Georgia: a primary health care case study in the context of the COVID-19 pandemic

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Executive summary

The case study examines primary health care (PHC) in the context of the COVID-19 pandemic in Georgia between January 2020 and July 2021. The Astana PHC components are used to consider integrated integrated primary care and essential public health functions, and essential public health functions, community engagement and multisectoral collaboration. A desk-based review was conducted, supplemented by a trend analysis of secondary data.

The Government of Georgia reacted to COVID-19 with timely and coordinated response activities that delayed the arrival of the first COVID-19 case in the country and slowed spread of the infection during the first wave of the epidemic. The government’s multisectoral actions were coordinated by the Interagency Coordination Committee (ICC) under the Prime Minister’s leadership, with the ICC serving as the main decision-making platform. An effective public health response was guided by the Ministry of Health and the National Center for Disease Control and Public Health (NCDC), and was implemented through coordinated efforts that spanned different sectors.

At the time of the country’s first confirmed case of COVID-19, the primary care system was not yet ready to serve as a first contact level for patients with suspected infection. To avoid an influx of patients at primary care facilities and mitigate the risks of infection, people were asked to use the ambulance service or self-refer to designated hospitals that had greater capacities for infection prevention and control.

Meanwhile, drawing on Georgia’s experience during the 2018–2019 flu epidemic, an online consultation service was established, based in 25 PHC facilities. Their primary tasks were patient triage, remote home-based management and follow-up. This service was gradually expanded to 60 PHC facilities, and was supported with trainings and methodological guidance, different reimbursement schemes and quality monitoring mechanisms.

The establishment of the patient pathways, with clear roles for the emergency hotline (112), online clinics, ambulance service and referral points was critical to ensure safe access to the services that were needed. During the second wave of the epidemic, the operation of online clinics under central online clinic supervision ensured the management of most COVID-19 cases and prevented the collapse of the system.

Georgia’s routine primary care services did not stop during the COVID-19 pandemic. All essential preventive and curative services were retained, although physical visits were replaced in many cases by online consultations – a pattern that was more common in urban than in rural areas. However, mobility restrictions and fears of contracting COVID-19 had a negative impact on the use of services such as immunization, cancer screening and tuberculosis diagnostics. In addition, community engagement in the COVID-19 response was weak, as it lacked the active involvement of community groups in discussions and in two-way dialogue with the government.
The pandemic also revealed long-standing structural problems with primary care such as the fragmentation of care, shortages of human resources, weak capacities in infection prevention and control, and an underdeveloped health management information system (HMIS). The pandemic revealed that strong PHC plays an essential role in mitigating risks and reducing pressures on the entire health system. By exposing the weakness the system, the pandemic has catalysed major changes for its future improvement.

Assessment of PHC in the country is essential to draw lessons and to inform the design of multisectoral preparedness plan for future public health emergencies. Moreover, the COVID-19 response learnings can be considered in the design of the planned primary care reform.
Methods

The case study used the Astana PHC components to examine PHC in the context of the COVID-19 pandemic between January 2020 and July 2021, considering primary care and essential public health functions, community engagement and multisectoral collaboration.

Information was obtained primarily from a desk review, involving collection and review of policy documents, government and programmatic reports and other grey literature such as articles, blogs, and media coverage. To enable trend analysis, secondary quantitative data were retrieved and analyzed from national statistical yearbooks and programmatic reports.

The case study can be considered in conjunction with the previous Georgia Case Study on Primary Health Care Systems (PRIMASYS) (WHO, 2017), which provides an overview of Georgia’s PHC approach, describing its structures, processes and outcomes and the way in which it has evolved over recent decades.

Introduction and national context

Political commitment and leadership

The government recognizes the need and the right of Georgian citizens to comprehensive, integrated, quality, patient-centred PHC that is accessible to all, including the most vulnerable. Almost two years after the introduction of the Universal Health Care (UHC) Programme in Georgia, the government issued a Decree emphasizing the role of PHC in achieving the country’s UHC goals through disease prevention and the removal of financial barriers to citizens with chronic diseases associated with the costs of pharmaceuticals (Government of Georgia, 2014).

According to a vision document prepared by the Health and Social Issues Committee of the Parliament of Georgia in 2017 – the Vision for developing the health care system of Georgia by 2030 – PHC is seen as a basic principle for the strengthening of the health system, with UHC identified as a pathway to the achievement of the SDG targets (Parliament of Georgia, 2017). Since 2017, the Basic Data and Directions Document of the government identifies PHC reforms, particularly the introduction of new health financing methods for improved service delivery and investment in early disease diagnostic and management as a cost-containment strategy (Ministry of Finance of Georgia, 2017).

While the government’s political agenda acknowledges PHC as a priority direction, the implementation of the planned reforms up to 2020 and the PHC spending landscape has moved slowly. First, per capita payment for outpatient care has not been adjusted since its introduction in 2012, and there has been significant medical inflation over the past decade. Second, half of the country’s primary care expenditure is made up of households out-of-pocket (OOP).
payments, with the government contribution to PHC funding amounting to only 43% (Curatio International Foundation, 2019a, 2019b). As a result, PHC spending remains a significant health financing burden for the population.

One major change in Georgia’s PHC policy took place in early 2020, when MoILHSA introduced selective contracting elements for primary care facilities under the UHC programme in three main cities: Tbilisi, Kutaisi and Batumi, aiming to improve the quality of care (MoILHSA, 2020b).

### Governance and policy frameworks

Almost 90% of health care providers operating in Georgia’s health care market are private, following massive privatization reforms from 2007 to 2010 (Curatio International Foundation, 2018). The National Health Agency (NHA), which comes under the MoILHSA is the country’s only public purchaser that contracts health care facilities to provide state-funded benefits to the public.

In addition to the country’s pursuit of UHC, there are disease-specific so-called vertical health programmes for HIV, Tuberculosis (TB), Hepatitis C, Mental Health, Maternal and Child Health, and more, that deliver outpatient and inpatient services red to the population. The MoILHSA prepares and updates the content of vertical programmes each year with budget estimations approved by the Government Ordinance.

Major decisions envisioned in relation to PHC are discussed by the Primary Health Care Coordination Council (PHCCC) which was re-established at the MoILHSA in 2020 with renewed composition.

Monitoring remains a key challenge. State health programmes lack monitoring and evaluation frameworks, and there are no mechanisms in place to identify the poorest or best practices in the health system as a basis for the effective application of state financial resources (Curatio International Foundation, 2019a). The Ministry of Finance is responsible for state health programme budget monitoring, but this monitoring is poorly designed in terms of the selected indicators and does not deliver the expected results.

The government’s concept of UHC identifies Health in All Policies as a multisectoral approach and intends to develop an efficient mechanism for interagency coordination across different sectors such as education, agriculture, environment and defence (Government of Georgia, 2014). There have also been several joint decrees by the MoILHSA and other ministries, such as the ministries of Education, Science, Culture and Sport, Agriculture, Environment and Justice. Several strategic and legislative documents, including the Tobacco Control Law, have been developed jointly by sectoral ministries.

There is, however, no clear accountability framework for the Health in All Policies approach. The COVID-19 epidemic has reinforced the importance of health for all sectors and has made it clear that intersectoral action is critical for an effective response to such an emerging threat. The onset of the COVID-19 pandemic may
have further delayed health improvement strategies, given that attention and efforts became focused on health protection strategies to prevent the spread of COVID-19 infection.

Different sectors adopted policies to respond to COVID-19. Threats. The Ministry of Finance, for example, expanded the role of Georgia’s border control, while the Ministry of Education and Science has revised policies for educational processes for schools and other institutions.

Funding and allocation of resources

The government’s political commitment to UHC has been supported by significant public budget allocations to health. During the period 2012–2020, the state budget allocations for health quadrupled in volume terms (albeit from a low base of 1.6% of GDP) and reached 3.2% of GDP and 9.7% of general government expenditure (Ministry of Finance of Georgia, 2020; National Statistics Office of Georgia, 2020).

While households’ OOP expenditure on PHC decreased between 2012 and 2017, it remains high and continues to place a heavy financial burden on the population (Fig. 1).

![Figure 1. Sources of primary health care spending (2012-2017)](source: MoILHSA, National Health Accounts 2012-2017)
Moreover, although public expenditure on health has increased significantly, its distribution between outpatient and inpatient care remains uneven. Inpatient services are prioritized, with a maximum of 20% of public health expenditure spent on outpatient care (Ministry of Health, 2018).

This situation is the result of existing health financing methods that provide perverse incentives to reimburse health services. Planned outpatient services are financed on a per capita basis, while emergency outpatient and inpatient services are reimbursed on a fee-for-service basis leading providers to refer patients to secondary and tertiary levels of care to utilize costly inpatient services. Therefore, a patient-centred approach is still lacking in most cases (Curatio International Foundation, 2019a).

The MoILHSA has been working on PHC reform since 2019. The stepwise approach of this reform aims to address key structural challenges to PHC, such as poor gate-keeping roles, fragmentation of services, a lack of incentives and performance-based outcomes, and the diminished role of nurses. The reform package emphasizes the use of digital solutions in health care, and the creation of a better financial stimulus to provide unified, people-centred care at the level of PHC and increase the competencies and role of nurses. In 2020 the technical working groups under the MoILHSA leadership developed a reform roadmap for 2021-2025 that envisioned implementation of these reforms from autumn 2021 (Curatio International Foundation, 2018, 2019a; PHC Reform Working Group, 2020; WHO Regional Office for Europe, 2018).

**Engagement of communities and other stakeholders**

Participatory approaches in decision-making through the engagement of communities and other stakeholders are limited (Curatio International Foundation, 2018; WHO Regional Office for Europe, 2018). Communities represented by health service users and affiliated groups have few, if any, effective mechanisms for their participation in governance, planning, or oversight of primary care in the country. For example, the PHCCC at the MoILHSA does not have a community representative among its members. At the same time, there are different practices for HIV/AIDS and TB responses. Mechanisms such as the Country Coordination Mechanism (CCM) and the HIV Prevention Task Force (PTF) play important roles in disease-specific policy design, programme, oversight and advocacy initiatives.

**An overview of the COVID-19 pandemic**

The first COVID-19 case in Georgia was detected on 26 February 2020, almost two months after the novel virus was identified. Through its multisectoral response and its appropriate and coordinated activities, the GoG managed to delay the arrival of the first COVID-19 case entrance in the country (Government of Georgia, 2020b).

The activation of effective response measures slowed the spread of the virus. The weekly number of cases remained low during the first wave of the pandemic.
(the cluster spread of the infection). A state of emergency was declared to prevent the uncontrolled spread of the virus on 21 March 2020, which lasted for two months (Government of Georgia, 2020b).

Increased mobility in summer 2020, an outbreak in the Adjara region as a result of high tourist activity, and large-scale gatherings before and after the parliamentary elections led to the second wave of the pandemic from September 2020. The number of daily new cases climbed sharply and peaked in December 2020. Strict infection control measures, including a night curfew, were enforced from October 2020 to May 2021.

The third wave started in April 2021 and peaked in May when the Delta variant was first detected. After controlling the spread of the infection, the easing of strict control measures triggered the fourth wave of the pandemic from July 2021.

### How primary care and essential public health functions are responding to COVID-19

The government adopted a new state programme on COVID-19 prevention and control to cover expenses for quarantine measures, diagnosis and management (Government of Georgia, 2020c).

#### The response of public health functions

Immediately after the confirmation of the first COVID-19 case in Georgia, the system reacted with effective public health response based on case identification, isolation of all cases, contact tracing and quarantine. Infection control and surveillance activities were planned centrally at the NCDC emergency operations centre and implemented through the coordinated efforts of the health sector alongside other sectors, as ensured by the GoG.

The case definition of COVID-19 was adopted on 31 January 2020 and added to the list of diseases that require immediate surveillance. The GoG adopted border testing and introduced mandatory quarantine (at home or in a dedicated facility) measures from 6 March 2020 – measures that were periodically revised (WHO Regional Office for Europe & European Observatory on Health Systems and Policies, 2020). The Tbilisi-based Richard Lugar Research Centre, Georgia’s hub for surveillance, rapidly developed the country’s testing capacity for COVID-19. From January to March 2020 the Lugar laboratory was the only one in the country to provide PCR testing, with other laboratories gradually becoming involved in the process.

The NCDC regional public health branches organized and supported testing, monitoring, contact tracing and epidemiological investigations (McBrien, 2021). Individuals with COVID-19 were self-isolated or transferred to special quarantine zones (hotels that served as a triage facilities in cases where self-isolation at home was not possible, given the household’s conditions). The police, together
with representatives of the NCDC and local governments, ensured contact tracing and monitored compliance with the applicable rules of self-isolation (WHO Regional Office for Europe & European Observatory on Health Systems and Policies, 2020).

The primary care response to COVID-19

There were some initial delays in the involvement of primary care in COVID-19 case management. Because the system was not yet ready to manage patients at the primary care level without creating additional risks for the spread of infections, the MoILHSA advised people to refrain from visiting primary care facilities if they suspected that they had COVID-19 symptoms. The decision was made to care for COVID-19 patients in hospitals, regardless of the severity of their symptoms. People in need used ambulances or self-referred themselves to designated hospitals. This model was manageable during the initial stages of the pandemic as a result of the small number of cases. It also gave the system time to prepare for a more efficient model of care, whereby patients with mild symptoms were treated at so-called COVID-19 hotels or at home under the remote supervision of a family doctor.

Meanwhile, 25 existing PHC centres were mobilized throughout the country for online (phone) consultations, starting in April 2020. People with fever or other symptoms who called the emergency hotline (112) were directed to family doctors for distant consultation (Government of Georgia, 2020b). If the patient required hospitalization, as determined by the family doctor, an ambulance was arranged by 112 services.

Family doctors working in these 25 PHC facilities were trained in the early identification of suspected COVID-19 case, infection prevention, and control, and the principles of patient education. Although their main task was to provide distant counselling on COVID-19, they retained their routine responsibilities and continued to monitor patients with chronic diseases on a remote basis. This required management to redistribute and optimize the tasks and roles of the existing workforce as the clinics retained routine services that required physical visits.

Online centre personnel (family doctors and nurses) were reimbursed on a daily basis and received around US$38 for a 24-hour shift (Ministry of Health, 2020a) – an arrangement that had been used during the flu outbreak in 2018-2019. These primary care centres were involved in PCR sample collection that gradually expanded to other service providers.

Multisectoral involvement across the system during the first wave created lines of defence to prevent the overload of the hospital sector and enable preparations for the second wave. These defence lines included the linking of the emergency hotline with online clinics for triage, the remote management of COVID-19 cases at home or their referral to hospitals according to case severity (Gotsadze & Uchaneishvili, 2021).
Shortly after the COVID-19 outbreak in the country, the MoILHSA started to work on COVID-19 prevention, diagnostics, and case management protocols based on the recommendations from the World Health Organization (WHO) in cooperation with public health professionals and expert associations. The guidance documents were updated as new evidence emerged.

The training of primary care personnel on the COVID-19 protocols started in spring 2020. While that process stagnated in summer, active training was renewed in October 2020 when the second wave of the epidemic started in Georgia. At that time, the number of PHC facilities involved in online service provision increased from 25 to 60 (see Fig. 2 for the pathway for COVID-19 patients in the PHC system, as prepared by the MoILHSA). In October 2020, the MoILHSA approved a new protocol for post COVID-19 patients and the management of discharged cases at the PHC level.

The staff of online clinics became overwhelmed during the second wave of the epidemic in late autumn 2020, and failed to manage all incoming requests. In response, the MoILHSA handed triage of suspected COVID-19 cases to family doctors contracted under the UHC programme. An online portal (http://ambulatoria.MoILHSA.gov.ge) went live in November 2020, enabling UHC programme beneficiaries to find out which family doctors and clinics would serve them if they showed COVID-19 symptoms. Individuals with private insurance were asked to contact their insurance companies. The uninsured (those eligible for UHC but not registered) were told to call the MoILHSA hotline for registration purposes (WHO Regional Office for Europe & European Observatory on Health Systems and Policies, 2020). Online clinics retained their responsibility for the management of confirmed cases of COVID-19 and were working to the very limits of their capacities during the peak of the second wave.

By the end of November 2020 laboratory and instrumental investigations became available for patients who were undergoing treatment at home or isolated in COVID-19 hotels (locations for the isolation of mild cases and quarantine).
How primary care and essential public health functions are responding to COVID-19

Source: revised graph from MoILHSA, NCDC, 2021.

Figure 2. COVID-19 patient pathway in Georgia’s primary health care system (after September 2020)

Suspected case → PCR testing result in max 24-48 hours → COVID-19

COVID-19 Positive → Self-monitoring and observation

COVID-19 Negative → Lab Portal, administrated and coordinated by the NCDC

Lab Portal → Contact tracing

Remote triage by online clinics → 112 Emergency Hotline

112 Emergency Hotline → 112 ensured safe transportation

Asymptomatic/mild cases with possibility of self-isolation at home, under online clinic supervision

COVID-19 hospitals → COVID-19 hotels for asymptomatic/mild cases with no possibility of self-isolation

Source: revised graph from MoILHSA, NCDC, 2021.
The MoIHLSA formed a Central Online Clinic on 30 October 2020 to provide quality assurance for the performance of online clinics. This clinic was staffed with doctors, junior doctors, medical residents and operators who received special training. The Central Online Clinic has provided the systematic and effective monitoring of the patients’ condition and ensured the relevant referral of serious cases.

Online clinics provided the remote management of 88.6% of COVID-19 cases at the primary care level during the second wave of COVID-19, preventing the complete collapse of the system. From September 2020 to April 2021, only 7% of COVID-19 cases were referred to hospitals by the online PHC centres.

Although the adaptation of Georgia’s PHC system to the new realities of the COVID-19 pandemic was quick and perceived to be effective, some bottlenecks were identified by service providers and epidemiologists, including limited access by family doctors to patient data in the health management information system (HMIS), shortages of primary care staff, and gaps in information sharing between primary and secondary care providers.

The impact of COVID-19 on routine primary care services

Georgia’s primary care services did not stop during the COVID-19 pandemic. All essential preventive and care services were retained, although physical visits to family doctors were replaced by online consultations in many cases – a pattern that was more common in urban rather than rural areas. Nonetheless, after removing online consultations related to COVID-19, per capita primary care visits declined compared to 2019 (Fig. 3).

Several modifications to service provision were made to comply with the health needs of the population. Major changes took place at the beginning of the pandemic. For example, during the first period in which restrictions on movement were introduced, there was a ban on travelling for three weeks. To ensure access to medicines for the management of chronic diseases, family doctors were allowed to issue online prescriptions to the patients through phone consultations. There were adaptations across many aspects of primary care, according to the type of service being delivered, as follows.

Immunization

The immunization programme reacted promptly to the pandemic by introducing new guidance for service providers. Although the services continued without interruption, childhood immunization coverage declined by up to 8% for most antigens in 2020. There was a particularly dramatic fall in booster doses (25%-30%), which could contribute to future disease outbreaks if not rectified by catch-up campaigns (NCDC, 2020b).
Mobility restrictions in the spring and autumn of 2020 created access barriers for immunization services. Many families moved to rural areas and while the new regulations allowed the vaccination of children regardless of where they were living, many parents opted to postpone the visits. There was also a reduction in supportive supervision of immunization services as a result of the diversion of public health staff to COVID-19 response activities and, in part, mobility restrictions. This has had an additional and negative impact on immunization performance.

Georgia started its COVID-19 vaccination with the AstraZeneca vaccine and limited Pfizer doses at primary care and hospital levels respectively in March 2021. One fatal incident following the administration of AstraZeneca vaccine in one regional facility resulted in the restriction of COVID-19 vaccine delivery to the hospital level only. Vaccine administration at the primary care level resumed from May 2021 with Sinopharm and SinoVac vaccines being added to the Pfizer and AstraZeneca vaccines as they became available in the country.

Antenatal care

Antenatal care (ANC) services were continued, although utilization deteriorated during March and April 2020. The timely initiation of ANC visits declined by 4% in 2020 compared to 2019 as a result of mobility restrictions. During the
initial stages the pandemic, in the absence of government regulation on the provision of ANC services, several medical facilities decided to switch to remote service provision. The resulting consultations were not registered or reimbursed (Gotsadze, 2021). In March 2020, with the support of the United Nations Population Fund (UNFPA), the MoILHSA developed a protocol for ANC during the COVID-19 pandemic, instructing providers to minimize direct contact with patients. The protocol proposes adjustments to service delivery modalities according to the standard schedule of eight ANC visits and allows selected ANC appointments to be conducted using remote contact (e.g. phone calls) (MoILHSA & NCDC, 2020).

In May 2020 the NCDC launched an innovative model of virtual shared antenatal consultation (multilingual) in partnership with UNICEF, aiming to share information on modern guidelines and scientific evidence regarding COVID-19 infection. As of 23 October, 31% of pregnant women in Georgia had participated in the sessions (UNICEF, 2020). This project raised the awareness of pregnant women and increased the number of antenatal visits (NCDC, 2020a).

**Cancer screening**

The COVID-19 pandemic led to a decline in cancer screening rates. Although the baseline coverage rates for cervical, breast, prostate and colon cancer screening for 2019 were already unsatisfactory, a two-fold reduction in these low rates was observed across the country in 2020.

One consequence of reduced cancer screening is the reduction in the diagnosis of new cases. The cancer incidence rate per 100 000 people dropped by 7% in 2020 compared to 2019. Furthermore, there was an increase in the share of cancer that was only diagnosed at a later stage in 2020.

**Mental health**

As in many other countries, COVID-19 had a negative impact on the mental well-being of the Georgian population. A cross-sectional survey conducted in 2020 identified a high prevalence of mental disorders that were strongly associated with increased concern about COVID-19. The prevalence of these disorders was as follows: depression (30.3% women, 25.27% men), anxiety (23.9% women, 21.0% men), post-traumatic stress disorder (11.8% women, and 12.5% men), and adjustment disorder (40.7% women, 31.0% men) (Makhashvili et al., 2020).

A pilot project was initiated in 2021 in two cities to respond to the needs of the population and manage mild mental health conditions at the PHC level (Makhashvili et al., 2021. This included training of family doctors and nurses on the identification of prevalent mental disorders, the management of mild cases at primary care level, and proper referral where more specialized care is needed. Family doctors received a modest incentive for each case they have managed (US$3.0), which was covered by the project. The project was expected to identify key barriers to provision of mental health care.
How primary care and essential public health functions are responding to COVID-19

Tuberculosis

Georgia’s TB programme outpatient service provision was curtailed during the country’s state of emergency in 2020. Prior to COVID-19, TB patients would receive their medicines through Direct Observed Treatment (DOT) or Video Observed Treatment (VOT), with a different frequency for Drug Sensitive TB (DS-TB) and Drug Resistant TB (DR-TB) patients. VOT was used mainly by DR patients. Mobility restrictions resulted in many patients being transitioned to VOT, but this modality is not suitable for all patients. In addition, the process of transition was uneven and slow. Such patients were given a one-month supply of drugs and left without any visual monitoring. However, they were often contacted by TB doctors and nurses to support them and make sure they followed recommendations.

Trend analysis demonstrates a sharp decline of newly diagnosed TB cases in 2020, which does not align with the projected trend line (NCDC, 2021). This indicates that the system has been potentially missing new TB cases, giving rise to a rapidly growing pool of undetected and unreported TB.

Personal protective equipment

Primary care and especially public health staff required appropriate personal protective equipment (PPE) to work safely during the pandemic. Public health personnel did not experience any PPE shortage: primary care facilities received a one-time provision of supplies from the MoILHSA, while further supplies were covered by primary care service providers themselves, as well as other safety measures to ensure the continuity of their work.

Investments from external donors

The health sector received significant investments from external sources through grants and loans for the COVID-19 response, and the MoILHSA used this opportunity to advance the primary care reform agenda. A major investment is planned in the primary care system, highlighting areas for future collaboration with donors. In addition, resources were mobilized in the form of a grant from the Asian Development Bank to develop and further strengthen the emergency service. The European Union also provided EURO 4.7 million (around US$ 5.1 million) in grants to introduce telemedicine services and digital solutions to primary care.
How multisectoral policy and action are supporting COVID-19 responses

Multisectoral policy and action was enabled through the establishment of the Interagency Coordination Council (ICC) one month prior to confirmation of the first COVID-19 case in Georgia. Led by the Prime Minister, the Council has been the main decision-making platform on issues related to the COVID-19 pandemic and consisted of members of the government, Parliament, the President of Georgia administration, medical representatives, and other interest groups including health system experts. The ICC coordinated efforts across priority sectors, including health, economic, financial, logistics, border control, and education. Its primary aim was to protect the health and lives of the people and support the national economy (Government of Georgia, 2020b). Other major donors included USAID, the Global Fund and the World Bank.

ICC meetings have been held on a regular basis to coordinate the national response. At the start of the pandemic, the ICC met several times each week and solicited inputs from experts on questions related to the national health system capacity and the experiences of other countries in dealing with the pandemic (Gotsadze & Uchaneishvili, 2021).

Examples of the response actions of various sectors beyond the health sector include the following.

- Georgia’s tourism industry supported the creation of quarantine spaces for temporary isolation for (a) traced contacts; (b) citizens returning from abroad; and (c) COVID-19 patients with mild infection who were not able to isolate themselves at home. The Ministry of Economy and its tourism department held active negotiations with more than 300 hotels (small, medium-sized, and large) in the capital and several regions of Georgia. During the process of selecting hotels to act as quarantine zones, the GoG relied on the WHO criteria endorsed by MoILHSA. In total, 6500 hotel rooms were mobilized by the tourism sector, and epidemiologists trained hotel staff in quarantine management. In addition, the MoILHSA mobilized 405 doctors and nurses for COVID-19 hotels to manage mild cases who could not self-isolate at home because of their living conditions. Medical personnel were equipped with first-aid gear and medicines, as well as pulse oximeters for the rapid assessment of condition severity (Government of Georgia, 2020b). Citizens received this service free of charge under the government-funded programme for COVID-19 management.

- The police helped the NCDC and local government representatives in the contact tracing and quarantining of traced contacts in addition to monitoring compliance with applicable rules. More than 10,000 employees of the Ministry of Internal Affairs were engaged in the process of enforcing restrictions under the state of emergency to prevent the spread of the virus and to stop the PHC and hospital sectors from being overwhelmed (Government of Georgia, 2020b).
• The Public Safety Management Center of the Ministry of Internal Affairs (112) worked to ensure the effective engagement of the PHC network in COVID-19 case management by redirecting 112 phone calls from feverish patients or those with respiratory symptoms to general practitioners (Government of Georgia, 2020b).

• The government managed to secure a public-private partnership in COVID-19 crisis management, involving the private sector directly in the crisis-management process. For example, to respond to the global shortage of facemasks, the GoG started active communication with private companies to produce facemasks locally. As a result, 14 companies and over 900 people produced the facemasks that were needed. The production of multiple use gauze facemasks made it possible to meet demand in a relatively short time (Government of Georgia, 2020b).

A multisectoral approach was also utilized during COVID-19 vaccination planning. The ICC created a special task force and engaged relevant institutions for effective vaccination planning and rollout (WHO Regional Office for Europe & European Observatory on Health Systems and Policies, 2020).

On 15 December 2020, a special COVID-vaccination Commission was established, chaired by the Minister of Health (Government of Georgia, 2020a). The Commission included the Deputy Ministers of MoILHSA, Finance, Foreign Affairs, Economy and Sustainable Development; the Directors of NCDC, NHA, State Regulation Agency for Pharmaceuticals and Medical Activities, Emergency Situations Coordination and the Urgent Assistance Center; the Dean of Tbilisi State Medical University and the Chairperson of the National Council on Bioethics, as well as representatives of donor and partner organizations.

The commission was tasked to: a) develop a national action plan for the introduction of the COVID-19 vaccination in close coordination with the ICC, and, where necessary, update the plan; b) ensure the coordination and monitoring of the execution of the plan. The Commission was also authorized to: a) facilitate the coordinated activities of state-, international- organizations, and trade unions for the introduction of COVID-19 vaccination; b) communicate with the COVAX Facility; and c) coordinate the attraction of financial resources for COVID-19 vaccination (Government of Georgia, 2020a). The National Plan for COVID-19 Vaccine Deployment was also elaborated through the close and active collaboration of all relevant stakeholders and was approved by the GoG in January 2021 (Government of Georgia, 2021a).

Another example of intersectoral coordination related to human resources planning to address health workforce shortages during the COVID-19 outbreak. A total of 1844 final-year medical students from various universities completed a one-week training course in coronavirus management, including personal safety, case management of COVID-19, effective communication under pandemic conditions, psycho-social assistance for infected people and tools to identify the contacts of newly infected individuals. The rapid training course was available both online and offline and was developed by the Ministry of Education, Science, Culture and Sport of Georgia. Course materials were jointly elaborated by the
representatives of the National Family Medicine Training Center of the Ministry of Health and the Georgian Red Cross Society (GRCS). Trainers of the 112 hotline were also actively involved in the process (Ministry of Education Science Culture and Sport of Georgia, 2020). As a result, trained students helped epidemiologists in contact tracing for confirmed cases (WHO Regional Office for Europe & European Observatory on Health Systems and Policies, 2020), with some of these students engaged in the administration of the online consultations in the Central Online PHC clinic (IDI with MoILHSA Representative).

**How communities are responding to COVID-19**

The government introduced strict measures in response to the pandemic, including movement restrictions and closure of all non-essential business activities, curfews, travel restrictions within and outside the country and the closure of borders. The aim was to prevent COVID-19 from shifting to the community transmission stage.

Community adherence to these measures was high at the beginning of the pandemic in spring 2020, but mobility decreased while social distancing increased (Government of Georgia, 2020b). The attitudes of Georgian citizens were studied by UNICEF in Analytical Report of the First, Second and Third Wave Studies. According to this, most respondents supported strict measures to prevent the spread of COVID-19 at first. However, the picture changed for the third wave, when the majority of the respondents – 59% - did not support the imposition of excessively strict measures (UNICEF & UKAid, 2020).

Frustration with led to a protest by some Georgians to defy the 9 pm to 5 am curfew in March 2021 – a curfew that had been in place for four months. The protesters claimed that the measure was no longer necessary, as the country had registered a drop in the infection rate (RadioLiberty, 2021).

The government was criticized for a lack of clarity in its communication with communities to ensure their engagement in the COVID-19 response. This was assessed as a management weakness by some health system specialists. While there were continuous debriefings by high-level officials from the start of the pandemic, there was a lack of proper explanations about some restrictive measures and this led to a lack of both public trust and a sense of being part of collective efforts to manage this crisis (Gzirishvili, 2020; IDFI, 2020).

The pandemic had a severe impact on Georgia’s economy, and GDP declined by 6.2% in 2020 in stark contrast to growth of 5.0% in 2019. Unemployment increased from 17.6% in 2019 to 18.5% in 2020 (National Statistics office of Georgia, 2021b). Low income populations were affected disproportionately: 21.3% of the population lived below the national poverty line in 2020, compared to 19.5% in 2019, with rural and urban poverty rates at 27.5% and 171% respectively (National statistics office of Georgia, 2021a).
How communities are responding to COVID-19

Meanwhile, community-based organizations, civil societies, nongovernmental organizations (NGOs), and society provided support to vulnerable people in the country and act as a bridge between the government and society. The STOPCOV fund was established as a private sector initiative through which companies and citizens could contribute to the COVID-19 response.

The Georgian Red Cross Society (GRCS) increased its home-based care services in response to both increased demand and the reduction in services from other home-based care providers (Georgian Red Cross Society, 2020). According to the GRCS representative, the programme covered more than 4000 elderly people in Tbilisi and 29 municipalities. GRCS volunteers were involved in the delivery of medicines to old people who became more reliant on external support. The GRCS has been also involved in awareness-raising about safe COVID-19 vaccination among the general population. GRCS volunteers, together with Georgian citizens with a high sense of social responsibility, have provided food and hygiene parcels to the most vulnerable groups including those who are socially vulnerable (including vulnerable families where someone has contracted COVID-19) and single older people. In addition, GRCS has provided training not only for its own approximately 4500 volunteers, but also for around 5000 other volunteers. At the time of writing, an online platform was also available to offer online trainings. A number of community initiatives have provided food, medications and other essential items provision to deprived families.

The government created the main webpage (https://stopcov.ge) to provide all necessary information on COVID-19 to the population of Georgia including ethnic minorities (Abkhazian, Armenian, Azeri, Iranian). The media also played a critical role in information sharing. To ensure efficient, coordinated and regular information sharing with the media, each agency appointed a media spokesperson (including the personnel of the COVID-19 hospitals). Information was also spread through educational posters, informational graphics and video materials via social media, with SMS (text messages) (Government of Georgia, 2020b). Nevertheless, community representatives emphasize the paucity of relevant information on COVID-19 related issues, particularly during the first phase of the pandemic in the country (Women’s Initiatives Support Group, 2020).

As in other countries, social media misinformation became increasingly widespread. Fake news spread on different topics, including virus etiology, disease severity, self-treatment approaches, the use of facemasks use, vaccines, etc. (Panchulidze & Tsitsikashvili, 2020). From September 2020, two watchdog organizations partnered with Facebook as third-party fact-checkers to tackle the dissemination of fake news on that social media platform (Panchulidze & Tsitsikashvili, 2020).
Conclusion and lessons learned

Primary care has featured prominently in Georgia’s policy agenda, yet gaps were evident in the COVID-19 pandemic. Primary care has been subject to numerous reforms over the last three decades and has been acknowledged as a vehicle for the achievement of UHC. However, there has been little PHC-related system reform in the last five years. PHC has received insufficient prioritization within public funding in comparison to the hospital sector.

The COVID-19 pandemic highlighted the important role of a resilient health system in an effective response to public health emergencies, with strong PHC systems playing an essential role in mitigating risks and reducing pressure on the entire health system. The pandemic exposed all the weaknesses within Georgia’s health system and catalysed reform efforts.

The public health response, which involved multisectoral collaboration, was quick and effective in minimising the spread of COVID-19 during the early months of the pandemic through the establishment of early alarm systems and case detection, isolation, and the contact tracing scheme.

The primary care system responded by rearranging service delivery modality to ensure the provision of emergency services without creating additional risks for spread of infection and avoiding the contracting of the disease by service providers. While primary care workers were engaged in the respond to COVID-19, the primary care response was slightly delayed as the system was not ready and required rapid adaptation to respond to the new threat.

Georgia’s previous experience with the flu epidemic in 2018 and 2019 was instrumental in its shift to a new online clinic modality. Online clinics proved to be an effective method for the remote management of COVID-19 and their operation received technical and financial support. However, a lack of performance monitoring led to quality issues and concerns.

Coordination between primary care and epidemiological services was established from the beginning of the pandemic and was essential for adequate response, with roles and responsibilities clarified. In institutional terms, there are strong ties between primary care and public health services on communicable disease surveillance and immunization and this provided the basis for subsequent coordinated efforts. However, communication and care that is coordinated horizontally across primary care providers and vertically between the primary and hospital sectors remain fragmented, suggesting a need to improve information sharing.
Public health staff had the leading role in the response to COVID-19, yet the shortage of staff was one of the most critical issues faced by the system, in addition to a lack of digital tools for contact tracing, both of which placed a heavy burden on human resources. Existing staff shortages in primary care were aggravated by the pandemic. Moreover, traditional reimbursement schemes for primary care (per-capita) were not adapted to the emergency response. This experience indicates that additional staff time and safety measures are likely to require adequate compensation. The public health system can be strengthened by ensuring an adequate number of proficient and incentivized health professionals who are equipped with digital solutions for simplified contact tracing.

The continuity of essential PHC services was maintained, but mobility restrictions and fear of contracting COVID-19 have jeopardized the use of services that required face-to-face interaction, particularly preventive activities (e.g., immunization and cancer screening). Services that could be handled distantly were delivered virtually, e.g., medication prescription, while services under the UHC programme remained in-person. This shift to distant mode created access barriers to those who experienced difficulties using phones (mainly elderly people who lived alone). Primary care has a leading role to play in patient triage, management, referral and follow-up. However, to fulfil this role, improvements are needed to clarify patient pathways, improve knowledge and skills of health professionals, support implementation of digital solutions, and provide adequate remuneration and supervision.

Experience with the pilot on mental health services indicated that adequately trained, financially motivated and well-supervised primary care staff could identify and, to some extent, manage common mental health disorders. However, the pilot also demonstrated an inadequate skill-mix between doctors and nurses, and a lack of time for consultations. An underdeveloped HMIS added to the challenges that already faced fragmented services.

While there were several examples of community engagement in the COVID-19 response, these tended to be limited to the passive sharing of information, rather than consultations, discussions and two-way dialogue. Efforts are needed to strengthen community engagement and the accountability of the government on emergency response design, choice of strategies at various stages of the epidemic and operational issues. This can be achieved through better understanding of the importance of these factors and their integration within policies and operations.
Assessment of the PHC performance in the context of the COVID-19 pandemic is essential to draw out lessons that will feed back into the design of a multisectoral preparedness plan for future public health emergencies. The assessment should consider managerial, financial and quality aspects of PHC delivery. The design of the planned primary care reform should be reassessed to consider the lessons learned from the COVID-19 response. The reform should emphasize the introduction of telemedicine and an improved HMIS (as well as strengthened public health function and community engagement) as critical attributes of a modern system.
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This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, in collaboration with the WHO Regional Office for the Eastern Mediterranean (EMRO) and WHO country offices. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic, applying the Astana PHC framework considering integrated health services, multisectoral policy and action and people and communities. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.