSS program).

The following HSS support options were defined based on the situation analysis and in response the problem statement:

1. Increase motivation of PHC staff to achieve immunization coverage targets
2. Increase capacity for outreach services
3. Increase professional skills of public health specialists (at the district level)
4. Increase managerial capacity of district public/health authorities for supportive supervision
5. Increase PHC medical teams' professional skills related to immunization
6. Improve epidemiologic statistical systems performance
7. Improve capacity of Public Health institutions to deliver services

There is a master plan for rehabilitation of physicla infrastructure including PHC facilities and hospitals that is financed by the Government of Georgia, the WB supported Georgia Health Reform Project II, EU/EC, DfiD and USAID.

The master plan covers a period of 2007-2011 and meets critical needs for the delivery of medical services (from fixed sites). Therefore allocation of the GAVI HSS support funds to the rehabiliation of physical infrastrure was considered unreasonable. The only exception was the purchase a 4WD track as far as transportation issues (other than ambulances) are not addressed by the master plan. The track will be used by public health organizations for the supply of goods from central to district levels in remote mountaneous areas (all year around) such as desinfection/deratization supplies, drugs and other commodities for the prevention of malaria, vaccines and injection supplies, etc. It is believed that availability of such a vehicle will minimize shortages of supply because of natural (climatic) conditions.

The GAVI HSS support is intended to be invested in human resources through the improvement of professional skills and introduction of new standards/methodologies. It is planned to conduct a series of trainings to PHC medical staff including doctors, nurses and midwifes, as well as to public health specialists in each district (2 specialists per district in average).

2-day trainings are envisaged for family doctors and nurses in order to improve their skills and knowledge related to immunization services and basic management issues.

The training curriculum will cover issues that are not reflected adequately in PHC specialist retraining programs (implemented under the PHC reform). For instance, only 8 hours are devoted to the immunization component of a comprehensive training program consisting of 7 modules for doctors (940 hours) and 18 modules for nurses (816 hours).

The trainings will be conducted at the district level by local public health specialists with the support by national public health specialists. The "catch-up" training courses will be delivered for those PHC specialists who already have graduated the retraining program under the PHC reform. Gradually, from 2008 year the GAVI HSS supported training program will be integrated into the mainstream human development program of the PHC reform. The curriculum/training under the GAVI HSS support program will specifically cover the following issues: vaccination, vaccine characteristics, safe immunization, contraindications, medical waste management, logistics, reporting forms and procedures, vaccination techniques, planning of immunization sessions, post-vaccination complications and their management.

The need in training of public health specialists is prompted by the necessity to upgrade their level of knowledge and managerial skills related to the issues such as training/mentoring, supportive supervision, vaccination techniques, planning of immunization sessions, injection safety, post-vaccination complications, disease surveillance, medical waste management and logistics.

UNICEF supported to organize mobile teams in 2001-2003 and to provide immunization services in some hard to reach areas with the lowest immunization coverage. Unfortunately the provision of outreach services was interrupted and there are still pockets with children missing vaccination. Despite the obvious direct impact on immunization coverage this option was rejected in HSS proposal because of two reasons: low sustainability and relatively low impact on health system strengthening. The government intends to recommence the provision of services initially through ISS support with gradual take over by state health programs.

Supportive supervision is an essential management activity within human resource management: it impacts both the performance of individual staff and the organization as a whole and ultimately health outcomes. Supervision assists in planning or refining activities, organizing tasks, and monitoring performance. It is necessary for the staff to be aware of all standards, performance expectations, and tasks in order to keep the MOLHSA running efficiently. Staff also needs ongoing support and feedback with regard to their work.

Supportive supervision advocates for the building of a relationship that fosters support and encouragement from the viewpoint and input of both the supervisor and employee but does not neglect performance. It provides the opportunity to not only evaluate performance, but to also foster the professional development of an employee. Supportive supervision activities for the purposes of the project will focus on:

- diagnosing problems
- improving micro-planning practices (district and facility level)
- improving interpretation and use of data
- improving data-recording and reporting practices
- ensuring safety of immunization process
- planning adequate interventions for addressing the existing problems

Sustainability

Sustainability was used as one major criterion for the selection of the GAVI HSS

support options.

As far as the majority of GAVI support is an investment in human resources and capacity building of critical public health services there is no doubt in the sustainability of the proposed interventions (unless very high turnover of medical personnel at the PHC level and public health specialists at the district level happens that is very unlikely).

Considering the only proposed investment in transport infrastructure, the government commits to allocate necessary funds for the operation and maintenance, therefore the sustainability of this option lasts over the period equal to the useful life years of the asset.

Program impact

The proposed program will have primary impact on the performance of public health services at the local level benefiting health of at least 2/3 of population in terms of prevention of communicable diseases (including vaccine preventable diseases).

The program is supposed to change technology and therefore quality and efficiency of public health interventions (through the introduction of supportive supervision and improvement of management skills of public health specialists at the district level).

Thirdly, the program contributes to the integration of preventive services including immunization in the package of PHC: effective and proven medical personnel motivation mechanisms at the PHC level along with their capacity building ensures that policy decisions and corresponding state health programs meet their targets related to preventive care.

Please outline the indicators selected to show progress at every stage of the GAVI HSS support.

Table 9: How progress will be monitored *(from pages 14-15):*

Progress monitoring indicators

	Program components	Indicator(s)	Data source(s)
HSS Inputs	1. Motivation of medical personnel	Resources spent on impact assessment as a % of planned	Project implementation report
	2. Increase professional skills of public health specialists	Resources spent on curriculum development as a % of planned Resources spent on trainings as a % of planned	Project implementation report
	3. Introduction of supportive supervisions	Resources spent on the introduction of supportive supervision as a % of planned	Project implementation report
	4. Increased skills of PHC personnel	Resources spent on trainings as a % of planned	Project implementation report
	5. Improve capacity of Public Health institutions to deliver services	Resources spent on the procurement of the track as a % of planned	Project implementation report

	Program components	Indicator(s)	Data source(s)
HSS Activities	1. Motivation of medical personnel	Presence of the assessment methodology # PHC medical personnel interviewed # of findings and recommendations # of meetings conducted with policy makers and other stakeholders	Project implementation report
	2. Increase professional skills of public health specialists	# of experts mobilized for the development of curriculum # of trainers prepared # of training sessions conducted # of participants by categories and districts # of participants as a % of planned	Project implementation report
	3. Introduction of supportive supervisions	Availability of implementation plan # of supportive supervision visits conducted Supportive supervision visits conducted as a % of planned (by districts)	Project implementation report
	4. Increased skills of PHC personnel	# of experts mobilized for the development of curriculum # of trainers prepared # of training sessions conducted # of participants by categories and districts # of participants as a % of planned	Project implementation report
	5. Improve capacity of Public Health institutions to deliver services	Availability of 4WD track # and % of districts with vaccine supply and stock management plans	Project implementation report
Outcomes (improved capacity of the system)		# and % of PHC specialists with high performance of preventive services # and % of public health specialists applying acquired skills % of districts with no stock out Supply of vaccines and injection materials is maintained throughout the country	Project implementation report Medical statistics annual report Public health institution\s (district and national) annual performance reports
Impact on immunization		DPT3 Drop out rates Wastage rates Share of districts with DTP3 coverage <80%	Annual report of the NCDC MICS report
Impact on child mortality		Under 5 Mortality	National annual report on health status of population MICS report

Table 10: Expected progress in indicators over time *(from page 16-17):*

Expected progress in indicators over time (2007 – 2011)

Indicator(s)	Indicators: baseline and targets				
	Base-year	Year 1 of implem.	Year 2 of implem.	Year 3 of implem.	Year 4 of implem.
	2005	2007	2008	2009	2010
HSS Inputs					
• Motivation of medical personnel	0	116,870	141,000	142,017	156,001
• Increase professional skills of public health specialists	0	16,864	17,464	3,144	3,144
• Introduction of supportive supervisions	0	0	24,660	50,820	57,220
• Increased skills of PHC personnel	0	10,902	56,124	56,220	51,120
• Improve capacity of Public Health institutions to deliver services	0	39,800	9,000	8,496	8,040
HSS Activities					
• Presence of the assessment methodology	N/A	N/A	Yes	N/A	N/A
• # PHC medical personnel interviewed	N/A	N/A	100	N/A	N/A
• # of findings and recommendations	N/A	N/A	15	N/A	N/A
• # of meetings conducted with policy makers and other stakeholders	N/A	N/A	8	N/A	N/A
• # of experts mobilized for the development of curriculum	N/A	4	N/A	N/A	N/A
• # of trainers prepared	N/A	N/A	144	24	24
• # of training (training of public health specialists) sessions conducted	N/A	N/A	6	1	1
• # of participants (public health Specialists)	N/A	N/A	Tbilisi 14 Other d. 130	Tbilisi 3 Other d.21	Tbilisi 3 Other d. 21
• # of participants (public health Specialists) as a % of planned per year	N/A	N/A	144 (100%)	24 (100%)	24 (100%)
• Availability of implementation plan	N/A	N/A	Yes	Yes	Yes
• # of supportive supervision visits conducted (at providers' level)	N/A	N/A	426	946	1074
• Supportive supervision visits conducted as a % of planned per year (from central level for district health specialists)	N/A	N/A	21 (100%)	22 (100%)	22 (100%)
• # of training (family physicians, nurses) sessions conducted	N/A	N/A	58	58	58
• # of participants (family physicians, nurses)	N/A	N/A	1392	1392	1392
• # of participants (family physicians, nurses) as a % of planned	N/A	N/A	1392 (100%)	1392 (100%)	1392 (100%)
• Availability of 4WD track	N/A	Yes	Yes	Yes	Yes
• # and % of districts with vaccine supply and stock management plans	N/A	N/A	65 (100%)	65 (100%)	65 (100%)
Outcomes (improved capacity of the system)					

• # and % of PHC specialists (family physicians, nurses) with high performance of preventive services	N/A	N/A	1392 (33.3%)	2784 (66.7%)	4176 (100%)
• # and % of public health specialists applying acquired skills	N/A	N/A	144 (100%)	144 (100%)	144 (100%)
• % of districts with no stock out	N/A	N/A	100%	100%	100%
• Supply of vaccines and injection materials is maintained throughout the country	N/A	N/A	Yes	Yes	Yes
Impact on Immunization					
• DPT3	84%	90%	92%	95%	95%
• Drop out rates	10.7%	9%	5%	5%	5%
• Wastage rates	1.28	1.18	1.18	1.18	1.18
• Share of districts with DTP3 coverage <80%	24%	10%	0%	0%	0%
Impact on Child					
• Mortality Under 5 (per 100 000 population)	552.8	552.0	550.0	548.0	546.0

HSS Financial Analysis and Planning

Please indicate the total funding required from government, GAVI and other partners to support the identified activities and areas for support.

Ø Please refer to existing plans and estimates where relevant (please attach).

Table 11: Cost of implementing HSS activities:

Cost of implementing HSS activities by years

Activity / Area for Support	Cost per year (US$)				TOTAL COSTS
	Year 1 2007	Year 2 2008	Year 3 2009	Year 4 2010	
1. Increase the motivation of medical personnel:	116,870	141,000	142,017	156,001	555,888
2. Increase knowledge and skills of public health specialist at the local (district) level:	16,864	17,464	3,144	3,144	40,616
3. Introduce supportive supervision at the district level public health departments and primary health care providers:	0	24,660	50,820	57,220	132,700
4. Increase knowledge and skills of medical personnel of primary health care providers:	10,902	56,124	56,220	51,120	174,366
5. Improve capacity of Public Health institutions to deliver services	39,800	9,000	8,496	8,040	65,336
Management costs	6,000	12,000	12,000	12,000	42,000
Technical support	0	0	0	0	0
TOTAL COSTS	190,436	260,248	272,697	287,525	1,010,906

Table 12: Sources of funding (including Government, GAVI & 3 main named contributors):

Funding Sources	Cost per year (US$)				
	Year of GAVI application and year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	TOTAL FUNDS
	Year 1 2007	Year 2 2008	Year 3 2009	Year 4 2010	
Government	121,670	138,000	150,513	166,141	576,324
1. Integrate the motivation mechanisms into the state health programs	**116,870**	**129,000**	**142,017**	**156,001**	**543,889**
2. Print training materials				**2,100**	**2.100**
3. maintenance costs for the track with cross-country capacity	**4,800**	**9,000**	**8,496**	**8,040**	**30,336**
GAVI (HSS proposal)	68,766	122,228	122,164	121,464	434,622
Other Sources	0	0	0	0	0
TOTAL FUNDING	**190,436**	**260,228**	**272,677**	**287,605**	1,010,946
Total unfunded	0	0	0	0	0

Management and Accountability of GAVI HSS Funds

Please describe the management and accountability arrangements for the GAVI HSS Funds

a) Who is responsible for approving annual plans and budgets for use of GAVI HSS?

The project annual implementation plan with the budget is approved by the MoLHSA to ensure consistency with the MTEF/budgetary cycle.

b) Which financial year is proposed for budgeting and reporting?

A fiscal year starts on 1 January and ends on 31 December.

c) How will HSS funds be channelled into the country?[2]

The GAVI HSS funds will be channeled to Georgia through the following mechanism: if the HSS application is approved, the money will be transferred to the bank account of the NCDC in accordance with the Georgian legislation.

d) How will HSS funds be channelled within the country?

The funds will be channelled , managed, disbursed and reported in accordance with the national legislation.

[2]Countries are encouraged to use existing health sector accounts for Health System Strengthening System funds

The NCDC will contract personnel for the implementation (e.g. short term consultants for the development of curriculum) and management of the program.

d) How will reporting on use of funds take place (financial and activity/progress reports)?

The NCDC will be accountable to the Health Sector Coordination Committee (established specifically for the purpose of this application): Annual reports (financial and activity/progress reports) will be prepared by NCDC and submitted to the Committee and endorsed before submission to the GAVI.

e) If procurement is required, what procurement mechanism will be used?

Purchases of goods and services will be carried out in accordance with the "Georgia Law on Public Purchases".

f) How will use of funds be audited?

An assessment of the appropriateness of allocation of funds and external audit will be carried out by the Control Chamber of Georgia

g) What is the mechanism for coordinating support to the health sector (particularly maternal, neonatal and child health programs)? How will GAVI HSS be related to this?

Health Sector Coordination Committee, for reaching global health goals, will establish powerful partnership in the Health Sector by means of coordination of input and existing resources from internal, as well as external funds.

Involvement of Partners in GAVI HSS Implementation

The active involvement of many partners and stakeholders is necessary for HSS to be successful.

Please describe the key actors in your country and their responsibilities below. Please include key representatives from the Ministry of Health, Ministry of Finance, the Immunization Programme Manager, the key Bilateral and Multilateral partners, relevant co-ordinating committees and NGOs.

Description of partners and their roles

Title/Post	Organization	Roles and Responsibilities **related to GAVI HSS**
1. 1.Deputy Minister	The MoLHSA	Facilitate a policy dialogue on health system support Make policy decisions related to the program design and implementation Ensure consistency with ongoing reform initiatives
2. Deputy Minister	The MoF	Ensure that the state health programs necessary for the implementation of policy decisions are integrated/reflected in the MTEF
3. CTO	USAID	Support to ongoing health system reforms (in areas of health care financing, secondary care, organizational development, family planning and reproductive health, communicable diseases) Ensure synergy between GAVI HSS support and other USAID supported health reform interventions
4. Program officer	DFID	Support to ongoing health system reforms (in areas of primary health care, training of health managers and family physicians, organizational development, human resource development) Ensure synergy between GAVI HSS support and other DfID supported health reform interventions

Title/Post	Organization	Roles and Responsibilities **related to GAVI HSS**
5. Program officer	EU	Support to ongoing health system reforms (in areas of primary health care in east Georgia, health care financing, human resource development) Ensure synergy between GAVI HSS support and other EU supported health reform interventions
6. Liaison officer	WHO	Ensure synergy between GAVI HSS support and other WB supported health reform interventions including immunization and communicable diseases
7. Task team leader	WB	Support to ongoing health system reforms (in areas of primary health care such as rehabilitation of outpatient clinics in countryside, health care financing, human resource development) Ensure synergy between GAVI HSS support and other WB supported health reform interventions
8. Health officer	UNICEF	Support to ongoing health system reforms (in areas of maternal and child health, communicable diseases) Ensure synergy between GAVI HSS support and other UNICEF supported health reform interventions
9. Medical coordinator	VRF	Ensure sustainability of and synergy between GAVI HSS support and VRF supported immunization program

Injection Safety Support _ N/A

Ø Please attach the National Policy on Injection Safety including safe medical waste disposal (or reference the appropriate section of the Comprehensive Multi-Year Plan for Immunization), and confirm the status of the document: DOCUMENT NUMBER…….

Ø Please attach a copy of any action plans for improving injection safety and safe management of sharps waste in the immunization system (and reference the Comprehensive Multi-Year Plan for Immunization). DOCUMENT NUMBER…….

Table 13: Current cost of injection safety supplies for routine immunization

Please indicate the current cost of the injection safety supplies for routine immunization.

	Annual requirements		*Cost per item (US$)*		*Total Cost*
Year	***Syringes***	***Safety Boxes***	***Syringes***	***Safety Boxes***	***(US$)***
20…					

Table 14: Estimated supply for safety of vaccination with …….. vaccine

(Please use one table for each vaccine BCG(1 dose), DTP(3 doses), TT(2 doses) [1], Measles(1 dose) and Yellow Fever(1 dose), and number them from 6.1 to 6.5)

		Formula	**20…**	**20…**	**20…**	**20…**	**20…**
A	Number of children to be vaccinated [2]	#					
B	Percentage of vaccines requested from GAVI [3]	%					
C	Number of doses per child	#					
D	Number of doses	*A x B/100 x C*					
E	Standard vaccine wastage factor [4]	*Either 2.0 or 1.6*					
F	Number of doses (including wastage)	*A x B/100 x C x E*					
G	Vaccines buffer stock [5]	*F x 0.25*					
H	Number of doses per vial	#					
I	Total vaccine doses	*F + G*					
J	Number of AD syringes (+ 10% wastage) requested	*(D + G) x 1.11*					
K	Reconstitution syringes (+ 10% wastage) requested [6]	*I / H x 1.11*					
L	Total of safety boxes (+ 10% of extra need) requested	*(J + K) / 100 x 1.11*					

[1] GAVI supports the procurement of AD syringes to deliver two doses of TT to pregnant women. If the immunization policy of the country includes all Women in Child Bearing Age (WCBA), GAVI/The Vaccine Fund will contribute to a maximum of two doses for Pregnant Women (estimated as total births)
[2] To insert the number of infants that will complete vaccinations with all scheduled doses of a specific vaccine.
[3] Estimates of 100% of target number of children is adjusted if a phased-out of GAVI/VF support is intended.
[4] A standard wastage factor of 2.0 for BCG and of 1.6 for DTP, Measles, TT, and YF vaccines is used for calculation of INS support
[5] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero under other years. In case of a phased introduction with the buffer stock spread over several years, the formula should read: [F – number of doses (incl. wastage) received in previous year] * 0.25.
[6] It applies only for lyophilized vaccines; write zero for other vaccines.

Ø If you do not intend to procure your supplies through UNICEF, please provide evidence that the alternative supplier complies with WHO requirements by attaching supporting documents as available

Additional comments and recommendations from the National Coordinating Body (Health Sector Strategic Committee / ICC)

DOCUMENTS REQUIRED FOR EACH TYPE OF SUPPORT

Type of Support	Document	DOCUMENT NUMBER	Duration *
ALL	WHO / UNICEF Joint Reporting Form	3	2005
ALL	Comprehensive Multi-Year Plan (cMYP)	4	2007-2010
ALL	Endorsed minutes of the National Coordinating Body meeting where the GAVI proposal was endorsed **and signatures**	1	January, 2007
If relevant	Endorsed minutes of the ICC meeting discussing the requested GAVI support	2	January, 2007
HSS	National Health Sector Strategic Plan (Georgian National Health Policy)	10	1999-2009
HSS	Medium Term Expenditure Framework **, Basic Data and Directions for 2007-2010, Government of Georgia	8 9	2007-2010
HSS	Recent Health Sector Assessment documents: 1.Georgia:Review of the Health Sector, Report No. 29413 –GE 2. Immunization Program Management Review, Georgia.	5 6	2004 2006
HSS	Outline of HSS Programme with budget and Justification for support or HSS Relevant parts of National Planning Document	7	2007-2010
HSS	Other Health Systems Strengthening Plans / estimates Economic Development and Poverty Reduction Programme of Georgia	11	2003

** Please indicate the duration of the plan / assessment / document where appropriate*
*** Where available*

ANNEX 1

GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATION	Banking Form

SECTION 1 *(To be completed by payee)*

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunization dated . . . . . , the Government of . . Georgia. . . . . hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: *(Account Holder)*	National Center for Disease Control and Medical Statistics		
Address:	9 M. Asatiani st., Tbilisi, 0177, Georgia		
City – Country:	Tbilisi, Georgia		
Telephone No.:	: (995-32) 39-89-46, 43-54-38,	**Fax No.:**	Fax: (995 - 32) 43-30-59
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**	
For credit to: ***Bank account's title***	*VTB Bank, Georgia Saburtalo Branch SWIFT: UGEBGE22670 C/A:04165347*		
Bank account No.:	7463612		
At: ***Bank's name***	Deutsche Bank Trust Company Americas, New York, USA SWIFT:BKTRUS33 ABA: 021001033		

Is the bank account exclusively to be used by this programme? YES (X) NO ( )

By whom is the account audited? Ministry of Labour, Health and Social Affairs , Administration Department

Signature of Government's authorizing official:

Name:	Paata Imnadze	**Seal:**
Title:	Director, National Center for Disease Control and Medical Statistics	
Signature:		
Date:	19.02.07	

SECTION 2 ***(To be completed by the Bank)***

FINANCIAL INSTITUTION	CORRESPONDENT BANK (*In the United States)*
Bank Name:	
Branch Name:	
Address:	
City – Country:	
Swift code:	
Sort code:	
ABA No.:	
Telephone No.:	
Fax No.:	

I certify that the account No. . . . . is held by *(Institution name)* . . . . . .at this banking institution.

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name:	**Signature :**
Title:	**Date:**
2 Name:	**Seal:**
Title:	
3 Name:	
Title:	
4 Name:	
Title:	

COVERING LETTER

United Nations Children's Fund
Georgia
Tbilisi Office
UN House, IV Floor
9 Eristavi str., Vake
0179 Tbilisi, Georgia
Telephone +995 32 232388/251130
Facsimile +995 32 251236
www. unicef.org/georgia

გაერთიანებული ერების
ბავშვთა ფონდი
თბილისის ოფისი
საქართველო, ვაკე, 0179
ერისთავის ქ. 9
გაეროს სახლი, III-IV სართ.
ტელ.: +995 32 232388/251130
ფაქსი: +995 32 251236
www.unicef.org/georgia

Ref.: GB/TO/041
Tbilisi, Georgia

TO: GAVI – Secretariat
Att. Dr Julian Lob-Levyt
Executive Secretary
C/o UNICEF
Palais des Nations
CH 1211 Geneva 10
Switzerland

On the 28 March 2007 I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	***Paata Imnadze***	***Director, National Centre for Disease Control and Medical Statistics***
Bank's authorizing official	***Mikheil Jangirashvili***	***Branch Manager, Vake Saburtalo Branch, "VTB Bank Georgia"***

Signature of UNICEF Representative:

Name ***Giovanna Barberis***

Signature

Date ***1 March 2007***

1946 - 2006
UNITE FOR CHILDREN

unicef

ვითიბი VTB

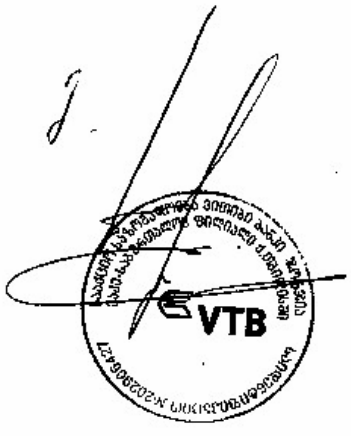
28.02.2007№02-1/4/277

To Whom It May Concern

This is to verify that , National Center for Disease Control and Medical Statistis has an active bank account №7463612 in the JSC "VTB Bank Georgia".

Branch Manager

Mikheil Jangirashvili



სს "ვითიბი ბანკი ჯორჯია"
ვაკე-საბურთალოს ფილიალი
სააღრიცხვო 0179
თბილისი
ი.ჭავჭავაძის გამზ. 54

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