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ARMENIA
SOCIAL
TRANSITION
PROGRAM

# REPORT NO 125
# ARMENIA SOCIAL TRANSITION PROGRAM FINAL REPORT

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# ARMENIA SOCIAL TRANSITION PROGRAM FINAL REPORT

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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# ASTP FINAL REPORT: 1. INTRODUCTION

## 1.1. AN OVERVIEW OF THE ARMENIA SOCIAL TRANSITION PROGRAM

The Armenia Social Transition Program (ASTP) was a five year $26.5 million project,, to, in the short-term, meet the immediate social and health care needs of the most vulnerable members of the Armenian population[1] and, in the longer term, establish the basis for sustainable and effective social insurance and health care systems. USAID has defined social insurance systems to include unemployment, disability, health, and pension systems. The program included three components:

Component 1: Establish the Foundation for Sustainable Social Insurance Systems.

Component 2: Improve the Efficiency and Effectiveness of the Government of Armenia in Providing Social Assistance and Primary Health Care.

Component 3: Strengthen Governmental Capacity to Provide Primary Health Care in Selected Regions.

USAID's Scope focused ASTP on those elements of the program related to establishing the longer-term foundation for social insurance systems, while, in the short term, increasing the efficiency and effectiveness of the government in providing social assistance and primary health care to vulnerable people. The project began in July, 2000 and ran through October 20th, 2005[2]. In July 2003, USAID exercised the two-year contract option.

**ASTPs Achievements Measured Against USAID Indicators**

USAID established a wide array of indicators against which to measure ASTP's achievements in concrete terms. The final indicator measures against the full range of intermediate results etc are shown in Attachment A. Some highlights include:

| | | | |
|---|---|---|---|
| **I.R. 3.4.1.** Improved Social Assistance Program for targeted Populations | Percentage of beneficiary households with children | 2000 – 47.19% | 2005- 69.29% |
| **I.R. 3.4.2** Reduced Need for Government Subsidies | Percentage of households registering for PFB reduced. | 2000 – 52.85 | 2005- 16.48% |
| **L.L.R. 3.4.1.1** Strengthened Mechanisms for Service Provision | Social Security Card System Introduced<br>Number of Armenians holding social security cards | 2003 – 0 | 2005-<br>2.5 mil |
| **I..R. 3.4.3.** Social Insurance Programs Strengthened | Number of employees contributing to SSI<br>Percentage of salary employees contributing to pensions as a percent of total employed in the economy | 2000- 35.79% | 2005- 43.88% |
| **S.O. 3.2** Increased Utilization of Sustainable, High Quality Primary Healthcare Services | Utilization rates for Family Group Practices (FGPs), FAPs, and other health facilities in program areas.<br>Number of client visits for identified primary healthcare facilities in program areas | 2001 - 0 | 2004- 57,649 |
| **I.R.3. 2.2** Improved Service Delivery in Priority Primary Healthcare Disciplines | Number of patients registered in open enrollment in program areas | 2002 -0 | 2004- 204616 |

## 1.2. IMPACTS OF THE ARMENIAN SOCIAL TRANSITION PROGRAM

**Poverty has been sharply reduced**. In 1999 23 percent of the population lived in extreme poverty. By 2001 this declined to 16 percent. By 2003, only 7.4% lived in extreme poverty. By 2004, extreme poverty fell further, to 5.4%. Decreases in extreme poverty were accompanied by reductions in government spending on social assistance. In 1999, before ASTP began, the caseload exceeded 217,000 families – 45% percent of all families in Armenia. By September 2005, when the project ended, only 131,000 families were still receiving benefits- 16.48% of all families in Armenia. The reduced caseload was achieved with no public protests or even increases in complaints because the truly needy are receiving bigger benefits; others are receiving less and those who should not be receiving benefits were removed from the benefit system. Armenia's poverty reduction strategy, developed in 2002 and 2003, was approved by the World Bank which assumed the implementation of many of the initiatives.

[1] For the purposes of this Program, the "most vulnerable" have been defined as those not able to meet their basic health, nutrition and shelter needs. The most vulnerable are likely to include extended family households with three or more children.

[2] In May 2005, USAID approved a two-month no cost extension to ASTP. Later in September 2005 USAID approved a further 20 day no cost extension to carry out a specific task on pension options analysis.

**Public services to the needy are greatly improved**. The benchmark ASTP household survey carried out in November 2000 indicated that only 46% of the customers who visited a social service office were satisfied. Two years later, 70% of customers of Regional Social Service Agencies indicated that they are satisfied with the service provided[3]. One indication of the improvements is the award to the Ministry of Labor and Social Issues of the prestigious title of "The Most Open and Transparent State Institution" by the UN office in Armenia on December 11, 2003. The contest was held by the UN Office in Armenia, the Center for Freedom of Information, the Institute of Civil Society and the Institute of Civil Rights.

Economic and Social Expansion

Thanks to its stable government and effective reforms in the economic, social and health spheres, Armenia has moved ahead of its neighbors in the Caucasus. The recently released UN Annual Report on Human Development ranked Armenia as 83rd amongst 182 countries on the level of life development, passing ahead of neighboring Azerbaijan and Georgia (101st and 100th respectively).

According to the Report, in 2005 life expectancy in Armenia's citizen was higher than that of Azeri and Georgian citizens. Average lifespan in Armenia totaled 71 years, in Azerbaijan - about 67 years, and in Georgia - 70 years. Armenia passed its neighbors in literacy. Finally, GDP index per capita in Armenia totals $3.700, in Georgia $2.600.

**Armenia's Primary Health Care system now rests on the concept of Family Medicine**. The Armenian health system has adopted Family Group Practice as the cornerstone of primary care ensuring that people have better access to better care. Individuals have a choice among doctors and Family Group practices. The ability to choose is part of a system that encourages constant improvements in health services and strengthens the doctor – patient relationship. The ASTP-supported PHC pilot sites in Yerevan and Lori Marz successfully demonstrated the value of the Family Medicine approach. New systems of patient and provider management have been effective in real family practice settings. Referrals to specialists fell from 30% in 2003 to 15% today. The conference, "Primary_Care Reform in Armenia: Lessons Learned from the Pilot Program and Options for the Future" held in Yerevan on May 17-19, 2005 demonstrated the MOH's and other stakeholder's confidence in the successful piloting of the new PHC model. More than 350 participants attended the conference which offered over 20 panel and group sessions. The Conference confirmed that Armenia's focus on PHC reform is sound and its priorities and approaches are in line with Armenian as well as international trends and developments.

**Government fiscal capacity strengthened**. Armenia's budget grew by 21.1% and totaled 132.6 billion AMD (US$299 million) – growth that was supported by increased compliance in the field of social insurance contribution collection. In the first six months of 2005, for example, the amount of social insurance contributions collected rose by one-third over the same period of 2004. The introduction of the Social Security Card coupled with training provided to the Ministry of Labor and Social Issues on benefit fraud control, improved targeting of benefits and administrative improvements at local office level enabled the GOA to target scarce resources to the most needy and eliminate fraudulent claims and applications. The Ministry of Labor and Social Issues conducted data-matching using the Social Security Card and monitoring and inspection visits to local offices with the support of ASTP. In the period January –September 2005 alone the savings achieved by eliminating fraud and errors in social protection caseloads saved the government $1.2 million. These impacts were achieved through the following achievements.

**IMF's View of Armenia**

IMF's Deputy Managing Director, Augustin Carstens, while visiting Yerevan in August 2005, stated that "Very few countries have achieved such an important progress in such a short period of time. Armenia, he added, is on a "promising path [of] sustained growth and alleviation of poverty."

## 1.3. MAJOR ACHIEVEMENTS LINKED TO ASTP ACTIVITIES

**A New Legal Foundation for Social Protection and Health Care has been Built**. The achievements of the GOA with ASTP support thoroughly fulfilled the scope of the project. ASTP supported the 6 laws of the

[3] The DFID "Modernization of Public Services" intends to carry out a survey of customer satisfaction in 2005/2005 using the same questionnaire used by ASTP and the same group of respondents

Republic of Armenia that were enacted and 7 draft laws still under active consideration. It also supported the drafting and enactment of 24 Government Decrees relating to social issues and 26 Decrees related to health and regional issues.

**Social Security Card System Implemented**. Armenia has created and implemented Social Security Cards used in all financial transactions by the population. Almost 2.5 million Armenians now hold a Social Security Card. The card numbers have been used to eliminate more than 50,000 people collecting social benefits (pensions, unemployment, disability etc) in error. The Social Security Card has reduced the possibility of both external and internal fraud virtually eliminating double-claiming and false claims and strengthening internal controls. Rampant internal fraud has been almost eliminated. Culling the caseloads could save the GOA more than $2 million annually when the system is fully operational. This is a major step forward in fighting fraud, error and abuse, reducing corruption and establishing the rule of law.

**Health Management Information Systems now operate in Pilot Sites to Support New Primary Care Model.** Nine polyclinics (4 in Yerevan and 5 in Vanadzor) and 3 independent rural ambulatories with 20 rural health centers now operate open enrollment. The total number enrolled is 214,033, representing 77.4% of the population of the catchment area. The following table illustrates the population enrolled as of June 30th, 2005 as a percentage of the population of the facility's catchment area.

| Polyclinic | Enrolled to date | Percent of reported catchment population |
|---|---|---|
| PC 17 | 35,269 | 80.6% |
| PC 2 | 32,614 | 64.7% |
| PC 10 | 10,937 | 68.6% |
| Erebuni center | 25,045 | 58.1% |
| Hayq center | 7,802 | 88.0% |
| **Total Yerevan** | **111,667** | **68.9%** |
| Vanadzor PC4 | 14,272 | 71.0% |
| Vanadzor PC1 | 12,122 | 55.4% |
| Vanadzor PC2 | 18,974 | 84.3% |
| Vanadzor PC3 | 30,920 | 92.5% |
| Vanadzor PC5 | 15,224 | 67.5% |
| **Total Vanadzor** | **91,512** | **76.0%** |
| Rural ambulatories | 10,948 | 82.6% |
| **Grand Total** | **214,127** | **72.4%** |

**Primary Care Quality Improvement Systems are now in place in Pilot Sites**. Quality Monitoring and Continuous Improvement System are in Place in all pilot sites. The system includes-

- Internal clinical protocols for PHC-sensitive diseases so patient care can be organized to treat them. Diseases include: Hypertension, Diabetes Mellitus and Respiratory Infections;
- Health screening systems to improve early diagnosis of PHC sensitive diseases like Pediatric Diseases, Hypertension, Colorectal Cancer and Women's Reproductive System Cancers;
- Improved prevention of common chronic health problems and disorders through patient education systems in healthy lifestyle and nutrition;

- Improved prevention through education in early signs and symptoms of common chronic diseases such as Diabetes Mellitus, Hypertension or cancer disorders.
- An established cross-training and peer auditing system using Peer Chart Reviews for regular feedback;
- Evidence-Based Medical (EBM) libraries f in each pilot site and a peer audit system linked to EBM approaches which encourages contemporary medical approaches;
- A quality monitoring system made up of Coordination Committees, Patient satisfaction surveys, Patient Encounter Systems and focused studies on outpatient record-keeping by doctors;
- Regular feedback in place to inform PHC providers on their performance based on selected criteria and indicators of PHC quality.
- Improved physical environment for primary health care facilities including expanded capacity through delivery of USAID-procured medical equipment and other medical supplies.

**IT systems created**. ASTP helped to develop 7 major new IT systems being operated by Government ministries, agencies and health care facilities. ASTP provided its counterparts with more than 700 computers and the related equipment.

**Facilities Upgraded**. ASTP financed and managed more than $350,000 in renovation projects, leveraging more than $150,000 in funds from Armenian partners and international donors.

**Management and Administrative Strengthening skills provided**. More than 3,000 government officials and NGO staff participated in ASTP-sponsored training. In the social sector ASTP provided training on diverse topics such as social work skills, management skills, administrative skills, customer service, teamwork, training of trainers, public education techniques, legal drafting and benefit fraud control. Almost three thousand (2,956) physicians were trained in Family Medicine skills and management skills necessary to introduce family medicine in operational polyclinics. Under ASTP auspices, counterparts visited and observed social and health systems in the USA, Russia, Republic of Ireland, UK, Poland, Georgia, Kyrgyzstan, Estonia and Ukraine. In the health and social sector 12 staff training manuals were produced, disseminated and used in staff training sessions countrywide. A legal manual covering all laws in the social and health sector was produced by ASTP in 2002 and reprinted and updated in 2004.

These successes are sustainable. USAID designed ASTP to ensure that improvements in social and health services would continue in the future. ASTP has served as the catalyst to spur improvements in services and, more important, to create the permanent government capacity to continue reforms and deliver services with greater efficiency in the future.

## 1.4. PROCESS AND SCOPE OF ASTP

The breadth and depth of the Armenia Social Transition Program is nearly unique in USAID's global project portfolio:

- Breadth – ASTP activities embraced systemic changes in health, social insurance, social assistance, and general government administration.
- Depth – In all its major activities, ASTP provided assistance to its counterparts from the design of new policies and public education to the details of training, implementation and administrative procedures.
- Participation - Large numbers of counterparts and co- implementers allowed ASTP to build trust, high visibility, credibility, and mobilization of collateral resources.
- Close collaboration - Counterparts were out in front of all project activities from design to implementation.
- Sustainability – Activities were designed to continue after ASTP and many are already self-supporting.

In a combined social and health program, ASTP worked with 77 partners and counterparts in Armenia – including 12 multinational donors, 6 bilateral donors, 18 other USAID-supported programs, the National

Assembly, the National Statistics Service, 3 ministries, and more than 30 local agencies, NGOs and organizations. ASTP collaborated with its Armenian partners in drafting 62 laws and decrees in both sectors.

The ASTP team included experts drawn from 13 different nations. It prepared 120 analyses and reports outlining specific recommendations as well as several hundred papers and other formal communications which provided the foundation for implementation of wide-ranging legal/regulatory reform, information systems, financial and education systems essential to social and health reform. (See Attachment C for a full list of reports). To educate the public regarding social and health reforms affecting their lives, ASTP assisted partners to produce 12 posters – printing and distributing more than 111,000 copies in total, 50 brochures (in total 2,750,400) for public distribution, 14 Public Service Announcements placed in all national radio and national and local TV channels, 4 TV talk shows, special inserts to national newspapers (in total 100,000 copies), conducted 7 Public Education training sessions for state officials, social security and pension reform implementers, social workers and hot-line staff in addition to public education workshops and seminars for community leaders, journalists, NGOs, medical institutions, focus groups and town hall meetings at communities and Yerevan condominiums.

## 1.5. OUTLINE OF THIS REPORT

ASTP achieved results in the following 12 areas around which the following report is organized. A series of attachments provide additional detail supporting these chapters.

1. Social Security Cards – Almost 2.5 million Social Security cards were designed and issued. The cards are used in social security, tax and financial transactions. They have increased administrative efficiency and reduced corruption. Data privacy legislation was enacted in conformity with EU conventions.
2. Pension reform – A 3 pillar system approach was adopted and the development of a pension reform strategy has advanced. Social benefits were transferred to the state budget. Collection of social contributions and taxes were integrated in the State Tax Administration. Social insurance collections have increased. Pension benefits increased.
3. Targeting social benefits – Poverty Family Benefits are now targeted at families with children so that social assistance is now more effective in reducing poverty. Effective targeting of benefits reduces poverty while still cutting government spending.
4. Strengthening of social statistics –Poverty levels are measured using a more systematic and transparent methodology. National Statistics Service (NSS) staff were trained so that the NSS is now issuing regular and readable reports, and GOA is using the statistics in policy-making.
5. One stop social services center pilot – Integrated Social Service Centers (ISSCs) were established which improved services for citizens. ISSCs broadened citizen access to NGO services and through the co-location of national and local services, helped to create closer links between local government and national government. The World Bank will support the creation of further Integrated Social Service Centers countrywide.
6. Actuarial Profession – The profession of Actuary was legally established. A B.A. and M.A. program in actuarial science was established at Yerevan State University, based on new syllabus and curricula. An Actuarial Resource Center was also installed at Yerevan State University (YSU). YSU graduates have jobs and internships and actuarial analysis is used in government decision making.
7. Building government capacity – Training was delivered throughout the Ministries of Health and Labor and Social Issues, as well as to partner agencies like National Statistics Service and the Nork Center in areas ranging from the use of software and computers to management and meeting the media. Policy sessions and mentoring were conducted. Seven IT systems were developed and the Nork Center for information management was created for the Ministry of Labor and Social Issues.
8. Free choice of health care provider- Creating the systems to allow the public to choose their primary care provider has stimulated doctors to improve care.

9. Armenia's Primary Care system now rests firmly on the concept of Family Medicine – Family Medicine was successfully modeled in pilot sites, with physicians retrained to allow them to treat basic patient problems, with medical education curricula teaching medical students the new skills needed for Family Medicine practice.
10. Quality assurance is now embedded as a standard part of medical practice.
11. Armenia's primary care physicians receive financial incentives based on the quality of the care they provide and their ability to attract patients who voluntarily register with them.
12. Family Group Practice Management is strengthened by the use of IT systems and new patient-oriented procedures such as patient encounter forms that record the outcome of each clinic visit.

Each of these activities involved counterparts from design to implementation. Each of the eleven following sections explains how ASTP supported its partners in the following ways:

- Policy design through broad involvement in working groups and roundtables;
- Creation of a sound and sustainable legal framework;
- IT and administrative systems design and implementation
- Training in computer literacy, administration, policymaking, actuarial skills, management and medicine; quality control and statistics;
- Public education covering why policies change, the services offered and their locations and requirements, and providing feedback to policymakers.
- Ensuring sustainable change.

The changes brought about by ASTP's support for GOA counterparts have touched the lives of all Armenians and stimulated a process of reform with accountability that will continue under its own momentum well beyond the end date of the ASTP project – and the lives of Armenians will continue to be touched by ASTP in the future.

# ASTP FINAL REPORT: 2. SOCIAL SECURITY CARDS[4]

## 2.1. OVERVIEW

ASTP supported the Government of Armenia to design and implement the country's new Social Security Card system. The system assigns unique social security numbers to citizens which remain unchanged throughout their lifetime. These numbers allow the integration of the government's social security databases of pensioners, social assistance recipients and taxpayers – improving services and increasing government efficiency. The use of the cards and of its unique number in financial transactions, from opening a bank account to collecting a monthly pension, reduces error and fraud in distributing government benefits. It is also proving a powerful incentive for economic activity to move out of the shadow and into the formal economy

President Robert Kocharyan holding his Social Security Card

Creating and implementing the Social Security Card (sometimes referred to as the Social Card) system involved a series of challenging steps: designing the system, creating the legislative framework, developing an IT Center, training many levels of employees and educating the public.

The first step involved designing the system and determining the uses of the cards. The system needed to continue operating without problems after ASTP support ceased. The next step involved creating the legislative framework – defining how the cards would be used and how numbers would be assigned. The legislative framework also had to protect the privacy of personal data as the government moved into the computer age.

To implement the system, the Government needed an IT center that could administer the complex manual and electronic processes. Processing and storing the millions of application forms and records that issuing Social Security Cards would create required designing and testing procedures and training. Government social insurance and social protection databases had to be designed and implemented to take advantage of the unique identification numbers.

Hundreds of civil servants in the Ministry of Labor and Social Issues, State Social Insurance Fund, State Tax Administration as well as local government officials countrywide had to be trained in how the system would work in order to process SSC applications. Computer specialists had to be trained in the skills related to programming and system administration.

The public had to be educated about why and how to apply for their cards. The success of the system – from design to card distribution – during the five year ASTP – is one of the fastest such transitions in the world. (The UK, for example, has already spent more than 20 years on developing its card system and UK citizens have not yet received their cards.) The GOA Social Security Card system was introduced against a background of public protests from religious groups who were opposed to the cards. Public education had to respond to the concerns of these religious groups.

[4] The program was originally called the Personal Number system by the Ministry of Social Security (MOSS) (now Ministry of Labor and Social Issues MLSI). The name of the system was changed in 2003 following objections to the concept of numbering people by some religious groups.

**Number of Social Security Card Holders and Population of Armenia**

| Categories | Number of Social Security Card holders *as of 27th October 2005* | Percentage of Social Security Card holders *as of 27th October 2005* | Census data October 2001 de facto population[5[1]] |
|---|---|---|---|
| **Total population including** | **2,431,853** | **80.99 %** | **3,002,594** |
| **Male** | **1,132,121** | **80.45 %** | **1,407,220** |
| **Female** | **1,299,732** | **81.46 %** | **1,595,374** |

## 2.2. SYSTEM DESIGN

ASTP began work on the Social Security Card system immediately in July, 2000. It built upon preliminary work performed by the World Bank. Development of the system concept started in 1997 with the support of the World Bank and TACIS. Activities became more intense after the adoption of the "Concept Paper on the Introduction of Personal Identification System of the Citizens of the ROA" by the Government in 1999.

The ten-digit Social Security Card number is determined by the applicant's birthday and by the order in which the application is received. The GOA listed the main objectives for introducing Social Security Cards as:

**Social Security Card Highlights**

Almost 2.5 million cards have been distributed to 81% of Armenian citizens.

Using cards to verify caseloads of recipients of pensions, invalid benefits, and social assistance and unemployment benefits has already saved the Government $2 million in the first 9 months of 2005.

In September 2005, in a TV interview the Minister of Labor and Social Issues said "ASTP support of the implementation of the Social Security Card in Armenia was profound, systematic, constant and comprehensive."

- Allowing the transition from the system of labor workbooks to a computerized and centralized system of record keeping;
- Establishing a system for keeping personified records of individuals in their relations with state social and health services – especially those receiving social assistance and social insurance benefits;
- Establishing personified accounts for people covered by social insurance programs that store information on work experience, social insurance payments and, if necessary, other data that would be used for assigning state social insurance reimbursements;
- Creating the capacity for verifying and amending data submitted for benefit assignment;
- Creating incentives for employers and employees to pay the correct amount of social insurance contributions to the State Social Insurance Fund;
- Establishing a unified and transparent database that will allow the more efficient administration of social programs, reducing the budgetary costs of administration;
- Allowing the accurate calculation and reporting of major social indicators – showing changes in the social welfare of target population groups and allowing accurate forecasting of budget expenditures and the evaluation of policy options;
- Establishing systems and databases that allow the effective auditing of expenditures on social programs;
- Creating the basis for personification of record keeping in other state sectors – such as health and the state cadastre system (registration of real property);

- Increasing the efficiency of information exchange about individuals among sectors, agencies, and levels of government;
- Helping to formalize the informal economy;
- Reducing the possibility of using the banking system for money-laundering activities.

Overall, the implementation of the system involved the following steps.

1. Social Security Card (SSC) law drafted (May 2002), approved by the GOA (December 2001), passed by the National Assembly (May – September 2002) and signed by the President (Oct 2002).
2. Privacy Protection law drafted (May 2001), approved by the GOA (March 2002), passed by the National Assembly (June – October 2002) and signed by the President (October 2002).
3. Nork Analytical Center established (October 24th, 2000,) space identified, renovated, equipped, and begins operating (June 2001).
4. Design of procurement Plan for computers necessary to implement SSC's for Regional Social Service Agencies (RSSAs), Republican Employment and Labor Agency (EAs), State Social Insurance Fund (SSIF), and pilot OSIRIS sites (for Ministry of Justice) (August 2001).
5. Support for USAID tender design for computer procurement. Tender issued (April 2002). Equipment delivered Nov-Dec 2002.
6. Interagency data sharing protocols developed (Ministry of Interior agrees to provide passport database to Nork Center – December 2001).
7. SSC assignment software program redesigned (Jan – April 2002), tested (May – Sept 2002), and application software designed and tested (May – July 2002), field office SSC applicant software replaced with simplified manual process (Oct 2002).
8. PARNAS automated personified reporting system and centralized database designed (Oct 2001 – May 2002), Approved by MLSI and SSIF (May – Sept 2002). Pilot tested – 2003 – 2004; and nationwide rollout began in 2005.
9. OSIRIS Civil Status automated recording system (births, deaths, marriages) system designed (Dec 2001 – July 2002), Approved by Ministry of Justice (MOJ) (May – Sept 2002). Pilot-tested June 2003. The OSIRIS system remains at the pilot stage as neither the GOA or the MOJ had funds to implement the system countrywide.
10. SSC Pilot for Abovyan designed (Jan – May 2002). Implemented (June – Sept 2002). Analyzed (Oct 2002), extended to test new field office procedure and form modifications (Oct 2002).
11. SSC National Rollout Strategy (including document flow) developed (Oct 2002), adopted by the MLSI January 2003, rollout began September 2003.
12. Training of the SSC application process provided to over 350 civil servants in MLSI, SSIF, Tax Administration and others beginning in September 2003.
13. Comprehensive Social Security Card Public Education campaign developed in 2003 and implemented jointly by ASTP and MLSI targeting citizens, public representatives, employers, community leaders,NGOs and community groups.

## 2.3. CREATING THE LEGAL FRAMEWORK

Implementation of the Social Security Card Program involved the passage of two major laws and 6 Government decrees and 7 ministerial instructions.

### *2.3.1. Laws of the Republic of Armenia*

Two laws were needed to set up the system. These were: The *Law on Personal Numbers* – defining the system – and the *Law on Personal Privacy* – to ensure that the new government databases would not lead to the violation of personal privacy. ASTP worked closely with experts from the Ministry of Labor and Social Issues. International experts and GOA experts met in seminars and roundtables on the construction of social security data systems. Intense discussions during these seminars resulted in refinements and improvements in the quality of the drafts as well as a deeper understanding of the issues by GOA counterparts. This collaborative, innovative approach included key deputies from the National Assembly who were well-informed during the formative stages of bill-drafting. The result was the approval by the full Government of

the draft laws and their submission for consideration to the National Assembly in the spring of 2002 and their passage and Presidential signature by the fall of 2002.

To encourage informed debate within the Assembly, ASTP supported the design and development of brochures and information packages by the Ministry of Labor and Social Issues that were printed and distributed to all members of the Assembly. To test the effectiveness of the promotional material, ASTP organized focus groups of citizens to review and comment on it. This citizen participation helped make the messages clearer and more user-friendly. ASTP also advised key officials from the MLSI at numerous meetings with deputies as well as with business leaders, community leaders and journalists.

#### *2.3.2. Decrees of the Government of Armenia*

While the laws established the overall framework, actual implementation of the system required dozens of decrees of the GOA and regulations and instructions issued by MLSI. These normative acts covered the creation and administration of the Nork IT Center, the acceptance of protocols and software systems, the creation of the pilot test program in Abovyan City, and the plan for the national rollout of the SSC system.

ASTP assisted the MLSI to prepare two decrees underpinning the implementation of the SSC.

The Presidents Decree (signed on December 16th, 2003) instructs all government ministries, Marzpets and heads of all local government bodies to collaborate with the MLSI in implementing the SSC. The Government Decree (signed on December 24th 2003) directs all government ministers, Marzpets and heads of local governments to ensure that a) all their staff applied for SSCs before January 25th, 2004, b) staff would organize events to publicize the SSC, and c) staff must collaborate with the MLSI. This Presidential decree specifically mentions the Tax Service and the Social Insurance Fund and instructed both organizations to implement SSCs through their local offices.

Decree on the Use of Social Security Cards. On June 25, 2004, the Government of Armenia approved the "Decree on the Use of Social Security Cards and Social Security Card Numbers." The Decree established January 1, 2005 as the date when Social Security Cards became obligatory for citizens to avail themselves of important state services.

ASTP assisted in the development of a number of other government and ministerial amendments to decrees and laws underpinning the SSC system including the administrative violations law establishing fines for not having an SSCand amendments to Labor Code related to SSCs among others.

### 2.4. BUILDING THE IT SYSTEMS

To gain the intended benefits of the Social Security Card system and the social protection databases it is linked to, it was first necessary to create the permanent capacity within the Ministry of Labor and Social Issues to administer the system, develop new software when laws and regulations were changed, and train state and local officials in the skills needed to operate in an increasingly computerized social protection system.

#### *2.4.1. Creating the Nork Information and Analytic Center*

The Nork Information and Analytic Center was established under a Government Decree on October 27th 2000. ASTP financed about $200,000 of the costs of the center and its equipment as well as the majority of technical support. The World Bank provided computers and technical support. On June 16, 2001, the the Nork Center for Information and Analysis (then known as the Nemrout Center for Information and Analysis) was officially opened by U.S. Ambassador Michael Lemon, then Minister of Social Security Razmik Martirosyan and Economist Lev Frenkman from the World Bank. The opening event was widely covered by television and in the press.

The center is the first of its kind in the Caucasus. ASTP worked closely with the Ministry of Labor and Social Issues and the newly-appointed director of the Center, Andranyk Satryakan, to design the center with innovative space for its computer specialists.[6] The space needed a complete overhaul since it had been unmaintained and empty for several years. The ASTP team and its counterparts performed all the design work and completed the renovation within four months. They supplied nineteen of the Center's computers. The Center celebrated its 5-year anniversary in October 2005 with a a staff of 35 and a major media event

[6] The space was a complete floor in the National Institute for Labor and Social Research – about 400 $m^2$.

where both USAID and PADCO were awarded "Certificates of Gratitude" by the MLSI for assistance in establishing the facility.

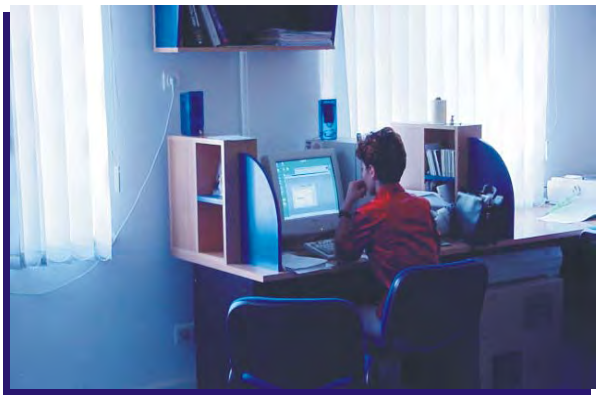
### *2.4.2. Creating the IT Training Center*

After the official opening, Nork and the ASTP collaborated to create a computer-training center on the ground floor of the same building. The center – with a dozen ASTP computers – was used to provide basic training in computer literacy to all staff from the Ministry of Labor and Social Issues and many staff from other government agencies – including the Ministry of Health, local government officials and others. Training was also provided in mathematics and statistical methods to selected staff. In an unusual collaborative effort, much of the training was provided by computer and mathematics specialists from the National Statistical Service – who, in turn, were trained by ASTP specialists. Training NSS professionals created a permanent training capacity within the Government of Armenia. The Center facilities and the trainers both receive top marks from participants in the training courses. The Training Center is now fully sustainable and computer training sessions are carried out there for new MLSI staff and new staff of other government agencies.

Razmik Martirosyan, Minister of Social Security, cuts the ribbon opening the Nork Center, June 16, 2001. He is assisted, on the right, by US Ambassador Michael Lemon and by Lev Frenkman from the World Bank

A worker begins demolition of interior walls in February 2001.

A Nork Specialist at work in the newly created space in June 2001.



### *2.4.3. Developing SSC Number Assignment Software*

The World Bank supported initial work on the design of the software that would convert the personal data submitted on application forms into unique social security numbers.

ASTP carried on the project once the necessary legislation and regulations had been adopted – using a software specialist from Kyrgyzstan to support the Nork Center staff who previously worked with World Bank support. The assignment software program was redesigned in early 2002 and formally tested during the summer. The program has worked efficiently and effectively in assigning numbers to 2.5 million Armenians.

As the SSC assignment software was being created, ASTP was supporting the development of new database systems that would take advantage of the social security number. These systems included a personified database system for pension records to be administered by the State Social Insurance Fund (described in detail in section 2 where pension reform is discussed), and the database for the Poverty Family Benefits program (described in detail in Section 3 where ASTP support for the reduction of poverty is discussed).

### *2.4.4. Creating Archives for SSC Documents*

On June 12, 2003, SSC archives for the Nork Center for Information and Analysis were officially completed. The archive stores over three million Social Security Application forms submitted by the Armenian people.

The Archive is an essential part of ASTP's support for implementation of the new Social Security Card system. ASTP supported the renovation and contributed two paper counters to the Nork Center to verify the number of application forms received from the local offices. ASTP spent $19,000 to renovate the Archive.

Personal Code application forms being counted on the Nork Center paper counter

#### *2.4.5. Providing Computers and Related Equipment to Nork and MLSI*

ASTP provided the following equipment to the Nork Center to support the production of Social Security Cards: 16 servers, 29 donated servers, 155 (PIII, PIV) computers, 40 (PII) donated computers, 155 UPSs, 124 printers, 3 high speed scanners, 17 barcode scanners, 1 projector, 7 laminators, 6 cutters, 2 paper counters, 2 corner-rounders, 1 digital camera, 2,500,000 lamination film packs, 2,500,000 pre-printed SS cards, various LAN equipment (hub/switch, cable, connectors, etc.) This support amounts to almost $1.1 million dollars in addition to the construction costs of $100,000 to create the Center.

#### *2.4.6. Maintaining Data Security*

- PADCO and the Nork Center organized the installation of an alternative power line for the Nork Center. The back-up power line has enhanced the security of the Nork Center and the Social Security Database.
- Magnetic film to back up the Social Security database was ordered by PADCO and was delivered to the Nork Center in December 2004.
- PADCO with the assistance of the Nork Center developed a renovation plan for the Social Security Card Database server room and the Social Security Card administrative room. Renovation began in mid December and work completed January 21st 2005.

### 2.5. TRAINING

Training was vital at each stage of the SSC program. Staff of agencies which were implementing SSC were trained so that the stakeholder base increased. Training addressed unanticipated problems in collaboration with its MLSI colleagues. For example, in early 2005, high error rates in application forms were noted in some locations. Local offices with high error rates received monitoring visits and local trainings were provided through ASTP assistance. One hundred sixty-nine (169) staff members in 45 local offices, as well as community leaders, were retrained during these visits. Demonstrating the broad approach of ASTP, more than 80% of those trained were employees of agencies which support MLSI such as Republican Employment and Labor Agencies and SSIF office staff. The results were dramatic reductions in error rates. Training covered the future uses and importance of the SSC in documenting financial transactions in Armenia.

**Training for Nork Center specialists**. ASTP provided Nork center specialists with formal training in Oracle, SPSS, and other programming and analytic skills.

**Training for Social Protection Specialists**. As the MLSI and SSIF computerized operations, staff needed training in computer literacy and higher computer skills to maintain customer data.

**Training for the SSC Pilot Program**. In order to prepare local staff in Abovyan to conduct a pilot test of the SSC application and card distribution system, ASTP delivered a 14-day training-workshop in April 2002. Employees of the State Social Insurance Fund (SSIF), EA and Regional Social Service Agencies (RSSA) were trained and tested on procedures for SCC system implementation.

**Training for State Tax Administration**. In February 2004, in collaboration with MLSI, ASTP organized a two-day training course on the Social Security Card system for 29 staff of the State Tax Service. Participants learned about the system, about enabling legislation, how to use the Social Security Card software, the protection of personal privacy, public education techniques and local implementation of the SSC in State Tax Service offices. In March, staff in the local offices of the State Tax Service began accepting applications for SSCs, joining the larger group of almost 200 staff dealing with SSC applications in the Regional Social

Service Agency, State Social Insurance Fund and the Republican Employment and Labor Agency local offices in all regions of Armenia.

**Training for the National Rollout**. Public Education activity for the Social Security Card intensified in early 2004. ASTP supported the production and distribution of posters, brochures and leaflets to all marzes (regions of Armenia). This material explained why citizens need to have an SSC and how to apply for an SSC and complete an application form. A Question and Answer Brochure and leaflet on the SSC was printed and distributed widely through visits to marzes, seminars, community visits and other public education events. ASTP also provided assistance to print and distribute letters to employers encouraging them to lodge bulk applications for SSCs to cover their employees. Extensive media coverage during the quarter included TV programs and talk shows, newspaper articles, news spots and radio interviews. Seminars were organized for various state agencies, NGOs and other special interest groups to explain the SSC system and to encourage staff to lodge their applications.

A three-day workshop was held on June 10–12, 2004, supported by ASTP. The seminar was attended by the key implementers from the MLSI, the Deputy Head of State Tax Service, the Head of Economic Legislation, Department of the Ministry of Justice, Customs Committee, Head of Technical Analysis and Development, Department of the Central Bank, the Head of State Tax Service IT Division, the Chief Specialist of the Tax Department of the State Tax Service, the Head of Social Assistance Department of the State Social Insurance Fund, the Advisor to the Director of the State Social Insurance Fund and the Head of Employment Services. The purpose of the seminar was to discuss the future use of the Social Security Card as a key to government services and develop a draft government decree on the use of the card by the State Social Insurance Fund, the State Tax Administration and Customs Services.

**Other Training**. In November 2004, ASTP trained 50 staff members from 19 commercial banks and the Central Bank on the application and use of Social Security Cards. In December a special seminar was organized for Managers of Banks on “Specific cases where Banks are authorized to demand Social Security Cards”. As a result the Central Bank (with the assistance of MLSI) has prepared a draft decree on the use of the SSC in the Banking sector.

In December 2004, ASTP held a three-day seminar for journalists in Tsakhkadzor to inform the Armenian media, including journalists accredited to the Ministry, Government and the National Assembly, about the use of Social Security Cards.

In December 2004, ASTP supported MLSI in training staff members of the State Tax Service on the application and use of Social Security Cards.

#### *2.5.1. Foreign Study Tours for Government Officials*

**Ireland**. A study visit to Ireland for 17 participants took place for 5 days from October 13th 2004 to look at the implementation of the Social Security Card system there. Ireland uses the card in social, health and education services. The participants were drawn from MLSI, MOH, SSIF and the government including the Presidents Office, Tax Administration and ZAKS as well as from the influential Armenian Apostolic Church. The MLSI Minister headed the study visit. As a result of the visit the Minister of Labor and Social Issues of Armenia and the Minister of Social and Family Affairs of Ireland signed a Memorandum of Collaboration on social security issues.

**Ukraine**. In April, 2004, officials from the Ministry of Labor and Social Issues traveled to Ukraine for one week to study the implementation of the social security number system there. Seven Armenian officials from the Ministry of Labor and Social Issues, the State Social Insurance Fund, and Tax Administration were shown how the system had been implemented in Ukraine and explored issues of mutual interest with their Ukrainian counterparts. PADCO Ukraine organized the study tour and set up meetings with key government officials with USAID funding, through the Academy of Educational Development.

### 2.6. COORDINATION WITH OTHER DONORS AND LEVERAGING FUNDS

The successful completion of the SSC program involved cooperation with several other donors and programs. Through USAID, ASTP collaborated closely with the World Bank. Collaborative efforts with a broad range of donors valuable to the implementation of SSCs included:

- Sharing the costs of procuring equipment for the Nork Cente as the WB provided equipment worth $200,000;
- Building on the original WB concept for the overall scheme;

- Using former a WB consultant to design and implement the software;
- Providing comprehensive SSC information to 112 international organizations and foreign enterprises and 27 Embassies and Consular offices working in Armenia.
- Presenting Social Security Card introduction in Armenia, particularly use of the cards in business, to one hundred-seventy (170) participants from Armenia, Georgia, China, Czech Republic, Russia, and USA at the the tenth trade and industrial exhibition ARMENIA EXPO–2004 from September 10th - 13th, 2004. Organized by the LOGOS EXPO Center with the assistance of the Armenian Foreign Ministry, the Union of Businessmen and Manufacturers of Armenia and the Armenian Agency for Development, the exhibition was the largest in the South Caucasus Region. Specialists from Nork Center answered many questions on the system and distributed 1000 Q&A brochures on SSCs.

In collaboration with the NGO Center, ASTP organized seminars on Social Security Cards for NGOs and their beneficiaries. One such event was a seminar organized on December 16, 2004, in collaboration with the Ministry of Labor and Social Issues, for representatives of NGOs on the use of Social Security Cards. Representatives of 40 NGOs attended the event. Many of those NGOs provide services to people throughout Armenia, reaching an estimated audience of 40,000 throughout Armenia. NGOC distributed brochures and other information materials among their customers.

## 2.7. PUBLIC EDUCATION

Public education begun almost as soon as work on designing the SSC system began. The drafting of the enabling legislation was accompanied by public seminars and press conferences. Parliamentary consideration was accompanied by intensive distribution of brochures, press conferences and workshops to open public debate. ASTP assisted MLSI in distributing SSC public education materials, preparing Public Service Announcements (PSA) on Social Security Cards and preparing radio programs.[7] It helped prepare a film on Social Security Cards containing comprehensive information about the benefits of the system and how to get the card. Special SSC informational inserts (23,000 in total) were prepared for Armenian newspapers.

### *2.7.1. Public Education for the Pilot Project*

Before rolling out the SSCs nationwide, a pilot project was carried out in the city of Abovyan to test administrative systems and to assess the cost of nationwide implementation. Local staff were trained and a special service “hotline” was created to answer enquiries and to promote the advantages of the new system. ASTP trained a specialist to staff the “hotline” and also trained 31 staff from the local offices in the handling of application forms and the distribution of cards.

On June 17th, 2002, twelve citizens of Armenia received the first Social Security Cards from Prime Minister Andranik Markaryan in a ceremony in Abovyan. The Prime Minister welcomed the Social Security Card as a means of improving access for citizens, especially citizens in need, to public services. The Prime Minister promised budget support the following year to operate the SSC system and the following year $120,000 was allocated in the state budget for SSC implementation. The Abovyan pilot proved successful – with 25,000 cards issued – far exceeding the pilot target of 10,000.

ASTP supported MLSI in discerning public views on Social Security Cards. Focus groups in Vanadzor and Yerevan in September 2002 indicated continuing concerns among the public on privacy and religious grounds which MLSI addressed. ASTP has prepared a manual on “How to conduct PE campaigns” for MLSI and Marz officials.

### *2.7.2. National Rollout*

In July and August 2003, ASTP organized Town Hall Meetings to publicize implementation of the Social Security Card which were attended by the MLSI Minister, MLSI staff, SSIF staff, and local government officials. Fifteen hundred (1500) people from all walks of life attended, providing a unique opportunity for public feedback on Social Security Cards and an opportunity to tailor the materials to be produced for the PE campaigns.

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[7] MLSI obtained agreements from both major and minor TV channels for free broadcast of the PSAs. Among the channels who agreed to free broadcasts were Public TV, H2, Armenia TV, Yerkir TV, and AR TV channels. The PSAs have been broadcast 15 times each per day by Public TV channel, 12 times by h2 TV channel, 21 times by Yerkir TV channel, 10 times by Armenia TV and AR TV channels. Fifteen (15) local TV channels were broadcasting 4 times per day. Public radio broadcasted messages 5 times per day in January 2005.

In February 2004, ASTP supported MLSI to establish Social Security Card Information Centers or "Info Centers" with Hot-Lines in all 10 Marzes and the City of Yerevan as well as in the Ministry itself. Info Centers answer public telephone and walk-in inquiries but also served as local media centers where media representatives could obtain information on SSCs. Hotline staff were recruited and equipped with a two-day ASTP training course on effective communication skills. The training emphasized the importance of communicating laws regarding individual rights and responsibilities and the protection by law of the privacy of personal data maintained in government databases. ASTP presented the participants with information folders for training, including handouts on pension reforms. ASTP also provided brochures and booklets on social assistance. Ten Hot-Lines were created, one in each Marz. These helped the Ministry carry out all public education activities at the local level, in cities, towns, villages and communities throughout each Marz. Hot-Line telephone numbers are widely advertised on posters and in Marz newspapers. The Hot-Line staff met regularly with local office staff (SSIF, EA, SMEC and State Tax Service) to ensure that Social Security Card posters, information brochures and leaflets (printed with the support of ASTP) were widely distributed and available to the general public. Hot-Line staff also created 193 "Information stands" in public places such as buildings of Marzpetarans, RSSA, SSIF, EA and State Tax Service local offices. Hot-Line staff collaborated with local TV channels, radio and the printed media to regularly provide updated information on the Social Cards. Through its Hot-Line network MLSI was able to link with local TV channels and arrange free broadcasting of PSAs on Social Cards -- ensuring coverage not just in Yerevan but also in the remote regions of Armenia. The following statistics show the breadth and size of this effort:

- Hot- Line staff received 5,582 telephone calls and had over 6000 personal customer enquiries between September 2004 and March 2005.
- Hot-Line staff organized over 400 community meetings in towns and villages, distributing public education materials.
- Hot-Line staff organized the printing of more than 50 articles in the local press and PSA announcements on more than 25 local TV channels, with approximately 470 broadcasts. Approximately 120 interviews and live talk shows with Marzpets and Marzpetaran officials answered citizens' queries.

Between March 2004 and March 2005, Hot-Line staff visited almost all villages in Armenia, especially remote villages, to ensure public awareness of the Social Security Cards in rural communities.

A Government Decree dated June 25, 2004 envisaged extending the use of Social Security Cards to payment of taxes, payment of customs duties, issuing of various licenses, banking, and other state operations. Informing the public of this extended use of the Social Security Card is an essential part of the public education campaign. An initial mass media campaign on the application of the Social Security Card used radio PSAs, TV talk shows, and interviews with MLSI staff to increase public interest and gain public support, ASTP's approach was to help the MLSI organize at least 10 one-day seminars for approximately 200 NGO representatives, 4 one-day seminars for approximately 100 employers, and 6 one-day seminars for 120 mass media representatives. Mass media, brochures, leaflets, and posters were used to inform the public throughout this quarter of 2004. Roundtables and seminars with special interest groups who informed their member audiences about the card were used extensively.

Several religious groups opposed the Social Security Cards. ASTP assisted MLSI to counter opposition with "good news" stories, giving a high media profile to the Prime Minister and other government Ministers when receiving their cards. The favorable statement of the Armenian Apostolic Church towards SSCs followed by the application and receipt of their SSCs by His Excellency the Catholicos and the officials of the Church governing body, at the end of June 2004 helped assuage opposition. With the assistance of ASTP, two videos were prepared on SSCs for local TV channels in September 2004. The videos covered the SSC system and the approach of the Armenian Apostolic church to the issue, and included a report on the receipt of SSC by the Catholicos. The videos were regularly screened by local TV channels.

Because of the unforeseen costs associated with the redesign of the SSC program to respond to opposition concerns, USAID provided ASTP with supplementary funding between October 1, 2004 and February 2005. This complemented the ASTP work that PADCO was already performing. The supplementary program covered technical assistance in public education regarding the need to apply for a card, assistance in ensuring

protection of data in line with International Data Security Standards and assistance to the Ministry of Labor and Social Issues and its Nork Center

Because of the January 1st 2005 deadline requiring the use of the cards, public education about the Social Security Card was expanded in late 2004. This increased activity included:

- ASTP organized increased coverage of Social Security issues on all TV channels.
- 100,000 redesigned brochures were printed and distributed throughout the country.
- ASTP designed a poster titled "How You Will Use Your Social Security Card" and distributed 50,000 copies nationwide.
- ASTP supported MLSI in organizing 3 roundtables in December 2004 with NGO representatives, private employers and the heads of the Armenian mass media on "How the Social Security Card Will Be Used". In December a special seminar for journalists accredited to the Ministry of Labor and Social Issues was organized on the SSC.
- ASTP and MLSI created a "Mobile Public Education Unit" to inform the public especially those living in towns and villages outside of Marz Centers. The Mobile Public Education Unit completed 24 visits to towns and villages in rural areas.
- A 2 day seminar was organized in December at the request of the Union of Armenian businessmen and entrepreneurs. Seventy representatives of 50 of Armenia's largest companies attended.
- The www.astp.am website disseminated information on the Social Security Card registering 1,312 hits in December 2004 alone.

## 2.8. RESULTS OF THE SSC SYSTEM

The implementation of the SSC system is already saving the GOA more than $2 million annually. Article 5 of the Law of the Republic of Armenia "On Social Security Cards" outlines one of the primary purposes of the card, stating that "The Social Security Cards system is created for the purposes of identification of a citizen during the process of personal data processing in the information systems, regulation and improvement of the information exchange processes between different information systems and ensuring the protection of confidentiality of personal data of a citizen". The SSC will help to identify fAlmost 2.5 million persons now hold a Social Security Card, and it is estimated that 99% of people holding an SSC are in receipt of salaries, pensions, Poverty Family Benefits, other benefits and/or are paying taxes and social contributions. The Social Security Card database is being data matched with other databases. Results to date of this data matching exercise are[8]:

1. Pension Database. Matching between the SSC and the pension databases helped MLSI discover that the data matched in only 355.000 (65.7%) out of 540.000 pension cases. Thirty-five thousand pensions 35.000 (6%) were still unmatched. With the assistance of ASTP, MLSI scheduled visits to the homes of these 35,000 pensioners to determine if they exist, are alive and still entitled to a pension. Annual savings: $500,000.

**Presidential Support**

At press conference on February 26, 2005, the President of Armenia stated: "No effective social security system is possible in Armenia without Social Security Cards. The Social Security Card concept is not our invention. It is generally accepted in the world and is especially effective in countries with high levels of social security. This system is aimed at protecting the rights and freedom of Armenian citizens".

2. Disability Database. Initial data matching with the SSC database and the Disability database indicated that 492,000 of 508,003 disabled persons had a Social Security Card. Twenty thousand (20.000) of those in the database are referred to as "depositor pensioners" – pensioner who allow their pensions to accumulate for 3-4 months before collecting. MLSI checked 15.000 disabled persons (5000 from Yerevan and 10.000 from Marzes) and results indicated savings from depositor pensioners. Annual Savings: $350,000.

3. Poverty Family Benefit Database. Initial data matching between SSC and PFB databases showed that 300,000 out of 448,021 households in the database did not match. Further data checking eliminated 17,000 and verification of the validity of the remaining 23,487 was checked. Annual Savings: $600,000.

[8] Savings are estimates until MLSI reports to the GOA in late 2005 and figures are released. Estimates are based on discussions with MLSI specialists.

4. Unemployment Database. A similar data matching exercise was undertaken with the unemployment database where 100,000 out of 170,000 cases matched initially. Of those not matching, 65, 000 were found to be in order by September, 2005 and the remaining 5,000 are still being checked. Estimated Annual savings: $350,000.

ASTP supported MLSI and Nork through support for Monitoring visits to the regions. During these visits mismatched cases are checked locally to identify if there is a data entry error, error in processing or if in fact, these are fraudulent claims.

## 2.9. SUSTAINABILITY

As intended by USAID in its ASTP program design, all aspects of the Social Security Card system will continue after the end of the project. By conducting all activities in collaboration with counterparts, their capacity not only to administer the system but to respond to changes in design and use in the future have been assured. On July 29-31, 2005, ASTP in collaboration with the Ministry of Labor and Social Issues and the "NORK" Information Analytical Centre organized a two-day seminar on the future uses of the Social Security Card. This was a working meeting with participants from the State Tax Administration, State Customs Committee, Ministry of Justice, State Cadastre Committee, Central Bank, Employment Services and the State Social Insurance Fund. The purpose of the seminar was to discuss the future use of the Social Security Card in the area of taxation, property registration and property tax, customs and import and export areas and the banking system. Government officials and agencies are able to fully administer the program.

# ASTP FINAL REPORT: 3. PENSION REFORM

## 3.1. OVERVIEW

Pension reform was a major priority for ASTP. In 2000, pensions provided low monthly benefits of less than US$10 to most pensioners forcing many to rely on Poverty Family Benefits to support a meager living. Administrative systems within the State Social Insurance Fund (SSIF) had not kept pace with computerization with outdated lists of contributors and pensioners full of errors. There was no capacity within the GOA to make the financial forecasts necessary to determine affordable changes in the pension system to ensure a sustainable and more equitable design. ASTP's support to the GOA for pension reform emphasized four elements:

- Creating the legislative foundation for a new pension system embodying three pillars;
- Creating the IT infrastructure to support more efficient, effective and equitable administrative system for the collection of social insurance contributions and the distribution of pension benefits.
- Strengthening the administrative infrastructure to support the management of social insurance systems – including training staff, reforming administrative procedures, and other measures.
- Creating actuarial capacity within the GOA (Section 6 of this Report).

*SYSTEM DESIGN*

In 2000, Armenia had enacted several normative acts establishing Armenia's commitment to creating a three pillar old age pension system: 1) a PAYG mandatory system providing old age pensions on the solidarity principle; 2) a mandatory accumulation system; and 3) a voluntary system based on contributions to non-state pension funds.[9] ASTP focused its support of pension reform in four areas:

- Drafting laws to enact the principles adopted in the reform embodied in Government Decree #734;
- Drafting laws and regulations necessary to create Non-State Pension Funds;
- Building the IT infrastructure to support the administration of the new system of pension insurance;
- Strengthening the administrative capacity of the State Social Insurance Fund.

## 3.3. CREATING THE LEGAL FRAMEWORK

ASTP's first priority was the design and enactment of the legal framework for future pension reform. This involved drafting two major laws:

### *3.3.1. Law on State Pensions*

The law "On State Pensions" was signed by the President in 2002 making important changes:

- Establishing the principles for each Pillar within the three pillar system;
- Raising the pension age in stages from 55 for women to 63 and for men from 60 to 63 by 2011;
- Revising the system of accrual and calculation of pension benefits;
- Reducing the numbers of categories of employees entitled to early retirement pensions.

### *3.3.2. Law to Create Non-State Pension Funds.*

ASTP helped MLSI to develop a draft law to create non-state pensions which is likely to be revived within the framework of the new pension strategy.

- A working group, set up by the President and comprised of representatives of the main actors in the pension field, MLSI, SSIF, Ministry of Finance and Economy and the Central Bank reported on pension reform strategy in March 2005 in "*Conceptual Approach to Pension Reform in Armenia,*" which was adopted by the GOA on April 28th 2005. This simple concept paper maps out the direction Armenia should take towards creating the third pension system including a program for pension reform activity for 2005-2007.

[9] In December 1999, the Government of Armenia adopted Decree #734 "On Confirming the Principles of the Strategy for Pension Security in the Republic of Armenia."

- MLSI with Ministry of Economy and Finance, Securities Commission, Central Bank and the SSIF, will develop a new pension strategy by September 2005. This proposal for a new strategy will include a description of the technical issues involved and the estimated cost of the new system.
- In September and October 2005, at the request of both MLSI and the Central Bank, Mitchell Wiener, ASTP's actuarial consultant, analyzed the pension system in Armenia and presented options for pension reform in Armenia. In two reports ASTP Report 122 and Report 123, he presented his actuarial analysis of the current pension system in Armenia, his actuarial projections for the sustainability of this solidarity system, and four options for reform.

#### *3.3.3. Other Normative Acts*

The ASTP legal team provided recommendations on the content of a government decree covering the implementation of the personified reporting system. Decree 1143 was passed by the National Assembly and signed by the President on September 20th 2003. ASTP supported the SSIF in piloting and later implementing in some areas, a personified reporting system which ensures that employers report on each employee's wages and social insurance contributions.

On July 13th 2005, the President of Armenia signed a Decree on Personification after extensive negotiation, discussion and debate between MLSI and SSIF. This decree anticipates countrywide implementation of PARNAS, the personified reporting system, on October 1st 2005 (later delayed to November 15th 2005).

At the request of MLSI, ASTP translated all normative acts and instructions (800 pages) on which the administration of the current pensions system is based from Russian into Armenian. This guide has proven an invaluable resource for the MLSI Pension Department.

### 3.4. BUILDING THE IT INFRASTRUCTURE

Pension reform in Armenia required substantial IT developments because administration of social insurance systems requires creation of large databases to be maintained for the working life of employees and throughout their retirement. First, the creation of a system of personified reporting to create a database of all contributors to the system and maintain their work history was needed; and second, the computerization of the SSIF and the related training of personnel had to be accomplished.

#### *3.4.1. Personified Reporting*

In 2001, the ASTP began assisting the SIF and MLSI in implementing a program to personify the system by which enterprises report to the Social Insurance Fund on the wages and contributions of each employee and the systems by which the SSIF maintains these records. ASTP contracted with the Yerevan Institute for Computer Research and Development (YICRD) (also known as the Mergelyan Institute) to develop and test the software to support the personified reporting system. The name of the software is PARNAS (Personal Accounts Registration Numbering and Analysis System). In September 2005, SSIF formally accepted the PARNAS system developed over the previous four years. The PARNAS system provides an automated tool for employers to report employee contributions to the State pension fund at the individual or "personified" level. The Social Security Card number is the main identifier for individual employees entered in the PARNAS system. Previously, employers aggregated individual pension contributions for all employees, making it impossible to report contributions by individuals to the pension fund. ASTP provided technical assistance in implementing the personified reporting system, first piloting the system in two Districts of Yerevan and implementing the system fully in Yerevan from June 9, 2004.

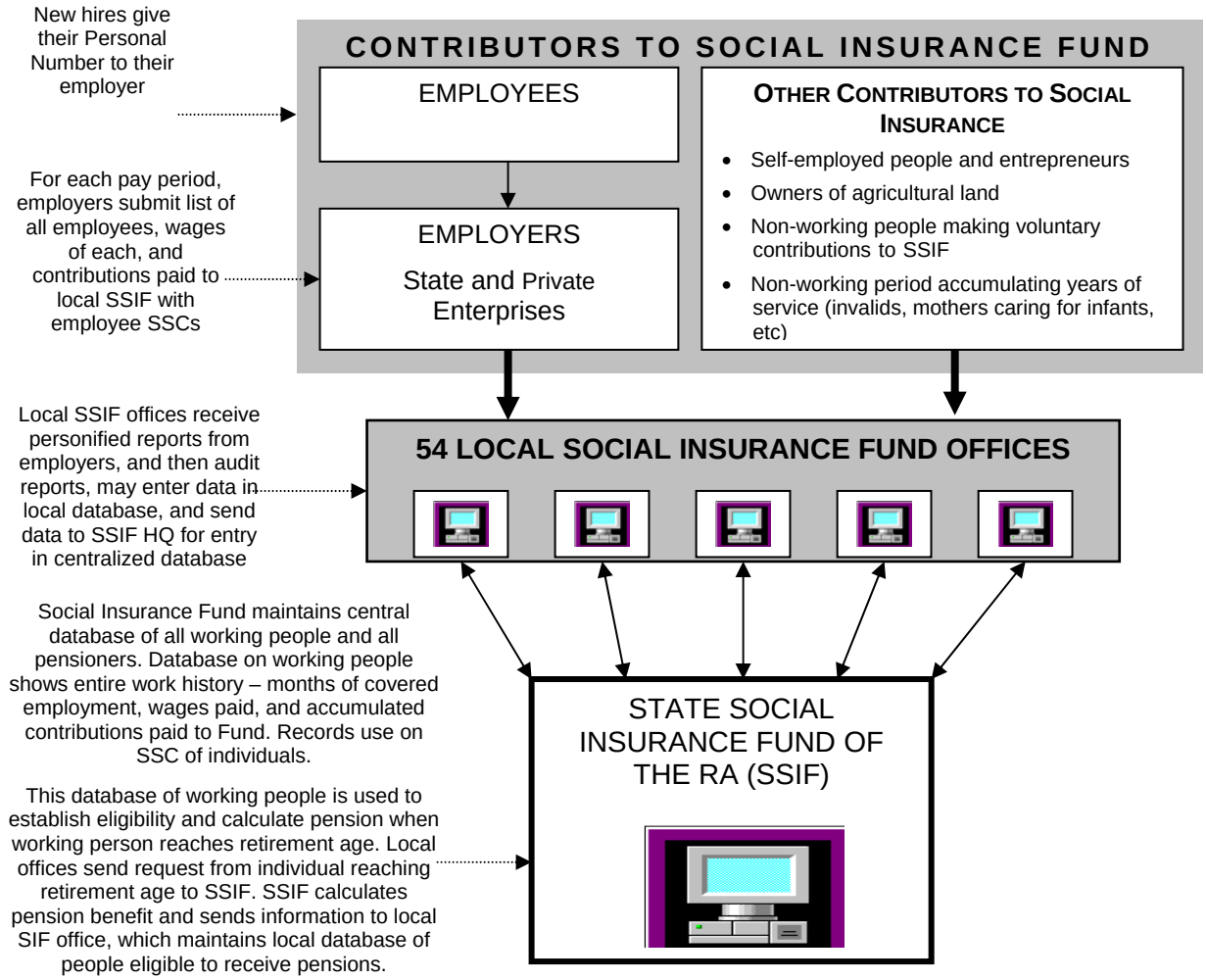
Personified record-keeping covered more than half of all employees in Armenia by September, 2005. **Almost 11,500 employers and self employed businesspersons and over 221,000 employees were included in the personified reporting system by the third quarter of 2005**. The President of Armenia signed Government Decree N 938 (Decree of May 12, 2005) on July 12, 2005, which implements the personified reporting system countrywide from October 1st 2005. Implementation is now delayed to November 15th but SSIF has purchased 45 computers to support the nationwide rollout.

The personified database records each person's work history, including months worked and other service credits, wages earned, and contributions paid to the Social Insurance Fund with regular updates (see Figure 2.1 below).

Personification of pension reporting and records is bringing widespread benefits to enterprises, to employees, and to the government:

- SSIF gains fully computerized records as the basis for calculating pensions at retirement and for ensuring that pension benefits are more closely linked to work history and wages than they are today.
- Efficiency of the administration of state pension benefits improves through accurate and up-to-date information on what contributions have been paid.
- Stricter control over both internal and external fraud and elimination of the duplication of claims and payments increases transparency and reduces fraud;
- SSIF can better enforce compliance in payments of contributions, and citizens are encouraged to work in the formal economy because they will no longer be able to accumulate service credits unless they are also being paid by the enterprise holding their workbooks;
- Paperwork and administrative costs of reporting and transferring payments to the pension system are simplified, especially through electronic reporting;
- Customer service improves through a simpler process of certification of eligibility for pensions and easier applications procedures for pensions.

*Figure 2.1: Overview of Personified Reporting System*




### *3.4.2. Strengthening IT Capacity in the State Social Insurance Fund and in SIF Regional Offices*

To implement the personified reporting system, the capacity of the SSIF staff to use computers and the level of computerization of the SSIF and its 54 local offices had to be increased. ASTP, and its subcontractor, YICRD, installed over 80 computers, 25 servers, 50 printers, 50 UPSs and 8 high speed scanners at SSIF Headquarters and the 10 District Offices in Yerevan. PADCO and YICRD also provided the supplies and technical assistance to install Local Area Networks (LAN) in all the locations to support the PARNAS system. The total value of the technical equipment support to SSIF under ASTP is approximately $300,000.

### *3.4.3. PARNAS Use in SSIF headquarters.*

As indicated above, the PARNAS system is fully operational at the SSIF headquarters. The technical support provided by PADCO and its subcontractor YICRD, enabled SSIF to fully use the PARNAS system including its added functions for statistical analysis, forecasting and monitoring. PARNAS was pilot tested in the 10 SIF offices in Yerevan, which account for about 50% of all contributors and covered employees in Armenia. Since the 10 district offices are connected electronically, information flow has increased, improving customer service to the public and reducing the time needed for submission of employer reports (see Table 2.1 below).

*Table 2.1: Use and Coverage of PARNAS System in the Pilot Yerevan Offices*

| Local Offices in Yerevan | Number of Employers | Number of sole Self employed | Number of employees |
|---|---|---|---|
| Arabkir | 1,716 | 224 | 27,077 |
| Davidashen | 221 | 3 | 3,395 |
| Kanaker-Zeytun | 529 | 116 | 11,986 |
| Erebuni | 1,178 | 375 | 21,245 |
| Xorhrdayin | 735 | 121 | 13,483 |
| Kentron-1 | 1952 | 150 | 56,981 |
| Kentron-2 | 1004 | 113 | 32,455 |
| Mashtots | 597 | 221 | 12,830 |
| Shahumyan | 787 | 202 | 18,498 |
| Shengavit | 1,119 | 136 | 23,793 |
| **Total** | **9,838** | **1,661** | **221,743** |

#### *3.4.4. PARNAS-E Use by employers.*

Use of the electronic version of PARNAS is increasing as employers file electronic social insurance returns. Employers have realized that PARNAS-E is a valuable tool to save time and reduce errors for social insurance payments. PARNAS-E software is provided to employers free of charge while PADCO's subcontractor, YICRD, provides technical assistance and customer support on its use. With more employers adopting the PARNAS-E software, the SSIF will increase its efficiency in processing insurance payments.

By September 2005, 21,743 employers and self-employed persons in the ten districts of Yerevan were filing returns of social security contributions for employees using the personified reporting system (PARNAS) developed under ASTP. They are providing returns for 221,743 employees. This huge step towards building the foundation for a sustainable fair pension system is built on new and effective record keeping. The next major step is countrywide implementation planned by the GOA under Government Decree N 938 (Decree of May 12, 2005).

### 3.5. STAFF TRAINING

#### 3.5.1 Computer Use Training for SSIF and SIF Local Offices

Training courses on basic computer skills in Windows applications (Windows, Microsoft Word, Excel, Access, Network, Internet, E-mail) were provided to 11 staff-members of SSIF headquarters and 30 staff-members of Vanadzor SIF local office and 8 staff-members of Masis local office within the framework of "Integrated Social Services Centers". Training on PROST (Pension Reform Options Simulation Toolkit) and SPSS skills was provided to 6 staff-members of SSIF headquarters.

#### 3.5.2 Other Skills Training for SSIF and SIF Local Offices

A wide range of training courses in actuarial subjects (mathematical statistics, macroeconomics), effective management, legislative frameworks, technical application of the Social Security Cards system as well as public relations were given to the staff of SSIF headquarters. Reception and customer service skills classes for the SSIF staff of the local offices of Vanadzor and Masis were delivered within the framework of Integrated Social Services Centers' training.

#### 4.5.3 Three Observational Study Tours

In November 2000 ASTP organized an observational tour for 12 officials from MOSS and SSIF to visit Moscow to review the Russian Federation's experience with the creation of a personified reporting system for its social insurance system.

In October 2003 ASTP organized an observational study tour for 17 officials from different state institutions, including a representative of the SSIF headquarters, to visit Ireland to review the Irish experience of

implementing the Personal Public Service numbers, equivalent to the system of Social Security Cards in Armenia.

In April-May 2004 ASTP organized an observational study tour for 6 officials from the MLSI, NORK Information Analytical Center, State Tax Service and SSIF headquarters to review the Ukrainian experience implementing the Tax Identification Numbers system, equivalent to the system of Social Security Cards in Armenia.

## 3.6. COORDINATION WITH OTHER DONORS AND LEVERAGING FUNDS

For Council of Europe, ASTP facilitated an exchange of social data project between Azerbaijan and Armenia to ensure that refugees in both countries could access their pension/benefit rights.

ASTP collaborated with MLSI in developing a draft law that would create the framework for private pension funds. IBM Consulting assisted in refining the draft law and developing the regulatory system to ensure the financial viability of private pension funds.

Because ASTP's mandate was limited to testing PARNAS, The World Bank Social Protection Administration Project (SPAP), launched on April 21st 2005, envisages the provision of assistance, mainly hardware, to MLSI and SSIF to support PARNAS. The World Bank procurement process is such that assistance is not anticipated until after March 2006. SSIF purchased, using its own funds, 45 computers in September 2005 and plan to implement PARNAS countrywide by the new start date of 15TH November 2005.

## 3.7. PUBLIC EDUCATION

Pension reform touches most Armenians, as pensioners and contributors today, and as pensioners in the future. Any changes in a familiar, if malfunctioning, system need to be carefully explained to the public.

### *3.7.1. Public Education before Passage of the Law*

The successful passage of the Law on State Pensions was accompanied by an intensive education campaign aimed at lawmakers and the public. "Approval of the Law on State Pensions is the beginning of transition to a more effective pension system and reforms" was the message on all news broadcasted throughout Armenia on June 4th, 2002 after the National Assembly passed by 96 votes for and 3 abstentions the Law on State Pensions at first reading. ASTP, in collaboration with MLSI, educated parliamentarians, providing them with information about the pension reform.

ASTP succeeded in involving National Assembly staff in review of the Law on State Pensions. Pension experts with detailed information explained the experience of foreign countries. Discussions and meetings were conducted regularly. Initial meetings with experts revealed what political groups expected to be active in draft law discussions, and as they presented their expectations and opinions, materials were drafted that focused on their issue.

### *3.7.2. Chart of Publications on the New Pension system*

| Name | Year | Quantity | Comments |
|---|---|---|---|
| The special issue of the "View on Economics" Magazine dedicated to pension reforms in Armenia | 2002 | 5000 | ASTP helped the Nork Center to prepare and print a special issue of a magazine for NGOs, decision-makers and general public. The issue included articles by policy makers and information about future developments, public opinion and professional analysis. It was distributed to parliamentarians. |
| Q&A "The Social worker advises" | 2002 | 5000 | The booklet was designed and printed for Social workers, pensioners, Poverty Family benefit receivers, unemployed people. It contained simple information about peoples' rights to pensions. Later reprinted in another edition of 6,000. |
| Collection of legal acts of Pension sphere | 2003 | 15000 | ASTP printed for two years with continued demand from Government. |
| Why we need Pension Reforms | 2003 | 8000 | The target audience included experts and pensioners to justify the need of pension reforms. |

| | | | |
|---|---|---|---|
| On Pension Age | 2003 | 8000 | The target audience was experts and pensioners to inform them of the ge and why it was changed. There was also information about international experience. |
| Q&A on Pension Reforms and pension system | 2003 | 8000 | ASTP supported MLSI to print Q&A brochure on new pension system for general public of Armenia. Our surveys showed that people have lack of information on new pension system. Questions had been formed during focus groups and surveys and a comprehensive FAQ brochure was published. |
| PE materials for PARNAS system | 2004 | 980,000 | PE materials were designed and printed for employers and employees to describe the PARNAS system, its advantages, reasons for introducing the system, and how to complete application forms. |

### *3.7.3. List of Seminars and workshops on new Pension System*

| Name | Year | Number of Participants | Comments |
|---|---|---|---|
| Workshop in Dilijan on SSCs and pension system | 2001 | 20 | ASTP described to Armenian counterparts the details of the pension reform program and SSCs. |
| Public Education training | 2001 | 13 | Representatives from MoH, MLSI, SSIF and local authorities were trained in the practical skills of public education |
| Training on "Public Relations: the Strategy of Trust" | 2002 | 15 | Training and Development Co. trained participants in necessary skills for designing and organizing PE campaigns on social issues -- including pension reform. |
| Training on Media Relations | 2002 | 15 | Representatives from MLSI, SSIF, MoH, and other counterparts were trained in media relations – including how to develop public education programs, handling press conferences and briefings, crisis management, preparing press releases, and practical guidelines on handling TV appearances. |
| Seminar on SSCs and Pension reforms for journalists | 2003 | 20 | ASTP in collaboration with MLSI organized a seminar for journalists on SSCs and pension reform presenting information press kit to the journalists. |
| Seminar for journalists on Pension reforms | 2003 | 30 | The seminar informed the media about pension reforms. |
| Seminar for journalists on Social Security Cards and use of SSCs in the pension system | 2004 | 35 | ASTP and MLSI held a 3-day seminar for journalists to inform the media about the use of SSCs and pension reforms. Participants from all major Armenian mass media, TV channels attended. ASTP distributed press kit materials outlining the key elements of SSCs |
| Roundtable on Pension Reform Options | Sept 2005 | 40 | Mitchell Wiener, ASTP consultant actuary, presented his report on pension reform in Armenia to an audience of representatives from the Office of the President, the Ministry of Finance and Economy, the Central Bank, the State Social Insurance Fund, the Securities Commission and Nork Analytical and Information Center, Ministry of Labor and Social Issues. Meeting and discussions were chaired by the First Deputy Minister of Labor and Social Issues. |

## 3.8. THE RESULTS

- Legislation establishing the framework for a three pillar system was been enacted -- raising and equalizing pension age for men and women.
- Pension arrears have been eliminated. In July 2000, more than 40% percent of pensioners were owed payments for past pensions due. By July 2002, all pension arrears had been eliminated.
- The law to create non-state private pension funds has been drafted.
- Legislation for personified supporting has been enacted.

- Pension benefits have been increased from an average of 4421 AMD ($10) in 2000 to an average of 9812 AMD ($22) in September 2005.
- Personified reporting and record keeping encompasses more than half of all employers and employees in Armenia by the end of September 2005.
- Fraud, abuse and errors have been reduced. The introduction of SSCs has allowed cuts in the number of pension beneficiaries of 50,000 (9%) – people who had been receiving pensions but who never applied for SSCs presumably because they had died, emigrated or never existed.
- Privileged pensions are being phased out for employees in certain sectors (e.g. the judiciary) making the pension system more equitable and reducing the financial burden on the SSIF.
- Pension benefits are more closely linked to the amount of social insurance contributions paid during the beneficiary's working life.
- Social pensions – paid to the elderly who had never contributed to the system -- have been transferred from the Social Insurance Fund to the State Budget. This step is in line with the recommendations of the World Bank and had been supported by the ASTP.
- Consolidation of the Tax and Social Insurance System- On January 1st, 2005 responsibility for the collection of social insurance contributions was transferred to the State Tax Administration, together with certain assets of the State Social Insurance Fund (computers, 450 staff, office equipment and vehicles). After the transfer the SSIF role was diminished. They were left with 1) responsibility for inspection of employer's social insurance contributions returns received from the State Tax Administration and 2) responsibility for taking applications for pensions, establishing eligibility and allocating pensions. Results of this consolidation are positive so far, with a substantial increase in amount of social insurance collected. In the first quarter of 2004, for example, the State Social Insurance Fund collected 9.5 billion drams. In the first quarter of 2005, the State Tax Service collected 12.9 billion drams in social insurance contributions, an increase of almost 36%. ASTP provided legal assistance and technical guidance (through subcontractor YICRD) to both MLSI and SSIF, related to the transfer of functions.

### 3.9. SUSTAINABILITY

Much remains to be done to create a pension system that meets the goals of the GOA and the needs of working and retired Armenians. While ASTP has effectively created the foundation for a new, sustainable pension system, Armenia is still constructing a sustainable path to pension reform. Many recommendations for an improved pension system are contained in ASTP Reports 121 and 123. These include:

- Further increasing pension benefits through increasing the accrual rate---the percentage of average income that employees receive when they reach pension age.
- Refining and enacting legislation for Non State Pension Funds and creating the regulatory regime necessary to ensure safe, efficient private pension funds.
- Ensuring fiscal sustainability beyond 2026.
- Improving compliance in payment of contributions. The number of contributors today is too low. According to statistics from the government of Armenia, the total number employed in the formal and informal sectors combined is about 1.1 million. There are approximately 330,000 farmers who are not required to contribute to the solidarity system. They receive a social pension from the budget. This leaves 770,000 who should be contributing to the Social Insurance Fund (SIF). However, only about 480,000 are actually contributing. About 38% of all workers are evading the responsibility to pay for Armenia's social insurance system.

The World Bank will play a major role in the further development of Armenia's pension system. As the Bank stated in a press release in April 2005, announcing a credit to support further work: "Establishment of a modern pension system administration is a key priority and it will be addressed under the third component.

Within the framework of the project the management information system (MIS) will be created, including the establishment of a data base of individual client records."[10]

The PARNAS system is now fully installed and operational in all 10 SSIF Yerevan offices. With the completion of the Yerevan implementation PADCO and its subcontractor, YICRD, prepared estimates of what is required for a complete countrywide rollout. SSIF and YIRCD continue to monitor and adjust/improve the PARNAS system to optimize its use. The number of employers and self-employed persons now using the system is meeting and exceeding expectations for Yerevan implementation.

SSIF will continue to subcontract to YICRD for ongoing technical support to the PARNAS system when ASTP ends. This function will gradually pass to the SSIF IT staff ensuring the sustainability of the PARNAS system. Due to the technical assistance in software development and implementation provided by ASTP for PARNAS, the SSIF possess the financial and technical means to maintain the PARNAS system in Yerevan.

[10] Quote from World Bank/MLSI press release dated April 21st 2005 announcing the $5.71 million Social Protection Administration Project Development Credit Agreement.

# ASTP FINAL REPORT: 4. TARGETING SOCIAL BENEFITS

## 4.1. OVERVIEW

Reducing poverty was a central goal of the Armenia Social Transition Program and the results have far exceeded the targets. In 1999, 23 percent of the population lived under extreme poverty. By 2001 this declined to 16 percent. By 2003, only 7.4% lived in extreme poverty. By 2004, extreme poverty fell further, to 7.00%.

At the same time, the number of families receiving Poverty Family Benefits (PFB -- the Armenian system of social assistance targeted at the very needy) was dramatically reduced. In 1999, before ASTP began, the caseload exceeded 217,000 families – 45 percent of all families in Armenia. By September 2005, when the project ended, only 131,000 families received benefits- 27% of all households. The reduction in caseload was achieved with no public protests or even increases in complaints. The reduced caseload allowed overall government spending to be cut while the average size of benefits was increased from 7,675 AMD/month in 2000 to 12,000 AMD/month in 2005.

Services for the needy were improved. The benchmark ASTP household survey carried out in November 2000 indicated that only 46% of the customers who visited a social service office were satisfied with their visit. Two years later, 70% of customers of Regional Social Service Agencies expressed satisfaction with the service provided

How did ASTP achieve these results?

During the first quarter of 2002, state budget fiscal constraints forced a 25% cut in spending on Poverty Family Benefits. ASTP worked with MLSI to develop the most effective way to absorb this shock. MLSI implemented one of the alternatives suggested by ASTP – focusing the PFB on households with children. Weekly meetings with the Minister, Deputy Ministers and Department Heads of MLSI proved to be an effective method in ensuring a regular exchange of information so that ASTP was aware, on a regular basis, of issues of concern to the MLSI. Having USAID's representative at each meeting ensured open and effective communication between MLSI, USAID, and ASTP and allowed for harmonizing ASTP priorities and MLSI priorities. ASTP activities were based on close collaboration with MLSI throughout all stages of drafting, revising, and promoting new normative acts to implement social sector reforms. The November, 2003 ASTP household survey found increased public support for the PFB program despite the 25% budget cuts.

ASTP helped the Ministry of Labor and Social Issues (MLSI) to train staff intensively in the provision of an improved service to the public. Better targeting achieved through ASTP assistance meant that qualified recipients got greater benefits and unqualified recipients were removed from the program. The following steps improved targeting:

1. Assisting in the transfer of the database (named PAROS) of vulnerable families in Armenia from a semi-state body to the MLSI.
2. Making major revisions in the PFB to target benefits more effectively at truly needy families: first, to those with the most children as described above, and second to provide a progressive three-tier benefit system that provided larger benefits to poorer families.
3. Tightening the administration of the PFB program – through audit visits to local Regional Social Service Center (RSSC) offices, home visits, and improvement of the PFB audit system at the Nork Center.
4. Conducting massive staff training and retraining programs – creating 12 staff manuals covering customer service, claim processing, human rights and social work, social legislation and office administration
5. Educating the public that targeting was creating a more effective and efficient system of social assistance through nationwide distribution of posters and leaflets explaining how to apply for benefits and eligibility rules.
6. Improving pensions so that fewer pensioners were eligible for PFB (discussed in Section 2 of this report).

## 4.2. SYSTEM DESIGN

ASTP worked closely with MLSI on improving the efficiency and effectiveness of the PFB system. Support was provided through a number of channels including: training of staff; legal advice on the social assistance laws, actuarial analysis of the PFB database, and audit visits to local offices. The audit visits have been particularly successful in identifying training needs, identifying common errors and mistakes in data entry and in ensuring that local office Directors and Administrators pay more attention to managing their offices efficiently. Improvements in office management resulted in improved targeting of assistance and smoother benefit distribution.

## 4.3. CREATING THE LEGAL FRAMEWORK

ASTP has provided continuous assistance to MLSI in strengthening and restructuring the legal framework for the social protection system in Armenia, to unify and integrate a series of independent decrees. Until passage of the new law, the legal framework is based solely on government decrees, Prime Ministerial decrees and MLSI decrees which ASTP would help modify in response to budgetary and other issues. In early 2003 MLSI requested technical assistance from ASTP in the preparation of a solid legal framework for social protection. On October 21-23, 2004, PADCO organized a Round Table on two Draft Laws on Social Assistance and State Benefits in Tzakhadzor. Participants included representatives of the President's Office, the National Assembly and the Ministries of Finance and Economy, Justice, Science and Education, Health and Labor and Social Issues. NGO representatives from Mission Armenia, NGOC and others attended. Deputy Minister of Labor and Social Issues, Ara Petrosyan, launched the three days of public discussion and spoke of the need for clear comprehensive legislation in the social sector which would improve citizen's access to their social rights. He thanked USAID and PADCO for the assistance given to MLSI over the last four years and commented that such round tables/discussions on draft laws have become a very productive tradition due to their assistance. The two laws benefited from further discussions, supported by ASTP, with NGO representatives in Yerevan and Lori Marz in early 2005 and the laws were placed before the National Assembly in Spring of 2005. The laws passed their third reading in September 2005 and await the signatures of the President of Armenia.

## 4.4. BUILDING THE IT SYSTEMS

When the ASTP started in 2000, few local offices had computers and the database of the Poverty Family Benefit system was held by an outside agency. With ASTP assistance and in collaboration with the World Bank, the Ministry created a well-equipped computer center, Nork Information and Analytic Center, where the main databases on social assistance, disability, Social Security Cards, residential homes for the elderly and orphans and unemployment are now held. These databases are updated by delivery of diskettes from local offices. Computerization of offices was accompanied by intensive countrywide training. ASTP installed over 300 computers and 35 file servers countrywide. Additionally, ASTP sourced 300 used computers donated by a UK NGO which served to underpin the reforms. In total 541 computers and associated equipment were provided by USAID in local social services offices and HQ Departments.

### *4.4.1. Transferring the Poverty Family Benefits Caseload to the Nork Information and Analytic Center*

Andranyk Satriyakan, Director of the Nork Center signs archive records received from Khachik Sharoyan, head of YICRDs PAROS database team. Armen Sahakyan, from the Ministry of Labor and Social Issues looks on

On December 25th, 2001, the Ministry of Labor and Social Issues and the Nork Center formally accepted operational control of the Poverty Family Benefits database (referred to as PAROS). The PAROS software and data archives had been developed and administered by the Yerevan Institute for Computer Research and Development (YIRCD). Since its introduction in January 1999, the Poverty Family Benefits Program (PFB) program had been managed by YICRD because the Ministry of Labor and Social Issues lacked the computer resources capable of the task. The PAROS database was originally used only as the basis for distributing humanitarian aid. In 1999, with the support of the World Bank, the database was used as the basis for creating a targeted welfare system known as the Poverty Family Benefits Program. To ensure that there would be no interruption in the distribution of welfare payments, mirror databases were created in YICRD and Nork, allowing specialists from both entities to work together. YICRD maintained responsibility for the regular updates of the PAROS database – which includes entering births deaths and marriages, and comparing welfare families with databases of monthly telephone payments and electricity billing to verify that the families are needy enough to qualify for benefits.

ASTP supported the transfer by providing both YICRD and Nork each with nine computers and related equipment and financing the development of updated software and detailed “how-to” manuals for the new users. Standardized procedures for software and database transfers had to be developed by ASTP legal advisors. The carefully-structured transfer took 12 months to complete – including two months for preparing the documentation of the archives of nearly 700,000 families that have registered at one time or another for humanitarian assistance or welfare.

As part of the system transfer, ASTP also supported the testing of email links with the 55 local Regional Social Services Centers through which the PFB is administered. Testing of this email system proved that it is possible for local offices to send and receive from the Government updated caseload data. Poor communication links countrywide make it unfeasible to go beyond the testing stage to countrywide implementation. Under a WB credit awarded in 2005 Nork is now charged with the task of further development of countrywide links to local offices.

### *4.4.2. Designing and Implementing a “Complaints Database” for MLSI*

To improve administrative efficiency at MLSI, ASTP supported the development of a complaints database – which maintains a record of all complaints from the public concerning the administration of social assistance and social insurance programs. The Complaints Assessment, Tracking, Evaluation and Reporting System (CATERS) is designed to manage complaints and inquiries received from the public, as well as to allow the MLSI to better manage its document flow -- organizing documents received from all sources both inside and outside the Ministry.

In November 2003, ASTP started working with the MLSI Secretariat to develop functional requirements for CATERS. MLSI’s Secretariat functions as a communications bridge between the Ministry, private citizens, state organizations and non-governmental organizations, as well as between departments inside the Ministry. As the MLSI did not have funds to proceed further with the development of the CATERS system, ASTP advised them to seek donor funding to develop the desired software. On behalf of MLSI, ASTP approached DFID’s “Modernization of the Civil Service” project to interest them in funding development. The DFID program engaged a local firm of software developers in early 2005 and the system developed is now at the test stage.

## 4.5. STAFF TRAINING

In the years prior to the beginning of the ASTP program, the Ministry of Labor and Social Issues had been unable to provide training programs for its staff – either for Ministry staff or for the staff of the 55 regional social service centers through which the Poverty Family Benefits program was administered. ASTP, in collaboration with MLSI quickly developed a comprehensive training program for the 800 managers and staff of the RSSCs. There was no comprehensive set of manuals to guide staff in their work, and there were no information leaflets, brochures or posters for customers of these offices. Lengthy queues were commonplace as were incidences of serious conflict situations between staff and customers, and there were many critical articles in the media on the poor service at offices. In close collaboration with MLSI, ASTP developed a comprehensive countrywide public education program.

The issue of a reduced Poverty Family Benefit budget for 2002 was a matter for much discussion at the workshop.

**Management Training**. In 2000, ASTP designed and delivered two weeks of training for Directors and Administrators of PFB. To signify the importance of training MLSI established the position of Head of Training within the Ministry. In November 2002 ASTP organized a comprehensive eight-day management-training course for all Heads of Departments at MLSI. The training program was designed to provide MLSI management with basic management skills and included such topics as practical and strategic-management, project management, team-building and staff motivation.

In December 2001, the ASTP assisted the Ministry of Labor and Social Issues in organizing a workshop with the Heads of Social Assistance of all the Marzes of Armenia responsible for administering the 55 Regional Social Service Centers which process the Poverty Family Benefit program and Lump Sum Assistance. The workshop reviewed 2001 and planned for 2002.

ASTP organized a similar workshop, in Yerevan, in January 2002 for all Directors of the 55 Regional Social Service Agencies (RSSAs) in Armenia. The objective was to obtain recommendations on how to make poverty alleviation programs work more effectively and how to deal with the 25% budget cut for social assistance.

In March 2001 a manual was published containing all laws, decrees and government orders currently in force affecting the health and social sector in Armenia. Fifteen hundred (1500) copies of this were distributed to the staff and also to the media, NGOs and educational institutions. This manual was republished in 2004. A selected staff member from each SSC underwent a two-week “Train the Trainer” training program learning the skills and techniques necessary to train others in their offices using a “Customer Service” training manual developed by ASTP.

**Social Work Skills Training Course**. Over 700 social sector staff and NGO representatives were trained throughout Armenia in 2003 over a period of 11 months. Each participant received 4 weeks training. The “Social Work Skills” training course was funded by USAID and organized by the Academy for Educational Development (AED). PADCO and Yerevan State University collaborated with AED and the Ministry in the design of the training program, the training manuals and in monitoring the training. The staff trained included workers from social services offices, staff of Social Assistance Departments of all Marzpetarans in Armenia and NGO representatives.

**Legal Drafting Seminars**. In March 2003, ASTP’s legal expert conducted intensive legal training seminars for 20 Heads of Departments at MLSI. The sessions covered the civil code, non-state pensions and how legal acts are formulated.

**Home Visit Training**. ASTP produced a 20-minute training video on “Best Practice in Home Visits” at minimum cost using a local TV company and actual MLSI staff as the actors. A “Manual for Home Visits” was also developed with ASTP assistance. Together these were used to train RSSC staff in a more effective approach to home visiting of PFB recipients. This improved services and eliminated fraud and errors.

**Caseload Auditing and Management**. ASTP helped improve the allocation and targeting of social assistance through training of staff, strengthening systems of auditing and monitoring and support to the MLSI. ASTP and MLSI instituted an aggressive program of unannounced office visits and home visits to reinforce the importance of customer service and proper screening of applicants. The results were almost immediate. While the campaign was still under way, fewer members of the public reported having to pay for application forms or for copies of documents. ASTP's six monthly survey reported the following:

| | May 2001 | Nov 2001 |
|---|---|---|
| Required to pay for application forms | 44% | 32% |
| Required to pay for photocopying of documents | 76% | 47% |

## 4.6. COORDINATION WITH OTHER DONORS AND LEVERAGING FUNDS

The intensive effort to improve the targeting of the PFB program and strengthen the MLSI's administrative and policymaking capacity benefited greatly from collaboration with many other donors and programs. These joint efforts included:

- ASTP and the World Bank jointly equipped the Nork Information and Analytic Center that administers the Poverty Family Benefits Program and the Social Security Card system on behalf of the Government of Armenia. The World Bank provided technical support for improving the targeting of Poverty Family Benefits.
- ASTP negotiated with UNDP for the supply of a high capacity server for the Nork Information and Analytic Center in early 2005 to underpin the safety and security of the Social Security Card database.
- In 2005, UNDP provided $20,000 to MLSI to create a homeless shelter underpinning ASTP's work on the new Social Assistance Law which made provision for shelter for homeless people a MLSI responsibility
- ASTP translated and helped distribute 2000 copies of a Council of Europe report "Access to Social Rights" which is a tool to increase the efficiency and effectiveness of MLSI.
- ASTP managed a grant fund of $20,000 on behalf of the Council of Europe to improve access to social services for vulnerable people in Lori Marz.
- The EU Food Security Program funds approximately one month of Poverty Family Benefit by a transfer to the state budget each year. ASTP collaborated with EUFSP in setting conditionality for this transfer.
- The EU TEMPUS Program funded a distance learning social work training program in collaboration with YSU. ASTP worked with YSU in developing training programs for MLSI workers in the social sector and with EU TEMPUS to ensure that the distance learning social work training programs were suited to the social sector. EU TEMPUS funded a study visit for the Minister of MLSI and an ASTP representative to the Irish Ministry of Labor and Social Issues. A Social Work Distance Learning Program was set up in the ISSC in Vanadzor and a number of local office staff are undergoing the course.
- DFID supported the Ministry of Labor and Social Issues in designing a mid-term expenditure forecasting system for the MLSI budget and is also supporting a policy analysis training program for MLSI senior staff. ASTP collaborated with DFID in providing data and in designing policy case studies as well as on a DFID project to modernize the Armenian Civil Service focusing on MLSI, MOH and Ministry of Culture.
- ASTP collaborated with AED on developing and delivering a Social Work Training program – April 2003- December 2003.
- ASTP and the USAID Legislative Strengthening Program collaborated in several training programs for members of Parliament on social and health issues

## 4.7. PUBLIC EDUCATION

Making fundamental changes in the system of social assistance requires intensive public education to avoid generating public criticism. ASTP focused on not only to developing public education materials with MLSI

but on ensuring that the Ministry developed the capacity to design and carry out its own public education campaigns. It is a tribute to these collaborative efforts that the reforms in the system – including cutting the PFB caseload dramatically – met no public resistance. In fact, the public's approval rating of social services increased.

Brochures, leaflets and posters on the rules of eligibility for PFB were designed, printed and distributed to all offices. TV programs, newspaper articles and radio programs were used to inform the public about their rights to social benefits. In May 2001, the household survey showed that the training and public education programs were taking effect with a 15% rise in satisfaction of users and a 34% rise in the number of users who responded that they considered that the rules had been explained clearly to them. ASTP engaged Armenian training providers such as Prosme and the NGO-Union of Armenian Government Employees to provide public education training for MLSI staff.

A customer with failing sight being assisted in completing a PFB application

To encourage all families to re-register for PFB during the months of January, February and March 2004, the ASTP communications team, with MLSI's Social Assistance Department, informed citizens of the need to register through a media campaign. Posters were produced covering PFB entitlements. Reprints of a series of leaflets provided information explaining the rights of various groups in the community and how individuals can exercise their social rights. This process was repeated in 2005.

The brochures were distributed to remote villages in Lori Marz.

ASTP assisted MLSI in printing Poverty Family Benefit Posters for display countrywide in public areas (including social service centers, post offices, and mayor's offices) informing people of their rights and entitlements. In addition, ASTP assisted in the printing and dissemination of 100,000 copies of a leaflet describing the Poverty Family Benefit system and the eligibility requirements.

ASTP supported the MLSI in using local newspapers to reach a wider public with information and on two consecutive weeks the brochures were reproduced by the newspaper in full. The newspaper also published interviews with social sector employees and NGOs in the main part of the paper. The Lori Marz newspaper is the major local newspaper in Lori Marz. Both editions sold out in full and newspaper suppliers, citizens and organizations were calling to the newspaper office for more copies. The newspaper inserts can also be used as a poster and many organizations have posted this in a prominent place in their offices.

Gagik has been out of work for five years and needs the Poverty Family Benefit for his family.

Feedback from community leaders and NGOs indicated that the publication in the newspaper of information on NGOs working in the locality was very useful for the vulnerable sector of the population, disabled, elderly and those in poverty. It has also helped social sector workers in their efforts to expand social services. "I consider that the Armenia Social Transition Program has been a major factor in shaping Government and NGO partnership and providing an enabling framework to help this activity, " said Tigran Papanyan, Head of Lori Marz Social Assistance Department. " The publication of the Poverty Family Benefit brochure at this time is also very opportune" he added, "as poor families are obliged to re-register in and they now have clear information on how to register and the eligibility conditions".

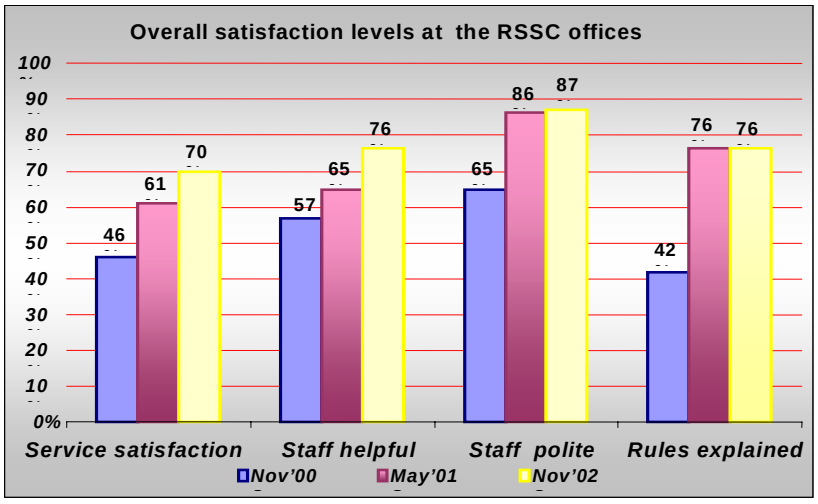
On August 2, 2004, the Ministry of Labor and Social Issues unveiled their improved customer reception plans at the ministry offices. In order to improve access for the public and to provide an improved customer service ASTP provided clear signposting at the ministry HQ at Government Building Number 3. A large notice board was installed in the lobby area which guides customers to the correct department and room number where their queries can be answered. Easily-read signs were erected outside each room of the ministry with the room number and a notice giving the function of that particular room and the Department name. The Minister and the ministry staff expressed surprise at the swift positive reaction of the public.

The table below summarizes public education materials prepared, printed, and distributed with ASTP support.

| Title of Publication | Year | Target Audience | # of Copies | Type |
|---|---|---|---|---|
| Collection of legal acts of Social sphere | 2001 | Social workers, NGOs, experts | 1500 | Book |
| Poverty Family benefits | 2001 | PFB recipients | 500 | Poster |
| Poverty Family Benefits /eligibility changes/ | 2002 | PFB recipients | 150,000 | Leaflet |
| Q&A on the rights of the disabled | 2002 | Disabled, Social workers | 5000 | Brochure |
| Q&A "The Social worker advises" | 2002 | Social workers, pensioners, PFB recipients, unemployed people | 5000 | Booklet |
| Human Rights and Social Work | 2002 | NGOs, Civil servants, Social workers | 1000 | Book |
| Manual for Social Workers | 2002 | Social workers | 1000 | Book |
| "Access to social rights in Europe" Council of Europe report | 2003 | Experts, NGOs, general public | 2000 | Book |
| Poverty Family Benefits | 2002 | PFB recipients | 500 | Poster |
| Poverty Family Benefits -- Eligibility Changes | 2003 | PFB recipients | 100,000 | Leaflet |
| New system of Poverty Family Benefits | 2004 | PFB recipients, Social Workers, General Public | 150,000 | Brief let |
| New system of Poverty Family Benefits | 2004 | PFB recipients, Social Workers, General Public | 1000 | Poster |
| Reprinting of the brochures Q&A on the rights of disabled and Q&A "The Social worker advises" | 2004 | Social Workers, people with disabilities, pensioners, PFB recipients, unemployed | 6,000 + 6,000 | Brochures |
| The New system of Poverty Family Benefits | 2005 | PFB recipients, Social Workers, General Public | 150,000 | Leaflet |
| The New system of Poverty Family Benefits | 2005 | PFB recipients, Social Workers, General Public | 1,000 | Poster |

| Title of Publication | Year | Target Audience | # of Copies | Type |
|---|---|---|---|---|
| Manual for Social Workers dealing with children with disabilities, their parents and elderly | 2005 | Social Workers, Experts | 5,000 | Book |
| Training Manual for Poverty Family Benefit | 2005 | Social Workers, NGOs | 1000 | Book |

**Presidential Recognition of PFB success**. The Government of Armenia adopted a decree signed by the President on March 24th 2002 commending the Minister, Deputy Minister and the Head of Social Assistance for the efficient, effective and targeted allocation of PFB. The Minister, Razmik Martirosyan, thanked ASTP for the substantial contribution to this success.




**Public Approval of Social Services has Increased**. Visits to the RSSAs have increased and in fact there has been an increase in the overall satisfaction of services rendered at these offices – more reporting that staff were polite, information was readily available and other qualitative indicators (see Figure 2). The proportion of households aware of the complaints and appeals process increased from 45 percent in May 2001 to 71 percent in November 2002. The proportion of households who felt that waiting times at RSSAs were too long declined by 19%. A large proportion - 89% of the households who knew about PFB program and 93% of households who are receiving benefits- felt that the PFB system is important. There has been a comparable improvement in the perceptions of the quality of services in local pension offices.

## 4.8. THE RESULTS

**Poverty Has Been Reduced**. The results of improved targeting, training, public education, and other measures have proved striking. Severe poverty has been sharply reduced and the percentage of Armenians living below the poverty line has also declined (see Table below). At the same time, the PFB caseload has been reduced.

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|---|---|---|---|---|---|---|
| Percentage of population living in "Severe Poverty" | 22.91 | 16 | 13.1 | 7.4 | 7.2 | N/A |
| Percentage of population living below the poverty line | 55.05 | 50.9 | 49.7 | 42.9 | 39 | N/A |
| Number of PFB beneficiary households | 187357 | 171924 | 147193 | 139706 | 134436 | 131000 |
| Average size of benefit (Armenian drams) | 7675 | 7215 | 6295 | 7200 | 8900 | 12000 |
| Number of lump sum assistance recipients | 13955 | 17215 | 21255 | 25617 | 31675 | N/A |
| Average size of lump sum assistance (drams) | 3000 | 3000 | 4000 | 4000 | 4500 | 6000 |

The success of the ASTP emphasis on improving the capacity of MLSI to improve PFB policy and administration is evident from the following:

- Better targeting has resulted in an increase in the individual amounts of PFB paid to eligible individuals
- The Armenia Household Income and Expenditure Survey indicates a reduction in the percentage of Armenian households in the extremely poor category from 23% in 1999 to 16% in 2001 and the

figure for 2002 is likely to be in the range of 14%. As PFB is a very important source of family income this demonstrates that households in the extremely poor category number are becoming increasingly better targeted.

- ASTP surveys demonstrate a rise in public knowledge of the PFB system. The proportion of households who know the program well has gone up from 50 percent in the two surveys conducted in 2001 to 78 percent in the most recent survey. In addition, the proportion of households who had no knowledge of PFB fell from 7 percent in May 2001 to 5 percent in November 2001 and 4 percent in November 2002. Only 0.9 percent of households who needed to borrow money for basic bread and food had no knowledge of PFB. This represents a decrease from 2% in the May 2001 survey.
- The quality of service at the 55 RSSCs, key delivery points for the PFB program, improved dramatically according to the ASTP household survey. Customers indicate increases in service satisfaction of 25 percent since 2000

## 4.9. SUSTAINABILITY

The reforms in social assistance are clearly sustainable. As the chart below illustrates, the number of families in Armenia who consider themselves poor has halved in the 5 years of ASTP, the percentage of families who apply for PFB and are successful is rising due to better targeting and education. The percentage of PFB recipients who have children has almost doubled. Better targeting of benefits has ensured that the PFB program is fiscally sustainable. The strong public awareness and public support of the program ensure that it is politically sustainable. And the strengthened administrative capacity of MLSI ensures that social assistance programs are managed efficiently and effectively. Working collaboratively with ASTP and programs sponsored by other donors has also ensured that the Ministry has the expertise to respond to new needs for social services.

| | **1999** | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** |
|---|---|---|---|---|---|---|---|
| Families who applied for PFB (as a % of total families of Armenia) | 67.70 | 52.85 | 43.99 | 38.61 | 28.37 | 26.96 | 25.42 |
| Families who actually received PFB (as a % of registered families) | 40.68 | 50.52 | 54.70 | 54.86 | 67.84 | 63.88 | 64.81 |
| Families who actually received PFB (as a % of total families in Armenia) | 27.54 | 26.70 | 24.06 | 21.18 | 19.25 | 17.22 | 16.48 |
| Families with children who actually received PFB (as % of registered families) | 36.26 | 47.19 | 54.47 | 60.75 | 63.5 | 65.56 | 69.29 |

# ASTP FINAL REPORT: 5. STRENGTHENING SOCIAL STATISTICS

## 5.1. OVERVIEW

Public policy decisions are best made when they are based on timely reliable data. Good data are especially important when major reforms in social protection and health systems are being considered. Therefore, beginning in December 2000, ASTP worked closely with the National Statistics Service (NSS) to improve the Household Incomes and Expenditures (HIES) Sample Survey. This survey involves interviews with between 300 and 400 households each month by trained interviewers to collect answers to 300 questions concerning the households' income sources and expenditure patterns. Each year the HIES collects 50 million pieces of information. HIES is the main source of information on the poverty level in Armenia and of the research on the factors that contribute to poverty.

Before ASTP, the HIES was conducted irregularly and many methodological issues in preparing the data were unresolved. Lack of IT systems meant that the annual data waited for analysis for 12 months after the completion of the survey. Data were not used by policy makers.

ASTP provided NSS with computers and provided extensive training in computer use and in statistical methodology. ASTP experts developed algorithms necessary to clean the HIE database and provided recommendations on improving the system of logical control of data. ASTP experts helped NSS staff to prepare, publish and distribute publications based on the results of the annual surveys – bringing statistics in user-friendly form to potential users in other ministries. Preparing the publications directly involved specialists from the MLSI and MOH to ensure that statistics directly entered into the policy design activities of these ministries. ASTP, with the Academy for Educational Development, supported NSS in organizing the First International Conference "Statistical Monitoring of Poverty in the Post Soviet Environment" in November, 2002.

ASTP also supported two observational tours to Kiev for specialists from NSS Information Resources and Technology Department. The first tour focused on the methodology as well as the software used in the households' living standards sample survey of Ukraine. The second tour was a working visit by ten key specialists from MLSI and NSS to meet their counterparts and share approaches to social statistics.

## 5.2. BUILDING THE LEGAL FOUNDATION

A working group of local experts from MLSI, NSS, MOH, MOFE, Trade Union and NGOs in cooperation with ASTP experts designed at new "minimum consumer basket and minimum consumer budget" for Armenia. Serious debates among the Agencies and about the use of these terms in the law led to requests for more information on international experience and assessments by international experts. The rich experience of Poland, Bulgaria, and Lithuania were presented to local authorities and experts and a more completed concept paper on composition and structure of the minimum consumer basket and minimum consumer budget was presented to GOA.

**Getting Better Numbers**

In 2003 the IMF invited NSS to become a member of the Special Data Dissemination Standard (SDDS) -- an international standard of excellence, an honor linked to some of the following successes.

The turnaround time from completing the HIES survey to publishing the annual report was reduced from 12 months to 7 months.

Strengthened collaboration between government agencies in developing the state social policy: MLSI revised the State social assistance programs according to the results received from HIE surveys, directing the assistance mostly to families with children. This approach reduced the extreme poverty by about 6%.

Improved reporting skills: ASTP supported 15 sessions of computer literacy trainings for more than 150 staff of counterparts including NSS.

## 5.3. BUILDING THE IT SYSTEMS

Timely and accurate statistics require effective IT systems. ASTP experts worked carefully with NSS staff on developing a plan for HIE survey automation and provided assistance to NSS staff to improve the documentation and instructions on operation of the HIE survey data processing software packages.

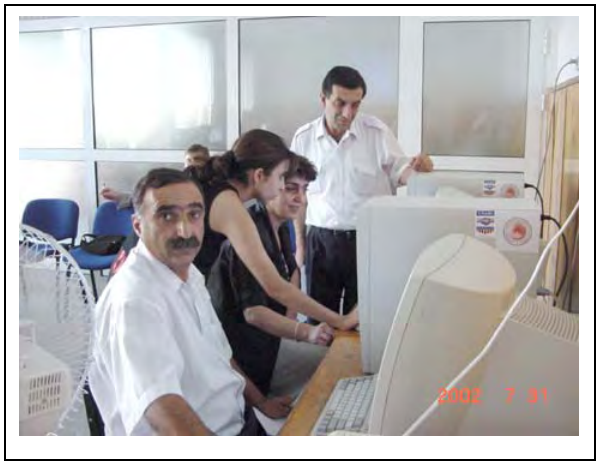
ASTP support included:

- A total of 12 computers were transferred from the ASTP to the NSS department responsible for the HIES survey.

- ASTP provided licensed copies of SPSS Data Processing Software.
- ASTP provided staff with extensive training in the use of the software – both in Moscow and in Yerevan. SPSS is now the basic software used by NSS in processing the results of the HIES and the labor survey conducted annually by NSS.

## 5.4. STAFF TRAINING

Extensive training was necessary to raise the quality of statistics and to ensure that the improved quality was sustainable. ASTP was able to provide training very effectively by the use of NSS specialists and by providing training to statistical specialists from other counterparts (MLSI and MOH, and SSIF) in the same training sessions. This had the collateral benefit of building an inter-ministerial cadre of specialists who were able to share experiences and provide each other with peer support.




### *5.4.1. Basic Computer literacy*

Staff from two NSS divisions – those involved in HIE sample survey activities- Households Sample Surveys Division and Labor and Wages Division) were trained on Windows Applications. The training lasted 8 days and, in order not to interrupt the regular work of the trainees, sessions were limited to half-days. The success of the NSS training led to other counterparts requesting similar support. ASTP arranged 15 Training sessions on Windows Applications between autumn 2001 and summer 2003 that trained 150 trained specialists from NSS, MLSI, MOH, and SIF. These trainings were conducted at the training hall of the Nork Information and Analytical Centre of MLSI furnished with computers by ASTP. Trainers from the NSS Information Technologies Department received positive feedback from trainees on the quality of trainings.

### *5.4.2. Training in Statistical Techniques*

ASTP organized training on *Introduction to SPSS and Applied Statistics* for NSS representatives in February, 2001 by the SPSS Russia in Moscow. The three-day seminar provided fundamental knowledge on applied statistics, data editing, transformation, data analysis, description of variables and their interrelationship, as well as necessary manuals, which would help all participants to use the software efficiently. Subsequently the trained staff provided training to their colleagues at the NSS.

At the request of counterparts, ASTP arranged training on SPSS Software in Yerevan. Two groups of trainees, 24 participants in total, including 4 participants from NSS RA, 8 from MLSI and the NORK Center, 5 from MOH, 4 from YSU and 1 participant from SIF underwent the training at the NORK center. Second and third training sessions were conducted in September and November 2001.

Training in statistical techniques was an important element in ensuring the improved quality of the Household Income and Expenditure Survey. ASTP experts provided training to NSS staff in a variety of areas, including:

- Design and implementation of sample surveys;
- Stages in sample surveys data processing;
- Software for data control and imputation;
- Evaluation of sample survey data quality and sample errors;
- Peculiarities of samples with a complex design.

ASTP experts developed algorithms necessary for cleaning the HIE database and provided their recommendations on improving the system of logical control of data which helps to identify and eliminate the main errors and problems in the database, as well as recommendations on their elimination or minimization in further surveys.

ASTP experts worked carefully with NSS staff on developing a plan for HIE survey automation and provided assistance to NSS staff to improve the documentation and instructions on operation of the HIE survey data processing software packages.

### *5.4.3. Training in Survey Methods*

Each spring and fall, ASTP conducted two-day training sessions for the 45 interviewers and 15 supervisors from NSS to improve the quality of the HIES sample survey and to raise the professional standards of the survey administrators. Modifications in the questionnaire and a new interviewer manual developed by ASTP formed the core training materials. In 2004, when the sample size of the survey was increased, the NSS hired additional field staff whose training was supported by ASTP.

### *5.4.4. Training in Presentation Techniques*

ASTP trained NSS staff (and MLSI staff) in three rounds of Power Point training in 2002.

### *5.4.5. International Seminars*

With support from AED and, on behalf of the National Statistics Service, an International Conference on Poverty Assessment entitled "Statistical Monitoring of Poverty in the Post-Soviet Environment" was organized by ASTP on November 19-20th, 2002. The Conference included participants from Russia, Ukraine, Georgia and Lithuania representing both Ministries of Statistics and Ministries of Social Protection from the participating countries. AED's participant training program (PTP) supported the participation of these foreign representatives. Speakers at the conference included the Prime Minister of Armenia, Andranyk Margaryan, the Minister of Social Security, the chairman of the National Statistics Service, the USAID Mission Director, Keith Simmons, as well as World Bank and UNDP officials.

ASTP assisted NSS to prepare and publish two significant annual reports in each of the years 2002, 2003 and 2004 – the first were launched at the Conference, “Social Snapshot and Poverty in Armenia” and “Income, Expenditures and Food Consumption in Armenia in 1999 and 2001”. On December 14, 2004, the 5th report on Social Snapshot of Poverty in Armenia was presented at the Conference Hall of the National Statistical Service (NSS) of the Republic of Armenia. The report covers the dynamics of social conditions and living standards in Armenia from 1996 to 2003 and was prepared with the financial and technical support of the Armenia Social Transition Program. The purpose of these publications is to provide the Government and civil society with updated information on social developments, the poverty level in the country and the impact of the Government reforms initiated to reduce poverty. The report covers the findings of five household income and expenditure surveys which were conducted in 1996, 1999, 2001, 2002 and 2003. The first two surveys were conducted with technical/financial assistance from the World Bank. The next three surveys were conducted with financial assistance from the EU Food Security Program and the Armenia Social Transition Program. The 2003 sample survey covered 4641 households countrywide.

### *5.4.6. Observational Tours*

ASTP organized two observational tours to Ukraine. The first, in October 2001, involved two specialists from NSS studying the statistical methodology and software of the Ukrainian households’ living standards sample survey and the use of SPSS for software development and statistical reporting.

The second tour was organized in July 2002. It was a working visit of ten key specialists from MLSI and NSS to Ukraine State Committee of Statistics to study the Ukraine experience in the use of data from the households’ living standards sample survey to develop social policy. The visit allowed participants to review the methodological and analytical procedures of the State Committee for Statistics of Ukraine, where a similar program of enhancing economic surveys and upgrading analytic skills began in 1997 – under the USAID/PADCO project supporting social sector transition.

### *5.4.7. Training in Poverty Measurement Methodology*

In December, 2004, ASTP convened the First Consumer Basket Workshop in Armenia to develop a consumer basket for Armenia. International practitioners and experts on consumer baskets from Poland, Latvia and Bulgaria shared their knowledge, skills and experience with Armenian practitioners. The workshop was organized by The Academy for Educational Development (AED) Armenia office in collaboration with PADCO with USAID funding. The 3 day workshop was a unique opportunity for professionals, officials and decision makers from Ministries of Labor and Social Security, Finance and Economy, Health, the National Statistics Service and the Trade Unions of Armenia to listen to international experience and develop their own best practice. On April 6, 2004, the President signed the law on minimum subsistence levels in Armenia. The minimum subsistence basket will serve as a government guide for setting levels of pensions and benefits and will also affect minimum salary and non taxable income. The value of the minimum subsistence basket will be calculated once a year based on HIES data.

## 5.5. COORDINATION WITH OTHER DONORS AND LEVERAGING FUNDS

ASTP collaborated closely with the **World Bank** on improving statistics. The Bank provided NSS with additional computers and in 2004, the Bank provided NSS with supplementary financing to build a new master sample based on 2001 population census database and increase the sample size of the survey. In 2004, the sample covered more than 6,000 households nationwide. The NSS and ASTP specialists worked with the WB to amend the methodology used to measure the level of poverty – a move necessitated by Armenia's rapid economic development. At ASTP's recommendation, NSS published the new methodology in 2002 and 2003 in reports entitled Social Snapshot and Poverty in Armenia, which informed a broader range of policy makers about the necessity to transfer to the new methodology, and prepared a background for smooth transition to a new methodology dating from 2004. Since ASTP's conclusion, the World Bank is providing technical/financial assistance to publish the next issue of the Social Snapshot of Poverty in Armenia- using a former local ASTP employee as an expert.

ASTP worked with AED to organize an International Conference on Poverty Assessment in 2002 and the Consumer Consumption Basket seminar in 2004.

ASTP worked closely with the EU FAO Armenia office supporting the translation and dissemination of the "Poverty and Food Security" Quarterly Statistical Bulletins produced by NSS RA on the basis of HIE surveys.

The European Food Security Program provided funding to the National Statistics Service covering some of the costs of administering the Household Income and Expenditure Survey (HIES).

UNDP representatives actively participated at the ASTP presentations of Social Snapshot and Poverty in Armenia annual reports, seminars on Consumer Basket Development and ISSC.

## 5.6. PUBLIC EDUCATION

With ASTP support, NSS created and staffed a public information center to ensure that the public was adequately informed about the survey and the implications of its results.

In 2004 ASTP also supported the publication and dissemination of a leaflet on "How and Where the Results of HIE Surveys are Used" among the households participating at the surveys. This will increase public awareness about the importance of the survey and particularly how reliable data reporting could further support the Government in improving state social policy.

## 5.7. THE RESULTS

**IMF Recognition of NSS Quality**. A clear indication of the high level of NSS expertise was the invitation in 2003 by the International Monetary Fund for the NSS to become a member of the Special Data Dissemination Standard (SDDS) -- an international standard of

excellence in statistical presentation. Armenia is only the third country of the NIS to achieve this distinction. The NSS Chairman attributed the achievement to ASTP training and support as well.

**Increased GoA funding for Statistics**. Based on the highly visible success of the NSS with its HIES, the GOA committed state budget funds to finance the survey. In the years prior to ASTP the survey had been conducted irregularly and only with support from international donors. The first survey was conducted in 1996; the second was conducted between July 1998- July 1999 both with the WB support; the 2000 HIES was never conducted due to insufficient financing from the state budget and the fact that social statistics were not used in policy decisions. In developing the PRSP, the significance of the HIE surveys became more evident and the ASTP technical support was much welcomed. In November 2002 the Government adopted a Decree which assured the regular annual implementation of the survey under the Annual Works Plans of NSS.

**Increased Use of Social Statistics by GoA Policymakers**. Equally important was the growing use of NSS statistics by the Ministry of Labor and Social Issues in designing and implementing targeted social assistance programs (see Section 3 of this report). MLSI experts were directly involved with NSS in preparing the annual statistical snapshots.

**Regular and Timely Publication of Handbook**. Since 2002, the "Social Snapshot and Poverty in Armenia" and a "Statistical Handbook on the Income, Expenditures and Food Consumption in Armenia" became regular annual event. The first, a poverty report, covers the dynamics of social conditions and living standards in Armenia from 1996 to 2003, and reflects close coordination with ASTP. The second, a Handbook, contains information on living standards of the population in terms of the structure of incomes, expenditures, and consumption of basic food products and other socio-economic indicators. The report also outlined some approaches toward providing a more precise estimation of poverty.

In December 2004, the 5th report on Social Snapshot and Poverty in Armenia was launched by the National Statistical Service (NSS). The report was prepared with the financial and technical support of ASTP, using the results of the 2003 household income and expenditure survey and showing the dynamics of social status and living standards in Armenia from 2001 to 2003.

### 5.8. SUSTAINABILITY

Better statistics are now built into the permanent capacity of NSS and the use of these statistics has become embedded in the MLSI and MOH. NSS has become a member of the international community of statistical agencies and receives increased GOA financing to ensure the continued pursuit of excellence. NSS has gained improved skills and understanding of:

- how to arrange, conduct and monitor HIE surveys;
- cleaning and processing of HIES data;
- developing the consumption aggregates and preparation of data on poverty incidence;
- international experience in poverty estimation and consumer basket design and application;
- the value of collaboration between GOA agencies;
- presentation of statistical data;
- improved access to and use of statistical information by users produced regularly by NSS; and
- how to respond to increased public interest in statistical data on poverty.

# ASTP FINAL REPORT: 6. INTEGRATED SOCIAL SERVICES CENTER PILOT PROJECTS

## 6.1. OVERVIEW

An important legacy of ASTP are the two pilot Integrated Social Services Centers (ISSCs) that have been created – the first in Vanadzor, the second in Masis. The concept of a one-stop shop for social assistance and social services was developed in collaboration with the Ministry of Labor and Social Issues with partners in Lori Marz. The goals of the one-stop shop were to:

- Improve access for the citizen to social services by co-locating all social services in one building, improving access to information, and eliminating the need for citizens to visit multiple offices on the principle that the ISSC would "collect all application data once.
- Create a more open and transparent appeals system.
- Enhance and extend the range of social services provided to citizens by including NGOs in the ISSC.
- Improve information sharing among the three organizations by creating systems for sharing databases to simplify application and verification processes.
- Improve the administration of social benefits programs by streamlining administrative procedures, structuring more efficient work practices, and allowing more intensive and regular training of staff.
- Reduce the incidence of error, fraud, and corruption by allowing better data sharing and improving auditing system of social benefits; and
- Make more efficient use of staff and technical resources among co-located offices.
- Help Armenia align with Council of Europe recommendations on social service delivery.

Prior to the creation of the Integrated Social Services Center in one location, the organizations providing social services were located in four different offices in Vanadzor and in three different locations in Masis. Citizens needing access to social services in Vanadzor and Masis now have a single location where they can make applications for pensions and benefits, register as unemployed, be medically examined in order to qualify for disability pensions and inquire about alternative social services.

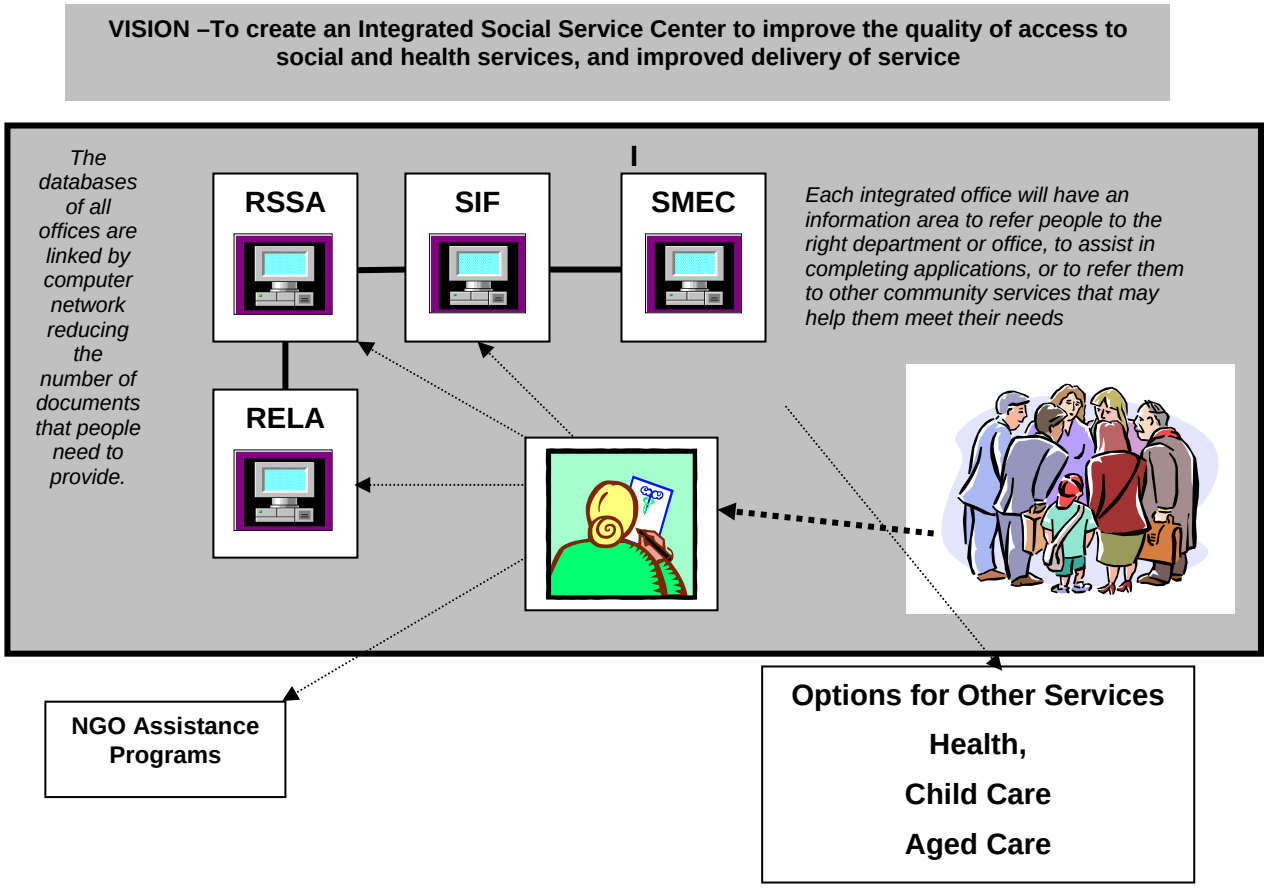
The services co-located in both Vanadzor and Masis are

- State Social Insurance Fund office where citizens can apply for their pensions and employers pay their social insurance contributions for employees;
- Regional Social Service Agency where families can apply for the social assistance payments, humanitarian assistance, Poverty Family Benefit and Lump Sum Assistance payment;
- Employment Services Agency where unemployed persons can apply for unemployment payments and apply for job vacancies and also access training opportunities;
- The Social Medical Expertise Commission where persons with disabilities can apply for medical exams so that the severity of their disability is assessed and certified and persons with disabilities can obtain disability pensions; and
- "NGO GATEWAY," where more than 30 NGOs in Vanadzor and 40 in Masis joined to provide services for the vulnerable, the elderly, refugees, and give a wide range of social advice and information.

The main focal point of the ISSC is the Customer Reception Area on the ground floor at Vanadzor and Masis where representatives of all the organizations are located. Staff in the reception area are available to answer all queries from the public and to respond with a full range of social services. An NGO representative in the reception area provides information and assistance to citizens who

have a need but may not qualify for state benefits, and for those citizens who need additional services that state social service offices are not able to provide.

## 6.2. System Design




The design of the ISSC had to overcome both technical barriers – finding a suitable facility, securing the agreement of all participants to relocate and share resources, the low level of computerization in social service offices, and developing new administrative procedures. But it also had to overcome the inevitable inertia of five separate agency cultures and the fear of change. The pilot projects also had to be developed in an environment of large and repeated cuts in funding for social services.

ASTP overcame these barriers by ensuring the widest possible participation in developing the pilot site. Representatives of all the government agencies, NGOs, the Ministry, ASTP, and representatives of the Marz and the city governments were involved in dozens of meetings structured and organized by ASTP. Citizens were also involved through focus groups and town hall meetings – during which their problems with the current delivery of services and their vision of an improved system were solicited. TV and newspaper coverage of the different stages of project design and implementation also ensured broad public awareness.

In order to ensure high visibility, broad participation and greater sustainability, ASTP organized multiple sources of funding for the Vanadzor pilot – including the Council of Europe, the Armenia Social Investment Fund, the Marzpet, and the city of Vanadzor.

An important element in the design was to ensure that local NGOs were active participants in the new ISSC. Before the pilot site work began, ASTP had developed a brochure listing all local NGOs, their areas of specialization, and contact information. This helped build a cadre of NGOs involved in social service delivery as well as teaching the NGOs the importance of public outreach. The goal was to create a seamless system through which private organizations can supplement the services available to people through government offices. “This brochure,” stated Minister of Social Security Razmik Martirossian, “is an important step toward linking the government with the private sector. The needs of the people of Armenia

are beyond the fiscal capacity of the Government. Therefore we must begin developing new partnerships." This brochure lists the 35 health and social service NGOs operating in Lori, their addresses and contact persons. These brochures were distributed widely throughout the Marz in towns and villages and were made available at polyclinics, hospitals, regional social service centers, post offices, community centers and other popular locations. The goal is to continually provide citizens with information on private organizations supplementing the services available through government offices and to recognize the vital role of voluntary activity in the community.

## 6.3. CREATING THE LEGAL FRAMEWORK

ASTP worked with the MLSI on a set of government decrees which placed the Integrated Social Service concept on a sound legal footing. Decree 247 -A (February 26, 2004) entitled "Establishing a Social Service Center in Vanadzor within the framework of the Pilot Project "One Stop Shop" was signed by the President on March 15th 2004. A Prime Ministers Decree dated April 12th 2004, numbered N204-A, set out the working procedures and structure of the Board of the Integrated Social Service Center in Vanadzor.

A Government Decree dated December 2, 2004 No 1676-U entitled "The Establishment of a Social Service Center in Masis and Implementation of the pilot "One Stop Shop", was signed by the President on December 11th 2004. On January 20, 2005, the Prime Minister approved a "Decree on the Working Procedure of the Board of Masis Integrated Social Service Center" and named the members of the Board who include the Deputy Minister of Labor and Social Issues

## 6.4. BUILDING THE IT SYSTEMS

To gain the greatest benefit from collocation in a single facility, new database and data sharing systems had to be developed.

Appeals Database Operating in ISSC. The Appeals database system for the ISSC Vanadzor became fully operational in late 2004. The Appeals system, developed and installed by the Nork Center, registers appeals by citizens and tracks the flow of appeals applications through the system. The Appeals database system has begun to be used by customers, particularly within the RSSA (local level). The RSSA level is where appeals of specialists' decisions are more likely. The Appeals system software will also be installed in the new Integrated Social Service Center in Masis.

ISSC computerization. ASTP provided computer equipment for both Vanadzor and Masis ISSC pilot sites. In Vanadzor, 5 Pentium IV computers were installed together with 10 donated computers and a local area network on the first and second floors. In Masis, 5 Pentium IV computers were installed together with 8 donated computers and a local area network. ASTP also developed the IT systems necessary to ensure sharing of data among the participating social service agencies. The staff have access to data exchange software that has been developed by the Nork Center with financial assistance from ASTP. This system enables each of the offices in the building to access certain limited data sets from key state social service office databases. The shared database helps to increase the efficiency of service to clients and ensure proper targeting of benefit recipients. It also helps to reduce:

- Paperwork by each office;
- The time it takes to process applications and appeals;
- The number of documents applicants must bring to a particular state social service office; and
- The time it takes a citizen to make an application, make an appeal, or make an inquiry.

This has greatly streamlined the application process.

## 6.5. STAFF TRAINING

### *6.5.1. Training ISSC Staff in Use of Computers, IT Systems, and Social Services*

**Vanadzor**. In March 2002, the Armenia Social Transition Program (ASTP) initiated a program of intensive computer training to directors of local social services offices in Vanadzor. Computer training is intended to support new information systems in health and social services. The first program was provided to staff from Regional Social Services Centers, Republican Employment and Labor Services, the Socio-Medical Expertise Commission (which determines eligibility for invalid benefits) and Social Insurance Fund offices. It is linked to the program to create social inspection mechanisms to audit social benefit recipients. Additionally, the

training course was provided within the framework of the pilot project in Vanadzor to create an Integrated Social Services Center. The training took place at the ASTP office in Vanadzor, located in Polyclinic No. 1 where ASTP has created and equipped a large training facility. ASTP provided 5 computers and training tools: flip charts, whiteboard and power point projector.

**Masis**. On February 4-6 and 11-13, 2005 the Armenia Social Transition Program conducted two training courses to improve and develop the computer skills of the NGO staff that work in the reception of Masis Integrated Social Services Center. The three-day training courses were attended by a total of 16 staff from Masis-based organizations. ASTP also provided all training tools, training handouts, manuals and general support for the program. On February 16-18, 2005, ASTP organized a 3-day ISSC/NGO seminar in Masis in collaboration with Yerevan State University Department of Sociology. Participants included senior representatives from Masis-based NGOs and ISSC representatives. The group discussed approaches to assisting vulnerable groups, their types and characteristics and the role of NGOs as service providers for the vulnerable. The group also examined the social protection system of Armenia in relation to vulnerable groups and ways to improve the quality of services to the vulnerable.

In 2004, an umbrella group of more than 20 local NGOs in Masis were trained in a five-day course at the newly established Resource Center of the Masis ISSC in theoretical and practical knowledge in social legislation, customer reception skills and social assistance projects as well as being given the opportunity to share their experiences with others. Through practical casework and demonstrations by participants, the necessity of quality customer service and effective communication with clients was emphasized. Role-playing was used to identify the importance of creating a positive and professional first impression by ISSC customers. Participants were also taught how to distinguish behaviors in order to build a rapport with clients. Feedback from trainees was very positive in all training sessions.

#### *6.5.2. Training NGO Staff in Customer Service*

From 16-20 May 2005 ASTP conducted a training course to improve and develop the reception and customer services skills of NGO staff working at the Masis Integrated Social Services Center. Training and Development Ltd. in cooperation with Armenian Young Lawyers Association were selected as the training provider through an open tender. The five-day training course was attended by 16 representatives from Masis-based organizations that have become part of the Social Integrated Services (‘SIS’) union representing the non-governmental sector in the Masis ISSC.

### 6.6. COORDINATION WITH OTHER DONORS AND LEVERAGING FUNDS

The cost of refurbishing the building for use as the ISSC was funded collaboratively by ASTP, the USAID sponsored energy conservation program (conducted by AEAI), the Armenia Social Investment Fund (ASIF) (financed through a World Bank grant), the Marzpet, local NGOs and the city of Vanadzor. The total cost of preparing the facility was $160,000, and contributions from these partners were: ASTP -- $75000, ASIF--- $60000 AEAI -- $2000, the SSIF -- $4000, the Marpet-- $12000, local NGOs $1200--- and the City of Vanadzor (Mayor)-- $6000. The Council of Europe also funded various initiatives connected with the ISSC related to improving access to services for citizens at a total cost of $20,000. On March 29, 2004, the Integrated Social Services Center at 14 Garegin Nzhdeh Street, Vanadzor was formally opened by the Minister of Labor and Social Issues, the Marzpet of Lori Marz, the USAID Mission Director and UN Resident Representative attended. Also present was the advisor to the President of Armenia.

On November 2, 2004, the second "One Stop Social Services Shop" was opened by the US Ambassador and the Minister of Labor and Social Issues. The center provides services to 4000 needy families, 1500 unemployed persons and 3000 pensioners living in Masis. A key element of the center- as in Vanadzor- is the "Gateway to NGO Services"- over 30 local NGOs operate from a Community Resources Center at the ISSC.

The logo designed by the social partnership advisory group to symbolize partnership between NGOs and Government in harmony

ASTP also worked closely with the USAID-funded Armenia Legislative Strengthening Program (ALSP) to create National Assembly Info Points at the ISSCs in Masis and Vanadzor where citizens can access information on their public representatives. This builds on the concept that ISSCs should be centers where citizens not only access social services under one roof; they can also be agents for change by having their opinions on the quality of social services taken into consideration in the design of social policy. Using the National Assembly Info Points at the ISSCs in Masis and Vanadzor citizens can communicate electronically with their public representatives, access information on draft laws under discussion and generally give feedback to public representatives and policy makers.

The Training and Development Company Ltd. provided training in customer service and reception management to 17 volunteers from NGO's in Masis ISSC

## 6.7. PUBLIC EDUCATION

Intensive public education in both Vanadzor and Masis used TV, radio and newspapers as well as public meetings to underpin the establishment of the new centers. In 2001, the social partnership advisory group, set up following the USAID-sponsored social partnership study tour to Ukraine in November, launched the "Year of NGO and Government Collaboration in 2002."and this helped to galvanize NGO activities around the ISSC. On April 14, 2004, Lori TV transmitted "One Stop Shop - What it means for You - The Citizen." The program focused on the official launch of the Vanadzor "Integrated Social Service Center". A panel consisting of Filaret Berikyan, Deputy Minister of the Ministry of Labor and Social Issues, Brian Kearney, ASTP Chief of Party and Lyudmila Haratunyan, Head of the Department of Sociology at Yerevan State University discussed the background to the creation of the center and how the center improved access to social rights. The audience comprised all the Directors of Social Services involved in the Center, the Director of Nork Center, the Nork computer center of the Ministry of Labor and Social Issues, representatives of the local authorities, the Deputy Mayor of Vanadzor, Michael Wheelahan, ASTP Social Sector Advisor and a large number of NGO representatives. Film footage of the official opening on March 29th was included in the program together with the visit of President Kocharian in October 2003. In an interview during his visit the President voiced his satisfaction with this innovative approach to improving citizen's access to government services and indicated that the Government will open such centers in each Marz in Armenia. Film footage showed the center before and after renovation, and also included interviews with social service staff, customers who were using the Integrated Social Service Center and random street interviews.

The overall public response was very positive with customers expressing their satisfaction with the improved service and the fact that all services were now more accessible. A key element of customer satisfaction was the improved access to accurate and clear information on their rights through information booklets, posters, leaflets and through the staff at the Information Center at the Integrated Social Service Center. Representatives from the Council of Europe visited the Integrated Social Service Center in September 2003 to study the Integrated Social Service Center approach and filmed excerpts from their visit were included. The "NGO Gateway," at the Integrated Social Service Center was the subject of much discussion among the studio audience. A group of more than 30 NGOs in Vanadzor have come together to provide services for the vulnerable, the elderly, refugees, and people who need advice and information and representatives of this NGO group are located in the reception area of the building. Many of the studio audience considered that having government services and NGOs under one roof has had a major positive impact on the working relationships between social services and NGOs.

The role of the Social Security Card in improving the linkages between social service databases was outlined by the Director of the Nork Center. He also spoke of the improvements in services expected under the

expected passage of the proposed law on electronic signatures and described how this law would impact positively on the citizen.

Brian Kearney, ASTP Chief of Party, described how the Council of Europe supports the concept of improving citizens access to social rights through the One Stop Shop model and how some advances had been made in countries such as Malta and the United Kingdom in implementing the concept. He referred to the interest from Romania, Lithuania, Moldova and Georgia in visiting Vanadzor to see the Integrated Social Service Center. The Deputy Minister, Filaret Berikyan, emphasized the organic nature of the Integrated Social Service Center Pilot, indicating that it will not remain static, services will be constantly improved, we will listen to our customers, and we will constantly examine how we can do things better.

*Anti-corruption Impact*

*'As to the corruption in the RSSAs, the participants noted that they know about it and it happens everywhere. But working in one building with the other services makes the RSSA inspectors be more alert and helps reduce such cases' (members of NGO focus group).*

## 6.8. THE RESULTS

Establishing the ISSCs in Vanadzor and Masis provided efficiency in operating costs and in social service delivery. For example, in Vanadzor the building contains a community resource center, an NGO resource center, a hall for larger meetings, a training center, reception area, shared heating and water system, and shared building maintenance. Joint training courses in modern management and administration principles, computer skills, and customer service were provided and continue to be provided to all ISSC staff at the Center's shared training space. In addition the Regional Employment and Labor Agency uses the training area to provide training sessions to unemployed persons. Similar successes are also being achieved at Masis ISSC which opened in November 2004 and is currently recording visits of 500-1000 customers per day.

The evaluation results of these two pilots ISSC confirm that they are providing many important benefits for citizens. Individuals no longer need to travel from location to location to apply for benefits. For example, in Vanadzor this represents a major improvement from the previous situation where the services were available in four locations in different parts of the city and, for many customers, could only be reached by expensive bus journeys. SSIF, which provides pensions for the elderly, disabled, and pregnant women and is located on the first floor of the building, has increased access to services for these vulnerable groups. Each ISSC has a clearly signposted Reception and Information Center on the first floor, staffed by representatives of each social service located in the building, provides an improved information and customer reception point. Informational brochures, bulletins and posters on a variety of social service topics and resources are on display in the reception area. The management and customer service training has resulted in better and more polite treatment to all citizens who enter the door. The addition of the NGO Gateway helps those who need assistance that cannot be provided by state social service offices.

An important element in establishing the pilot ISSCs was to ensure that the services were more responsive to the needs of the citizens and that the new ISSCs were providing a gateway for community access and involvement at the local level. Each ISSC is managed by an ISSC Board which also has a local NGO/community representative. Specific strategies initiated by the Board are targeting increased public awareness and involvement in local programs and the development of broad community-based partnerships and initiatives most appropriate for each location.

The shared resource room at each center is being used by NGOs, community organizations and other interested parties to focus on social sector issues. Examples of activities include meetings of local citizens and community representatives, training sessions and workshops providing information and support for specific target groups. Legal advice and psychological counseling services are also being organized by local NGOs to provide access to these services to citizens who have no other access to such services.

*Intergovernmental cooperation*

*'Working in one building and seeing how the other services work, they become more responsible, more vigilant and attentive to the customers. The heads of the services know each other, meet each other nearly every day, they have an opportunity to discuss together the issues of common concern; and this makes the cooperation among them more effective.' (Community leader's focus group).*

**ISSC Received President's Award**. The President of Armenia and the US Ambassador visited the ISSC on October 9th 2003, receiving a high level

of media coverage. The President was impressed by the ISSC concept. Following his visit, he issued a protocol to the GoA instructing that every effort should be made to create ISSCs in every Marz. On April 29th 2005 the ISSC concept was awarded the Presidents Prize[11] for innovation in improving service to citizens. The prize of $5,000 was presented to those local people who had played a significant role in establishing the center. This included the Mayor, the representative of the Regional Governor and three others local persons who were involved in the creation of the ISSC. The prize has been used to start a fund at the ISSC, managed by the ISSC Board, which will help the NGO Gateway at the ISSC to achieve its objective of providing professional social work services.

**Council of Europe Recognized Vanadzor ISSC as a model for social services delivery**. On November 25, 2004, Françoise Kempff from the Social Policy Department of the General Directorate of Social Cohesion visited the Integrated Social Service Center in Vanadzor. The Council of Europe has demonstrated a deep interest in the Integrated Social Service Center model in Armenia since its inception. There is heightened interest of late as the Council of Europe is setting up, in December 2004, a new intergovernmental committee to work on integrated social services delivery. ASTP has received enquiries on Integrated Social Service Delivery from a number of the 46 member countries of the Council of Europe.

**NGOs Find New Clients through ISSCs.** The NGO referral office provides information and assistance to citizens who have a need but may not qualify for state benefits, and for those citizens who need additional services that the state social service offices are not able to provide.

## 6.9. SUSTAINABILITY

The collaborative development of the ISSCs, the intensive training of staff, and the high level of community commitment has ensured that the pilot sites are fully sustainable and will continue development and improvement beyond the end of the ASTP project. On September 13-15, 2005, the ISSC Concept was presented at the Annual Conference of the Europe and Central Asia Regional Network of Social Investment Funds, held in Yerevan. ASTP provided assistance in holding the conference. At the Conference the Ministry of Labor and Social Issues presented the Integrated Social Service Center concept a.k.a. “One Stop Shop”. Representatives from more than 20 countries attended the conference. The conference showcased the experiences and results of the first two pilot Integrated Social Services Centers at Vanadzor and Masis. WB is planning to support the ISSC concept through ASIF in order to expand ISSCs to every Marz in Armenia.

*Integrated Databases*

*‘Comparing databases between RSSA, RELA and SSIF used to take 30 – 40 days; now it takes 2 hours.’ (RSSA specialist).*

[11] The Presidents Prize is funded by the All Armenia Fund and a donor from the Diaspora, Ter Poghosyan. Prizes are awarded annually to outstanding persons in the areas of IT, literature, humanitarian science and physics.

# ASTP FINAL REPORT: 7. BUILDING ARMENIA'S CAPACITY FOR ACTUARIAL ANALYSIS

## 7.1. OVERVIEW

The need to strengthen actuarial capacity became apparent as ASTP began work in supporting reform for Armenia's impoverished pension system (Section 2 above). In collaboration with the World Bank, PADCO trained staff in the Ministry of Labor and Social Issues and the Social Insurance Fund in the use of the World Bank's PROST actuarial model but permanent actuarial capacity was needed. The Ministry strongly supported the new profession and has provided several jobs for its graduates.

## 7.2. PROGRAM DESIGN

ASTP's program to develop actuarial capacity in Armenia had seven elements:

1) Developing a permanent education program to prepare actuaries according to international standards.
2) Creating a Center for Actuarial Sciences at YSU.
3) Establishing the profession of actuary in Armenia.
4) Developing an actuarial model of the state old-age pension system and training specialists in the Social Insurance Fund and the Ministry of Labor and Social Issues in the use of this model.
5) Creating an Office of the Actuary to provide actuarial estimates for social insurance programs.
6) Organizing short-term on-the-job training for trainee actuaries.
7) Developing actuarial models for the social and health sector.

***What is an actuary?***

An Actuary is a professional who analyzes the financial consequences of risk. Actuaries use mathematics, statistics, probability, and financial theory to study uncertain future events, especially those of concern to insurance and pensions. Actuaries may work for insurance companies, consulting firms, government, employee benefits departments of large corporations, hospitals, banks and investment firms, or, more generally, in businesses that need to manage financial risk. A career as an Actuary is better described as a "business" career with a mathematical basis than as a "technical" mathematical career.

In addition to having a sound knowledge of -- and a definite liking for -- mathematics, a successful actuary must have practical business sense, the creativity to come up with innovative solutions to new problems, effective communication skills, and the ability to work with many different types of specialist. Many actuaries are skilled in areas such as computers, economics, investments, marketing, and general management.

## 7.3. CREATING THE LEGAL FRAMEWORK

A powerful incentive for the development of actuarial capacity was the inclusion in the "Law on State Pensions" of the requirement that pension increases should be based on actuarial modeling of their financial viability. Full development of the program required the drafting and adoption of complementary normative acts.

The Ministry of Labor and Social Issues supported the concept of developing actuarial capacity and, in June 2002, issued a decree establishing the Office of Actuary which it located in the Nork Information and Analytic Center.

A Governmental Decree #1628 (October 23, 2002) included the specialty "0139-Actuarial Mathematics" in the list of university programs and the profession of actuary appeared in the list of professions in Armenia. This Decree resulted also in launching the Bachelor's Degree Program with an actuarial focus in 2003. The enrollees shall pass enrollment exams in mathematics, and Armenian and English languages.

A law on Insurance in Armenia adopted on June 11 2004 includes a requirement that all insurance companies employ an actuary and all insurance products must be priced by an accredited actuary.

## 7.4. BUILDING THE IT INFRASTRUCTURE

Minister Razmik Martirosyan, the Rector of Yerevan State University, Mission Director Keith Simmons, and the Dean of the Mathematics Faculty pose with the incoming class of actuaries at the opening of the Actuarial Sciences center at Yerevan State University. The center was equipped and the graduate education program created under the PADCO Armenia Social Transition Program

ASTP ensured that actuarial skills would not only be developed but would become a central part of decision-making by those concerned with social insurance programs in the GOA. This involved close three-way collaboration among MLSI, YSU and ASTP.

### *7.4.1. Creating the Actuarial Science Center at Yerevan State University*

ASTP supported Yerevan State University in the design and creation of an Actuarial Sciences Center – the first in the Caucasus. The Center was opened on September 26, 2001. The Center includes classrooms, teaching materials, a library and eight computers – all supplied by ASTP. From initial meetings between ASTP and the University to the opening of the center and the induction of the new class of students took only eight months. The cost of the renovation and classroom furnishings and the computer equipment was less than $25,000. Working with Yerevan State University, ASTP supported the development of the new actuarial center. ASTP brought Professor Alexander Ponamarenko, a member of the mathematical faculty from Kyiv Shevchenko University of Ukraine, to Armenia to advise on the design of an actuarial curriculum – which combines statistics, mathematics and finance skills.[12]

"The students who will be produced here represent a major leap forward in the financial security of a growing number of Armenians," noted Keith Simmons at the Center's opening in 2001. "Actuarial scientists trained through this program will assure the long-term viability of the Armenian pension system, allow effective development of both public and private insurance programs, and significantly enhance Armenia's ability to understand and engage in the world of global finance."

YSU's actuarial program offers a two-year graduate degree in actuarial sciences and a one-year undergraduate program. There have been three graduating classes averaging 6 students each year. The graduates have faced little problem in finding employment for their skills. The term "actuary" was new to Armenia. ASTP therefore prepared a brochure that explains the concept of the science, which has been widely distributed.

Since 2003, representatives of the actuarial program participated in annual EXPO international Exhibitions on Education and Career, which is one of the most important events in Armenia for students and employers, relating to the reform of education and education service provision. Public interest in the Actuarial Degree Program was high with over one thousand enquiries at the exhibition stand. Young and old, students and schoolchildren, lecturers and scientists, different companies and a substantial number of foreign students, including those from India, China, Syria and Lebanon have requested information actuaries, what they do, where they work, what area of science they study, and how they can become an actuary. Answers to these questions were provided by booklets and leaflets prepared by ASTP.

### *7.4.2. Creating the Office of the Actuary*

In June 2002, the Ministry of Labor and Social Issues opened the Actuarial Office, located in the Nork Analytical-Informational Center. ASTP supported MLSI and Nork Center in selecting the Actuarial Office staff, equipping it with computers, software and financial calculators. The Actuarial Office non-student employees take part in the Actuarial Master Degree Program (AMDP) classes and use YSU Library

[12] PADCO had collaborated with Kyiv Shevchenko earlier in other USAID supported work in developing the program and the teaching materials at that university.

collections. The creation of an Actuarial Office is critical for analysis of pension and social insurance/protection reforms. The Office provides actuaries and actuarial students with the opportunity to work on practical problems. With assistance from ASTP, four people were selected to undergo rigorous training, working in the Actuarial Office based in the Nork Center:

#### *7.4.3. Creating the Armenian PROST Model*

The first application for the new actuaries was to work on developing the World Bank PROST model of Armenia's state pension system (see Section 2 of this report on Pension Reform). Actuarial students received training in the use of the model and participated in policy simulations.

### 7.5. STAFF TRAINING

Fourteen participants, including employees of the Actuarial Office at "Nork" Analytic-Information Center, graduates of the actuarial degree program, and second year students of the Actuarial Master's Degree Program students completed 10 weeks of accountancy training provided under ASTP.

Four specialists from the MLSI and SIF were sent to Washington DC in May 2001 where they received one week of training in the use of the PROST model. The ASTP identified the specialists and paid for their travel and accommodations while the World Bank provided the training.

ASTP organized a series of on-the-job training opportunities and seminars on actuarial subjects involving both local and international experts. Examples of the trainings conducted are: the Theory of Probability and Mathematical Statistics; Windows Applications, SPSS, and PROST; Financial Mathematics; Mathematical Statistics for Economics; Macroeconomics; Actuarial Mathematics; seminars on "Non-State Pension System Prerequisites", "The Regulator: Its Creation, Role, and Functions", Statistical Methodology, "Household Income/Expenditure Survey Database Cleaning Issues", and the "British Pension System". Presently, a series of seminars on the "Pension System in Armenia" is implemented by the Head of the Pension Security and Social Insurance Department (MLSI) for building up understanding of the pension system of Armenia. The seminars conduct actuarial analysis of the state and voluntary pension schemes to build indigenous capacity.

The Actuarial Office employees and students took English language classes organized by AED. These classes increase the students' access to international actuarial best practices as most actuarial publications as well as accreditation programs are in English.

ASTP tendered and selected the "International Accountancy Training Center" Educational Foundation (IATC) to carry out the accounting training for actuarial graduates and employees. Fourteen participants, including employees of the Actuarial Office at "Nork" Analytic-Informational Center, graduates of the actuarial degree program, and second year students of the Actuarial Master's Degree Program (AMDP) students will attend. Classes cover Accounting Frameworks and Accounting Standards, Financial Accounting, Applied Accounting, Business Law and Contracts and Taxes and Customs.. Students will attend the course for two and a half months

### 7.6. COLLABORATION WITH OTHER DONORS AND USAID PROJECTS

ASTP collaborated with the Partnership for Accounting Reform and Development in Armenia on strengthening the membership association representing financial advisors (Auditors, Accountants and Actuaries) and in the strengthening of accounting training in YSU

### 7.7. PUBLIC EDUCATION

In 2002, ASTP prepared, printed and distributed a brochure entitled "What is an Actuary". The brochure is distributed by YSU as part of its promotional activities.

A "Day of the Actuary" was organized in collaboration with YSU and USAID contractor IBM Consulting in December 2002. The purpose was to celebrate the two-year collaboration between ASTP and YSU and to involve private insurance companies and other GOA agencies in providing internships for the graduating students from YSU's first actuarial class. One Armenian insurance company "EFES" accepted two students for internships. The event was attended by more than 100 participants from banks, insurance companies, government agencies and educational institutions and was extensively covered in the media. ASTP also presented the Actuarial Center with subscriptions to two international actuarial journals.

In 2003, YSU, with PADCO assistance, took part in a major three-day education fair in Yerevan which was attended by over five thousand people. The 2nd International Exhibition entitled "Education in Armenia" took place in the Government Building from May 16-18, 2003, organized by the Ministry of Education and Science. The PADCO/YSU exhibition display, advertising the profession of "Actuary-Mathematician" and the actuarial educational programs at YSU, received over 300 enquiries from members of the public, students, and educational organizations. The Actuarial exhibition presented the development of the actuarial education program from its inception in September 2001 up to today. There was a steady demand for the actuarial informational leaflets and brochures keeping the staff at the stand busy throughout the three-day event. The stand was staffed by YSU Actuarial Master Degree students and managed by ASTP.

Over one thousand students, members of the public and employers visited the exhibition stand on the Actuarial Profession in Armenia at the 5th International Exhibition on Education and Career - EXPO 2005**.** From April 6-8, ASTP assisted Yerevan State University and the Nork Center of the Ministry of Labor and Social Issues to present the new profession to the public. On April 8th 2005 the actuaries of the Nork Center gave a presentation to an interested audience on the work of the Center and the different types of Actuarial Analysis carried out by the Actuarial Office.

In February 2005**,** ASTP provided support for a Job Fair at the Nork Center, "Career Opportunities for Armenian Actuaries," which provided an opportunity for trainee actuaries to meet with representatives from the banking sector, insurance sector and financial sector in Armenia. The job fair provided a unique opportunity for representatives from the financial sector to hear how the actuarial profession can help them in their business. The Director of the Nork Center Hayk Chobanyan outlined briefly the 4-year history involved in establishing the actuary profession in Armenia and the key elements of cooperation between the Center of Actuarial Sciences in YSU and Nork Information-Analytical Center. Ara Petrosyan, Deputy Minister of MLSI pointed out that events of this kind help to highlight the activities that had already been implemented and the plan for further developments. He was pleased to mention that each year there had been small but positive progress in the foundation of an actuary profession in Armenia. Radik Martirosyan, Rector of YSU pointed that the actuaries will lend a hand in carrying out social sector reforms in line with international standards and help policy makers to avoid possible mistakes by providing sound projections. The 1oth of February was adopted as an Actuary Day and was agreed to arrange small events annually on that day.

In May 2005**,** ASTP took the opportunity of the graduation of 6 MA actuaries to organize an event to introduce the graduates to potential employers in the Insurance and Banking industry in Armenia. All graduates received offers of internships with various companies and one is to be employed by the

Ministry of Economy and Finance. The government has already developed legislation to coordinate and manage what is still a new field in Armenia because the key requirement for establishing a sustainable insurance net is the need for proper actuarial modeling and projections. As a result, the government is interested in encouraging the employment of professional actuaries within insurance companies. Indeed, this requirement is now obligatory under Armenian law. Levon Altunyan, President of Association of Insurance Companies and Director General of the Armenia Insurance Company INGO, was certainly happy with the opportunity to meet and become acquainted with the new actuaries. In his opinion, insurance companies need professionals in this sphere to help develop secure businesses.

## 7.8. THE RESULTS

Between 2002 and the end of September 2005, the Actuarial Department of YSU graduated 17 students from its Masters degree program, and had 25 enrolled. Actuarial students and graduates are actively involved in applying their skills. Of the master's degree program graduates, 5 have found jobs in the private sector and 5 in various government departments and agencies**.**

Among the intern activities were the following:

- In October 2002, four intern actuaries and staff at Nork's Actuarial Office prepared a comprehensive report of their findings from an intensive audit of the PFB system to MLSI. The report outlined errors and omissions in the system, which have, since then, been addressed by MLSI and corrected. This work in addition to being a valuable auditing tool was particularly important in advance of the assignment of SSCs.
- Since March 2005, with close collaboration and guidance of YSU lecturers, the actuaries of the Nork Center are working on actuary modeling of the pension system in Armenia. These activities are the first attempt in Armenia and test the actuaries in applying the knowledge obtained and in their knowledge of the PROST model, Mitchell Wiener has reviewed their analysis during his visit in June 2005 and provided recommendations for further improvements.

## 7.9. SUSTAINABILITY

The YSU actuarial studies program -- and the use of actuaries by the GoA – will continue after the end of the ASTP program. ASTP has provided no financial support for these activities for the final two years of the ASTP project. Armenia's emerging financial markets – including the insurance sector -- are growing slowly, and therefore job opportunities will also grow slowly. YSU's program is appropriately sized for this small market. However, the depth of training of actuaries must be increased in order to move slowly towards international standards. Coursework must be broadened to develop a curriculum that is compatible with Western standards. This will probably require a resident actuary in the YSU center. This would also support the further development of pension reforms.

Since the YSU center offers the only actuarial studies program in the Caucasus, marketing for potential students in Georgia and even Southern Russia could add to the status and the enrollment in the program Regional cooperation could benefit from USAID involvement.

# ASTP FINAL REPORT: 8. BUILDING GOVERNMENT CAPACITY

## 8.1. OVERVIEW

To ensure that all the reforms initiated with ASTP support continue beyond the end-date of the project, ASTP invested heavily in strengthening the capacity of the GOA to administer programs. This involved three types of activities:

- Creation of the legal framework for social and health services
- The redesign of many administrative procedures
- Computerization of functions within ministries
- Intensive staff training in a wide array of skills relevant for their jobs – from computer literacy, customer service, management, and policy analysis.

## 8.2. CREATING THE LEGAL FRAMEWORK

In addition to the legal drafting described in other chapters of this report (a complete list is contained in Attachment F), ASTP supported the development of the following laws:

**Draft Law on Volunteers and Volunteerism.** In May 2005, MLSI asked ASTP for assistance in developing a Draft Law on Volunteer Activity. The idea of developing such a law began with the Network of Lawyers established in June 2003 within the World Learning NGO Strengthening Program. The Network of Lawyers consisted of 12 participants including specialists from World Learning, NGO Center, ASTP/PADCO, National Assembly, Ministry of Labor and Social Issues and NGOs. During 2003-2004 the Network members had regular meetings and developed a Draft Law on Volunteers and Volunteer activity. The members of the Network made changes in the Draft Law taking into account all reasonable comments and suggestions; however, little progress was made on bringing the law to the point of government discussion. In December 2004, after the termination of the World Learning program, the former staff members established an NGO "Professionals for Civil Society". This NGO is implementing a project to remove obstacles to volunteerism in Armenia and to raise public awareness on the role of volunteerism in the development of civil society. ASTP studied best practice in FSU countries and obtained copies of laws on volunteerism in Poland and the Czech Republic. These laws on the Legal Status of Volunteers and Regulation of Volunteer Activity were translated into Armenian by ASTP to provide examples of best practice to specialists in MLSI. In July 2005, ASTP held a round table on a Draft Law on Volunteers and Volunteer Activity in Vanadzor jointly with the Ministry of Labor and Social Issues and "Professionals for Civil Society" NGO. About 30 representatives from active local NGOs of Vanadzor participated in the round table discussion, including specialists from the Ministry of Labor and Social Issues and the National Assembly. ASTP then assisted with further revision of the draft law.

**Child Care Standards**., MLSI, with the assistance of ASTP developed a set of important standards for the welfare of children in institutions in Armenia. This work was carried out in collaboration with the EU Food Security Program, TACIS and the USAID-supported World Vision program. EU-TACIS provides experts in children's law and welfare. World Vision supports assistance to institutions for children with learning disabilities. Such donor synergies ensured that MLSI had the most comprehensive assistance available in this area. Key tenets of the standards ensure that the one thousand children in Armenia's orphanages live in a safe, secure environment; that the children are empowered to take part in decisions that affect their future; and that their relatives have the opportunity to provide input into their welfare. A wide range of views of multiple donors, childcare organizations and orphanage directors were solicited and incorporated into the standards. Decree 1324-N was on Standards of Childcare in State Institutions was ratified by the Government of Armenia in November 2004. Following the passage of the decree ASTP designed a training program to underpin the standards. This training was delivered to Orphanage Directors and Administrators in December 2004.

## 8.3. BUILDING IT SYSTEMS

In addition to the specific IT systems described in other chapters, ASTP supported the GOA and many different agencies in developing the following IT systems:

**Rebuilding the State Health Agency's Financial Database**. ASTP, through its subcontractor YICRD, completed the reconstruction of the software that maintains the SHA databases and re-entered the data for 1999 and 2000. In May 2000, prior to ASTP's arrival, the software system collapsed because of a deliberately set virus in the software.

**Data Exchange Software for MLSI and SSIF.** The data exchange software developed by the Nork Center to exchange data between the MLSI's Poverty Family Benefit Program (PAROS) and the SSIF pension fund (ARAKS) in Vanadzor ISSC has now been installed in Masis. Based on the initial experience at Vanadzor, improved software is being used in both ISSC sites to speed up the annual registration process for Poverty Family Benefits assistance, beginning January 2005. The integrated database is reported to have reduced from 30 days to 2 hours the time it takes to compare the data of the different databases to ensure that there are no mismatches in people and services received. As a result of the installation of this database, the number of mismatches between the databases used by the different services has been reduced considerably. The passage of the decree on electronic signatures, expected early in 2005, will yield significant benefits from the system as the need to issue paper certificates is removed.

**IT Support for the Ministry of Justice.** The Official Status Identification and Registration Information System (OSIRIS) for Civil Status Registry was installed at the archives site, making it the fifth OSIRIS pilot site. Other sites include two Civil Status Registry Offices, Kentron Nork Marash and Shengavit, the Funeral Service of Yerevan, and the Civil Status Registry Department in the Ministry of Justice. The ASTP subcontractor, the Yerevan Institute for Computer Research and Development, installed the computer and network equipment provided by the ASTP project in all the pilot locations, trained staff and provided technical support.

ASTP provided all computer equipment necessary to complete the installation of the Official Status Identification and Registration Information System (OSIRIS) for Civil Status Registry reporting at the five pilot sites. OSIRIS was developed for Civil Status Registration Offices and Archives in the Ministry of Justice by ASTP subcontractor YICRD with USAID funding. The initial system development work began in October 2001. OSIRIS provides an information network for delivery of civil status information throughout Civil Status districts, Central Archives and the Civil Status Registration Office. The Ministry of Justice has not rolled out the system nationwide.

**Renovated State Archives of the Civil Status Central Archives officially reopened.** The renovated State Archives of the Civil Status Central Archives were officially reopened on March 9th. The opening was attended by Davit Harutyunyan, Minister of Justice of Armenia, and Keith Simmons, USAID Director. With USAID funding, ASTP has supported the preparation of five pilot sites, the fifth and last being the Republican Archives, as well as the development and installation of a new information system in these sites.

## 8.4. SUMMARY OF ASTP TRAINING ACTIVITIES

ASTP provided 904 days of participant training in a wide variety of skills (see table below and Attachment H to this report for a complete list). This broad and intensive training program was implemented to ensure the sustainability of ASTP activities beyond the end of the project.

| Training Type | Training was delivered in the following topics/themes/spheres | People trained | Organizations whose staff were trained | Participant Days |
|---|---|---|---|---|
| **Computer skills** | Windows application, Microsoft package: Word, Excel, Access, Power Point, Network, Internet, E-mail, Advanced Excel, PROST, SPSS, Web Design, Corel Draw, Social Security Card database, HHIE sample survey database | 573 | Actuaries, MLSI, MOH, SSIF Headquarters, Nork, YSU, NSS, National Institute of Labor and Social research, Polyclinics #17, #1, #4, Erebuni Polyclinic, Local offices of RSSA, EA, SMEC, SSIF, NIH, Medical University, Medical College, NGOs | 374 |
| **Statistical** | HHIE survey interviewing, SPSS package, Statistical Methodology, Statistical data processing and analysis, survey methodology, HHIE sample survey database, Monitoring & Evaluation data collection | 673 | NSS, MLSI, MOH, YSU, Actuaries, Nork, SSIF Headquarters, Polyclinics #17, #1, #4 | 70 |
| **Public Relations & Public Education** | Public Relations skills, Public Education skills, TV interview techniques, Media Interview techniques, Talk-show techniques | 75 | MLSI, MOH, Nork, SSIF Headquarters, Polyclinic #17, NGOS, Vanadzor Mayor's Office | 20 |
| **Actuarial Science** | PROST and SPSS packages, Excel and Advanced Excel, Financial Mathematics, Mathematical Statistics, Macroeconomics, Actuarial Mathematics, Statistical methodology, HHIE sample survey database | 353 | Actuaries, MLSI, Nork, NSS, YSU, SSIF Headquarters, MOH, National Institute of Labor and Social Research | 69 |
| **NGOs** | NGO financing mechanisms, social partnership training, training of Social Partnership trainers, Social Partnership Proposal writing skills, Social Partnership capacity building training, basic computer skills | 278 | NGOs, NGO Centre, MLSI, MOH, Vanadzor Municipality, Lori Marzpetaran, RSSAs, World Learning, National Institute of Labor and Social Research | 72 |
| **Social Assistance** | How to conduct home visits, presentation skills, TOT in Training methodology and customer service, management, leadership, conflict management, legal issues, reception skills in social legislation, customer service, social partnership and social assistance | 173 | MLSI, YSU, NGOs, RSSAs, EA, SAD, SMEC, SSIF, National Institute of Labor and Social Research, Nork | 98 |
| **Social Security Card** | SSC database use, training in SSC legal framework and technical application, adaptation of SSC numbers and rules, regulations, procedures for country-wide implementation, monitoring and on-site training in SSC system, study tour to Ireland and Ukraine on similar systems, creating and training the HOTLINE institution | 1,755 | RSSAs, EAs, SSIFs, Hotlines, MLSI, State Labor Inspectorate, Nork, NSS, STS, MOH, SSIF Headquarters, MOJ, OVIR, GoA, National Assembly, Government, Holy Echmiadzin, Media journalists, STSs, Banks staff, Customs staff, NGOS, employers | 201 |
| **Total** | | **3,880** | | **904** |

Other ASTP training activities not discussed in other chapters include the following:

ASTP sent three GOA officials to Moscow in October 2001, to participate in an international conference on invalid benefit reform.

**Child Care Training.** In December 2004 ASTP provided 4 days of training to orphanage directors and administrators (32 persons) to underpin the implementation of the new childcare standards. Trainers with extensive childcare experience conducted the training program covering protection of children's rights, orphanage entrance procedures and integration in the orphanage, care, education and upbringing, and relations between staff and the children. The program also covered maintaining contacts with family and relatives and developing individual life plans for each child.

> Capacity-building in Social Protection
>
> The Minister of Social Security, Razmik Martirossyan, in a TV interview in 2003 said, "Trained, knowledgeable and helpful staff are a critical factor in ensuring that Armenia develops a modern, sustainable social protection system and thanks to the training initiatives supported by ASTP we are well on the road towards this goal".

**Disability Seminar in Hrazdan.** On December 3, 2004, a Disability Seminar was held in Hrazdan. The seminar covered services, legislation and discrimination against disabled persons. The seminar was attended by representatives from MLSI, the City of Hrazdan, the Marzpet and the Director of the Disability School at Hrazdan. Local doctors and persons with disabilities also attended. The Director of the National Institute for Labor and Social Studies, presented aspects of the new Training Manual for Social Workers dealing with the elderly and the disabled. The Training Manual was developed by the National Institute for Labor and Social Studies and printed with financial assistance from ASTP.

**"Access to Social Rights in the Caucasus" Conference.** On March 15, representatives from the Ministries of Social Security of Georgia, Armenia and Azerbaijan and NGO representatives from each country met in Tbilisi for a major conference, "Access to Social Rights in the Caucasus." The conference was organized by the Council of Europe. The ASTP Chief of Party attended at the request of the Council of Europe and with the approval of USAID. The conference focused on initiatives to improve access to social rights in Armenia and Azerbaijan. A program to encourage government and NGO collaboration was carried out in Armenia and Azerbaijan. This program, "Breaking the Barriers", jointly-performed by the Council of Europe and PADCO, Inc., is focused on pilot initiatives to improve access to social services for vulnerable groups, particularly refugees, persons with disabilities and families with young children. In Armenia the program centered on Vanadzor, while in Azerbaijan the program was focused on a large suburb of Baku.

With the MLSI, a program of training was developed to improve the knowledge and skills of the staff, materials were gathered to develop staff manuals and all of this was coupled with a comprehensive public education program to inform the public of their rights and responsibilities.

**Social Partnership**. ASTP supported a social partnership event at the Ministry of Labor and Social Issues which brought together international and local donors to work with the Ministry to provide vulnerable schoolchildren with backpacks and school supplies. This year, like the past two years, the Armenia Social Transition Program encouraged and supported the Ministry of Labor and Social Issues to lead international and local donors and NGOs in focusing on and addressing this important social need. USAID and ASTP representatives attended this year's gathering. MLSI pledged continued cooperation with international and local donor NGOs and will modify the "When September Comes" program according to the needs identified. The Ministry also plans to monitor the countrywide implementation of this program and conduct an evaluation survey which will help to improve the program. The Ministry also plans to gradually increase the involvement and strengthen the commitment of self-government bodies and local NGOs to social partnership initiatives.

## 8.5. Coordination with Other Donors and Leveraging Funds

ASTP collaborated with 11 multi-lateral donors, 6 bi-lateral international programs and 17 other USAID programs (see Attachment B to this report).

## 8.6. Public Education

ASTP supported the creation of public education units in MLSI, NSS, and MOH. Specific examples of ASTP's public education activities are contained in other chapters. A complete list of materials prepared in the social area is provided in Attachment D and in health in Attachment E.

Public education materials.

# ASTP FINAL REPORT: 9. CREATING A SYSTEM OF OPEN ENROLLMENT IN PRIMARY CARE FACILITIES

## 9.1. INTRODUCTION

The Law of Health Care Services for the Population of Armenia, adopted in 1996, provides a legal right to everyone to choose their health care provider. However, prior to the ASTP project, the entire population was served by Primary Health Care (PHC) physicians based on allocated catchment areas defined by residential addresses. The rationale for open enrollment is that it allows patients to choose PHC physicians based on their preferences and encourages PHC providers to improve their practice by delivering a better quality service and a wider scope of services to attract and register as many people as possible (within established limits) with them. The enforcement of patients' rights to choose their health care providers established by Law in 1996 was not sufficient to change the existing practices of service delivery. Institutional resistance remained – and ASTP has had to engage in a vigorous public education campaign to educate the population on the importance and benefits as well as persuading practitioner to accept the principle. Financing systems also needed to be changed. PHC providers were paid under a per-capita mechanism dependent on the population in the catchment area. Changing this system was necessary to provide financial incentives for providers to register more patients in order to earn more money (see Chapter 11 of the final report, below).

## 9.2. DESIGNING THE OPEN ENROLLMENT SYSTEM

Introducing the principle that people should be free to choose their primary care provider was directed towards increasing patients' satisfaction as a result of their own involvement in choosing their PHC physician. A nationwide Open Enrollment system contributes towards achieving several major benefits for the public, including:

- Enforcing the population's right to choose their physicians – creating the regulations, mechanisms, infrastructure, resources and procedures.
- Establishing a democratic and equitable system for patients. Choosing a physician should be a right exercised by all Armenians -- promoting greater social equity.
- Strengthening relations between physicians and the population, based on choice and trust rather than on compulsion.
- An open enrollment PHC provider system stimulates competition to attract clients for primary health care services -- an incentive for physicians to improve their performance.
- Choice encourages optimization of PHC services. Not all physicians will be able to attract enough patients to be financially viable. The minimum number of the population served by a PHC physician is determined by the RoA Ministry of Health on an annual basis. Those falling below this minimum will be forced to close or merge with more successful group practices.
- Open enrollment on the one hand promotes more active and better quality performance to keep those already enrolled with the PHC physician and on the other hand encourages the provider to enroll new patients. The more people enrolled the more the successful practitioner will be paid.
- The process of population enrollment with a PHC physician is paired with the formation of a population computer database. This includes pertinent characteristics of the population that are of primary importance as proxies for individual health status and risks. These databases allow providers to plan, organize and implement the delivery of preventive and protective public health measures.
- The automated population database provides continuously updated information to allow the effective allocation of PHC financing. Specific risk factors related to the health status of various population groups can be used to better target and differentiate PHC-level resource allocations. High risk groups more than others, need permanent health control, improvement and follow-up, and require more financial resources.
- The enrollment database may be used to create an information register on the population health status. This database information will be used in the identification and interpretation of health indicators, helping the MOH and SHA develop a more efficient allocation of overall health resources and interventions in Armenia.

## 9.3. ESTABLISHING THE LEGAL FOUNDATION FOR OPEN ENROLLMENT

In the GoA Decree No. 1533, adopted on 13th November, 2003, the Government required MOH to develop and test mechanisms for open population enrollment, nationwide, with PHC physicians. In the GoA Decree No. 624, adopted on 12th May 2005, the Government assigned the MOH the task of developing and submitting the population enrollment provisions for approval during the 3rd quarter of 2005. This task is already in progress – the Ministry of Finance and Economy as well as some Marzpets provided comments, and after comments have been received from the Ministry of Justice in September 2005 the document will be submitted to the Government for approval.

Several GoA Decrees and Marzpet resolutions listed below have created the legal basis for population enrollment pilot testing and for the current draft GoA decree on enrollment provisions.

- Lori Marzpet decree No 200A, 30 June, 2004 launched population open enrollment with therapevts, pediatricians and Family Physicians providing PHC/ambulatory polyclinic services in the city of Vanadzor.
- GoA Decree No 1045 issued on 15th July 2004 on family physician performance financing made enrollment performance of physicians the basis for allocating variable bonus funds to pilot facilities and their providers.
- GoA Decree No 624 issued on 12th May 2005 introducing amendments in the GoA Decree No 1533 created a new performance-based financing mechanism with population enrollment as one of the performance indicators.

## 9.4. IMPLEMENTING OPEN ENROLLMENT

The MOH and ASTP were responsible for developing and testing open enrollment mechanisms under Decree No. 1533. ASTP team members and MOH specialists developed a new registration form to gather data on PHC providers and on enrollees. The signed and approved form is now a legal basis for additional per-capita financing of PHC providers. The enrollment form includes basic demographic, social and health data on the enrollee as well as information on the PHC provider facility and the physician of choice. Before pilot implementation began, the enrollment form data set and the rules on how it was to be completed were thoroughly discussed with physicians and administrative staff in the three pilot polyclinics. For national implementation only minor changes in the form will be required.

Based on the original design of the pilot program the open enrollment process started in May 2003 in three urban polyclinics with catchment area populations as follows:

| | |
|---|---|
| Erebouni Medical Center Polyclinic | 32,070 |
| Yerevan Municipality polyclinic #17 | 42,379 |
| Vanadzor polyclinic #4 | 20,098 |
| Total | 94,547 |

According to the GoA decree, all pilot activities involving open enrollment were only required to be replicated in an approved fourth pilot site however the process was successfully expanded over a period of 25 months to 13 pilot sites.

1. The first stage began with three urban pilots.
2. The second stage involved three additional polyclinics serving 68,279 people in the same administrative district of Yerevan City where two of the original pilot sites were located.
3. The third stage expanded piloting to three rural sites – ambulatories providing PHC services to a rural population of 13,258.
4. The fourth stage of open enrollment involved the remaining 4 polyclinics in Vanadzor city, adding 100,394 residents of Vanadzor.

During the four pilot stages more than 215,905 of the possible 276,478 in the catchment areas (78.1%) used their right to choose and registered with the PHC physicians of their choice. The process covered about 9.2% of the total population of Armenia. To test the capacity of pilot facilities to manage the enrollment process all pilots were recommended to start by enrolling only those who visited health facilities. After 2-3 weeks physicians started to enroll patients when visiting them at home. Then nurses worked together with PHC doctors and started actively visiting community members. The same approach is recommended for national

implementation. Human and resource capacities in facilities will limit how many enrollees they can process within a given time period. Implementation of open enrollment assumes three types of activities:

1. Voluntary selection of PHC physician by patients.
2. Official registration of the patient with the PHC physician.
3. Entering PHC physician selection and patient's registration data into the automated system.

A patient chooses his/her PHC physician and not the PHC facility. Each patient chooses his/her physician personally and voluntarily (except for children and persons with mental disabilities). Although enrollment is an open and voluntary action, nevertheless, some limitations should be applied during implementation especially at early stages. PHC facilities should provide written information on the professional biography and work experience of each PHC physician. Large scale information campaigns are vital to ensure informed choice by the population and informed response by the medical community on the details of the process and to ensure that procedures are carried out efficiently. Official registration with a chosen PHC physician is the legal basis for targeting health finance. Creating automated population enrollment data is a major innovation in the organization of PHC services. The automated enrollment system that confirms choice of a PHC physician is built as a three-level system.

The first level of database formation is at the health care facility as they collect paper forms -- patient enrollment data is entered into the database later. This stage ensures accuracy and protection of the data accumulated and allows for later entry into the automated database as the facility develops its own capacity. Cases of double enrollment with different physicians within the polyclinic are detected and eliminated as the data is entered into the computer. The database software system allows a search for double enrollments according to chosen criteria. The system also permits the transfer of data from one physician to another physician's list of enrollees.

The second level is when the Departments of Health and Social Security of Yerevan Municipality and all Marzpeterans accept automated data from individual facilities and compile it into a single, aggregated database. Regional health departments need IT capacity and staff who know how to process health and demographic statistical indices and perform appropriate data analysis. Such analyses are needed to plan for public health measures specific for the primary care system and to allocate funds effectively.

The third level – the introduction and operation of integrated data collected from each marz -- is the responsibility of the Ministry of Health through the State Health Agency (SHA) which allocates funds for services for State-guaranteed free health care. SHA maintains information on all the cases of treatment performed within the framework of State-guaranteed free hospital care and on all patient visits handled by narrow specialty services of the PHC system. The information system to manage health care services provided within the framework of State-guaranteed free health care will function effectively if SHA maintains comprehensive data on all levels of health care.

Detection of cases of double (or multiple) enrollment of the same patient and removal of redundant information from the database is one of the most important functions of the automated system. Redundancy must be checked in the automated systems of all the three levels. It can be performed by comparing patient data – the first letters of the name and surname, data of birth, passport number or alternatively the Social Security Card (SSC) number as more people receive their SSCs.

## 9.5. RESULTS

By the end of the ASTP project, population open enrollment had become a widespread pilot activity with the following achievements:

- **Number of enrolled population**: 215,905 of the possible 276,478 in the catchment areas (78.1%) people served by the pilot PHC health facilities were enrolled – or 9.2% of the population of Armenia.
- 13 PHC facilities implemented open enrollment over 25 months.
- About 450 physicians and nurses and 60 other professionals from the pilot health care facilities participated in the process.
- ASTP provided 56 computers and 17 printers and other IT equipment to build the automated database.

All methodologies, mechanisms, paper and electronic forms and procedures have been designed and tested for open enrollment implementation during the pilot process. Open enrollment seminars and discussion meetings were held involving top-level policy-makers and health facility representatives. The following policy and methodological documents on open enrollment or directly linked to the enrollment process were developed by ASTP and disseminated nationwide:

- Choosing and registering with a PHC physician – Conceptual approaches.
- Choosing and registering with a PHC physician – Implementation Manual.
- Preparation of PHC facilities for Population Outreach and Public Education.
- Conducting a comprehensive Open Enrollment Public Education Campaign.
- Primary Health Care Management Information System Development --Conceptual approaches.
- Setting up PHC Health Management Information Automated Systems and Improved Use of Data – a practical guidebook.
- Defining the Functional Requirements Specification for Enrollment and Encounter Database
- Defining the Technical Requirements and Specifications for Enrollment and Encounter Database (System).
- Enrollment and Encounter Database User Manual.
- Developing a Training Plan for Enrollment and Encounter Database User.
- PHC Provider Remuneration: Strategies and Practical Approach for Performance-Based Payment.

New financial mechanisms for PHC service performance and new reimbursement methodologies were developed and tested during 16 months of the pilot process based on population enrollment data. All 13 pilot facilities and all pilot staff received supplemental incentive payments based on performance results (see Chapter 11 below). In this process one performance measure was the number of enrollees. As a result an enrollment data base was created that serves as the basis for new financing and incentive systems and for the development and establishment of service quality indicators.

## 9.6. FUTURE DIRECTIONS AND RECOMMENDATIONS

Mechanisms, methodologies, policies and procedures developed and tested during ASTP's pilot period have created the necessary background for future nationwide implementation.

The measures below are the necessary steps for open enrollment system implementation.

### *9.6.1. Resource and Activity Planning*

In order to assist the GOA in resource planning for the nationwide implementation of Open Enrollment in the new primary care system, ASTP has made the following provisional calculations (see Table 8.2)..

*Table 9.2: Resources Needed for Group Practice to Implement Open Enrollment*

| The size of population served by polyclinics | | 35,000 | 35,000 | 15,000 | 25,000 |
|---|---|---|---|---|---|
| Main expenditure categories | | Price | | | |
| Equipment including: | CPIV computer including software (MS Windows, MS Office) | 800 | x2=1600 | 800 | 800 |
| | Display | 200 | x2=400 | 200 | 200 |
| | UPS | 50 | 50 | 50 | 50 |
| | Printer | 200 | 200 | 200 | 200 |
| | CD writer | 100 | 100 | 100 | 100 |
| Total for computer equipment | | 1350 | 2350 | 1350 | 1350 |
| IT maintenance/per year | | 200 | 200 | 200 | 200 |
| Additional operator reimbursement – 2 operators in large PCs and one in small PCs in a year | | 250 | 250 | 125 | 125 |
| Information materials | | 100 | 100 | 50 | 50 |

| | | | | |
|---|---|---|---|---|
| Office supplies | 250 | 250 | 150 | 150 |
| Enrollment forms N citizens x 5 drams | 350 | 350 | 150 | 250 |
| National and Marz level substructures | 50 | 50 | 50 | 50 |
| Total in Armenian Drams | 1,275,000 | 1,775,000 | 1,037,500 | 1,087,500 |
| Total in USD | 2,550 | 3,550 | 2,075 | 2,175 |
| Investments made per citizen in drams | 36,4 | 50,7 | 69,2 | 43,5 |

### *9.6.2. Preparation for Scaling Up*

- A legal basis for process implementation needs to be approved to establish the rules of registration and electronic database operation. The draft GoA decree has been developed with ASTP support and circulated through the MOH, MoF&E. Marzpetarans and other interested health institutions. After inclusion of MoJ comments, it is to be submitted to the GoA in September 2005.
- Comprehensive public education activities should be used to inform the public and medical community about the enrollment process objectives, rules, and procedures. Begin public education activities two-three months prior to the beginning of enrollment.
- The necessary human and resource capacity should be established at each PHC service provider facility and at managerial bodies at all levels.
- Personnel coordinating enrollment in facilities, in marzpetarans, and in the MOH should be trained on all methodologies and techniques of enrollment processes and procedures.

Implementation conditions and actions should be defined and approved by GoA decree by the end of 2005. Implementation should be carefully monitored. The monitoring and feedback systems should keep the process manageable and within established rules and conditions.

# ASTP FINAL REPORT: 10. INTRODUCING FAMILY MEDICINE

## 10.1. OVERVIEW

In the mid 1990s, Armenia introduced health care reforms focused on strengthening Primary Health Care (PHC). Under the reforms, Armenia adopted the principles of family medicine (FM) as an internationally recognized way to enhance the nation's primary health care. But the introduction of Family Medicine required that other structural and functional changes take place at the same time as vocational and continuing education of family physicians and nurses. Otherwise, the retrained practitioners would return after training to unchanged facilities to work under the old systems of regulation, management, and financing. The newly qualified family physicians would risk losing their skills and motivation. Urban polyclinics required reorganization of their regulations, management practices, financing, clinical and patient flow practices, enrollment processes, and needed new information systems to support the practice of family medicine. Fewer changes were needed in the simpler rural ambulatories.

## 10.2. DESIGNING THE FAMILY MEDICINE PROGRAM

The introduction of Family Medicine (FM) required enormous changes in the way physicians are educated and trained as well as a nationwide program to retain existing practitioners. It also required changes in the way primary care is managed, financed and regulated. ASTP was able to build on the progress that had already been made in developing FM. It focused on developing systems for preparing the family medicine workforce and on developing new approaches to workforce planning.

During the first year of the project, ASTP conducted an assessment of existing FM training and education in Armenia[13]. It analyzed the FM retraining and residencies taking place in the National Institute of Health and the State MU, and family nurses training in Basic Medical College and NIH. It evaluated training capacities, analyzed the content and structure of two different curricula for family physicians, revealed weaknesses and areas for improvement. The report made clear that the existing FM and FN training does not provide trainees with relevant opportunities for clinical experience. The FM program should embody dedicated clinical teaching facilities where patient volume and continuity of care will allow the value of FM to be recognized. The ASTP suggested estimating how many FM practices (including family nurse practitioners) would be needed within the next ten years to meet the health care needs of the Armenia people, and assessing the training requirements - clinical, psychosocial, and administrative - of family practitioners, developing FM (Training Of Trainers) TOTs, establishing a National Family Medicine Training Center (NFMTC) and some other options to support the introduction of FM. It was agreed with the MOH that ASTP would coordinate its efforts with WB to support Yerevan P17 to become a NFMTC. An initial draft paper on establishing such a center was devised by ASTP. Later in the project, a more comprehensive and broader package of standard requirements for all clinical training sites was prepared by ASTP and accepted both by MOH and the main training institutes – NIH and SMU.

During its first two years, ASTP activities were mostly focused on supporting the FM training in its current state while introducing innovative training approaches and formulating recommendations to the MOH and other counterparts on improving PHC performance. ASTP prepared training materials, procured up-to-date medical and evidence-based literature and disseminated MOH-WB-developed clinical practice guidelines, and organized continuing medical education short courses for improving patient management skills of PHC physicians. American family physicians provided worksite-based training in patient physical exams, evaluation and management. ASTP contracted Armenian Association of Pediatrics (ArAsPed) to deliver a training course on Well Child Care and Evaluation of the Problems Revealed by Health Checks. The 126 hour course was conducted in May 2002. The course was repeated for the new generations of physicians and nurses working in the ASTP pilot sites.

## 10.3. CREATING THE LEGAL FRAMEWORK FOR HEALTH CARE REFORM

Implementing a new approach to the delivery of primary care required laying a new legislative foundation. ASTP collaborated with MOH to draft several major legislative initiatives.

[13] See ASTP report #30 "FM Training and Education in Armenia and Recommendations for Improvement", May 2001.

### *10.3.1. Draft Law Health Care*

The ASTP legal consultant led a working group of experts formed by MOH to prepare the new draft Law on Health, addressing issues including the responsibilities of the government, MOH, local government and local self government bodies. The law addressed health financing, licensing, education, rights and responsibilities of health facilities, health professionals and patients, and many other issues. ASTP analyzed best international experiences and adapted them for Armenia. To ensure the draft was consistent with existing legislation, ASTP reviewed the entire legislative framework relating to health care. TheLaw on Sanitary Epidemiological Safety of Population, Law on Drugs, Law on Local Self Government, Law on Budgetary System, Law on Education, Law on Licensing, Law on Science and Scientific Activities, Law on Legal Acts, Personal Data Protection Law, and related legislation was reviewed.

During the development of the draft, ASTP experts met with representatives of health care system, civil society and international organizations (WHO, WB, Oxfam, World Vision, etc). ASTP experts also participated in numerous discussions on the draft Law on Health with representatives of the ministries of Justice, Finance and Economy, Trade and Economic Development, Labor and Social Issues, Education, the Standing Committee on Social and Health Issues of the National Assembly and the Office of the President. ASTP prepared several policy notes explaining the reasons for particular changes and prepared a set of accompanying documents required by law for submission of the draft law to the National Assembly. The draft Law on Health was approved by the government and submitted to the National Assembly.

### *10.3.2. Support for formation of legally independent primary health care group practices*

ASTP provided recommendations for creating autonomous primary health care group practices outlining the existing legislative framework for forming and operating independent practices. The report presented options for the legal structure that private independent practices could adopt, explaining the advantages and disadvantages of each option in term of founders' liability, management of organization, taxation, staffing, etc. ASTP also analyzed the procedures for creating legally independent primary care practices with detailed instructions on how to establish a legal entity and manage its activities. The report contained model documents necessary for establishing and operating legally independent PHC practices. These model documents include agreement to establish a legal entity, sample charter of an organization, contract for provision of health services under state health programs, employment contract, contract of lease, and other.forms.

ASTP organized workshops and seminars for health care providers to build their capacity on legal issues related to the creation of legally independent practices. In 2002 ASTP organized a workshop with the participation of MOH, SHA, Yerevan municipality, professional associations and health care providers. In 2005 seminars were organized for representatives of health care providers of Yerevan and Lori marz.

### *10.3.3. Creating the Legal Foundation for Family Medicine Pilot Projects*

ASTP assisted the MOH in creation of a legal foundation for implementation of pilot projects in Yerevan and Lori Marz. ASTP experts prepared a draft governmental decree on approving the experimental program for introducing new methods of organizing and financing primary health care. ASTP participated in monitoring the legal and regulatory environment of day-to-day operations of the pilot PHC facilities and developing the management capacity of staff.

### *10.3.4. Status of State Health Agency and Contractual Issues*

ASTP analyzed the legal status of the State Health Agency and provided recommendations for improving the legislative and regulatory framework defining its status and responsibilities. SHA was established pursuant to a governmental decree and subordinated to the Government, while under the Constitution the Government lacks the authority to establish such entities. Establishment of SHA should have been envisaged by a law adopted by the National Assembly – only in this case the Government by its decree could provide particulars of its structure and activities. ASTP recommended that the role and status of SHA would be legislatively defined. Later, in 2002, following a presidential directive SHA was subordinated to the MOH. ASTP reviewed the model contract that SHA used in financing health care facilities under state health programs. Several recommendations were proposed to improve SHA's contractual mechanisms.

### *10.3.5. Patients' personal data protection*

ASTP provided recommendations to the MOH and health care facilities on ways to protect the personal data of patients in health care facilities, which included operational and organizational measures necessary for adequate protection of patients' personal date from accidental loss or destruction, and prevention of unauthorized access to medical records. The recommendations were based on the Law on Personal Data and internationally accepted standards of patients' data protection and were accepted and implemented.

## 10.4. CLINICAL TRAINING FOR PHYSICIANS

Developing FM training programs was an extremely challenging task in a system that historically emphasized narrow medical specialization over PHC doctors and nurses. There were more than 90 medical specialties. In 1997, as part of the MOH program to introduce FM, two FM Chairs were added to a medical education system already saturated with specialized physicians. The existing medical education system also emphasized basic sciences, academic research, and theoretical knowledge rather than practical experience with patient management. Cost-effective approaches to patient management were neither understood nor taught. Several major problems were identified through evaluations of training programs, training processes, and monitoring and assessment.

1. The FM training consisted of hospital rotations through narrow specialty chairs unfamiliar with FM content and practice needs. Specialist FM faculty members who instruct FM residents and trainees know their specialties well but have little knowledge – some even have misconceptions – about the goals and scope of family medicine practice. Trainees did not receive training in the subspecialty component appropriate for FM. There was no defined set of skills for trainers to teach or trainees to learn. Narrow specialty chairs taught the same content to FM trainees that they taught their narrow specialty trainees.
2. The clinical training was itself limited. Some program faculties used teaching methods that are outdated. Didactic teaching is emphasized while hands-on clinic-based teaching is infrequent. In the national clinical chair rotations, FM trainees rarely got opportunities to examine or manage patients. Experience making patient management decisions under appropriate supervision was rare.
3. In multiple-choice testing on an international Family Medicine qualification exam (selected questions from a pretest for the American Board of Family Medicine) and in their own self-assessments, FM graduates rated poorly.[14]

Meanwhile, the new discipline required a unified set of specialty requirements, and remodeling and restructuring of the training process so that family physicians (FP) would be able to provide safe, broad-based, cost-effective, evidence-based care and possess relevant practice management and planning skills.

Skilled nursing professionals are a vital link to patient care and an essential component of any health system. In Armenia, as in other countries in the former Soviet Union, the nursing profession had become increasingly neglected over time. Since independence in Armenia, nursing has undergone a further crisis due to a lack of professional standards for nurses, an inability of nurses to engage in clinical or administrative decision-making processes and a lack of adequate nurse training programs.

In response, along with other health system reforms, the Government of Armenia (GoA) designed and introduced changes in the nursing field beginning in 1997. Armenia began to improve its nursing education system. A three-year course with a revised and expanded curriculum replaced the former 2-year curriculum used in Armenia's medical colleges. The scope and functions of the PHC/Family Nurse (FN) in Armenia were initially formulated by the PHC strategy approved in 1997 and by the Statement of the Family Nurse issued in 2001 that gave a new definition to the scope of qualification and activities of the Family Nurse. Nevertheless, nurses did not see themselves as patient advocates, patient educators, critical thinkers, or decision-makers, and functioned largely as low-level aides to physicians.

[14] ASTP research- Armenian FM Graduates and other primary health care physicians took a modified version of the American Board of Family Practice pre-test quiz and scored on average in 30th percentile compared to average test results of 80% in America.

### *10.4.1. Creating Unified Family Medicine Curriculum*

In 2002, the MOH requested that USAID and ASTP cease ongoing medical training and provide support in developing a unified curriculum for Family Medicine training programs. Initially, the MOH requested a traditional theoretical curriculum that specifically defined the content of all lectures.

The ASTP was able to coordinate the work of the two leading medical education institutions providing FM retraining and residency through a contract with the Armenian Association of Family Physicians (AAFP) -- an NGO, the FM Chair at NIH, and SMU. This cooperation strengthened the capacity of the AAFP as a professional association advocating on behalf of Armenia's family physicians. The Unified FM Curriculum was reviewed and approved by the MOH in July 2002 and assigned to NIH and SMU for implementation.

The curriculum is notably different from the traditional curriculum and reflects the philosophy, essence and requirements of Family Medicine. Most modules are designed based on the health needs of human beings of different ages and gender. For example, the modules on Men's Health and Women's Health define the competencies needed – attitudes, values, and skills (such as counseling) – to manage health concerns effectively specific to those particular groups. Other groupings of competencies by age, such as Health of Infants and Children, Adolescents' Health, Care of the Elderly and End-of-life Care, are new in the Armenian academic context.

Additionally, rather than define each specific lecture, the UFMC writes learning outcomes for FM training based upon the services family physicians are legally allowed to provide and that are medically needed in Armenia. This structure allows for greater flexibility, evolution and innovation in specific training but clearly defines the knowledge, skills and attitudes that the training should develop.

All in all, the UFMC provides common learning objectives for residency training in FM, national retraining[15] and continuing education[16] for family physicians.

### *10.4.2. The UFMC-based Training and Assessment*

In the course of 18 months, 15 physicians underwent family medicine modular training at NIH chairs interspaced with worksite-based clinical training. Local clinicians (about 25 narrow specialists and family physicians called CPSs) were competitively chosen both in Yerevan and Vanadzor and trained to become trainers to precept and guide physicians' hands-on training. These were the first steps towards establishing more practice-oriented and applied training in Armenia. Worksite-based training lasted 11 months spread over a total of 18 months. Trainees were coached by CPSs to safely practice newly learned or acquired skills on CPSs' or their own patients.

### *10.4.3. Results of Clinical Training Intervention and Recommendations*

The ASTP supported and monitored UFMC-based training of 15 physicians from its pilot sites. They successfully completed the 18-month training and returned to their organizationally, managerially and financially changed work sites to practice family medicine in the environment favorable for the new model of care.

While still at the pilot implementation stage, the new approaches in preparation of family physicians proved effective. They allow for training of large numbers of trainees utilizing not only central but also peripheral facilities and human resources. Also, they strengthen clinical component of training and do not interfere with trainees' professional and personal lives.

The same approach was adopted by the MOH and educational institutions – NIH and SMU. The nationwide training of PHC physicians into family medicine was organized on the same principle, i.e. intensive rotations at official clinical chairs are interspaced with worksite-based training under the safe supervision of CPSs. For economic reasons and to fit into the WB-supported credit program lifetime the span of the course was later reduced from 18 months (7+11) to 12 (8+4).

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[15] The ASTP has developed documents Family Medicine Training Concept and FM Training Master Plan the former recommending new approaches to family physicians' preparation and the latter presenting concrete recommendations based on the pilot UFMC-training experience.

[16] The ASTP has developed a document Recommendations for Continuing Professional Development of Family Physicians and Credit System for Armenia. It was approved by the NIH – the main institution responsible for CPD of nurses and physicians in Armenia

ASTP has developed packages of recommendations for MOH and training institutions, relating to safely multiplying training centers and clinical sites preserving quality standards, to effectively utilizing the best cadre in the regions, to flexibly organizing physicians and nurses continuing professional development. NIH, SMU and MOH responded positively to the proposed standards for Training Centers although they consider that achieving those standards will require considerable time and resources. As described in the training concept paper, decentralization of FM training and developing local capacities will motivate and help to gradually develop the continuing education of other specialties outside the capital city.

## 10.5. Expanding the Role of Nurses

Over the course of the pilot program, ASTP worked intensively with 80 nurses in the pilot polyclinics. Like physicians, PHC nurses lacked opportunities for continuing professional development. Nurses were under-trained and underutilized. In the new model for health care nurses play a larger role as specialists. Emphasis was placed on their understanding of individual patients, ethical and attitudinal issues, health education of patients and their families, disease prevention, working in tandem with physicians and organizing medical care and rehabilitation, etc. As a result of piloting efforts, nurses significantly expanded their scope of practice, improved their performance, and demonstrated their functional and financial value to primary health care. Nurses helped implement and institutionalize most aspects of the reform process, supporting population rostering and enrollment. This encouraged district nurses to visit patients in their homes more frequently and actively, bringing with them information and materials about choosing a physician and seeking appropriate primary health care.

### *10.5.1. Continuing Education and Improved Performance*

Involving nurses was important in continuing quality improvement activities, particularly in infection control. A ten-hour training course was delivered on infection control and medical waste management, improving the nurse's knowledge from an average pre-test score of 51.4 percent to an average post-test score of 85.2 percent and improving performance from a pre-training average assessment rate of 1.7 to an post-training average assessment rate of 2.3 (scores range between 1 and 3).

Protocols were developed for nurse management of patients with hypertension and diabetes and nurses were trained in use of that material. As a result nurses contributed to enhanced adherence to clinical practice guidelines, improved patient safety, improved documentation and organization of medical information and charts.

The distribution of USAID-donated equipment and supplies, the implementation of the health information system, and the creation of a related database also improved the quality of nurse activities and expanded the scope of their practice.

ASTP viewed continuing education as very important for improving nurses' performance. Seventy-five (75) hours training seminars on Family Nursing topics were conducted for more than 80 nurses. Topics included taking vital signs, nursing process in PHC sensitive conditions, and helping patients deal with pain and death. After these seminars, nurses began to communicate with other staff members, each other, and patients more effectively and this stimulated their professional growth and conduct.

ASTP created libraries in pilot sites with manuals and teaching guides on nursing in Armenian and Russian, as well as clinical guidelines for nurses -- including guidelines for Family Nurses developed by NIH and BMC FN chairs with World Bank HPIU support.

### *10.5.2. Nurses in Public Education and Patient Education*

Nurses informed the population about health reform, particularly on their right to choose the PHC physician they prefer and on the process of open enrollment, distributing brochures and leaflets on health care reform, open enrollment, Family Medicine and general practice, and the services provided free by the state. They also distributed brochures on health education materials on hypertension, nutrition, diabetes and other topics.

### *10.5.3. New Job Descriptions for Nurses*

ASTP helped develop job descriptions that better defined job duties and supported the implementation of more flexible, responsive and consensus-based management, adequate and supportive supervision, and attitudinal changes on the part of physicians and facility management. These measures allowed nurses to take a more active role in their primary health care team, to better weigh options and make decisions. These activities were reflected in the Toolkit for Strengthening and Expanding the Role of PHC Nurses developed

by ASTP to be used in PHCs in Armenia. The Toolkit includes in five sections: 1) Example of an expanded role for PHC nurses from pilot PCs; 2) Recommendations for PHC facility managers to support introduction of Family Nursing (FN); 3) Knowledge and competency assessment tools; 4) Training materials; and 5) Job descriptions.

The ASTP staff worked with MOH PHC department as well as with BMC and NIH FN faculty to design a recommendation package for strengthening and expanding PHC nurses role in Armenia. The document includes recommendations for different levels: for MOH, training institutions, donor organizations and PHC managers.

## 10.6. MANAGEMENT TRAINING

Introducing the New Model of Care meant strengthening management in the PHC facilities and improved management of FM departments for effective work and organization of PHC services. The new model of care requires a new approach to decision-making and operations as PHC facilities carry out many innovations and undergo organizational changes. The implementation of the structural components of the new model of care, paired with new organizational arrangements in their turn required new knowledge and skills as well as management adequately prepared to assume successful implementation.

In addition to clinical training, basic management and health management training building the capacity of the PHC facility to deliver high quality, efficient PHC services was provided. A wide spectrum of training was developed and conducted during 2003 and 2004 for ASTP first and second generation pilot sites. Training included basic management concepts, business planning and management, legislation and regulations, human resource management, marketing of health care services, and health financing and financial management.

Management training delivered as stand-alone courses for FM department heads, facility managers and administrators is based on the UFMC modules taught to PHC physicians: PHC Organization and Management, Care Management.

More then 2,150 hours/person training and seminars on improving managerial skills were conducted for polyclinic directors and head doctors, FM department heads and family doctors of polyclinics of Erebouni district of Yerevan and Vanadzor including rural Health Centers in villages Vahagni, Dsegh and Tumanyan.

The training and seminar topics, the level of study and timing of training activities were proposed based on pre-training evaluation of future participants.

## 10.7. PUBLIC EDUCATION

A vital element in introducing Family Medicine was to involve the public. This required not only notifying the public about the new, choice driven Family Medicine system but also informing the public about health issues. ASTP was deeply involved in many different types of public education – listed in the table below:

**Public Education Health Materials**

| Posters | Quantity | Comments |
|---|---|---|
| Choose your Physician (1) | 200 | Posted in all pilots and public places of Vanadzor community |
| Choose your Physician (2) | 500 | Posted in all pilots and public places of Vanadzor community |
| BBP poster for year 2004 | 600 | Placed in every health facility in the country |
| BBP poster for year 2005 | 600 | Placed in every health facility in the country |
| BBP poster for year 2005 - appendix | 600 | Placed in every health facility in the country |
| **Leaflets** | | |
| Hypertension | 10,000 | Distributed to the patients of first generation pilot sites through PHC physicians |
| Diabetes Mellitus | 10,000 | Distributed to the patients of first generation pilot sites through PHC physicians |
| Smoking secession | 10,000 | Distributed to the patients of first generation pilot sites and to second generation pilot sites through PHC physicians |
| Breast self-exam techniques | 22,000 | Distributed to the patients of first generation pilot sites |

| Posters | Quantity | Comments |
|---|---|---|
| | | through PHC physicians |
| Healthy nutrition | 10,000 | Distributed to the patients of first generation pilot sites through PHC physicians |
| "Choose Your Primary Health Care Physician" | 16,000 | Distributed to the patients of all pilot sites; provided to journalists |
| New PHC Model | 1,000 | Distributed to the attendees of the May 17-19 New PHC Model of Care Dissemination Conference and journalists |
| **Brochures** | | |
| Family Doctor tells | 250 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| European Charter of Family Medicine/General Practice | 250 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| Family Nurse Provisions | 250 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| Family Doctor Provisions | 250 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| Basic Benefits Package for year 2003 | 2000 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| Information color brochures on Vanadzor and Yerevan polyclinics | 5,100 | This booklet is used by PC PHC physicians and nurses to market themselves and their services, and motivate enrollment and increase utilization. PC personnel who make home visits show the booklets to the population – helping the latter make informed choices of their physicians. |
| **Other Media Activities** | | |
| **Choose Your Physician stands in pilot sites** | 13 | These were erected in each first generation and second generation pilot sites |
| **Films** (produced and broadcasted) | 7 | 5 films on Vanadzor polyclinics were prepared and aired by local Lori TV twice (within "Healthy Society" series);<br>2 other films were prepared by Yerevan TV (about Yerevan PC 17) and Shoghakat TV on the New PHC Model. |
| **Radio PSAs** (produced and broadcasted) | 6 types | Broadcasted for three months in Vanadzor (Interkap radio and Vanadzor branch of Armenia Public Radio) and for one month through two Yerevan FM channels. |
| **Radio programs on healthy lifestyles** (produced and broadcasted) | 9 topics | Broadcasted in Vanadzor (Interkap radio and Vanadzor branch of Public Radio of Armenia) and through two Yerevan FM channels (twice). |
| **Call-in TV programs on Lori TV** (produced and broadcasted) | 2 | In "Healthy Society" TV series in Vanadzor |
| **Talk shows** (produced and broadcasted) | 6 | 5 talk shows on Lori TV (within "Healthy Society" series) |
| **Newspaper inserts** | 2 newspapers | "Lori marz" and "Vanadzoryan Khchankar" newspapers published an insert "Choose a Physician for Your Family" and the health education material "Hypertension". |
| **PSA on newspaper** | 2 newspapers | "Lori Marz" and "Vanadzoryan Khchankar" newspapers published announcements on the process of open enrollment in Vanadzor. |

## 10.8. THE RESULTS

Pilot results show a dramatic change in attitudes and approaches towards Family Medicine. It will take many years to complete nationwide implementation of the Family Medicine approach to delivering primary health care.:

- Almost 300,000 people have enrolled in the PHCs
- More than 500 health care workers, including 210 PHC physicians and 235 PHC nurses have been trained
- The rate at which primary care physicians refer patients to specialists has declined from 30% in 2002 to 16% today.

# ASTP FINAL REPORT: 11. INTRODUCING CONTINUOUS HEALTH CARE QUALITY IMPROVEMENT

## 11.1. INTRODUCTION

Creating incentives for continuous quality improvement (CQI) was an essential part of the ASTP health care program in Armenia. Setting up systems to encourage continuous quality improvement is a multi-dimensional activity that requires all the stakeholders in the health sector to change their behavior.

ASTP focused on two aspects of CQI: 1) *Facility level CQI activities* and 2) *System level support* for both Quality Assurance and Quality Improvement activities aimed at achieving and maintaining higher professional standards. A major part of the latter involved negotiations and discussions with key stakeholders on how transparent and professional licensing and accreditation systems would function.

Patients were the central focus for ASTP's quality improvement activities. Health education aims to change people's behavior and they are encouraged to exercise their legal rights, including the right to choose among providers and the right to lodge complaints or provide feedback through a formal processes that ensure providers response to patients' needs.

Physicians and PHC facility administrators were also encouraged to change their behavior as a result of peer review, selecting and identifying clinical indicators, and studying high risk events. CQI programs must be based on internal clinical protocols and algorithms, EBM guidelines, and strategies for reducing errors, assuring practice safety, and continuously improving medical care quality.

Professional organizations and associations were involved by creating clinical practice guidelines and protocols advocating and assuring higher professional performance in relevant clinical areas of PHC. Professional organizations also provided relevant trainings and continuous education for PHC providers. By these activities professional associations such as the Armenian Associations of Family Practitioners (AAFP) and the Armenian Association of Pediatrics (ArAsPed) built up their capacity. The Government was involved through using its regulatory and funding powers – primarily through the licensing system – to ensure that health professionals are properly qualified and that health facilities meet basic standards for public health and safety. During the piloting period, the government required PHC facilities to demonstrate the quality of healthcare services provided to receive performance-based financing.

## 11.2. DESIGNING THE CQI PROGRAM

### *11.2.1. Primary Health Care in Armenia in 2000*

Even with an extensive network of PHC providers covering the entire population, the clinical capabilities deteriorated over time and, indeed, the overall role of PHC providers in the health system shrunk because PHC providers were not accorded high priority and were subordinated to specialty care providers. The challenge of improving PHC providers' quality of care was to overcome this deeply ingrained discrimination. The public has little confidence in the primary care system, which lacks the resources or competence to deal with the majority of common diagnoses and treatments.

ASTP initiated a baseline assessment that confirmed that:

- Evidence based, cost-effective prevention interventions are not practiced. Few clinical practice guidelines and patient education materials are available in Armenian. Most are not available at all.
- PHC practitioners have a very narrow scope of clinical practice with limited theoretical knowledge and practice skills.
- Patients are excessively referred to narrow specialists for services that typically and cost-effectively can be provided by PHC physicians, such as simple health checks or ear infections', mild orthopedic problems and common traumas.
- Patients can visit narrow specialists without referral. There is a weak feedback loop between primary care providers and narrow specialists, especially for adult patients.
- Patients self-refer to an ambulance or Emergency Room for urgent care, and there is no feedback to inform primary care doctor about the outcome of cases.

- Physicians' performance is not routinely monitored and problems are not addressed through peer review and personnel involvement.
- About 20 - 30% of patient records are missing. Records are not always kept securely. Medical record information flow is not controlled. Medical record card forms have no documentation standards, and are not designed for efficient access to critical information. Records frequently are incomplete, hard to read or missing. Some patients (especially those with chronic health problems) carry their own medical records and keep them at home.
- PHC premises are in poor repair, unheated, with minimal running water, lacking supplies and absent Western-standard procedures for preventing infection.
- Limited equipment maintenance and minimal exam room privacy.
- Poorly regulated patient flow in PHC premises.
- Excess staff and low workloads. Staffing is determined historically, not by workload.
- Poorly-managed information necessary to assure appropriate measures of clinical performance, revenues and expenditures.
- Patients are not queried regarding what services they value. The poor have little access to both inpatient and outpatient health services.
- Providers are not paid based on enrollment, so face no incentives to attract patients. Patients can seek other care at their own expense.
- Patients generally know about basic benefit package (BBP), but the document is not readily available to them.
- PHC facilities do not routinely survey patients regarding their satisfaction with services they received.

#### *11.2.2. ASTP Clinical Care Quality Program*

Quality Improvement is a multi-dimensional concept, based on scientific principles and a series of factual tests, but the term also carries value judgments and perspectives concerning good or bad quality health care. This lack of a consistent view explains the number of definitions of quality concepts as well as the different approaches. ASTP designed its CQI activity defining quality health care as:

- *Safe:* Avoids injuries to patients from the care that is intended to help them.
- *Effective:* Provides services based on scientific knowledge to all who could benefit and refrains from providing services to those who likely could not benefit..
- *Patient-centered:* Provides care that is respectful and responsive to individual patient preferences, needs, and values.

### 11.3. BUILDING THE LEGAL FOUNDATION FOR CQI

ASTP actively collaborated with the Ministry of Health, Lori Marzpetaran and Yerevan Municipality Health and Social Affairs Departments, National Institute of Health, State Medical University, Basic Nurse College, and professional NGO's to develop the concepts, the mechanisms and the principles of PHC Continuous Quality Improvement activities.

In early 2003 ASTP began strengthening the understanding of CQI among counterparts and developing pilot sites to strengthen primary health care and family medicine services within PHC facilities based on the Primary Health Care Strategy of the Republic of Armenia that required primary health care to become more efficient, more accessible, of higher quality, and with a greater emphasis on patient-centered care.

To support the reforms, ASTP, in collaboration with its counterparts, developed a range of policy papers, Governmental decrees, and other regulatory documents – listed in full in Attachment F to this report. The new model of care recommends the introduction of facility-level and practitioner-level processes to continuously monitor and improve quality. The main foci of the CQI activities are increasing the role and utilization of PHC services, expanding the scope of practice of primary care practitioners, and achieving PHC practice consistency with internationally accepted standards of care.

## 11.4. IMPROVEMENTS IN CLINICAL CARE QUALITY MONITORING AND ASTP PILOT SITES

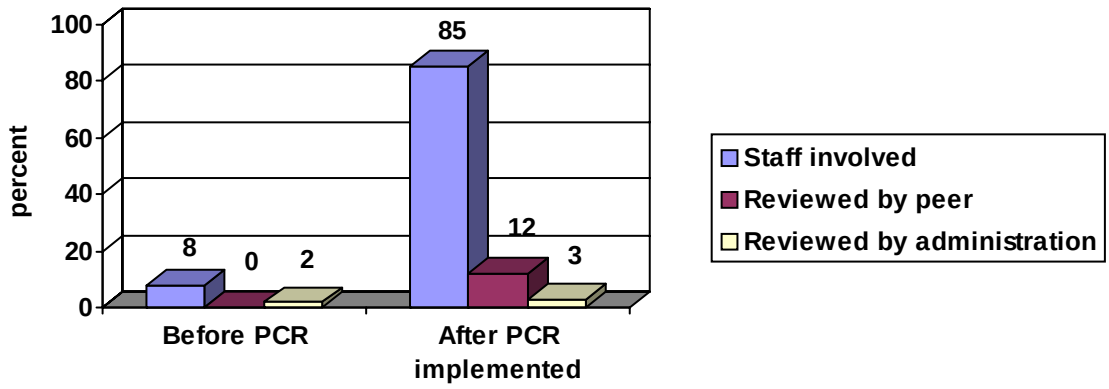
### *11.4.1. Clinical Care Quality Monitoring System*

ASTP's system for continuously monitoring and improving the quality of care follows the traditional CQI cycle of gathering evidence about performance, identifying performance gaps, choosing interventions to improve performance, and re- measuring and assessing performance.

Standards and baseline measurements were created to provide pre-intervention (baseline) data against which to measure compliance to standards or changes in quality. Evidence-based medicine and clinical care internal protocols served as reference points against which performance, compliance, and quality was measured. The following were the tools for clinical care quality monitoring and assessment:

- **Patient encounter system** – computerized database tracking each particular case and encounter of PHC services utilization both for office and home visits. The system makes it possible to receive and analyze information, such as the purpose of the encounter, main medical procedures and treatments provided, the referrals to narrow specialists and auxiliary services, the type of health problem or disease and the outcome of the health problem.
- **Peer chart review (PCR) data** – A non-punitive CQI approach helps providers work together to develop patient safety systems and processes to review against international evidence and best practice and to improve against previous clinical practice and health outcomes. In all ASTP pilot sites, systematic peer review of medical records functions as a type of both medical practice monitoring/audit and continuous cross training among PHC practitioners.
- **Patient satisfaction surveys** – Success in CQI requires a willingness to respond to patient needs and concerns. ASTP helped urban polyclinics to assess patients' needs as well as their satisfaction with PHC services semiannually. The assessed results were regularly shared with the polyclinic administration and health care practitioners.
- **Focused Studies** – Specifically designed investigations and studies conducted to address issues such as the theoretical knowledge possessed by PHC practitioners and the need for continuous medical education as well as problems with medical records and medical documentation flow in PHC facilities. Studies included also focus group and crosschecking information and conformity evidence gathering.

*Figure 11.1. Percent of staff involved and charts reviewed per month before and after PCR implementation in PC17*




### *11.4.2. Established and functioning Clinical Care Protocols and Algorithms outlining "best practice"*

Based on the findings from peer chart reviews, focused studies and pilot site baseline assessments, ASTP identified key clinical performance areas including early detection of PHC-sensitive conditions[17] in children

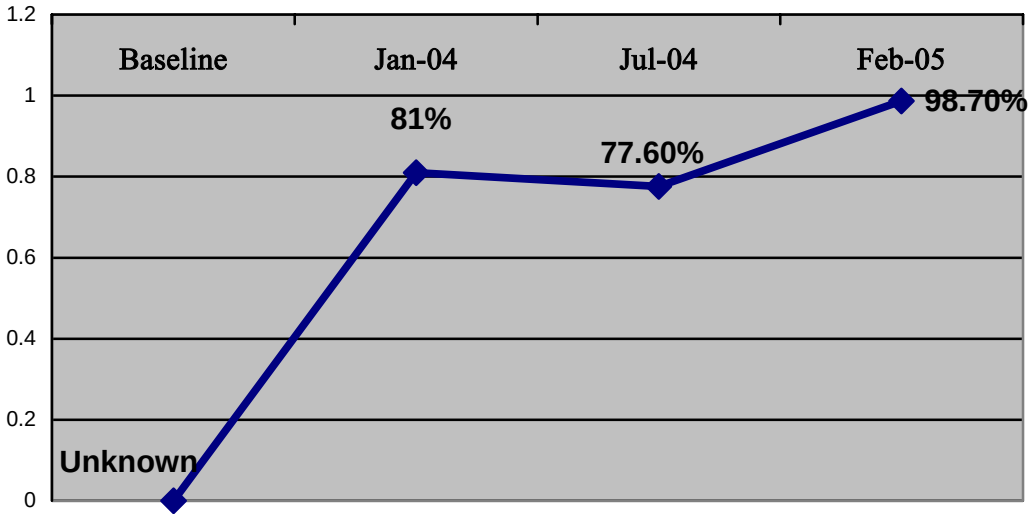
[17] Common diseases which have a significant impact on population life expectancy and quality and being effectively preventable and/or treatable at PHC level.

and adults, patient education, preventable diseases, and treatment of chronic conditions. Based on the evidence, working with MOH, ASTP classified the following as chronic conditions in Armenia:

A. Hypertension prevention and management
B. Acute upper respiratory infection (URI) management
C. Diabetes Mellitus prevention and management
D. Early detection of PHC sensitive adult diseases (breast cancer, cervical cancer, colorectal cancer, and hypertension)
E. Early detection of PHC sensitive pediatric diseases (growth problems, child developmental problems, hearing loss, eye diseases, anemia, cryptorchidismus, hip dislocation, hypertension)
F. Patient health education (especially counseling on smoking cessation, injury prevention, and nutrition)

ASTP helped pilot site PHC providers to develop and implement internal clinical care protocols for management of all clinical conditions and health problems mentioned above. ASTP developed and conducted about 175-hour continuous education courses for doctors and 75-hour continuous education courses for nurses. In collaboration with the Armenian Association of Pediatrics, ASTP also developed national program standards for Pediatric Primary Care and requirements for Well Child Care and implemented them in all pilot sites. MOH certified doctors and nurses for ASTP-organized courses of continuous education in Primary Care. In December 2004, three clinical protocols developed and tested by ASTP - hypertonic disease management, healthy patient management, and breast self exam - were adopted by the MOH for nationwide use.

*Figure 11.2. Use of EBM literature and Clinical Care Protocols*

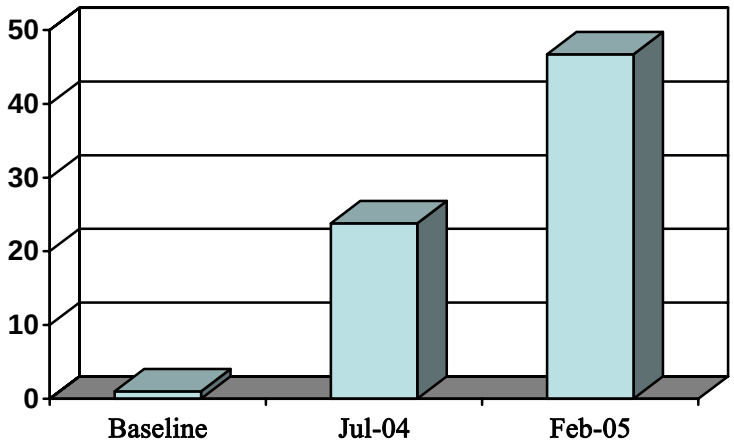



Note: baseline data for use of EBM literature in clinical practice was hard to assess because of the absence or very limited number of EBM guidelines or Clinical care protocols in the PHC facilities at the beginning of pilot activities

### *11.4.3. Improved diseases early diagnoses and prevention*

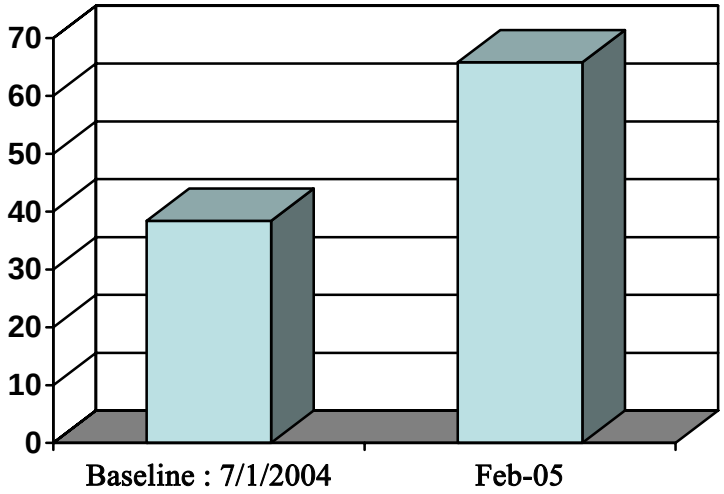
The quality improvement system aims primarily to improve prevention and early diagnosis of PHC-sensitive diseases. Targeted areas include advising parents on preventing accidents and injuries among children (see Figure 10.3), establishing pediatric screening programs as well as adults' screenings on cancer for early detection and common disorders' prevention such as Hypertension (see Figure 10.4).

*Figure 11.3. Percentage of Physicians Consulting Parents on Injury Prevention for Children under 5*




In most of the targeted diseases prevention activities pilot sites show positive developments. Along with all protocols included in the Pediatric Primary Health Care National Program, Breast cancer and Hypertension screening protocols were approved by the MOH as nationwide protocols and standards for PHC services under state guaranteed BBP package (RA MOH Order # 1350 issued in December 12, 2004).

*Figure 11.4. Performance in early diagnoses of Hypertension, %*

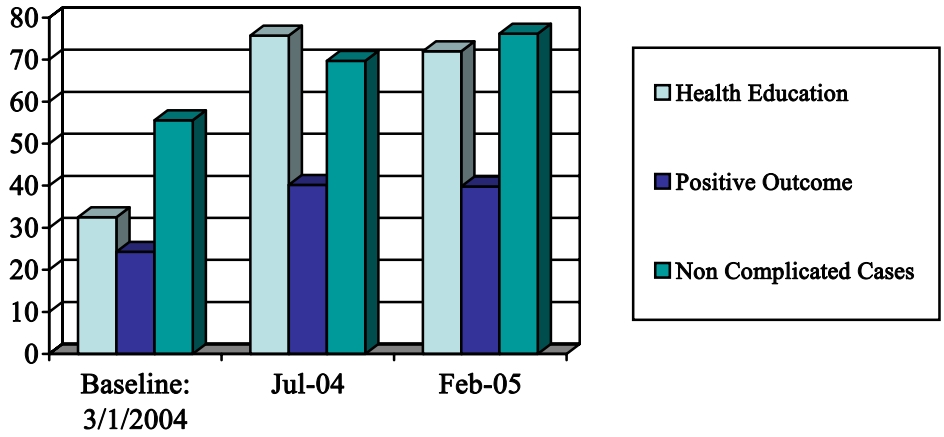



### *11.4.4. Improved management of common diseases*

Written evidence-based rules are a necessary condition for improving the management of any health problem Rules must be reflected in clinical protocols of the health facilities. All ASTP/MOH pilot sites that implemented internal protocols on Hypertension, Diabetes Mellitus and Acute Respiratory Infections management show improved medical practice when compared with international standards.

*Figure 11.5. Performance and outcome in management of Hypertension, %*

**Designed and Implemented series of procedures for medical care**

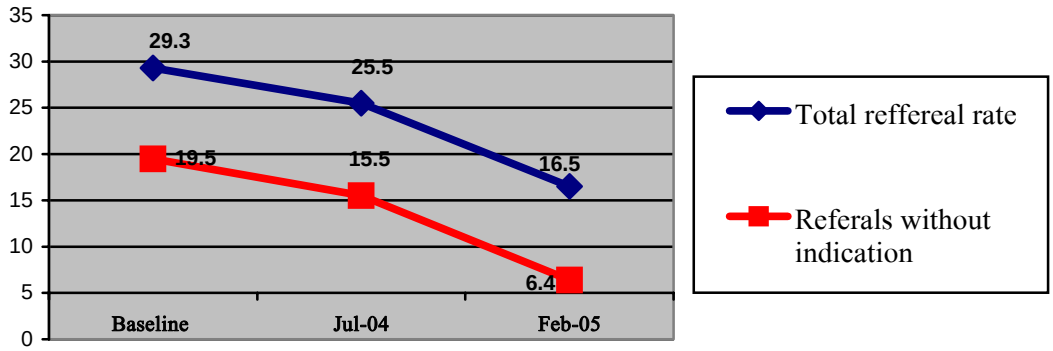



### *11.4.5. Organization and Management*

ASTP identified key aspects of organizational behaviour and structure that should be addressed by CQI program, including:

- **Controlling infection in polyclinics** – in ASTP/MOH pilot sites an internal protocol on Cross-Infection control along with a ten-hour training course on infection control and medical waste management was designed and delivered.[18]
- **Effective documentation of patient visits** – ASTP designed and implemented an internal procedure on "Outpatient records keeping, forms circulation and storage" in pilot sites. Focused studies and site visits confirm that both polyclinic administration and health care providers are committed to the procedure, which means that each outpatient visit is appropriately recorded and documented. Current ASTP CQI monitoring data suggest that this 30% gap is reduced up to 1-8% depending on the site.
- **Reduced referrals of patients to narrow specialists** –ASTP emphasized reducing referrals to any clinical services other than PHC. This measure helped to regulate the patient flow into the pilot facilities and to reduce both the referral rate to Narrow Specialists and rate of "referrals without indication"[19]. Figure 10.6 shows the tendencies.

*Figure 11.6. Rates of Patient Referral to Narrow Specialists, %*




[18] This improved nurses' theoretical knowledge from an average pre-test score of 51.4 percent to an average post-test score of 85.2 percent as well as practice performance from a pre-training average assessment rate of 1.7 to an post-training average assessment rate of 2.3 (the scores ranged between 1 and 3).

[19] In contemporary practice PHC physicians are skilled in wide scope of health screening activities for early detection of common diseases. They refer patients to narrow specialists only after diagnosing health problems or suspecting of such. In terms of early diagnosis of PHC sensitive diseases, ASTP defines referral as "without indication" if PHC doctors refer a patient to narrow specialist without any revealed or suspected health problem.

### *11.4.6. Establishing Advisory Bodies Responsible for Measuring and Improving Quality of Medical Care*

ASTP helped pilot sites create and maintain supportive governance bodies such as Coordination Committees (CCs) to monitor the use of CQI tools in both urban and rural PHC facilities. The main role of CC's was to discuss health care management and organization and to suggest ways to improve the efficiency and quality of health care. CCs in all ASTP/MOH pilot sites organized weekly meetings. Another important CC activity was providing feedback to PHC providers about their performance.

### *11.4.7. Improved patient education methods, approaches and skills*

In collaboration with the American University of Armenia, ASTP designed health education materials covering 16 common disorders, health risks and topics. The health education materials were developed by AUA-contracted local experts and passed a very thorough review by relevant departments of National Institute of Health. In 2003 MOH approved these health education materials for nationwide use. Full texts of the ASTP/AUA designed health education materials are available on www.astp.am

In 2004 ASTP developed and published short-text forms of some health education materials (e.g. healthy nutrition, early signs of Diabetes, how to do breast self exam, how to deal with increased blood pressure) for wide distribution among the Armenian population served by MOH pilot sites.

### *11.4.8. Expanded the Scope of Practice of PHC Providers*

CQI activities ensured a safe expansion of the narrow scope of practice of terapevts, pediatricians and family doctors revealed by baseline assessment. ASTP selected two main indicators to assess the expansion of scope of practice for PHC doctors. The first indicator, shown in Figure 10.7, shows the results of treatment provided by PHC doctors -- including some illnesses which had been traditionally treated only by narrow specialists such as Otitis Media or Diabetes Mellitus. The second indicator, shown on the Figure 10.8, shows how many different types of medical procedures were provided by PHC doctors. The list of procedures includes traditionally "non PHC procedures" such as otoscopy, skin surgery, orthopedic tests, eyesight checks, ear lavage, simple lung tests and others.

*Figure 11.7. Number of Unique Diagnoses*

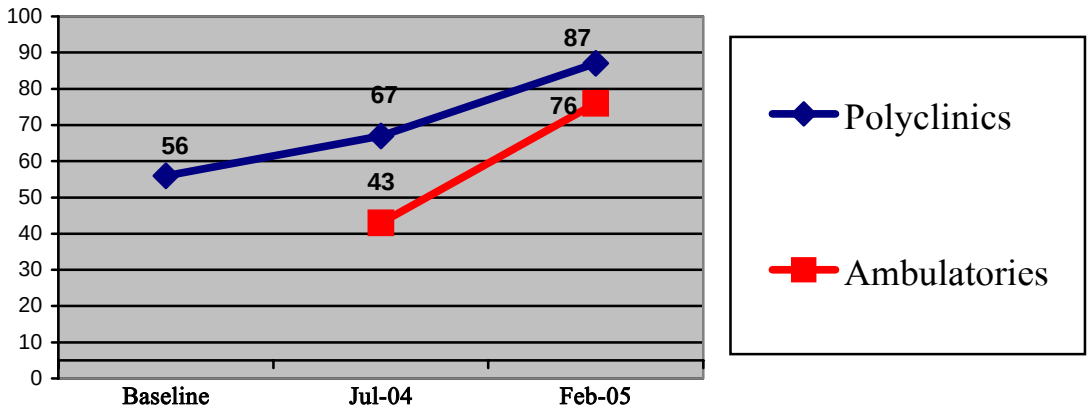
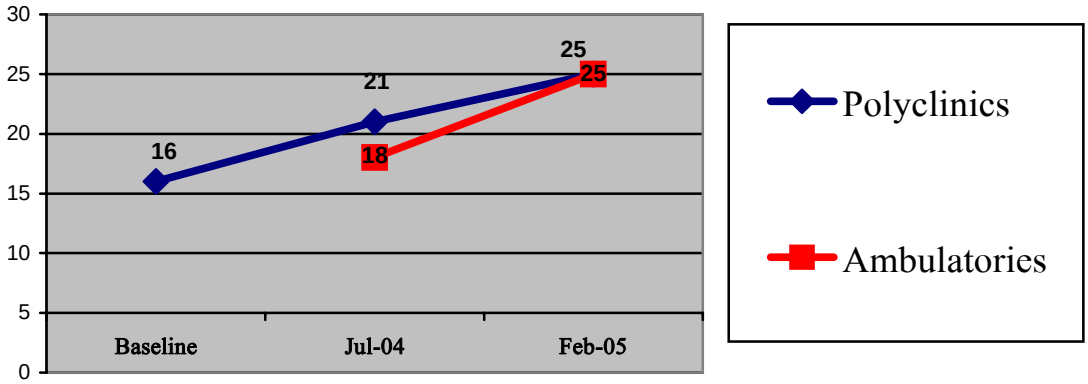



*Figure 11.8. Number of unique procedures provided by PHC services*

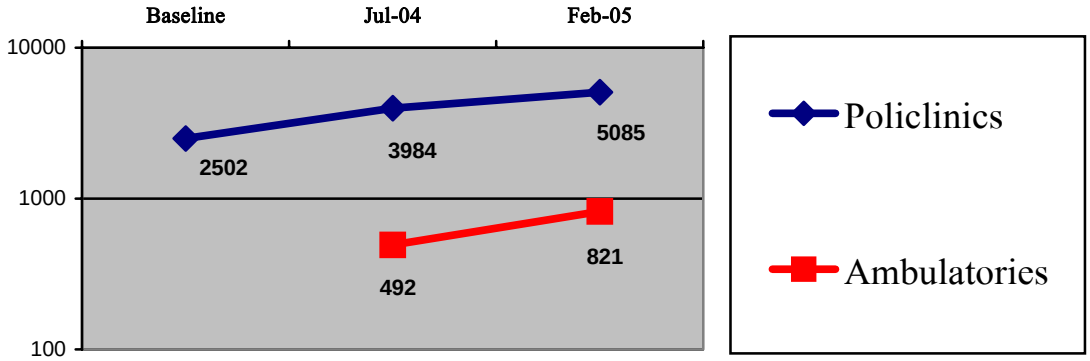


### *11.4.9. Increased utilization of PHC services in ASTP/MOH pilot sites*

The overall impact of the pilot CQI program was an increased workload for physicians and nurses participating in both internal CQI processes and providing more patients visits than the PHC providers did previously. ASTP evaluates the utilization indicator as one of the key indicators of PHC quality, because it provides also some insight about the level of trust of PHC services and how accessible PHC services are for the population in general.

ASTP also evaluated several factors directly or indirectly affecting the utilization of PHC services, such as drug prescription and pharmacological services regulations, patient referral system to clinical services other than PHC, health care financing, and others. ASTP provided MOH with complete analyses of the factors impacting on PHC utilization rate in Armenia.

*Figure 11.9. Average number of visits for PHC services per month in about six-months periods*




### *11.4.10. Improved PHC premises and Provision of Medical Equipment and Supplies*

ASTP's baseline assessment showed that many of PHC premises are poorly furnished and equipped, preventing staff from providing the full scope of clinical activities in the ASTP CQI program. Through U.S. government donations and procurements facilitated by USAID, ASTP was able to distribute supplies and equipment to pilot facilities to introduce better Family Medicine principles in polyclinics and in rural ambulatories, where even the most basic first aid kits were not available. In practice, rural ambulatories and FAPs often handle emergency cases. A list of basic equipment and supplies was prepared by ASTP and procured by USAID.

ASTP also procured and provided some essential office furniture such as desks, chairs and other inventory for pilot sites. Overall, ASTP improved premises, furnished and provided basic medical equipment and supplies to 145 PHC doctors' offices serving more than 270,000 people. Each physician received:

- Otoscope Ophthalmoscope
- Sterilizer
- Stethoscope (25" large)
- Stethoscope (infant)
- Sphygmomanometer/Cuff Kit
- Sphygmomanometer (infant)
- IV Stand (4 legs)
- Peak Flow Meter
- Penlight
- Reflex Hammer
- Digital Thermometer
- EKG
- Gynecological Exam Tables
- Tuning Fork

Over time, pilot facilities are expected to ensure proper maintenance of equipment and adequate stock of supplies and disposables. Cost accounting, improved budgeting and planning processes, and more efficient use of staff will contribute to the ability of Family Medicine Departments to plan for these costs.

# ASTP FINAL REPORT: 12. PROVIDING FINANCIAL INCENTIVES TO HEALTH CARE PROVIDERS

## 12.1. OVERVIEW

Currently, primary health care services in Armenia are funded through a capitation payment. The total amount received by a PHC facility primary health care services, is based on a formula that multiplies the catchment area population over the age of 18 by the adult capitation rate and the population under the age of 18 by the capitation rate for children. This fixed capitation approach creates a number of problems:

- It is a "lazy" payment model – PHC facilities and physicians receive the same payment regardless of how many patients they actually serve and are guaranteed fixed revenues from the state for the populations assigned to them.
- Capitation as currently figured does not encourage improved patient services and provider performance (in terms of volume and quality).
- Current age adjustment of capitation rates (two groups – children and adults) does not reflect differences in actual health status and health risks and health status, and hence is not relevant to differences in PHC service demand and utilization costs.
- Coexistence of fixed capitation payment for PHC and utilization-based reimbursement for ambulatory care by medical specialists encourages excessive patient referrals to specialists – which greatly increases the overall costs of the health care system and diminishes the positive effects of PHC financing.

Given these problems, ASTP worked with the MOH and the SHA to design and pilot a payment system for Primary Care facilities and for providers. Both gained an incentive to market their services to the population and to allow the population to choose their primary care provider, and to target increased service utilization and quality of PHC services.

## 12.2. DESIGNING THE FINANCIAL INCENTIVE SYSTEM

The base objective of the new financing and remuneration system was to offer incentives for PHC personnel. The system is aimed at motivating pilot site managers and their staff to expand the scope and improve the quality of services provided, to improve their knowledge and qualifications, and to increase the clinical and economic efficiency of both the PHC providers and the facilities. Facility financing and salary payments from any source of funding can provide incentives only when they are linked to work done.

Rather than setting fixed revenues for facilities and fixed salaries for physicians and nurses the new provider payment model offers incentives for improved performance in line with ongoing PHC reforms. The PHC financing and remuneration pools consist of the base and incentive components. The base component is established on capitation rates (two types - for PHC financing and for personnel remuneration). The incentive component is calculated in accordance with the quality and quantitative indicators of PHC personnel performance. In 2005 a PHC financing and remuneration system was piloted in 13 ROA MOH/ASTP pilot sites. PHC personnel performance was tracked and analyzed, based on facility performance reports incentive allocations from the state budget have been processed by the SHA, and the incentive remuneration funds have been established in every pilot and distributed to individual physicians, nurses, and PHC related staff on a quarterly basis.

## 12.3. IMPLEMENTATION APPROACH, PROCESSES, SCOPE AND DYNAMICS

New financing and remuneration model means splitting the total financing pool (for pilot facilities) and remuneration fund (for personnel of every participating facility) into two parts: base financing pool and incentive financing pool for PHC facilities, and base remuneration fund and incentive remuneration fund for personnel of every facility.

### *12.3.1. Base Financing Pool and Base Remuneration Fund*

The base financing pool is established on a capitation basis and reflects the composition of statistical population that constitutes the catchment areas of pilot facilities. This pool is estimated similarly to any other PHC facility in the country by multiplication of age adjusted capitation rates and population size of a facility.

The base part of wages is guaranteed to the personnel and depends on the number of work days (hours). It is formed as a product of the *number of statistical or enrolled population (choice made by facilities)* and the remuneration capitation rates (differentiated for adults and children) as defined by ROA MOH.

### *12.3.2. Incentive Financing Pool and Incentive Remuneration Fund*

Incentive financing pool is held by the State Health Agency in an amount defined against the base pool. For 2005 this pool has been defined as 20% to capitated (base) pools of all pilot facilities. Allocation of the incentive pool across participating facilities is made according to facility performance results every quarter.

The incentive payroll fund is distributed to the personnel based on individual performance measured against certain qualitative and quantitative performance indicators.

### *12.3.3. Selection of Performance Indicators*

With the MOH and SHA, ASTP developed a list of indicators that measure the performance of PHC personnel. In the scope of 2004 PHC pilot financing, only enrollment performance indicators were applied to formation of and allocations from the incentive financing pool. In 2004 the pilot remuneration model used indicators from the MOH list selecting those to apply to the remuneration system and hence calculating performance based supplementary monthly wages for the PHC staff. The selection of indicators was retrospective – to be used when the reporting period was over. Staff were aware of the complete list of indicators but were not told which indicators would be selected at the end of the reporting period for incentive remuneration. This approach was intended to encourage staff to pay attention to the whole list as well as discouraging them from deliberately inflating the data reported.

The number of indicators selected for performance appraisal was important. Physicians were usually unhappy if only a small number of indicators were used because different categories of patients had different reasons for physician contact – some requiring extensive consultations and referrals and others requiring simple and quick consultations. On the other hand, using a large number of indicators made the process of analysis and assessment more complicated and the incentive remuneration system would lose economic feasibility.

In the 2005 model the approach was changed to establish a better link between financing and remuneration indicators and to have uniform remuneration indications used across all pilots.

### *12.3.4. Performance Assessment*

Different approaches were applied to assess PHC personnel performance:

1. **Performance-based payment**: This was applied when opportunities for staff to receive incentive payments were not limited. For example, if it is applied to indicators such as the number of people enrolled or the number of patient visits. All providers receive additional payments based on the overall performance of the facility as a whole.
2. **Benchmarks**: This was used to reward PHC specialists who met or exceeded defined benchmarks. All staff who met these targets would receive incentive payments.
3. **Mean Values of Indicators**: This was rarely used because it restricted the opportunity for PHC providers to receive incentive payments. The indicator was calculated based on past staff performance and incentive payments given to those equaled to or exceeded the mean. Obviously, everyone cannot perform above average. While this may encourage some below average performers to do better, some may be unable to surpass the mean value of indicators – perhaps because their starting positions were below others. This was regarded as unfair. This approach to performance assessment can be applied only if all the PHC staff members start with equal qualifications and experience.

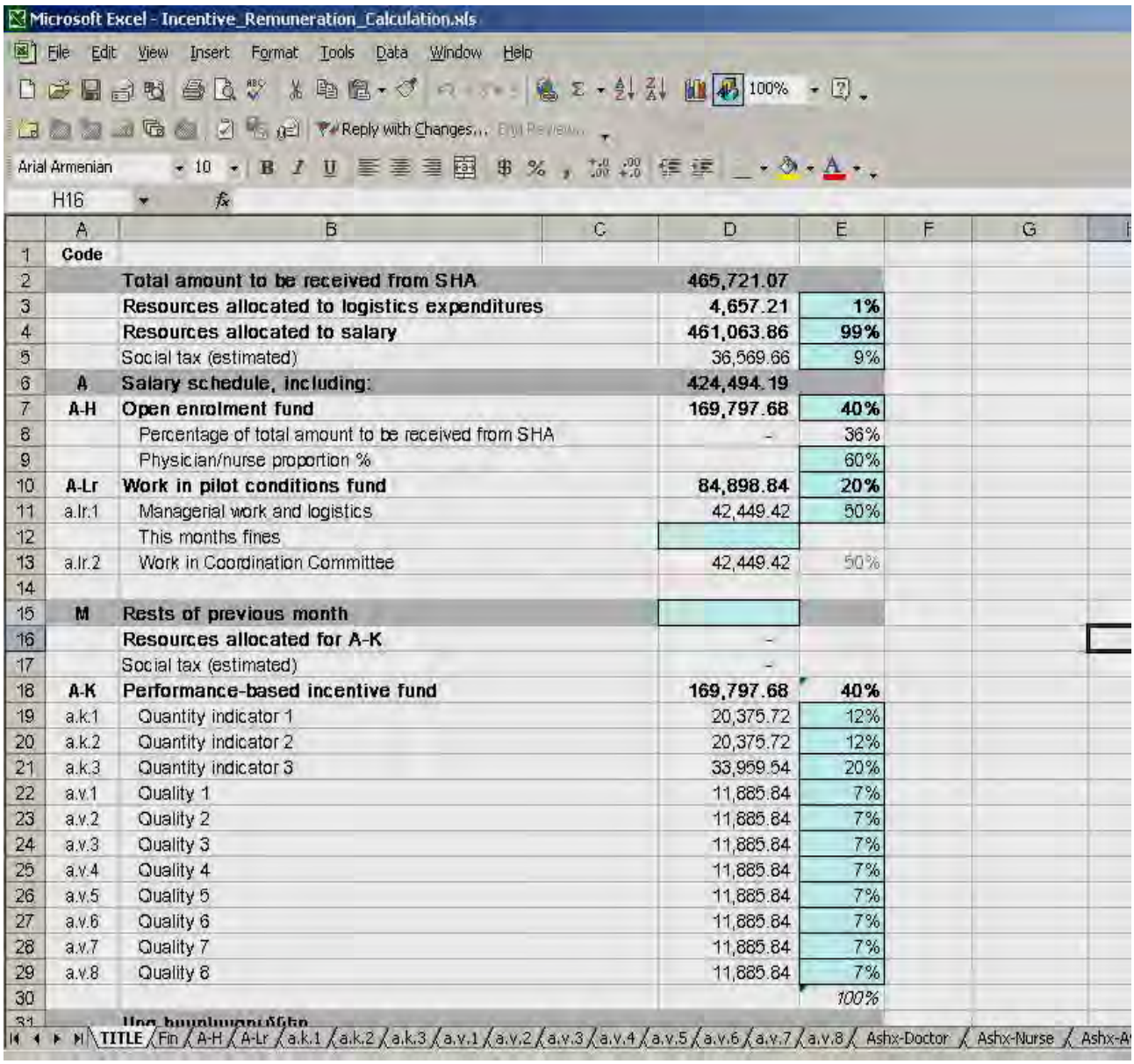
### *12.3.5. Automated Calculation of Incentive Payments*

Calculation of performance-based incentive payments for each staff member requires the accountants to perform additional work. To avoid imposing this burden on accountants and to avoid any miscalculations, ASTP automated the process during the piloting, using Microsoft Excel electronic spreadsheets. A multi-sheet electronic tool was developed which calculated incentive payments and the total wages (including the base fund) for each PHC provider once his/her performance indicators were entered. The first sheet included the following data and calculations:

- Incentive (incentive) fund allocated to the facility (Figure 11.3.5.1);

- Calculation of total incentive payments, mandatory social insurance contributions;
- Distribution from the incentive payment fund based on population enrolled, PHC providers' performance, and addition function funds.

*Figure 12.1. Electronic tool. First sheet.*



| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | Code | | | | | | |
| 2 | | Total amount to be received from SHA | | 465,721.07 | | | |
| 3 | | Resources allocated to logistics expenditures | | 4,657.21 | 1% | | |
| 4 | | Resources allocated to salary | | 461,063.86 | 99% | | |
| 5 | | Social tax (estimated) | | 36,569.66 | 9% | | |
| 6 | A | Salary schedule, including: | | 424,494.19 | | | |
| 7 | A-H | Open enrolment fund | | 169,797.68 | 40% | | |
| 8 | | Percentage of total amount to be received from SHA | | - | 36% | | |
| 9 | | Physician/nurse proportion % | | | 60% | | |
| 10 | A-Lr | Work in pilot conditions fund | | 84,898.84 | 20% | | |
| 11 | a.lr.1 | Managerial work and logistics | | 42,449.42 | 50% | | |
| 12 | | This months fines | | | | | |
| 13 | a.lr.2 | Work in Coordination Committee | | 42,449.42 | 50% | | |
| 14 | | | | | | | |
| 15 | M | Rests of previous month | | | | | |
| 16 | | Resources allocated for A-K | | - | | | |
| 17 | | Social tax (estimated) | | - | | | |
| 18 | A-K | Performance-based incentive fund | | 169,797.68 | 40% | | |
| 19 | a.k.1 | Quantity indicator 1 | | 20,375.72 | 12% | | |
| 20 | a.k.2 | Quantity indicator 2 | | 20,375.72 | 12% | | |
| 21 | a.k.3 | Quantity indicator 3 | | 33,959.54 | 20% | | |
| 22 | a.v.1 | Quality 1 | | 11,885.84 | 7% | | |
| 23 | a.v.2 | Quality 2 | | 11,885.84 | 7% | | |
| 24 | a.v.3 | Quality 3 | | 11,885.84 | 7% | | |
| 25 | a.v.4 | Quality 4 | | 11,885.84 | 7% | | |
| 26 | a.v.5 | Quality 5 | | 11,885.84 | 7% | | |
| 27 | a.v.6 | Quality 6 | | 11,885.84 | 7% | | |
| 28 | a.v.7 | Quality 7 | | 11,885.84 | 7% | | |
| 29 | a.v.8 | Quality 8 | | 11,885.84 | 7% | | |
| 30 | | | | | 100% | | |

On the second sheet the incentive payments based on the number of population enrolled by each physician were calculated (Figure 12.2.).

*Figure 12.2. Electronic tool. Open enrollment sheet.*

Microsoft Excel - Incentive_Remuneration_Calculation.xls

| | A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | Name, Family Name | Number of population enrolled | Additional reiumbursement from SHA | per-capita | min. | max. | | | |
| 2 | | | | | | | | | | |
| 3 | | FM (adults) | | | | | | | | |
| 4 | 1 | Family physician 1 | 973 | 18,219.43 | 53.5 | 700 | 1200 | 25% | 35% | 40% |
| 5 | 2 | Family physician 2 | 2,028 | 43,399.20 | 53.5 | 700 | 1200 | 25% | 35% | 40% |
| 6 | | FM (children) | | | | | | | | |
| 7 | 1 | Family physician 1 | 494 | 19,567.09 | 113.17 | 300 | 500 | 25% | 35% | 40% |
| 8 | 2 | Family physician 2 | 562 | 25,440.62 | 113.17 | 300 | 500 | 25% | 35% | 40% |
| 9 | | Theravet | | | | | | | | |
| 10 | 1 | Therapevt 1 | 1,108 | 20,747.30 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 11 | 2 | Therapevt 2 | 1,549 | 29,005.03 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 12 | 3 | Therapevt 3 | 1,035 | 19,380.38 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 13 | 4 | Therapevt 4 | 1,260 | 23,593.50 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 14 | 5 | Therapevt 5 | 1,190 | 22,282.75 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 15 | 6 | Therapevt 6 | 933 | 12,478.88 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 16 | 7 | Therapevt 7 | 1,017 | 19,043.33 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 17 | 8 | Therapevt 8 | 1,081 | 20,241.73 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 18 | 9 | Therapevt 9 | 1,215 | 22,750.88 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 19 | 10 | Therapevt 10 | 1,767 | 33,087.08 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 20 | 11 | Therapevt 11 | 1,125 | 21,065.63 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 21 | 12 | Therapevt 12 | 943 | 12,612.63 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 22 | 13 | Therapevt 13 | 941 | 12,585.88 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 23 | 14 | Therapevt 14 | 963 | 13,147.63 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 24 | 15 | Therapevt 15 | 1,040 | 19,474.00 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 25 | 16 | Therapevt 16 | 1,370 | 25,653.25 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 26 | 17 | Therapevt 17 | 980 | 13,107.50 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 27 | 18 | Therapevt 18 | 1,006 | 18,837.35 | 53.5 | 1000 | 2000 | 25% | 35% | 40% |
| 28 | | Total | 24,600 | 465,721.07 | | | | | | |

Calculations of incentive payments for each indicator based on the PHC providers' performance is done on a separate sheet (Figure 12.3.).

*Figure 12.3. Electronic tool. Performance indicator sheet.*

Microsoft Excel - Incentive_Remuneration_Calculation.xls

| | A | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 25 | | **Name, Family Name** | **Indicator** | **%** | **Coefficient** | **Total amount of incentive remuneration** | **Physician's salary** | **Nurse's salary** | Ph/N | Meth. | Avg |
| 26 | | **FM (adults)** | | | | | | | | | |
| 27 | 1 | Family physician 1 | 35 | 35.00 | 35.00 | 502.57 | 301.54 | 201.03 | 60% | a | 70.95 |
| 28 | 2 | Family physician 2 | 121 | 121.00 | 121.00 | 1,737.46 | 1,042.48 | 694.99 | 60% | a | 70.95 |
| 29 | | **Total** | | | **156.00** | **2,240.04** | | | | | |
| 30 | | **Actual average** | **78** | | | | | | | | |
| 42 | | **Theravet** | | | | | | | | | |
| 43 | 1 | Therapevt 1 | 23 | 23.00 | 23.00 | 330.26 | 198.16 | 132.10 | 60% | a | 70.95 |
| 44 | 2 | Therapevt 2 | 54 | 54.00 | 54.00 | 775.40 | 465.24 | 310.16 | 60% | a | 70.95 |
| 45 | 3 | Therapevt 3 | 101 | 101.00 | 101.00 | 1,450.28 | 870.17 | 580.11 | 60% | a | 70.95 |
| 46 | 4 | Therapevt 4 | 104 | 104.00 | 104.00 | 1,493.36 | 896.01 | 597.34 | 60% | a | 70.95 |
| 47 | 5 | Therapevt 5 | 64 | 64.00 | 64.00 | 918.99 | 551.39 | 367.60 | 60% | a | 70.95 |
| 48 | 6 | Therapevt 6 | 52 | 52.00 | 52.00 | 746.68 | 448.01 | 298.67 | 60% | a | 70.95 |
| 49 | 7 | Therapevt 7 | 84 | 84.00 | 84.00 | 1,206.17 | 723.70 | 482.47 | 60% | a | 70.95 |
| 50 | 8 | Therapevt 8 | 56 | 56.00 | 56.00 | 804.12 | 482.47 | 321.65 | 60% | a | 70.95 |
| 51 | 9 | Therapevt 9 | 68 | 68.00 | 68.00 | 976.43 | 585.86 | 390.57 | 60% | a | 70.95 |
| 52 | 10 | Therapevt 10 | 115 | 115.00 | 115.00 | 1,651.31 | 990.79 | 660.52 | 60% | a | 70.95 |
| 53 | 11 | Therapevt 11 | 80 | 80.00 | 80.00 | 1,148.74 | 689.24 | 459.49 | 60% | a | 70.95 |
| 54 | 12 | Therapevt 12 | 50 | 50.00 | 50.00 | 717.96 | 430.78 | 287.18 | 60% | a | 70.95 |
| 55 | 13 | Therapevt 13 | 60 | 60.00 | 60.00 | 861.55 | 516.93 | 344.62 | 60% | a | 70.95 |
| 56 | 14 | Therapevt 14 | 45 | 45.00 | 45.00 | 646.16 | 387.70 | 258.47 | 60% | a | 70.95 |
| 57 | 15 | Therapevt 15 | 117 | 117.00 | 117.00 | 1,680.03 | 1,008.02 | 672.01 | 60% | a | 70.95 |
| 58 | 16 | Therapevt 16 | 58 | 58.00 | 58.00 | 832.83 | 499.70 | 333.13 | 60% | a | 70.95 |
| 59 | 17 | Therapevt 17 | 47 | 47.00 | 47.00 | 674.88 | 404.93 | 269.95 | 60% | a | 70.95 |
| 60 | 18 | Therapevt 18 | 85 | 85.00 | 85.00 | 1,220.53 | 732.32 | 488.21 | 60% | a | 70.95 |
| 61 | | **Total** | | | **1,419.00** | **20,375.72** | | | | | |
| 62 | | **Actual average** | **71** | | | | | | | | |
| 63 | | Fund to be allocated | 20,375.72 | | ***The rest*** | - | | | | | |
| 64 | | Coefficient value | 14.36 | | | | | | | | |

TITLE / Fin / A-H / A-Lr / a.k.1 / a.k.2 / a.k.3 / a.v.1 / a.v.2 / a.v.3 / a.v.4 / a.v.5 / a.v.6 / a.v.7 / a.v.8 / Ashx-Doctor / Ashx-Nurse / Ashx-Ayll

The total wages (including the base and the incentive payments) were calculated by physicians, nurses and other support staff on separate sheets (Figure 12.4.).

*Figure 12.4. Electronic tool. Salary calculation sheet.*

Microsoft Excel - Incentive_Remuneration_Calculation.xls

| | | Name, Family Name | Initial salary (without incentives) | Social payment | Enrolment | Performance | Additional functions | Total incentive | Final salary (C+E+F+G) | Social payment | Social tax | Deduction | Taxable ammount | Income tax | Net salary |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | | **FM** | | | | | | | | | | | | | |
| 4 | 1 | Family physician 1 | 28,800.00 | 6,320.00 | 6,075.44 | 3,649.79 | 3,056.36 | 12,781.59 | 41,582.00 | 8,237.30 | 1,247.00 | 20,000.00 | 20,335.00 | 2,034.00 | 38,301.00 |
| 5 | 2 | Family physician 2 | 28,800.00 | 6,320.00 | 10,726.24 | 10,061.32 | 3,395.95 | 24,183.51 | 52,984.00 | 9,947.60 | 1,590.00 | 20,000.00 | 31,394.00 | 3,139.00 | 48,255.00 |
| 6 | | **Theravet** | | | | | | | | | | | | | |
| 7 | 1 | Therapevt 1 | 28,800.00 | 6,320.00 | 4,588.68 | 5,082.25 | | 9,670.93 | 38,471.00 | 7,770.65 | 1,154.00 | 20,000.00 | 17,317.00 | 1,732.00 | 35,585.00 |
| 8 | 2 | Therapevt 2 | 28,800.00 | 6,320.00 | 6,415.04 | 9,678.23 | 3,056.36 | 19,149.63 | 47,950.00 | 9,192.50 | 1,439.00 | 20,000.00 | 26,511.00 | 2,651.00 | 43,860.00 |
| 9 | 3 | Therapevt 3 | 36,000.00 | 7,400.00 | 4,286.36 | 5,604.61 | 3,056.36 | 12,947.33 | 48,947.00 | 9,342.05 | 1,468.00 | 20,000.00 | 27,479.00 | 2,748.00 | 44,731.00 |
| 10 | 4 | Therapevt 4 | 30,700.00 | 6,605.00 | 5,218.17 | 1,630.04 | 3,056.36 | 9,904.57 | 40,605.00 | 8,090.75 | 1,218.00 | 20,000.00 | 19,387.00 | 1,939.00 | 37,448.00 |
| 11 | 5 | Therapevt 5 | 28,800.00 | 6,320.00 | 4,928.27 | 2,755.99 | | 7,684.26 | 36,484.00 | 7,472.60 | 1,095.00 | 20,000.00 | 15,389.00 | 1,539.00 | 33,850.00 |
| 12 | 6 | Therapevt 6 | 28,800.00 | 6,320.00 | 3,863.93 | 962.38 | | 4,826.31 | 33,626.00 | 7,043.90 | 1,009.00 | 20,000.00 | 12,617.00 | 1,262.00 | 31,355.00 |
| 13 | 7 | Therapevt 7 | 28,800.00 | 6,320.00 | 4,211.81 | 6,747.12 | 3,056.36 | 14,015.29 | 42,815.00 | 8,422.25 | 1,264.00 | 20,000.00 | 21,531.00 | 2,153.00 | 39,378.00 |
| 14 | 8 | Therapevt 8 | 28,800.00 | 6,320.00 | 4,476.86 | 5,474.53 | | 9,951.39 | 38,751.00 | 7,812.65 | 1,163.00 | 20,000.00 | 17,588.00 | 1,759.00 | 35,829.00 |
| 15 | 9 | Therapevt 9 | 28,800.00 | 6,320.00 | 5,031.81 | 7,472.74 | | 12,504.55 | 41,305.00 | 8,195.75 | 1,239.00 | 20,000.00 | 20,066.00 | 2,007.00 | 38,059.00 |
| 16 | 10 | Therapevt 10 | 30,700.00 | 6,605.00 | 7,317.87 | 4,119.43 | | 11,437.30 | 42,137.00 | 8,320.55 | 1,264.00 | 20,000.00 | 20,873.00 | 2,087.00 | 38,786.00 |
| 17 | 11 | Therapevt 11 | 28,800.00 | 6,320.00 | 4,659.08 | 8,315.77 | | 12,974.85 | 41,775.00 | 8,266.25 | 1,253.00 | 20,000.00 | 20,522.00 | 2,052.00 | 38,470.00 |
| 18 | 12 | Therapevt 12 | 28,800.00 | 6,320.00 | 3,905.35 | 878.42 | | 4,783.77 | 33,584.00 | 7,037.60 | 1,008.00 | 20,000.00 | 12,576.00 | 1,258.00 | 31,318.00 |
| 19 | 13 | Therapevt 13 | 28,800.00 | 6,320.00 | 3,897.06 | 4,217.74 | | 8,114.80 | 36,915.00 | 7,537.25 | 1,107.00 | 20,000.00 | 15,808.00 | 1,581.00 | 34,227.00 |
| 20 | 14 | Therapevt 14 | 28,800.00 | 6,320.00 | 4,071.00 | 5,749.62 | | 9,820.62 | 38,621.00 | 7,793.15 | 1,159.00 | 20,000.00 | 17,462.00 | 1,746.00 | 35,716.00 |
| 21 | 15 | Therapevt 15 | 33,800.00 | 7,070.00 | 4,307.06 | 1,483.47 | | 5,790.53 | 39,591.00 | 7,938.65 | 1,188.00 | 20,000.00 | 18,403.00 | 1,840.00 | 36,563.00 |
| 22 | 16 | Therapevt 16 | 33,800.00 | 7,070.00 | 5,673.73 | 7,137.28 | | 12,811.01 | 46,611.00 | 8,991.65 | 1,398.00 | 20,000.00 | 25,213.00 | 2,521.00 | 42,692.00 |
| 23 | 17 | Therapevt 17 | 28,800.00 | 6,320.00 | 4,058.58 | 4,386.90 | | 8,445.48 | 37,245.00 | 7,586.75 | 1,117.00 | 20,000.00 | 16,128.00 | 1,613.00 | 34,515.00 |
| 24 | 18 | Therapevt 18 | 28,800.00 | 6,320.00 | 4,166.26 | 7,073.12 | | 11,239.38 | 40,039.00 | 8,005.85 | 1,201.00 | 20,000.00 | 18,838.00 | 1,884.00 | 36,954.00 |
| 26 | | TOTAL | | 129,550.00 | | | | | | 163,005.70 | | | | | |

The data required for calculation of incentive payments by *each PHC staff member* was retrieved from the PHC information system through automated reports. This data was submitted to the accounts department to be entered into the electronic system and to reflect the amount of incentive payments by each PHC specialist.

## 12.4. ASTP Designed Expenditure Tracking System for PHC/Family Medicine Units

In the pilots of the first generation – three polyclinics and three rural health centers-- ASTP created systems for tracking revenues and expenditures for PHC facilities and disaggregated them for each department, with a special emphasis on family medicine departments. This provided managers with accurate information on the financial aspects of activities of different departments, allowing them to identify ways to increase the cost-effectiveness of PHC services. Tracking revenues and expenditures supports activity planning and budgeting, improves efficiency of decision-making and improves oversight over the implementation of management decisions. This tracking system is the first step toward the autonomy of FM departments and other PHC units to use for finance and resource management. It also has resulted in more effective allocation of funds for performance incentives, purchase of medication and medical supplies (to improve distribution and prevent over-utilization), as well as capital outlays (giving departments the right to determine where to allocate existing financial resources).

The system tracks revenues from paid services monthly by the types and volume of different services provided. Tracking state revenues also is performed monthly by measuring the volume of services provided during the month and determining unit service cost. Monthly revenues from capitation payments are

calculated based on the normatives of annual funding per one patient and the number of people enrolled with facility PHC providers.

Based on the type of tracking the expenditures of both the health care facility and its different departments are divided into two groups:

- Direct costs are those costs directly related to delivering health care that can be allocated to different departments and services; and
- Indirect or overhead costs which are the expenditures made on organization of the facility activities, management and health care provision that cannot be ascribed directly to the expenditures made by any of the departments or to the cost price of the services provided by them.

The direct costs of a department include:

- Remuneration of the department personnel;
- Mandatory social insurance fund contributions made by the employer for each employee;
- Medical materials required for health care provision – medication, medical supplies, etc;
- Non-medical material costs, such as medical forms and blanks, stationery, household utilities, etc;
- Depreciation of medical and non-medical equipment and assets;
- Medical equipment basic maintenance and current repair costs.

Other expenditures have been also tracked and allocated among departments.

Indirect (overhead) costs are facility-level expenditures necessary for ensuring the functioning of the medical departments but are not directly related to delivering health services. Allocating indirect costs among different departments is important for accurately tracking their expenditures. There are several allocation mechanisms for indirect costs. They may be pro-rated:

- In proportion to the direct costs of departments;
- In proportion to the physical space occupied by departments; or
- In proportion to the number of employees or the payroll fund of departments.

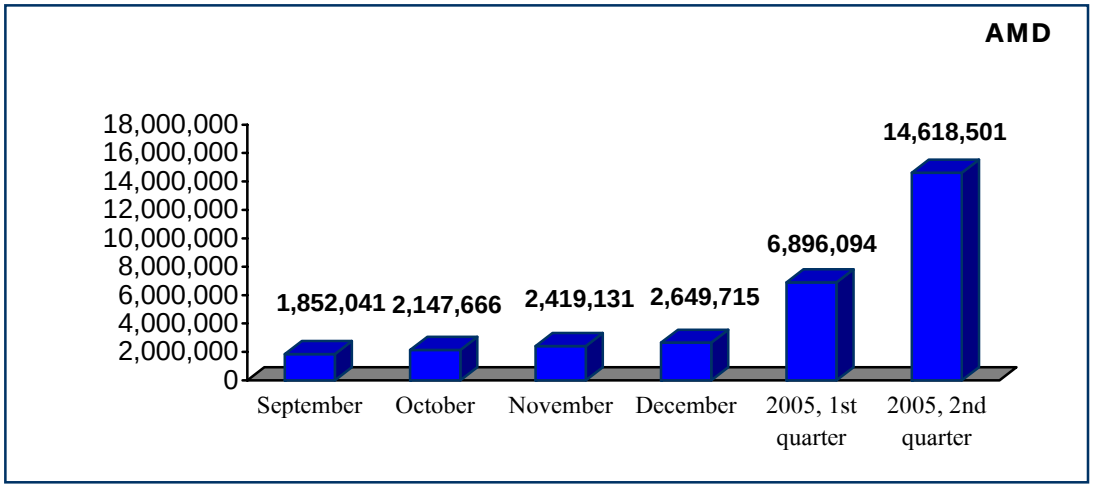
Expenditure analysis undertaken by accountants in pilots reveals the impact of each expenditure item on the departments' results and shows what expenditures are ineffective and how to reduce them.

## 12.5. RESULTS

The introduction and implementation of the new incentives-based PHC personnel remuneration system was successful as it led to improvements in PHC service utilization and quality.

From September 2004 up to the 2nd quarter of 2005, the new PHC financing and remuneration system has been introduced in 13 health facilities with total allocations for performance rewards reaching 30,583,148 AMD (Figure 12.5.).

*Figure 12.5. Dynamic of incentive payment volume September-December, 2004*



In 2004 PHC physicians in pilot facilities earned an average of 16-17% more and nurses of pilot facilities 17-18% more compared to their base salary (Figure 11.5.2 and Figure 11.5.3). Incentive individual salary payments varied from 0.0% to 73.3% of the base salary of pilot PHC physicians, and from 0.0% to 79.6%.

*Figure 12.6. Co- relation between base fund and incentive remuneration in 2004*

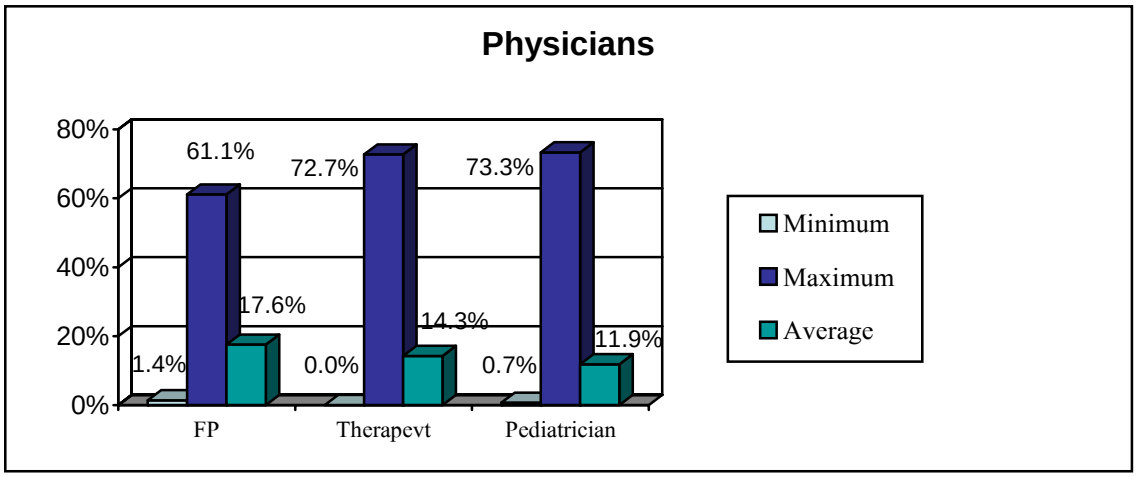
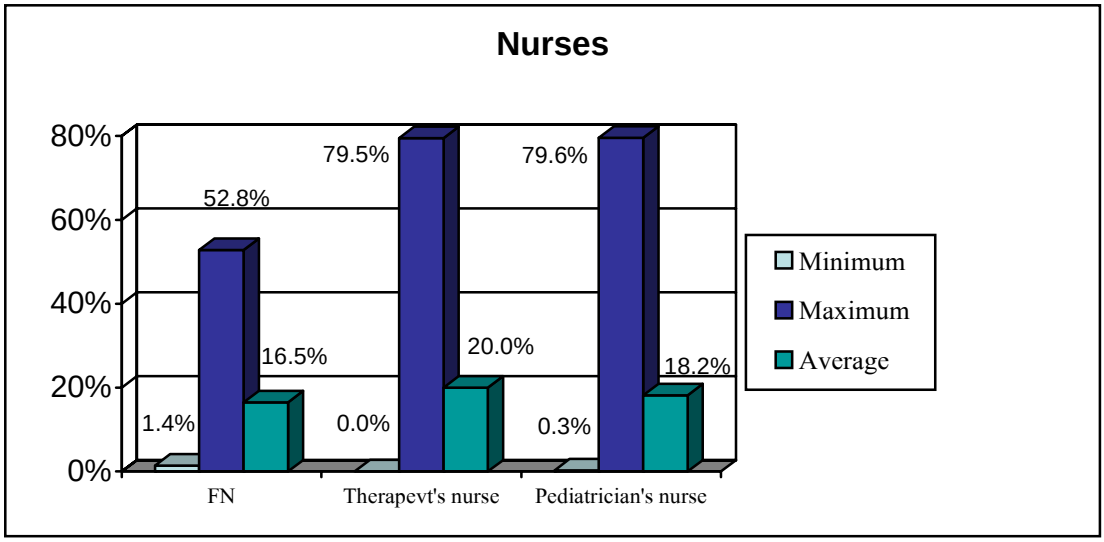



*Figure 12.7. Co- relation between base fund and incentive remuneration in 2004*




1. The increased state budget was effectively used for incentive allocations that proved to be able to change providers' behavior. The effects of the incentive system require some time to change and sustain providers' behavior.
2. Implementing the system is not expensive nor is it dependent on the investment of time and money.
3. Incentive-based remuneration helps achieve the overall goals of health care reform.

Piloting of the new mechanisms of incentive payments continued in 2005. The performance of PHC personnel has been assessed based on appropriate quality and quantitative indicators. Based on 2004 lessons learned and new opportunities the 2005 pilot approach differs in some aspects from the 2004 piloting, specifically:

- Additional funding for incentive payments to the pilot facilities was initially appropriated in the 2005 State budget, while in 2004 a decision on pilot financing was made after the fiscal year started.

- A PHC Performance Assessment Committee affiliated with the MOH was organized to review performance reports, assess performance trends in the pilots and make recommendations for further improvement and nationwide implementation.[20]
- Financial incentive payments are made quarterly while in 2004 they were distributed monthly. This became necessary for data collection, reporting, and analyses when the pilot system started using more financing indicators than in 2004.
- In 2005, 13 universal remuneration indicators were used to determine incentive payments, which allows more comparability across pilots and over time and better focus on particular aspects of PHC performance. In 2004, the list of indicators was excessive and pilots could choose any of them on their own for targeting various aspects of performance and choice of indicators for remuneration could differ from month to month.
- In 2005, remuneration payment indicators were directly linked to financing indicators for facilities. In 2004, various remuneration indicators were linked only to one financing indicator - the number of people enrolled by each physician.

## 12.6. FUTURE DIRECTIONS AND RECOMMENDATIONS

Further nationwide reforms in the mechanisms of PHC personnel remuneration are required to improve the quality and utilization of PHC services. The following recommendations are made in this regard:

1. With implementation of open population enrollment in Armenia the PHC facilities, unlike current practices, should be funded based *on the number of patients enrolled rather than on the number of the population in the catchment area (assigned).*
2. In addition to *capitation payments*, a system of *performance-based funding* of PHC facilities should be implemented as an additional mechanism to stimulate better performance. Such approach combines and strengthens the positive features of both: capitation and performance-based payment methods.
3. Incentives for facilities should be incentives for personnel and reach every participating PHC provider – this is achievable through establishing a consistent system of indicators, in which financing and remuneration indicators are linked and interdependent on each other. Implementation of performance-based remuneration system at the facility level requires:

- Incentive selection of quantity and quality indicators. These should be measurable as well as “clear and fair” for all staff members. Indicators can be changed or extended depending on what is needed to ensure effective and high quality PHC services and financial resources available.
- Introduction of an information system that reflects the performance of each PHC physician and summarizes the results across providers and facilities for calculating incentive payments.
- Adoption of procedures that clearly define the mechanisms for distribution of funds as well as methods for personnel remuneration by an implementing facility.
- Tracking and summarizing reimbursement indicators monthly and informing each staff member of the results.
- Monitoring and assessing the results of the implementation of the new remuneration system.

[20] This committee includes representatives from ROA MOH, SHA, Departments of Health Care and Social Security of Yerevan Municipality and Lori Marzpetaran, Yerevan State Medical University, Armenian Association of Family Physicians, and “Sevan” polyclinic of Gegharkunik marz (non pilot institution).

# ASTP FINAL REPORT: 13. IMPROVING PHC MANAGEMENT

## 13.1. INTRODUCTION

Before Armenia's Primary Health Care (PHC) system was reformed around the concept of Family Medicine (see Chapter 9 above), the way PHC facilities were managed did little to encourage innovation, goal-oriented participatory decision-making, or the pursuit of efficiency. Until the early 1990s, medical councils that formally existed to administer urban polyclinics addressed only immediate clinical and administrative problems. They did not address overall management issues. Management issues were addressed only by the head doctors of the facilities with medical skills but no management background.

After the enactment of the Law on Joint-Stock Companies in 1996, urban polyclinics were re-organized as closed joint-stock companies. The organizational change required the PHC facilities to be managed by directors who should have medical background and adequate management skills. MOH and NIH began offering basic managerial courses for PHC facility directors.

PHC facilities still lack modern management skills and tools. Managerial decisions are taken by a single person -- the head doctor or director. Core staff responsible for the main operational areas do not participate in management. This makes it difficult to respond immediately and adequately to the dramatic changes in the economic, social and health environment that emerged after Armenia's independence.

Management Information Systems were as archaic as management systems. Better health management information systems (HMIS) with more reliance on computerized systems were needed to support family medicine and to modernize PHC services. But better HMIS require fundamental changes in hardware, software, human skills as well as a considering information technology support for effective and reliable PHC HIS. This is true for the HIS at all levels of the Armenian health system.

## 13.2. SUPPORT FOR MANAGING THE NEW MODEL OF PRIMARY CARE

Implementing the new model of care entrusts new functions to management. Management practices must become more informed and participatory and be aimed at continuous improvements in PHC practice in a dynamic environment. This requires complementary improvements in information management to ensure timely and effective decision-making. A more flexible, responsive, and consensus-based management approach will enable PHC facilities to weigh options and take advantage of the opportunities offered by PHC reforms.

ASTP technical assistance ensured that implementing new health care activities -- such as open enrollment (Chapter 8) and continuous quality improvement (Chapter 10) – was possible through participatory management and new HMIS. Improving management in the pilot sites has four critical components:

- Operational Management
- Financial Management
- Human Resource Management
- Information Management (health and financial)

These are the core management functions applicable to any organization and ASTP technical assistance aimed at applying these management functions to PHC facilities. Thus, management aimed to achieve:

- Improved quality and efficiency in the pilot PHC facilities.
- Efficient use of human and financial resources.
- Reduced clinical service costs without sacrificing quality of care.
- Creating an environment that supports new and creative ways to better satisfy patients needs.
- Developing an effective work force and introducing performance incentives and performance appraisal tools.
- Introducing new systems for managing health information with greater reliance on computers.

## 13.3. ASTP SUPPORT FOR IMPROVED MANAGEMENT

ASTP employed several approaches to strengthen management in the pilot sites. These included the creation of facility level Coordination Committees (CC), the adoption of new internal policies and procedures, and the development of job descriptions and contracts for facility employees. In line with these tools, the

financial management component was strengthened by introducing elements of managerial accounting such as PHC service cost calculation, and tracking revenues and expenses of departments[21]. As a support to the financial management component and linking open enrollment procedures to performance based remuneration an automated financial accounting system[22] was implemented.

### *13.3.1. Coordination Committees in ASTP/MOH pilot sites*

In September 2003, Coordination Committees were introduced to first generation ASTP/MOH pilot sites (Yerevan Municipality Policlinic #17, Policlinic of Erebuni Medical Center and Vanadzor Polyclinic #4) as advisory boards serving the facility director. The Coordination Committees created a supportive environment for the introduction of Family Medicine and promoted quality improvement. They communicated with the staff about reform issues, provided staff feedback to administrators, made recommendations to polyclinic directors on how to improve quality and efficiency, advocated for staff training, and monitored execution of facility contracts. The Committees were given a clear role in facility governance and decision-making, terms of reference, and received management training. Physicians and nurses participating in Coordination Committees were exposed to management issues.

Establishing CCs began with the development of charters and introducing the concept to staff. Together with ASTP specialists, senior staff of polyclinics were involved in the development of the charter. Staff involvement ensured the charters reflected the unique aspects of each polyclinic. CC members were elected from among core staff representing clinical departments (FM, pediatric and therapeutic) and general administration. Each facility determined its CC structure. Members of an elected CC were assigned specific tasks by the Chairperson.

The seven to nine members of the CC played an active role in identifying problems and offering solutions on administrative issues, human resources questions and information management systems. CCs were directly involved in monitoring CQI procedures, the open enrollment processes, performance based remuneration, and monitoring of clinical protocols. CC sessions are convened either by the Decree of the Chairperson or according to a preliminarily fixed day and time. Prior to each session the Secretary and the Chairperson prepares the Agenda of the session and provides it to all CC members.

### *13.3.2. Internal (facility) Policies and Procedures*

New internal policies and procedures were introduced to improve the operational management processes. They help standardize activities by clearly communicating facility goals and expectations to all staff and to promote the development of broader management systems within the facility. They also help the staff to manage their time efficiently by acting as guidelines for complex situations and in training the staff for new procedures and processes in the facility.

Two groups of clinical and non-clinical policies and procedures were established during 2003-2004 to guide employee conduct, organize administrative and financial operations, improve documentation and paper flow, support continuous quality improvement -- including infection control, screening, and diagnostic procedures -- and improve PHC HMISs. Examples of such policies are “Confidentiality of Patient Personal Data and Medical Records Policy”, “Enrollment and Encounter Flow and Data Entry Procedures", “Peer Chart Review Procedures”, “Maintenance of Medical Charts and Their Circulation Procedures”, “Infection Control Procedures,” and “Prevention of Infections Transferred Through Blood.”

### *13.3.3. Job Descriptions and Employee Contracts*

New job descriptions and employee contracts were drafted by ASTP to reflect new duties related to the implementation of the Family Medicine model of primary care. The goal of the new job descriptions was to clearly define the scope of responsibilities in a way that included the objectives of improving organization activities -- organizational management, delivering primary care, and financial management. The job descriptions guide employees in fulfilling their responsibilities and define key roles and functions. Job descriptions were developed for heads of departments, family physicians, other PHC physicians, PHC nurses, facility managers, accountants, statisticians and enrollment encounter data entry operators.

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[21] More on this subject can be found in PHC Financing and Remuneration Final Report

[22] For complete and detailed information see “How to Track Revenues and Expenditures”, section -Automated Financial Accounting System

Newly designed employee contracts specify facility and employee relationships -- updated to reflect the requirements of the new GOA labor code. Prior to implementation in pilot sites, the new job descriptions and employee contracts were reviewed and approved by MOH.

## 13.4. MANAGEMENT AND MIS TRAINING

### *13.4.1. Management Training*

The new model of primary care required new knowledge and skills to prepare management. In addition to clinical training, ASTP organized basic management and health management training that exposed participants to basic management concepts, business planning and management, legislation and regulations, human resource management, marketing of health care services, and health financing and financial management. A total of 2,150 hours of training and seminars were delivered to improve the managerial skills of polyclinic directors and head doctors, FM department heads and family doctors of polyclinics of Erebouni district of Yerevan and Vanadzor including rural Health Centers in villages Vahagni, Dsegh and Tumanyan.

### *13.4.2. MIS Training*

Management training was augmented by training in the new HMIS for the specialists who would be responsible for running the systems. More than 1,750 person/hour training was conducted for about 32 operators in all ASTP pilots and for 20 physicians, nurses and registrars from EMC polyclinic and polyclinic #17. The accounting software developed vendor SoftMaster LLC was chosen to develop and conduct individual and group training courses. The training course included:

1. The organization and components of the software
2. Transaction data entry sequence
3. Transaction data adding and editing procedure
4. Processing financial and business transitions
5. Archiving the accounting data base
6. Generating five basic financial accounting reports

Two accountants and the chief accountant from pilot sites – a total of 10 people – also received training. During the two-week course in August 2003, the accountants received intensive training in the use of accounting software. The training was conducted in two phases. The first phase covered the asset and liability accounts, ledgers, cash receipts and distribution journals of the main book. In the second phase the trainees were given practical tasks for individual work and covered payroll accounts of salary and wage module of the software.

## 13.5. BUILDING IT SYSTEMS TO SUPPORT BETTER MANAGEMENT

### *13.5.1. The Old MIS Systems*

The ASTP/MOH pilot sites were employing information management systems that dated back to the Soviet period. The numerous reporting forms were inherited from that time -- many still using the Russian language. ASTP studies at 3 pilot facilities found that medical records were not regularly and accurately updated. By comparing the number of actual medical records at the polyclinic with the catchment area population attached ASTP found that between 25% and 30% of records were missing. Medical records of people no longer served by the doctors (because of death, relocation, or emigration) remained stored in the facility.

The combination of poorly organized patient records and limited updating impeded the provision of better, continuous patient care. Each PHC had a centralized HIS focusing on morbidity and mortality reporting, with data flowing from individual health units to the district and national levels. There was little reporting to facility management. Financial data and data on clinical performance units were not directly linked. Data tended to be over-reported in some areas and under reported in others..

Previously, accounting departments of almost all PHCs were conducting only financial accounting, neglecting reporting of financial matters that should be of critical concern to management for planning, controlling, and decision making. Recording, processing and generating financial accounting statements and reports was performed manually – preventing the delivery to management of timely data necessary for decision making. The quality of information -- its accuracy and level of disaggregation -- were inadequate for expense and cost tracking by the functional departments within the PHC Facility. But implementing

automating information system was problematical -- including technological issues and psychological resistance to change.

### *13.5.2. Developing and Implementing the New Primary Care HMIS Systems*

Key components of the new PHC HMIS were:

- **Population open enrollment and rostering** – – reflects patients' choice of PHC physicians and includes a database on enrollees' basic demographic, social and health related indicators. ASTP's 13 pilot PHC facilities -- serving 276,478 people with 210 PHC physicians -- have tested the open enrollment implementation techniques. The software was developed by the ASTP team based on similar systems designed and tested in Albania and Egypt. During the last four months of 2004, quarterly reporting of the enrollment database were tested and used to determine financial incentive payments.
- **Patient encounter records** – – collects snapshot data on each contact between patient and PHC provider including the purpose and result of the visit, health problems, diagnostic procedures, medical interventions, treatment, and referrals. To assess the PHC physician performance 26 indicators for children and adults were defined and 2 - 8 indicators were used in the pilots for performance incentive payment. Automated standardized reports are submitted to the SHA every quarter to assess the results for each PHC pilot. The database generates 19 other standardized reports for provider feedback.
- **Facility financial accounting** system contains comprehensive databases, tracks revenues and expenditures, embodies separate subsystems for cost centers, generates financial accounting ledgers, cost-accounting functions, meeting financial accounting needs of the whole facility. Automated financial accounting enables the maintenance of separate accounts for each subdivision or department within the facility and allows the preparation of financial reports for management.

New HMIS elements were developed and tested during 24 months in 13 urban and rural PHC health facilities. This was a period for testing not only the HIS itself but other systems. Health financing and quality improvement components of PHC delivery were also developed and tested as HIS data user systems. The major activities undertaken to create sustainable finance system in ASTP primary care pilot sites were:

1. Implementing a cost tracking system and use of database utility or spreadsheet application for periodically preparing cost summaries and analyses.
2. Defining cost centers. Reviewing in polyclinic and family medicine departments the human, physical plant, equipment and other resources for estimating costs of services and matching resources with local cost classification.
3. Implementing cost accounting and costing methods in pilot sites and using them for preparing facility budgets.
4. Developing a self-supporting pilot financing model, to include capitation, co-payments, fee-for-services and other revenue sources, as well as facility revenue distribution, implemented in pilot polyclinics.

ASTP provided 56 computers, 17 printers and other IT equipment to 13 pilots. MOH, regional authorities, and SHA were directly involved and supported the automated enrollment and encounter systems. Facility financial accounting databases contain comprehensive input databases, tracks revenues and expenditures according to accounting, economic and cost center classifications, generates financial accounting ledgers, offers cost-accounting functions, and comprehensively satisfies financial accounting needs of the whole facility.

## 13.6. RESULTS

### *13.6.1. Better Management*

While still at the pilot implementation stage the new approaches to management of Family Medicine facilities has proved effective. Currently, all first generation pilot sites have functioning Coordination Committees. ASTP/MOH pilot sites of the second generation are actively seeking advice and support to adopt the ASTP PHC management model including CCs and new policy and procedures. ASTP has prepared a "Manual on How to Improve PHC Management" to guide PHC management improvement independently.

PHC clinical capacity will strengthen when they become fully engaged in disease prevention and health promotion. Facilities will be able to develop and maintain high quality clinical practices that will attract the surrounding population. Reformed PHC facilities will continually improve service provision responsive to population health needs and demands, using evidence-based, cost-effective delivery of medical care, with carefully monitored performance of individual staff members. The reformed facility will become increasingly autonomous with efficient and effective internal management structures and operations.

#### *13.6.2. MIS Systems Improvement*

The new PHC health management information systems are already contributing directly to improved PHC management and assessment of continuous quality improvement systems (see Chapter 10). An HMIS is now functional in all 13 pilots. Patient enrollment and encounter data began with paper forms and entering the data into computerized databases for data storage, processing and analyses. In Yerevan and Lori marzpetaran a new enrollment database has been established, and the database will increase in both places with the increase of involved PHC providers and the population in the open enrollment process. The physician, administration and managers feedback information system will operate and they will receive systematic information feedback based on an established schedule, and specific queries can compose other reports per user needs or per any other authorized agency request. The automated MIS will provide data to generate indicators for the new performance incentive financing model which is also in pilot testing during 2005.

The PHC HMIS was officially submitted to the MOH in September 2005 for its future free use by the system based on the MOH decision on expansion of enrollment and encounter systems over the PHC services in the country.

At the beginning of June 2005 ASTP completed the implementation of AAS in Vanadzor PC#4. At present the accounting department generates all five required accounting statements: Balance Sheet, Income Statement, Cash Flow Statement, Changes in Equity, and Adjustments to Balance Sheet Statement.

The Polyclinics of Erebouni Medical Center (EMC) is completing justification of synthetic accounts and instructions of financial statements, on which the generation of five financial statements are based. After completion of the task and after an implementation check, EMC will conduct phased-in automated accounting (see description in section 2.3). PC#17 transitioned to automated accounting in July 2005 after implementation proceeded with fully automated processing of financial accounts.

### 13.7. FUTURE DIRECTIONS TO ENSURE SUSTAINABILITY

As the autonomy of Family Medicine Departments or group practices is increased, Family Physicians and Family Nurses must assume additional management responsibilities, either as active members of polyclinic or facility Coordination Committees or as Heads of Departments or group practices. With support from the polyclinic directors the Coordination Committees can evolve from advisory boards to governance structures that are delegated decision-making authority on and accountability for particular issues, supporting the evolution of more collegial and participatory forms of facility governance.

In rural pilot sites the number of staff is small and communication should occur on an informal basis everyday. It may not be feasible to have Coordination Committees in each rural site, but perhaps a Committee comprised of representatives of several neighboring rural sites may be more appropriate.

# ATTACHMENT A: ASTP'S CONTRIBUTIONS TO USAID STRATEGIC OBJECTIVES IN SOCIAL PROTECTION AND ACCESS TO QUALITY PRIMARY HEALTH CARE

The Armenia Social Transition Project was designed by USAID to address specific problems related to gaps in social protection and social service delivery and to accessible, affordable health care. The emphasis in ASTP has been to assist the GOA to develop the foundations, systems and capacity to create and implement deep reforms in social services and health care, as well as to manage these new systems and approaches. This attachment specifically describes and provides evidence of how ASTP has contributed to USAID objectives in these important sectors.

## STRATEGIC OBJECTIVE 3.4: IMPROVED SOCIAL PROTECTION

USAID/Yerevan devised a three pronged approach to achieving improved social protection in Armenia. This consists of: 1) improved social assistance programs for targeted populations; 2) reducing the need for government subsidies through employment and through targeting of social assistance; and 3) establishing viable social insurance programs. Together, these approaches should reduce the levels of vulnerability for Armenian citizens who are most at risk.

The primary indicator used to measure advances in improved social protection is the percentage of Armenians living in extreme poverty. These numbers have been going down since the year 2000 as can be seen in the following chart.

*Table 1. Percentage of Armenians Living in Extreme Poverty.*

| Year | Percentage |
|---|---|
| 1999 | 22.9% |
| 2001 | 16% |
| 2002 | 13.1% |
| 2003 | 7.4% |
| 2004 | 7.2% |

### *Intermediate Result 3.4.1 – Improved Social Assistance Program for Targeted Programs and the Contribution of ASTP*

Based on an analysis of statistical data on the incidence of poverty within the Armenian social structure from the 2001 HIE survey, NSS and ASTP was able to provide evidence to the Ministry of Labor and Social Issues and to the Ministry of Finance that the absolute poorest families in Armenia were those with three or more children in the household. The evidence for this claim is based on integrated surveys of living standards of Armenian households conducted since 2001 with additional financial assistance from the Food Security of the European Commission. The analysis and publication of survey results have been supported by ASTP since 2001, resulting in published Statistical Bulletin in 2002 and 2003, and in the publications (same dates), Social Snapshot and Poverty in Armenia. These compelling data led to improved targeting of state social assistance, specifically, the Poverty Family Benefit system. Since 2002, families with children get higher benefits. The new formula for determining the amount of benefits is further indexed based on the amount of income each of these families has, as well as the number of children in the household. Thus, the most poor receive higher benefits. Households located near conflict borders and households located in high altitude areas were also found to be extremely poor. The poverty family benefit payment is targeted to these households as well.

While other factors have indeed contributed to the reduction of poverty and extreme poverty in Armenia, one can point to the improved targeting of the poverty family benefit system to the poorest families as one of the primary factors associated with this reduction. Furthermore, the amount of the poverty family benefit has increased. This increase can be associated with ASTP recommendations and support to remove pensioners from the poverty family benefit system, and to the reduction of families who now apply for the poverty family benefit based on wide spread public education campaigns supported by ASTP on the eligibility

criteria. These factors have contributed to making it possible for the benefit to increase as shown in the following table.

*Table 2: Changes in Average Monthly Benefit Payment for Qualifying Families*

| Year | Amount (drams) of Monthly Benefit Payment |
|---|---|
| 2000 | 7,675 |
| 2001 | 7,215 |
| 2002 | 6,295 |
| 2003 | 7,200 |
| 2004 | 8,900 |
| 2005 – Three Tier Benefit System Introduced | 12,000 for poorest |

*Lower Level Result 3.4.1.1: Strengthened Mechanisms for Service Provision and the Contribution of ASTP*

While systematic improvements in the Armenian economy and in stable job creation are required for a permanent and sustainable reduction in the incidence of poverty and extreme poverty, future reductions will be supported in part by improvements in the administration of social services to the most vulnerable, and through the benefits that will accrue to all Armenian citizens with the introduction of a national Social Security System. ASTP's major contributions to this result include the introduction and implementation of the Integrated Social Service Center, fundamental support for a national Social Security Card system, and support for the drafting of an improved and comprehensive social service and benefit law.

*The Integrated Social Service Center*

With USAID funding, ASTP has introduced a model of improved social assistance administration through the concept and implementation of the Integrated Social Services Center (ISSC). First piloted in the city of Vanadzor in Lori Marz and more recently in the town of Masis, ISSCs have been established in cooperation with mayors, municipal officials and NGOs. The essential features of ISSCs include the co-location of offices providing social services, sharing of databases between offices, a reception area with an NGO representative and representatives from each municipal level social service office for answering basic questions and providing information, referrals to NGOs for further assistance that cannot be provided by the State, customer orientation training for representatives, and an NGO and community room. Initial assessments of these ISSCs conducted six months after their establishment are already showing an increase in customer satisfaction, time efficiencies for both social service offices and customers, a reduction in costs incurred by citizens in travel, time and in the need for duplicating necessary materials required for services, and improved treatment of citizens who come in for social services. Referrals to NGOs and the NGO representative have resulted in the expansion of social service delivery to Armenians who do not qualify for State social assistance and to citizens who need additional services not provided by the government.

The ISSC in Vanadzor has recently been given the President's Award. Based on the early encouraging results of these two ISSCs, the World Bank have made commitments to fund ISSCs in other marzes throughout Armenia. With MLSI, ASTP presented the ISSC concept at a two WB day conference in September 2005 with the purpose of discussing lessons learned and the benefits of ISSCs for both citizens and service providers. Other improvements that have been introduced with the assistance of ASTP include an improved appeals system, training of social assistance staff and the provision of staff manuals, and improved audit visits to reduce fraud. Public education campaigns launched through various mediums have widely and effectively publicized the qualifying criteria.

*Social Security Card System Designed and Implemented*

ASTP's support for this important achievement include the development of a comprehensive implementation plan, assistance for the design of necessary reforms, acts and regulations to underpin the system, the provision of necessary hardware and the design of software. ASTP worked with MSLI and regional offices to pilot test the system in Abovian, and worked with the MLSI Public Education Unit, also supported by ASTP, to design and mount public education campaigns that introduced the Social Security Card system and

its benefits to Armenian citizens. ASTP supporting training for social service providers to process applications and to provide guidance to citizens applying for their cards. ASTP also provided assistance to the NORK Center for processing and printing Social Security Cards, as well as support for the implementation of the system nationwide.

*Support for the Design and Passage of the Law on State Social Assistance and the Law on State Benefits*

The Government of Armenia lacked a comprehensive overarching law governing the provision of state social assistance. Legislation was developed piecemeal following the collapse of the Soviet Union, with normative acts addressing individual social issues and needs. Coordination between and within Ministries and other governing bodies administering social services existed only when individuals made special efforts. To aid the Government in developing a framework and comprehensive approach to guide the delivery of social assistance, ASTP translated social assistance laws from CIS and European countries for discussion by interested stakeholders in the government. They also brought in an international expert on social assistance laws to speak to them about world wide experience. Based on a mutual study of international experience and the Armenian experience over the past 12 years, MLSI began drafting a social assistance law that fit Armenia's needs. ASTP provided MLSI with substantive legal support in drafting sections of this law, and organized a conference for important stakeholders around Armenia (including representatives from Ministries, Agencies, the Prime Minister's Office, the National Assembly, and key NGOs) to discuss each feature of the proposed law.

The new law was approved by the GOA and formally submitted for reading by the National Assembly. Passage is expected this fall. The Law puts forth a coordinated framework for the sustained provision of social assistance to all categories of beneficiaries, as well as the institutions that may now be included as social service providers. The State Law on Social Benefits sets forth the criteria for eligibility for Poverty Family Benefits and for Lump Sum payments upon the birth of children. When passed, it will also expand the provision of social benefits to two new categories of beneficiaries: working mothers with children under age two, and the homeless. The law will also require MLSI and other agencies to use HIES data for making social policy and for adjusting formulas.

*Lower Level Result 3.4.1.2: Increased Awareness of Programs and Requirements and the Contributions of ASTP*

AST assisted the MLSI to create a Public Education Unit to support publicity and understanding of reforms in benefit programs. The eligibility requirements for receiving the Poverty Family Benefit were changed in 2002 with a focus on poor families with children, households in conflict border areas, and households located in high altitude regions. ASTP collaborated with the MLSI Department of Social Assistance and the Public Education Unit to develop a comprehensive public education campaign using a variety of media vehicles to inform Armenian citizens of these changes. The aim was to encourage qualified families to apply, as well as to dissuade those families who do not meet the eligibility requirements from applying. Leaflets, brochures, and posters were distributed to communities throughout Armenia, and particularly in remote locations where often the poorest reside. Results show that in 2003 there was a significant reduction in the proportion of Armenian households that registered for the PFB as shown by the table 3 below. These figures demonstrate the growing public awareness of program eligibility requirements.

*Table 3. Proportion of Households Registered in the PFB System as a Percent of the Total Number of Households in the Republic of Armenia*

| Year | Proportion of Households Registered in PFB System |
|---|---|
| 2000 | 52.85% |
| 2001 | 43.99% |
| 2002 | 38.61% |
| 2003 | 28.37% |
| 2004 | 28.20% |
| 2005 (September) | 16.48% |

ASTP also launched a major public education campaign in collaboration with MLSI to describe both the benefits of, and instructions for, applying for a Social Security Card. ASTP monitored the implementation process through visits to communities around Armenia to discuss what problems social service officers were having in registering applications, and the problems that citizens were having in filling out their applications. Hot Lines were set up for citizens to ask questions, and Hot Line teams held community meetings for people to ask questions about the application process. As a result of the comprehensive messaging in cooperation with many Social Service Offices around the country, 77% of the Armenian people now hold a Social Security Card (as of May 31, 2005).

### *I.R. 3.4.2 Reduced Need for Government Subsidies -- ASTP's Contribution*

While this particular IR is related to the labor and employment portion of USAID's Strategic Objective program, ASTP has also contributed to reducing the need for government subsidies. Based on the effectiveness of the public education campaign (described above), over 6,000 fewer families in Armenia are receiving Poverty Family Benefits as compared to 2002 when the revised targeting for Poverty Family Benefits was introduced.

### *I.R. 3.4.3 Social Insurance Programs Strengthened -- ASTP's Contribution*

Armenia's social insurance programs are being strengthened as a result of progress being made in the rollout of the personified reporting system (PARNAS), the improved social insurance collection rate now that the State Tax Service Center has assumed collection responsibilities, and to fundamental reforms in the pension system.

ASTP's landmark assistance to improving the personified reporting system, coupled with the national rollout of the Social Security Card system, is leading to an increase in the number of employers that are making payments to their local SSIFs based on the number and income of each of their employees, and more employees are contributing to the SSI directly through their paycheck deductions. See Table 4 below.

*Table 4: Number of Employees contributing to SSI through Paycheck Deductions*

| Year | Number of Contributing Employees |
|---|---|
| 2003 | 365,500 |
| 2004 | 290,000 |
| 2005 | 455,000 |

One key aspect of the recent important pension reforms supported through ASTP assistance (see LLR 3.4.3.1 below) led to the successful transfer in 2004 of tax collection responsibilities from SSIF to the State Tax Administration Center. This transfer has resulted in a greatly improved tax collection rate equal to about 50% over what SSIF was able to collect in 2004. As a result, the foundation of the SSI program has been strengthened, and the Government of Armenia has begun to increase the minimum pension amount it distributes (from 4,000 drams in 2004 to 5000 drams in 2005). As more shadow employees are encouraged by these reforms which link future pension payments directly with contributions, and shadow pensioners are weeded out of the system, Armenia's social insurance programs will stabilize and provide even greater benefits for deserving pensioners.

### *LLR 3.4.3.1 Framework and Infrastructure Developed (for Strengthened Social Insurance Program) -- ASTP's Contributions*

The framework and infrastructure for Armenia's social insurance program have been achieved through reforms to the pension system, the development and implementation of systems for personified reporting and Social Security Cards, and the establishment of a professional actuarial program. In each case, ASTP closely collaborated and supported the GOA in:

1. Designing and implementing **key reforms underpinning the pension system** which increase the efficiency, solvency, and social justice within the current system. Highlighted aspects of these reforms include transfer of social pensions from the Social Insurance Fund to the State Budget, transferring the collection system from SSIF to the State Tax Administration Center, the equalization of pension ages for men and women, and eliminating privileged pensions for certain sectors (e.g. the judiciary).

2. Designing an implementation plan for a **personified reporting system** (PARNAS), including support for software, the installation of hardware, training in the use of the system, and successful pilot implementation. This system, designed in collaboration with the State Social Insurance Fund as well as with the Ministry of Labor and Social Issues, links reporting with the Social Security Card of individuals which will ensure that employers will make their social insurance returns based on actual contributions to the social insurance fund.
3. Designing an implementation plan and a law **Social Security Card system** with MLSI, followed by the design of Social Security Cards, pilot testing, establishing a social security database, mounting a public education campaign, trouble shooting sources of application errors, and supporting the processing and issuance of cards. Implementation of the system was completed in 2005. The implementation of the system of requiring Social Security Cards in order to receive a pension benefit has eliminated from the system many fraudulently or erroneously listed beneficiaries (see Table 5 below).
4. Establishing a **Government Actuarial Office** to carry out analysis to support pension planning and policy decisions on pension reforms, and to determine the effects of policy decisions (2003); and a BA and MA level Actuarial Science Educational Program at Yerevan State University. The Actuarial profession was certified by the Ministry of Education in 2002, and the Bachelor Degree and Masters Degree Program in Actuarial Science was established at YSU in 2003. To date 11 Masters level students have graduated with a degree from this program.

#### *LLR. 3.4.3.2 Increased Transparency and Accountability – ASTP's Contributions*

With support from ASTP, the social security database, established in 2004, has been linked with the pension, unemployment and social assistance databases. The Social Security Card provides the key link between all of these databases for information on income, which can now be verified for use in establishing benefit eligibility and benefit amounts. This linkage has provided a key means of bringing transparency and accountability to the social insurance and social benefit system. The linkage of these databases also contributes to the strengthening and accuracy of targeting for the poverty family benefit system, and reduces the need for documentation from each social service office that applicants must supply in order to receive the benefits that are due to them.

### STRATEGIC OBJECTIVE 3.2 INCREASED UTILIZATION OF SUSTAINABLE, HIGH QUALITY PRIMARY HEALTH CARE SERVICES

In coordination with the Ministry of Health, SHA, and many other partners, ASTP has played an instrumental role in increasing the availability and access of sustainable, high quality primary health care services in Armenia. These program areas are comprised of pilot sites that have established family medicine units in 13 clinics. The numbers of client visits are supported by documentation of the visit through encounter forms and patient records. Availability has also been increased through legislation and training provided to expand the number of conditions that family medicine practitioners can treat, and through an increase in the number of primary health care providers that have been trained using curriculum designed under the support of ASTP.

At the same time, the quality of primary health care has increased through the establishment of a quality care system and a performance-based payment system for physicians which depends on the number of clients the physician can attract and retain through the open enrollment system. The financial sustainability of this evolving primary health care system is enhanced by contracts between the State Health Agency and primary healthcare provider organizations using this performance-based payment mechanism, as well as through community-based social insurance schemes and the improvement of the National Healthcare Account system which will be used for improved decision-making and budgeting.

The Monitoring and Evaluation (M&E) component of ASTP served two purposes: (1) examining the effectiveness of key interventions in pilot sites; and (2) serving as a model for the facilities to use data in program management and decision-making. As a tool for tracking successful program implementation, the M&E system was designed to examine the progress regularly to see whether the interventions intended to produce desired effects actually do so

*Baseline assessments*

In order to obtain a baseline picture of pilot sites, the following assessments/surveys were conducted:

- Organizational self-assessment
- Providers knowledge test
- Provider skill self-assessment
- Utilization data collection
- Patient satisfaction survey
- Financial assessment
- Household survey at catchment areas of polyclinics

The organizational self-assessment (adapted from the US Accreditation Association for Ambulatory Health Care) was conducted by ASTP staff together with the Coordination Committees of each polyclinic. The assessment tool consisted of a variety of questions on patient rights, internal management mechanisms, quality of care standards used at the polyclinics and other aspects of the polyclinic functioning. The questions were discussed with Coordination Committees who were asked to describe how things were done in their polyclinics and how everyday functions of the polyclinics were carried out.

Provider knowledge test was done through a multiple-choice questionnaire, a modified American Board of Family Physicians sample examination, which asked a variety of questions on family medicine topics. The provider skills self-assessment asked the providers to evaluate their skills in the areas specified in Family Doctor and Family Nurse Statements developed and adopted by the Ministry of Health of Armenia.

The utilization data was collected from polyclinic directors to get the key measures of utilization, such as overall number of visits, referral rates, types of conditions managed by providers, rate of medical visits vs. non-medical visits, etc.

The patient satisfaction survey was conducted through an anonymous self-administered questionnaire consisting of 23 questions asking questions about the care and medical advice provided, about the physical layout of the premises, the attitude of staff, and about waiting time and length of visit. The survey was facilitated by surveyors whose role was to greet patients, hand out the questionnaires, explain the purpose of the study and ask to fill out the questionnaire. The survey was the first in the series of follow-up surveys to be conducted semiannually.

Financial assessment included periodical analysis and monitoring of main financial indicators of facility's performance, as well as introduction of the cost accounting and price setting mechanisms for the services. Main objectives of the financial assessment were cost-effectiveness analysis and search for the ways to improve the effectiveness, as well as comparative analysis of performance indicators of different functional departments (so-called "cost centers") within the polyclinic. Major focus was put on the assessment of the newly established Family Medicine Departments.

A major source of baseline data was a household survey conducted in the catchment areas of the polyclinics which provided a variety of baseline data on population perceptions of and access to primary healthcare. Center for Health Services Research of the American University of Armenia was subcontracted to do this household survey.

**Summary of Findings of Baseline Assessments and Use of Information for Program Design**

*Organizational self-assessment*

The strengths of the polyclinics were in the area of pediatric care and continuity of care in pediatrics, as well as the close contact of patients with their providers. According to doctors patients had access to them after hours. This information was confirmed by patient satisfaction survey. The weak sides were lack of information for patients, such as patient rights and patient education materials, and not following externally defined standards of medical care, such as evidence based protocols and guidelines. The findings of this assessment were used for designing all major interventions of the new PHC model.

*Physician knowledge test through Multiple Choice Questionnaire*

In spite of the fact that mean scores among different specialists were approximately the same, the performance by topics was different, e.g. pediatricians had strong knowledge in child care, therapists had good knowledge in Men's Health and Occupational and Sport Medicine, Ob-gynecologists were rather

strong in Woman Health and Care of Older Adults. The weak spheres of participants' knowledge were found to be End of Life and Emergency Care, Medical Statistics, Conditions of Nervous, Musculoskeletal System and Skin, as well as Human Behavior and Mental Health. The findings of this study were used when designing the Unified Family Medicine Curriculum and continuous education of providers.

*Physician self-assessment*

Of the eleven subject areas the priorities were distributed in the following way: the highest priority for training was given to Ophthalmologic Procedures, then to Emergency Care and Essential Procedures in Neurology. Consistent with Nursing self-assessment results, the lowest priority was given to Health Screenings and Procedures and Skills in Pediatrics. The findings of this study were used to design the continuous education of providers and other CQI activities, such as introduction of screening protocols.

*Nursing self-assessment*

Self-assessment showed that Nursing Process has the highest priority for training. The stratified analysis also showed that almost all groups mentioned Nursing Process as one of the main priorities for their training. Using Medicines, Health Screenings and Peculiarities of Care in Narrow Specialty Cases were also mentioned as top priorities. Unexpectedly, Health Screenings had received a very low score for priority among nurses with least experience. The findings of this study were used to design the continuous education of providers and other CQI activities.

*Utilization data*

According to statistics provided by the polyclinic directors utilization is different in all three polyclinics, with the highest being in PC17 and the lowest being in Vanadzor PC#4, which is explained by the size of polyclinics and by the fact that PC17 had contracts with different enterprises to conduct periodic prophylactic checkups of their employees. Referral rates also were different in the three polyclinics, although pediatricians consistently referred less frequently than terpevts, and this was true for all three polyclinics. The utilization data certainly provided some general idea about patient flow at different sites. However the data provided by pilot sites proved to be of low quality because it was manually counted, used inconsistent definitions of patient visits and referrals and was generally unreliable. Therefore the baseline data for utilization measures was considered the data generated by the HMIS introduced by the project in pilot sites in the beginning stages of the new PHC model implementation.

*Patient satisfaction survey*

Most visitors to polyclinics were people who came periodically and were probably those who had chronic conditions. Waiting time wasn't very long (less than 15 minutes), considering most people had appointments specifying the day of the visit, not the time. An important finding was that even if a person does not see his/her provider that day, another doctor substituted him/her in 100% cases. There were more visits to narrow specialists than to primary care providers, especially where visits were for illness vs. documentation or immunization. There were comments from patients regarding improving services. Most of the comments were about payment and unaffordability of healthcare, some were about waiting time and renovation. Each polyclinic Coordination Committee received the list of these comments to work on implementing specific suggestions where possible. The subsequent surveys measured the same indicators to see whether changes were occurring as a result of all the new model of care interventions.

*Household survey at catchment areas*

Household survey revealed that the most prevalent health problems were cardio-vascular diseases, gastrointestinal diseases, ear, nose and throat diseases and other chronic conditions. It also showed low utilization of primary health care services and low financial access to health care facilities. Attitudes toward primary health care providers were positive; however, utilization of primary health care as compared to specialized care was low. Most people prefer to self-treat instead of seeking care. Fewer adults used a district physician as a first contact physician, but most children did. The findings of this survey were used to design all major ASTP interventions.

**Use of data for decision making**

One of the objectives of the new PHC model and its interventions was building the pilot sites' capacity to make decisions based on data and evidence, thus the M&E component focused on providing tools and examples for PHC facilities to use data in facility administration and decision-making. The introduction of the automated PHC MIS system, various CQI activities, routine patient satisfaction surveys, and facility

financial data provided the facilities with new, reliable data sources. PHC facilities needed the capacity to analyze data, cross-check the findings, and make valid conclusions and extrapolations. This was an important step towards evidence-based decision making and breaking away from the habit of using personal subjective judgment for making decisions. In order to foster the process, the M&E system of the model has conducted a variety of focused studies both for program monitoring purposes and for providing evidence for decision making. These focused studies ranged from direct observations of skills of providers to surveys among patients and providers, from medical record counts to impact of performance-based remuneration on provider behavior. Where possible and appropriate study results were shared with the management of pilot sites and with Coordination Committees. Along with the results interpretations and inferences have been offered to guide the process of analyzing the findings and applying them in decision-making.

Aside from focused studies aimed at finding out about specific issues, other simpler tools have been devised for pilots to be able to quickly track information on enrollment and encounter numbers, on the number of entered forms into the automated database so that the managers could quickly find out what the progress has been on operational indicators to make possible adjustments if necessary.

No individualized physician data has ever been shared with Coordination Committees. Such data has only been shared with respective doctor or with respective manager; however polyclinic averages have been shared not only with respective pilot site but also with other pilot sites. This has provided pilots with grounds for comparisons and has created some sense of competition among them. This in turn resulted in desire to perform better to show better results.

**Brief Description of Major Studies**

*Regular patient satisfaction surveys*

A total of four patient satisfaction surveys have been conducted during 2003-2004 on a semiannual basis. The responses of each of the 23 questions have been compared each time with the results of all previous surveys. Trends have been analyzed and provided to the Coordination Committees along with suggestions and comments from patients.[23]

*Enrollment and Encounter weekly updates*

ASTP has been tracking the numbers of filled enrollment and encounter forms at pilot sites since the launch of the new PHC model in pilot sites. Because in the beginning stages of the HMIS implementation there was a continuous data entry gap, the HMIS could not provide real-time data, thus the purpose of weekly updates based on weekly counts of paper forms allowed the pilots to be informed of the weekly changes in real time. The data has been used to provide quick weekly analyses of some simple indicators such as average number of visits per doctor per week, average number of enrollment per doctor per week, percent of catchment population enrolled, etc.

*Direct observations of pediatric practices*

The purpose of this study conducted in November 2003 was to find out the effectiveness of two types of trainings of pediatric primary care in terms of provision of evidence-based pediatric care at pilot sites. The findings showed that both trainings (NIH FM training and Pediatric Primary Care training provided by the Armenian Association of Pediatrics) had an impact on the provision of evidence-based pediatric primary care, however the training offered by the Association was more effective. The findings were shared with both organizations and were taken into account when designing the Unified Family Medicine Curriculum (UFMC).

*Regular peer chart review reports*

Peer chart review process is an important component of CQI. Aside from being an effective tool for continuously improving quality of care, it also provided important data on indicators like use of evidence based literature in clinical practice. These reports have been provided to pilot sites on monthly basis starting from January 2004.

*Medical records survey*

This survey was conducted in February 2004 and was a combination of counts of medical records and a questionnaire and interviews with randomly selected physicians. The purpose was to find out what

[23] See ASTP report 113.

percentage of medical records was missing, why and what could be done to improve the situation. The results showed that there were up to 30% population with missing medical records. This finding triggered implementation of different CQI measures and introduction of policies and procedures to improve the situation.

*Medical records counts*

This study was done one year after the previous study in February 2005 to find out whether the situation of missing medical records had improved since the implementation of different interventions. The same physicians as in the previous study were sampled and the same counting methodology was used to compare the findings with the results of the previous study. The results showed significant improvement with the percentage of missing records reaching as low as 1% in Vanadzor PC4.

*Medical records and encounter forms conformity study*

This study was initiated in summer 2004 by ASTP with the purpose of handing the methodology over to the pilot sites to do periodic checks of the information contained in the medical records and in the corresponding encounter forms. In the ideal situation there shouldn't be discrepancy among these two carriers of information on patient visits. This will be used as a valuable tool for preventing inconsistencies and possibly even fraud in paperwork.

*Referral forms assessment*

New referral forms had been introduced by MOH in all ambulatory care facilities in 2004. A survey of providers at pilot sites was conducted in August 2004 to find out the usefulness and user-friendliness of these forms. According to the responses the forms were considered useful by the providers but not very user-friendly. Simplification of the forms filling and circulation were proposed by physicians.

*Medical records short forms assessment*

ASTP had introduced medical record short forms for replacing/restoring any missing medical records. The usefulness and user-friendliness of these forms were assessed through a survey among providers in August 2004. The forms were considered useful and easy to use by providers.

*Infection control skills baseline and post training observations among nurses*

As part of nurses' continuous education and CQI activities, ASTP conducted infection control trainings among pilot site nurses. In order to assess the effectiveness of the trainings a baseline and post-training observation of infection control skills was conducted by ASTP staff. The findings revealed that improved their infection control skills as a result of trainings.

*Infection control knowledge baseline and post training tests among nurses*

For assessing the knowledge of infection control among nurses and the effectiveness of the infection control trainings pre- and post-training tests were used. The findings revealed that the trainings had improved not only the skills of infection control but also the theoretical knowledge of nurses.

*Telephone survey on open enrollment awareness in Vanadzor*

In order to assess the public perception of Primary Health Care (PHC) institutions, PHC physicians, PHC services and public awareness of open enrollment issues in Vanadzor, as well as to collect information necessary for designing open enrollment information campaign, a telephone survey was organized in Vanadzor in August 2004. The findings showed that the idea of open enrollment as opposed to district attachment to PHC physicians was very well accepted by Vanadzor population (acceptance rate of 95%). It also provided valuable information for the Public Education team to devise an effective PE campaign on open enrollment awareness in Vanadzor.

*PHC reform retreat participant survey*

This September 2004 retreat brought together all important counterparts including policy makers, first and second generation pilot sites and educational institutions. The participants were asked to participate in a survey to determine their acceptance and perceptions of different ASTP interventions. The findings provided important information about the sustainability and replicability of the new model components.

*Study on performance-based remuneration impact on provider behavior*

Based on data on clinical and financial indicators of the period when performance-based remuneration system was implemented in pilot sites (September-December 2004) the trends in clinical and organizational

behavior of providers were studied. The results showed that indicators linked to remuneration for more than two months did reveal positive trends.

*Marz workshop participant survey*

A survey among participants of marz dissemination workshops (June-July 2005) is conducted to better understand the opportunities for replication of the new PHC model in the facilities other than ASTP/MOH pilot sites.

*Focus group among providers on peer chart reviews*

A focus group among pilot sites physicians was conducted in June 2004 to find out doctors' attitudes to peer chart review as a CQI tool and to listen to their suggestions regarding improving the procedures for the reviews. According to the participating physicians the peer chart reviews were very important for making physicians use evidence-based protocols both in their practice and in reviewing cases. Their suggestion was making the reviews less frequent to make the workload more manageable.

*Focus group among UFMC trainees on work of Clinical Practice Supervisors*

In September 2004 ASTP organized a focus group discussion among UFMC trainees to understand the effectiveness of trainees' work with their Clinical Practice Supervisors which was a new approach in medical education. The trainees were overall supportive of the approach and had many suggestions about improving the process of work with them, such as better explaining to CPS's their role in UFMC training and expectations from them.

**Future directions**

The M&E system provided the pilot sites with tools to make evidence-based decisions, and the first steps to establishing this practice at the pilots were successful. The pilot managers and Coordination Committees were provided with data to facilitate their decision making process. However the pilot sites were still in a passive mode and did not initiate any studies, or even formulate any questions themselves. They were in a beginning stage of understanding and appreciating the possibilities of the automated HMIS that could generate many useful reports for them. Thus, the next step would be creating a demand for information and helping the facilities to formulate questions and hypotheses themselves that could be answered through data from the HMIS system or through focused studies.

Another important direction for future work is helping policy-makers use the information better to make policy decisions. The demand and the knowledge that this is an important aspect of their work are already there among the policy makers. However the knowledge and use of actual methodologies of reliable data collection, analysis and use is still a sphere that requires further work.

### *I.R. 3.2.1 Strengthened Institutional Capacity to Implement Healthcare Reform – ASTP's Contribution*

ASTP has contributed to the capacity of Armenia to implement primary health care (PHC) through various means such as establishing improved management and decision-making systems and through the provision of training in key areas related to implementation.

**ASTP activities at pilot facilities level to establish a new PHC model:**

1. Introduction of family medicine (in three pilot sites);
2. Introduction of open enrollment of the population with PHC providers (currently covers 9% of Armenia population);
3. Introduction of continuous quality improvement system components in PHC facilities;
4. Testing of performance-based PHC financing and remuneration mechanisms;
5. Introduction of new PHC information system (development and implementation of a three-level data base system);
6. Clinical and management training of PHC providers;
7. Introduction of participatory management in PHC;
8. Implementation of public education;
9. Monitoring and evaluation.

**ASTP activities at a regional level to support the new PHC model and strengthen regional governance:**

1. Introduction of PHC computerized information system;
2. Building new capacity for future functions in planning and monitoring primary care and public health interventions;
3. Strengthening capacity to act as a principal agent for protecting population rights (starting with open enrollment);
4. Facilitation of smooth transition to wide scale enrollment with PHC providers through comprehensive public information and education campaign.

**ASTP support to national level effort in reforming PHC and strengthening state regulatory functions:**

1. Ongoing technical assistance to the Ministry of Health (MOH) and the State Health Agency in development of PHC strengthening regulation and mechanisms including family medicine training, open enrollment, service contracting, financing incentives, clinical protocols, and health information system (HIS).
2. Support to regulatory and legislative initiatives of the MOH (e.g. Law on Health, Strategic Workforce Planning).
3. Assistance to the MOH in production and countrywide dissemination of information materials on Basic Benefits Package for raising public awareness of free of charge health services guaranteed by the state.
4. Technical assistance to the MOH in establishing National Health Accounts development processes and infrastructure.

*LLR 3.2.1.1 Improved Capacity of Educational Institutions to Prepare Primary Healthcare Providers - ASTP's Contribution*

1. The National Institute of Health (NIH) and the State Medical University (SMU) utilize a unified and systematized methodology in Family Medicine (FM) training, monitoring and assessment, developed by ASTP. The training syllabus is systemic and symptomatic and utilizes a logbook approach to ensure appropriate clinical exposure.
2. Largely academic training has been substituted by clinical practice oriented training with strengthened capacity of educational institutions to deliver quality training: e.g. the NIH and the SMU staff have been trained to be capable to deliver intermittent training of PHC providers: intensive rotations interspaced with worksite-based training; the NIH with support from the ASTP established an institute of local clinical practice supervisors/preceptors, who deliver on-site clinical training to FM trainees.
3. Capacity building to deliver training outside the capital city of Yerevan has benefited from the ASTP technical input in developing standard requirements for clinical training sites/centers to provide quality training in FM. Technical recommendations on continuous medical education in FM developed and submitted to the MOH and educational institutions (NIH and SMU) contributed to improving their capacity in implementing continuous medical education in FM and ensuring the overall quality of FM training.
4. NIH, SMU and Basic Medical College for Nurses were provided with technical assistance, Unified Family Medicine Curriculum (UFMC) books, training materials and other literature, equipment and supplies.
5. The first 15 PHC providers, who were trained in accordance with the UFMC and became the first cohort of trainees to test UFMC and its implementation tools, graduate in FM at the NIH in June 2005. Two FM chairs (NIH and SMU) apply UFMC and its requirements and techniques in massive training of PHC providers that started in January 2005 and is funded from the World Bank loan funds.

*LLR 3.2.1.2 Improved Primary Healthcare Financing Mechanisms and Practices – ASTP's Contribution*

1. PHC performance-based financing and remuneration systems piloted for four months in 2004 involving 12 facilities and about 500 primary health care workers. On average pilot facilities earned additional 11% to their capitation funding and an average increase in PHC provider's salary reached

16.5% (a range between 1% and 65% increase depending on individual performance results). Implementation of pilot system underwent monitoring and evaluation of its impacts.

2. A refined model of PHC performance-based financing and remuneration was developed for 2005, its approval is expected in April 2005. Performance financing pool was established at the SHA accounts for 40-45 million AMD or additional 10% to capitation budgets of participating facilities. This pilot system proposes establishment of a joint PHC performance assessment commission under the auspices of the MOH that will be receiving performance reports from pilot facilities and deciding on rewards according to the pilot PHC financing provision adopted by the MOH. The Commission will start its functioning in April-May 2005. There is an indication of commitment to have this commission as a permanently acting body for regular assessments of PHC performance countrywide.
3. The MOH is actively involved in monitoring improved PHC financing mechanism and practices: analysis of the dynamics of performance indicators applied by 3 pilot polyclinics was prepared at the request of the Deputy Minister of Health. This analysis was focused on salary costs and their share in the polyclinics' revenues, both for the entire facility and by departments.

*I.R. 3.2.2 Improved Service Delivery in Priority Primary Healthcare Disciplines – ASTP's Contribution*

*LLR 3.2.2.1 Expanded and Enhanced Services at the Primary Healthcare Level – ASTP's Contribution*

1. Encounter data show increased utilization of PHC services that can be associated with improved access, trust, quality and scope of primary care services: in the previous 12-month reporting period number of patient visits was recorded as 57649, and from October 1, 2004 till March 25, 2005 this number totaled to 40613.
2. Encounter data show increased activity in prevention-focused approach to patient care after the creation and rollout of protocols for screening of hypertension, diabetes and cancer of breast and colon. This is in addition to developmental screening of children.
3. Activity recording confirms increased utilization of clinical protocols to treat hypertension, diabetes and lower respiratory chest infection.
4. Ten percent increase has been registered in utilization of family medicine services in ASTP/MOH pilot sites.
5. Six new pilot sites with enhanced quality of care systems in place (they start in April).
6. Increase in utilization of services and quality improvement activity is linked to remuneration of polyclinics and individual clinicians in 13 pilot sites.
7. Continued enrollment of population in all pilot sites contributes to improved service delivery, as patients are aware of their opportunity to change a chosen PHC provider to a better one, and physicians have professional and economic interests to keep attracting their patients with competent, quality and wider scope services.

*LLR 3.2.2.2 Improved Management and Administration of Services – ASTP's Contribution*

Improved Regulatory Environment for PHC Services Delivery

1. The MOH together with ASTP works on defining regulatory gaps or deficiency and contradictions in PHC service delivery regulation.
2. ASTP provides direct TA to the MOH and the SHA in developing regulatory acts in the area of PHC (e.g. piloting a new model of PHC including family medicine training, open enrollment, service contracting, financing incentives, clinical protocols, and health information system (HIS)) pursuing two main goals: improving regulatory environment for PHC and contributing to capacity building of the MOH, the SHA, and regional health authorities to perform regulatory functions.
3. ASTP timely responses to requests or initiates itself provision of feedback on drafted and already adopted regulatory acts to inform the MOH and other stakeholders about strengths and weaknesses, including inconsistency and other problems, in PHC and broader health system regulation.
4. Clinical practice regulation was enriched by the following clinical (evidence based medicine (EBM) type), PHC organization and management protocols and procedures developed and implemented in pilot

sites on: a) early diagnosis of PHC-sensitive diseases such as hypertension, breast and cervical cancer, colorectal cancer, that improves the regulatory environment and encourages a common approach to these clinical challenges; b) management of common diseases such as hypertension, diabetes mellitus and respiratory infections according to protocols, which are recognized internationally and evidence based; c) completion, circulation and storage of medical documentation in the PHC facilities; d) creation and functioning of Coordination Committees (CC) in the PHC facilities. On April 1, 2005, six additional PHC facilities in Yerevan and Vanadzor start implementation of these protocols.

5. The MOH included ASTP-designed three clinical protocols on diseases prevention and early diagnosis in Basic Benefits Package methodological package for the year of 2005, hence making these elements of clinical practice regulation universal across the country. However, we consider staff training, procurement of supplies, organization and monitoring of new clinical processes as necessary inputs to implementation of these protocols in every PHC facility.
6. Regulating PHC reform piloting: the GOA decree on PHC pilot program (November 2003) set its duration as 2003-2004.A new decree on continuing PHC pilot program in 2005 was developed, and currently undergoes review for adoption by the GOA (expected in April).
7. Open enrollment mechanism graduates from its piloting phase and will be approved by the GOA as a national provision in July 2005 (tentative).
8. Draft Law on Health developed with the support of ASTP approved by the Government in December 2004 and submitted to the National Assembly. More political negotiations and technical inputs will be needed to produce and adopt a quality legislative act in the process of hearings at the National Assembly.
9. ASTP provided technical advice to the MOH on development of National Health Policy (November 2004), specifically in determining major directions of health financing policy. Proactive TA and stakeholders' mobilization is needed to ensure production and adoption of a consistent, comprehensive and technical quality document (it is WHO's task, we just input to the process).

In ASTP/MOH pilot sites:

1. The scope of medical procedures provided by PHC doctors has increased by about 15-20% and the list of unique diagnoses dealt with by PHC doctors has increased by about 25%.
2. PHC doctors are skilled to provide all basic health checks and health screenings, some of which in the past were provided by narrow specialists only.
3. Regular surveys show some positive trends in patient satisfaction with PHC services.
4. There are established PHC practice quality monitoring and improvement mechanisms such as encounter recording and analysis, peer medical chart review, continuous medical education of PHC providers, patient education, implementation of EBM clinical protocols, and others.

Improved PHC Management and Administration of Services

1. Implementation of participatory management in ASTP/MOH pilots: Coordination Committees (CC) in pilots continue active functioning as advisory boards strengthening management of PHC facilities and addressing issues of proper implementation of systems and mechanisms that improve PHC. ASTP anticipates that CCs will be established in six more sites starting April 1, 2005.
2. Improved financial management and PHC resource management:
   a. Three pilots have fully operational automated financial accounting systems that ensure accurate and timely reporting of accounting statements to tax authorities, and internal use for effective management.
   b. Progress in improving managerial efficiency and capacity, improving financial transparency, and in identifying cost centers and actual costs, has been made in each pilot site.
   c. Since October 2004, pilot polyclinics implement PHC revenues and expenditures tracking system (separate financial accounting of PHC units/FM departments) to prepare for actions in improving practice of retaining earnings in PHC for full cost recovery and practice development use.
2. Informed management in place and being scaled up: in addition to improved generation and flows of information on financial status of pilot facilities and their PHC units, pilots have implemented comprehensive PHC enrollment and encounter information system that informs about enrollment process (coverage, pace, etc), enrollees, and volume, structure, duration, content and scope of interventions, as

well as referrals, diagnoses, clinical outcomes, etc. Clinical and organization management has benefited from becoming an informed management practice. On April 1, 2005, six pilots that have introduced only enrollment system start implementation of encounter module of this PHC HIS.

3. Managing new systems and mechanisms at facility level by internal means and skills: ASTP has been setting up a process of transferring the ownership for the new model of PHC to ASTP pilot sites. This activity has been aimed at ensuring the sustainability of project's innovations through effective functioning of facility level CCs, use of internal protocols and procedures and motivation established by a new PHC financing and remuneration mechanism. ASTP anticipates that by the end of the project (July 2005) a progress will be made in level of ownership pilot facilities have in innovations implemented with ASTP's support.
4. Development of management skills adequate for entering a period of PHC organization change: Management training for extended number of PHC facilities in Yerevan and Lori Marz (scheduled for June) will deliver knowledge and skills in business/activity planning to prepare for adequate action and alternatives' selection in future organizational reform of the PHC sector.

*LLR 3.2.2.3 Increased Outreach Services Provided to Vulnerable Populations – ASTP's Contribution*

Open enrollment procedure under piloting in Yerevan and Lori marz implies that enrollment of vulnerable populations (e.g. elderly and disabled) is carried out through home visits and includes health checks and counseling rendered by a PHC physician of a patient's choice. This contributes to efforts reaching out vulnerable populations.

*LLR 3.2.2.4 Increased Consumer Driven Demand for Primary Healthcare Services in Program Areas – ASPT's Contribution*

1. Since October 2004 ASTP has been implementing an active citywide open enrollment information campaign in Vanadzor that is also supposed to contribute to increase of consumer-driven demand for PHC services. Patient encounter suggests so (we can provide specific data on Vanadzor PC 4 and rural ambulatories), and the follow-up survey scheduled for April 2005 will provide data on that.
2. Assistance to the MOH/SHA in publishing information about the Basic Benefits Package and further dissemination of that information did (in 2004) and should also contribute to increasing consumer-driven demand in 2005, as more people did (last year) and will learn in 2005 about free of charge services that they are eligible for.

# ATTACHMENT B: ASTP AND ITS PARTNERS

In the course of conducting its wide-ranging activities, the USAID Armenia Social Transition Program (ASTP) has entered into many collaborative projects – both with international and local organizations. These collaborations extend the reach of all partners –reducing project implementation costs and avoid duplication of effort. The following table lists some of ASTP's partners and describes briefly the activities carried out through the mutually beneficial arrangements.

The partners listed in the table below do not include formal subcontractors that are providing goods and services for ASTP activities nor the entities that comprise the ASTP (PADCO, Abt, AIHA, QED, and AMEG).

| ASTP Partner | Activity Description |
|---|---|
| ***International Multi-Lateral Organizations*** | |
| 1. World Bank | There are many areas of collaboration between ASTP and the World Bank:<br>• ASTP supported the design and planning for the creation of Polyclinic 17 as a Family Medicine Clinical Training Center<br>• ASTP and the World Bank jointly equipped the Nork Information and Analytic center that administers the Poverty Family Benefits Program and the Personal Code system on behalf of the Government of Armenia<br>• ASTP and the World Bank jointly developed the operating systems for the Personal Code program that will allocate unique government record numbers for all Armenians<br>• ASTP and the World Bank jointly provided support for improved targeting of Poverty Family Benefits<br>• ASTP and the World Bank have jointly supported the strengthening of statistical survey capacity and analytic capacity within the National Statistics Service<br>• ASTP and the WB have collaborated on the development of elements of the planned HIS system for Armenia<br>• ASTP and the WB collaborated on developing and delivering FM training activities and on institutionalization of FM<br>• ASTP and the WB collaborated on developing National Health Accounts in Armenia. |
| 2. Council of Europe (COE) | COE supported with small grants a series of NGO/Government partnership pilot projects in Lori Marz – those pilots that were begun under ASTP's work on Social Partnerships. In addition, in collaboration with COE, ASTP facilitated the development of an exchange of social data project between Azerbaijan and Armenia to ensure that refugees in both countries could access their pension/benefit rights. The COE has also sponsored several workshops (in Malta, Ireland and Hungary) to promote sharing of information about the ISSC concept in Vanadzor between MLSI representatives and other COE member countries. ASTP translated and helped distribute 2000 copies of a report "Access to Social Rights" which is a tool to increase the efficiency and effectiveness of MLSI. |
| 3. European Food Security Programme | The European Food Security Programme provided funding to the National Statistics Service covering some of the costs of administering the Household Income and Expenditure Survey (HIES). The EUFSP funded approximately one month of Poverty Family Benefit by a transfer to the state budget each year. ASTP collaborated with EU Food Security Program in setting conditionality for this transfer. In addition ASTP collaborates with EUFSP in their program for improving the management of state orphanages |
| 4. FAOUN -- Food and Agriculture Organization of the United Nations | The FAOUN has a general Agreement with the Government of Armenia and European Commission to implement a Food Security program in Armenia. Under this General Agreement the European Commission has an Agreement with FAOUN for a package of Programs which support the implementation of Food Security program in Armenia. ASTP collaborated with FAOUN experts and NSS specialists in developing and translating a quarterly Poverty and Food security brochure. This is a useful tool for policy makers at MLSI and MOH |

| ASTP Partner | Activity Description |
|---|---|
| 5. TACIS (EU Technical Assistance Program to the CIS) | TACIS created 6 public information centers in Lori Marz. When the project ended in 2001, ASTP assumed responsibility for maintaining the public outreach project – providing staff with training and supplying the centers with information brochures. |
| 6. EU TEMPUS Program | The EU TEMPUS Program funds a distance learning social work training program in collaboration with YSU. ASTP collaborated with YSU in developing training programs for MLSI workers in the social sector. ASTP worked with EU TEMPUS to ensure that the distance learning social work training programs were suited to the social sector. EU TEMPUS funded a study visit for the Minister of MLSI and an ASTP representative to the Irish Ministry of Labor and Social Issues. A YSU Social Work Distance Learning Program is located at ISSC Vanadzor. |
| 7. OECD | ASTP collaborated with an OECD program that is assessing the affordability of water and wastewater tariff increases proposed by the GOA. Tariff increases may require changes to the PFB – an issue that is being reviewed by the WB and ASTP. |
| 8. EuroQol Group and Management Center (Netherlands) | ASTP has translated and registered health outcome measurement standard questionnaire EQ-5D into Armenian. EQ-5D was applied to population health study in 5 Marzes of Armenia in 2002. 2336 respondents participated in the study. Results were presented to the EuroQol Work Group and published in the Measuring Self-reported Population Health: An International Perspective based on EQ-5D booklet. For 2004 HIE nationwide survey the EQ-5D was completed by 17,443 respondents aged 16+ years. |
| 9. UNDP | ASTP translated a manual "Human Rights and Social Work" produced by the UN and collaborated with UNDP on the producing, launching and distributing one thousand copies to workers in the social sector, educational institutions and NGOs throughout Armenia. UNDP representatives actively participated at the ASTP presentations of Social Snapshot and Poverty in Armenia annual reports, seminars on Consumer Basket Development and ISSC. In 2004 at the request of ASTP UNDP provided a server to the Nork Center, to underpin the Social Security Card implementation. In 2005 UNDP provided $20,000 to MLSI to create a homeless shelter underpinning ASTP's work on the new Social Assistance Law, which made provision for shelter for homeless people. |
| 10. UNICEF | ASTP collaborated with Armenian office of UN Children's foundation in terms to coordinate pediatric health care training programs and continuous education of PHC providers in ASTP/MOH pilot sites. ASTP pilot sites received patient education leaflets and posters on common diseases prevention and management designed and printed by sponsorship of UNICEF health program. UNICEF shared with ASTP their reports related to poverty reduction and health status monitoring and held feedback discussions with ASTP staff. |
| 11. WHO | ASTP has supported WHO activities aimed at replacing ICD-9 with ICD-10 diagnostic coding systems and on HIS issues. ASTP collaborated with Armenian WHO representative office in designing clinical care protocols for Hypertension, Diabetes Mellitus and Acute Respiratory Infections management. ASTP collaborate with WHO on National Health Accounts and Health Workforce Planning. |
| 12. OXFAM | ASTP collaborated with OXFAM on health policy issues, and health sector regulation addressing issues of PHC and rural health system strengthening, resource mobilization, inequities, anti-corruption measures, etc. |
| ***International Bilateral*** | |
| 13. US Peace Corps | ASTP has worked for 18 months with Peace Corps volunteers in Lori Marz to deliver training to health care workers and NGOs |
| 14. Canadian Society for International Health | Canadian Society for International Health (with funding from Canadian International Development Agency developed patient encounter software that was being piloted in Artashat for maternal and child health care programs. During each mission, CSIH and ASTP met to discuss HIS development in the country. ASTP representatives have participated in several local and regional meetings organized by CSIH. |

| ASTP Partner | Activity Description |
|---|---|
| 15. Canadian International Development Agency (CIDA) | CIDA funded development of patient encounter software that is being piloted in Ashtarak for maternal and child health care programs. This software can be integrated with ASTP-developed one. |
| 16. UK Department for International Development (DFID) | DFID supported the Ministry of Labor and Social Issues in designing a mid-term expenditure forecasting system for the MLSI budget and is also supporting a policy analysis training program for MLSI senior staff. ASTP collaborated with DFID in providing data and in designing policy case studies.<br>DFID funded a three year program to modernize the Armenian Civil Service focusing on MLSI, MOH and Ministry of Culture. ASTP collaborate with DFID on this project. |
| 17. GTZ (German Foreign Aid Program) | GTZ and ASTP together with the European Food Security Programme jointly developed the fifth floor of the Ministry of Labor and Social Issues as a public education, training and policy resource center. |
| 18. TNO (Dutch HIS consulting firm) | TNO and ASTP worked with the Ministry of Health to devise a plan for the development of health indicators (mortality and morbidity rates) |
| ***USAID Contractors*** | |
| 19. AED | ASTP has developed several programs in collaboration with the Academy for Educational Development, including:<br>• Social Partnership study tour to Ukraine in 2001<br>• PHC reform conference in Uzbekistan, March 2002<br>• PHC reform conference and study tour to Kyrgyzstan, April 2002<br>• First International Conference on Poverty Monitoring in Yerevan, Nov 2002<br>• Social Work Training program – April 2003- December 2003<br>• International workshop on consumer basket: Definition and Approaches for Development December 8-10, 2004<br>• Nationwide Seminar on Integrated Social Services: Armenian Experience, Results And Next Steps June 14, 2005<br>• Health Promotion and Primary Healthcare, Vitae Litera, Kaunas, Lithuania, November 2004<br>• AED has provided logistical support to organization of the USAID/ASTP International Conference: "Primary Care Reform in Armenia: Lessons Learned from the Pilot Program and Options for the Future", May 17-19, 2005.<br>• AED has provided training opportunities for ASTP counterparts, e.g.:<br>• Quality Improvement in Health Care, University of Leeds, UK, June 2003 |
| 20. Advanced Energy Associates International | In Vanadzor, ASTP and AEAI jointly renovated the building that houses the Integrated Social Services center (ISSC).<br>Also in Vanadzor, AEAI and ASTP are collaborating on the provision of a heating system and weatherization of Polyclinic No. 1 – one of ASTP's pilot Family Group Practice sites. |
| 21. DAI Legislative Strengthening Program | ASTP and the DAI Legislative Strengthening Program collaborated in several training programs for members of Parliament on social and health issues<br>ASTP and the Legislative Strengthening Program DAI collaborated to create pilot citizen information centers in Masis and Vanadzor ISSCs.<br>ASTP and DAI collaborated on disseminating draft of the Law on Health |
| 22. Deliver Project (John Snow Consulting) | ASTP collaborated with Deliver in the design and development of pharmaceutical monitoring program for MOH<br>JSI and ASTP worked together reviewing the Armenia Public Sector Commodity Security and Logistics Management Information System (LMIS) for Essential Drugs illustrative work plan and have developed together a short proposal on Quantifying the Ministry of Health's Essential Drug Requirements |

| ASTP Partner | Activity Description |
|---|---|
| 23. IBM Consulting | ASTP in collaboration with the MLSI developed a draft law that would create the framework for private pension funds. IBM Consulting assisted in refining the draft law and developing the regulatory system that will have to be created to ensure the financial viability of private pension funds.<br>ASTP and IBM Consulting collaborated on creating the "Day of the Actuary" on December 5th, 2002. |
| 24. IRD | IRD provided medical equipment and pharmaceutical supplies for ASTP pilot sites |
| 25. PRIME II project | ASTP and PRIME share office space in Vanadzor and are working together to create the maternal and child health care training module for the Unified Curriculum and a conference for Family Medicine Faculty on developing Clinical Training Sites and implementing clinical training.<br>ASTP and PRIME share office space in Vanadzor and are working together to create the maternal and child health care training module for the Unified Curriculum and a conference for Family Medicine Faculty on developing Clinical Training Sites and implementing clinical training. PRIME II used developed by ASTP package of PHC providers' job descriptions (JD) in designing JDs for rural providers of reproductive health services. |
| 26. NOVA Project | ASTP and NOVA project practice regular consultations and exchange on a wide range of issues related to PHC reform, FM training, quality of care, health management, rural sites strengthening. We usually we attend each other's events and technical meetings. |
| 27. Carelift | Carelift provided medical equipment to pilot sites in Vanadzor, and provided ASTP with waste management poster that were placed in ASTP pilots. |
| 28. World Learning | ASTP collaborated with World Learning on NGO training and in the design and implementation of the Open Doors project in Vanadzor |
| 29. UMCOR | Coordination on pharmaceutical monitoring planning and implementation |
| 30. Accounting Reform | ASTP collaborated with the Partnership for Accounting Reform and Development in Armenia on strengthening the membership association representing financial advisors (Auditors, Accountants and Actuaries) and in the strengthening of accounting training in YSU |
| 31. IFES | ASTP in collaboration of IFES has disseminated information brochures and information materials among people in marzes. |
| 32. NGOC | In collaboration with NGOC ASTP has organized number of seminars on Social Security Cards for NGOs and their beneficiaries. NGOC has assisted also in distribution of brochures and other information materials among their customers.<br>ASTP collaborated with NGOC in collecting health education video materials used for educating patients in ASTP pilot sites |
| 33. AIPRG -- Armenia International Policy Research Group | ASTP participated and presented reports at the annual international conferences of AIPRG on developments in Armenia: May 29, 2005 Armenia: Financial Sector Development—Directions and Challenges, Armenia, Tsakhkadzor; January 15-16, 2005 Third AIPRG International Conference on "Armenia: Challenges of Sustainable Development" World Bank Headquarter Washington DC; January 18-19, 2004 Second AIPRG International Conference on Armenia World Bank Headquarter Washington DC. |
| 34. SPSS international | ASTP arranged training of 3 NSS specialists on SPSS package in Moscow at the SPSS Russia Headquarter, February 26-28, 2001 |
| 35. World Vision | ASTP collaborated with World Vision in disseminating health education materials developed by ASTP in cooperation the American University of Armenia |
| 36. Save the Children | ASTP has collaborated with Save the Children in arranging public education meetings in Lori marz villages. |
| ***Local Organizations(Public and Private)*** | |
| 37. Social Investment Fund of Armenia | The SIF was one of the partners in the renovation of the building that will serve as the pilot Integrated Social Services center in Vanadzor |
| 38. Armenia Association of Family Physicians (AAFP) | ASTP worked with the AAFP to design and develop a unified curriculum (UFMC) and FM training monitoring and assessment procedure. They are used as the basis for education in family medicine and training programs for family physicians.<br>ASTP participated in annual congresses of the Association. |

| ASTP Partner | Activity Description |
|---|---|
| 39. Yerevan State University, Faculties of mathematics and Economics | Yerevan State University and ASTP collaborated on creating a two-year graduate program in Actuarial Sciences, and Actuarial Studies center and an undergraduate program in actuarial mathematics and in creating and equipping a Center for Actuarial Sciences. |
| 40. State Medical University, Family Medicine Chair | Collaborated to develop family medicine curriculum, and to upgrade skills and teaching techniques of faculty staff. |
| 41. Vanadzor Polyclinic 4 | Under a Memorandum of Understanding, ASTP and Polyclinic 4 created a pilot Family Medicine Department, and comprehensively tested structural and functional components of a new model of PHC. In collaboration with AEAI, ASTP provided running water ad heat for the Polyclinic. |
| 42. Yerevan Polyclinic 17 | Under a Memorandum of Understanding, ASTP and Polyclinic 4 created a pilot Family Medicine Department, and comprehensively tested structural and functional components of a new model of PHC. |
| 43. Erebuni Medical Center | Under a Memorandum of Understanding, ASTP and Erebuni Medical Center created a pilot Family Medicine Department in the polyclinic managed by Erebuni, and comprehensively tested structural and functional components of a new model of PHC. |
| 44. Dsegh Rural Health Center | Under a Memorandum of Understanding, ASTP and Dsegh Rural Health Center comprehensively tested structural and functional components of a new model of PHC. |
| 45. Vahagni Rural Health Center | Under a Memorandum of Understanding, ASTP and Vahagni Rural Health Center comprehensively tested structural and functional components of a new model of PHC. |
| 46. Tumanyan Rural Health Center | Under a Memorandum of Understanding, ASTP and Tumanyan Rural Health Center comprehensively tested structural and functional components of a new model of PHC. |
| 47. Medical Center Grigor Narakatzi | Under a Memorandum of Understanding, ASTP and Polyclinics “Nor Areshi” and “Sari Taghi” of Grigor Narakarzi Medical Center (former Yerevan city Polyclinics 2 and 10) tested open enrollment, new PHC HIS, and CQI. |
| 48. Yerevan State Medical University Clinical Hospital 2 | Under a Memorandum of Understanding, ASTP and YSMU Clinical Hospital 2 (former Polyclinic of Hayq Medical Center) tested open enrollment, new PHC HIS, and CQI. |
| 49. Vanadzor Polyclinic 1 | Under a Memorandum of Understanding, ASTP and Polyclinic 1 tested open enrollment, new PHC HIS, and CQI. |
| 50. Vanadzor Polyclinic (Gugark) | Under a Memorandum of Understanding, ASTP and Polyclinic Gugark tested open enrollment, new PHC HIS, and CQI. |
| 51. Vanadzor Polyclinic 3 | Under a Memorandum of Understanding, ASTP and Polyclinic 3 tested open enrollment, new PHC HIS, and CQI. |
| 52. Vanadzor Polyclinic 5 | Under a Memorandum of Understanding, ASTP and Polyclinic 5 tested open enrollment, new PHC HIS, and CQI. |
| 53. National Statistics Service | ASTP had a long term program to support the strengthening of the Household Income and Expenditure Survey – including training, transfer of equipment, and technical assistance<br>ASTP also employed NSS to provide computer literacy training to officials from counterpart ministries. Training space is provided by the NORC Information and Analytic Center<br>The National Statistics Service also conducted special surveys for the ASTP project -- monitoring public awareness of and participation in social and health reforms.<br>ASTP collaborates with NSS on development of National Health Accounts. |

| ASTP Partner | Activity Description |
|---|---|
| 54. Yerevan Institute for Computer Research and development | ASTP has several subcontracts with YICRD (The Mergelyan Institute) for the design, testing and implementation of new IT systems. These include:<br>• PAROS – database for the Poverty Family Benefits social assistance program<br>• MIDAS – health care reimbursement reporting systems for the State Health Agency<br>• PARNAS – personified reporting systems for the Social Insurance Fund<br>• OSIRIS – automation of Civil Status reporting and data maintenance systems for the Ministry of Justice |
| 55. NORK Information and Analytic Center | • ASTP has several subcontracts and agreements with Nork Center (formerly Nemrout Center) and individual programming specialists for the design, testing and implementation of new IT systems. These include:<br>• Nationwide roll-out of the Social Security Card<br>• Design and development of database for recording complaints by benefit recipients to MLSI (based on NORK providing space for ASTP-hired programming specialists)<br>• Design and development of database for developing data sharing protocols for the pilot ISSC in Vanadzor (based on NORK providing space for ASTP-hired programming specialists)<br>• Design and development of database for identifying job vacancies and job seekers (based on ASTP providing technical advice for the testing of the new system in the Vanadzor ISSC)<br>• Actuarial Analysis and Modeling of Pension system under the requirements of pension reform : Actuarial office of Nork Center in close collaboration with YSU and ASTP analysis PAYG pension system operating in Armenia and provides actuarial models for pension system development |
| 56. Basic Medical College | Provides undergraduate and postgraduate training on Family Health Nursing. ASTP provides technical assistance. USAID donated equipment and supplies were also provided by ASTP to the Family Health Nursing chair for strengthening training capacity. |
| 57. AUCON | ASTP contracted AUCON to conduct an assessment to reveal the financial situation and basic financial flows of the PC 17 in order to establish knowledge and a database for financial analysis. ASTP also contracts AUCON to prepare payroll documents for the GOA |
| 58. Meditec | ASTP contracted Meditech to conduct an assessment of the health care facilities and equipment in Lori Marz |
| 59. Digital Links | Digital Links (an NGO in the United Kingdom) provided 300 donated computers and 50 donated file servers to ASTP to implement the Social Security Card system (saving the project over $700,000) |
| 60. American University of Armenia | In collaboration with ASTP AUA undertook a study on developed patient education handouts and training on motivational interviewing for ASTP. Additionally, there have been multiple presentations, classes and other informal collaboration. ASTP has also collaborated with the School of Health Care Management to provide Family Doctors with management training |
| 61. Nork Marash Hospital | ASTP provided technical advice to improve Nork Marash's medical record system. |
| 62. Armenian Association of Pediatricians. | ArAsPed provided training courses on Pediatric Primary Health Care for all ASTP pilot site primary health care physicians and nurses. |
| 63. Business Support Center | BSC provided business management, strategic planning and financial management training to pilot site management staff, physicians, nurses, and accountants in Yerevan and Lori marz. |
| 64. "Audit Firma" CJSC | The company provided Financial accounting and Managerial accounting training to pilot sites accountants during ASTP retreat in Tsakhkadzor in 2004. |
| 65. Training and Development Company Ltd | Training and Development Company Ltd provided training in customer service and reception management to 17 volunteers from NGO's in Masis ISSC |

| ASTP Partner | Activity Description |
|---|---|
| 66. Children's Neurological Hospital #6 | Cooperation around development of patient information system. Hospital specialists had developed medical recording electronic system for neurological patients through over the country. ASTP supported to upgrade their existing system. ASTP will use their experience and consultancy for similar systems' design. |
| 67. Ophthalmologic Hospital | Ophthalmologic Hospital is one of ASTP pilots where the electronic communication system with SHA for reports submission was tested |
| 68. National Institute of Health | Coordination in Family Medicine Training. UFMC-based training of MOH/ASTP pilot-site physicians utilizing collaboratively developed approaches to organizing and assessing it. |
| 69. Health Magazine | ASTP has supported Health Magazine in capacity building; ASTP has a permanent rubric in the magazine devoted to ASTP activities in every issue of the magazine. |
| 70. Armenian Public Relations Association | ASTP in collaboration with the Ministry of Labor and Social Issues and the Armenian Public Relations Association has organized seminars and round table discussions for NGOs and heads of the Armenian mass media. |
| ***State organizations and Departments*** | |
| 71. Press and PR Department and Information Analytical Center of the Government | In collaboration with the Government's Press Service and the Information analytical Center of the Government, ASTP has printed special editions of their official magazine on Social Security Cards and Pension reforms. The Press Service of the Government has also provided ASTP with free air time, which they have on Public TV channel of Armenia to cover Social Reforms. The Press Service also assisted in organizing number of press conferences on Social Security within the Government sometimes making the social topic a "day topic" after the Government's sessions. |
| 72. PR Department, Commission for legal affairs, Commission for Social and Health issues of the National Assembly | ASTP, the Ministry of Labor and Social Issues and the National Assembly have implemented PE campaign among parliamentarians on the law "On state pensions", "Social Security Cards", "Personal Data" in 2002 and 2003. Many seminars, parliamentary hearings, visits to Abovian Pilot site, Special commissions' sessions, round tables and discussions, media interviews and TV programs were prepared. Special information events were organized for Armenian National Assembly's staff members, especially for ones working in the permanent commissions. In Collaboration with the PR Department ASTP and the Ministry of Labor and Social Issues have organized seminars and trainings for the journalists accredited in the Parliament and covering discussions on Social issues in the Parliament's sessions. |
| 73. Press service of the Ministry of Justice | ASTP in collaboration with the press service of the Ministry of Justice (MOJ) has implemented PE campaign of OSIRIS system, which was a major step towards e-governance in Armenia. With OSIRIS, an information network for delivery of Civil Status information was build, covering all Civil Status districts, Central Archives and Civil Status Registration Office of the Ministry of Justice. There were five OSIRIS pilot sites implemented: MOJ Central Archives, Civil Status Registration Office, Funeral Service of Yerevan, and Shaoumyan and Kentron district offices. |
| 74. Press service of the Ministry of Health | ASTP in collaboration with the Ministry of Health press service organized nation-wide Mass Media coverage of numerous events (press conferences, media briefings, launch events, site visits by officials, trainings, seminars) in order to promote the PHC reforms. In collaboration with MOH press service and State Health Agency ASTP developed and organized nationwide disseminated of Public Education materials on Basic Benefits Package for years 2004 and 2005, and developed and distributed Public Education materials on healthy lifestyles and open enrollment with PHC physicians throughout communities covered by the PHC pilot program. ASTP together with the MOH press office organized a seminar on PHC reforms for journalists. ASTP assisted the MOH press service with sponsoring development of a film on the PHC reform, which was broadcasted by Shoghakat TV. ASTP provided the MOH press office with necessary equipment for better organization of Public Education activities and Public Relations. |
| 75. Press service of Lori marzpetaran | In collaboration with the press service of Lori marzpetaran ASTP organized open enrollment information campaign in Vanadzor. All local Mass Media channels were used during the campaign. |

| ASTP Partner | Activity Description |
|---|---|
| 76. All marzpetarans, Yerevan Municipality and Yerevan Quarter Municipalities | In Collaboration with all marzpetarans and Yerevan Municipality ASTP has created "hot line" and information centers in all marzes and Yerevan. The objective was to assist citizens to properly understand the Social Security Card system. At the same time ASTP through Yerevan quarter Municipalities has collaborated with condominiums of Yerevan to distribute information materials, put posters in houses organize town hall meetings, public events dedicated to different celebration days. In collaboration with the Ministry of Labor and Social Issues and Marzpetarans ASTP has organized also mobile Public education Units which visited all marzes especially small cities and villages to explain to people SSC system and generally peoples rights to have proper access to social services. In all marzpetarans and regional social service agencies which also are under marzpetarans' supervision special information boards were created in publicly accessible places. |
| 77. Abovian Municipality and Kotayk marzpetaran | ASTP in collaboration with the Abovian Municipality and Kotayk marzpetaran, as well as with local social services offices, has implemented successful Pilot site on Social Security Cards. They assisted ASTP to organize public events, e.g. pilot site launch one, town hall meetings, to create information center for citizens, to visit all enterprises and hospitals, to organize SSC information seminars for NGOs, mass media, community leaders, employers, employees and unemployed people. |

# ATTACHMENT C: ASTP PUBLICATIONS AND REPORTS SUPPORTED

| MASTER LIST OF REPORTS PREPARED BY AST | | | |
|---|---|---|---|
| *No.* | *Report Name and language(s)*<br>*E-English, A-Armenian, R-Russian* | *Primary Author* | *Date Issued* |
| 1. | Improving the Household Income and Expenditure Survey (E, A) | Olga Romanyuk | Oct 30, 2000 |
| 2. | Legal Analysis of the Concept Strategy on Pension Reform in Armenia (E) | Anna Nechai | Oct 30, 2000 |
| 3. | Should State Pension Benefits in Armenia Be Based on Notional Accumulation Accounts? (E, A) | Anna Nechai | Oct 30, 2000 |
| 4. | Analysis of Reporting Requirements of Enterprises to the SIF (E, A) | Aucon | Dec 14, 2000 |
| 5. | Legal Analysis: Issues related to Organization and Delivery of Health Care in Armenia (E) | Arameis Kocharyan | Nov 30, 2000 |
| 6. | Analysis of Reporting Requirements of Enterprises to the State Health Agency (E, A) | Aucon | Dec 11, 2000 |
| 7. | Protecting Individual Privacy in Government Information Systems in Armenia (E) | Steven Schiffman | Dec 13, 2000 |
| 8. | Reporting Requirements of Enterprises to the Ministry of Labor and Social Issues (E, A) | Aucon | Dec 13, 2000 |
| 9. | Achievements in AST Health Sector Reform in Armenia: August – December 2000 (E) | Gillespie/Vaughan | Dec 13, 2000 |
| 10. | Recommendations for Creating Actuarial Capacity to Support Social Insurance Reform in Armenia (E, A) | Mitchell Wiener | Dec 14, 2000 |
| 11. | Report on Observational Tour to Moscow on Social Insurance Reform (E) | Anna Nechai | Dec 15, 2000 |
| 12. | Basic Legal Requirements for Creating Safe Private Pension Funds in Armenia (E, A) | Anna Nechai | Dec 18, 2000 |
| 13. | Analysis of Issues related to the Implementation of Pilot Project in Lori Marz (E, A) | Dean Millslagle | Feb 6, 2001 |
| 14. | Main Issues in Creating Unified Information System for the Social Security Sector of the Republic of Armenia (E) | Anton Levitsky | Jan 15, 2001 |
| 15. | Capacity of the GAO to Implement Social and Health Sector Reforms (E, A) | Ludmilla Harutyunyan | Jan 15, 2001 |
| 16. | How to Create a Transparent Appeals System for the Poverty Family Benefits Program (E, A) | Brian Kearney | Jan 15, 2001 |
| 17. | Recommendations for Improving the Effectiveness of Local Social Services Offices in Armenia (E, A) | Beate Gross | Jan 20, 2001 |
| 18. | Recommendations for Improving Communal Services for Low Income Families in Armenia (E) | Roger Vaughan | In process |
| 19. | Workplan for AST Program (E) | Roger Vaughan | Jan 15, 2001 |
| 20. | Draft Law to Protect Privacy (E) | Steven Schiffman | Jan 15, 2001 |
| 21. | Two Alternative Draft Laws (E, A) | Anna Nechai | Dec 11, 2000 |
| 22. | Assessment of NGOs in Armenia to Support AST Pilot Projects (E) | Roy Kelegian | Feb 6, 2001 |
| 23. | Recommendations for Improving the Targeting of the Poverty Family Benefits Program (E) | Brian Kearney | NOT ISSUED |

| MASTER LIST OF REPORTS PREPARED BY AST | | | |
|---|---|---|---|
| *No.* | *Report Name and language(s)*<br>*E-English, A-Armenian, R-Russian* | *Primary Author* | *Date Issued* |
| 24. | Recommendations and Workplan for Personifying Reporting and Information Systems for the Social Insurance Fund of Armenia (E, A) | Roger Vaughan | March 6, 2001 |
| 25. | Law on Personal Identification Numbers (E, A, R) | Anna Nechai | March 6, 2001 |
| 26. | Procedures for Collaboration with NGOs under the Armenia Social transition Program (E) | Thomas Carmody | March 6, 2001 |
| 27. | Overview of Procedures for Collaborative Development of Health Information Systems in Armenia (E, A) | Roger Vaughan | March 12, 2001 |
| 28. | Procedures for Collaborative Development of Health Information Systems Software in Armenia (E, A) | Russell Dionne | March 12, 2001 |
| 29. | Overview of Procedures for Collaborative Development of Social Protection Information Systems (E, A) | Roger Vaughan | March 19, 2001 |
| 30. | Plan for Improving Training and Education of Family Practitioners (E, A) | Robert McPherson | March 31, 2001 |
| 31. | Recommendations for Developing a Policy Resource Center in the Ministry of Heal (E, A) | Vaughan | March 29, 2001 |
| 32. | System and Data base architecture for the Civil Status Registry application (OSIRIS) | Roger Vaughan | December 20, 2001 |
| 33. | Developing the Capacity of the Ministry of Labor and Social Issues to Analyze Social Protection issues (E) | Roger Vaughan | March 31, 2001 |
| 34. | Implementation of the automated data at NSS (E, R) | Olga Romanyuk | March 19, 2001 |
| 35. | Financial and Actuarial Analysis of the Armenian Pension System (E, A) | Mitchell Wiener | March 19, 2001 |
| 36. | Survey of Household Attitudes to Social and Health Programs (E) | Neelima Grover, Alka Kacker | June 11, 2001 |
| 37. | Valuation Report on Proposed Pension Reform (E, A) | Mitchell Wiener | June 14, 2001 |
| 38. | Training Needs Analysis for Ministry of Labor and Social Issues (E) | Jess Price | June 29, 2001 |
| 39. | Functional Analysis Redesign of Polyclinic 17 Yerevan, Armenia (E, A) | Robert McPherson | July 10, 2001 |
| 40. | Workplan for Health Reform Activities (E) | Brad Else, Michael Borowitz | July 30, 2001 |
| 41. | Optimization Developments and Licensing & Accreditation Training Plans in the Health Systems Component of the ASTP (E) | George Purvis | June 13, 2001 |
| 42. | Plan of Program to Enhance Health Information Systems in Armenia (E, A) | Roger Vaughan, Russell Dionne | July 27, 2001 |
| 43. | Strategy for ASTP support for Reforms in the legal basis for social and Health Programs (E, A) | Anna Nechai, Arameis Kocharyan | July 30, 2001 |
| 44. | Short-Term Strategy for MOH and MLSI Communications Systems (E) | Dr Armen Khuchugyan | July 31, 2001 |
| 45. | Workplan for the implementation of pilot social services projects in lori marz (E, A) | Brian Kearney | August 2, 2001 |
| 46. | Communications Strategy and Workplans for the Armenia Social Transition Program (E) | Roger Vaughan | August 6, 2001 |
| 47. | An Assessment of Health Financing Options for Armenia (E, A) | Alexander Telyukov | August 8, 2001 |
| 48. | Problems with the Draft Pension Law (E, A) | Mitchell Wiener | August 17, 2001 |

| MASTER LIST OF REPORTS PREPARED BY AST | | | |
|---|---|---|---|
| *No.* | *Report Name and language(s)*<br>*E-English, A-Armenian, R-Russian* | *Primary Author* | *Date Issued* |
| 49. | Advancing Hospital Financing in Armenia to Casemix Global Budgeting: A Proposal of Technical Tools and Transition Strategies (E, A) | Alexander Telyukov | August 23, 2001 |
| 50. | AST survey finding, may 2001 use, knowledge and public perception of social assistance, pensions and health care (E, A) | Neelima Grover | September 14, 2001 |
| 51. | Recommendations for How to Develop a Non-State Pension System in Armenia (E, A) | Darrell Brown | October 11, 2001 |
| 52. | Gender Issues in Pension Reform in Armenia (E, A) | Mitchell Wiener | October 24, 2001 |
| 53. | Analysis of Implications of Transferring Costs of Privileged Pensions to Employers (E, A) | Mitchell Wiener | November 1, 2001 |
| 54. | Primary Health Care Reforms in Armenia and the Transformation of Yerevan Polyclinic #17 (E, A) | Alexander Telyukov | October 27, 2001 |
| 55. | Communications Strategy and Workplans for the Armenia Social Transition Program (E) | Sylvia Rosenberg | November 7, 2001 |
| 56. | Concept for Development of Voluntary Pension Insurance Law in Armenia (E, A) | Anna Nechai | December 7, 2001 |
| 57. | Pension Benefit Manual (R) | Vitali Lukovich | November 20, 2001 |
| 58. | A strategy for Providing Survivors' Benefits through the Pension System in Armenia (E, A) | Mitchell Wiener | December 1, 2001 |
| 59. | Recommendations for Strengthening the Capacity of SIF to Administer Social Insurance programs (E, A) | Anna Nechai | December 7, 2001 |
| 60. | Workplan for the Implementation of Personal Numbers in Armenia (E, A) | Askar A. Arzerbaev | October 1, 2001 |
| 61. | Implementing a regional primary care reform demonstration project: Constraints and Opportunities (E) | Michael Borowitz | December 23, 2001 |
| 62. | Recommendations for a Strategy to Implement Licensing and Accreditation in Armenia (E, A) | Nancy Fitch | November 30, 2001 |
| 63. | Operational Plan for Yerevan Polyclinic 17 as Family Medicine Training Center and Pilot Family Medicine Group Practice Site (E, A) | Robert McPherson | December 28, 2001 |
| 64. | Improving Health Management Indicators for Armenia (E) | Charles Burge, Gayane Gharagebakyan | December 10, 2001 |
| 65. | Analysis of Information Flows at Polyclinic 17 in Yerevan (E) | Gayane Gharagebakyan, Vardan Tokmajian | January 31, 2002 |
| 66. | Recommendations for the Reform of Health Care Finance in Armenia (E) | Alexander Telyukov | January 31, 2002 |
| 67. | Summary of Approach to Creating Integrated Local Social Services Offices in Armenia (E, A) | Brian Kearney | January 21, 2002 |
| 68. | Analysis of facilities data for Yerevan Polyclinic #17 (E) | Meditech and Aucon | February 2, 2002 |
| 69. | Analysis of financial data for health care facilities in Lori marz (E) | Meditech and Aucon | February 2, 2002 |
| 70. | Recommendations for the Development of Health Quality Care Development Systems in Armenia (E) | Nancy Fitch | February 1, 2002 |
| 71. | Users' Guide for the Medical Personnel Database (E) | Vardan Tokmajyan | February 6, 2002 |

| MASTER LIST OF REPORTS PREPARED BY AST | | | |
|---|---|---|---|
| *No.* | *Report Name and language(s)*<br>*E-English, A-Armenian, R-Russian* | *Primary Author* | *Date Issued* |
| 72. | Prototype and System Specifications for Personified Reporting System for the Social Insurance Fund of Armenia (E) | Charles Burge | February 6, 2002 |
| 73. | Recommendations for improving the System for Auditing Social benefit payments (E) | Brian Kearney | February 6, 2002 |
| 74. | Report on activities conducted between October 29 – December 31, 2001 (E) | Ludmilla Harutyunyan | February 6, 2002 |
| 75. | Final Report of the ASTP Household Survey — November 2001 Survey | QED | March 27, 2002 |
| 76. | Options for Indexing Pension Benefits in Armenia | Mitchell Wiener | March 27, 2002 |
| 77. | Draft of Law to Introduce Mandatory health Insurance | Anna Nechai | April 2, 2002 |
| 78. | Workplan for Implementing Health policy and Information center in the Ministry of Health | Dean Millslagle, Roger Vaughan | June 3, 2002 |
| 79. | Collateral Legal Changes and Agency Responsibilities to implement Private pensions in Armenia | Anna Nechai | June 24, 2002 |
| 80. | Training of Methodists for Ministry of Labor and Social Issues | Jess Price, Brian Kearney | July 25, 2002 |
| 81. | Needs Assessment: Primary Health Problems and Health Education Needs Of Vulnerable Populations in Armenia | AUA, Department of Public Health | July 29, 2002 |
| 82. | Analysis of potential roles of Government and NGOs in ProviDinG Health and Social Services in Armenia | Counterpart, Brian Kearney | August 2, 2002 |
| 83. | Recommendations for Design and implementation of system for pharmaceutical monitoring in Armenia | Roger Vaughan, Charles Burge | August 6, 2002 |
| 84. | Family Medicine Training and Curriculum: The role of Family Medicine in Armenia Health System Performance Improvement | Nancy Fitch | August 1, 2002 |
| 85. | World Wide Experience of Health Insurance | Roger Vaughan | August 2, 2002 |
| 86. | Recommendations on How to Reduce informal Payments for medical Services in Armenia | Dean Millslagle, Saro Tsaturyan | August 6, 2002 |
| 87. | Recommendations for Improving the Definition and Administration of the Basic Benefits Package (BBP) (E, A) | Michael Borowitz | August 6, 2002 |
| 88. | Recommendations for Improved Data Management and Aggregate Poverty Indicators From the Household Income And Expenditure Survey of 2001 | Sasun Tsirunyan, Gayane Ghukasyan | August 6, 2002 |
| 89. | Recommendations for creating a legal framework to support health sector licensing | Aramayis Kocharyan, Arsen Manukyan, Dean Millslagle | August 6, 2002 |
| 90. | Commodity Security for Essential Drugs in Armenia: Creating a Logistics Management Information System;<br>Options for Promoting Rational Drug Use | Jim Bates | September 9, 2002 |
| 91. | Recommendations For The Legal Framework For Creating Primary Care Group Practices | Arsen Manukyan | September 5, 2002 |
| 92. | Models For Targeting Social Assistance On the Basis Of Data of 2001 Households Income and Expenditures Survey of NSS RA | Sasun Tsirunyan, Hasmim Ghukasyan | November, 2002 |
| 93. | Procedures for Creating a Legally Independent Primary Care Group Practices | Arsen Manukyan | January 9, 2003 |

| MASTER LIST OF REPORTS PREPARED BY AST | | | |
|---|---|---|---|
| *No.* | *Report Name and language(s)*<br>*E-English, A-Armenian, R-Russian* | *Primary Author* | *Date Issued* |
| 94. | Monitoring and Evaluation Plan for the Integrated Social Service Center Pilot | | December 6, 2002 |
| 95. | The Armenia Social Transition Program (ASTP) Results of The Fourth Survey on Public Use of, Knowledge of, and Perception of Social Services | | March 23, 2003 |
| 96. | PR Guidelines (E) | | July 7, 2003 |
| 97. | IEPT MG (A) | | July 27, 2003 |
| 98. | Social Services in Lithuania (E, A) | | December 8, 2003 |
| 99. | Evaluation report on "Breaking the Barriers" projects funded by the Council of Europe (E) | | February 6, 2004 |
| 100. | Analysis of Enrollment Dynamics in Yerevan City Erebuni District, October 2003 – March 2004 (E, A) | | February 19, 2004 |
| 101. | Family Medicine Master Training Plan (E, A) | | March 1, 2004 |
| 102. | Assessment of Primary Health Care System activities based on the analysis of statistical reports and Forms N1 of statistical record keeping (E, R) | E. Fyodorova | March 4, 2004 |
| 103. | Primary Care Continuous Quality Improvement | | March 4, 2004 |
| 104. | Assessment of Financial – Economic Situation and Indicators at Armenia Social Transition Program Pilot Sites | | December 30, 2004 |
| 105. | ASTP Pilot Sites Physicians Performance based on Multiple Choice Questionnaire on Primary Health Care (Pretest) | | May 4, 2004 |
| 106. | Monitoring visits to local offices authorized to implement the SSC system in Armenia (E) | | July 7, 2004 |
| 107. | Monitoring and Evaluation Visits to Hot-Line representatives in the Marzes of Armenia (E) | | June 2004 |
| 108. | Cost Accounting Methodology for PHC Facilities (A) | | May 2004 |
| 109. | Continuous Quality Improvement in MOH Pilot sites (E, A) | | October 24, 2004 |
| 110. | Strategy for Workforce Planning for the Health Service in Armenia (E, A) | | September 2004 |
| 111. | General Practice/Family Medicine Training Center<br>Standard Requirements To The Training Center's Facilities, Practices And Trainers (E, A) | | December 2, 2004 |
| 112. | Evaluation OF the Integrated Social Services Center Pilot (E, A) | | December 2, 2004 |
| 113. | Fourth Patient Satisfaction Survey at Pilot Polyclinics (E, A) | | January 19, 2005 |
| 114. | Recommendations For Continuing Professional Development Of Family Physicians And Credit System In Armenia (E, A) | | March 22, 2005 |
| 115. | Integrating Social Services In Armenia - Expriences And Steps Towards Implementation (E, A) | | April 18, 2005 |
| 116. | On Vanadzor Social Service Complex Center Influence Estimate Research (E) | | May 3, 2005 |
| 117. | Evaluation OF the Integrated Social Services Center Pilot (E) | | July 1, 2005 |

| MASTER LIST OF REPORTS PREPARED BY AST | | | |
|---|---|---|---|
| *No.* | *Report Name and language(s)*<br>*E-English, A-Armenian, R-Russian* | *Primary Author* | *Date Issued* |
| 118. | Analyses And Projections Of Demographic Indicators For Pension Reform Modeling (E) | | July 28, 2005 |
| 119. | Continuous Quality Improvement in MOH Pilot sites (E) | | September 6, 2005 |
| 120. | End-of-Program Monitoring and Evaluation Report for the Health Component of ASTP | | |

*Many reports are revised – based on comments from counterparts, USAID, ST experts, and changing circumstances and new information. The date shown in the right hand column is the date of the latest version.

# ATTACHMENT D: ASTP PUBLIC EDUCATION PUBLICATIONS ON SOCIAL ISSUES

| Title of Publication | Year | Target Audience | # of Copies | Type |
|---|---|---|---|---|
| Collection of legal acts of Social sphere | 2001 | Social workers, NGOs, experts | 1500 | Book |
| Poverty Family benefits | 2001 | PFB recipients | 500 | Poster |
| Poverty Family Benefits /eligibility changes/ | 2002 | PFB recipients | 150,000 | Breaflet |
| Q&A on Personal numbers | 2002 | Population of Abovian | 10,000 | Booklet |
| What is personal number | 2002 | Population of Abovian | 10,000 | Leaflet |
| Poster on Personal numbers | 2002 | Population of Abovian | 2000 | Poster |
| Q&A on the rights of disabled | 2002 | Disabled, Social workers | 5000 | Brochure |
| Actuarial Sciences Bachelor Program in YSU | 2002 | Experts, NGOs, private companies, civil servants | 400 | Brochure |
| Center for actuarial sciences | 2002 | Experts, NGOs, private companies, civil servants | 400 | Brochure |
| The Profession of Actuary in Armenia | 2002 | Experts, NGOs, private companies, civil servants | 500 | Leaflet |
| List of Lori Marz NGOs | 2002 | General public, NGOs | 1000 | Leaflet |
| The special issue of the "View on economics" Magazine dedicated to pension reforms in Armenia | 2002 | NGOs, Decision-makers, general public | 5000 | Magazine |
| Informational-analytical booklet "What is the Personal Number" (jointly with the information-analytical center of the Government) | 2002 | NGOs, Decision-makers, general public | 5000 | Booklet |
| Q&A "The Social worker advises" | 2002 | Social workers, pensioners, Poverty Family benefit receivers, unemployed people | 5000 | Booklet |
| Q&A "On rights of people with disabilities and the elderly" | 2002 | People with disabilities and the elderly, social workers | 5000 | Booklet |
| "Social snapshot and poverty in Armenia, 2001" | 2002 | Experts, International Organizations, Civil servants, NGOs | 1000 | Book |
| "Income, expenditures and food consumption in Armenia: in 1999 and 2001" | 2002 | Experts, International Organizations, Civil servants, NGOs | 1000 | Book |
| Human Rights and Social Work | 2002 | NGOs, Civil servants, Social workers | 1000 | Book |
| Manual for Social Workers | 2002 | Social workers | 1000 | Book |
| "Access to social rights in Europe" Council of Europe Report | 2003 | Experts, NGOs, general public | 2000 | Book |
| Collection of Legal Acts of Pension Sphere | 2003 | Civil Servants, Experts and general public | 15,000 | Book / 95 pages |
| On Pension Age | 2003 | Experts and pensioners | 8,000 | Leaflet |
| Why We Need Pension Reforms | 2003 | Experts and pensioners | 8,000 | Leaflet |
| Q&A on Pension Reforms | 2003 | Experts and pensioners | 8,000 | Brochure |
| The Actuarial Educational Program at YSU | 2003 | Experts | 600 | Brochure |
| Poverty Family benefits | 2002 | PFB recipients | 500 | Poster |
| Poverty Family Benefits -- Eligibility Changes | 2003 | PFB recipients | 100,000 | Brief let |

| Title of Publication | Year | Target Audience | # of Copies | Type |
|---|---|---|---|---|
| Q&A on Personal Codes | 2003 | General Public | 170.000 | Brochure |
| How to complete a Social Security Card application form | | General Public | 1000 | Poster |
| 10 Years of Social Services in Armenia | 2003 | Social Workers | 1000 | Leaflet |
| Lori Marz NGOs | 2003 | NGOs, Civil servants | 1000 | Leaflet |
| New system of Poverty Family Benefits | 2004 | PFB receivers, Social Workers, General Public | 150,000 | Brief let |
| New system of Poverty Family Benefits | 2004 | PFB receivers, Social Workers, General Public | 1000 | Poster |
| What is Social Security Card? | 2004 | General Public | 320,000 | Brochure |
| What is Social Security Card? | 2004 | English speakers, Foreigners | 5000 | Leaflet |
| How to complete an SSC application form | 2004 | General Public | 10000 | Poster |
| Collection of legal acts of social and health spheres | 2004 | Experts, Social workers, general Public | 1000 | Book |
| What a SSC Will Give to Citizen | 2004 | General Public | 10,000 | Poster |
| Get Your SSC Now! | 2004 | General Public | 10,000 | Poster |
| PE materials for PARNAS system | 2004 | Employers and employees | 980,000 | Brieflets |
| Reprinting of the brochures Q&A on the rights of disabled and Q&A "The Social worker advises" | 2004 | Social Workers, people with disabilities, pensioners, Poverty Family benefit receivers, unemployed people | 6,000 + 6, 000 | Brochures |
| "ISSC: Vanadzor" | 2004 | Customers of Vanadzor's ISSC | 10,000 | Booklet |
| Annual Report of the Ministry of Labor and Social Issues | 2004 | MLSI domestic and International partners, general Public | 2,000 | Brochure |
| Social Snapshot and Poverty in Armenia, 2003 | 2004 | Experts, International Organizations, Civil servants, NGOs | 1000 | book |
| Social Snapshot and Poverty in Armenia, 2002 | 2004 | Experts, International Organizations, Civil servants, NGOs | 1000 | Book |
| "Income, Expenditures and Food Consumption in Armenia in 1999 and 2002" | 2004 | Experts, International Organizations, Civil servants, NGOs | 1000 | Book |
| ISSC: Masis | 2004 | Customers of ISSC | 5000 | Brochure |
| How You Will Use Your SSC | 2004 | General Public | 500,000 | Booklet |
| 2 Posters on use of SSCs | 2004 | General Public | 25.000 | Posters |
| How You Will Use Your SSC | 2005 | General Public | 25,000 | Special Inserts for Newspapers |
| List of Masis NGOs | 2005 | Customers of Masis ISSC | 5000 | Leaflet |
| The New System of Poverty Family Benefits | 2005 | PFB receivers, Social Workers, General Public | 150,000 | Brief let |
| The New System of Poverty Family Benefits | 2005 | PFB receivers, Social Workers, General Public | 1,000 | Poster |
| "Where and how are results of households living standards survey used" | 2005 | Households surveyed, NSS employees, experts | 6,000 | leaflet |
| "The Profession of Actuary in Armenia" | 2005 | Actuaries, Insurance companies, Experts, journalists | 5,000 | Leaflet |
| The Council of Europe: A New strategy for Social Cohesion (in Armenian) | 2005 | Social Workers, Experts | 1,000 | Booklet |

| Title of Publication | Year | Target Audience | # of Copies | Type |
|---|---|---|---|---|
| Manual for Social Workers dealing with children with disabilities, their parents and elderly | 2005 | Social Workers, Experts | 5,000 | book |

# ATTACHMENT E: PUBLIC EDUCATION MATERIALS PREPARED ON HEALTH ISSUES

| | Quantity | Comments |
|---|---|---|
| **Posters** | | |
| Choose your Physician (1) | 200 | Placed in all pilots and public places of Vanadzor community |
| Choose your Physician (2) | 500 | Placed in all pilots and public places of Vanadzor community |
| BBP poster for year 2004 | 600 | Placed in every health facility in the country |
| BBP poster for year 2005 | 600 | Placed in every health facility in the country |
| BBP poster for year 2005 - appendix | 600 | Placed in every health facility in the country |
| **Leaflets** | | |
| Hypertension | 10,000 | Distributed to the patients of first generation pilot sites through PHC physicians |
| Diabetes Mellitus | 10,000 | Distributed to the patients of first generation pilot sites through PHC physicians |
| Smoking secession | 10,000 | Distributed to the patients of first generation pilot sites and to second generation pilot sites through PHC physicians |
| Breast self-exam techniques | 22,000 | Distributed to the patients of first generation pilot sites through PHC physicians |
| Healthy nutrition | 10,000 | Distributed to the patients of first generation pilot sites through PHC physicians |
| "Choose Your Primary Health Care Physician" | 16,000 | Distributed to the patients of all pilot sites; provided to journalists |
| New PHC Model | 1,000 | Distributed to the attendees of the May 17-19 New PHC Model of Care Dissemination Conference and journalists |
| **Brochures** | | |
| Family Doctor tells | 250 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| European Charter of Family Medicine/General Practice | 250 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| Family Nurse Provisions | 250 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| Family Doctor Provisions | 250 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| Basic Benefits Package for year 2003 | 2000 | Made available in waiting areas of first-generation urban polyclinics and journalists |
| Information color brochures on Vanadzor and Yerevan polyclinics | 5,100 | This is used by PC PHC physicians and nurses for marketing their services, and motivates enrollment and increase utilization. The booklets are given to PC personnel who make home visits show pictures and biographies to the population helping the latter make informed choices of PHC physicians. |
| **Choose Your Physician Information Stand** | 13 | Set up in each first generation and second generation pilot site |
| **Films** (produced and broadcasted) | 7 | 5 films on Vanadzor polyclinics were prepared and aired by local Lori TV twice (within "Healthy Society" series);<br>2 other films were prepared by Yerevan TV (about Yerevan PC 17) and Shoghakat TV on the New PHC Model. |
| **Radio PSAs** (produced and broadcasted) | 6 types | Broadcasted for three months in Vanadzor (Interkap radio and Vanadzor branch of Armenia Public Radio) and for one month through two Yerevan FM channels. |

| | Quantity | Comments |
|---|---|---|
| **Radio programs on healthy lifestyles** (produced and broadcasted) | 9 topics | Broadcasted in Vanadzor (Interkap radio and Vanadzor branch of Public Radio of Armenia) and through two Yerevan FM channels (twice). |
| **Call-in TV programs on Lori TV** (produced and broadcasted) | 2 | As part of "Healthy Society" TV series in Vanadzor |
| **Talk shows** (produced and broadcasted) | 6 | 5 talk shows on Lori TV (within "Healthy Society" series) |
| **Newspaper inserts** | in 2 newspapers | "Lori marz" and "Vanadzoryan Khchankar" newspapers published an insert "Choose a Physician for Your Family" and the health education material "Hypertension". |
| **PSA in newspapers** | in 2 newspapers | "Lori Marz" and "Vanadzoryan Khchankar" newspapers published announcements on the process of open enrollment in Vanadzor. |

# ATTACHMENT F: ASTP SUPPORT FOR LAWS, DECREES AND DRAFT LAWS

| | Title of the Legal Act | Number of the Legal Act | Date of the Legal Act |
|---|---|---|---|
| **Laws Related to Social Issues** | | | |
| 1. | RA Law on Social Security Cards | RA Law N-1 | September 24, 2003 |
| 2. | RA Law on State Pensions | RA Law N-519 | November 19, 2002 |
| 3. | RA Law on Personal Data | RA Law-422 | October 8, 2002 |
| 4. | RA Law on the Social Protection of Children Left without Parental Care | RA Law N-411 | September 24, 2002 |
| 5. | RA Law on Life Support Minimum Basket and Life Support Minimum Budget | RA Law N-53 | March 16, 2004 |
| 6. | RA Law on State Labor Inspectorate | RA Law N-77 | March 24, 2005 |
| **Decrees Related to Social Issues** | | | |
| 7. | Government Decree On Implementation of Pilot Project to Introduce Personal Codes System | Government Decree N281 | March 21, 2002 |
| 8. | Government Decree On Implementation of Personal Codes System in the Republic of Armenia | Government Decree N-190 | January 30, 2003 |
| 9. | On Introducing Social Security Card System in the Republic of Armenia | Government Decree N-1783 | December 24, 2003 |
| 10. | Government Decree On Ensuring Enforcement of the Republic of Armenia Law on State Pensions | Government Decree N-793 | May 29, 2003 |
| 11. | Prime Minister Decree<br>On Coordinating (managing the program) Personal Codes System Implementation Activities in the Republic of Armenia and Creating Inter-institutional Working Group to Implement Personal Code System | Prime Minister Decree N-309 | July 8, 2003 |
| 12. | Government Decree On Approving Pilot Project to Introduce Personified Reporting System in the Republic of Armenia | Government Decree N 1143 | August 28, 2003 |
| 13. | Government Decree #1628 "Actuarial Mathematics”. | Government Decree N 1628 | September 2003 |
| 14. | Government Decree On Establishing an Integrated Social Service Center in Vanadzor within the Framework of the Pilot Project “One Stop Social Services” | Government Decree N-247 | February 26, 2004 |
| 15. | Prime Minister Decree On Approving the Working Procedures and Structure of the Board of the Integrated Social Service Center in Vanadzor | Prime Minister Decree N-204 | April 12, 2004 |
| 16. | Government Decree On Establishment an Integration Social Service Center in Masis City of Ararat Marz and Implementation of the Pilot Project “One Stop Social Services” | Government Decree N-1676 | December 2, 2004 |
| 17. | Prime Minister Decree On Assertion of the Individual Composition and Working Procedure of the Board of Masis Integrated Social Service Center | Prime Minister Decree N-33 | January 20, 2005 |
| 18. | Government Decree On the Assertion of the Pilot Project “Deinstitutionalization of Orphanages” | Government Decree N-988 | July 1, 2004 |
| 19. | Prime Minister Decree On the Assertion of the Charter of State Social Insurance Fund of the Republic of Armenia and on the Recognition of the Decree N-201 of the Prime Minister of the Republic of Armenia dated March 13, 2001 as Invalid | Prime Minister Decree N-497 | August 2, 2004 |

| | Title of the Legal Act | Number of the Legal Act | Date of the Legal Act |
|---|---|---|---|
| 20 | Prime Minister Decree On Approving the Working Procedure and the Composition of the Board of the Republic of Armenia State Social Insurance Fund and on Considering Annulled the Republic of Armenia Prime Minister's Decree N 267 dated April 10, 2001 | Prime Minister Decree N-498 | August 2, 2004 |
| 21 | Government Decree On the Minimum Social Standards for the Care and Upbringing of Children in Orphanages. | Decree 1324-N | October 4, 2004 |
| 22. | Government Decree On Approving Procedure for Allocating, Paying Pension to Convicts Being in Conviction Places and Recognizing Him/Her as Disabled | Government Decree N1457 | October 7, 2004 |
| 23. | Prime Minister Decree On the Assertion of the Program-Timetable Regulating the Process of Transfer of Functions of State Social Insurance Fund connected with the Calculation, Payment (levy) and Control over the Incomes Related to Mandatory Social Insurance Contributions to State Tax Service at the Government of the Republic of Armenia | Prime Minister Decree N-722 | November 10, 2004 |
| 24. | Government Decree On the Assertion of Spheres of Organization and Conditions of Implementation of Paid Public Work | Government Decree N-1854 | December 23, 2004 |
| 25. | Government Decree On Providing Financial and Statistical Data on Mandatory Social Insurance Programs to the Authorized Government Body | Government Decree N-350 | March 18, 2004 |
| 26. | Government Decree On Ensuring the Application of Social Security Cards and Numbers of Social Security Cards in the Republic of Armenia | Government Decree N-963 | June 25, 2004 |
| 27. | Government Decree On Recognizing the Ministry of Labor and Social Affairs the State Body Authorized by the Government of Armenia and Approval of the Minimum Social Standards for the Care and Upbringing of the Children in Orphanages | Government Decree N-1324 | August 5, 2004 |
| 28. | Government Decree On Assertion of the Conceptual Approaches to the Pension Security System Reforms of the Republic of Armenia | Government Decree N-666 | April 28, 2005 |
| 29. | Government Decree On Measures to Implement Personal (Personified) Registration in the State Social Insurance System | Government Decree N-938 | May 12, 2005 |
| 30. | On assertion of the Procedure of application for pensions, allocation/recalculation/ of pension, changing the type of pension, payment of pension and administration of the pension case /documents/. | Government Decree N-930 | May 12, 2005 |
| **Decrees on Health Issues** | | | |
| 31 | Government Decree: On approval of the procedure of licensing the manufacture of drugs, pharmaceutical activities, provision of medical aid and services and implementation of specialized secondary and higher medical educational programs in the Republic of Armenia as well as the license forms for the above-mentioned activities | Government Decree No 867 | June 29, 2002 |
| 32 | Government Decree: Concept on Improvement and Management of Health Care Provision to the Population of the Republic of Armenia | Government Decree No 46 | November 31, 2002 |
| 33 | Government Decree: "On Approval of the Requirements and Conditions for Technical and Professional Qualification Necessary for the Health Services Provided by Polyclinics (mix, adults and pediatric), different specialized offices, family physician offices, medical ambulatories, rural health centers, FAPs, women's counseling offices and inpatient (specialized) facilities" | Government Decree No 1936-N | December 5, 2002 |
| 34. | Government Decree: On State-guaranteed free health care and services in the year of 2003 | Government Decree N-246 | February 6, 2003 |

| | Title of the Legal Act | Number of the Legal Act | Date of the Legal Act |
|---|---|---|---|
| 35. | Government Decree: On approval of strategy of population primary health care in the Republic of Armenia for the years of 2003-2008 and on approval of pilot project on development of new methods of primary health care financing and organization for the years of 2003-2004 in the Republic of Armenia. | Government Decree N-1533 | November 13, 2003 |
| 36 | Government Decree: "On approval of types of service provision and procedure of patient referral performed by family physicians of ambulatory – polyclinic facilities". | Government Decree No 211 | February 19, 2004 |
| 37 | Government Decree: "Provisions on the organization of family practice and approval of family physician performance information form". | Government Decree No 539-N | April 8, 2004 |
| 38. | Government Decree On financing the activities of Family Physicians | Government Decree N-1045 | July15, 2004 |
| 39 | Government Decree No 1045-N "On Financing Activities of Family Physicians" | Government Decree No 1045-N | July15, 2004 |
| 40 | Government Decree: On Amendments and Additions in the Governmental Decree # 1533-N, issued on November 13, 2003. | Government Decree No 624-N | May 12, 2005 |
| 41. | MOH Decree: On organization of training courses within the frames of National Program on Pediatric Primary Health Care | MOH Decree No 252 | May 3, 2002 |
| 42 | MOH Decree: Family Medicine Unified Curriculum" | MOH Health Decree No 613 | July 21, 2003 |
| 43 | MOH Decree: On introducing changes in accordance with the procedure defined by ROA MOH decree No 185 of March 28, 2003". | MOH Decree No 937 | September 25, 2003 |
| 44 | MOH Decree: "On starting preparatory work for implementation of National Health Accounts in the Republic of Armenia". | Decree No 148 | February 23, 2004 |
| 45 | MOH Decree: On State Guaranteed Health Services Benefit Package | MOH Decree No 318 | March 4, 2004 |
| 46 | MOH Decrees: "On Standards and Guidelines for State Guaranteed Health Services Benefit Package" | MOH Decrees No 294-A, 285-A, and No 483 | March 26, 2004, May 11, 2004 |
| 45 | MOH Order No 37-A On Implementation of Paediatric Primary Health Care Program in a number of Armenian PHC facilities including ASTP pilot sites | MOH Order No 37-A | April 05, 2004 |
| 48 | MOH/Ministry of Health/ Order On Approval of Enrollment reporting forms and regulations on their circulation. | MOH Order No 896-A | August 30, 2004 |
| 49 | MOH Order On Approval of the Procedure of Delivery of State-Guaranteed Free Ambulatory and Policlinic Health Care. | MOH Order No 292-A | March 26, 2004 |
| 50 | MOH order On Implementation of Pediatric Primary Health Care Program in a number of Armenian PHC facilities including ASTP pilot sites. | MOH order No 37-A | April 5, 2004 |
| 51 | MOH Decree On UFMC approval | MOH Decree No 613 | July21, 2003 |
| 52 | MOH Order On Approval of Methodological Guideline on Distribution of Additional Reimbursement for PHC. | MOH Order No 916-A | September 3, 2004 |
| 53 | MOH Order issued in: "Standards on Primary Care Services Delivery by State Guaranteed Basic Benefit Package | MOH Order No 1350 | December 12, 2004 |
| 54 | MOH Order: On Approval of Methodological Guidelines on Formation and Distribution of Performance-Based Remuneration for PHC providers | MOH Order No 685-A | July 22. 2005 |

| | Title of the Legal Act | Number of the Legal Act | Date of the Legal Act |
|---|---|---|---|
| 55 | MOH Order No 687-A: On Board for Pilot's Performance Assessment and Reporting Forms for Performance-Based Reimbursement | MOH Order No 687-A | July 22. 2005 |
| 56. | Lori Marzpet decree: On population open enrollment with therapevts, pediatricians and Family Physicians providing PHC/ambulatory–polyclinic services | Government Decree N-200 | June 30, 2004 |
| **Draft Laws on Social and Health Issues** | | | |
| 57. | RA Law on State Benefits | Draft | Shall be discussed at the National Assembly |
| 58 | RA Law on Non State Pensions | Draft | Shall be discussed at the National Assembly |
| 59 | RA Law on Social Assistance | Draft | Shall be discussed at the National Assembly |
| 60 | RA law on Social Protection in case of Employment and Unemployment of Population | Draft | Shall be discussed at the National Assembly |
| 61 | RA Law on Volunteers and Voluntary Activity | Draft | Shall be submitted to RA Government |
| 62 | RA Law on Health Care | Draft | Shall be discussed at the National Assembly |
| 63 | RA Law on Mandatory Medical Insurance | Draft | Shall be submitted to RA Government |

# ATTACHMENT G: SUMMARY OF ASTP HEALTH TRAINING ACTIVITIES

| Name of training/workshop | Number of events | # Participants | Duration (hours) | Person-hours |
|---|---|---|---|---|
| Training in Hypertension management for Yerevan PC17 doctors | 1 | 25 | 1.5 | 37.5 |
| Training in Diabetes Mellitus management for PC17 doctors | 1 | 25 | 1.5 | 37.5 |
| Management of Hypertension, Diabetes Mellitus and LRT for Erebuni PC doctors | 1 | 14 | 3 | 42 |
| Early diagnosis of pediatric diseases (hypertension, hip dislocation, anemia, hearing check) for physicians of rural pilots | 1 | 5 | 3.5 | 17.5 |
| Hypertension guidelines (for physicians of rural pilots) | 1 | 6 | 3.5 | 21 |
| Diabetes management protocol (for physicians of rural pilots) | 1 | 5 | 3.5 | 17.5 |
| Training in Encounter and outpatient record form fill-in and circulation (for physicians of rural pilots) | 1 | 5 | 3.5 | 17.5 |
| Discussion of protocols on hypertension, diabetes and lower respiratory tract infections with Vanadzor PC4 doctors | 1 | 2 | 0.5 | 1 |
| Workshop on Health Promotion and Primary Healthcare: Lithuanian experience | 1 | 40 | 1 | 40 |
| Discussion of opportunities, challenges and organizational issues of worksite-based training (with CPS and trainees) in Yerevan and in Vanadzor | 2 | 25 | 3.5 | 87.5 |
| Ear-nose-throat and eye pathology (for physicians of rural pilots) | 1 | 5 | 3.5 | 17.5 |
| Management protocols on diabetes mellitus and hypertension, Introduction of Lithuanian experience (for physicians and nurses of rural pilots) | 2 | 28 | 4 | 112 |
| Seminar for social workers "Open choice of PHC physicians" | 1 | 9 | 2 | 18 |
| Coordination Committee, Peer chart review, short encounter forms (for physicians of rural pilots) | 1 | 6 | 3 | 18 |
| Introduction of short encounter forms (for nurses of rural pilots) | 1 | 11 | 1 | 11 |
| Discussion of remuneration indicators for performance (both quantitative and qualitative) with family physicians, challenges and organizational issues | 2 | 36 | 3 | 108 |
| Discussion of Coordination Committee Related issues; Certificate awarding ceremony (physicians) | 1 | 6 | 4 | 24 |
| Seminar on health education materials; Certificate awarding ceremony (nurses) | 1 | 8 | 3 | 24 |
| PHC Clinical Quality Improvement midterm results in MOH pilot sites (brainstorming with Educational institutions and professional NGO's) | 1 | 25 | 3 | 75 |
| Seminar on use of oto-ophthalmoscope for pilot physicians. | 1 | 15 | 2 | 30 |
| Seminar on End of life care for pilot nurses | 2 | 47 | 2 | 94 |
| ASTP workshop on PHC Clinical Quality Improvement midterm results in MOH pilot sites | 1 | 21 | 3 | 63 |
| Seminar on End-of-life care for nurses of Vanadzor PC 4 and rural pilots | 3 | 33 | 3 | 99 |
| Focus group discussion (1st session) to reveal the effectiveness of mass media instruments and messages used in open enrollment information campaign | 1 | 9 | 3 | 27 |
| Meeting with data enterers of Vanadzor polyclinics on "Correction of Invalid Data in the PHCIS Database" | 1 | 10 | 2 | 20 |
| Training on screening protocols implementation in PC # 1, # 2, # 3, # 4 and PC "Gugark"of Vanadzor. | 5 | 49 | 5 | 245 |
| Management protocols on diabetes mellitus hypertension and lower respiratory infections in PC #2 | 1 | 19 | 1 | 19 |

| Name of training/workshop | Number of events | # Participants | Duration (hours) | Person-hours |
|---|---|---|---|---|
| Training of GN MC "Nor Aresh" PC # 2 doctors on screening protocols implementation. | 2 | 37 | 2 | 74 |
| Management protocols on diabetes mellitus hypertension and lower respiratory infections in Vanadzor PC# 1, #2, # 3, # 4 and PC Gugark | 5 | 49 | 5 | 245 |
| Management protocols on diabetes mellitus, hypertension and lower respiratory infections in PC #10 | 1 | 5 | 1 | 5 |
| Training PC # 10 doctors on screening protocols implementation. | 2 | 12 | 2 | 24 |
| Training of GN MC "Nor Aresh" PC # 2 doctors on Encounter form fill-in and circulation procedure. | 1 | 12 | 2 | 24 |
| Training of Erebuni MC PC doctors on Encounter form fill-in and circulation procedure. | 1 | 18 | 2 | 36 |
| May 17-19, 2005 Conference "Primary Care Reform in Armenia: Lessons Learned from the Pilot Program and Options for the Future" | 1 | 329 | 27 | 8883 |
| June 15 2005 Regional Workshop "New Model of PHC Information Dissemination Workshop" in Tavush, Ijevan | 1 | 25 | 6 | 150 |
| Training on Business Planning and Legal Forms of Organizations for PHC facility managers (directors, economists and chief accountants) of Vanadzor City and ASTP pilot site Health Centers of Lori Marz. | 1 | 26 | 26 | 676 |
| Training on Business Planning and Legal Forms of Organizations for PHC facility mangers (directors, economists and chief accountants) of Yerevan City. | 1 | 49 | 26 | 1274 |
| Adult Learning and Teaching Methods and Techniques Workshop for FM trainers (Scheduled for Sept 6 2005) | 1 | 60 | 4 | 240 |
| **TOTAL** | **54** | **1,111** | **175.5** | **12954.5** |

# ATTACHMENT H. FISCAL REPORT

| | |
|---|---|
| Total invoiced through June 30, 2005 | $24,743,304 |
| July through September 2005 invoices | $1,116,915 |
| Total invoiced through September 30, 2005 | $25,860,219 |
| Total Contract Amount | $25,905,125 |
| Contract Balance as of September 30, 2005 | $44,906 |

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