

Quarterly Report
Fiscal Year 2006: Second Quarter (January – March 2006)

Introduction

The Armenia Primary Healthcare Reform project (PHCR), funded by the United States Agency for International Development (USAID) under the TASC2 IQC No. GHS-I-00-03-00031-00, was issued to Emerging Markets Group, Ltd. (EMG) on September 30, 2005. Subcontractors on this project are IntraHealth International, Overseas Strategic Consulting, Ltd., Social Sectors Development Strategies, and American University of Armenia's Centre for Health Services Research.

This PHCR Quarterly Report describes the project activities and results during the period of January 1st to March 31st, 2006. The Table below presents detailed elements of work conducted, organized by project component.

Management and Evaluation.

1. Approvals, buy-in, and cooperation for project activities received from stakeholders:

PHCR management established formal collaboration with Dr. Hayk Darbinyan, first deputy Minister of Health, who has been appointed by the Minister of Health to be the point of reference for the PHCR project within the Ministry of Health. PHCR project held a start-up meeting with the first deputy Minister of Health, together with PHCR's CTO and the Director of USAID's Democracy and Social Reform Office. Following the meeting, PHCR's COP and DCOP met with the deputy chief of staff and with deputy minister of health, Levon Yolyan, who is responsible for healthcare finance.

In March, nine members of the PHCR team visited Vanadzor and met with the Health and Social Security Department head, Dr. Dilbaryan, and discussed:

- establishing Marz Advisory Board to support reform activities and membership;
- criteria for choosing target facilities particularly for renovation;
- how to organize FM/FN training in the marz;
- if Polyclinic #5 should be considered as FM training center;
- management training, especially concerning the fact that most PHC directors are physicians and that they have only weak knowledge in finance and management, information use and feedback procedures;

The Team also visited Polyclinic #4 to discuss facility management and financing problems. On March 23, a meeting held with the head of Yerevan Municipality Health and Social Department, Dr Armen Soghoyan, about establishment of a Yerevan marz advisory board/working group to cooperate with PHCR. Dr. Soghoyan promised to submit the list of proposed WG members. He also suggested considering the need for polyclinic renovation/establishment in Jrvezh and Kharberd districts.

Weekly regular meetings have been held with USAID advisor team set regularly for every Thursday afternoon at 4pm or Fridays at 9am, providing regular updates on PHCR project progress and management procedures.

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On 14 March, PHCR staff participated at the NOVA presentation of the results of a study conducted in communities and health facilities in Gegharkunik and Kotayk Marzes, and in the launching of the PHC Management Guide.

2. Ensured logic and efficacy, with all activities and methods leading to the defined objectives:

Log-frame analysis training was undertaken with project staff and counterparts, and the work-plan and PMP were constructed to ensure links with the 5-year strategic objectives of the PHCR project. Project management systems were further refined and are fully functioning.

3. Project management systems functioning:

During the period, the project had STTA input in the area of M&E with Dr Tom Carson, and in the area of IT with Dr Herbert Koudry. Trip reports from consultants were submitted to USAID separately. Washington-based Project Manager, Anna Benton, arrived in mid-February to assist with preparing workplan and other activities.

The work-plan and PMP were developed after extensive LFA analysis, counterpart consultations and field-assessment of experience from the ASTP project. Baseline data on key elements of the PMP were collected from official MOH sources, and monitoring for auxiliary data was prepared with instruments and forms by the M&E team.

An Open Enrollment specialist announcement drafted and posted via www.careercenter.am. The PHCR Office Manual and Employment agreements finalized and distributed to the staff PHCR management staff held hand-over meetings with Project NOVA Chief of Party, Rebecca Kohler, on procedures to facilitate continuity of coordination between PHCR and NOVA. In this transition, job responsibilities of the FM&QoC team members, and needs for IntraHealth STTA as well as EMG-IntraHealth cooperation in financial issues were discussed and procedures for management settled.

On March 27th, a meeting was held with Project NOVA's finance manager on procedural management of IntraHealth-held PHCR budget for the FM component and organizational issues, procedures and logistics.

4. Project monitoring system established, and baseline data collected:

The PMP was revised and the final version submitted and approved by USAID.

The baseline facility assessment tool was completed (including meetings with the teams to discuss component-specific baseline issues, the format/content of the questionnaire, etc.), and a facility self-assessment instrument tool developed. A tool to measure client satisfaction was developed, circulated and refined based on the comments received from different project teams. A logistics plan was developed for baseline assessment in target facilities and a 5-year plan for project monitoring and evaluation was prepared. PHCR also drafted a Checklist for medical record completeness review, suggested for consideration of M&E team while refining the content of facility baseline assessment tool.

The M&E and PE team drafted a format for an introductory meeting with communities where facility baseline assessment shall be undertaken and an approach developed to formalize community authorities' involvement in the PHCR Project's activities. A letter to community leaders introducing both the PHCR project and the baseline facility assessment task was drafted along with a short questionnaire to measure the readiness of the community leaders to get involved into the project activities. The letter is designed to serve as a letter of commitment by the local authority for participation in Project activities.

The signing of the MoU between PHCR project, community leaders and facility heads will be applied after the baseline assessment, when the facility will be finally selected for project activities. The MoU will reflect decided areas of activities in each facility.

5. Project effectively communicating with external world:

PHCR drafted a document defining procedures for communications, including document circulation. Basic groups of project stakeholders were defined to help provide target topics in the Project Website and quarterly bulletin. A format for the project bulletin was drafted, and will be finalized to comply with USAID branding requirements and submitted to USAID for approval.

PHCR staff business cards have been sent to the print-house following the agreed branding, approved previously by USAID. The staff business cards will be ready for distribution during the next month.

Reports from the ASTP website have been downloaded and prepared for posting on the PHCR website, to be created over the next 3 months. PHCR has recruited and identified a Communications professional who will be responsible for creating and maintaining the website.

The PHCR Communications Specialist has begun to discuss and develop the PHCR website and a systematic study was undertaken of websites of other USAID-funded projects, to help design the most relevant information-structure for the PHCR website. The Specialist studied USAID website development guidelines, as well as a presentation sent by Anna Benton (a former Communications specialist) at EMG Home Office.

The team started developing a PHCR stakeholder matrix with which to identify target audiences for project website and bulletins. Based on the discussions with the Team Leaders, main external stakeholder groups were defined for the Project Website and quarterly bulletin.

6. PHCR field activities begun:

A letter has been drafted to Dr Satenik Beybutyan (Head of Shirak Marz Health Department) with accompanying document, and will be submitted to request specific decisions in preparation for the PHC site assessments. PHCR project has requested from SanEpid Service the relevant presently valid SNIP requirements for PHC facilities. SaniEpid department has promised to share copies with project. These standards are the official MOH requirements for the PHC facility standards.

On March 27 PHCR staff met the director of “Manuk” child polyclinic and head of Jhrashen ambulatory. Both expressed sincere interest to be involved in PHCR activities. The PHCR brief was shared with them. Jhrashen ambulatory head expressed his opinion on PHC regulatory package, mentioned weaknesses and gaps, and the director was invited to participate in the upcoming MOH workshop on primary healthcare recording forms. The director of “Manuk” polyclinic expressed interest in cooperation in pilot trial on health behavior in chronic disease management, in particular with interest in the area of management of children with diabetes. A concept of patient-education “diabetes school” will be further assessed and considered, as part of the FM and PE component of the PHCR.

PHCR held meetings with the director of the Health department in Lori and in Shirak marzes, with respect to creating Marz advisory boards, listing facilities against needs, survey of needs for training Family Medicine physicians in continuous education, identification of candidates for the clinical preceptor roles for continuous FM education, and about connections to be established with Marz Medical colleges and with Basic Medical college in Yerevan to provide back-stopping and support to build capability in staff at Marz college level. A workshop was arranged by the STTA for Family Medicine, which included the chairs of family medicine in YSMU and NIH, initiating the process of how to design a CFME program with which to support FM providers in the Marzes. Work was started to identify Polyclinics for support to establish increased number of FM training sites in Marzes and Yerevan.

Gyumri field office staff candidates have been interviewed and three candidates prepared for hiring, based on specific job descriptions and a specific three month work-plan was developed for the Vanadzor/Lori staff. The Gyumri recruitment process was slower than what was possible to achieve in Vanadzor/Lori, due to lack of access to the internet.

PHCR developed a methodology for allocating budget for renovations between the marzes, and agreed with Marz Health directors on clear facility selection criteria for identification of PHC sites for renovation. PHCR has created an initial short-list of facilities that are candidates for renovation in Zone 1 (Lori and Shirak marzes), based on preferences by Marz Health directors and advisory boards, and based on set criteria. An activity timetable for renovation activities has been drafted with help from engineers. Meetings have been held with

World Vision, and WB PIU, to build on experience from PHC renovation work done previously both regarding the most common types of renovation activities, and mechanisms for management. Contact was established with USAID project CHF, and PHCR project has been promised access to a copy of the CHF renovation manual.

Component 1: Expansion of Reforms

1. Project has delivered support to change policies and to improve the regulatory environment for PHC reform:

The project has endeavored to clarify with the MOH who is dealing with the new project laws: (i). law on “Healthcare” and (ii) law on “Public health security”. PHCR has identified that the first item is under the management of deputy minister Tatul Hakobyan and the second by the Minister’s Advisor on legal issues, Suren Qrmoyan, together with the MoH Chief Sanitary-Epidemiologic Doctor Artavazd Vanyan.

Presentation materials and Powerpoint materials were developed on the topic of Medical Records and QoC, for the upcoming PHCR workshop on Encounter Forms and Records at PHC facility level.

2. Criteria for facility selection defined, facilities mapped and selected in Zone 1:

Criteria for facility selection in Zone 1 was defined in collaboration with Marz Health Directors. Selection of facilities give priority to (a) Communities with willingness to participate (b) Long travel distance from community to referral healthcare resources (b) Presence of FM trained physician or physician in training to become FM provider (c) Presence of Nurse trained to be FM Nurse, Community Nurse or, presence of nurse who is willing to enroll in training (d) Poor physical standard of existing facility (e) Poor equipment in existing facility. Each indicator is graded on a scale 1—10 where 0 represents very poor or “absent”, 10; “high score”.

Each indicator is then provided with a relative weight, and this weight can be different from Marz to Marz, depending on the MAB's priorities and depending on the overall standard of primary healthcare in one Marz compared to other Marzes. This provides a decision-making matrix, where highest Summary score gives guidance for short-listing facilities for selection (for the whole PHCR reform package).

A one page framework of all PHC facilities has been created for Lori and Shirak marz, reflecting their structural network and categorizing them based on their need for basic or cosmetic renovation. Research has been carried out on needs for renovation and equipment purchase from previous projects which that have been implemented, and/or are being implemented by other donor funded programs. PHCR has reviewed legal and procedural aspects of renovating health care facilities in Armenia.

PHCR has started collecting info on providers of architecture, design, engineering, and construction services, as well as suppliers of building materials. PHCR is planning to create a database of providers of architecture, engineering, and construction services, and providers of building materials. PHCR has drafted a questionnaire for collecting information on the physical condition of facilities from marzpetarans. PHCR has contacted the MOH licensing department and checked requirements regarding space and physical conditions in FAPs and ambulatories.

3. Skills and mechanisms for workforce planning methods and rural incentives mechanisms are transferred to and used by MOH:

Feeding into the planning of training of Family Medicine physicians, the PHCR labor economist has conducted data collection and projected needed staffing with family doctors. The projection of workforce needs has included a first attempt to assess the impact of the new "free of charge primary care" policy, using experience from January 2006 in comparison with January 2005 visits.

A report has been compiled and presented about worldwide experience on rural incentives and medical staff deployment (USA, Europe, Canada, Australia, South-Eastern Asia and CIS countries) and translated to Armenian in preparation for submission to Ministry of Health, Department of Education, Science and Personnel Management by their request and according to PHCR workplan. Data input of information on sample survey on rural incentives, is under analysis. The workforce planning specialist has started a financial consequence-analysis, of the different alternatives for rural incentives.

The first draft regulation on rural incentives for primary healthcare providers (Family medicine doctors) was changed by MOH in response to recommendations provided by the PHCR specialist team. The resulting second draft regulation on rural incentives for primary healthcare Family Medicine providers has now also been commented on by PHCR, and sent to medical institutions for the residency programs for further comments.

The PHCR Report on worldwide experience on rural incentives and medical staff deployment was discussed during its development with key counterpart officials in the Ministry of Health, Department of Education, Science and Personnel Management for consideration in the further development of the second draft of regulation on rural incentives. A quantitative analysis of sample survey data on incentives covering 126 family doctors and 30 family nurses has been undertaken using the SPSS statistical analysis software package. Tables on frequencies are being generated by indicators and questions, with cross-tabulation data generated. Detailed results and discussion of results will be generated in a separate written report.

Based on PHCR recommendations submitted to the Ministry of Health a second draft Government regulation has been drafted on “Assignment of health specialists to health institutions in the remote and bordering regions of the Republic of Armenia. This draft decree also needs some adjustments, amendments and changes before it can be submitted to the Government. This work with changes and amendments is ongoing during Q2.

A report (Power Point presentation) has been prepared on results of sample survey, international experience on use of rural incentives and current draft regulation on rural incentives for the workshop. The Power Point presentation about “Rural incentives: World experience and local applications” will be presented on Thursday, March 30. The presentation will cover the review of accumulated experience from other countries on use of incentives for rural doctors, quantitative and qualitative analysis of survey results, and main points of draft Government decree on rural incentives. A meeting was held with the Department of Health and Social Security, of Yerevan municipality where an agreement was reached on the provision of necessary municipal data for the health-sector workforce planning.

4. Key target facilities have access to IT resources (hardware, software, support):

In the harmonization of software and hardware solutions for facility level management, open enrollment and encounter forms, PHCR STTA Dr Herbert Koudry and MIS/IT specialist Dr Khachatryan and OE specialist Gayane Gharagebakyan have worked in the established Working Group (World Bank and SHA staff), to bring about a unified software solution. The final version is still pending decisions about Format by MoH.

5. Improved management, supervision and financial oversight at facility level - with IT systems coordinated:

An approximation of the OE MIS IT overall cost has been calculated for two different options and shared with PHCR staff members. Additional cost projection need now also to include healthcare finance IT support needs. This estimation is undertaken alongside further IT activity planning. Technical support from EMG Senior Manager for IT (Scott Vickland) has been initiated to prepare the IRM document for USAID approval of hardware needs for tendering and procurement.

Renovation, equipment

6. First phase: PHC facilities renovated and equipped for medical purposes:

The model used by Save the Children in renovation of facilities under project NOVA has been evaluated and considered for a segment of the PHC renovation to be undertaken by the PHCR project. Mechanisms for engaging a renovation engineering and architect partner for work, is aiming for renovation work and community mobilization to start in parallel during the summer months of current year. Based on same PHC facility selection list, the Family Medicine team is currently evaluating the needed equipment and supplies which shall be provided at the FAP, Ambulatory and Polyclinic level.

A SOW for construction engineers has been finalized and two engineers identified for field-assessment, to prepare defect-acts on short-listed facilities in Zone 1. Preparation for announcement of SOW for a limited competition announcement on renovation has been prepared; finalization is pending the final on-site PHC facility assessment by engineer during April.

7. Second phase: mechanisms for sustaining the physical improvements (renovation, equipment) of PHC facilities are in place:

PHCR is evaluating reasons for weak maintenance as part of the baseline assessment instruments. A preliminary draft has been considered for facility managers and community leaders' agreement – where the pre-renovation agreement will include commitments from local community and facility managers to provide long-term input to facility maintenance. A draft TOR has been developed for subcontractors for renovation and non-medical equipment supply.

Component 2: Family Medicine

1. M&E plan for FM component developed and functioning:

Instruments for Monitoring training needs and clinical performance have been developed and are ready to be field-tested during the facility baseline assessment. Two new questions added for family medicine assessment: 1) list of disease-conditions for which there are clinical guidelines available in the assessed facility. (2) list of drug information sources available and used by the providers at the PHC facility.

2. Project delivered assistance changed the PHC/FM policy and regulatory framework:

Work has started to define regulatory barriers which limit FM physicians' ability to translate learned skills into practice. PHCR project has identified a wide range of limitations which hamper the work of the FM physicians, such as regulatory limitations against the use of insulin for managing diabetic patients.

PHCR staff contributed to drafting a new directive / decree for the future function of FAPS; their defined services, staff, physical standards and equipment. This work is done alongside the work with revision of the Family Nursing curriculum and feeds directly into the defining practical targets for PHCR support to nursing training, and for renovation and equipment supply at FAP level.

FM & QoC team has started ongoing work to review the BBP PHC regulation package for identifying gaps and barriers for FM practice expansion.

3. Providers use up-to-date clinical standards and procedures, through training delivered by well equipped and strengthened Family medicine training departments:

Draft materials have been developed as templates for job-aids *cum* training-packages on urinary tract infections, dermatology, primary care parasitology, a draft primary care laboratory methods training manual, and clinical standards for disease-prevention and health promotion outreach (PHAST).

An extensive outline defining training goals has been developed, defining targets for the training package in urinary tract infections management for Family Medicine. Another developed draft module provides PHAST training core skills for FM outreach and community-mobilization for disease prevention. Draft modules have also been prepared in the areas of pain control, and draft job-aid templates have been prepared for 40 diagnostic-treatment-referral flow charts. Those drafts are developed as base-template for work to be undertaken by working groups in Family Medicine (UFMC and CFME) module development.

4. Institutions training and re-training of Family Medicine and Family Nursing providers have increased capability (Increased capacity in delivering training modules and widened ability to deliver new forms of training):

Meetings have been held with Lori Marz college for nursing, Shirak college for family nursing and with the Yerevan based BMC: Basic Medical College for Nursing and NIH nursing department. These meetings allowed for planning how PHCR can enable BMC support to be provided to strengthen competence and skills of teaching staff at the Marz-based Medical colleges. Work continues with practical activity plans linked with plans for delivering training in FN for 130 nurses in Shirak and Lori. The identification of the 130 nurses is ongoing in parallel with identification of facilities for renovation in Lori and Shirak in close collaboration with the Marz advisory Boards in each Marz.

5. Family Medicine curriculum is up-to-date with training modules (UFMC curriculum content):

STTA input from Dr Martha Carlough has mapped the needs for training faculty at NIH and YSMU and BMC, in developing up-to date modules for Family medicine and Family Nursing, and in delivering training which focuses on clinical skills ToT.

Working procedures for the development of training modules have been drafted, along with mechanisms for enrolling and contracting faculty and specialists for the development and testing of training packages (including specialists, FM faculty and clinical preceptors). PHCR is planning a workshop-retreat for key stakeholder to outline the priorities for curriculum module design, tentatively scheduled for last week of March.

March 06 PHCR staff visited Vanadzor PC#4 and held technical discussion with PC director on sustainability of FM and QoC components of the ASTP model. Individual meetings were also held with FM providers to discuss their continuing education needs and experienced barriers against expanding their scope of work.

A workshop on “Strengthening FM Education and Practice” for about 15 local FM counterparts was held on March 07. Dr Martha Carlough made presentation on “Overview of current thought in medical training methodologies” including Evidence based medicine, Problem based learning and Competency based testing. A follow-up group exercise was led by Dr Martha Carlough and Sam Tornquist on international examples of FM training programs – pros and cons, and applications to Armenian context.

A workshop on Strengthening FM Education and Practice was carried out April 5-6 at “Golden Tulip” Hotel, and a summary report from the workshop was compiled (Separate report presented to USAID health team). Results from the Workshop include consensus on four first modules for Family Medicine and Continuous Family Medicine Education, and establishment of a Coordination Committee with representation from the Chairs for Family Medicine in NIH and YSMU, representation from Family Medicine Association and Family Medicine Society, and four clinical preceptors. There were at least 50 participants at the workshop.

Summary outcomes of the workshop are:

- (1) FM training working group established
- (2) List of priority topics in UFMC to develop training packages
- (3) Topics for CME courses
- (4) Quality requirements for training package development

The MOH order on Regulations of CME Credits was furthermore discussed during the workshop with the purpose of ensuring that training modules and continuous education program elements developed and delivered by PHCR (and other USAID funded projects) provides formal credits as formally required in the Armenian healthcare system.

6. First phase undertaken to establish FM training centers and sites:

In collaboration with Lori Health director and Marz advisory Board, Polyclinic 5 in Vanadzor and one additional PC-based training site has been proposed. In Yerevan, a Polyclinic in Kanakri is being considered both for renovation and as a base for building a clinical training site for FM training.

On March 15 a meeting was held with professor Samvel Hovhannisyan and MoE specialist of Qanaqer-Zeytun Community administration, Ashot Vardanyan, about the proposed establishment of a FM training center cum Polyclinic in Kanaker suburb of Yerevan. A site-visit was carried out on March 17 to the site. Dr Samvel Hovhannisyan promised to submit documents on standard requirements for PHC facilities based on size of facility following needs assessment of the Qanaqer-Zeytun community administration chief of staff.

On March 16 PHCR staff visited Vanadzor, met the head of health and social department Dr. Robert Dilbaryan, and participated in discussions on Lori marz advisory board establishment and PHCR target facility selection. At this visit, PHCR staff also visited PC#5. Dr. Dilbaryan expressed concern about underutilization of this polyclinic which previously received USAID funded support to become a Training Center (since 1999 by USAID funded support through AIHA support, with upgrading of physicians offices and PC Training Center with modern equipment and supplies, and a series of clinical trainings of medical staff abroad at Milwaukee College experience exchange). PHCR staff also visited a Nursing College to assess the feasibility of conducting Lori marz nurse retraining there. A Family Nursing chair has been established there by WB PIU, equipped and supplied. Plans were drafted for PHCR support with methods and staff skills for strengthening the FN chair.

PHCR team visited a site proposed by Qanaqer-Zeytun Community Administration as a potential PHC facility/ FM training center. The Head of NIH FM faculty, Dr Samvel Hovhannisyan will submit documents on standard requirements for PHC facilities to Qanaqer Zeytun Administration based on which they will present size of facility and rough cost estimation for PHCR consideration. After this visit, Qanaqer-Zeytun Community Administration submitted estimated cost for Polyclinic/FM center establishment to PHCR with a total budget estimate at 410,000 USD covering the needed building and equipping of new building, or as alternative 80,000 USD as needed for renovating and equipping existing buildings which could be converted into a polyclinic.

To cover this budget frame completely is outside the feasible scope for PHCR. Instead PHCR is considering partial contributions in such settings, perhaps with focus on a specific component of a new Polyclinic (laboratory, waiting room or other “modular elements” of the renovation target). Contribution from Qanaqer-Zeytun Community Administration to enable the more extensive work would be necessary. No commitment has been made from PHCR, and this polyclinic proposal must be considered further alongside other Polyclinic needs-assessments which PHCR project is scheduled to undertake within the wider collaboration with the Yerevan Marz Health director and Yerevan Marz Advisory Board.

7. Zone 1 Clinical training centers and sites upgrading started:

To be started later in Year 1.

8. At least 25 FM providers retrained and/or trained through UFMC and/or in-service continuous FM education:

The needed number of Family physicians has been addressed in several follow-up discussions after the USAID-PHCR workshop which was held in Nov/Dec 2005. PHCR Workforce planning experts have assessed the relevance of the original calculation of the needed number of Family doctors; the basis for the ongoing retraining undertaken with World Bank support. The number of doctors trained to become Family doctors amounts to 930 in the WB program.

The figure “needed to train” was then calculated simply by dividing the population number with what was considered the nominal target (2000 inhabitants per FM Dr).

Considering the reality of the Armenian population dynamics, the workforce planning must however also consider other factors, including age distribution of the workforce, and actual workload. This is particularly important with the new political situation with *free of charge primary healthcare*. In one pilot site (Polyclinic 17) this new situation has led to a 22% increase in visits, comparing Jan 2006 with 2005.

To what extent a similar trend also has been seen in the rural ambulatories will also be assessed using data from pilot sites, which is being planned for later during 2006, when the initial impact of the new situation has settled. However, when considering the very low number of patients seen per day by the average FM Dr, and after also considering that many FM Drs work only part-time, there is already an over-supply situation. There is an overcapacity which can be used, before the workload per FM Dr reaches anywhere near the international optimal of at least 3,6 patients per working hour. Results from workforce planning so far leads to the conclusion that it is more rational to invest PHCR resources in continuous education, than to add 150 new candidates to the ongoing World Bank PIU retraining program.

Together with the Marz Health Directors and Marz Advisory Boards, PHCR is working on the identification of candidates for Continuous Family Medicine education in Lori and Shirak Marzes, along with identification of facilities for renovation and alongside identification of candidates to receive TOT training to become skilled clinical preceptors for CFME in Lori and Shirak.

9. FN training departments in Zone 1 nursing colleges given support with methods, equipment and staff skills:

PHCR held a meeting with the local Nursing colleges in Lori and Shirak, starting a needs-assessment for delivery of project support (involving Yerevan-based Basic Medical college) to train/support marz-based faculty and staff.

10. 130 PHC nurses have begun retraining to be family nurses (FN) and community nurses(CN) in Zone 1:

Identification of candidates for FN training started in February and is being undertaken alongside selection of primary healthcare facilities for renovation, in close collaboration with Marz Health Directors, and Marz Advisory Boards.

11. Unified Family Nursing Curriculum developed:

PHCR has agreed with WHO that PHCR will take responsibility for the UFN-Curriculum, including developing modules, and linking this work with ongoing work in MoH-WHO-NOVA-PHCR working group, defining new roles and development needs for nursing at FAP level. Two working group meetings were held in February.

The PHCR specialist on Family Nursing has continued work with the unified family nursing curriculum, identifying needed input to fill the training modules. The needs-assessment has also identified that training for Family Nurses must address policy issues in order to avoid missing the target of nurses at FAP level. The reason for this is that MoH has a set policy that FAP stations shall not just have Family Nurses, but “Community Nurses” who have additional training in specific areas, such as emergency care.

A meeting was held with WHO and an agreement reached whereby WHO will propose to MoH that PHCR will take over where the WHO support to family nursing curriculum ended by the end of year 2005.

The head of MOH HR and Education department have requested PHCR to submit comments on Unified Family Nursing Curriculum, which is ongoing work to be completed during April 2006.

12. Educational packages developed for 2 selected modules of the UFNC:

Draft modules and templates for a training module package for Urinary tract diseases have been developed, as well as detailed package and training manual for primary healthcare laboratory methods. Activities of work by contracted work group members starts later in the year. There have been several FM&QoC team discussion of UFMC module training packages, FM continuing medical education and clinical protocols/job aids development.

13. Feasibility study undertaken of "Models" for autonomous FMGPs, in line with provisions of Gov. Decree:

Activities for evaluation starts later in the year.

14. Up-to-date clinical standards, job-aids provided for target-facility Family Medicine providers in Zone 1:

Draft flow-charts and SOP (Standard Operating Procedures) for FAP and Ambulatory level have been developed as template for working groups.

15. Polyclinic support for Yerevan prepared for Y2:

To be started later in the year.

Component 3: Open Enrollment

1. Policies and regulations in place to support open enrollment:

The project is operational and delivers results directly to Ministry of health on several levels. In the area of Open Enrollment, the Open Enrollment specialist is delivering practical input to the MoH Primary Care department and has supported the design of the new decree on open enrollment, and detailed roll-out step-by-step mechanisms for roll-out.

The OE/Health reform team amended the open enrollment decree in January and provided follow-up support to the Primary Care department of the MOH, in preparation for the re-submission of the Decree to the Ministry of Justice. The OE Adviser and OE team also have prepared the Manual and instruction handbook for OE preparation/training and software harmonization for OE.

Meetings held with 1st deputy Minister of Health, Dr.Hayk Darbinyan and with Dr Vahan Poghosyan (Head of Health Care Organization Department) to discuss OE policy issues, such as location for the placement of the national central server(s) of the Open Enrollment system, the role of marz health department heads in the system preparation activities, need for recruitment, training and involvement of new IT specialists based at the marz health departments to run the OE IT system. A decision with Mr. Poghosyan was that the PHCR Project develops OE implementation/preparation plan. In response to this decision, a

Workshop with key stakeholders has been planned, to be carried out April 25th with MOH and Marz level stakeholders. A clear step-by-step draft activity-plan for the OE preparation stages has been developed.

2. A national, regional and facility level network of facility-based and Marz and MoH employed OE coordinators established:

Planning of the network functions is underway, included in the Manual for OE introduction, where training of trainers and the in-facility know-how training is outlined to enable the OE introduction process. PHCR prepared a draft order for Marz level health authorities for employment of key staff for the OE process.

3. OE coordinators' and implementers' trained:

To be undertaken later in the year.

4. Open enrollment information system established, with vertical reporting system functional and ready for the launch of OE Q1 2007:

Hardware and software specifications have been defined, with **three high capacity servers** to be placed at the level of the SHA, the MOH Health Information Center and at the level of Yerevan Municipality HSSD.

In addition, **ten (10) mid-capacity servers** of medium size will be placed at HSSD level in the 10 Marzes.

For regional authorities, hardware specifications define 1 x Intel Xeon Processor 2.8 GHz/2MB cache, 800 MHz FSB, 2 x 80 GB RPM serial ATA hard drive, SATA RAID Card, RAID 1,2 SATA Hard drive, 48X IDE Internal secondary CD-RW/DVD ROM Drive, 1024MB DDR2, 333/400/533/667MHz, 4X512MB, Single Ranked DIMMs, Ethernet NIC 10/100 Mbps, Video Card 32/64MB etc. for the ten Marz level servers. The function of these servers is to feed data to the National level duplicate databases for OE, kept at duplicate servers with different physical locations (Health Information Center and SHA of MOH). Those servers will have 6 x 40GB 7.2K RPM Serial ATA hard drive. This is the backbone of the hardware in the OE vertical reporting system, onto which software and human resources are being tailored, alongside training in procedures and software management and data entry/data analysis.

A new infrastructure of IT staff is discussed with COP and MIS specialist and their functional specifications are in the process of development. PHCR continues the development of Enrollment third level database. The development of an SQL Server login tool has been continued. These tools are a required component for the database and serve as a secure mechanism to store SQL login password and provide to the clients each time of the session. Development of OE information system continues. An address catalogs for marzes has been collected and included to the database. Work on IRM documents to prepare a hardware procurement plan and estimate hardware and software cost for the system is underway, with assistance from EMG head office. The full IRM document shall be ready for submission latest by end of April 2006.

Work is ongoing to update and develop the Open Enrollment database system. All marzes and Yerevan city address catalogs in process of preparation and formatting. Raw list of addresses had been divided into smaller fields and placed in separate columns for effectiveness of usage and fast search capacities. Also the list of addresses had been updated into UNICODE format to fit OE MIS requirements.

In all, 11 applicants for the PHCR project IT MIS position have been reviewed and short-listed candidates invited for interviews. In all 9 candidates were interviewed with a technical test for professional IT skills.

5. Open Enrollment Monitoring system developed:

The Monitoring system for Open Enrollment has been designed to operate as an internal integrated element of the system function, whereby enrolled number of patients from the facility level provides the operational function of the OE System. In addition, quality control functions are designed integral to the software function and data quality control, in elements such as automatic control for double registration. The design of the M&E element of the OE system has been designed in parts and in parallel with the work on the OE software which has been addressed in the Software harmonization workgroup during February. The M&E system will begin ‘reporting’ as it is implemented alongside/integrated with the OE system itself during Y2.

Component 4: Quality of Care

1. Policies and regulations in place to support QoC in Family Medicine and primary care; Draft amendments and corrections to Licensing Regulations for PHC facilities provided:

Work started, ongoing.

Quality indicators, benchmarks, standards, and quality monitoring mechanism for PHC/FM have been prepared based on experience from ASTP by the FM&QoC team, to be field-tested alongside the baseline survey. A comprehensive study of international experience in Primary healthcare quality of care monitoring and use of indicators has been carried out. The staff have studied materials (printed and electronic) related to QoC issues, and these have been used to propose practical quality indicators and methods for data collection. This work has been linked with discussions in the healthcare Finance team, about mechanisms which can be used also for the performance-based contracting and performance-based remuneration system (See further report about STTA input by professor Igor Sheyman, Healthcare Finance). The FM & QoC team conducted meeting on PHC physician’s performance-assessment by checklist to be used in target facilities as a monitoring tool. Several sources of performance assessment checklists were reviewed.

An Outline Paper prepared for PHCR use of Quality indicators, benchmarks, standards, quality monitoring for PHC/FM and as impact monitoring to be used to assess impact of renovation, equipment and training.

2. Draft amendments and corrections provided to Regulations for the authorization of persons to practice Family Medicine in Primary healthcare:

Work started, ongoing.

3. Monitoring system for QoC in place:

Work included integrated in PMP, and development of evaluation ongoing.

Suggestions have been developed on Quality requirements for treatment guidelines for the “Draft for development of clinical job-aids and Guidelines” provided by COP. PHCR has developed presentation slides on the topic of Medical Records and QoC, for upcoming Encounter and Records workshop.

4. PHC QoC strategy to define targets for renovation, training, Forms and equipment established:

Meetings have been held with project NOVA and Save the Children, assessing feasibility of the STC method for PHCR renovation of FAP and ambulatories in Lori and Shirak Marzes. The project specialist for Quality of Care developed a draft Concept Paper on Quality of Care, which will be developed further through feedback from experience during the life of the project.

Reality-assessment regarding the need for Quality of Care interventions was part of the field-visits to Gumri Family Medicine Centre in Shirak. The visits shows that the basic record keeping and encounter forms used in the clinic do not allow for the needed analysis of diagnosis or treatment. The record keeping is thus a very important element, which needs to be strengthened in the PHCR support to QoC improvements. PHCR has therefore made plans for a specific workshop targeting Forms, Records and Charts used in primary healthcare level, in collaboration with key counterpart departments in the MOH. The workshop is scheduled to be held at the end of April 2006.

Site-observations have also shown that the Family Doctor lack working tools and supporting systems (literature, information access, instruments). Also the clinical preceptors who are responsible for training, lack many essential tools.

Preliminary assessment of the equipment-needs indicates that in Family Medicine, the physician's equipment list need also to include a basic bag of equipment available in portable form for home-visits and emergency calls. Such portable basic medical equipment was not found during the site-visits. During site-visits, it was also observed that the primary care doctor also lack access to the basic information sources, such as a national drug formulary (physicians drug-use handbook). This is one of the most basic tools for any (primary care) physician. This tool is needed to provide objective, and producer-independent and scientifically sound, correct and advertising-free information on the function and place in therapy of drugs for diagnostic, therapeutic and preventive use. Approved indications for the use of drugs need also to be clear, and specific issues such as contraindications and necessary precautions (e.g. which patients must NOT be treated, for example in case of known allergy, etc) need to be available for every doctor.

Such clinical practice handbooks need also to provide guidance for what every doctor needs to consider in the treatment of the pregnant and breast-feeding women, and provide the physician with justified and well founded instructions for the treatment of patients who have complicating conditions, for example instructions on how to deal with (dose-adjustments) a patient who also has a kidney or liver disease, or is treated with other drugs which influence the patient's ability to eliminate given drugs.

There was no access to such basic and essential clinical information in the visited clinics. The PHCR project concludes from site-visits that the lack of drug-use information is a barrier and relevant target for quality of care interventions. It is well documented worldwide that such information-deficiency results in unnecessary risks for treatment failure, and increases the risk for adverse drug reactions.

In regard to QoC activities, PHCR staff has also identified a perception barrier, which needs to be addressed by the PHCR project. There is currently unease and a fear of criticism, which

makes the physicians unwilling to conduct QoC work through collegial and peer review. This attitude problem must be addressed, and turned into an environment of supportive supervision as to enable QoC interventions.

The field observations lead the PHCR team to reach important conclusions about what needs to be priority elements of QoC in a revised work-plan. The Ministry of Health also appealed to PHCR for support to a workshop to start a review and produce unified Encounter Forms and patient Records for primary healthcare. This clearly connects well with above described problems, identified by the PHCR team during field-visits. Clear and safe encounter-forms and records provide a necessary foundation for further interventions and monitoring in the area of Quality of Care. Revision of Forms will also provide a necessary link with other key project elements, such as the proposed performance-based contracting mechanism under Healthcare Financing.

During February, PHCR began defining the basic lists of equipment and for PHC facilities with, beginning with the equipment required for licensing (minimum-list), with added needs defined by the skills and services which shall be learned during PHCR delivered training of Family Medicine providers.

From the extension of competences and skills obtained during this training, PHCR QoC adviser and the FM team have started to prepare an extended list of equipment and an extended set of qualities and functions which a PHCR renovated PHC facility need to support. The work is ongoing and integrates with the definition of modules for UFMC, UFNC and CFME. Drugs and barriers to access to needed drugs, for example for reproductive health, and for basic Family Medicine functions/services, is currently being assessed with the intention to provide a better supply and equipment base for FM Drs and nurses to deliver needed services.

5. Patients have access to primary healthcare family medicine at good level of quality of care:

Preparation of baseline data collection includes to record status on pre-intervention QoC.

6. Patient satisfaction with quality of care monitored and assessed:

This activity will be undertaken later in the year.

Component 5: Healthcare Financing

On January 19, we received USAID approval to hire Gayane Igitkhanyan as health finance specialist. She worked on a part-time basis through the end of February until she fully transitioned her responsibilities at her prior employment after which she joined the Project on a full-time basis.

On February 3, we received approval to hire Saro Tsaturyan as a local STTA for the healthcare finance work on a part-time basis and he was designated as the Acting Healthcare Finance Team Leader.

1. Technical Assistance Provided to NHA Working Group

On the level of healthcare Financing, the PHCR specialist in NHA is actively embedded in the inter-agency NHA working group. This working group is an ongoing direct-technical assistance given through PHCR. During the quarter areas of technical input were in the areas of assessing the international organizations' expenditures in the healthcare sector in Armenia

and classification of the types of economic activities realized in the healthcare sector. Our NHA Specialist assisted the NHA Working Group in preparing a presentation and materials for the upcoming joint meeting of the NHA WG and the Steering Committee on March 29 at the MOH, which the DCOP also attended.

Together with NHA WG members the NHA Specialist continued the development of the questionnaire on the random study of healthcare facilities and pharmacies, and healthcare expenses realized by households.

Also assistance was provided in the development of possible methodological approaches on assessing the expenses realized by non-for-profit local or non-governmental organizations in healthcare sector during the discussions of NHA WG planned for April 3.

PHCR held a meeting and discussion with the WHO Armenian office representative Dr. Elizabeth Danielyan and WHO Regional Office for Europe/ Regional adviser Dr. Bakhuti Shengelia on NHA development and Health System Performance Assessment in Armenia. PHCR presented and received appreciation for its methodology for collecting information on funding of Armenia's health care sector by donor organizations.

The NHA Specialist studied and analysed the questionnaire on financial activities of healthcare facilities and pharmacies used in the random study of healthcare expenses of households, as well as healthcare organizations and pharmacies (2002). Also he studying and analyzing a number of RA NSS reports, report on incomes and expenditures of healthcare organizations providing medical care and services (approved by RA MOH Order No. 346 dated 09.04.2004) and other relevant reports.

As data was collected from various international donor organizations regarding the expenses made in RA Healthcare System during 2004 and 2005, NHA Specialist studied and analyzed the presented data. He participated in WB discussions on this topic including the need to prepare follow-up questions to donor agencies for clarification and revision of the received information.

2. National MOH health planning and budgeting process is based on policy objectives.

HF staff reviewed the current national MOH health planning and budgeting process and documented this process for internal review. A summary of the Armenia Health Budget for 2004-2006 was prepared and distributed to PHCR staff members.

Planning of activities to support this effort was conducted.

3. Information is provided to MOH/SHA to enable decision on the continuation or discontinuation of performance based payment system to facilities and performance based remuneration for providers at facilities.

PHCR identified STTA professor Igor Sheiman as an appropriate candidate to conduct the performance based payment system assessment work. Igor Sheiman visited Yerevan from March 9 to March 23. Together with PHCR Health Finance team members he conducted series of meetings and discussions with Armenia's health sector representatives, aimed at analysis of results of PHC providers' performance based payment system, which was piloted in 2005. Meetings a MoH, SHA and former ASTP pilot health facilities were conducted.

Based on the ideas expressed during the meetings by different stakeholders, PHCR organized a seminar on March 17 to discuss the main findings from the pilot and provide relevant information to the SHA and other stakeholders to make an informed decision on the

continuation or discontinuation of performance based payment system.

The seminar was attended by representatives from MOH, SHA and Yerevan Health Department. STTA Igor Sheiman facilitated the seminar and made a presentation on “Performance Based Payment System in Armenia: Preliminary Assessment and Recommendations”. Active discussions, which followed the presentation, suggested that it is necessary to continue further develop performance based payment system at the PHC level by taking the learning experience from the ASTP pilots and further refining the performance indicators, as well as data collection and assessment mechanisms. Igor Sheiman’s idea on implementation of the performance based payment system in Yerevan PHC facilities as a first stage of nation wide roll-out was also supported by the seminar participants.

Another major outcome of the seminar was the decision to establish a working group in order to facilitate further discussions on this subject. Working group members were suggested by seminar participants and include the following:

1. Ruzanna Yuzbashyan, Head of PHC Department, MOH
2. Samvel Kharazyan, Head of Contracting Department, SHA
3. Khachik Kolozyan, Head of SHA Yerevan Department
4. Robert Sukiasyan, Deputy Head of Yerevan Health Department
5. Gagik Sahakyan, Director of Yerevan Polyclinic #17
6. Saro Tsaturyan, PHCR Health Finance Adviser
7. Gayane Igitkhanyan, PHCR Health Finance Specialist

Main objectives of the working group are:

1. To develop a detailed workplan on piloting PBP system in PHC facilities of Yerevan
2. To develop the list of performance indicators
3. To develop draft legislation which can be necessary to implement the PBP system
4. Carry out other tasks on “as needed” basis in order to facilitate the implementation of PBP system

First meetings of the working group were held on March 20 and 21 at the PHCR Project office. Working group members discussed some of the main findings from piloting performance based payment system in 2005, as well as similar initiatives in different regions of Russia, information on which was provided by Igor Sheiman.

However, it was our opinion (as suggested by our STTA Igor Sheiman) that although we were able to form the provider payments working group and set near-term objectives and tasks for the working group, the sustainability of the working group could not be ensured without formalization through a ministry order.

Consequently, at the first regular meeting with First Deputy Haik Darbinian (organized by USAID) at the end of the Quarter, we presented the work of Igor Sheiman including the newly established provider payments working group. There we suggested that the MOH issue an order to formulize the work objectives for the provider payments working group. First Deputy Minister Haik Darbinian agreed with this approach and this was documented in the minutes prepared by USAID and submitted to MOH.

4. SHA (central and regional) and facility reimbursement/reporting system is streamlined.

The PHCR Project participated in a seminar organized by the WB and State Health Agency (SHA). The WB international consultant Carolyn Stanforth, presented recommendations for

strengthening the SHA and opened a discussion with the staff of the SHA including Ara Ter-Grigoryan, Director of SHA, and other participants. The presentation and the consecutive discussion provided us with information that we will use in our approach for assisting the SHA.

The PHCR Project conducted a review of current contracting mechanisms between SHA and facilities. Meetings and discussions with following SHA officials were conducted: Director Ara Ter-Grigoryan, Deputy Director Karlen Antonyan, Head of Economic and Planning Department Arsen Davtyan. PHCR obtained detailed information on contracting phases and procedures, as well as data flow and legal provisions. A chart, summarizing budgeting and contracting processes between SHA and PHC facilities, was prepared and distributed to PHCR staff members.

5. Cost of services is determined

The PHCR Project met with WB to gain insight on progress of WB BBP costing study. This work will begin next quarter.

6. Financial management systems and computer equipment are in place at targeted facilities.

PHCR assessed the use of computers and accounting software at Polyclinic #17 and Polyclinics #4.

7. Facility staff trained in sound management and governance practices.

In order to assess the training needs several targeted questions on this subject were included in the baseline assessment tool for PHC facilities. Based on the information from baseline assessment, PHCR will conduct focus group discussions and in-depth interviews in selected facilities to design its training strategy and identify potential group of trainees.

The PHCR Project started research on management training activities implemented by other donor programs. Information was collected on local providers of management, finance, and accounting trainings. Different options for training courses and providers were reviewed.

Component 6: Public Education

Job orientation has been developed for new staff members (See below under Recruitment). Meetings have been held with stakeholders, projects NOVA, IRD project (Intl Relief and Development), and with staff at the Yerevan city Polyclinics Grigor Narekatsy and Erebuni.

1. Public education campaign monitored and results evaluated

To be undertaken later Y1

2. MOH has methods and capacity to conduct public education campaigns

PHCR PE staff has held meetings with MoH to identify needs, starting the collaboration with preparation of Public Education materials about new BBP.

A SOW for STTA input from public education specialist Chris Wild has been finalized and submitted to USAID for an upcoming trip for April 10 through May 13. One of the purposes of the STTA visit is to lead a PHCR PE capacity assessment of MoH.

3. Health-literacy, health-responsibility and rational health-seeking behavior improved in target communities.

The polyclinics were visited to assess use of available public education materials for patients (and need for PE training of providers). Continuously meeting with other teams within the PHCR, to discuss collateral connections in planning of work, and to identify where PE, HP, DP connects with Open Enrollment, Family Medicine, Quality of Care.

In response to USAID call for consultation, the PE team has contributed possible modalities for addressing public education visavis the threat of Avian Flu

Review of educational materials for patients has started alongside with assessment of the PE materials available from the previous ASTP project. All materials from the ASTP project (Medical related reports) have been downloaded to the PHCR server.

Draft ToT materials have been designed for adult training, to be presented to the Family Medicine team and to health education / training facilities. These include interactive and cooperative teaching methods, Curriculum design, Adults educational learning strategies, Training assessment and evaluation methods.

The PE team has developed baseline monitoring instruments and visited ASTP pilot sites such as polyclinic # 4; and held meetings with ASTP Lori branch team for discussion of PE activities and PE materials developed under ASTP/USAID umbrella. There have been discussions of specific health issues with the head of Polyclinic #4 and with experience gained from field-visits, PE team has started to review PE materials obtained during the Vanadzor trip.

The PE team has started the process of development of Mobilization Manual using:

- a. Community-participatory approach method (PHAST);
- b. Knowledge gained from the Project Design and Management (PDM) workshop (initiated by Peace Corp) and
- c. Lessons learned from stakeholder meetings will be considered and adapted to PHCR goals and objectives.

A new BBP poster with messages adapted to the new “Free of charge situation” has been developed based on the BBP content provided by MoH.

Dr Ruzanna Yuzbashyan (Head of Department of Primary Healthcare of MOH) was invited to a meeting called by PHCR Financial team in design of the BBP poster. The drafted poster has been field-tested and a separate workshop meeting for approval after gained USAID clearance of the BPP poster has been set for April 14th.

During the discussion about the BBP poster, Dr Ruslana Gevorgyan, Head of PE Department, MoH, presented an additional proposal – for the PHCR Project to produce one more poster for drugs and medications provided for the population for free of charge based on government decree. PE team proposes discussion of the issue with COP, and it has been concluded that following international practices and national pharmaceutical regulations it must be carefully considered how this is done. As a fundamental principle, prescription drug-information and prescription-drug advertising must not be targeted to non-medical groups of the population.

This is a general principle promoted by WHO and most national drug laws/medical legislation. There need however be information available about what is free of charge. To present that a “Drug” is free of charge does however not make sense from a medical point of

view. What makes medical sense is to define for what ailment treatment is provided free of charge. This is already done in some areas, such as with the statement that treatment is free of charge for patients diagnosed with tuberculosis. The information does however not state that Isoniazide or Rifampicin is provided free of charge, since this would open for irrational uses of these important drugs! A similar approach needs to be considered, in regard to information about pharmaceuticals.

The PE team met with Dr. Gagik, as Lori branch representative of the previous ASTP project for sharing of experience and methods used during the ASTP project implementation.

BBP Poster:

- Discussions held with Dr. Robert Sukiasyan, Deputy Head of Health Department, Yerevan “Marz” health department, Yerevan Mayor’s office,.
- Discussions with MoH – to finalize the contents of the BBP poster
- Discussions with State Health Agency to finalize the BBP poster
- BBP poster testing design: in collaboration with the M&E team of PHCR, a convenient sampling approach was applied with the selection of two polyclinics (one in Yerevan and one in Vanadzor) based on a questionnaire for testing.
- Testing of the BBP poster was conducted in Yerevan and Vanadzor.
- Test strategy checked how well the population catches the main idea of the poster with a sample size for the study set at 20 participants at Polyclinic #17 in Yerevan and Polyclinic # 4 in Vanadzor. Pre-test of the poster was also done among primary health care physicians.

PE team has made contact with the USAID funded RPM+ project to clarify their possible participation in the design of a BBP pharmaceutical component, and learned that RPM+ are not involved in such initiatives.

Dr. Armen Karapetyan, as Head of Health Economics Department MoH was contacted to receive information on the list of socially vulnerable and special categories of population who are beneficiaries of certain health care services, as base for information at the BBP poster.

The SOW for Chris Wild, Public Education Specialist (April – May) involves finalizing PHCR community mobilization strategy and move to field-based testing stage. The SOW for Robert Zielony, Ph.D., Behavioral Change Communication Specialist is in the process of development.

A review of community-based methods for community-participation and collaborative decision-making in health, such as participatory rural appraisal (PRA) and SARAR/PHAST is in process. This work also includes to identify specialists and institutions with experience from using these community mobilization methods alongside primary healthcare reform projects in other CIS countries, where Family Medicine also has been introduced under USAID- and WB support. Needed input from specialists and institutions is being considered.

4. General awareness of Open Enrollment established.

PE messages and means of communication have been drafted, and avenues of communication have been investigated – to link with PE roll-out. A review of ASTP developed OE messages and PE materials has been conducted.

5. General awareness of Family Medicine in the population increased.

To be undertaken later in Y1.

6. Public is aware of service packages provided in primary care.

The PE team has started preparation of information materials in collaboration with head of primary care department of MoH.

7. Journalists trained in health issues.

To be undertaken later in Y1. The SOW for Chris Wild, Public Education Specialist (April – May) includes initiating media training activities for FM/OE National Media Campaign and Community Participation in support of Health Status Improvement.

8. Community involved in and contribute to renovation and maintenance of Primary healthcare facilities

Baseline survey was planned and spot-visits undertaken.

9. Small grants to NGOs resulting in improved NGO capacity to conduct community education, health promotion, and disease prevention.

To be undertaken later Y1. Manual for Grants management drafted.

SOW for Public Education Specialist (April – May) involves contribution to NGO small grants program form, strategy and design stage, to testing and implementation stage.

Performance Management Plan (PMP)

During the revision of the workplan, it became apparent that it will be necessary to include the following activity under each project area: designing, testing and implementing a monitoring (baseline and impact and project data collection) system, alongside and integrated with the delivery of interventions.

Together with project staff, the COP and DCOP worked intensively with in-country STTA Dr Tom Carson with a Logical Framework Analysis (LFA) as base for the revision of workplan and PMP. An important finding during this work was the need for further technical input of a monitoring advisor at the end of the first year. Consequently it is planned to engage Dr Tom Carson for a month's mission preliminary scheduled for August-September, in analysis of monitoring results in preparation of first annual PMP-based report to USAID.

M&E operative resources are being integrated into each of the project components and work has started to recruit an MIS specialist to design and make operational a project M&E database, for the practical data collection during baseline assessments and following analyses. In relation to the PMP, baseline and post-intervention impact of project, it was identified that data from the DHS (Demographic Health Survey) needs to be utilized and will be proposed as a base for post-PHCR project impact assessment. This is timely, considering that next DHS is planned in five year. PHCR has therefore asked to get access to materials, methods and forms from the DHS survey, to assess methodological applicability. The PMP was prepared with assistance of STTA Dr Tom Carson. This was presented to and commented upon by USAID.