



Primary Healthcare Reform

Quarterly Report

Fiscal Year 2006: First Quarter (October – December 2005)

Introduction

The Armenia Primary Healthcare Reform project (PHCR), funded by the United States Agency for International Development (USAID) under the TASC2 IQC No. GHS-I-00-03-00031-00, was issued to Emerging Markets Group, Ltd. (EMG). Subcontractors on this project are IntraHealth International, Overseas Strategic Consulting, Ltd., Social Sectors Development Strategies, and American University of Armenia's Centre for Health Services Research.

PHCR is a five-year project supporting the health sector reform efforts of the Ministry of Health. This project builds on the healthcare reform experiences of the Armenian Social Transition Project, and aims to expand key reform efforts across the country. The goal of PHCR is the increased utilization of sustainable, high-quality primary healthcare services, leading to the improved health of Armenian families, and a more productive workforce that can better contribute to the growing Armenian economy.

This PHCR Quarterly Report describes the project activities and their results during the period of October 1 to December 30, 2005. PHCR is in a start-up period and has been reviewing the first year's work-plan, recruiting staff, setting up the office, and designing and conducting the initial assessment of ASTP pilot facilities to recommend model components for further development and implementation nation-wide. February 24th has been set as the date for the final revised Year 1 Workplan and PMP, after the ongoing assessment work is completed. Consequently, indicators used in this Quarterly Report have not yet been finalized in the form of a final PMP format.

Progress

Intense work was begun by PHCR staff immediately upon award of the contract to start recruitment and to establish office premises. PHCR staff began planning for a series of workshops and fact-finding meetings, which commenced at the end of November/early-mid December. These meetings enabled the project to discuss areas of collaboration and synergy with other USAID health projects, the World Bank, WHO, and the Ministry of Health.

Information gathered during the discussions necessitate that PHCR carefully consider certain elements of the project where there is technical overlap, in particular with the World Bank PIU (treatment guidelines, retraining of FM doctors, and issues under healthcare financing). The discussions also brought to light recent policy decisions of the Ministry of Health which have radically changed the situation for the project, for example through the decision on nation-wide implementation of Open Enrollment by early 2007. Other crucial issues identified during the workshop include the political uncertainty regarding the role and feasibility of a Medical Council in Armenia.

The Table below presents key elements of work conducted during the first quarter of the project, with achievements presented under each component. Major undertakings relating to the establishment of the project have no representation in the project work-plan, but will nevertheless be commented upon below,

due to the extensive efforts of project staff to achieve these essential first steps of the project.

Component 1: Expansion of Primary Health Care (PHC) Reforms

During the first quarter, the project began assessing methods and actions needed to achieve key deliverables of the project, based on experience gained during the ASTP project, knowledge gained from the PHCR planning meetings, and from discussions with counterparts in MoH, WB-PIU, USAID projects and USAID. Preparations were made for a pilot site review, and initial work was undertaken by PHCR specialists to project workforce-planning needs.

Work-planning meetings

The formal PHCR work-planning meetings were held from November 28th to December 2nd. During these collaborative meetings, participants shared experiences and work-plans, which resulted in improved awareness of activities between USAID-funded projects and other partner projects. The workshop also led to highly successful collaboration and information-sharing with other entities, especially the World Bank PIU and the Ministry of Health. The workshop served to bring widened understanding and support of core PHCR project activities among the partner projects and other stakeholders.

As a result of the Workshop, the project began revisions of the PHCR first year work plan, based on issues which were identified during the workshop. Many of these issues require further fact-finding. For example, a recent decision by Ministry of Health has declared that Open Enrollment shall be introduced nation-wide across Armenia, which conflicts with the gradual marz-by-marz roll-out plan envisioned in the original PHCR plan. This issue was consequently identified as a priority PHCR activity in need of further elaboration and careful planning/feasibility assessment.

Likewise, discussions with the World Bank PIU team during the workshop revealed that there are serious capacity limitations in the ongoing retraining of FM doctors. The head of the World Bank PIU, Dr. Khachatryan, expressed his concern that if PHCR adds on another 150 doctors to the ongoing retraining program, this risks overloading the already-strained training capacity of the family medicine chairs, thereby compromising the quality of the delivered FM doctor retraining. This situation must therefore also be carefully considered and the element of PHCR retraining of FM physicians possibly be modified to a compatible modality for the final revision of workplan and PMP.

Among other important results from the workshop, there was an identified need to achieve better coordination between the PHCR workplan and core items under the healthcare financing activities already being undertaken by the World Bank PIU. The workshop also identified areas of overlap which need closer coordination, including how best to contribute to work with treatment guidelines, since this work already has been undertaken and is well done by the World Bank. Also discussed was how best PHCR could contribute to facility-level costing and financial management support, also being undertaken by WB PIU. Other areas where there is a need for better coordination and planning include the supply of computer hardware and software and facility level training.

As a result of the workshop, very good collaborative links were established between World Bank PIU, PHCR and other partner projects. Specific Work-Groups were established to address identified technical areas of concern.

Facility-level preparation

In preparation for Facility Selection, PHCR developed a specific Data Collection Form for PHC facility inventory and status assessment. This data set will be collected to support the project activity and resource planning work to be undertaken early during the next quarter. Based on collected facility inventory, data analysis methods and techniques for facility selection for support will be further refined during January and February 2006.

Initial plans have been laid for an in-depth review of experience gained in/by other projects, in procuring equipment and healthcare facility upgrading and renovation. Special attention will be given to practical experiences with out-sourcing upgrading and renovation work to subcontractors. Mechanisms needed for supervision and audits, and criteria for how to handle tenders for renovation of facilities will be considered by PHCR.

Workforce planning

After considering experiences from elsewhere (including published reports on workforce planning from reform and FM in Lithuania) a first calculation and brief report has been prepared by PHCR's Labor Economist on the topic of Workforce Planning. This first projection considers the dynamics set by workforce age distribution to match between demand and supply of Family Medicine doctors and nurses. This first assessment calculation was conducted based on census data from 2002, and provides input to the wider HR support from PHCR, and to MOH's capacity building in workforce planning.

In conjunction with this work, a follow-up STTA input has been planned from PHCR's sister-project NOVA, where PHCR will join in with specialist staff contribution during the second quarter. This will entail the presentation and introduction of a dedicated workforce planning software for use at the MoH level. Using the generated figures on projected demand, PHCR is also revisiting the planned number of FM doctors to be trained – also taking into consideration the planned number of doctors and nurses which also will be trained under the World Bank project. The calculations in the brief report on workforce planning were based on a questionnaire specifically developed for the assessment of health workforce development and needed incentives for effective workforce deployment in rural sites.

Assessment

PHCR has initiated the design and implementation of ASTP's PHC model review, which will use both quantitative and qualitative research (by in-depth interviews and focus group discussions with the policy makers, administrators and pilot facility key staff). Four focus group discussions (two with nurses and two with doctors) were conducted in Polyclinic No 17 and Grigor Narekatsi polyclinic in Yerevan. Six in-depth interviews with the representatives of the MoH, WB PIU, Head of Polyclinic No 17, and the Head of Family Medicine Chairs were completed during December 2005. Studies will be continued in regional ASTP pilot sites during January and February and the results will be summarized for use in revision of the PHCR workplan.

During workgroup sessions conducted with involvement of IT staff from the World Bank PIU, SHA and the PHCR, a separate study is being conducted to review the status of available software solutions for facility level use, including the ASTP software for Open Enrollment and Encounter software, and assessing experience from the introduction, training and operation of the ASTP software at key ASTP pilot sites. PHCR plans to bring out an IT specialist to assist with the large-scale analysis of these issues, as well as with the procurement plan, in late January.

Component 2: Family Medicine

Preparations have been made for policy analysis, going back to experience from ASTP reports and recommendations. Initial contacts have been made with faculty (Chairs of Family Medicine and Family Nursing), and PHCR has also begun to address the issues of curriculum updating with functional and evidence-based modules, and the needs for clinical training centres. As mentioned above, specific capacity limitations have been identified and discussed regarding the contracted training for 150 FM doctors. Regarding the originally planned training for 670 nurses, assessment has been started to evaluate the feasibility of using Yerevan or Marz based institutions (medical colleges). The topic of support to establish 80 new Family Medicine Group Practices has so far been set aside, to be undertaken in a later project phase.

During the meetings held with USAID partner projects on December 2nd, the World Bank PIU Director, Dr. Kachatrian, expressed concern that adding more doctors to be retrained within the ongoing FM doctor retraining program funded by PIU would both compromise capacity and quality in actual retraining of FM doctors. The PIU also expressed that it would be more effective if alternative modalities for retraining were considered by PHCR, thereby providing complementary quality-of-care-enhancing effects to boost the long-term retraining of FM doctors who already are being retrained through the PIU WB support project. PHCR and the USAID team responded to this statement by planning an in-depth discussion with the chairs of family medicine and family nursing, aiming to assess best possible ways forward, to deliver most effective and needed support to achieve the skills- and competence- building of FM doctors and nurses in Armenia.

On December 5th the PHCR team members met with heads of NIH, SMU, BMC Family Medicine and Family Nursing chairs, to discuss training needs, both in regard to needs as seen from the perspective of FM doctors retraining (such as it already is being undertaken with support from the World Bank project), and the needs as seen from the perspective of what competence and skills are needed among the clinical preceptors. Needs were also discussed from the perspective of continuous education of FM doctors in Armenia today. Such training is much needed to link the continuous skills and competence development of Armenian FM doctors, with the world-wide drive to improve medical practice and quality of care as reflected by the ongoing revision of diagnostics and treatments protocols presented in the Cochrane collaboration, and as reflected by other world-wide networks for evidence-based medicine in/for Family Medicine and primary care. Likewise, issues relating to PHCR support to build training-capacity at Marz-level training centers for Family Medicine and for Family Nursing were also discussed, and as a consequent step, the chairs of Family Medicine and Family Nursing submitted letters on FM and FN chairs' training needs for further PHCR workplan consideration. Alternatives and possible modalities for FM doctor retraining will be part of the assessment work done by PHCR during January and February 2006.

PHCR developed a questionnaire and conducted a quick study on learning needs of physicians completing one year's retraining in FM by UFMC. PHCR also developed a questionnaire and conducted a FM clinical preceptors' performance and learning needs assessment. Study results will be summarized in a report in mid-January and will recommend which training gaps be addressed by upcoming activities.

Component 3: Open Enrollment:

PHCR staff has started to review the experiences from the ASTP period, and the PHCR OE specialist and Health financing team is following up on recommendations, legislation, procedures and guidelines, and feasible indicators for full-scale open enrolment rollout. This work has a direct connection with work started on the health information systems situation-analysis, where a dedicated

cross-project working group has been established (World Bank PIU, MoH and PHCR). This working group also looks specifically at needs for hardware-software harmonization, and has prepared for an incoming STTA mission.

PHCR specialists received the enrollment *prekas* draft provision from Ruzan Yuzbashyan (PHC department head, MoH) and contributed with adjustments and corrections based mainly on the last version of the (ASTP developed) *prekas* draft. Important changes included wording in clause 2.7 which establish a limitation of physician selection only within the *hamaynk* (community) clinics. PHCR also contributed by rewriting the roll-out strategy and time-plan for implementation.

Experience from this work has fed into parallel planning of associated activities listed under the public education component, and with regard to procurement of hardware, software installation, and training for staff in use of hardware and software to undertake the open enrollment process. The fact that the Ministry of Health has announced simultaneous introduction of open enrollment across Armenia (latest statement by early 2007) has also led to discussions on rescheduling the in-facility training, replanning the computer procurement, and adjusting other PHCR components to enable moving from the original model (zonal roll-out) to the new timeframe for country-wide all-at-once PHCR support for open enrollment.

PHCR staff, along with colleagues from World Bank PIU and SHA, have started collaborative workgroup proceedings and discussions to assess the hardware needs for the open enrollment process. PHCR initiated a collaboration with the MoH Health Information Analytical Center, which previously developed the WB PIU HIS software product. Work has begun with developing characteristics of software products and a timed work-plan for the practical software integration. We have also developed a Scope of Work to invite an short-term international expert (Dr. Herbert Koudry), to contribute to the further IT systems development.

Component 4: Quality of Care

PHCR has begun preparation for implementation of project support in 310 facilities and specific renovation and equipment supply in 100 FAPS and 130 ambulatories/polyclinics. PHCR has also begun development of an inventory assessment instrument, based on which the project will be able to design a clear and transparent decision-matrix for facility selection. PHCR has also established collaboration with the Project NOVA GIS database system.

The FM and QoC team initiated revision of publications and discussions on PHC quality indicators and possible research methods. Feasible methods considered for the assessment of quality of care link in with the retraining and competence development for FM doctors and nurses, as well as with elements of facility-level equipment. A conceptual model for a Quality of Care three-tier system was presented during the PHCR Workshop during the week of November 28.

PHCR has identified specific project overlap between PHCR and WB-PIU in the case of clinical guidelines and protocols. World Bank PIU has apparently developed a full set of guidelines intended for use as a tool to improve quality of care in diagnostics and treatment. This work, which is currently underway with revision and further development, presents a challenge for PHCR.

From PHCR's point of view, treatment guidelines are per definition not the endpoint per se. There is a world-wide paradigm regarding such guidelines, and mere development of guidelines without direct involvement of the healthcare professionals who shall use guidelines, will in fact not bring about the desired results. Treatment guidelines are widely considered 'live processes' rather than final truth-written statements. It is through active involvement with the international community

in ongoing scientific debate and sharing of best practice in diagnosis, treatment and prevention that a continuous upgrading of praxis is brought into education, re-education and daily medical practice.

This process will be best achieved through participation of the Armenian Family Medicine Association in the World-wide Cochrane collaboration and in other similar collaborations of excellence. Experience from a large number of other countries shows that local quality of care will and can be driven forward effectively through such involvement. Consequently, while the World Bank PIU has now concentrated on preparing and printing treatment guidelines for the Armenian healthcare system, it could be valuable to add another dimension to the work by facilitating the active involvement of Armenian healthcare professionals in the international Cochrane network.

The PHCR Quality of Care team is currently assessing if this would be a feasible approach as an alternative to merely producing more treatment guidelines. PHCR would prefer not to mimic the World Bank in developing treatment guidelines, but rather to assist professional organization in accessing, using and making available to primary care and FM doctors and nurses, clinical preceptors, and FM chairs, the current status of best practice in Family medicine and nursing.

The Quality of Care team has observed that there is a weakness in the unified Family Medicine curriculum, in that the quality of the training depends highly on the individual teacher or trainer. There is a clear need for a set of quality-assured contents of the training modules, well anchored in evidence-based medicine (QoC). The QoC team has therefore also concluded that this element of QoC is not only a concern for the Family Medicine component of PHCR, but will likely need a closely coordinated team effort integrating FM and QoC work in the revised workplan.

Component 5: Healthcare Financing

During the first quarter, methods and actions needed to achieve the key deliverables of the Healthcare Financing component have been assessed against experience gained during the Workshop. Work began by assessing experience from ASTP and other donor projects as presented in reports, websites, and interviews, and there was special attention paid to the need to find ways to work collaboratively with the World Bank PIU. Specific methods for PHCR contribution to national-level planning and budgeting will be further elaborated during the coming quarter(s).

On an on-going basis, PHCR project staff is participating as an advisor to the joint NHA (National Health Accounts) working group. PHCR sponsored four National Health Account experts at an NHA conference in Georgia in December. In preparation for this event, PHCR participated in preparation of the presentation that was presented on behalf of Armenia. PHCR also initiated and proposed an approach for determining the funding provided by international donor organizations in Armenia's health sector for the purposes of developing the National Health Accounts. The NHA working group members, including Ara Ter-Grigoryan, SHA Head, reviewed and approved this approach. Further to this, we developed a questionnaire table and draft cover letter for the working group to send to international donor organizations.

Our Health Finance Specialist participated in a presentation by Marc Reveillon, Health Economist engaged by the WB PIU, and discussion on the WB-developed BBP costing methodology. The PHCR Specialist developed comments for internal discussion addressing the WB PIU expert's methodology on cost accounting.

During the second part of December, PHCR met with the WB PIU and obtained information such as space (sq. meters), number of doctors and budget. However, information for ambulatories and FAPS was only available in summary form. PHCR was told that this information, along with a list of the

facilities where the WB will be providing computer equipment, renovations, and training, would be provided when available.

Component 6: Public Education, Health Promotion, and Disease prevention (PE)

During the first quarter, work in this area focused on recruitment and on the first steps towards planning, development and testing of campaigns which can address rational health-seeking behavior, open enrollment, and family medicine. Various methods based on PRA and/or PHAST linked with community participation and community action for health have been considered and will be further evaluated from the perspective of the Armenian cultural setting and compatibility with the national “mentality” in the health arena.

The methodological issue of the small grants was also discussed internally as a possible tool with which PHCR could facilitate community mobilization and community-action for health. Based on the experience from other projects in similar settings, PHCR planning in this area is also assessing how the small grants can be utilized to stimulate community mobilization and involvement, in ways which can directly act on key determinants of health, changing behavior from high risk to safe behavior both in healthcare seeking, and in healthy lifestyles, and in building health literacy and individual/community ownership for preventive action (community action for health). This idea is to be further evaluated, and should be modeled on approaches with a proven ability to enhance the “value for money invested” in primary care. The issues relating to planning of journalist education have so far been left for a later stage of the project.

Public Education (PE) staff held multiple network-building meetings with health-sector stakeholders and media organizations in order to begin assessing potential PE synergy with pre-existing community-based health interventions, and potential media involvement with/coverage of PHCR.

PE Specialist Chris Wild, from Overseas Strategic Consulting, was in-country November 16 - December 20. Together with local PE Team Leader, Ruzanna Melyan, candidates for the Public Information Specialist and Health Education Specialist positions were interviewed and applications assessed.

During Chris Wild’s exit interview with USAID CTO and technical staff, the PE team and Open Senior Advisor updated USAID on activities of the PE team during the last three weeks, including staff hire, PE basic research needs, initial activities/preparation, and the work-plan. PE staff began reviewing PE outputs and strategies used in ASTP, and began drafting the PHCR Year 1 PE work-plan, which will be finalized after the ASTP model review assessment results provide necessary information.

Work started during the first quarter continues with feasibility study-planning, which continues alongside the wider assessment work during January and February. Results will feed into the revision of final workplan and PMP, to be presented Feb 24th 2006.

Management and Coordination

Project Management

The contract between EMG and USAID for PHCR took effect on September 30, 2005. The PHCR Deputy Chief of Party immediately began working to locate a temporary office space, and seven local staff began work on October 17th. EMG began working with its subcontractors to put in place formal contracts, and to work through all logistical, administrative, and financial arrangements. EMG held a

project kick-off meeting in its Washington office on October 17th with all subcontractors present.

In the first quarter there was heavy focus on logistical and administrative planning, while the technical staff familiarized themselves with the proposal and the technical work ahead. The Washington-based Project Manager, Anna Benton, arrived in Yerevan on October 23rd and provided technical support for project startup, particularly in organizing the planned series of workshop meetings with USAID, counterparts and other implementing partners at the end of November 2005. The Deputy Chief of Party, John Vartanian, officially began work on October 31st, but was working part-time on the project throughout the month. Washington-based EMG Managing Director, Leslie Flinn, was also in Yerevan from November 15th – November 23rd and provided technical leadership to the Project. Sam Tornquist, Chief of Party, arrived on November 23rd and participated in the workshop planning, draft workplan development, and various meetings with USAID and counterparts, as well as the workshop planning meetings during the week of November 28. He extended his stay in Yerevan and departed on December 9. The Washington-based Project Coordinator, Anna Thompson, arrived on October 27th and prepared a draft project office manual.

During the Quarter the project met many times with USAID staff, including the Health Team at USAID, the USAID Mission Director and Deputy Mission Director, and the Contracting Officer. An initial draft workplan was submitted to USAID on October 31 and a revised draft was submitted following the planning workshop meetings on December 13, 2005.

Finance/Administrative

During the Quarter the DCOP worked with the Office Manager and Finance Officer to quickly set-up a project office operational structure including a bank account, financial management controls and procedures, procurement procedures and controls, roles and responsibilities etc. Financial and administrative systems were further refined and strengthened towards the end of the quarter. Necessary office equipment and furniture procurement was conducted for existing staff and a tender package for a larger procurement for the new office was drafted for announcement after the holiday period. Additionally, local area network wiring and other required installations were conducted at the new office in preparation for the move. The move to the new office was made on December 29.

All documentation required for registration of the EMG Representative office in Armenia was prepared and submitted to the State Registrar during the second half of December. Due to the holiday period we expect to receive approval from the State Registrar by mid-January and complete the registration process (obtaining a tax code, seal, labor book etc) by the end of January.

It has become evident to date that additional local staff will be needed during the course of the project, including a communications specialist, grants manager, someone with an engineering background to help with the renovation procurement and monitoring process, additional translators and a secretary/executive assistant. We will be sending requests for approval for hiring of the staff not included in the original budget in due course. Upon completion of our situational analysis (“assessment”) that we will be conducting during January and February, we will determine additional modifications required to the PHCR budget and accordingly propose a reallocation of the budget to USAID.

Recruitment

Various job advertisements were placed for TBD positions and by the end of the quarter selection of the following additional staff were made: Public Education Specialist, Health Education Specialist, Health Finance Specialist, Local STTA Health Finance Specialist, Translator/Project Assistant, Project Accountant, Receptionist, Security Guards and Cleaning Staff. The CVs, biographical data sheets and job descriptions for relevant staff were either prepared or sent to USAID for approval by the end of December. Also, on December 16, we received approval for the American University of

Armenia to hire two Evaluation/Monitoring Assistants under a temporary duration contract. Responses to the job advertisements were being received through the end of the quarter for a grants manager and public policy and legal advisor. Once the job announcement closing date approaches in mid-January, we will review the CVs and begin the interview process.

Workshop Planning Meetings

In November, the second month of the project, efforts were concentrated around preparing for workshop planning meetings held November 28th through December 2nd, as mentioned above. Workshop participants included USAID, Ministry of Health, State Health Agency, relevant USAID-funded healthcare projects (World Vision, RPM+, AECF and NOVA) and other donor organizations including WHO, World Bank, MSF Belgium. The meetings produced many fruitful discussions around areas of collaboration and leverage, as well as agreements on strategic areas of concentration between different donors. The Project Manager, COP, DCOP and other technical staff met with many counterparts for follow-up during the month, including NIH, WB PIU, YSMU, NOVA, MOH, and MOE.

Progress toward project workplan and achievement of PMP benchmarks and indicators

PMP

USAID advisers have repeatedly called for PHCR's PMP indicators to be tailored to reflect project impact on Armenian population health status. Based on evidence-based medicine, PHCR project staff have since been considering viable methods for achieving this monitoring goal. It is generally understood from epidemiological scientific consensus today that population health status depends heavily on factors outside simple healthcare delivery (main determinants of health being much related to poverty, health behaviors and environmental factors). Consequently, mere interventions targeting primary healthcare delivery and data collection from inside the healthcare reporting system will not suffice to reflect population health or reflect the impact on population health brought about by combining reform in primary care with community action for health. Further discussion of PHCR's health status indicators and acceptable methods of data verification and validation have been linked both with aspects of specific disease-based surveillance and with planning of interventions and monitoring connected with the public education, health promotion and disease prevention component of the project.

Monitoring and evaluation

A monitoring and evaluation plan was developed to assess the experiences in/at ASTP project sites, with regard to key issues for PHCR work planning. Preparation of the evaluation plan was carried out with the monitoring team from American University of Armenia, and core staff of PHCR, defining initial monitoring indicators and assessment methodologies. Fieldwork has been started and will be ongoing during January and February, feeding into the revision of the PHCR workplan to be presented to USAID by February 24th, 2006.

PHCR is currently assessing possible methods for monitoring and evaluation, including a feasibility assessment on a cluster-based approach for tracking project work. In that context, the project has also started to gather essential baseline data (such as on healthcare facility inventory), and from baseline data calculate the needed cluster size for control and identify intervention sites to assess impact over time.