Healthy Women in Georgia

Making a Difference

Final Report of the Healthy Women in Georgia Project
October 2003 to September 2009

USAID
FROM THE AMERICAN PEOPLE

JSI Research & Training Institute, Inc.

Healthy Women in Georgia partner organizations:

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About Healthy Women in Georgia

The Healthy Women in Georgia Project, a cooperative agreement funded by the United States Agency for International Development, began September 24, 2003, just prior to Georgia's Rose Revolution. Originally, the project was awarded $2.9 million for a modest three-year demonstration effort in ten clinics and three hospitals in Imereti Region. At that time, there were enormous policy barriers to providing family planning, youth reproductive health education and modern maternity care in Georgia. Since then, many of these barriers have been overcome beyond all expectations.

Gradually the project grew in duration, geographic and technical scope. An amendment in September 2004 added new partners, a component to work with pharmacists and MCH/FP expansion work in Tbilisi and Khakheti. Eight subsequent amendments added funding and geographic focal regions, expanded the project's technical scope and extended the project. New technical areas included working with internally-displaced persons and in breakaway regions, more emphasis on effective perinatal care, stronger research and social marketing, breast and cervical cancer work, public-private partnerships, supportive supervision, expanded contraceptive distribution and, latest in the project, post-abortion care.

By the end of the project's six-year time span, HWG funding totaled over $12.8 million and covered a large portion of the country. This report summarizes the processes and results of this six-year USAID investment.

Photo: Julia Sherburne

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Acronyms

AMTSL	Active management of the third stage of labor
ANC	Antenatal care
CDC	US Centers for Disease Control and Prevention
CIF	Curatio International Foundation
CSMA	Caucasus Social Marketing Association
CYP	Couple-years of protection
DfID	Department for International Development (UK)
EE	Eastern Europe
EERFPA	Eastern European Regional Family Planning Activity
EPC	Effective Perinatal Care
ERC	Educational Resource Centers
FP	Family planning
HERA	Women's Wellness Alliance HERA
HLS	Healthy Lifestyles Program
HWG	Healthy Women in Georgia Program
IDP	Internally displaced person
IEC	Information, Education and Communication
IUD	Intra-uterine device
JSI	JSI Research and Training Institute, Inc.
KAP	Knowledge, Attitudes, and Practices
LMIS	Logistics Management Information System
MoE	Ministry of Education
MoLHSA	Ministry of Labor, Health and Social Affairs
NCDC	National Centers for Disease Control
NGO	Non-governmental organization
OB/GYN	Obstetrician/gynecologist
PAC	Post-abortion care
PHC	Primary health care
PY	Project year
RAMOS	Reproductive Age Mortality Study
RH	Reproductive health
RHS	Reproductive Health Survey
SDMS	State Department of Medical Statistics
SDP	Service delivery point
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TAR	Total abortion rate
TFR	Total fertility rate
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of reproductive age

SCOPE OF THE HWG PROGRAM IN GEORGIA

HWG started in ten sites in Imereti Region and grew over six years to include much of Georgia (red areas) — reaching almost three-fourths of maternity cases, 575 family planning sites, and over 6,000 youth. HWG's social marketing mass media coverage reached the entire country.

1. Overview: A Vision of Healthy Women in Georgia

The Healthy Women in Georgia Project (HWG) is a women's health project funded by the United States Agency for International Development (USAID) and managed by JSI Research and Training Institute, Inc. (JSI) with partners including Save the Children USA, HERA, the Women's Wellness Health Care Alliance, CLARITAS XXI, Curatio International Foundation and other Georgian NGOs. What began as a small project during a tumultuous time in Georgia's history (the Rose Revolution), gradually grew into an important force in transforming maternity and reproductive health care throughout Georgia.

Much changed during the six years in which HWG operated. Throughout this period, Georgia was slowly emerging from Soviet era thinking and practices in business, politics, education and in health care. As the private sector grew larger and more confident and the burden of a bloated, out-dated and cumbersome health system became overwhelming, the Government of Georgia committed itself to privatization of its health system, particularly hospitals. At the same time, Georgia moved toward an integrated primary health care model and privatized insurance-based payment mechanisms. With this process came awareness of the urgent need to modernize not just the health system's crumbling physical structures and antiquated equipment, but also to modernize medical practice. Evidence-based medicine, modern management of hospitals and public health programs, supportive supervision and client-oriented services have become increasingly important and accepted. HWG is proud to have been a leader of this reproductive health transformation.

USAID provided consistent, strong support to HWG, adding to its funding and programmatic mandate as needs evolved and opportunities to make a difference presented themselves. Increasingly strong and functional relationships with partners from government (Ministry of Labor, Health and Social Affairs—MoLHSA; The Reproductive Health Council, Ministry of Education, National Centers for Disease Control—NCDC), the medical universities and primary health care training centers, other health donors (UNICEF, UNFPA, WHO), and other USAID projects (CoReform, SHIP) were key to HWG's success.

In the last half of the project, partnerships with the private sector, particularly privatized hospitals and clinics, insurance companies and pharmaceutical chains, grew in strength and technical depth. The private sector is particularly keen to adopt modern practices that HWG research has demonstrated improve medical outcomes, decrease costs and increase client satisfaction at the same time.

The range of activities undertaken by the HWG Project is broad, encompassing community level activities such as youth peer education, breast cancer awareness and parents' schools, large scale provider

training, clinical improvement, contraceptive logistics/distribution, supportive supervision, and medical education in family planning and maternity care. Yet, as broad and diverse as HWG activities were, they shared underlying operational principles. All activities were based on a strong commitment to evidence-based programming, using both worldwide best practices/evidence and generating performance and outcome data in Georgia to validate success. The dual focus of all HWG activities was improving client welfare (clinical outcomes, empowerment and satisfaction) and improving the skills, effectiveness and morale of line service providers (doctors, nurses, pharmacists and teachers). All activities were conducted in cost-effective ways, paying attention to interactive learning principles and partnership and implemented with energy and commitment.

Most of all, JSI and its partners attribute their success to the fact that the overall VISION never wavered. Each and every HWG activity or component adhered firmly to a vision of improving the health and well-being of Georgian women and their families. This report proudly documents major results of this effort.

2. Modernizing Maternity Care

One of the main goals of HWG was to modernize maternity care in Georgia through introduction and institutionalization of evidence-based and family-friendly effective perinatal care (EPC). This goal was achieved beyond the specific USAID project objectives and beyond the expectations of everyone involved. As of September 2009, approximately 70 percent of deliveries in Georgia were at facilities using EPC techniques. JSI trained hospital teams at 16 hospitals. A total of 184 obstetrician/ gynecologists, neonatologists and midwives completed EPC course training, and an additional 300 providers received on-the job training. HWG launched 14 Parents' Schools, developed supportive supervision and monitoring systems. In collaboration with UNICEF, EPC is being institutionalized within pre-service medical education.

Results for the two USAID benchmark indicators of success ("F" indicators) exceeded expectations (Table 1).

EPC Results—Win-Win-Win-Win

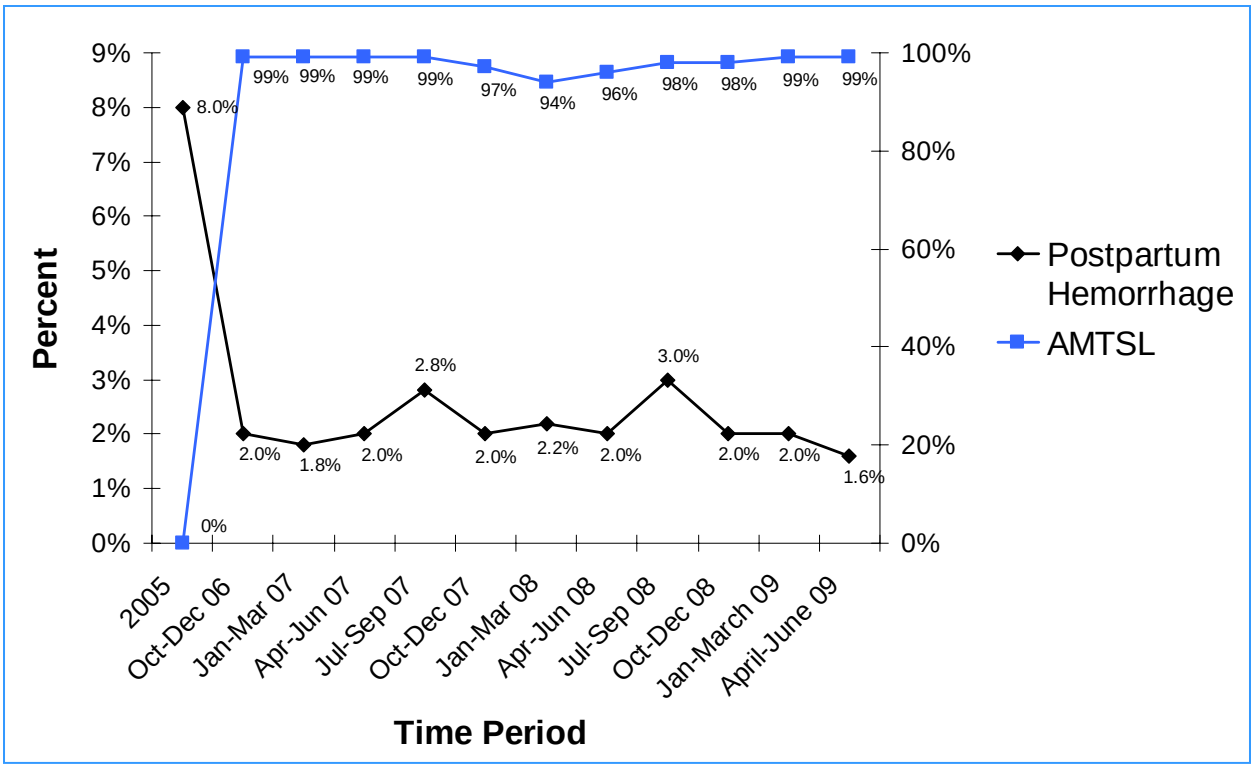
Results from the project's EPC component are a clear example of a four-way "win" strategy. The most important result is improved maternal and newborn clinical and care outcomes. Data on key obstetric and neonatal care practices and health outcomes from each site is regularly collected and analyzed. It documents clear success in a variety of clinical care areas, and the resulting reductions in morbidity due to such preventable causes as hemorrhage, birth trauma and newborn hypothermia.

Active Management of Third Stage Labor (AMTSL) is the most important evidence-based practice recommended by WHO and most international bodies to reduce post partum hemorrhage. AMTSL was instituted in 99% of vaginal deliveries in all HWG-assisted facilities. It had a dramatic effect, decreasing postpartum hemorrhage rates to less than 1%. Figure 1 shows AMTSL for

Table 1. Results for USAID "F" indicators

INDICATOR	BASELINE (SEPT 2006)	JULY 2009	END OF PROJECT TARGET
Cumulative number of women giving birth who received Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs	1,542	23,715	14,000
Cumulative number of newborns receiving essential newborn care through USG-supported programs	1,163	24,331	14,700

Figure 1. AMTSL and postpartum hemorrhage in target maternity hospitals in Imereti region, December 2005 to June 2009



target maternity hospitals in Imereti Region between December 2005 and June 2009. Similar trends were observed in all other maternity hospitals.

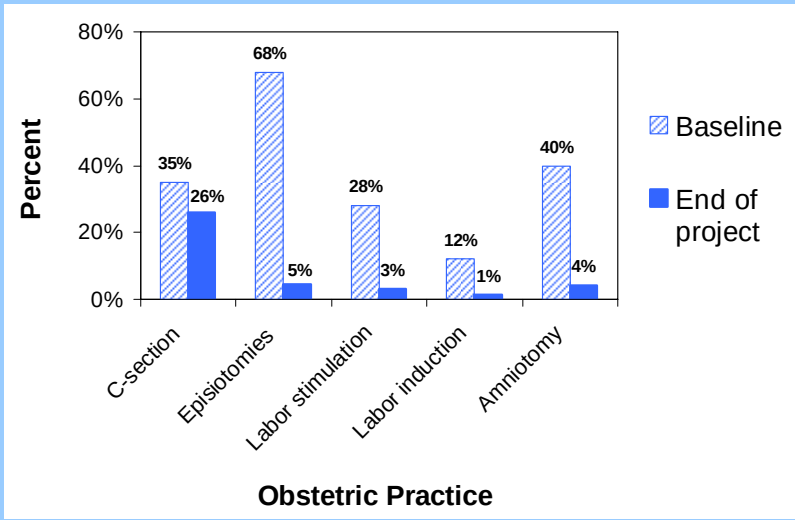
Likewise, a series of "essential newborn care" interventions were implemented systematically in HWG-assisted hospitals. These include skin-to-skin contact (for two hours), early initiation of breastfeeding, monitoring the newborn's temperature and other essential, and evidence-based newborn care practices (see Figures 2a and 2b). Before introducing "warm-chain", newborn hypothermia rates varied from 40 to 90 percent. Hypothermia was caused by not maintaining the "warm-chain", a set of ten interlinked procedures carried out at birth and later. HWG introduced the "warm-chain" technique in all maternity hospitals, which helped to drop the rate of newborn hypothermia to virtually zero. Neonatal complications, including birth trauma and neonatal asphyxia also were reduced. Figure 3 is for Tbilisi (the capital of Georgia) target maternity hospitals. Similar trends and outcomes are observed in other HWG sites.

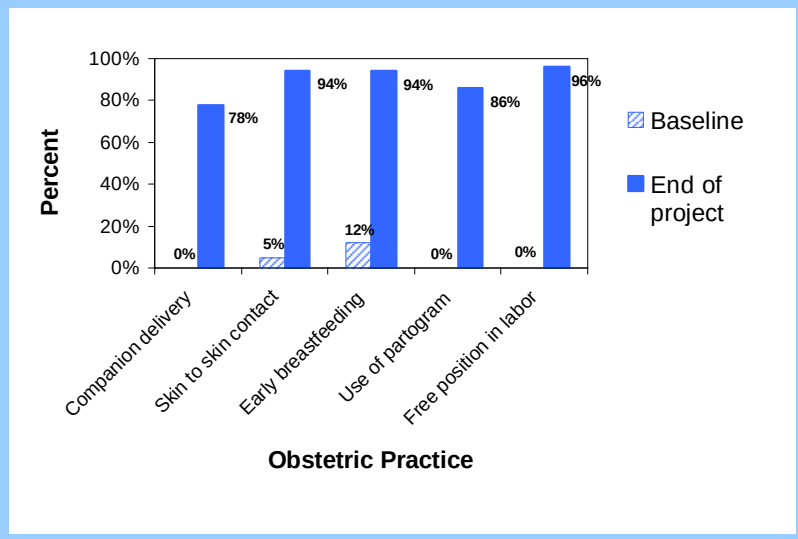
Quarterly statistics were maintained for each HWG-assisted facility throughout the life of the project (and will continue when HWG ends). A baseline assessment of practices was conducted for each participating maternity, and supervision visits (by Georgian Quality Assurance Teams) and on-the-job training are conducted regularly. Good documentation exists of clinical practice changes and key outcome results for each site on a regional basis. Thus Georgia has a sound body of tangible evidence to build upon for its maternity modernization efforts.

The second success area is reduction in service delivery costs. With severe economic stresses affecting young families and cost consciousness in newly privatized hospitals,

cost containment in delivery of high quality services is important. HWG undertook a cost study in two representative participating hospitals (one private, one public), comparing all costs of maternity and newborn care services before and after implementing EPC. Even with the addition recently of HIV testing of pregnant women (which is costly and now mandatory) in the second phase, significant cost reductions were documented, mainly due to decreases in unnecessary (and sometimes dangerous) medications during labor[1].

Figures 2a and 2b. Key obstetric practices before and after EPC interventions (cumulative results for all 16 HWG target maternity hospitals)





Costs also went down because there were fewer complications and shorter hospital stays. Other hospitals implementing EPC documented similar cost savings. The potential cost savings, combined with simultaneous improvements in quality of care, became an important advocacy factor for EPC, especially with private investors. Georgia's biggest hospital investor, Block Georgia, was so impressed with EPC results in their hospital in Zugdidi (in Samegrelo Region) that it now insists that EPC be implemented in every new hospital it takes over. As the director of Block Georgia said:

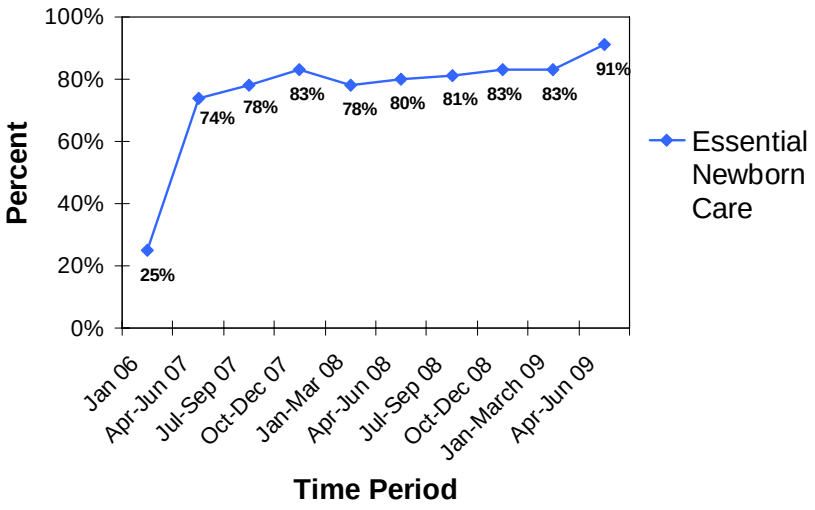
"We have seen the palpable benefits from promotion of EPC principles at Zugdidi Maternity Department through de-medicalization and reduced medical interventions during the delivery. The observed benefits—both in terms of improved health outcomes and reduced hospital expenditures—suggest us requesting JSI support in replication of EPC practices in our other medical facilities."

The third clear success area is improved client and family satisfaction. Many EPC interventions involve simplifying care and making it more humanistic and family-friendly. Some interventions involve simple changes in labor/delivery rooms, including

1. Berdzuli, N., et al., 2009. EPC Cost-Impact Study. Healthy Women in Georgia Program.

protecting women's privacy during labor and delivery and providing warm and friendly individual delivery rooms (hiding equipment, eliminating old Soviet-style delivery beds, adding curtains and painting labor/delivery rooms in pleasing colors). Practices which were more inclusive of the family and supportive of laboring women, such as companion deliveries and free choice of positions in labor, were popular. Use of labor balls has proven to be particularly popular. Hospitals also eliminated ineffective medical or hygiene procedures, such as shaving women, enemas and routine episiotomies. These seemingly simple changes were major steps resulting in tremendous improvements in women's birthing experiences.

Figure 3. Essential newborn care in Tbilisi target maternity hospitals, December 2005 to June 2009



The advent of "daddies in the delivery room" was a particularly big cultural step. HWG developed a program of parents' schools modeled loosely on childbirth education in the U.S. to prepare women and couples for upcoming changes and to communicate the importance of active participation by women, husbands and families in birthing and newborn care.

The faces of women, fathers and families tell the story better than any words or data can.

An additional, unexpected benefit was improved satisfaction of service providers. The typical pattern was that after initial resistance to new practices, particularly

Family-Centered Maternity Care

David and Natia were one of the first couples to labor and deliver together. Their daughter, Nino, was a long-awaited blessing and the experience was "unforgettable—the most precious in life!"

among older practitioners, most hospital staff embraced the changes, especially in light of good outcomes and clearly happy clients. Dr. Irakli Merkviladze, head of the Obstetrics and Gynecology Department of an HWG-assisted hospital described the changes under EPC: "The peaceful sleep finally came back to us after implementation of EPC principles, particularly Active Management of the Third Stage of Labor – no more dreadful fear of postpartum hemorrhage!" Neonatologists have also come to appreciate quieter, healthier and happier newborns that stay with their mothers (rooming in). Evidence-based neonatal care practices dramatically reduce newborn complications.

Increasing competition for maternity clients in Georgia also encourages health professionals to provide client-oriented, evidence-based services. Hospitals which have modernized practice using EPC are experiencing more rapid increases in client loads than non modernized facilities. Bolnisi Hospital (in Kvemo Kartli Region), for example, increased its annual deliveries from under 300 in 2006 to almost 800 in 2008, with no increase in their target population. Government-sponsored subsidies for poor clients account for some of these increases, but Bolnisi staff are convinced that satisfied clients are a major factor as well. These days, there are fewer and fewer home births among minority women in Kvemo Kartli Region.

The fourth area in the multiple win scenario is sustainable change in medical practice. The process of implementing EPC is challenging, but ultimately rewarding. Georgia took inspiration from a number of Eastern European countries, Russia, and most of all, the JSI Ukraine maternal care project (also funded by USAID), when it

"The peaceful sleep finally came back to us after implementation of EPC principles… no more dreadful fear of postpartum hemorrhage!"

Dr. Irakli Merkviladze, head of the Ob/Gyn Department of an HWG-assisted hospital

ONE! TWO! THREE!

Skin-to-skin contact to stabilize newborns' temperatures is a key "Warm Chain" principle. These infants were delivered by Caesarian section, so their fathers provided skin-to-skin contact. Fathers routinely describe this as "one of the most profound experiences of my life."

The first EPC course was held during a blizzard in Kutaisi in February 2006. This group of participants from Imereti Region, medical leaders from Tbilisi and the MoLHSA, HWG staff and a talented team of external trainers was at the forefront of EPC. Their enthusiasm and vision made rapid expansion possible.

began to improve maternity care. Observation visits led to an initial band of "EPC champions". JSI Georgia and Ukraine worked closely with the World Health Organization (providing both funding and technical partnership) to design the first WHO/USAID/JSI Effective Perinatal Care approved curriculum for the Eastern Europe (EE) Region. The original EPC curriculum was in Russian and English; it has since been translated into Georgia and posted on the HWG web site in all three languages.

The first Georgian EPC course was held in Kutaisi in February 2006. What followed was a difficult year of trial and error, as hospitals struggled to implement reforms and change ingrained staff behaviors. JSI and external training teams provided constant technical support, encouragement, monitoring and small subsidies for minor renovations to maternity units. The process was not universally smooth, but little by little, it succeeded.

A second course was held in Tbilisi at Gudashauri Hospital, the main referral hospital in Georgia, in February 2007. The support of key medical leaders from Gudushauri Hospital and a few other well respected maternity hospitals was another important step in gaining broad acceptance. The Georgian Orthodox Church's main maternity hospital also was a participant and became an EPC supporter. The MoLHSA provided consistent assistance and support, as did WHO and UNICEF. At this point, emphasis was placed on developing a national team of trainers, which later successfully replaced WHO experts in subsequent EPC courses. Georgia is now self-sufficient in EPC training, supportive supervision and monitoring and evaluation.

In March 2007, a second observation visit was made to Ukraine, this time including representatives from the breakaway region of South Ossetia. Soon, however, there was little need to take Georgians to third countries to observe EPC best practices. Local HWG target facilities have become examples of successful promotion of EPC technologies and serve as models for replication.

One outstanding example of a locally-inspired transformation is Zugdidi Hospital. A large group of practitioners from Zugdidi Hospital visited Zestaponi and Kutaisi Maternity Hospitals, observed closely, asked many, many questions and then joined the next EPC course. The hospital quickly became an outstanding EPC site. This largely self motivated transformation was remarkable given that on the first site visit, HWG staff found Zugdidi hospital to be "*one of the most old-fashioned and out of date facilities ever seen in Georgia".* Motivation and leadership by hospital management and chief doctors was a key determinant of the success of an EPC site.

By the end of 2007, a core number of hospitals was implementing EPC and JSI continued the cycle of assessments of new hospitals, training events, and supportive supervision. Increasingly, this involved Georgian experts and Georgian supportive supervision technical assistance teams, rather than expensive outside experts.

Privatization of hospitals offered an opportunity to speed up the process of implementing EPC reforms. In 2007, JSI and WHO co-sponsored the visit of a noted architect from Italy who is an expert on hospital design for EPC. Several private companies doing renovations or construction utilized his skills. HWG also facilitated private sector investors' site visits to observe successful EPC hospitals.

In the spring of 2008, HWG and UNICEF began working with the State Medical Academy to reform medical education for EPC. This process involves both technical content and teaching methodology stressing evidence-based science and interactive teaching methods. An EPC medical education curriculum has been designed; medical educators have been trained, and the curriculum is being used to train the next generation of Georgian doctors.

Currently, EPC is being implemented in 16 hospitals. Some are outstanding and virtually 100% compliant, while others still struggle. All understand that EPC is an ongoing learning process. Although these hospitals represent only about 70% of the deliveries in Georgia, unlike some other countries, the most prestigious Georgian hospitals/providers, the State Medical Academy and the largest private sector hospital owners are actively engaged, so momentum exists to continue forward.

Capacity building at maternity clinics and hospitals assures sustainability of many accomplishments. Facility-based Quality Assurance Teams responsible for the maintenance and further refinement of the evidence-based obstetric and neonatal care practices at the clinics are established and function effectively with HWG program support. Yet there is more to be done and more financial and technical assistance needed to address additional issues and increase sustainability.

To support EPC and clinical improvements, HWG designed and delivered six courses on "Infection Free Babies". The short courses provided 203 health care professionals in HWG target sites with up-to-date, evidence-based information about clinical and epidemiologic characteristics of perinatal infections, modern aspects of diagnosis, management and prevention, and strategies

My Story

My name is Tamara Antelava. I am an OB/GYN working in Chachava Institute, the most prestigious private maternity hospital in Georgia. I came to the Gudushauri EPC training a total skeptic. I thought my hospital did the best obstetrics possible and that we had little to learn. The expert trainers brought by JSI changed my mind. I'm a scientist, and I respected the evidence. And as I began to visit and actually see EPC hospitals, happy clients and better outcomes, I changed completely. I got inspired to become a rigorous advocate for evidence-based obstetric practices. I had an irresistible desire to share my newly acquired knowledge and experience with all my colleagues and professionals throughout the country. That is how I became the EPC national trainer.

I now think my career is divided into pre- and post Healthy Women in Georgia EPC. I was transformed! I have changed practices in my hospital. I now work as part of the Georgian EPC Training and Quality Assurance supervision teams. I train in the medical school. I've seen a lot of donor programs come and go, but this one has really made a difference.

to decrease risk factors of infections at maternity clinics.

What Does EPC Entail? Before and After

Table 2 below illustrates what childbirth for most Georgian women was like before HWG started its work, and what it is like for routine labor and deliveries now. The work that HWG has done in EPC represents a dramatic change in the way women give birth in Georgia, bringing better outcomes and bringing families together. And good results and solid evidence now stand behind these changes.

Georgia has gone from learning from other countries to being a model of how to modernize medical practice to conform to international standards. Much remains to be done however. For example, Caesarian section rates are still too high in most places, and neonatal intensive care practices need improvement. Nevertheless, sustainable, positive change has started, and Georgians are in the lead in carrying these to fruition.

Table 2. Giving birth in Georgia—before HWG and after

BEFORE	AFTER
Obstetric/neonatal care practices based on outdated "Soviet" school of medicine	Evidence-based principles incorporated into obstetric and neonatal care
Dehumanized birth experience: 2-3 women delivering together in the frightening delivery room, without supportive person, tied in uncomfortable "Rachmanov" chairs	Family-oriented delivery rooms & care: women deliver individually in nice delivery rooms, accompanied by a close family member and given a choice for labor and delivery positions
Excessive, medically unjustified interventions, overmedication, such as labor stimulation, routine episiotomies, etc.	Medical interventions restricted to those with strong clinical indications (labor stimulation reduced to 4%, episiotomies to 6%, etc.)
Expectant management of the third stage of labor	Active Management of Third Stage Labor (AMTSL) in 99% of vaginal deliveries, and, as a result, reduced postpartum hemorrhage rate to 1%
Babies born in very cold delivery rooms, separated from mothers, given formula or donor's milk instead of breast feeding	"Warm chain" principles widely practiced: Babies and mothers kept together (rooming in) in100%, skin to skin contact in 94% of cases; early breastfeeding initiated in 93% of cases
Infection prevention measures outdated and non-effective	Appropriate hand washing techniques by providers and effective infection prevention practices promoted in majority of facilities
High costs (to hospital and client) due to over-medicalization, unnecessary intervention, and higher maternal and infant morbidity	Fewer wasted resources due to modernized techniques

3. Modern Family Planning for All in Georgia

The overall goal of this component of HWG was to promote access to and utilization of quality family planning services as a basic right of women and to decrease high abortion rates in Georgia.

As with EPC, a wide range of progressively more targeted activities were undertaken. Step-by-step, HWG "grew" a family planning (FP) program, through provider and pharmacist training, provision of USAID-donated contraceptives, development of a logistics and information management system and ongoing supportive supervision. HWG also supported postpartum family planning and post abortion care (PAC), emphasizing counseling post-abortion clients to adopt a family planning method. Clinical services and client counseling go hand-in-hand with community education, information-education and social marketing, described in the next section.

The results of HWG efforts to expand family planning are exceptional. Over three-fourths of Georgia's poorest and most disadvantaged women now have access to FP counseling and low cost or free contraceptives. This is up from a small number of FP service sites, none in rural ambulatories (PHC clinics), when the project began. Results can be seen in achievement of the USAID indicators for this component (Table 3). Note that by the time the USAID "baseline" number was determined, HWG had already expanded to some 141 sites in the original pilot phase.

The story behind this achievement is one of patience and persistence.

Expanding Contraception in Post-Soviet Georgia

When HWG began in 2003, provision of contraceptive services was exclusively through specially trained OB/GYNs (called "Reproductologists"). These specialist providers charged high fees and practiced mostly in cities, leaving rural women with little access to services. Moreover, many of these providers also provided abortions at even higher fees, so they had little incentive to provide family planning. To make matters worse, post-Soviet attitudes (myths, rumors, worries about side effects) of both providers and clients about modern hormonal

Table 3. HWG achievements in family planning

INDICATOR	BASELINE (SEPT 2006)	JULY 2009	END OF PROJECT TARGET
Cumulative couple-years of protection (CYP) in USG-supported programs	3,977	60,555	45,000
Cumulative number of service delivery points providing FP counseling or services	141	575	390

contraceptives were pervasive. The challenge seemed enormous.

The impetus for family planning was assisted by strong worldwide evidence that use of modern contraception reduces abortion rates. This understanding, along with successful programmatic strategies, was reinforced when a high level delegation from Georgia made an observation visit to the successful USAID-supported family planning project run by JSI in Romania. The Romania visit, and the active discussions that happened during the visit, started the ball rolling in Georgia.

Abortion is legal in Georgia and is widely used to regulate fertility. At an average rate of 3.1 per woman, Georgia has one of the highest abortion rates in the world. Georgia also is in demographic crisis, seeing its population shrink due to economic out-migration and low fertility. Despite condemnation of abortion by the Georgian Orthodox Church and the desire by public health authorities to reduce high abortion rates, legal abortion continued to be the main means of fertility regulation at the inception of HWG. The possibility of reducing abortion rates through introduction of modern contraception opened a policy window for promotion of modern contraception.

With strong support from USAID, HWG secured a "waiver" letter from the Minister of Labor, Health and Social Affairs allowing an exception to existing restrictive FP service delivery policies so the project could train non-OB/GYNs, such as primary care doctors, pediatricians, and nurses in family planning counseling and services. These provider cadres have closer links to the average client in rural areas and city slums. Moreover, since none of these provider cadres routinely perform abortions, they have no particular disincentive to providing family planning, once negative attitudes, myths and low levels of knowledge and counseling skills were overcome.

To gain providers' trust, improve prenatal care and link with the safe motherhood component, HWG also designed and implemented a short course on evidence-based ante-natal care (ANC) care for primary care doctors and nurses. A total of 376 providers were trained on evidence-based ANC. This Georgian language course is posted on the HWG web site, and is frequently downloaded and used in primary health care training centers and by medical students.

Evidence-based Family Planning Training

Working with local and outside experts, HWG developed an evidence-based course in family planning services and trained expert local trainers. Unlike previous courses in Georgia (which had been designed for specialists), this course emphasized interactive learning and counseling skills, along with basic knowledge and skills needed to deliver services, particularly oral contraceptives and condoms, the two methods available through non-OB/GYNs. Data from the 2005 Reproductive Health Survey showed that Georgian women do not favor injectable contraceptives[2].

Changes in knowledge based on training were dramatic. All cadres of providers initially had low levels of knowledge on FP. Typically, the variance between pre- and post- test results was 30 to 35 points (out of 100). At times it was as high as 60 points. Nevertheless, HWG soon learned that on-the-job training and continuous reinforcement of skills was needed when providers first started talking to clients and providing contraceptive services. Over the

2. Serbanescu, et al. Reproductive Health Survey Georgia 2005: Final Report.

life of the project, a total of 2,361 doctors and nurses received direct in-service FP training under HWG. Training was provided by JSI and by its partners, CLARITAS (for pediatricians in Tbilisi slums) and Curatio International Foundation (in Kakheti Region). All partners used the same curriculum and Georgian master trainers.

To improve sustainability and make FP information more widely available, HWG placed its curriculum on its web site and also trained trainers from several primary health care training (PHC) centers. Currently most of Georgia's nine PHC training centers use this curriculum to train family doctors. As the program grew, momentum of satisfied users and skilled providers was created, thereby increasing both effectiveness and sustainability.

HWG noted that many medical students and providers were downloading the FP curriculum and other technical materials from the web site. Thus when USAID/ Georgia provided support for the EERFPA (Europe and Eurasia Regional Family Planning Activity), a regional program also run by JSI, HWG jumped at the chance to enter into a partnership to promote curriculum reform in medical education on

Over the life of the project, a total of 2,361 doctors and nurses received direct in-service family planning training under HWG.

FP. Georgian experts from the State Medical University made an observation visit to the US and participated in an EERFPA-organized international meeting in Tbilisi on FP and medical education. This not only resulted in a cadre of senior-level FP medical educators, it also reinforced FP "champions" among Georgia's influential medical elite. In the future, young doctors graduating from the State Medical University will be proficient in provision of FP methods, counseling and promotion. In-service education is likely to still be needed, but in the future it may be less extensive, less costly and locally sustainable.

A SATISFIED USER

The smiling face of a satisfied contraceptive pill user was important for both potential new clients and the newly-trained providers. Word of mouth coming from satisfied users increased program momentum over time.

Contraceptive Supply, Logistics and Market Segmentation

Without a doubt, one of the most strategic decisions behind the success of HWG-supported family planning expansion was USAID/Georgia's decision to provide free or subsidized contraceptives for clients with limited or no ability to pay for them. Donated contraceptives provided a much-needed economic subsidy, as well as an organizing force around which program expansion took place. Over the life of the project, contraceptives valued at US$922,430 were donated by USAID to Georgia. Arguably, contraceptives are one of the lowest cost/highest yield FP investments a donor can make. This certainly was true in Georgia.

In August 2004, JSI experts from the USAID/DELIVER project undertook the first of two ability-to-pay studies[3]. This study looked at the existing commercial market, current donated product (UNFPA) and various economic factors based on best available World Bank data. Conclusions pointed to inadequate supplies for lower socio-economic groups, lack of access to low cost contraceptives in rural and peri-urban areas, low income levels combined with high unemployment and the fact that approximately 40 percent of the population fell in the category of not being able to pay for contraceptives. The second ability-to-pay study, completed in October 2006, showed slight improvement in the economic situation, but still documented need[4]. The studies also documented existence of good quality, low priced product available in the commercial market and several high priced products as well. Early market segmentation strategies focused on protecting these markets. Commercial partners consistently noted that HWG promotion and social marketing efforts increased their product sales—another win-win strategy. It reflected overall growth of the contraceptive market.

Commercial Partnerships

As the HWG program expanded from a small number of PHC clinics in rural areas and urban slums to more prosperous areas of Tbilisi, HWG coordinated closely with the commercial pharmaceutical sector to segment the market so free donated commodities would not compete with the commercial products. In some clinics, for example, HWG undertook training and supervision, but did not supply donated contraceptives. By the end of the project, HWG had developed "memoranda of understanding" to work together with the major pharmaceutical distribution firms—Aversi, PSP and GPC. Together they account for the bulk of the pharmaceutical market in Georgia.

Pharmacists were an important component of HWG program throughout the life of the project. Frequently first-line sources of information for clients, pharmacists play a key role in expansion of contraception. Early on, through its partner CSMA, HWG provide some 600 pharmacists in Tbilisi, Imereti and Kakheti Regions with contraceptive updates. HWG designed a "two minute messages" curriculum to help pharmacists gain skills in rapid counseling of clients who come into their pharmacies with questions.

Later, in collaboration with Save the Children USA, HWG undertook an experiment in developing youth-friendly pharmacies. Some 120 pharmacists in Imereti and Kvemo Kartli Regions were trained in ten training events. Materials

3. Hudgins, T., Rao, R., 2004. Republic of Georgia Contraceptive Availability Assessment. Healthy Women of Georgia Project for the United States Agency for International Development. Washington, DC.
4. Republic of Georgia, 2006. Ability to Pay for Contraceptives Healthy Women in Georgia (HWG) Project.

HWG youth peer educators pre-test logos for youth-friendly pharmacies. HWG worked with pharmacists throughout the life of the project.

distributed in youth-friendly pharmacies disappeared as quickly as they were put out. Although HWG ultimately determined that this approach is not cost-effective, some highly useful lessons were learned about health promotion (e.g., future training of pharmacists) and social marketing (e.g., for pharmaceutical distributors interested in marketing contraceptives). A study conducted on youth-friendly pharmacies concluded that the most important variable in determining whether youth went to a particular pharmacy was not location, cost, confidentiality or other factors. Youth felt the key factor was whether or not the pharmacist *smiled*.

Pharmacists remain a key target group for sustainability and institutionalization of FP in Georgia. Between December 2008 and March 2009, HWG conducted 15 focus groups among women pharmacists (pharmacists are predominantly young women) in conjunction with its social marketing campaign. Findings show that pharmacists still share many of the same misconceptions and myths about contraception as the general public. Moreover, they frequently equate price with quality and so are reluctant to recommend the high quality, low price contraceptive brands which are on the market in Georgia today. Since increasingly pharmacists are part of commercial pharmaceutical distribution chains, a clear future strategy is to work in partnership with these chains and to focus on knowledge, attitudes and practices of pharmacists.

Getting Contraceptives to the Right Place at the Right Time

To manage receipt, customs clearance, storage, logistics, distribution and monitoring of contraceptives to 575 sites, HWG developed a system modeled on best practices of the USAID|DELIVER Project. Representatives from the MoLHSA and HWG logistics staff attended DELIVER training workshops in Ethiopia and South Africa. An important factor in the success of the logistics efforts was active involvement of local, rayon and national authorities. Rayon coordinators are responsible for distribution of contraceptives, data gathering and analysis for all HWG-assisted facilities in their rayons. Periodic meetings are held to review ordering, stocks, service trends and to problem-solve. The entire system is computerized. Supplies are provided based on previous use and projected use, taking into account that some facilities are virtually inaccessible in winter. Despite difficult terrain and a large number of sites, the system is working well. Stock-out rates in 2009 are under two percent. This is an unusually low stock-out rate for a program of this size and complexity.

HWG Logistics Officer Guram Machabeli delivering contraceptives to isolated PHC clinics in rural Kvemo Kartli.

EN ROUTE TO CHIATURA (Imereti Region)

Many communities in mountainous Georgia are isolated and virtually inaccessible in winter, but weather and geography were no obstacles for the determined HWG FP team!

Two important technical innovations of the HWG logistics and family planning management component are the joint logistics management system with UNFPA and integrated data collection forms at the site level for logistics and service delivery data. A unified computerized logistics management system now allows the MoLHSA to track donated commodities from a variety of sources from entry into the country down to the service delivery point (SDP). To accomplish this, the HWG site-to-headquarters computerized system was merged with the UNFPA country-level data monitoring system (designed in New York headquarters). Eventually, this could be a model for management of a broad range of PHC commodities, vaccines or other vital supplies.

The second innovation made life easier for service providers. Virtually the entire contraceptive supply and service system is run by doctors and nurses on a voluntary basis. Providers can receive a token payment for a medical visit, but contraceptives are free, and providers are not paid extra for this additional task. Thus it was important not to overburden providers with record-keeping and reporting. The solution was simple. HWG developed a three carbon copy form which combines service data and logistics (i.e., product distribution) information. Privacy issues were solved by having clients' names only on the bottom copy (which is retained at the clinic), and not on the tear-off carbon copies forwarded to rayons and headquarters. This system is a big success, cutting record-keeping time in half while improving data quality and management.

Expanding FP Services—the Formula for Scaling Up Rapidly

HWG organized its first FP training event in March 2005, working in Imereti and Kakheti Regions and in slum areas of Tbilisi. By August 2009, HWG had opened 575 FP service sites covering over 75% of the country. To accomplish this unusually rapid expansion, HWG came up with an efficient and cost-effective "formula" for expanding services, while supporting and sustaining existing sites. The formula had four components: program introduction/ training; logistics/contraceptive distribution; supportive supervision; and counseling/information-education.

When expanding to a new area, HWG undertook a brief needs assessment and met with regional and rayon authorities. Their support at the beginning and throughout the project was essential to success. Happily, HWG experienced consistent and usually enthusiastic local level support. Rayon coordinators are designated by local authorities at this stage. They receive logistics and record-keeping training. Most rayon coordinators also elect to undergo FP training with their colleagues. The stage is then set for expansion in an area.

Training was organized at low-cost or free local venues, using experienced Georgian trainers. Approximately 20 providers were trained at a time. Training content includes contraceptive technology, counseling skills, and a module on record-keeping, storage of stocks and reordering procedures. On the last day of training, each trainee/site is provided with a "starter kit" including contraceptives and IEC (information-education-communication) materials—posters, pamphlets and a wall chart explaining the benefits and potential side effects of each type of contraceptive. Materials are usually in Georgian, though some are in Azerbaijani or Russian for villages where ethnic minorities live. Providing contraceptives right after training allows providers to begin services immediately, when skills and information are fresh in their minds.

The logistics system provides for quarterly reporting and re-supply of contraceptives by rayon coordinators via the HWG team. At the same time, a cycle of supportive supervision visits begins. An important lesson learned is that supportive supervision, particularly early on when providers are inexperienced, is equally important—or more so—as the initial training event. When providers start serving clients, they have many questions. Clients frequently ask questions they cannot answer, or there are things they have forgotten from training. Regular visits by a trusted supervisor help new providers become confident and knowledgeable providers. HWG developed a simple color-coded (red, yellow, green) supportive supervision checklist. Once a provider/site is "all green," they are determined to be experienced providers of quality FP.

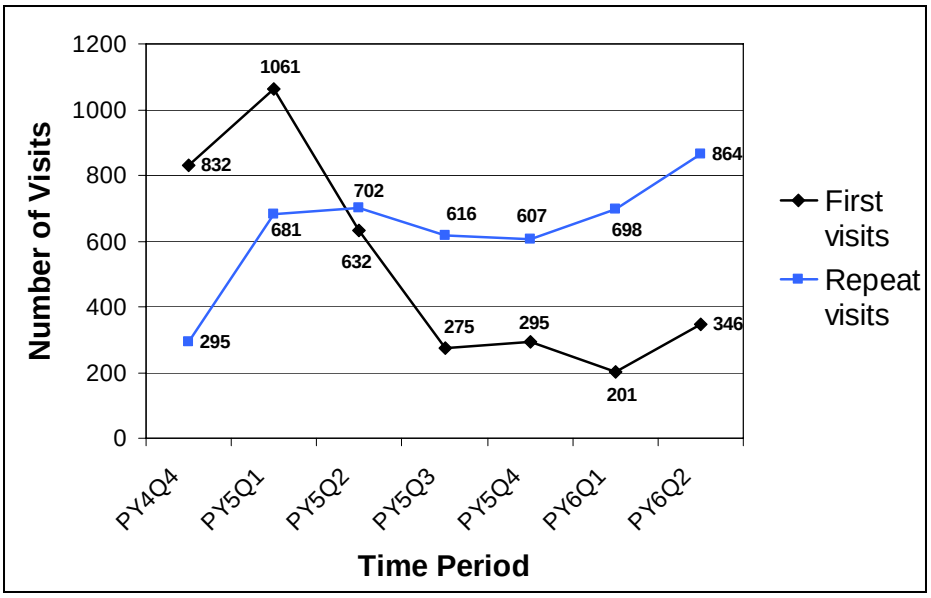
Regular visits and supportive supervision continue, however, even if frequency is less over time. Re-supply visits are an opportunity to determine if there are questions. Short on-the-job training events are organized for one or more sites if there is a persistent question or issue. HWG also developed provider materials (e.g., "job aides") to assist providers. Brochures were developed on "frequently asked questions" about oral contraceptives, myths and misconceptions.

Informing people about FP was a vocation as well as a job for all the HWG partners. Often, regional HWG supervisors from JSI, Curatio or CLARITAS, who are seen in communities as experts, would give PHC providers a boost by speaking at community meetings with women, teens or couples. FP messages and counseling were incorporated into a variety of activities. For example, the NGO HERA, which focused on breast cancer prevention, also included FP messages and materials in all their educational sessions. Orthos and Save the Children organized several "partnership defined quality" meetings in Imereti Region. HWG staff organized *ad hoc* sessions at health fairs organized by Peace Corps Volunteers or for internally displaced persons (IDPs). Invariably, at health fairs, family planning sessions would be the most popular—a testament to an ongoing interest Georgians

IMPROVED RECORD-KEEPING

JSI Clinical Advisor-Supervisor, Dr. Ketevan Kajaia, explains the FP joint logistics and clinical services record-keeping form to PHC provider, Dr. Manana Katsitadze, at Rodinauri clinic. The form dramatically reduced the time providers spend keeping records.

Figure 4. Quarterly dynamics of the first and repeat visits in Samegrelo region



have in learning more about contraception.

PHC clinics provided only oral contraceptives and condoms. Nevertheless, intra-uterine devices (IUD), which are the only long-term method in common use in Georgia, are important, safe, and popular. IUDs are inserted by providers trained by UNFPA and a previous USAID program who practice in Women's Consultation Centers. These centers also are assisted by HWG, with contraceptives (including IUDs), training and supervision. To promote quality IUD use, HWG conducted an assessment of IUD quality and needs assessment in the summer of 2008. The assessment concluded that provider skill was good, but that there is a need for additional equipment and IEC materials[5]. Supportive supervision with PHC clinics encouraged providers to refer women to the women's consultation centers for IUD insertion and to follow them up periodically from their "home" clinic.

The most important tool for guiding the project was analysis of regular quarterly reports from field sites. HWG took the concept of "data for decision-making" very seriously. Figures 4 and 5 demonstrate how data is used to track and guide program evolution. Figure 4 shows 21 sites from Samegrelo Region from the fourth quarter of program year four. Samegrelo was a later addition to HWG, but nevertheless was quite successful. Contiguous to the breakaway region of Abkhazia, it has a large population of internally-displaced persons (IDPs). Figure 4 shows a typical evolution over time. When the project starts, there is a spike in new client visits and a relatively low number of repeat visits. This is because the project is new, but also reflects the fact that contraception is new to many clients. Over time, if the project is running well (and this is the typical case), numbers of new visits will decrease and repeat visits will increase. Samegrelo shows relatively high rates of new visits over time because of an ongoing influx of IDPs and more since the 2008 conflict.

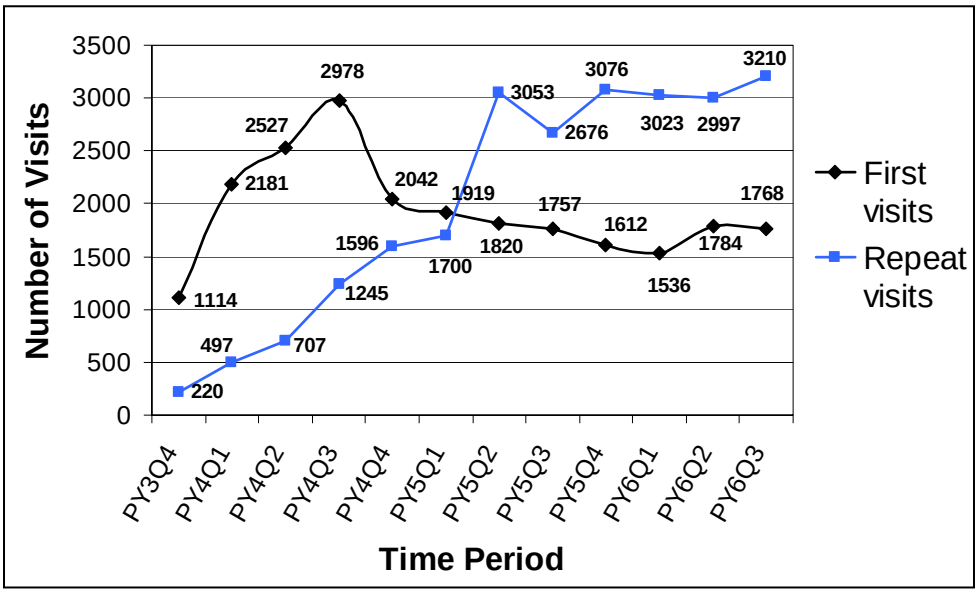
Figure 5 shows data from 148 sites in Imereti region over twelve quarters. The region has progressively added sites until the entire region was covered. A similar pattern with first and repeat visits is evident here as with Samegrelo region.

The recent spike in first visits over the last few quarters is due in part to improved

5. Chikvaidze, P., 2008. Report on IUD Service Provider Needs Assessment Study Conducted in USAID Funded HWG Program Target Facilities in Kakheti, Imereti, Guria, and Samegrelo Regions in Georgia.

supportive supervision. HWG and the EERFPA Project jointly developed a curriculum on supportive supervision, based on worldwide best practices and experiences of other large JSI service programs. It was piloted in a number of sites (some private sector, some public). A case study by EERFPA documents much higher acceptance, even in "older" sites, with improved supportive supervision techniques[6]. The lesson learned is that improvement is continuous, and that projects are dynamic.

Figure 5. Quarterly dynamics of the first and repeat visits in Imereti region



HWG has data for all its regions and sites, individually and compiled, on a computerized data system. At the regional level, staff and rayon coordinators look at quarterly data and trends in each site to assess the program. If, for example, there is a drop in services, HWG staff work with the rayon coordinator to investigate the reason.

The new supportive supervision curriculum and system has changed thinking in a variety of ways in Georgia. Although designed to improve family planning, it had unexpected, positive spin-off effects well beyond this realm. For example, the private sector insurance-funded clinic in Batumi, My Family Clinic, adapted the supportive supervision materials and methods to manage its entire health clinical program. They credit lessons learned through supportive supervision with tripling the clinic's output in six months.

Post-Abortion Care (PAC)

The last component added to HWG (in 2008) was a post-abortion care (PAC) program. Although abortion is legal in Georgia, USAID programs are strictly prohibited from funding abortions or promoting abortion in any way. On the other hand, USAID has long championed programs which help mitigate the consequences of abortion complications through evidence-based PAC and promotion of post-abortion and postpartum contraception. In Georgia, approximately 95% of first pregnancies go to term, whereas by the fourth pregnancy, this ratio is reversed. Reducing repeat and serial abortions provided a clear rationale for HWG focus on post-abortion counseling and FP.

One of the most powerful realizations for providers and clients alike was that a woman can get pregnant within two weeks

6. Haffey, J., Berdzuli, N., Umikashvili, L., Kajaia, K., 2009. Managing Uncertainty: Piloting Supportive Supervision in Georgia. Europe and Eurasia Regional Family Planning Activity.

after an abortion. HWG adapted the USAID post-abortion care curriculum, translated it into Georgian and trained local trainers. It also produced pamphlets and materials on PAC. Abortions are done in hospitals and large clinics, but linkages for PAC counseling and services were made throughout the system—hospitals, clinics and PHC sites. A total of 925 providers were trained in PAC in this component.

Reducing Abortion—Evidence of Change

Worldwide and throughout the former Soviet Union, increases in contraceptive use are associated with proportional decreases in abortion rates. Region wide evidence for reductions in abortion rates will not be available until the next Reproductive Health Survey (RHS), which is scheduled for 2010. If the upcoming RHS "over samples" for Imereti Region, where HWG began activities in 2004, HWG predicts statistically significant reductions in abortion rates. Whether abortion rates in the capital, Tbilisi, have declined is subject to speculation. Increases in contraception seen by HWG, UNFPA and by private sector (sales) are promising.

Anecdotal evidence suggests that abortion rates are falling. In villages where HWG works, providers tend to know every woman, her status, reproductive status and many other socio-economic facts. Providers report a sharp decrease in numbers of abortions. To document this, HWG undertook a "mini reproductive health survey" in two representative villages in Imereti and Kakheti Regions. This survey documents a decrease in abortions in these communities, dramatic increases in contraceptive use and, in the case of Kakabeti a small but encouraging rise in fertility rates. Figures 6 and 7 illustrate this important success.

Focus groups conducted by JSI among reproductive age women and men show widespread negative attitudes toward abortion, despite the fact that the practice continues. An encouraging sign is frequent naming of modern contraception as a suitable alternative to abortion. The tide, perhaps, is turning.

HWG cannot, of course, take credit for abortion reductions. There are many other factors, including increasingly vocal Orthodox Church opposition to abortion, the improving economic situation and general modernization of the country. Still, HWG is proud to have contributed to making contraception accessible and used. This is making a difference.

In sum, HWG built a strong and comprehensive family planning effort in Georgia step-by-step, with patience, persistence and an evidence-based approach. A firm belief in contraception as a human right, and a determination to reduce overly high abortion rates, were the philosophical engines that drove the project forward.

Figure 6. Total fertility rate (TFR) and total abortion rate (TAR) among all women 15-44 years of age, and current use of contraceptives among ever-married women in Kakabeti village (Source: Mini RHS 2009)

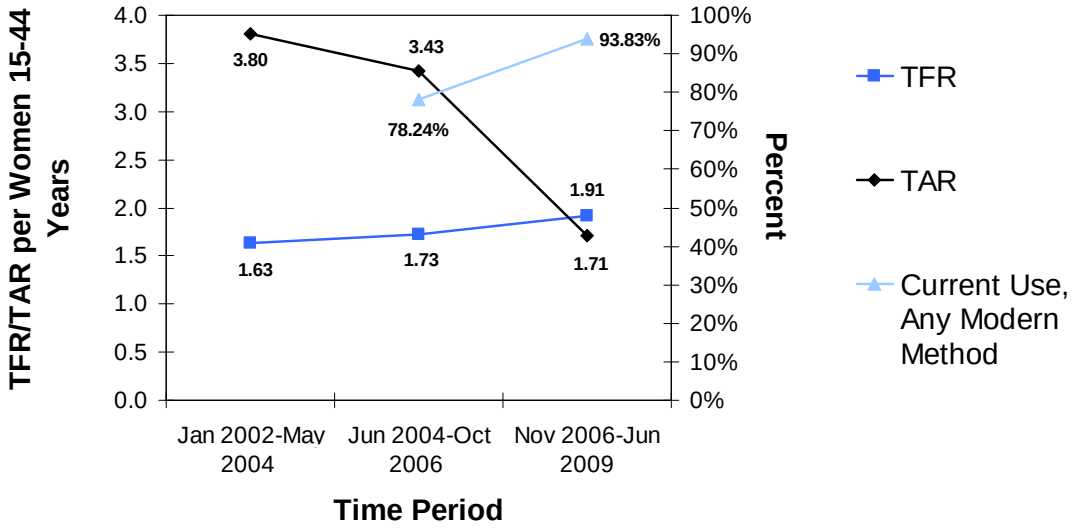
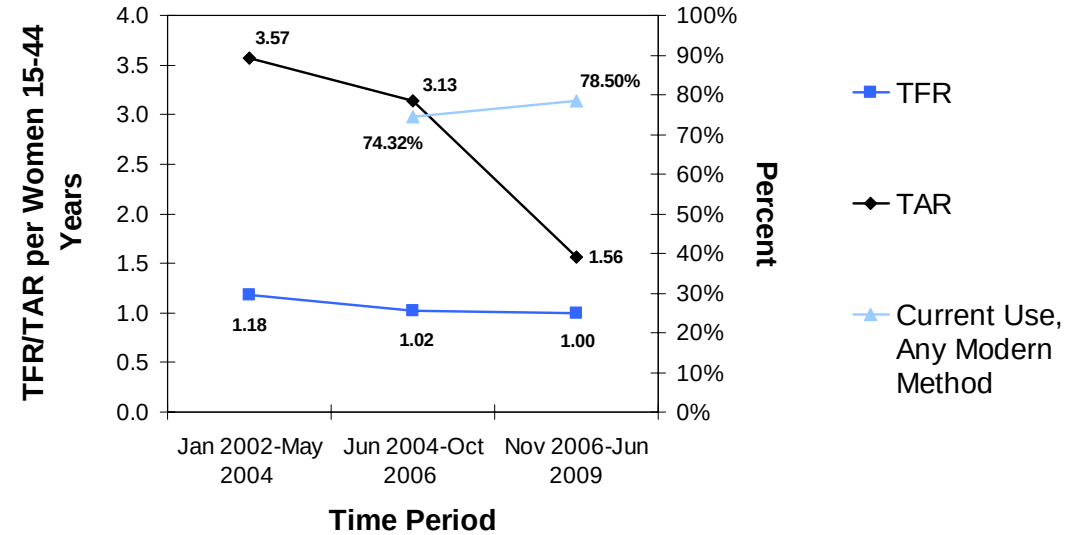


Figure 7. TFR and TAR among all women 15-44 years, and current contraceptive use among ever-married women in Rodinauli village (Source: Mini RHS 2009)



4. Advancing Health Promotion through Informed and Empowered Health Consumers

Creating a solid base of informed health consumers is one of the most important aspects of health reform in Georgia. Prevention is far less costly for stretched health systems than curative care, and informed consumers comply with treatment, seek treatment rationally, and reduce costs to themselves, insurance carriers and the government.

HWG undertook a broad range of activities with a goal of improving both knowledge and health-seeking behavior of reproductive age women, their families and youth. Taking a life cycle approach—beginning in childhood and adolescence and following through childbirth and contraception—HWG health promotion activities were complementary to clinical improvement and training. The underlying philosophy of all activities was to empower women, youth and families with information and confidence to improve their health and welfare through healthy lifestyles and pro-active prevention.

Measurable gains were made in several important areas, including:

- Promoting the benefits of modern contraception and dispelling myths and rumors about contraceptives.
- Educating young couples about ante-natal care, childbirth and newborn care, preparing them for a modern maternity experience, taking care of their newborn and postpartum care.
- Educating the public about breast and cervical cancer and improving outcomes through screening and early detection.
- Promoting healthy lifestyles among youth, preventing the scourge of HIV/AIDS, STIs and unwanted pregnancy.
- Keeping the public informed through an internet web site (www.jsi.ge) and public service events.
- Targeting special needs and disadvantaged groups (e.g., ethnic minorities, IDPs and breakaway regions).
- Creating partnerships and advocating for health promotion among public and private sector partners.

Contraception—Your Modern Choice

The social marketing component of HWG successfully launched three national campaigns over the life of the project. In each campaign, HWG worked closely with partner McCann Erickson-Georgia Advertising Agency, which was selected through a competitive bidding process. Throughout the process, HWG was advised by an expert Technical Advisory Group (TAG), whose members came from major

pharmaceutical manufacturers (Bayer-Schering and Gedeon Richter), the MoLHSA, USAID, UNFPA and other key stakeholders.

The objectives of the first and second campaigns were to raise the public's awareness about a range of modern contraceptive products and services noting tangible benefits to Georgian couples. The third campaign used market research to refine the message and themes and multiply impact. It underscored that modern contraception is safe, reliable and widely available to women all across Georgia. All three social marketing campaigns met their objectives, reaching wide audiences throughout Georgia. They helped advance the acceptance and use of modern contraception across the country and complemented one-on-one counseling and IEC in the FP program.

Evidence-based market research was used to formulate communication strategies for all national campaigns (see Box 1). Campaigns used multiple channels and media including: TV ads, television talk programs, print media placements, radio programs, outdoor display billboards, internet website publications, internet flash banners on social networking websites and client brochures. In all, eight TV ads were created and aired nationally across the campaigns; six radio spots, three outdoor billboards, and over thirty TV programs and popular magazine, newspaper and online articles were placed. Over two million families were reached with multiple exposures per family.

All campaigns were successful in supporting the overall HWG program as evidenced by significant increases in numbers of both first and repeat visits during campaigns. For example, the third national campaign in June 2009 resulted in an over 36% increase in first visits and a 19% increase in repeat visits at HWG sites across Georgia. The social marketing campaigns also were popular with private contraceptive manufacturers and distributors; they also reported spikes and increases in their product sales as a result of the campaigns.

Healthy Childbirth & Happy Families—Parents' Schools

Childbirth education plays a major role in fostering the health and wellbeing of pregnant couples and newborns during labor and after birth. It is documented that anxiety during pregnancy and delivery caused by lack of awareness increases the risk of morbidity and complications during labor and even after birth. Moreover, lack of antenatal information can lead to increased numbers of pregnant women seeking unnecessary medical interventions (such as elective Caesarian sections), without proper medical indications. Studies conducted in different countries have demonstrated the positive impact of childbirth education on birth outcomes. Before the HWG project, childbirth education was virtually non-existent in Georgia. It has now been included in the Protocol on Antenatal Care, which carries a recommendation for clinics.

CONTRACEPTION—YOUR MODERN CHOICE

This clip (left) is from a TV ad with the theme "Contraception—Your Modern Choice". All advertisements emphasized caring and protection in families. This clip shows a modern couple making positive choices.

BOX 1. EVIDENCE-BASED MARKET RESEARCH

Making good marketing strategy decisions requires research data and strong analysis. This is "best practice" in all of commercial marketing as well as social marketing, though it is seldom implemented due to time constraints or difficulties in producing high quality research. In Georgia, HWG used evidence-based market research whenever possible in making marketing decisions and forming communication strategies.

On the consumer research side, this included slogan testing, ad and local media pre-screening, target client surveys and campaign impact monitoring. On the market analysis side, this included regular scans of the pharmaceutical retail market and growth of the modern contraception segment and commercial product pricing, affordability and availability.

For example, HWG completed important consumer focus group research involving 31 focus groups with women, men and pharmacists in rural and urban areas in four regions. Objectives were to provide evidence-based data to refine the HWG communication strategy for the third national social advertising campaign and to better understand attitudes, beliefs and opinions about abortion and modern contraception. The study gave important insights into the societal and cultural acceptance of the concept of modern contraception. Contraception was spontaneously and most often mentioned as the best option available to women to prevent the need for abortion.

In addition, HWG completed a quantitative market analysis of the pharmaceutical market in Georgia which identified a significant (10%) total market growth in modern contraceptive product sales. Some of this growth can undoubtedly be attributed to the many capacity building, service delivery expansion, training and social marketing efforts of the HWG project.

In response to the increased need and interest of expectant parents to learn more about pregnancy, delivery and postpartum care, HWG launched a Parents' School component in 2004. Early parents' school classes were not based on a formal curriculum, although they did stress communication between provider and client. Progressively, HWG gained experience and improved its curriculum, which is now based on childbirth education in the US. Now the HWG product consists of a full package of parental classes which can be incorporated in the maternity hospitals or women wellness centers.

Organizing principles of the Parents' Schools include:

- Parents' Schools are physically located in a convenient, pleasant room equipped with chairs, TV/DVD player, visual aids and posters for attendees.
- Sophisticated training programs for Parents' School facilitators prepare them with an up-to-date curriculum which they deliver to their classes.
- Trained facilitators are mostly personnel of the same maternity unit where they work. One facilitator provides overall supervision and reporting.

HWG has learned important lessons through Parents' Schools. According to client exit interviews, clients who attended Parents' School classes had less anxiety and fear during labor, shorter mean duration time of the second stage of labor, and better overall

outcomes for mother and baby. Partner attendance, which is actively promoted through Parents' School classes, creates a positive emotional and physical environment for the women in delivery. The most desirable partner during delivery is a husband.

Attendance at Parents' School sessions differs somewhat in the state-owned healthcare institutions and private facilities. Private health institutions appreciate Parents' Schools for ensuring cost effectiveness of their hospitals and promoting client loyalty. Some private facilities are now charging fees for Parents' School classes.

Parents' Schools have a promising future, but more needs to be done to develop this effort. Under HWG, the average set-up cost for each Parent's School was about US$8,000, including physical rehabilitation and furnishing of the room and training of facilitators. These costs were shared between private hospitals and HWG. In the future, the cost should be decreased to promote expansion and provider training needs to be institutionalized in a medical or midwifery school. Although Parents' Schools are increasingly common, popular and effective, additional policy changes are still needed. Insurance companies must incorporate Parents' School classes in services they reimburse as part of anti-natal care. Participation in Parents' Schools needs to become routine, with hospitals, special government programs or individuals meeting recurrent costs. Finally, the MoLHSA needs to formally integrate childbirth education as part of the national health policy (rather than merely as a recommended practice).

Surviving Breast and Cervical Cancer

Even before its landmark RAMOS study (see Box 2), the HWG team knew that breast cancer was an enormous problem for Georgian women. Few facilities for cancer screening existed, medical practitioners were inexperienced at clinical diagnosis, and breast self examination was uncommon. Over half of breast cancers were being diagnosed too late for effective treatment. Compared to Western Europe and the US, Georgian women were dying too frequently from a disease that can be treated if caught early. Widespread stigma and ignorance about breast cancer compounded the problem and impeded early diagnosis.

BREAST CANCER EDUCATION

HWG Deputy Director, Dr. Nino Berdzuli, the First Lady of Georgia, Ms. Sandra Roelofs, and race participants examine materials on breast self-examination. Education and stigma reduction is saving lives.

BOX 2. RAMOS Study—Changing Public Health Priorities

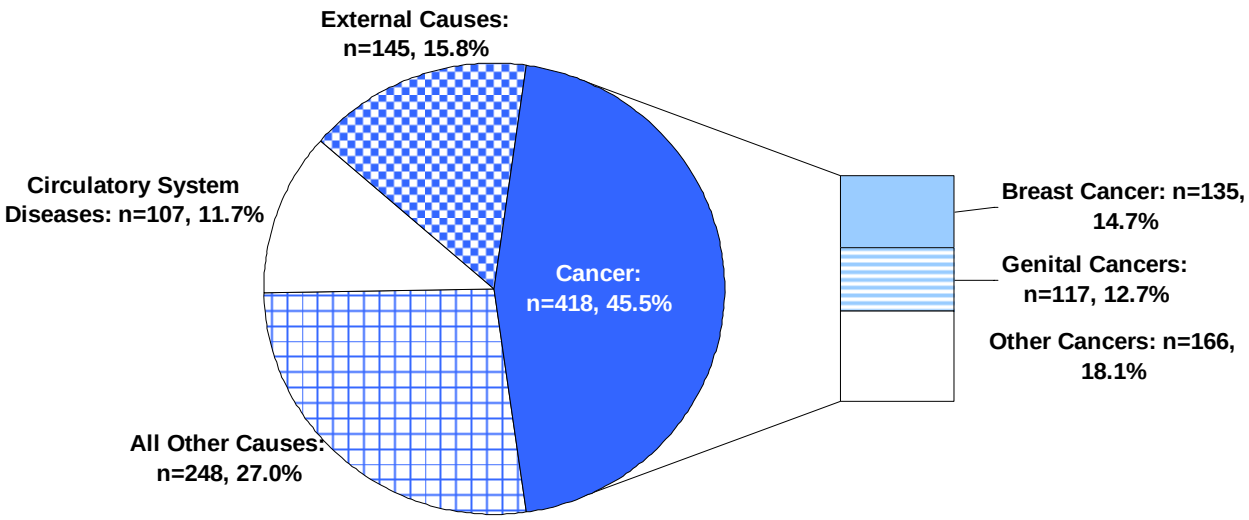
In 2007, Healthy Women in Georgia/JSI/USAID together with the US Centers for Disease Control and Prevention (CDC), and the National Center for Disease Control (NCDC) in Georgia embarked on what would become a landmark study. Designed to investigate the deaths of all WRA (15-49 years) who died in 2006, the study meticulously identified its study group from death certificates from the State Department of Medical Statistics (SDMS) and the Cancer Registry. Verbal autopsies were conducted interviewing families and providers, and expert physicians assigned underlying causes of death according to ICD-10 international codes. This was the first rigorous study of its kind in the EE region.

Results have long-term implications for public health in Georgia and possibly throughout the EE Region. Although it is often seen as a disease primarily affecting older women, in Georgia breast cancer is the single biggest killer of WRA as well (Figure 8). Moreover, almost three quarters of women were diagnosed in later stages (3 and 4) of the disease—too late for effective treatment. The average survival time of breast cancer victims was 8.8 months. The second largest killer was cervical cancer, followed by external causes, mainly accidents. Circulatory system diseases came next—far less as underlying causes of death than reported in the official Georgian yearbook. Direct maternal causes remain relatively small as a percentage of overall deaths. Nevertheless, maternal deaths were at least twice previous official estimates.

The implications are clear. First and foremost, the major causes of death of young women in Georgia (breast and cervical cancer and traffic accidents) are all *preventable* through early detection, prevention, screening, early treatment and enforcement of safety laws. Second, as Georgia moves ahead with rational health planning and privatization, vital events reporting must be improved. Finally, Georgia must remain attentive in its efforts to improve outcomes in maternal health and reduce maternal morbidity and mortality.

Study Co-principle Investigators: Mariella Tefft. RN, MS (JSI) and Dr. Florina Serbanscu, MD, PhD (CDC)

Figure 8. Leading causes of death of women of reproductive age (15-49 years) in Georgia in 2006 (preliminary results)



A small grant to a committed HWG partner, HERA, resulted in significant strides to address the issue. HERA is a small Georgian non-governmental organization, based in Kutaisi and made up of women doctors and nurses who had resolved to make a difference. With support from HWG and later the Susan G. Koman Foundation, they undertook community education (of teachers, hairdressers, anyone they could organize into groups) on breast cancer and family planning. They trained over 400 medical providers on clinical breast examination, promoted early detection and treatment by printing and distributing thousands of pamphlets and educational materials, and organized community awareness events.

By far the most successful awareness raising activity undertaken by HERA, and supported by all the HWG partners, by USAID and US Embassy staff and by the Peace Corps, was the Breast Cancer Awareness Walk. The first Walk was organized in Kutaisi in September 2006. It had the support of the First Lady of Georgia, the MoLHSA and many other groups, including hundreds of teachers and school children. A mystified mayor and other civil authorities in Kutaisi participated. They had never seen such an event. Social mobilization for such a cause was new to this small city.

The second Walk was organized the following year. It was larger and better organized than the first event, and by now well understood and warmly received by the population of Kutaisi.

As the momentum of the HWG breast cancer work increased, HERA grew and developed as an organization, increasing its impact and expanding geographically and adding partners. HERA became an important national resource, organizing a national meeting on the latest breast cancer research, conducting education sessions for embassies, private companies and others, and fund raising in the private sector. This private sector initiative led to financial support from such groups as British Petroleum, the International Women's Association, HSBC bank, Georgian Bottle and Mineral Water Company and other groups. Subsequently additional funding was secured for this innovative public-private partnership from the USAID Global Development Alliance. The

SOMETIMES, BREAST CANCER IS VERY PERSONAL

U.S. Ambassador John Tefft and Mariella Tefft supported all three breast cancer walks. They are standing with Mrs. Ciala Umikashvili and her daughter, Dr. Lika Mikashvili, HWG Senior Program and Policy Advisor. Ambassador Tefft's sister died of breast cancer. Ciala was the first breast cancer survivor in Georgia to publicly speak out about her illness. Tragically, she passed away in 2008.

SURVIVE Project functions under the auspices of JSI/HWG and has further advanced breast and cervical cancer education and screening.

HWG and HERA entered into partnerships with the National Cancer Screening Center which had funding from the French Government and Tbilisi Municipality for a large new screening center. HWG helped with computer support and HERA provided much-needed training in counseling and client education. A grant and technical assistance from the Joint Jewish Distribution Council resulted in the introduction of the first survivor support groups in Georgia.

To expand to scale, Tbilisi was selected as the site of the third breast health awareness walk.. This greatly expanded event received official sponsorship from the Susan G. Komen Breast Cancer Foundation, and used their trademarked Race for the Cure title. Over 2,000 people gathered at Turtle Lake, Tbilisi for the successful event, which included television programs and other media events, plus a special benefit ballet performance by Nina Ananiashvili and her company, all of whom volunteered their time. Because of its success and impact, the Komen Foundation has agreed to sponsor HERA and the Race for the Cure for three more years following the end of HWG.

The huge demand for screening services is evidence of the impact of these educational, community mobilization and training efforts. Nevertheless, more needs to be done, especially to insure access to screening for rural women and in small cities outside of the capital.

Youth Healthy Lifestyles

Young people in Georgia grow up quickly, and are "at risk" for early pregnancy, substance abuse, smoking and sexually transmitted infections, including HIV. Data suggest that youth are being initiated into drug use earlier, compounding prevention challenges.

Two Knowledge, Attitudes and Practices (KAP) surveys of youth were conducted by HWG in 2004 and 2006. They documented very low levels of knowledge by Georgian teens about reproduction and contraception, basic facts on substance abuse and sexually transmitted infections, despite high literacy and educational levels in the country. The survey[7] showed that notwithstanding Georgia's highly conservative culture, youth—especially young men—are initiating sex early (often with female sex workers), smoking and experimenting with drugs and alcohol. Attitudes data suggested that many youth were unaware of the health risks they face and they did not have negotiation skills and sound information. Clearly, youth healthy lifestyles education was a priority for Georgia. The second KAP study[8] showed gains in knowledge, but little difference in practices. Based on this report, adjustments were made to the teaching approach.

Understanding the need and starting a program were two separate matters. Because reproductive health education was extremely sensitive and because youth needed accurate information, a healthy lifestyles (HLS) curriculum was developed covering the following topics: puberty, the cycle of reproduction and reproductive health, dangers substance abuse—alcohol, smoking and drug use, sexually transmitted infections (STIs), including HIV/AIDs and early marriage. Trainers recruited were local doctors and psychologists with experience in youth education. From the start, training techniques were highly interactive, based on games, discussion and lively question-answer formats. Initially,

7. XXX ref???

8. Save the Children/USA, JSI, 2006. Assessing Change in the Knowledge, Attitudes and Practices of Youth in Two Districts of Imereti, Georgia, Regarding Healthy Lifestyles and Reproductive Health.

content was information-focused, but based on the second KAP study and a curriculum assessment, the course was reoriented to be more hard-hitting and focused on behavior change and negotiation skills.

Early courses were mild in terms of content, but they nevertheless engendered opposition and suspicion. A conservative religious leader in Chiatura, a town in the mountains in Imereti, for example, was publicly critical of the HLS effort. Thus school principals and teachers who volunteered to participate in the program in the first round were courageous and forward-looking. Later, as the program became well accepted and popular, schools literally lined up to participate. HWG earned awards from Kutaisi Municipality three years running for the best youth program in Kutaisi.

By the end of September 2008, 20% of the schools in Imereti region were covered by the HLS program, a similar percentage in Samegrelo region and 9% in Kvemo Kartli region, which was targeted for HLS expansion. In all, HWG worked in 155 schools, exposing 6,150 youth to HLS courses through 310 trainings (six sessions each).

Public School #17

With 450 students, Public School #17 in the city of Kutaisi is typical of most Georgian secondary schools—with one exception. Four enthusiastic volunteer teachers, volunteer peer educators and 80% of the student body have been active in the HWG after school healthy lifestyles program since 2004. In 2007 the school proudly took home 2nd place in the region-wide Sound Body/Sound Mind competition. To win, they organized skits, sports and informational competitions. Since students are actively involved, they report having less time to pursue harmful distractions, such as drugs and gangs. The school is now self sufficient in HLS; their teachers were trained last year to independently conduct sessions on reproductive health, communication/sensitivity training and to organize peer groups. Prior to the HWG program, teenagers in Kutaisi had few, if any, options to obtain accurate information on reproductive health and substance abuse.

Results come one teen at a time. A ninth grader recently walked into an early marriage session co-hosted by a teacher and a peer educator. She had a crush on her boyfriend and thought she was ready for marriage. After the session and personal counseling, she decided it was best to delay marriage and graduate from high school.

Young people participated actively in every aspect the HLS program: they were on the selection committee for trainers; youth representatives pre-tested initial messages for broadcasts on HLS on Kutaisi local radio stations; and they pre-tested IEC materials, including for youth-friendly pharmacies.

By far the most important contribution of youth to the HLS movement was through peer educators. Beginning in 2005, HWG partner, Save the Children began training volunteer youth from each school to be peer educators. Both KAP studies had noted that friends and peers were the most common source of information about reproductive health, drugs, etc., and this finding conforms to international evidence. Since youth turn to their peers for information, HWG reasoned that it was important that peer educators have the facts—along with skills to communicate them to other youth. Some 1,100 peer educators were trained in 44 training sessions.

HWG-affiliated peer educators were an extraordinary group. They reached out to other students, with information and counseling. They held classes on various topics. They organized ever popular theater programs which dramatized real life situations facing youth. They volunteered their time and energy to help organize every pubic event sponsored or co-sponsored by HWG, from the annual World AIDS Day events, to breast cancer walks, youth camps, sports competitions, outreach to parents' groups, holiday events for IDP children and technical sessions. There are many, many testimonials from youth—particularly peer educators—about how HWG changed their lives and world view. Peer educators gave back to their communities.

Initially skeptical of reproductive health education, as often happens with parents around the world, parents groups eventually came to be active supporters. One parent, Nana, began by saying "*I have a fear that trainings, especially on sexual relationship and contraception, might interest the youth at a very early age.*" Later, she reflected on the HLS classes and the experience, saying "*To my mind, these types of programs should also consider holding courses for parents, since, often, parents don't know about healthy lifestyles. When a parent is well informed about the issues, the child will be more educated.*"

One of the most popular single activities in the program was the annual healthy lifestyles calendar competition. Each year, HWG held a competition for drawings and paintings by youth in participating schools on various topics of HLS. The hundreds of creative and thoughtful drawings made the judges' job difficult, but each year only thirteen were selected. Student with winning drawings received a cash prize along with a recognition ceremony attended by their family and teachers. For one young artist, the cash prize was welcome for his struggling family, but the recognition gave him a boost in self esteem that was worth even more.

A watershed moment for the youth HLS component of HWG came in 2007. As the program met or exceeded its targets and fielded increasing numbers of requests for

PEER EDUCATORS

Youth are actively involved in the HWG healthy lifestyles program. Over 1,100 peer educators promote HLS.

HLS classes, the question of sustainability and long-term impact became important. The answer seemed obvious, if challenging—train teachers to take over HLS training and the organization of peer educator groups. It meant a big change and a turning point.

POSTER CONTEST WINNERS

Contest winners proudly pose with HWG staff. The annual poster competition brings out students' creativity, gets the HLS message across, and is one of the most popular HWG activities.

To do this in a sustainable way, HWG teamed up with representatives of the Ministry of Education, which was in the middle of an educational reform process, and the MoLHSA, which had an ongoing interest in health education. Over the next year, an expert group developed a comprehensive module-based HLS program, with teacher training materials, educational and instructional aides, and teaching guides. HWG then embarked on the process of testing this new curriculum. It sought official recognition by the Ministries of Health and Education, both of which have their logos on the materials. The teacher training curriculum was launched December 24, 2008.

To date, 325 teachers have been trained in 22 teacher training events. HWG is working with 22 local Educational Resource Centers (ERCs) to institutionalize HLS education in their secondary school programs. More needs to be accomplished, but HLS education is well advanced.

www.JSI.ge

Early on, HWG recognized the power of the Internet to spread sound health information and to reach out to ordinary Georgians and health providers. When HWG started, there was little, if any, Georgian language health information available. Information available in Russian or English was frequently confusing, hard to access or unreliable. From the time it was up and running in early 2004, HWG has seen a steady increase in hits from this increasingly internet-connected society. HWG has become a respected and trusted source of sound health information. It was reformatted to be more user friendly in 2007, and advertised through banners on popular web sites such as www.jobs.ge. Content is translated into Georgian, Russian and English.

In addition to the general public, HWG utilized its web site effectively as a medical and nursing education tool. It conducted several sessions at medical schools to publicize its curricula in FP, ANC, EPC and special topics such as Infection Free Babies. Most of the nine primary health care training centers report downloading the various curricula for their teaching. Pre-service education materials are now on the internet site as well.

The growing power of the internet can be seen in results from the latest social marketing campaign. During a 35 day period (in June-July 2009) HWG placed an internet flash banner on the popular social networking website odnoklassnikis.ru which generated 14,103 hits leading to the www.jsi.ge website.

WWW.JSI.GE

www.JSI.ge remains one of the few trusted sources of Georgian language health information. Even Georgians living abroad seek information on childbirth or family planning in their own language on this site.

Reproductive Health and Infant Feeding "Hotline"

Telephone "hotlines" manned by trained professionals who answer questions and give general counseling or referrals is a well established health promotion tool. HWG maintained a reproductive health and infant feeding "hotline" through its partner, the respected Tbilisi-based NGO CLARITAS.

Calls into the hotline were initially free from Tbilisi and later other places, such as Kutaisi. Free calls and other promotion activities (such as the breast cancer walk or social marketing campaign) increased numbers of callers. Providers manning the hotline were well trained to answer standard questions and refer questions they could not answer. HWG tested the hotline periodically through "secret shopper" calls. The majority of calls were on family planning, sexually transmitted infections, HIV/AIDS and infant feeding. In 2008, the last year HWG sponsored the Hotline, 8,000 calls were received. Although never as well patronized as the web site, the hotline provided an important source of information, especially for poor women without access to internet or other technologies. Nearly everyone in Georgia has a cell phone.

HWG in Print—Educational Materials for All

The appetite of Georgian women, families and youth for accurate health information on topics of interest was seemingly inexhaustible. To fill the gaps and not reinvent the wheel, at the start of the project, HWG convened an expert IEC working group to review existing materials for technical content, relevance and presentation. Whenever possible, permission was secured to reprint materials, thus saving time and money in development costs. HWG also secured permission from USAID projects in Azerbaijan (EngenderHealth) and Armenia (Emerging Markets Group/ Intrahealth) to reprint materials in Azerbaijani and Armenian languages for ethnic minorities living in Georgia.

As the program advanced, the need for specific materials and "job aides" for

providers (for example, hand washing posters for clinics and hospitals) made materials production an important activity. HWG developed cost-effective solutions for printing and reprinting materials. In all, 228,500 copies of some 52 posters, brochures, guidelines, booklets or "job aides" were produced. This does not include print materials from the social marketing campaign. Despite considerable effort and expense, HWG only touched the surface of the ongoing need for quality reproductive health education materials.

One innovation was imported from a JSI program in Africa. Noting that different providers gave health messages different ways, and that translation of medical terms into Georgian is sometimes a haphazard process, HWG teamed up with the USAID CoReform and the Oxford Policy Management Project (British DfID-funded), along with various health partners and the MoLHSA to produce a Georgian Language Reproductive Health "Message Guide" to harmonize RH language, common Georgian words for medical terms and client messages across a variety of providers and programs. Five thousand copies of the message guide were printed and distributed by USAID/ CoReform.

Reaching the Most Vulnerable

A crossroads of civilization for 2,000 years, Georgia has always suffered turmoil. In recent years, things have been difficult. Armed conflict in 1991 and 1993 resulted in the break away of South Ossetia and Abkhazia, respectively. The conflicts resulted in infusion of approximately half a million internally-displaced persons. The invasion of Georgia by the Russians in the summer of 2008 brought more IDPs, more instability and more suffering. As a group, IDPs are especially vulnerable, having been displaced from their homes and living with poor employment prospects. HWG prioritized working with IDPs from the start, organizing special programs, such as parents' schools and youth programs in IDP

On The Move

The Russian incursion into Georgia in August 2008 brought more suffering and more IDPs. Several HWG-assisted service sites in Gori Region were totally destroyed. Donations from JSI's president and staff helped rebuild them.

Photo: Irakli Gedenidze

centers. After the war, these efforts intensified. HWG work in areas in Samegrelo and Gori Regions served a high percentage of IDPs.

In 2007, USAID provided a modest amount of funding for a health and reconciliation effort—called HEAL—which aimed to bring together health professionals from Georgia, South Ossetia and Abkhazia to focus on reproductive health. The concept was that what draws health professionals together was more compelling than political differences. Site visits were made to Abkhazia and South Ossetia and two training events were organized in neighboring Ukraine. EPC training included South Ossetians and Georgians, and family planning training included all three groups. Modest progress was made in introducing evidence-based RH and, to a lesser degree, reconciliation, although this effort was hampered by a proscription from providing direct assistance in the breakaway regions. Efforts of the HEAL component were largely nullified by the Russian incursion.

The 2005 Reproductive Health Survey and many other studies have consistently documented the fact that ethnic minorities living in Georgia (Azerbaijanis, Armenians, Greeks, Roma) have lower overall health status—more abortions, home deliveries, early marriage, etc. Minority youth are frequently unemployed and language barriers in some ethnic minority villages prevent assimilation with Georgian culture. HWG worked with minorities in Kakheti and in 2007 began working in Kvemo Kartli Region, the most disadvantaged region in Georgia. Activities spanned the range of HWG program inputs, from EPC to FP and youth education. Results to date have been encouraging.

5. Conclusions and Reflections:

Making a Difference—Why Healthy Women in Georgia Worked

HWG staff and partners are proud of the many accomplishments of the project over the last six years. We are proud to have documented sustainable changes in health programs, and to have made a difference in the lives of many Georgians. As is usually the case, reasons for success are many and varied. Certainly the dedication, competence and persistence of staff are ultimately the most important factors in success.

Other key factors might be:

- Programmatic, budgetary and contractual flexibility (granted by USAID and managed by JSI) which enabled the program to grow and expand geographically and technically in accordance with needs and opportunities.
- Evidence-based programming—consistently using the best worldwide and Georgian evidence, combined with the "readiness" of the Georgian medical community to adopt evidence-based medicine.
- Provision of USAID-donated contraceptives.
- Consistent emphasis on partnership (even when it was the more difficult route to go) with public and private sectors, inside HWG with partners, with other USAID programs, with international agencies (WHO, UNFPA, UNICEF) and with other JSI projects (Romania, Ukraine, EERFPA, DELIVER).
- Creation of local Georgian "champions"—senior medical professionals, mayors and politicians, university professors, teachers and private sector leaders—who became both a cheering squad and a route to institutionalization of reforms.
- Leadership and team building by JSI.

Much has been accomplished. Much remains to be done. HWG thanks all its partners and collaborators and, most of all, its donor, USAID. Everyone at HWG looks forward to seeing Georgia grow and mature in its health programs, and to the day when all of Georgia's women are healthy, empowered and productive.

Acknowledgements

A project setting its sights as high as HWG involves a huge effort. It is not possible to acknowledge by name everyone who contributed to the project's success. We recognize the technical and managerial competence and the "beyond the call of duty" efforts of the staff of JSI, our implementing partners (Save the Children/USA, Curatio International Foundation, CLARITAS, HERA, CSMA and McCann-Erikson), consultants, research partners, trainers, field supervisors and quality assurance teams. These individuals, working along side doctors, nurses, administrators, rayon coordinators, teachers, community activists and peer educators are the soul of HWG. We hope the results are worth the effort and sacrifices.

We gratefully acknowledge the staff of USAID/ Georgia, the US Embassy/Tbilisi and USAID/EE Bureau in Washington. USAID is our donor, but also has been a true partner. USAID provided funding, policy support, flexibility and wise technical advice. We particularly recognize Dr. Tamara Sirbiladze, our Cognizant Technical Officer, for her professionalism and support.

The support of the Government of Georgia and senior Georgian health and education experts was crucial at every juncture of HWG. Many Georgians became "champions" of modern, evidence□based care. We acknowledge the leadership of the Reproductive Health Council, particularly the First Lady, Mrs. Sandra Roelofs; the Minister of Labor, Health and Social Affairs and his staff; the Minister of Education; the staff of the National Center for Disease Control; the Rector and Professors at the State Medical Academy; and the Governors and public health officials in all our partner regions. Ultimately, the credit for improvements in reproductive health in Georgia is theirs, as is the responsibility for sustaining progress.

HWG has been fortunate to have sound collaborators among other USAID-funded projects, including JSI projects in Romania, Ukraine, Russia, Central Asia (with Abt) and the EERFPA. HWG had good collaboration with CoReform (Abt Associates and CARE), MSCI, AIHA and World Vision. WHO, UNICEF, DfID, the Merlin Project (EU-funded), World Bank and UNFPA were excellent collaborators. We acknowledge local NGOs Charity Humanitarian Center "Abkhazeti" (CHCA), Tanadgoma," and "ABKHAZINTERCONT" and our many private sector partners, particularly Block Georgia, PSP, GPC, AVERSI, Public Pharmacy, Bayer-Schering, Gideon Richter, Aldagi BCI, Peoples' Insurance, IRAO Vienna Insurance Group, My Family Clinic, International Women's Association, Joint Jewish Distribution and the Susan G. Koman Foundation.

Finally, we are grateful to our clients. We applaud the brave Georgian men who were the first to support their wives in the delivery room, women who proved eager to improve their reproductive health, and young people with the courage to say "NO!" to drugs, alcohol, smoking and high risk behaviors. Often called program "beneficiaries", we consider them partners.

Finally, this report is dedicated to colleagues and family members who passed away from 2003 to 2009:

- Diane Hedgecock, our JSI/HWG Senior Advisor
- Tom Coles, former HWG Deputy Director
- Murman Nikabadze, father of Irina Nikabadze
- Ciala Umikashvili, mother of Lika Umikashvili
- Mamadashvili Romani and Qarumidze Lali, parents of Mamuka Mamadashvili

And to the healthy HWG babies born to staff:

- Giorgi Mamukelashvili, born to Nino Kobakhidze and Irakli Mamukelashvili
- Natalia Machabeli, born to Lali Chikovani and Guram Machabeli
- Anastasia Kopaliani, born to Ekaterine Pestvenidze and Giorgi Kopaliani
- Ketevan Orbeladze, born to Mari Vashakmadze and Ioseb Orbeladze
- Nikoloz Nikolaishvili, born to Natia Khudjadze and Merab Nikolaishvili
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- Alexasndre Gvetadze born to Tea Darakhvelidze and Nodar Gvetadze

THANK YOU!

Kartlos Kankadze, Nino Berdzuli, Nancy Pendarvis Harris

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