Republic of Armenia
Ministry of Health

OPERATIONAL MANUAL
HEALTH SYSTEM MODERNIZATION PROJECT-2

Jan 10, 2010

INTRODUCTION

The Health Systems Modernization Project is a two phased Adaptable Lending Program (APL) to be implemented over a period of approximately eight years. The rationale behind the Health System Modernization Project is support the reform of the health sector in Armenia in the three main areas: development of primary health care, hospital optimization and strengthening of the government institutional capacities. The first phase (APL1) —the ongoing Health System Modernization Project (Credit Agreement # 3920 and PHRD Grant Agreement # 05436 TF) started in December 2004 and is expected to end in December 2008. The second phase (APL2) of the project-- the Health System Modernization Project 2 (Credit Agreement # 4267 AM) is expected to start in June 2007and end in June 2012.

The project development objectives of the second phase are: (i) scaling up family medicine based primary health care reform by expanding the renovation of PHC facilities and upgrading of the medical equipment in the remaining marzes, (ii) optimizing and upgrading hospital networks in the marzes, (iii) strengthening Government capacity to develop and monitor effective health sector policies in the area of health financing, resource allocation and provider payments; and (iv) expanding investing in human resources to include formal and continuous education in health.

The project is classified under the Environmental Category B (as well as the on-going first phase of the Health System Modernization Project) in accordance with World Bank operational policies. Potential adverse environmental impacts on environment are restricted and are summarized below:

·Dust and noise due to demolition and construction;
·Encroachment into private property;
·Risk of damage to unknown historical and archaeological sites;
·Dumping of demolition and construction wastes and accidental spillage of machine oil, lubricants, etc; and
·Risk for inadequate handling of hazardous wastewater, waste gases and spillages of hazardous material during operation of the hospitals; and
·Risk from inadequate handling of medical waste.

These risks were reviewed during project preparation and an Environmental Management Plan (EMP) was prepared with appropriate measures of their mitigation envisioned in the design, planning and construction process as well as during the operation of the facilities.

The total cost of the project is US$29,623,333.3 of which Credit funds are US$ 22,000,000.0 and the contribution of the Armenian side is about US$7,623,333.3 (Government of Armenia-- US$ 7,171,649.8, Yerevan State Medical University— US$300,000.0 and communities-- US$ 151,683.6).
The project budget includes the following expenditure categories:
·Consultant Services: US$ 2.744,337.3
·Training: US$1.380,000.0
·Goods: US$4,912,099.1
·Works: US$19,333,671.6
·Operating costs: US$1,263,255.2

Background
Family Medicine Development
The Government of Armenia approved the first strategy for PHC development in 1997 and reoriented the PHC system toward the introduction of Family Medicine. Armenia was one of the first countries among the Commonwealth of Independent States (CIS) to establish Chairs of Family Medicine at the State Medical University (SMU), National Institute of Health and Basic Medical College (BMC) in 1997.

Under the World Bank supported first health project eighty-one community micro projects have been implemented which was a considerable input in reforming and modernizing the rural primary health care system of Armenia. Particularly, ambulatories were renovated or newly constructed, provided with ambulance cars, equipped with necessary and up-to-date devices. By 2003, 221 physicians received a qualification of family doctor, and 178 nurses were trained as family nurses. This was about
11 percent of the needs for family doctors and 5 percent of family nursing staff. Armenia has also developed, published, and distributed practice guidelines for family doctors (127 guidelines) and family medicine nurses (56 guidelines). The reimbursement of newly qualified family doctors by health care financing agency is consisted of capitation-based payment and fee for service financing for delivery of certain narrow specialist activities included in their scope of work. The overall information received during evaluation of the first health project (1998-2003) supported by the World Bank certifies that the Project played significant role in health care reforms and developments.
In 2003 the Government approved the follow-up PHC development strategy to scale up and complete the PHC reforms. Its general objective is to secure access to quality basic health services, in particular for the poor and in rural areas, and reiterates the basic principles of the PHC reforms in Armenia. The strategy consists of: (i) integrating separate streams of primary health care functions (children, adults, and women consultancies) within an institution of family doctor; (ii) strengthening the qualifications and skills of the PHC providers through retraining and training family physicians and nurses and developing practice guidelines; (iii) improving infrastructure for essential health services in rural areas; (iv) putting in place appropriate financing mechanisms; (v) increasing community ownership and responsibility of PHC services; (vi) increasing share of public expenditures going for PHC; and (vii) achieving

favorable results in population's health status by focusing on preventive care. The reform of the PHC is well progressing.
In 2004 Health System Modernization Project (HSMP) as the first phase of APL (APL1) was launched. Within second health project the capacity of training institutions have been enhanced: family physicians' and nurses' training centers were established and equipped in Lori, Shirak and Syunik marzes. NIH, SMU, BMC were provided with training furniture, equipment, supplies, IT equipment, and skill labs. Renovation of the Yerevan second clinical training has been started and will be completed in summer 2007. TOT courses were organized for 60 family physicians and 15 nurse trainers. In years 2005-2006 18 practical guidelines for family physicians were developed and published. TOT courses to core staff of FM/FN chairs have been provided by international expert. 412 family physicians and 390 family nurses have already been retrained, and at present 280 physicians are under family medicine retraining and will complete their retraining accordingly in September 2007 and January 2008. At present, 145 family nurses are under the retraining and will complete it in July, 2007. Civil works have been completed in 20 community ambulatories and another 150 community ambulatories and health centers were provided with standard sets of medical equipment, medical furniture, supplies and IT equipment. In April 2006 the Government adopted the decree on population open enrollment (OE). Starting from the second half of the year 2007 it is projected to start countrywide population free enrollment and introduce

independent family medicine group practices. At the same time according to the recently approved regional health systems optimization programs almost all rural ambulatories, which at present are merged with polyclinics will be separated in 2007 and have autonomous legal status and independent contracts with SHA. It is anticipated to introduce performance based reimbursement for primary care providers. PHC share of public expenditures on health care increased from 11.3 to 41 percent between 1997 and 2006. The advanced second phase of the project
-Health System Modernization Project 2 (APL2)
will allow training of additional 600 family doctors and 720 nurses, improvement of infrastructure of 50 PHC centers thus resulting in major gains in terms of time required to complete the transformation of the PHC network to Family Medicine based primary health care system.

Hospital Network Optimization
The Government of Armenia has been shown to be effective in the implementation of the optimization program as well. Following the adoption of the National Concept of Health System Optimization, the first round of marz health care delivery systems optimization plans were implemented in 2001. On

December 5, 2002, the Government adopted another resolution approving a hospital masterplan for the city of Yerevan with a long term aim to achieve a sustainable capacity of six-eight hospitals through mergers of the current 44 hospitals. Hospital optimization in Yerevan is politically difficult process; nevertheless, the

gains from consolidation would also be highest in the capital city where the bulk of excess capacity lies. And, on November 21, 2003, the Government adopted a decree that
consolidated twenty-four public hospitals and thirteen outpatient health care institutions into ten1networks in Yerevan. This was a significant step towards the optimization and modernization of health services network by the Government. The three of the ten hospital networks in Yerevan, namely the State Medical University Hospitals, Surb Grigor Lusavorich and Saint Marie Medical Centers were included in the on-going Health System Modernization Project (APL1) subcomponents B1-B3. Within the project the three hospital mergers receive support for civil works related to consolidation of services, are provided with essential medical equipment to improve quality and safety of care and IT equipment to improve management systems. They also receive technical assistance within the subcomponent B6 of the project to modernize management structures and improve management capacity, develop strategic development plans, and introduce quality assurance systems. The activities supporting improvement of handling medical waste are part of the environmental management plan linked to the project. The project hospitals received technical assistance to develop their individual waste management plans based on national guidelines developed under component C of the project, and trained a network of staff representatives. Essential waste management supplies and equipment will also be provided within the project funds.
By January 2007 the project hospital mergers have resulted in improvement of indicators of utilization of hospital in-patient and outpatient services, efficiency and productivity against the project targets. It is expected that after the completion of consolidation of services, introduction of improved management systems and provision with new biomedical equipment the indicators will be reaching the target levels.
In 2005, following the described positive experience of optimization in Yerevan, and in the scope of the subcomponent B5 of the on-going first phase of HSMP, regional (marz) optimization initiatives were undertaken through development of general masterplans of 1. The merger of the “Nork” infectious diseases hospital, the Republican Center of AIDS Prevention and the Scientific Center of Dermatology and STDs was afterwards unbundled due to several technical, medical and political complications.

marz health care delivery systems. On November 2, 2006 the Government approved the master-plans of optimization. This has been a politically sensitive and technically challenging process, requiring therefore a follow-up with major investment in the marz hospital networks.
It has to be noted that even before the approval of the plans intensive discussions were generated around the preferred schedule of investments to follow the implementation of the marz master plans. It was suggested that the program has to be carried out rather intensively, within a period of two years and covering concurrently principal hospital networks of all marzes of the republic. It is anticipated that by strengthening the principal hospital networks and turning them into a high quality health care providers patient flows would be reoriented to those hospitals, prevent referrals to the capital city Yerevan and result in increased accessibility of services. Although the marz investment program will be carried out simultaneously in all marzes, the hospital networks of the two marzes, will be covered under the on-going project (APL1) funds. The

second phase (APL2) of Health System Modernization Project will support optimization and upgrading of the hospital infrastructure in the rest of the marzes of the republic.
On December 2008 the Government approved the revision of the Shirak marz hospital system optimization plan envisioning a merger of three existing hospitals in Gyumri city of Shirak marz—Samariter hospital of therapeutic profile, Gyulbenkyan Surgical Hospital and multi-profile Shirak marz hospital into one 200-bed new Gyumri Medical Center to be newly constructed in the premises of Austrian Children's' hospital of Gyumri with subsequent closure of the above three existing hospitals.

Institutional Strengthening
The Government approved a decree in September 2004 that sets out the implementation plan to improve financial management and accountability in public hospitals. The decree calls for introduction of uniform set of accounts and a set of standard forms, training of accountants in hospitals, introduction of hospital governance board in a pilot public hospital, requirement of independent financial audits and introducing new reporting mechanisms to Ministry of Finance and Economy. A time-bound action plan of improved supervisory and oversight arrangements of hospitals was developed by MOH and approved by Governmental decree in Sept 2004 to improve governance arrangements that is based on three pillars: introduction of Hospital Supervisory Committees; improved SHA contracting; reporting arrangements for public and private hospitals; and, strengthened regulatory functions of the MOH for public and private hospitals. SHA has developed case-based reimbursement instruments for hospital care (within a capped budget) and capitation-based financing of PHC and capacity to develop and monitor contracts.
On May 19 2005 the Government approved the decree # 1187 on establishment of supervisory committees and regulation of their activities in joint stock companies with public shares of 50% and more. The decree stipulates the establishment of supervisory committees (supervisors) and sets forth rules of their functioning, incl. selection of committee members, their functions, obligations and rights, the order of committee sessions and check-ups, writing of a check-up certificate and conclusion of supervisory committee. Independent audit of public hospitals is performed by public hospitals upon written instruction of the founder and submitted to the latter. For the first time in the RA the 2004 National Health Accounts (NHA) report was developed with comprehensive, consistent and internationally comparable analysis on how health resources are spent on what types of services, and who pays which will improve transparency of health sector financing and offer a better base for policy decisions. The National Health Sector Performance Assessment (NHSPA) report is in the preparation stage. In future it is planned to institutionalize the process of NHA and NHSPA reports

development on regular basis in order to provide evidence-based information to the government for health policy formulation, analysis, and management. The MOH and SHA continue to develop with more focus and attention to the issues of appropriateness and quality of care, improvement of the health legislation, updating of information base, fine-tuning of the state order programs and introduction of performance-

based reimbursement systems both for PHC and hospital levels. APL2 would support the further strengthening of institutional base for effective system governance, including formulation of national health care policy, health care human resources strategy and planning framework.

The second phase of the project will also provide resources for further control and prevention of non-communicable diseases aimed at reduction of public health risks and improvement of health status indicators.

Improvement of the Undergraduate and Continuous Medical Education

The system of higher education of the Republic of Armenia gradually integrates in European higher educational zone and Bologna procedure, which assumes the following: (i) create a system of understandable and comparative stages of qualification, including the unification of diploma (ii) passes on to the double-stage system of higher education (iii) establish the universal European system of credit accumulation and transfers, (iv) assure the mobility of students, lecturers, researchers and educational administration in European zone, (v) promote the application of European standards in sphere of higher education. The APL 2 funds will support the revision of professional education standards, the skills and competencies assessment system and improve the technical supply of teaching capacities of medical educational facilities.

This operational manual describes the overall implementation arrangements and institutional schemes of the second phase of Health System Modernization Project-2 (APL2) as well as implementation arrangements of activities by each project component as listed and described in the Project Implementation Plan.

IMPLEMENTATION ARRANGEMENTS

The overall responsibility for project implementation rests with the Ministry of Health. The Ministry has designated the First Deputy Minister as focal point for overall project implementation. The Ministry will be supported by its Health Project Implementation Unit (HPIU), which oversees the implementation of the ongoing APL1 and will continue to do so for APL 2. The HPIU will be responsible for the fiduciary aspects of the project and provide administration and coordination support to MOH departments and agencies that are responsible for project activities. The Project Steering Committee oversees the project implementation with overall fiduciary oversight responsibility. Component-specific Coordination Committees will be established to guide and monitor implementation of individual project components or subcomponents (see below under description of implementation arrangements for each component).

Project Steering Committee

The Project Steering committee was established to guide and supervise the implementation of the project. The committee is chaired by the Minister of Health. The Minister of Health appoints the committee. Its members are:

·Minister of Health (chairman)
·First Deputy Minister of Health

·First Deputy Minister of Finance and Economy
·First Deputy Minister of Justice

·Deputy Minister of Territorial Affairs
·Deputy Minister of Health responsible for economic and financial Issues
·Head of Credit and Humanitarian Assistance Programs Department of the Staff of Government
·Head of Health Economics and Accounting Department of the Staff of the Ministry of Health
·Head of the Medical Care Provision Department of the Ministry of Health
·Head of the State Hygienic and Anti-Epidemic Inspectorate of the Ministry of Health
·Director of the HPIU

The TOR for the Steering Committee are the following: (i) review and approve the reallocations of the projects' budgets when necessary and submitting these amendments to the Government for approval with the prior agreement of the WB; (ii) supervise the operation of the HPIU; (iii) supervise the expenditures made under PPF or grants during the preparation period of the projects, and credits during implementation; (iv) review and approve the project annual time schedules and the budgets after approval of Credit/Grant Agreements; (v) review and approve progress and financial reports of the projects components; (vi) review and approve the final results of tenders for procurement of works, services and goods costing more than of USD 50,000; (vii) approve the amendments to the contracts, when the amount in the cost of the contact is changed by more then USD 50,000; (viii) present suggestions to the Government on the use of any savings during the implementation of the projects funds, as well as their reallocation with the prior agreement of the Bank; (ix) adopt decisions on actions eliminating the breaches and deficiencies revealed during implementation of the projects and supervise the implementation of those decisions; (x) convene an out of term meeting during Bank missions and discuss the progress made on the project implementation with the Bank team and present a report to the Government on the outcomes of the Bank missions.

Regular meetings of the Steering Committee shall be held every month; extraordinary meetings can be called by request of the chairman, director of HPIU or of the 1/3 of members of the Committee. Any decision of the Steering Committee will be considered valid by a simple majority of vote of the members present. In case of equal division of voices, ties will be solved by the quantifying vote of the Chairman.

The Health Project Implementation Unit has a core group of professional staff for the entire duration of the project including Project Director, Procurement Officer, Financial Manager, Accountant, Community Mobilization Specialist, PHC Component Coordinator, Hospital Optimization Component Coordinator and Institutional Strengthening Component Coordinator, as well as three additional professionals—Civil Engineer/Environmental Specialist, Legal Specialist, and Monitoring and Evaluation Specialist.

The Director of the HPIU is responsible for the general management and coordination of the project activities, including overseeing the implementation of the project components. The HPIU component coordinators work closely with the relevant Ministerial Departments as well as other stakeholders of the project (Yerevan Municipality, Marz Government Health Departments, National Institute of Health and Yerevan State Medical University, hospital and

other health facility administrations, etc.) and coordinate implementation of all component related activities. They prepare yearly and quarterly implementation plans, assure regular implementation monitoring, preparation of progress reports, as well as development of TOR of consultants within each project component. Implementation plans and progress reports are reviewed by the component specific Coordination Committees and approved by Steering Committee and the Ministry of Health. The project component coordinators are assisted by the rest of the professional staff members of the HPIU and consultants of the project (assistants to the coordinator, biomedical engineer, etc).
The legal specialist provides legal advisory services to HPIU, and also assists the MOH with the development of the necessary legislative and regulatory framework pertaining to hospitals, independent family medicine practices, etc. The M&E specialist helps to set up the overall M&E system for the project and prepares the framework for various impact evaluation studies, which will be carried out at specific times during project implementation. The Civil Works Engineer/ Environmental specialist appraises the physical condition of existing buildings of project hospitals, PHC and training centers, assures technical inputs to procurement of A&E and construction services by preparation of the technical documentation for conducting tenders, assures adequacy of planning, designs, bills of quantities, conducts periodic site visits to review progress and prepares supervision reports on behalf of the MOH. He is also responsible for implementation of the environmental management plans for the FMD and hospital components. He coordinates environmental training for staff, designers and local contractors; as well as and implementation of mitigation measures and environmental reviews within the project activities. The functions of Financial Manager, Procurement Specialist and Accountant are detailed in Financial Management Manual.
FAMILY MEDICINE DEVELOPMENT (FMD) COMPONENT
Component Institutional Set up Implementation of FMD component will be carried through the coordinated activities of three institutions:
The FMD component Coordination Committee,
The FMD component in the PIU,
The Management Boards at the PHC facilities.
The FMD Component Coordination Committee
Tasks
The FMD component Coordination Committee guides and supervises the implementation of
the FMD component activities in accordance with the FMD operational manual (OM).
Members
The Minister of Health appoints the FMD component Coordination Committee. Its members
are:
·First Deputy Minister of Health responsible for PHC (Chairman)
·Legal adviser of MOH
·Director of the State Health Agency (SHA),
·Head of Health Care Provision Department of MOH

·Head of Education and Science Department of MOH
·Head of PHC unit of Health Care Provision Department of MOH
·Head of Family Medicine Chair at NIH
·Head of Family Medicine Chair at SMU
·Head of Family Nursing Chair at BMC
·Director of HPIU
·Coordinator of the FMD component.

Meetings

Regular meetings of the Coordination Committee shall be held at least once every three months; extraordinary meetings can be called by request of any member of the Coordination Committee. There is quorum when at least 51% of the members are present. Any decision of the Committee is considered valid by a simple majority of votes of the members present. In case of equal division of voices, ties are solved by the qualifying vote of the Chairman. Terms of Reference for the FMD Coordination Committee

The following are the terms of reference (TOR) for the FMD component Coordination
Committee:

·approve family medicine implementation policies;
·ensure the harmonization between FMD sub-components' activities;
·approve annual plans for the FMD component and any modification thereof;
·make decisions on major problems emerging in the process of the project's implementation;
·guide and supervise the implementation of the FMD in accordance with the OM;
·approve annual report on the FMD component implementation to be submitted to the Minister of Health;
·ensure the coordination of the FMD activities with the projects implemented by other
donors involved in the field of PHC.

FMD Component

The FMD component is implemented by FMD Coordinator in cooperation with Community Mobilization Specialist, Procurement Specialist Civil Engineer/ environmental Specialist, Legal Specialist and Monitoring-Evaluation Specialist. Local technical assistance will as well beused for day-to-day supervision of civil works, facilitation of community mobilization, supervision of training process. The component coordinator reports directly to the director of
HPIU.

The FMD component has the following responsibilities:

·coordination support to the relevant MOH departments responsible for implementation of the activities and policies stipulated by component;
·development of the final version of the operational manual (OM) and subsequent amendments when necessary;

·development of the evaluation criteria for micro-project approval, and subsequent
amendments during implementation, if deemed necessary;
·dissemination of information and program promotion at the community and marz levels;

·supporting the creation and effective operation of PHC facility Management Boards;
·preliminary screening of micro-projects (pre-appraisal);
·provision of technical assistance to Health Facility Management Boards for the production of a Family Medicine Development Plan (FMD plan) and other required documents;
·signing of Contracts on Cooperation between HPIU and Heads of Communities for micro-project implementation;
·maintaining a filing system for proper record keeping of project related documents (contracts on cooperation signed between the HPIU and the Facility Management Board,
acceptance certificates of civil works completions, etc);
·monitoring of program implementation and ensuring the compliance with established norms and standards;
·health facility FM team performance monitoring and evaluation;
·liaise and work in close collaboration with regional health departments, local governments, and international agencies collaborating under the Project;
·coordination of family physicians and nurses training / re-training program;
·continues monitoring and evaluation of training / re- training process;
·make recommendations to the FMD component Coordination Committee on the approval or rejection of appraised micro-projects.
The Facility Management Board
The Facility Management Board is the main instrument of community participation and facility governance at the community level. It has been designed as a simple tool of social
control aimed at generating local participation in financing and management of the rehabilitated facility. As such, it is considered an important element for project sustainability
once the project is finished.
The Management Board consists of six members, some appointed and some elected. The appointed members include:
·Head of community (chairman)
·Head of the Marz health department, or his/her representative
·Head of the PHC facility

Elected members are:
·Three representatives of communities elected during the General Community Meeting and representing the users of facility services.

In the case of projects presented by a PHC network of facilities in rural areas (one ambulatory and one or more health posts), the network will have a single Management Board. The Page 11
11members representing the health professionals and the community members may be selected from any of the participating villages.
The roles and responsibilities of the Facility Management Board are the following:
·Collaboration with FMD component and HPIU for the overall period of micro-project
implementation;
·signing of contracts between HPIU Director and Heads of Communities;
·health needs assessment at the community level;

·submission of Proposal and other required necessary documents to be attached to the
Proposal;
·submission of the Letter of Intent;
·development of the family medicine development plan with the assistance of the FMD component Community Mobilization Specialist;
·participation in overseeing the implementation of the project at the local level;
·mobilization of the resources required for the community contribution.
·submission of all technical conditions for starting facility design process (if micro-project
is adopted)
Heads of communities and heads of facilities participate in signing of acceptance certificates
Of civil works completions. Supervision of the civil works implementation. is the responsibility of

HPIU.

2. Retraining of Family Physicians and Family Nurses Overall coordination of the family medicine training program will be assured by MOH Unit Of Education and Staff Management in collaboration with the HPIU FMD Component Coordinator. Marz health officials will select trainees to participate in each round of family medicine retraining from presently working district therapists, district pediatricians, narrow specialists (cardiologist, neurologist, endocrinologist, etc) and nurses employed by urban polyclinics, rural ambulatories, health centers and health posts of ambulatories included in the project. Lists of participants will be provided to the FMD component of HPIU for checking and submission to the MOH for approval by Ministerial Decree. The training of family medicine physicians and nurses is carried out at the National Institute of Health, State Medical University and Basic Medical College.
Actual organization and implementation of the training courses will be the task of the Family Medicine Chairs at Yerevan State Medical University, the National Institute of Health and Basic Medical College. According to order # 613 of 2003 of the Minister of Health of RA, family medicine specialization of district physicians has to be implemented based on the unified educational curriculum of Family medicine. The Family Medicine training consists of 12 months courses including 8 months of academic/clinical education in Yerevan and a total of 4 months practice in medical facilities without practice interruption of trainees (every two months of academic training are followed by one month of practical training). Training process is organized on the ground of modules grouped in four major blocks and intermitted by practical trainings in trainees' own working places and marz practical training sites. 6 months retraining of nurses is organized based on modules grouped in five major blocks.

Physicians, who are in the process of retraining return to their working sites for a month and, as envisaged in the training plan, visit pre-selected family physician trainers to strengthen their skills. During this one month period core staff from Family Medicine chairs regularly

visits the above-mentioned training sites and makes on-site training process observations. The responsibilities of the training institutions in relation to the quality of re-training programs are:
·Ensuring high quality practical and clinical training;
·Ensuring proper organization of the trainings in the regions;
·pre- and post- evaluation of trainee's competencies jointly with the HPIU staff as well as on-the-job (practical training part) performance assessment. The appropriate tools for training courses evaluation, such as knowledge tests, practical skills observations and satisfaction survey questionnaires have been developed by the FM Chairs;
·Conduction of appropriate final written and oral examinations including patient-based case management.
·Development of a system of continues education on Family Medicine for already practicing Family physicians and nurses.
In Yerevan clinical training will be conducted in second Yerevan clinical training centre and polyclinic #17, rehabilitated as practical-clinical centre. In Shirak, Lori and Syunik marzes clinical trainings are conducted at the newly created training sites. In the rest 7 marzes the ambulatories renovated and equipped within the first WB supported Health Project are used as clinical training sites.
Clinical training sites should fulfil the following requirements:
·Good practice and training premises
·Adequate medical equipment readily available for the trainee
·Retrained family physicians and nurses staff passed through "FM TOT " training courses
·A volume of practice workload which ensures a balance for the trainee between gaining of clinical experience and other opportunities for learning
·Well organized practice records, record-keeping and reporting
·Effective practice management
·Teaching materials: books, guidelines, internet access- as an advantage.
Relations between training institutions and practical training sites will be regulated on contractual basis.
Additional 15 physician and nurse trainers for Yerevan will be trained through 'Training of trainers' courses.
3. Promotion of PHC activities The government supports a public information campaign at the national level aimed at disseminating general information about the Armenian health care reforms. This campaign will have primary health care reforms at its core and FMD as one of its main components. At community level meetings with health providers and other interested parties will be held by
FMD component to increase awareness and capacity of communities on implementation of PHC reforms. PHC Strategy and evaluation reports of Health Projects are provided to representatives of PHC facilities and communities (see details in 4.1.1)

13 4. Community Micro
-Project Cycle The project is expected to rehabilitate facilities approximately for fifty (50)FM teams during the project's lifespan. During 2008 and 2009 six and seven community ambulatories will be newly constructed accordingly and 20 community ambulatories will be renovated. In addition, in 2010 10 community ambulatories will be renovated and 7 community ambulatories will be newly constructed.

4.1 Identification
According to HPIU appraisal, which was carried out during visits to 150 ambulatories and health centers in addition to the 75 community ambulatories rehabilitated within the WB supported first health project and 21 community ambulatories included in the WB supported second project (APL1), also approximately 80 rural ambulatories and health centers need improvement of physical infrastructure (building conditions). The lists of above mentioned community health facilities were preliminarily discussed and agreed with marz health officials. The main criteria for having been involved in the preliminary lists was the worst or bad building conditions of facilities(destroyed roof, floor, water, sewage and heating systems, etc) accompanied by the fact of involvement in FM retraining courses and medical equipment provision. During February – May 2007 revisits were done by HPIU FMD coordinator, community mobilization specialist, civil engineer/environmental specialist together with marz health authorities from 9 marzes to 76 community health facilities for identification of urgent needs for improvement of physical infrastructure. After each visit detailed reports were prepared on facilities' physical conditions. Meetings will be organized with officials of marzes to finalize the list of pre-selected micro projects. Every micro project will pass standardized implementation cycle as described below.

4.1.1. Community Participation - General Community Meeting
The FMD component promotion aims to provide detailed information at pre-selected community's level through participation in community meetings under the leadership of the authorities of Marz Health Department and head of community.

During each General Community Meeting the FMD unit will have the following tasks:
·brief presentation of the PHC reforms' strategy for years 2003-2008;
·brief presentation of the results of WB supported first and second Health Projects;
·presentation of the FMD component goals, strategies, and expected outcomes;
·presentation of the approach proposed for community participation;
·support for selection of non-appointed community members of Management Board;
·support for submission of Standard Proposal Form and Letter of Intent.
Once the project is at the implementation stage, the Community mobilization specialist will make periodic visits to the same regions and villages for assessment, using different tools such as interviews with the population and health providers. The information received from these activities will provide the FMD unit with an overview of the conditions, priorities, and
needs of local communities; this will be used to confirm the consistency of the real situation with the content of the proposal.

4.2.1. Pre-Appraisal - Eligibility Criteria
Proposals and Letters of Intent that are submitted to the FMD Unit will pass the process of pre-appraisal, conducted by the Community Mobilization

Specialist. All proposals will be presented using the Standard Proposal Form. Submitted proposals will be recorded in special files, including the following information: ·

name
·region and location of PHC facility
·contact person
·date of receipt
·amount of funding requested
·typology of the proposed activities
The PHC facilities eligible for financing include rural ambulatories and health centers supplied with PHC physicians. In most rural areas, an ambulatory has a supervisory and reference role in relation to health posts in nearby villages. The ambulatory is staffed by doctors and nurses, while the health posts - only by nurses. In any case, only one micro-project will be considered for one team - either working in one facility or in the network. The required organizational and managerial conditions include:
1.The facility has a status of independent legal entity (ambulatory or health center not included in polyclinic network)
2.The facility has opened and is operating a bank account
3.The Facility Management Board has been appointed and selected
4.Letter of Intent has been signed by Management Board Chairman
5.The staff has demonstrated commitment to be re-trained as family medicine providers
6.The Facility Management Board has agreed to the future use of the facility for training purposes
7.The community has demonstrated commitment to make contribution for micro project implementation.
Along with eligibility criteria proposals will include the information on PHC facility as well as on social-economic infrastructure of community. The Proposal is submitted to the HPIU for appraisal. Appraisal implies both review of documents and site visits. The main criteria used for prioritizing of proposals are the facility's building condition, current inventory of equipment and supplies, the distance of PHC facility from the nearest regional center (central polyclinic or hospital), population size of community, involved other donor projects and commitment of staff to be re-trained. The facilities with poor buildings condition, located far from regional center and having large served population size will be at the top of the prioritization list. If the proposal meets the preliminary criteria but still requires further information, a Letter of Request for further information is sent to the facility Management Board. If the proposal is complete and meets the preliminary criteria it is thoroughly analyzed based on criteria of evaluation. Those Proposals that are considered possible for approval and are at

the top of priority list are presented to FMD component Coordination Committee for assessment and approval. In case if the proposal does not meet the preliminary criteria, for example PHC facility is included in polyclinic network, has been rehabilitated by other donor organization, community contribution has not been assured, etc. a Letter of Rejection will be issued explaining the reasons for rejection.

4.3. Family Medicine Development Plan and Family Medicine Development Strategy After approval of micro project the FMD community mobilization specialist will provide technical assistance to Management Board and PHC staff for development of a FM Development Plan aimed at improvement of provided services and health indicators of the served population. The FM Development Plan will provide an organizational vision of the future success of micro-project implementation. It has been designed as a simple 2-3 years strategic plan in which the Management Board will propose alternatives for organizational change based on the current situation of the facility and further development. Within the general plan project-specific action plans can be developed and produce measurable results. The FM Development Plan will become an integral component for PHC performance evaluation by HPIU Monitoring and Evaluation Officer.
The FM Development Plan will include two major components: a strategy for Family Medicine development and an action plan
.4.3.1 Facility Family Medicine Development Strategy
The components of the strategy are the following:
Vision
:
Amental picture of what the facility should look like and how it will interact with its stakeholders Mission Statement:
A formal statement describing the facility's future direction, consistent with the values, goals, and objectives of stakeholders as a group.
Family Medicine Development Strategy: Given the baseline data collected during pre-appraisal and with the support provided by the Community Mobilization Specialist, the Boards will describe the proposed Family Medicine Development strategy for their facility.
The components of the strategy are the following:
1.What will be the future scope of FM activities and services (inside the facility and outreach) to be provided at the facility level according to the local situation and the external and internal forces analyzed;
2.How will quality of care be assured?
3.How will the enrollment of population groups of different ages be ensured?
4.How will the issues of sustainability assured?
5.How will equal access to health services for vulnerable population be assured?
6.How will patients be attracted by the facility?
7.How will the maintenance of the facility be organized and ensured?
8.What external factors (risks) may affect implementation of proposed strategy?

4.3.2 The Action Plan Once the strategy has been elaborated, an action or implementation plan must be designed, which main components are the following:
·Identification of the required/proposed investments for strengthening primary health care activities and services at the facility level;
·Establishment of the required actions for achieving the desired strategy. These actions can be performed by the MB, by the PHC team, by other staff in the facility, or by other social actors (community members, consumers, etc.). These actions are directed towards the solution of the main health problems of the community;

·Establishment of micro-project results, that can be of financial, organizational and health nature. They are realistic, short-term outputs that can be ascribed to the activities performed as part of the facility's strategy;
·Definition of risks;
-Establishment of present and future requirements for sustained success

in terms of staff, equipment, office equipment, building, and recurrent expenditures.

4.3.3 FM development plan performance indicators The goal of the FM development plans, submitted by the physicians of target facilities is to protect, promote and enhance the health of the community population through provision of high quality care. Performance indicators will measure the extent to which the planned activities took place as well as the objectives stated in the FM development plans are being met. The level of objectives achievement will indicate the micro project success in each facility. Some of the performance indicators mentioned in the FM development plan will be important outcome indicators of the project implementation. The main performance indicators will measure the improvement of the quality, utilization, access to health services at the PHC facility level, patients' satisfaction with the provided services and etc.

4.4. Financing of Micro Projects
Renovation or new construction of rural ambulatories will be carried out under the project. Estimated costs for construction and renovation calculated according to the tariffs of Ministry of Urban Development official bulletin of 2007.
·Renovated ambulatory 44,000.0 USD
·New constructed ambulatory 85,700.0 USD.
The above-mentioned estimated costs are subject to adjustment depending on the fluctuation of prices at the time of project implementation.

4.4.1 Community Contribution
The contribution coming from the local community will be 5 % of micro-project civil works cost. The World Bank will cover 90% and rest 5 % Government of RA. Community contribution will be stated in the Cooperation Contract. The community contributions should

17beonly monetary. If prices of civil works change during implementation of the project, the actual contribution size will be adjusted accordingly. The implementation of micro-project will not begin until the contribution of the community is made. For community contributions special bank account will be opened by HPIU.

4.5. Micro Project Approval
The community proposals appraised and considered eligible for funding are submitted to the FMD Coordination Committee for approval. Proposals should be delivered to the members of the Committee at least two days prior to the meeting. Before each meeting the FMD Coordination Committee members receive the following documents:

·a summary sheet with basic information regarding the proposal (location of PHC facility, name, type, performance indicators, cost for the entire proposal, etc.)
·the appraisal report with the recommendation for approval or rejection
In case if the proposal is rejected by the Coordination Committee, then a Letter of Rejection will be sent to the PHC facility Management Board, stating the reasons for rejection.
In case if the proposal is accepted without reservations or conditions then a Letter of Approval will be sent to the PHC facility informing about the approval.

4.6 Micro Project Implementation

4.6.1 Cooperation Contract

The micro-project implementation begins with the signing of the Contract on Cooperation. The Contract will be signed between HPIU and the Head of Community who is at the same the Chairman of the Facility's Management Board and define each actor's responsibilities.
·The HPIU responsibilities include the micro project implementation, and technical assistance.
·The Community's responsibilities include the provision of required contribution, and fulfillment of other requirements necessary for project completion (see the chapter above on Facility Management Board).

4.6.2 Civil Works All Civil Works' related activities (selection of contractor and civil works implementation) will be done in accordance with World Bank requirements and rules and legislation in force of Armenia. Architectural design company consulting services are procured by HPIU for the development of design, bill of quantities and supervision of the planned civil works. HPIU Civil Works Engineer/Environmental Specialist develops terms of assignment (technical requirements) for the procurement of architectural design services based on facility technical conditions documents submitted by community. In case of renovation of existing facility, before initiating the design activities seismic stability expertise should be accomplished by a consulting company hired by HPIU. The contract of Civil Works is signed between HPIU and the selected licensed civil works organization (contractor). HPIU is responsible for:
·provision of contractor with civil works architectural design, specifications and bill of quantities developed by architectural design company;
·supervision of the civil works process by periodically visiting constriction sites;

·payment of contractor upon acceptance of performance acts on properly completed works;
·accept the works executed in accordance to contract conditions.
The Contractor is responsible for:
·execution of works in the construction sites in accordance with the contract conditions and Urban legislation of Armenia;
·liquidation of defects in case of necessity.
Supervision of Civil Works on behalf of HPIU is carried out by its Civil Works Engineer/
Environmental specialist assisted by civil works' hired supervisors taking into account the big volume of civil works planned under the project. He is also responsible for coordination and supervision of the environmental

work undertaken in the project according to Environmental Guidelines developed during the ongoing APL1 project.

5. Medical Equipment

Equipment for the 150 PHC facilities including medical equipment, furniture, supplies and consumables have been procured and distributed during the first phase of the Health System Modernization Project (APL1). Bio-medical engineer hired by HPIU will make periodic visits and assessment of the working condition, usage and maintenance of the mentioned equipment.

6. Micro project finalization

The last stage of micro-project is the signing of Acceptance Certificate on Civil Works Completion by HPIU (Civil Works Engineer/ Environmental specialist, hired civil works' supervisor, FMD component coordinator), head of community, head of health facility, director of civil works' company and head of regional department of the State Urban Development Inspectorate; and approval by the Director of HPIU.

HOSPITAL NETWORK OPTIMIZATION (HNO)

Component Institutional Setup

Implementation of the Hospital Network Optimization (HNO) component will be supervised through the coordinated activities of the following institutions:

·Coordination Committee on Hospital Network Optimization
·HNO Component at HPIU
·Hospital Services Unit of the Health Care Provision Department of the Ministry of Health
·Regional (marz) governments and their health departments
·Management teams of the project hospital networks.

Coordination Committee on Hospital Network Optimization

The Coordination Committee on Hospital Network Optimization will be established to guide and supervise the implementation of the project. The committee is chaired by the First Deputy Minister of Health. The Minister of Health appoints the committee. Its members are suggested to be:

·First Deputy Minister of Health (chairman)

·Legal adviser of MOH
·Head of Health Care Provision Department of the Ministry of Health
·Head of Economy and Finance Department of the Ministry of Health
·Representative of the Ministry of Finance and Economy
·Representative of the Ministry of Territorial Affairs
·Representative of the Ministry of Justice
·Head of the Health Department of Yerevan Municipality
·Representative of State Health Agency
·Representative of the State Hygienic and Anti-Epidemic Inspectorate of the Ministry of Health
·Ten marz health department representatives (one representative from each of the ten marzes)
*
·HNO component coordinator

·Director of the HPIU
The TOR for the committee are the following: (i) review and approve the implementation of the marz optimization plans against the implementation time-schedule; (ii) oversight the implementation of hospital optimization process both in Yerevan and marzes; (iii) present suggestions to the Government on any changes, which may occur along with the implementation upon prior agreement with the World Bank; (iv) adopt decisions on actions facilitating the implementation of the hospital optimization and supervise implementation of those decisions; (v) present suggestions to the Government on respective changes/amendments to the existing legal framework regulating the hospital governance and management aspects. Regular meetings of the Committee shall be at least every three months; extraordinary meetings can be called by request any member of the committee. Any decision of the Committee will be considered valid by a simple majority of votes of the members present. In case of equal division of voices, ties will be solved by the quantifying vote of the Chairman.

HNO component at HPIU The HNO component activities are implemented by HNO component coordinator in cooperation with other staff members of the HPIU such as procurement officer, legal specialist, the civil engineer/environmental specialist, M&E specialist. The coordinator is as well assisted by consultants of the project (assistant to the HNO coordinator, biomedical engineer, etc). He/She reports directly to the Director of HPIU.

1. Selection of beneficiary hospital networks in the marzes

The selection of the beneficiary hospital networks will be proceeding upon mapping of regional health care facilities. The mapping exercise shall be undertaken at the expense of the on-going first phase of the project (APL 1) with the objective to provide enough data to make evidence-based decision on where and what to invest on to complement the optimization
*Each marz health department representative will be invited for and attend only those meetings of the steering committee that are relevant to his/her marz having been preliminarily notified on the meeting day and time in written form.

plans by preparing interactive map layers of all regions with all health facilities per type and location, their catchments areas and showing patient flows, service use and resources for each specialty.
The mapping exercise will be consisted of two parts.
1.A local consulting organization shall be procured by HPIU to assess existing capacities, utilization of services and patient flows in marz hospital institutions. The scope of activities of those consultants includes:
·Carry out a health care provider based survey of all regional hospitals
·Perform data entry
·Analyze the health care provider survey data as well as the official statistic sources and other relevant survey results and produce the required indicators of hospital service utilization and resources to be used for the mapping of regional health care
services.

·Analyze patient flows to regional hospitals, defining them by regions and facilities within and outside of their catchment areas.
·Perform assessment of needs of human resources, equipment and other technical capacity of regional hospitals
*.
2.
The second part of the mapping assignment will be the preparation of actual maps of regional health facilities based on the above described assessment. An individual local consultant shall be procured by HPIU to perform the listed below activities:
·Acquisition of the ArcGIS basic package and ArcGIS Network Analyst Extension Software in the name of MOH Republican Health Information & Analytical Center;
·Develop road shape file. The file contains digital road network covering the inter-community roads of Armenia;
·Develop elevations' contour shape file. The file contains the contour lines (100-m interval or less) for total area of Armenia.
·Develop hill shade GRID file. The file contains the raster elevation data.
·Develop shape file of boundaries of all communities of Armenia.
·Develop map document mxd file with all the layers above.
·In cooperation with the consultants working on marz hospital services and patient flows assessment, create an electronic database management system incorporating the data collected and the indicators constructed upon the health care provider survey as well as the results of the Health Sector Performance Assessment survey pertinent to hospital services utilization performed under component C of the on-going first phase of HSMP and PHC survey performed by "Avag Solutions" in 2006.

Upon completion of the described mapping assignment principal hospital networks from the marzes (presumably one for each marz) will be selected for the project implementation. The following selection criteria developed by the Ministry of Health and similar to those applied in Yerevan will be taken into consideration as well: (i) political will expressed by commitment of the regional/marz governments and hospital managers to follow on optimization through mergers, implement internal optimization programs and improve
*In the scope of the current first phase of Health System Modernization Project (APL1) technical assistance for
the detailed assessment of principal regional hospitals (40 hospitals buildings), their seismic stability and the
proposed refurbishment measures and cost estimates has already been completed.

management and governance arrangements, (ii) integration of specialist services with of hospitals and polyclinics and development of hospital out-patient services; (iii) granting opportunity to gaining independent status to rural ambulatories, in particular to those transformed into family medicine practices; (iv) application of the free enrollment principle in PHC with creation of family medicine independent group practices further on; (v) human resources planning and management through application of re-training and re-location programs aimed at recruiting of

the required personnel, (vi) significant potential for rationalization of facilities through elimination of overlap through consolidation of same services or underused services of similar character (e.g. different surgical or medical departments); and consolidation of laboratory and other diagnostic services;

·

reduction of fixed costs through divesting unused or underused facilities (reduction of square meters); and enhancement of the remaining facilities into a high utilization and efficient health care provider with occupancy rates of at least 75 percent, lengths of stay and other indicators that are consistent with modern acute care.

·Improvement of governance arrangements including expansion of ownership representation through supervisory committees, independent audits and printing and public dissemination of the audit reports, improved management structures with clearly defined roles and areas of responsibilities (human resources, operations, financial management, accounting, IT, quality assurance, etc.), strategic planning, annual reports, quarterly financial statements.

The Coordination Committee on Hospital Network Optimization/Modernization will pre- select the beneficiary marz hospital networks and submit the draft list of pre-selected hospitals to the Project Steering Committee for approval.

The marz hospital networks investment program will be carried out simultaneously in all selected hospital networks, however two of them will be subject to improvement during 2007-2008 in the scope of the on-going Armenia HSMP (APL1), while the remaining marz hospitals will be covered under APL 2. The project hospitals will receive support through provision of building renovation (civil works), essential bio-medical equipment, health care waste management equipment and supplies as well as management support technical assistance services.

2. Civil works

Rehabilitation and construction activities of the selected principal regional hospital networks will be carried out under the project. Initial assessment of the regional hospital buildings against their cadastre certificates showed that around 42000 square meters in total are subject to rehabilitation in the project hospitals.

Costs of renovation of hospitals per square meter (US$380) are estimated according to the tariffs of Ministry of Urban Development official bulletin of 2007 and are subject to adjustment depending on the fluctuation of prices at the time of project implementation.

All Civil Works' related activities (selection of contractor and civil works implementation) will be done in accordance with World Bank requirements and rules and legislation in force of Armenia. Architectural design company consulting services are procured by HPIU for the development of design, bill of quantities and supervision of the planned civil works. HPIU Civil Works Engineer/Environmental Specialist jointly with the HNO component coordinator develops terms of assignment (technical requirements) for the procurement of architectural design services based on detailed assessment of principal regional hospitals (40 hospitals buildings),

22 their seismic stability and the proposed refurbishment measures performed in the scope of on-going first phase of HSMP.
A civil works organization is then selected and hired by HPIU based on a contract of Civil Works signed between HPIU and the selected licensed civil works organization (contractor). HPIU is responsible for:
·provision of contractor with civil works architectural design, specifications and bill of quantities developed by architectural design company;
·supervision of the civil works process by periodically visiting constriction sites;
·payment of contractor upon acceptance of performance acts on properly completed works;
·accept the works executed in accordance to contract conditions.
The Contractor is responsible for:
·execution of works in the construction sites in accordance with the contract conditions and Urban Legislation of Armenia;
·liquidation of defects in case of necessity.

Supervision of Civil Works on behalf of HPIU is carried out by its Civil Works Engineer/Environmental specialist assisted by civil works' hired supervisors taking into account the big volume of civil works planned under the project. He is also responsible for coordination and supervision of the environmental work undertaken in the project according to Environmental Guidelines developed during the ongoing APL1 project.

The last stage of civil works is the signing of Acceptance Certificate on Civil Works Completion by HPIU (Civil Works Engineer/ Environmental Specialist, hired civil works' supervisor, HNO component coordinator), marz governor, head of health facility, director of civil works' company and head of regional department of the State Urban Development Inspectorate; and approval by the Director of HPIU.

3. Provision of medical equipment and furniture The selected marz hospital networks will receive essential medical equipment and furniture.
All medical equipment and furniture procurement activities will be done in accordance with legislation in force of Armenia and World Bank requirements and rules. The following activities will be performed:
·Based on the assessment of needs of equipment and furniture performed by the biomedical engineer hired by HPIU as well the results of the survey of health care providers in the scope of the mapping exercise the lists of essential hospital equipment and furniture to be procured will be developed by the bio-medical engineer hired by HPIU and agreed with hospitals' administration.
·Technical specifications of medical equipment and furniture to be procured shall be developed by the Medical Equipment specialist of HPIU.
·Bidding and evaluation of bids for procurement of skill labs shall be conducted in accordance with the WB's procurement Guidelines
·Contract shall be signed between HPIU and the successful bidder
·As soon as the purchased goods are supplied and delivered to the final destinations as specified in the contract, a delivery-acceptance certificate shall be issued by the HPIU and signed by the HPIU; marz hospital network director and the supplier
·The installation of medical equipment and furniture and other incidental services (if required) is carried out by the supplier.

·Training of about 80 medical and support staff of the project hospitals on usage of the new biomedical equipment will be provided by HPIU under the project.
·The marz hospitals may share the cost of renovation of their facilities to accommodate the medical equipment procured under the project, if cost of renovation exceeds the limits defined under the project.

4. Technical assistance

Local technical assistance services (individual consultancy) will be procured by HPIU on design and institutionalization of in hospital Quality Assurance (QA) projects, supporting improvement of the marz hospital network management arrangements and improving of hospital waste management systems. The consultancy will be based upon the outcomes of foreign and local technical assistance activities already implemented in Yerevan project hospitals under subcomponents B1-B3, as well as B6 of the current Health System Modernization Project (APL1). Terms of reference for local consultants will be developed by HNO component at HPIU.

Technical assistance in QA (local consultancy) will include: (i) assisting marz hospital networks in setting up a quality management structure, (ii) defining roles and responsibilities of the committee members and staff representatives in the different hospital units for maintaining and improving quality of hospital services. (iii) editing the main hospital processes and developing specific indicators for measurement of their, (iii) applying Total Quality Management (TQM), (iv) support in streamlining patient flow and optimizing the usage of diagnostic and treatment capacities, etc.

Technical assistance in supporting hospital management (local consultancy) will include: (i) developing management structures and underlying position job descriptions, (ii) developing
annual reports, business and strategic plans, (iv) developing human resource management capacity, (v) developing of internal and external communications.

Technical assistance for development of hospital waste management systems (local consultancy) will include (i) development of in-hospital health care waste management plan proceeding on the National guidelines on Health Care Waste Management and using the waste management plans of the Yerevan hospitals developed under the on-going Health System Modernization project (APL1) as prototypes, (ii) training of relevant personnel in safe waste management practices using the training materials developed and used for training of staffs of Yerevan hospitals under the on-going Health System Modernization project (APL1), (iii) based on the proposed in-hospital plans of improved health care waste management systems develop procurement lists of waste management equipment and supplies to be procured under the project.

5. Legal bases and implementation agreements

As stated above actual implementation of the hospital mergers and management improvements will be the responsibility of Hospital Services Unit of the Health Care Provision Department of the Ministry of Health, regional (marz) governments and respective hospital network managers.

Hospital Supervisory (Oversight) Committees are established under the Government action plan for improvement of hospital governance of 2004 and the decree of Government of
Page 24
24 Armenia # 1187 dated May 19, 2005 on establishment and rules of functioning of hospital Supervisory Committees (supervisors). The main responsibilities of the supervisory committee will be to initiate strategic planning, oversee the hospital management and overall Performance For each marz hospital network in Yerevan a tri-partite implementation agreement will be concluded between the MOH, owner of hospital (marz governor) and hospital network director satisfactory to the World Bank and outlining the content to the optimization and modernization program, incl. (i) investments committed by parties (ii) commitment to functional re-programming and optimization of units and facilities; (iii) hospitals contribution to the project, e.g. rehabilitation of space for housing medical equipment procured under the project; (iv) plan of action for dealing with vacant premises; (v) commitment to modernize the management and governance arrangements; (vi) specific performance improvement targets as described below under implementation of the project monitoring and evaluation.

INSTITUTIONAL STRENGTHENING (IS)

Component Institutional Set-up
IS component coordinator collaborating closely with the relevant Ministerial Departments as well as other concerned implementing bodies (State Health Agency, Yerevan Municipality, Marz Government Health Departments, National Institute of Health and Yerevan State Medical University, hospital and other health facility administrations, etc.) and coordinates implementation of all component related activities in cooperation with other staff members of the HPIU such as procurement officer, legal specialist and M&E specialist. The coordinator is as well assisted by consultants of the project (assistant to the IS coordinator, etc). He reports directly to the Director of HPIU. The component activities are predominantly local and foreign technical assistance services procured by HPIU according to the established procedure. The arrangements required for each subcomponent are described above:

1. Health Policy Development & Health System Performance Assessment

1.1 NHA Coordination Committee
was created in accordance with the decree #18-A of
Prime Minister, dated January 14, 2005 to oversee the analytical work on the preparation of NHA.
The scope of work of NHA Coordination Committee is summarized below:
·Working group coordination
·Feedback on results and findings
·Facilitation of an access to all potential data sources
·Assisting in interpretation of results

·Identification of key health systems requirements that determine the effective provision of health intervention
·Assisting in transferring of policy implications into the policy action
·Supporting NHA institutionalization by establishing ownership at the highest levels of policy making.
Current NHA working group comprises of representatives from SHA, MOF, NSS, donor organizations. At present, the NHA 2004 report and draft NHA 2005 report are submitted. The NHA data was collected from various Ministries and departments that have internal health care systems. Additional data sources for NHA development are

25surveys on household health expenditures as well as health care facilities and drugstores expenditures on health.
For NHA institutionalization, particularly for the establishment of separate departments for NHA data collection and report development within the SHA, it is planned to implement some changes in SHA structure and charter.

1.2
In order to provide evidence-based information to the Government for health policy analysis, formulation and management the Health Sector Performance Assessment (HSPA) should be done on the regular base. In order to assess whether the entire health system is moving toward success and policy objectives, the appropriate instrument of measurement is required. The instrument will allow measuring and monitoring a core set of indicators used for HSPA. The methods of measurements of these indicators are diverse and include both primary and secondary data collection. HSPA data were collected from various sources, particularly through routine statistical forms, reports from specialized hospital, household survey and so on. In 2005 year some structural changes took place at the Ministry of Health. To avoid duplication of functions/responsibilities of information flow department at the MOH and Health Information and Analytical Centre (HIAC), which leads to discrepancies and conflict of interests, it was decided to add activities of the mentioned entities and reassign these activities to the HIAC (Minister's Order N519-A, dated 30 May, 2005).
The information flow department at the MOH was reorganized to legal department.
The HIAC was merged in the National Institute of Health (NIH) and the following activities were implemented:
·Working Group (WG) was established
·National performance measurement framework for the health system was developed and maintained by the WG
·Appropriate national performance indicators within the national performance measurement framework were established and maintained
·The minimum set of indicators that should be monitored routinely were determined
·The Local consultant was selected to support the WG on the sampling methodology and instrument development as well as for secondary data reliability and validity checking
·IT equipment for NIH Heath Information Analytical Center was purchased, distributed and installed

During the project the following activities should be implemented:

·For institutionalization of HSPA, establishment of separate department within the HIAC at NIH, which will be approved by MOH and will be responsible for HSPA data collection, report development and dissemination on systematic basis (once in two years)
·Checking validity and reliability of data collected through the routine statistical forms
·Revision of routine statistical forms in accordance with updated list of HSPA indicators, to secure the routine flow of information

1.3 For the development of Health Policy Paper the following activities should be Implemented:

·Establishment of intersectional WG, involving representatives from different Ministries (MOH, Ministry of Finance, Ministry of Social Affairs and so on)
·Development of draft Health Policy Paper by the WG
·Dissemination of the mentioned paper among main stakeholders
·Organization of conference for the discussion of recommendations obtained from main stakeholders
·Incorporation of recommendations into the final version of the report
·Preparation of the final report for the Governmental approval.
·Approval of the Health Policy Paper by the Government of Armenia.

For the development of Human Resource (HR) strategy the following activities should be implemented:
·Establishment of Local WG
·Selection of foreign consultants
·Revision of current documentation related to HR management by the WG and foreign consultants
·Development of HR management recommendations by foreign consultants
·Development of HR management strategy by the WG based on the recommendations provided by the foreign consultants
·Dissemination of the draft Strategy among main stakeholders
·Incorporation of recommendations into the final version of the HR strategy
·Preparation of the final version of the strategy for the MOH approval by the WG
·HR Management Strategy approved by the MOH.

2. General support for improving health care legislation

·Establishment of WG for continuing revision of health care legislation including the legal documents related to the health care licensing and accreditation
·Development of input criteria for health care professionals' licensing based on the recommendations suggested by the local and foreign consultants, working within the previous project
·Establishment of accreditation system based on the recommendations of local and foreign consultants by the MOH
·Established health care licensing and accreditation system for health care professionals and health care institutions.

3. Improvement of Public Expenditures Management

For improvement of public expenditures management the following activities will be implemented:

3.1Development of methodology of costing of BBP services:

·Selection of consulting firm with local experience

·Revision of existing documentation related to the assignment by the local firm

·Development of the draft report on methodology of costing of BBP services

·Dissemination of the mentioned report among the main stakeholders

·Incorporation of stakeholders' recommendations into the final version of the report

·Submission of the report to the MOH and SHA for the improvement of BBP costing methodology.

3.2 Improvement of Quality monitoring of main BBP services:

·Selection of the consulting firm with local experience

·Revision of existing documentation related to the assignment by the local firm

·Development of the report on Quality monitoring of main BBP services

·Dissemination of the mentioned report among the stakeholders

·Incorporation of stakeholders' recommendations into the final version of thereport

·Submission of the report to the MOH and SHA for the improvement of quality monitoring process of main BBP services.

3.3 Structural and management improvement of SHA

-Selection of foreign consultant for development of report on structural and management improvement of SHA

·Revision of existing documentation related to the structure and management of SHA by the consultant

·Development of the draft report on structural and management improvement of SHA

·Dissemination of the mentioned report among the stakeholders

·Incorporation of stakeholders' recommendations into the final version of the report

·Submission of the report to the MOH and SHA for strengthening SHA structural and management capacities.

3.4 IT equipment of SHA divisions

·Technical specifications of IT equipment to be procured under the project shall be developed by the IT specialist of HPIU

·Bidding and evaluation of bids for procurement of IT equipment shall be conducted in accordance with the WB procurement Guidelines

·Contract shall be signed between HPIU and the successful bidder

·As soon as the purchased goods are supplied and delivered to the final destinations as specified in the contract, a delivery-acceptance certificate shall be issued by the HPIU and signed by the HPIU; SHA designated representative and the supplier

·The installation of IT equipment and other incidental services (if required) iscarried out by the supplier.

NCD Prevention & Control

For NCD Prevention and Control aimed at reduction of risk factors and improvement of health status indicators related to cardio-vascular diseases, respiratory diseases, diabetes,
and cancer through risk factors screenings among population groups. The following activities will be performed:
·Selection of the consulting firm with local experience

·Risk factor screenings of groups of population of the above mentioned NCD by a local firm
·Development of the report summarizing the results of the screenings
·Submission of the mentioned report to the MOH.

4. Improvement of Medical Education System

For the improvement of medical education system the following activities should be implemented:
·Selection of foreign and local consultants for revision of formal medical education and continues medical education (CME) curriculums as well as medical professional standards. Consultants should develop reports that involve above mentioned issues. Reports will be submitted to Yerevan State Medical University (SMU) and National Institute of Health (NIH).
·Selection of local consultants for revision of Legal Documents related to the Medical Education. Consultant should develop report that involve above mentioned issue. Report will be submitted to MOH and MOE.
·Selection of foreign and local consultants for the development of Knowledge Evaluation System. The recommendations for the development of above mentioned system should be summarized in the reports. The reports will be submitted to SMU and NIH.
·Selection of firm with local experience for the development of job descriptions
·Adoption of normative acts (job descriptions) by the Government
·Selection of foreign and local consultants to assess the NIH and SMU chairs' needs. The results of needs assessment should be summarized in reports. The reports will be submitted to SMU and NIH.
·Selection of firm with foreign experience to procure Skill Labs
·Technical specifications of skill labs to be procured shall be developed by the Medical Equipment specialist of HPIU based on preliminary needs assessment and lists of items developed and agreed with Medical University administration.
·Bidding and evaluation of bids for procurement of skill labs shall be conducted in accordance with the WB's procurement Guidelines
·Contract shall be signed between HPIU and the successful bidder
·As soon as the purchased goods are supplied and delivered to the final destinations as specified in the contract, a delivery-acceptance certificate shall be issued by the HPIU and signed by the HPIU; SHA designated representative and the supplier
·The installation of skill labs and other incidental services (if required) is carried out by the supplier.
·To organize study tours to learn about international educational standards, curriculum development approaches, knowledge evaluation system and so on.

IMPLEMENTATION OF PROJECT MONITORING AND EVALUATION

Within the project implementation the following monitoring and evaluation (M&E) activities will be coordinated, supported and carried out: evaluation of the project's Components A and B, final project evaluation and health system reform evaluation.
Page 29
29

The MOH, in close coordination with the Health Information and Analytical Center (HIAC) in National Institute of Health, will monitor and evaluate the progress, outcomes and impacts of the reforms in health sector. HSMP 1 has supported HIAC in designing and carrying out an evaluation framework for the reforms assessment and preparing the Health Sector Performance Assessment report.

The M&E of the HSMP 2 project serves two main purposes:
1. Examining the effectiveness of main interventions in project intervention sites
2. Serving as a tool for health care facilities to use data for decision-making and project management

Implementation of the project final evaluation The aim of the final evaluation of the project is to find out whether the proposed inputs are in place, activities performed, outputs produced, outcomes and objectives achieved and the goal fulfilled. The project final evaluation will describe the progress made toward the following types of indicators: process/output indicators, measuring the extent to which the planned activities took place; outcome indicators measuring the extent to which project objectives are being met and sector/impact indicators, measuring the impact of the project on the health sector. The project impact indicators will be monitored through comprehensive set of methods: analysis of the population health status and health care utilization indicators constructed from the routine administrative data; analysis of data from existing surveys performed on an ongoing basis by National Statistical Service of Armenia (Integrated Survey of Living Standards, Demographic and Health Survey, etc); design, implementation and analysis of additional surveys of households, health care providers; medical records and ambulatory reports reviews, marz hospital data, etc.

The project final evaluation report will give the answers to the evaluation questions such as the project’s main inputs, main activities and outputs, project components and sub-components implementation, etc. Since the real impact of the project can only be properly understood years after its completion, the project evaluation should also include formative issues (attitudes, opinions, lessons to be learnt, etc) where appropriate. The stakeholders identified for the final beneficiary assessment will be: MOH management, Ministry of Economy and Finance Representatives, Ministry of Social Security representatives, SHA management, Family medicine and family nurses faculties at NIH, SMU and BMC, working groups, marz governors, heads of the marz health departments, head of health department of Yerevan municipality, heads of communities, marz hospital administrators, marz policlinics administrators, PHC providers’ working in

the marz's policlinics, PHC providers' working in the rural ambulatories and health centers, marz and Yerevan polyclinics, family physicians, family nurses and trainers, hospital care providers (physicians, nurses) and selected population of Yerevan and marzes.

The data for measuring process/output M&E indicators are collected and analyzed periodically within the components of the project. Different methods (quantitative and qualitative) are used for the evaluation of the Component A and B activities: household, PHC provider and patient satisfaction surveys, marz hospitals data, retrained family physicians and nurses knowledge assessment, focus groups with project beneficiaries etc.

1. Implementation of Family Medicine Development component evaluation

30In order to find out whether the HSMP 2 has been able to positively change the quality, utilization and efficiency of PHC sector in areas of project intervention, it is necessary to assess the levels of performance indicators before implementing the project and after that and compare them. The PHC performance indicators are grouped into following categories: utilization, access and quality of PHC services, population health outcome and expenditures on health, patients' satisfaction, nature and extent of referrals etc. Since, by the end of the project, there will be no pure "control" communities in Armenia, because the project is planning to provide at least some inputs (health care provider training and rehabilitation or construction of the ambulatories) to all communities. Therefore, in order to assess the impact of the project, it is planned to apply the pre-post comparison evaluation design, which allows conducting the comparisons before and after the project implementation. The evaluation of the FMD component will utilize quantitative data collection methods including household survey and survey of primary health care providers as well as review of medical records, ambulatory reports as well as observation of the working condition of ambulatories/health centers using a structured guide.

Family medicine development plans submitted by the physicians of the target facilities will be taken into account for the FMD component evaluation. The goal of the FM development plans is to protect, promote and enhance the health of the community population through provision of highquality care. Performance indicators will measure the extent to which the planned activities took place as well as the objectives stated in the FM development plans are being met. The level of objectives achievement will indicate the micro-project success in target PHC facilities.

Within the Subcomponent A2 ''Retraining and Residency Training of Family Doctors and Family Nurses'' the physicians' and nurses' training programs are evaluated internally by the institutions doing the retraining and externally by HPIU M&E officer. There are three tests during the family physicians training: one at the beginning one in the middle, and the final one. There is also a satisfaction questionnaire being filled in by the training participants. Adequate and detailed analyses of family physicians and nurses training programs are having been done, the feedbacks are being provided to the training organizations and modifications of the training programs are being made if necessary.

The patient referral system is the most important element of carrying out the “gatekeeper” role of PHC providers. In order to explore the PHC physicians referral patterns in different
PHC settings, including the main reasons for PHC physicians referrals to an out-patient and in-patient specialized care, the main referred diagnosis, the average numbers of referrals within the PHC all visits the focus groups discussions among PHC physicians from rural ambulatories and health centers, marz and Yerevan polyclinics are organized.

2. Implementation of Hospital Network Optimization component evaluation
The improved quality of the provided health care services by the beneficiary marz hospitals will be assessed by the patient satisfaction surveys in all marzes at the beginning and at the end of the implementation of marz hospitals optimization projects. Besides, different data on marz hospital performance (total admissions and by departments, physicians and nurses distribution by departments, number of surgeries, number of X-rays, ultrasound and laboratory examinations, etc) will be collected from beneficiary marz hospitals on annual basis. The outcome indicators will be defined and calculated for further monitoring and evaluation purposes. The outcome indicators examples could be the following: total FTE/1000 patient days aggregated and by each department; average number

31 of surgeries by each surgeon per year (operating surgeon or first assistant); patients per physician, per nurse in each department; admissions total and per physician; lab tests total and per staff; bed occupancy rate, and average length of stay; outpatient contact per doctor as well as the application and availability of common chart of accounts, consolidated budgets, annual business plans, independently audited annual accounts and etc.

Monitoring and evaluation of the HSMP 2 project is a responsibility of the HPIU M&E officer. The M&E officer works in close collaboration with project components coordinators and reports to the director of the HPIU.

The project M&E officer is responsible for the development of appropriate framework and measures to assess the progress in implementation of the HSMP 2 and the extent to which the objectives of the project are achieved.

Scope of work of M&E officer includes:
1. Development of approaches and measurement framework for monitoring and evaluation of A, B, C components of the project;
2. Periodically reviewing indicators (process/output, outcome and impact) within the measurement framework;
3. Development of the project component M&E methodologies and instruments for baseline, midterm and final data collection;
4. M&E of the training courses organized within the frame of the project, including:
·instrument development
·data collection
·data entry, processing
·data analysis, using statistical software packages (SPSS, STATA)
·report writing.

5. Conduction of the summative and formative evaluation:
·periodically conduct evaluation of results of the project activities in certain stages;
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By the end of the project conduct overall project summative and formative evaluation.
6. Provide feedback to the project component coordinators on the effectiveness of main
interventions in project intervention sites for the purpose to use results of the evaluations for decision-making and project management;
7. Assistance to the MOH in developing of health sector performance assessment measurement framework;
8. Development of TOR for conduction M&E related special studies (qualitative: e.g. baseline/midterm/final surveys or quantitative: e.g. in-depth interviews, focus group discussions).
Local technical assistance is used for the implementation of the projects/components evaluation special studies. The general activities/stages for the evaluation special studies are
the following:
·TOR for survey conduction, including survey methodology and questionnaires, in-depth interview and focus group guides;
·Selection of the local consulting firm;

·Refined proposal of the survey conduction including survey methodology and
questionnaires, in-depths interview and focus group guides;
·Development of the survey supporting documentation, including guide for field procedures, interviewer and supervisor manuals and data entry manual; field team training; pre-testing the survey questionnaire;
·Survey conduction;
·Submission of the draft evaluation report;
·Incorporation of the comments/suggestions/recommendations into the final version of the report;
·Dissemination of the results of the survey among the stakeholders.

The M&E officer is responsible for the development of the ToRs for the conduction of the evaluation special surveys, including surveys methodologies, development of the questionnaires, in-depth interview and focus group guides and assurance of the quality of the submitted evaluation reports.

HPIUOrganizationChart:(Total20StaffembersIncludingAvianInfluenzaPreparednessProjectStaff)32DIREHPIULawyerSecretary/translatorchitect/EnvironmentalSpecialistHNOCoordinatoISCoordinatorFMDCoordoFinancialManagerMonitoringandEvaionSpecialistCommunityMobilizationSpecialist2Accounntants2ProcurementOfficersOfficeManager4DriversAIPPHHCordinator