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RECOMMENDATIONS FOR INSTITUTIONALIZATION OF SELECTED PHCR ACTIVITIES INTO GOA/MOH

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ACRONYMS

AMD	Armenian Dram
ASTP	The Armenia Social Transition Project
BBP	Basic Benefit Package
CBL	Competency-based learning
CHC	Community Health Committee
CME	Continuing Medical Education
EBM	Evidence based medicine
ENER	Computerized System for Open Enrollment and Encounter
FM	Family Medicine
FN	Family Nursing
GOA	The Government of Armenia
HE	Health Education
HPIU	Health Project Implementation Unit (WB)
IT	Information Technology
LSMS	Living Standards Measurement Integrated Survey
MOF	The Ministry of Finance
MOH	The Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organization
NHA	National Health Accounts
NIH	National Institute of Health
NSS	National Statistical Service
PBL	Problem-based learning
PHC	Primary Health Care
PR	Public Relations
QA	Quality Assurance
QIB	Quality Improvement Board
QoC	Quality of Care
SC	Steering Committee for National Health Accounts
SHA	State Health Agency
SNCO	State Non Commercial Organization
TOT	Training of Trainers
USAID	United States Agency for International Development
WB	The World Bank
WHO	The World Health Organization
YBMC	Yerevan Basic Medical College
YSMU	Yerevan State Medical University

Table of Contents

ACKNOWLEDGEMENTS	1
ACRONYMS	2
Table of Contents	3
1. INTRODUCTION AND BACKGROUND	4
2. OBJECTIVES	4
3. METHODS	5
4. FINDINGS AND RECOMMENDATIONS.....	5
4.1 Quality of Care Policy and Strategy (QoC)	5
4.1.1. Home/office for QoC:	6
4.1.2 Estimated costs of institutionalizing QoC.....	7
4.1.3. Implementation plan for institutionalizing QoC	8
4.2. Continuing Medical Education of Family Physicians and Family Nurses (CME).....	8
4.2.1 Home/office for CME.....	9
4.2.2 Estimated costs of institutionalizing CME	10
4.2.3 Implementation plan for institutionalizing CME.....	11
4.3 Public Health Education (PHE)	11
4.3.1 Home/Office for PHE	11
4.3.2 Estimated costs of institutionalizing PHE.....	13
4.3.3. Implementation plan for institutionalizing PHE.....	14
4.4 Open Enrollment (OE).....	15
4.4.1. Home/Office for OE	15
4.4.2 Estimated costs of institutionalizing OE.....	16
4.4.3 Implementation plan for institutionalizing OE	17
4.5 National Health Accounts (NHA).....	17
4.5.1 Home/Office for NHA	18
4.5.2 Estimated costs of institutionalizing NHA	18
4.5.3 Implementation plan for institutionalizing NHA.....	19
4.6 PHC facility level strategic planning and budgeting (P&B).....	20
4.6.1 Home/Office for P&B.....	20
4.6.2 Estimated costs of institutionalizing P&B	20
4.6.3 Implementation plan for institutionalizing P&B.....	21
5. CONCLUDING COMMENTS	22

Appendices

- Appendix 1: Estimated Costs for Institutionalizing QoC
- Appendix 2: Estimated Costs for Institutionalizing CME
- Appendix 3: Estimated Costs for Institutionalizing PHE
- Appendix 4: Estimated Costs for Institutionalizing OE
- Appendix 5: Estimated Costs for Institutionalizing NHA
- Appendix 6: Estimated Costs for Institutionalizing P&B
- Appendix 7: Summary Table of Cost Estimates

1. INTRODUCTION AND BACKGROUND

Past experience of several donor funded technical assistance projects in health care sector of Armenia demonstrates that many activities supported by the projects (both technically and financially) stop as soon as the project life ends. Therefore, PHCR project is placing a special focus on ensuring sustainability and continuity of its efforts through institutionalization of key interventions of the project into the GOA/MOH. This idea is also emphasized in the PHC Strategy document, which was approved by GOA. Chapter 3.8 of the PHC Strategy states: “since 1999 the PHC sector has been receiving assistance from international organizations aimed at supporting the reforms underway. Steps should be taken to continue the activities currently funded externally when the projects end”.

In this report, selected high value activities of the project have been identified and recommended for institutionalization into the GOA/MOH so they continue when the project ends in 2010. It is important that the process begins early enough so that the GOA/MOH has time to build the new activities into its budget – a process that can sometimes take several budget cycles before the activities become fully institutionalized into the government. The key elements of institutionalization include:

1. **The activity:** identification of the activities to be institutionalized
2. **Systems/guidelines/procedures/etc** - that make up the work of the activity
3. **An office** in the GOA/MOH where the activity is located. Depending on the scale, scope, and importance of the activity, this could be an existing office or a new office, or it could be part of an existing position or a new position. Ultimately, there needs to be one person responsible for the operation of the activity; otherwise accountability is weak.
4. **Skilled staff:** staff with the skills required to carry out the work of the activity (or oversee if the activity is out-sourced). This generally involves capacity building and training of staff to independently use the systems and procedures.
5. **Financing:** Budget, or funds, within the GOA/MOH with which the activity will be carried on from year to year after the project is ended, and independent of donor funds. Estimates of the financing required for each activity will be derived from a cost analysis that includes both capital and recurrent costs.

2. OBJECTIVES

Main objectives of this study are to:

- a. make recommendations on the most appropriate “home” for the institutionalized activity, i.e. which public body and/or public/private organization shall “host” the task and be responsible for implementation of proposed activities,
- b. provide estimates of the marginal costs (capital and recurrent) of institutionalizing the selected activities, and
- c. prepare a plan for having these selected activities institutionalized over the life of the project.

The set of activities recommended for institutionalization include:

1. Quality of Care Policy and Strategy,
2. Continuing Medical Education (CME) of Family Physicians and Family Nurses
3. Public Health Education
4. Open Enrollment systems and operations, including computerized data base
5. National Health Accounts
6. PHC facility strategic planning and budgeting process.

The report is organized according to the above mentioned objectives for each of the listed PHCR project activities.

3. METHODS

In order to achieve the objectives of this study and to develop recommendations for institutionalization of PHCR activities, the Consultant held a series of meetings and discussions with key counterparts from MOH and SHA, as well as with the team leaders of project's major components. PHCR Chief of Party and the Team leaders have provided numerous valuable comments on the initial drafts of the Report.

GOA PHC strategy paper, other legal acts related to the health care sector, as well as number of PHCR project documents have been studied and discussed with relevant specialists and team members.

For each selected activity relative benefits and costs of different models of institutionalization -- such as out-sourcing vs. in-house (MOH) operations -- as well as the structure, functions, staffing needs, etc. of the proposed activity to be institutionalized have been assessed.

Furthermore, an Excel based adjustable model was built in order to provide estimates of the marginal costs (capital and recurrent) of the GOA/MOH absorbing the activity (see the Appendixes 1 to 7). These tables enable decision makers to get different estimates of costing options for each activity to be institutionalized by simply changing certain input values (unit costs), such as annual salary of civil servant, or estimated capital costs for establishment of one working place, etc.

4. FINDINGS AND RECOMMENDATIONS

4.1 Quality of Care Policy and Strategy (QoC)

PHCR has developed an extensive Quality Assurance Plan for PHC sector, which includes also an Implementation Toolkit. According to the plan, the first stage of implementation will cover 137 "large" PHC facilities with more than three PHC providers in each, while the second stage will deal with more than 220 "small" PHC facilities that have less than three PHC physicians. Before the end of the project PHCR will support both training of quality coordinators and the first stage implementation. The main issues for institutionalization of this activity, therefore, are:

- How should the implementation of quality assurance system be organized and financed for the second stage ("small" facilities) and in general for the future period, and

- How the national system of quality assurance, including MOH, marz and facility levels, should be structured, organized and operated.

4.1.1. Home/office for QoC:

A coordinating body for QA activities should be established at *national level*, i.e. in MOH, for which two options are suggested (see below). Quality coordinators at *marz level* will be selected among the PHC facility staff (managers /chief doctors, or deputy managers or senior/highly qualified clinicians and preceptors) and will combine this task with their existing responsibilities. Marz Health and Social Services Department will provide necessary logistical support and coordinate activities of quality coordinators.

Option 1. Quality Improvement Board at MOH shall be set up consisting of representatives from the following MOH structures:

- PHC division
- Specialized services division
- Mother and Child division
- Department of Education, Science and Human Resource Management
- Division of Organization of Pharmaceutical Activities, Provision of Drugs and Technologies
- State Health Agency (SHA)

It is assumed that the QIB will be chaired a Deputy Minister of Health, who will be assigned to that position by Minister's order. Creation of QIB at the national level will require redefining the scope of work for those who will be involved, adding to their responsibilities issues related to QA. This, in turn, assumes revision of the civil servants' job description, which, according to the existing laws and regulations, must be justified by certain changes in the structure of the MOH.

Creation of QIB at national level will be followed by establishment of similar Boards at Marz level and in each "large" facility. For the second stage ("small" PHC facilities), which will start in 2011, two organizational options are considered:

- a. Un "umbrella" QIB will be established to cover three to five facilities, i.e. in average four to six such "umbrella" QIB's per Marz, or
- b. Marz level QIB will coordinate QoC activities for all "small" PHC facilities.

The final choice between these two options for the second stage will be made based on the lessons learned from the first stage implementation.

Option 2. PHC division is transformed into PHC department, and a special Quality Assurance division is created within the PHC department. Implementation of this option again requires changes in MOH's approved staff structure and adoption of new job descriptions for new positions at QA division. QA division will be in charge of such functions as quality tracking and reporting about the performance of the various quality indicators by PHC and marz level, development, updating and training of staff in new quality standards.

At marz level, an existing staff member of Department of Health and Social Services should be made responsible for supporting QA activities in the respective marz. This will also

require revisions in the job description. Other members of the marz level Quality Improvement Board may include: all QCs from that marz, one active member from each of the selected PHC facilities (3-4 members that could be rotated on an annual basis), marz level staff member responsible for conducting/coordinating CME trainings, 1-2 community members.

PHCR has organized and implemented TOT courses to prepare 53 people to become quality coordinators for the whole country. Therefore, it is assumed that by the end of the project Armenia will have a trained corps of professionals to carry out QA activities across the country. PHCR may need to further focus on providing some policy guidelines to potential QIB members or dedicated MOH staff that will be ultimately in charge of sustaining QA coordination efforts nationwide.

4.1.2 Estimated costs of institutionalizing QoC

Institutionalizing QoC will require certain investment in human resources. Under Option 1, setting up the proposed QIB at MOH may require no additional funding, since existing MOH staff members from each of the above mentioned units will be delegated to QIB, while under Option 2 it will require paying for two or three additional full-time positions at MOH. Quality coordinators should be paid for their activities, including training of facility staff and supportive/monitoring clinic visits. This can be realized through combination of ways: either adding a new provisions into SHA contracts, that will ensure evidence-based funding by SHA for facility visits (covering travel and accommodation costs), or providing additional remuneration to quality coordinators for their new tasks, based on service provision contracts between them and marz health department. As it was mentioned above, PHCR will provide funding for the first stage implementation till 2010, so the GOA funding will be required to continue it starting 2011, as well as for second stage implementation. The table below provides a summary of preliminary cost estimates for institutionalizing QoC.

Table 1
Cost Estimates for Institutionalizing Quality of Care Activities

Option	Capital Costs (AMD)	Recurrent Costs (AMD)	Total Costs 2011 (AMD)	Total Costs each additional year, starting 2012 (AMD)
1. Remuneration of Quality Coordinators at Marz level, Training of "Small" Facility Staff	-	67 800 000	67 800 000	50 400 000
2. Establishment of a new unit at MOH, Remuneration of Quality Coordinators at Marz level, Training of "small" Facility Staff	1 350 000	69 960 000	71 310 000	52 560 000

Payment mechanisms for quality coordinators at marz level need further discussion and clarification with MOH. For more detailed estimates see Appendix 1.

4.1.3. Implementation plan for institutionalizing QoC

Institutionalizing QoC requires coordinated efforts of MOH and PHCR project staff members, in collaboration with other relevant stakeholders, aimed at development and implementation of following necessary measures over the next few months period:

- a. Presentation of main findings and recommendations for institutionalizing QoC to MOH counterparts (proposed date – February 2009)
- b. Based on comments from MOH, development of revisions of MOH charter and/or new (revised) job descriptions (depending on which option will be selected) related to relevant MOH departments/divisions (March 2009),
- c. Submission of revised MOH charter and job descriptions (along with similar recommendations for other activities to be institutionalized) to GOA for approval (April 2009),
- d. Development of recommendations for including additional funding requests into 2010 budget proposal and MTEF for 2010-2012, submission to MOF for review and further submission to GOA (April-August 2009).

4.2. Continuing Medical Education of Family Physicians and Family Nurses (CME)

PHCR closely cooperates with both family medicine chairs at YSMU and NIH, as well as FM nursing chair of YBMC for elaboration of training packages and materials for FM practitioners. It is envisaged that about 35 such training packages, covering different areas of FM curriculum, shall be worked out for doctors alone. At this point, four training packages have been developed, and another four will be finished before the end of the project. WB Health Project and PHCR also contribute to the organization of training courses for FM practitioners.

Issues for institutionalization include:

- Ensuring elaboration of good quality training materials for FM providers, and their continuous revisions and improvements.
- Institutionalization of a modern and practical Instructional design methodology through providing a reference guide “Learning for Performance” in Armenian language, published by PHCR project and introduced to training Institutions
- Introducing competency based learning methodologies to FM/FN training institutions.
- Ensuring further process of training of FM providers according to the numbers and scale required by the country.

Main problems here are insufficient public funding for training activities, and lack of regulations to guarantee continuous medical education of FM providers. In theory, FM chairs and their professors always have been and are currently responsible for elaboration of training materials and packages, but lack of adequate funding did not provide any incentives for actually performing that work. PHCR project introduced a novel approach, the idea of developing training packages with all the essential components for organization of the training courses and by the end of the project will provide 8 training packages for the most important areas of PHC. Within the training packages clinical standards are developed congruent with evidence-based medicine (EBM) standards. The training materials design enables competency-based learning (CBL) and problem-based learning (PBL) methodologies, with instructions for tutors and learners. On the other hand, although it is assumed that every medical professional should get some training at least once in five years in order to earn necessary credits (for example, family doctors must gain 175 credits and family nurses 125 credit), in reality, however, there is no mechanism in place that can guarantee this provision. Some

recent polls among PHC providers demonstrated that only half of them had had any training during the last five years. Ultimately, it is left up to the will of facility managers to follow on this issue, and even existing licensing regulation does not provide necessary provisions for strict control over the issue.

The credit system established in medical education system in 2000 is not currently functional: the two main medical education institutions - the YSMU and the NIH - have independently developed credit systems neither of which is applied nationwide. In addition, the systems lack viable implementation procedures. On the contrary, the international best practice provides for a unified credit system that is equipped with simple and practical procedures¹.

4.2.1 Home/office for CME

Institutionalization of CME process will not require setting up any new educational institution. YSMU, NIH, YBMC and “Erebuni” Medical College with their respective chairs should continue to carry out this task (as they in fact are currently doing). At the same time more attention should be paid to increasing the quality of CME process and capacity building, therefore, responsibility for that should be clearly assigned to the MOH Department of Education, Science and Human Resource Management.

First of all, a new regulation should be approved in order to establish sound control mechanisms over the process of CME. Although legal options for such regulation may still be discussed, it seems that it can at least take a form of a Ministerial Executive Order, which will mandate all health facility managers to submit annual reports to the MOH with the list of their medical staff, including information about each provider’s (i.e. doctors and nurses) training for the last five years. Similar information is submitted for facility licensing, and according to licensing procedures, at least 75% of the medical staff should have passed training for the last five years, otherwise MOH may reject issuing the license. However, since licensing is a single-moment procedure, and licenses are issued for unlimited period of time, this mechanism does not guarantee process of CME. Such a measure, if properly implemented and monitored, can stimulate both facility managers and the medical professionals themselves to follow existing requirements for medical training, which will result in increase of number of trainees and therefore bring more revenues to the training institutions (YSMU, NIH).

The next issue is to ensure effective and efficient use of resources, which should be addressed at development of high quality training materials and conducting the trainings. This issue is related to the internal management of training institutions, which must give clear priority to above mentioned activities instead of possibly redirecting some of the funds for other purposes. MOH Department of Education, Science and Human Resource Management will have to adopt certain regulations for procurement of training materials, in order to ensure transparency and competitiveness of the process. Combined with additional

¹ Study tour with participation of the representatives from medical education organizations, NGOs and the MOH on Credit System Improvement would be required for creating a qualified pool of specialists in this area. It would allow for understanding and future application of international best practices on the matter. This will also help to build a capacity for filling in suggested new positions at the Department of Education, Science and HR Management. It is assumed that such a study tour will be supported by donor funded projects, that’s why it is not included in cost estimates.

funding that should be made available both from state budget (as State Order for training institutions) and from increased number of self-funded trainees, these measures will ensure CME institutionalization.

4.2.2 Estimated costs of institutionalizing CME

CME process will be carried on based on existing human resources, which will receive further training aimed at capacity building. It is important to stress that in general CME funding from state budget must increase, since current level of public financing is not sufficient to ensure quality. That increased funding must be primarily aimed at creating more opportunities for PHC providers to undergo CME, since Armenia has a general surplus of specialists and the general need for more trained PHC providers with expertise in both family medicine and primary health care with emphasis on prevention and promotion of health. Besides, PHC has been declared a priority by the GOA, that's why we suggest that additional public funding should be first of all directed to cover PHC providers' training costs (another justification for this approach is that PHC services are free of charge and are fully funded by Government, so PHC providers have no source of income to pay for their trainings themselves other than their modest salaries). However, estimating country's need for additional financial means to cover CME goes beyond the scope of current study, therefore we will focus on specific financial aspects of strengthening GOA capacity, which is necessary to provide better oversight and monitoring of the CME process in the country. We would suggest strengthening the existing capacity at MOH by adding three positions in the Department of Education, Science and Human Resource Management (which can also take a form of a small unit within the department). This new unit (or staff positions) shall be responsible for registering existing training courses, defining the quality, providing certain amount of credits for each course, with a further aim of developing an on-line registration system, including an electronic data-base of all health care providers in Armenia with their respective credentials. The table below provides brief summary of preliminary cost estimates for institutionalizing CME.

Table 2
Cost Estimates for Institutionalizing Continuing Medical Education Activities

Option	Capital Costs (AMD)	Recurrent Costs (AMD)	Total Costs 2010 (AMD)	Total Costs each additional year, starting 2011 (AMD)
1. Adding three new positions in the Department of Education, Science and HR Management of MOH or creating a Unit within the same Department	1 350 000	2 160 000	3 510 000	2 160 000

For more detailed estimates see Appendix 2.

4.2.3 Implementation plan for institutionalizing CME

Institutionalizing CME requires coordinated efforts of MOH and PHCR project staff members, in collaboration with NIH, YSMU, medical colleges and other relevant stakeholders, aimed at development and implementation of following necessary measures over the next few months period:

- a. Presentation of main findings and recommendations for institutionalizing CME to MOH counterparts (proposed date – February 2009)
- b. Based on comments from MOH, development of MOH draft Executive Order, revisions of MOH charter and/or new (revised) job descriptions (depending on which option will be selected) related to Department of Education, Science and Human Resource Management positions (March 2009),
- c. Submission of revised MOH charter and job descriptions (along with similar recommendations for other activities to be institutionalized) to GOA for approval (April 2009),
- d. Development of recommendations for including additional funding requests into 2010 budget proposal and MTEF for 2010-2012, submission to MOF for review and further submission to GOA (April-August 2009).

4.3 Public Health Education (PHE)

Recently adopted PHC development strategy for 2008-2013 prioritizes public health education and healthy lifestyle promotion as key elements of GOA health policy. PHCR strategy in health education is based on community mobilization through establishment and trainings of Community Health Committees (CHC) through local NGO's. These activities are identified in 2008-2013 MOH PHC strategy document as a positive development implemented by PHCR that later on must be continued by MOH. Number of local NGO's has already been selected by PHCR and received extensive TOT training in adult learning techniques, advocacy, project design and management and number of health topics. CHC's has received trainings through those NGO's in 57 rural communities of Shirak, Lori, Kotayk, Gekharkunik and Tavush marzes. Similar activities in Armavir, Ararat and Aragatsotn marzes are currently underway and remaining two marzes, Vayots Dzor and Syunik, will be covered by the end of the PHCR project. The methodology and the details of two-phase NGO and CHC trainings are also briefly described in newly adopted PHC strategy document. Urban communities require different approach for public education (mainly based on involvement of mass media), and therefore are not considered at this stage for community mobilization.

4.3.1 Home/Office for PHE

Currently there are two units in MOH structures that are supposed to deal with certain aspects of public health education: the PR division and Communicable and Non-Communicable Diseases Department of Sanitary and Anti-Epidemiological Inspection (Sanepid). None of them, however, is up to the task and is able to cover the whole range of issues that must be addressed.

Existing network of NGO's and CHC's that was created with PHCR efforts can serve as a basis for future activities in public health education field (through outsourcing). However, a new entity must be established (or assigned responsibilities) for strategizing, planning,

implementation and monitoring of specific projects. This structure should have access to public financing sources and at the same time should be able to procure services on a competitive basis through transparent and fair bidding process (see below). This new structure shall be responsible for identification of new topic(s) each year for health education, subsequent development of training manuals based on the identified topic(s), and providing TOT trainings of selected NGOs.

In the future this task will require:

- Extension of the same two-stage training programs for CHS to other communities, not covered by PHCR, and
- Covering other public health topics through additional trainings that shall be conducted on annual basis in all communities of Armenia (see the Table 3 below).

Table 3

Number of Rural Communities of Armenia by Marz, covered by Public Education Component of PHCR Project

Marz	Number of Communities covered by PHCR*	Number of Communities not covered by PHCR	Total Number of Communities
Aragatsotn	23	92	115
Ararat	19	78	97
Armavir	13	84	97
Gegharkunik	8	84	92
Kotayk	19	48	67
Lori	8	105	113
Shirak	13	106	119
Syunik	27	86	113
Tavush	9	53	62
Vayots Dzor	13	31	44
TOTAL	152	767	919

* - including those communities that have been selected and will be covered before the project ends.

We suggest discussing two major options: (a) adding new functions to the existing structure (short-term option), and, (b) Establishment of a new structure (long-term option). Under the first option, MOH can assign certain new functions to the existing structures within its staff to provide policy, regulatory, and technical oversight, along with administrative support for health education programs. Under this option, both the technical work (development of training manuals, providing TOT trainings, etc.) and delivery of trainings for CHC's would be outsourced.

As to the second option, the experience of other former Soviet states also demonstrates that some of them have opted for establishment of a separate structure in charge of health education under some sort of MOH supervision, rather than directly incorporating those functions into the staff of the MOH itself. As one of the possible options, in Armenian context this can be done through establishment of a separate legal entity under MOH with a

legal status of State Non-Commercial Organization (SNCO). Such status will provide greater flexibility for service procurement and decision making, compared to MOH or other public governance structures. This entity may be called “National Center for Public Health Education, Disease Prevention and Healthy Lifestyle Promotion” (for example), and its establishment should be planned in MTEF for 2010. Before that, the charter of the center should be drafted to include all necessary functions and to establish both staffing structure and the funding arrangements. Under this option development of training manuals and providing TOT trainings for selected NGO’s will be carried out by the staff of the newly established Center, while delivery of trainings for CHC members would be outsourced to local NGO’s.

Compared to other possible legal status options for such a new structure (foundation, state governing institution), the status of SNCO have certain comparative advantages, such as:

- the law specifies more simplified procedure for founding and registration of SNCO;
- SNCO to some extent is replacing state governing bodies; however it is relatively flexible selecting the directions of its activities and in organization and management of its activities;
- Certain public activities or some part of those activities may be attributed to State Non-Commercial Organizations;
- SNCO is also relatively flexible in terms of forming its assets: it has its own property and property attached to it. In both cases the property is provided to the Organization by the state;
- SNCO is primarily funded by the State, but it also has a right to conduct entrepreneurial activity and obtain properties;
- It is also important to note that the SNCO’s financial independence allows it to involve well qualified employees in its activities and to pay relatively high salaries, since employees of a SNCO are not considered as civil servants and they can be paid as much salary as decided by the management, etc.²

4.3.2 Estimated costs of institutionalizing PHE

For the short-term approach, two new staff positions can be added to the PHC division of MOH, being solely responsible for public health education programs. It is highly desirable that this change can be made as soon as possible, so the new MOH staff members can have an opportunity to work with PHCR HE team before the end of the project to learn necessary skills and ensure capacity building. Under this scenario, MOH could extend the two-stage trainings to other communities of Armenia (with its own resources, i.e. through public budget funding), not covered by PHCR, while PHCR project would continue its activities in other marzes.

As for the second option, National Center should be rather a small entity (at least for the beginning), since delivery of trainings will be outsourced to local NGO’s. Therefore, it may have four technical (professional) staff members and three administrative/logistical staff, including: Director/Team leader, health education specialist, community mobilization specialist, logistical support specialist, administrative assistant, accountant, and driver.

² For more information on comparative advantages and disadvantages of different legal options see the Memorandum re: Legal Frameworks and Regulations Of A Foundation, State Non-Commercial Organization And A Ministerial Division by PHCR Consultant Narine Gasparyan.

- c. Submission of newly developed documents (MOH charter, job descriptions, National Center's charter, budget etc.) to GOA for approval (April 2009),
- d. Development of recommendations for including additional funding requests into 2010 budget proposal and MTEF for 2010-2012, submission to MOF for review and further submission to GOA (April-August 2009).

4.4 Open Enrollment (OE)

Implementation of population's open enrollment system for PHC services has begun in Armenia in 2006. Significant work has been done so far, and this system is up and running nationwide. Legal provisions are established by GOA decrees and Ministerial orders. A computer network has been established and special software has been designed and developed to run the open enrollment system. PHCR has provided more than 200 personal computers and other related equipment for this system. Furthermore, PHCR contracted a local company to provide technical service and advice to those health facilities where the computers with the OE software are installed (contract ended in December 2008). From this perspective, the main issues for institutionalization are:

- How to ensure the system's further sustainable development, including system and software revisions in accordance with new health care policies and regulations,
- How to organize the process and ensure necessary funding for provision of technical services without donor support,
- How to organize the process of consultant selection in order to ensure that competent organization or people will be put in charge for computer hardware and software maintenance and service.

4.4.1. Home/Office for OE

Population's open enrollment based on free choice of PHC provider is an essential element of health care reforms; therefore MOH should be responsible for overall management of this system, which will require establishment of certain new structures and positions. Two major functions related to OE should be concentrated in MOH: (a) further development of the system, i.e. elaboration and implementation of necessary revisions into the existing OE software, based on new health care policies and regulations, and (b) data security and handling (what data can be transferred to whom and when), data analysis (validation) and data retention. As to the support services, they should be outsourced to an organization that will have adequate resources to provide necessary technical services for solving both hardware and software related issues at all levels (facility, Marz, MOH).

For the first part of the above mentioned functions, we suggest discussing establishment of Health Sector Policy and Planning Unit at MOH (hereinafter "Unit"), which will deal with different aspects of the reforms and health system performance monitoring, including OE system. Necessity to have such Unit (which in fact existed in MOH before) has been repeatedly emphasized by different donor projects during the last years. While this new Unit may have up to five positions (at least for the initial period), only two of them may be required to provide policy-level oversight for further development of the OE system. Other functions of the Unit may include coordination of the process for development of PHC

facility development plans (see Chapter 4.6), monitoring and evaluation of the reform implementation process, planning of health care resources, etc.

Second part of the two major functions of the Unit will require strengthening existing IT service in MOH, possibly by formally establishing an IT Unit with three employees. This Unit will be also responsible for running of MOH's internal network, its web site, etc. Management of the system (hardware, software, network, and information) will require technical resources (system administration, database administration, user level help desk, network administration and operations) as well as adequate data analysis and assessment resources.

Support service processes to be institutionalized by procedure would include: user "help desk", incident and problem tracking/response, configuration management (including PHC facility level desktop environment and software version release controls). In order to manage the support processes outlined above a properly staffed organization should be selected. Armenia has a good choice of high-skilled professionals in computer hardware and software design and maintenance, therefore the contract for providing support services can be awarded through competitive bidding process in order to ensure best possible outcome.

4.4.2 Estimated costs of institutionalizing OE

Major financial burden for institutionalizing ENER system will be associated with providing support services through outsourcing. MOH is intended to include a new provision into PHC service delivery standard for 2009 that will guarantee earmarked funding from SHA to cover hardware and software maintenance costs for OE. While this may formally solve the financing problem, it still must be decided how these money should be spent by each facility. It is obvious that it makes no sense to have a special staff member in each facility for this purpose, since given the real workload and the scale of potential problems one full-time person can serve several facilities at the same time. So, it is recommended that there should be a competitive bidding process organized on national level for procurement of those services, with an obligation for potential winner to provide maintenance visits to each facility once in three or four months, and to have representatives attached to each Marz (and actually located there), so prompt feedback can be provided, if needed. Under this scenario the winner of the bid will have to sign individual service contracts with each facility.

The second option for payment arrangements is the following: bidding process will be organized in the same way, but, instead of providing additional funding to PHC facilities, MOH directly allocates budget funds to the winner of the bid, so there will be one payer instead of many. This option may simplify the whole process and make it more manageable, but it contains also some risk of reduced responsibility by the service provider toward facilities.

For cost estimates the current contract between PHCR project and "Harmony" Information Technologies and Education Development Fund is considered as a source of information, although it is impossible to foresee the exact future budget due to proposed bidding procedure (i.e. the winning bid cannot be projected beforehand).

Table 5
Cost Estimates for Institutionalizing Open Enrollment Activities

Activity	Capital Costs (AMD)	Recurrent Costs (AMD)	Total Costs 2010 (AMD)	Total Costs each additional year, starting 2011 (AMD)
1. Establishment of Health Policy and Planning and IT Units at MOH, outsourcing of support services	2 250 000	25 400 000	27 650 000	25 400 000

For more detailed estimates see Appendix 4.

4.4.3 Implementation plan for institutionalizing OE

Institutionalizing OE requires coordinated efforts of MOH and PHCR project staff members, in collaboration with other relevant stakeholders, aimed at development and implementation of following necessary measures over the next few months period:

- a. Presentation of main findings and recommendations for institutionalizing OE to MOH counterparts (proposed date – February 2009)
- b. Based on comments from MOH, development of revisions of MOH charter and new (revised) job descriptions (March 2009)
- c. Development of bidding requirements and procedures for selection of external consultant and outsourcing of support services (April-May 2009),
- d. Submission of revised MOH charter and job descriptions (along with similar recommendations for other activities to be institutionalized) to GOA for approval (April 2009),
- e. Development of recommendations for including additional funding requests into 2010 budget proposal and MTEF for 2010-2012, submission to MOF for review and further submission to GOA (April-August 2009).

4.5 National Health Accounts (NHA)

PHCR activities in regard to National Health Accounts (NHA) are built on USAID/ASTP health financing activities, and also on activities currently being implemented by other donors and counterparts including the MOH, NSS, WB and the WHO. In 2003-2004, with USAID support, staff from MOF, MOH and SHA was trained in NHA methodology and a working group (WG) with representatives from MOH, SHA, USAID/ASTP and HPIU was established; in 2005 the WG was expanded with representatives from NSS. In January 14, 2005 multi-agency NHA Steering Committee (SC) was created to oversee the analytical work on NHA development and includes high level representatives from the MOH, MOF, SHA, and NSS (the personal structure of the SC needs to be revised and updated due to new appointments).

Issues for institutionalization include:

- Coordination of NHA activities should be fully assumed by SC, including those functions that are currently performed by donors,
- SHA should become legally responsible for NHA,
- WG should continue its activities regardless of the donor support, i.e. in each of the agencies that have delegated their staff members to WG, NHA related tasks should be assigned to a certain staff position.

4.5.1 Home/Office for NHA

SHA should become the «home» for NHA activities, where all information will be gathered, processed, analyzed and NHA produced. This will be fixed by amendments in the SHA Charter.

New Prime Minister's Decree should be enacted, that will revise SC structure and streamline its activities by establishing broader scope of work to be coordinated and more regular meeting schedule. SHA Charter must be revised, and NHA development and report preparation/dissemination should be added to its main responsibilities. Job descriptions of current members of the WG (from NSS, MOF and MOH and SHA) should be revised too, so they will continue to collect and share information necessary for NHA production.

Job description should be developed for a person/s that will be in charge for NHA. Another important source of information for NHA matrices development is surveys conducted by the National Statistical Service (NSS). WB HPIU has sponsored focused surveys of households', health care facilities' and drug stores health expenditures. However, NSS annually conducts also the Living Standards Measurement integrated Survey (LSMS), and if the health module of the survey will be revised in accordance to NHA current categories, it will be possible to collect more reliable and valid data on households' health related expenditures. Therefore there will be no need for conducting special costly surveys every two years. Considering observed differences between these two types of survey, NSS may make adjustments for subsequent years for certain categories.

4.5.2 Estimated costs of institutionalizing NHA

WG members that have been trained with donor support will continue to be the core task force in charge of NHA, regardless of the formal status of the WG (i.e. whether the WG will continue to work as such or the same people will do each their part of the work in their agencies). WG members from SHA will either lead the new to-be-created NHA department or will supervise NHA activities and gradually pass their expertise to new staff. Once the NHA task will be formally assigned to SHA, it shall be up to the Head of SHA to decide who should personally be in charge for that (option 1), alternatively, there will be a special unit created within SHA (option 2).

NHA WG has been provided with donor support both in terms of hardware and capacity building. They have accumulated sufficient expertise that will allow carrying out this task forward, as long as each relevant agency will be obligated to supply necessary information (to be controlled by SC), and SHA will be put in charge for its collection, processing,

analysis and preparation of NHA report. Since WG members were able to do their part of job with donor support, they should continue it after such support will not be available anymore (based on revised job descriptions). However, as it was mentioned above, either a special staff position or a small unit/department (with three employees) must be created within SHA that will be specifically in charge of NHA, so there will be certain costs associated with it (cost estimates take both options into account).

Table 6
Cost Estimates for Institutionalizing Works on National Health Accounts

Option	Capital Costs (AMD)	Recurrent Costs (AMD)	Total Costs 2010 (AMD)	Total Costs each additional year, starting 2011 (AMD)
1. Adding a new position at SHA	450 000	720 000	1 170 000	720 000
2. Establishment of a new unit at SHA	1 350 000	2 160 000	3 510 000	2 160 000

For more detailed estimates see Appendix 5.

4.5.3 Implementation plan for institutionalizing NHA

Institutionalizing NHA requires coordinated efforts of MOH and PHCR project staff members, in collaboration with other relevant stakeholders, aimed at development and implementation of following necessary measures over the next few months period:

- a. Presentation of main findings and recommendations for institutionalizing NHA to MOH counterparts (proposed date – February 2009)
- b. New Prime Minister’s Decree on adoption of refined structure of the SC is issued (March, 2009)
- c. Based on comments from MOH/SHA, SHA Charter revised and job descriptions are developed for the staff, who will be responsible for NHA, and agreed by the SC (March 2009),
- d. Submission of revised SHA Charter and job descriptions (along with similar recommendations for other activities to be institutionalized) to GOA/MOH for approval (April 2009),
- e. Development of recommendations for including additional funding requests into 2010 budget proposal and MTEF for 2010-2012, submission to MOF for review and further submission to GOA (April-August, 2009).

4.6 PHC facility level strategic planning and budgeting (P&B)

With PHCR Project assistance up to this date 183 PHC facilities (polyclinics, ambulatories and health centers) of Yerevan, Lori, Shirak, Tavush, Gegharqunik, Kotayq, Ararat, Armavir and Aragatsotn developed 3 year Strategic Plans, using template designed and guide developed by the Project. The Project also performed analysis of 3 year Strategic Plans, developed by all 183 PHC facilities. The feedback on these plans was provided to PHC facilities and the Marzes Health Departments for consideration in the development of Marzes' Development Plans. Yerevan Municipality Health Department used the unified form and guide, developed by the Project, to obtain strategic plans also from the hospital sector. With PHCR assistance the Yerevan municipality developed Yerevan City 3-year Development Plan. Yerevan Municipality also performs the monitoring of the PHC facilities in accordance to directions/activities/projected expenses mentioned in their plans. The ultimate aim of this task is to gradually change the MOH/local government program budgeting process from its current top-down scheme to the bottom-up approach, and to link this process to the three-year cycle of MTEF development.

4.6.1 Home/Office for P&B

MOH should be ultimately responsible for coordination of the process. Since PHC facilities had no previous experience of developing three-year strategic plans, in order to ensure continuation of this process certain administrative leverages should be used at least for the first years. Down the road, facilities may feel the benefits of having their strategic plans, assuming that at least some elements of those plans will be reflected in MTEF and annual budgets, and therefore they may become more eager to develop better quality plans later on. Two options can be discussed with regards to institutionalization:

Option 1. MOH issues an Executive Order (or sends out a Circulation Letter), requiring all Marz and Yerevan Health Departments to follow up on development and submission of strategic plans and report back to the MOH on a specified date each year (e.g. not later than March 1). It will be justified by the process of MTEF development that must take into account Marz Health Plans, which, in turn, should be based on facility development plans. PHC Division will be assigned with responsibility to monitor and coordinate this process.

Option 2. If viewed as a part of a broader picture of health care reform coordination, this task can suggest some structural changes at the MOH, particularly establishment of the Health Sector Policy and Planning Unit. The Unit, in addition to health sector performance monitoring and evaluation and other functions, will collect and analyze information obtained from Marzes and formulate into the Sector Strategy as well as link with the MTEF and budgeting process. Creation of the Unit will require revisions into the MOH charter by GOA.

4.6.2 Estimated costs of institutionalizing P&B

PHC facilities received training from PHCR on strategic planning and budgeting. A guideline on the subject was developed and provided to the facility managers (and marzes Health Departments) by the project. MOH and Marz health authorities are familiar with program budgeting principles since health sector was one of the first in country to follow that

approach for MTEF development. Combined together, those skills must be sufficient to guarantee successful continuation of facility strategic plan development process.

In case if GOA will adopt the second option to establish a new Health Sector Policy Unit, then it will require at least three new positions, which should be recruited on a competitive basis.

Further development of facility strategic plans alone should not require any specific additional financing. However, if the Health Sector Policy and Planning Unit will be established (see Option 2 above), then MOH's budget will need adequate revision.

Table 7
Cost Estimates for Institutionalizing PHC Facility Level strategic Planning and Budgeting

Option	Capital Costs (AMD)	Recurrent Costs (AMD)	Total Costs 2010 (AMD)	Total Costs each additional year, starting 2011 (AMD)
2. Establishment of a new Health Sector Policy and Planning Unit at MOH	1 350 000	2 160 000	3 510 000	2 160 000

For more detailed estimates see Appendix 6.

4.6.3 Implementation plan for institutionalizing P&B

Institutionalizing PHC facility level strategic planning and budgeting requires coordinated efforts of MOH and PHCR project staff members, in collaboration with other relevant stakeholders, aimed at development and implementation of the following necessary measures over the next few months period:

- a. Presentation of main findings and recommendations for institutionalizing P&B to MOH counterparts (proposed date – February 2009)
- b. Based on comments from MOH, development of draft MOH circulation letter and/or revisions into the MOH charter related to Health Sector Policy Unit (February, 2009),
- c. PHC Strategic Plans are developed, collected at each Marz level and analyzed (March, 2009)
- d. Marz Strategic Plans are submitted to MOH and analyzed (April, 2009)
- e. Consideration of regional strategic plans into MTEF (April-August, 2009)
- f. In case if the second option with establishment of new Unit will be approved, submission of revised MOH charter (along with similar recommendations for other activities to be institutionalized) to GOA for approval (March 2009),
- g. Development of recommendations for including additional funding requests into 2010 budget proposal and MTEF for 2010-2012, submission to MOF for review and further submission to GOA (March-April, 2009).

5. CONCLUDING COMMENTS

Selected PHCR activities that are discussed in this report are directly related to the most important directions of health care reforms in the Republic of Armenia. MOH is implementing ongoing activities together with local health authorities aimed at further expansion of PHC reforms in particular, which are also supported by PHCR and other donor funded projects. Thus, the situation with the status of different reform components which are reflected in the current document is subject for constant change.

During the meetings and discussions with different stakeholders involved in this study, substantially wider range of ideas and concepts has been discussed, but only those recommendations that were deemed as more viable from implementation viewpoint are presented here. However, additional suggestions and recommendations are welcome since institutionalization of certain key health care reform components may indeed take different forms and directions over a period of time.

Costing tables that are included in this report should be considered as an attempt to provide very tentative estimates for different scenarios (options), which are neither final nor all-inclusive but can be rather adjusted based on needs. Input data figures that are used in costing tables reflect the Author's own estimates and may be a subject for further discussion.

Finally, institutionalization of selected PHCR activities into GOA/MOH should be considered as a process, which can be implemented stage by stage. Based on the progress and lessons learned, some ideas and recommendations may be revised later, but it is very important to start the process as soon as possible, so each component can be discussed more deeply with special focus on action plan, assigned responsibilities and approved timeline.