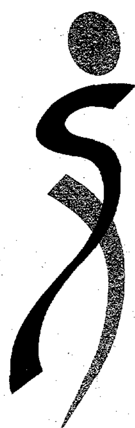

18218

SOCIAL DEVELOPMENT NOTES

ENVIRONMENTALLY AND SOCIALLY SUSTAINABLE DEVELOPMENT NETWORK

Note No. 37 May 1998

Social Assessment Helps Sharpen Sector Reforms in Armenia

Armenia's recent experience underscores the value of using social assessment (SA) in social sector reform projects. The Government of Armenia and the World Bank carried out an SA to evaluate the social and institutional feasibility of the government's proposed education and health sector reforms. The social assessment helped to identify key stakeholders and their expectations and attitudes toward health and education reforms; test the compatibility of beneficiaries' stated needs and the proposed reforms; adjust proposed project components to meet beneficiary needs and reflect socioeconomic realities; and collect and organize baseline data for ongoing participatory monitoring.

Health and Education in Context

Many of the newly independent states of the former Soviet Union inherited inefficient and deteriorating health and education services. Throughout the region ministries face enormous leadership challenges in setting social sector priorities and developing regulatory systems. Gross human resource imbalances continue to exist and oversized facilities, too costly to operate and maintain, are deteriorating.

The situation is no different in Armenia where state resources for health and education, equivalent to just 4 to 5 percent of GDP in 1997, are much lower than in Central and Eastern Europe's middle-income transition economies. Costs have shifted to the population in the form of informal payments, sharply limiting the poor's access to services. The health care system has failed to improve the population's health status, and school enrollments and attendance continue to decline.

Box 1. The Armenian Government's Proposed Reforms

Education: The Armenian government's education reform strategy is designed to rationalize school facilities and teacher deployment, implement cost recovery measures (for textbooks, university fees, elective and vocational courses), promote school-based management, financial independence for schools, and improve monitoring of educational outputs.

Health: Strategies to restructure and strengthen primary health care include providing essential health services free of charge to the entire population, subsidizing essential clinical services for disadvantaged groups and cost sharing for nondisadvantaged groups, transferring full costs to patients for nonessential services, and establishing performance contracts with service providers as a basis for financing the health care system.

Gillian Perkins is task team leader of the Education Financing and Management Reform Project. Laura Rose and Toomas Palu are co-task team leaders of the Health Financing and Primary Health Care Development Project. Alexandre Marc is program team leader for Human Development in Armenia. For more information on the social assessment, contact Mary Beth Schmidt, The World Bank, 1818 H Street, NW, Washington, DC 20433, USA, Fax: 202-522-3665, E-mail: mschmidt@worldbank.org.

The views expressed in this note are those of the author(s) and do not necessarily reflect the official policies of the World Bank.

Armenia's government developed strategies for sector reform and asked the World Bank to help them prepare two projects—the Health Financing and Primary Health Care Development Project and the Education Financing and Management Reform Project. Early in preparation, the Bank and counterparts realized that there was little government or public ownership for the reform strategies on which the projects were to be built. Low pay, difficult working conditions, and lack of continuity in leadership undermined ministerial capacity to share strategies with or generate support from civil society. These same factors also seriously threatened the government's ability to implement reforms.

The Government/Bank team recognized that before they could ensure that reform strategies were appropriate, or that they could be articulated through sustainable projects, they needed to gather and share a great deal of information. The task team used social assessment methods to carry out social and institutional analysis, and to foster stakeholder participation and ownership in policy reforms and project components.

Social Assessment Objectives and Methods

The social assessment sought to:

- Identify stakeholders and develop ways to involve key stakeholders in defining, implementing, and monitoring the progress and impact of reforms, especially on the poor and vulnerable
- Collect information on community involvement, school enrollments, formal and informal expenses, health status and service utilization, access to health and education services, attitudes of service providers and users, satisfaction with and expectations of service, and the coping mechanisms (for example, selling assets, or borrowing) used to obtain services
- Establish channels for sharing information among ministries, local governments, professionals, donors, nongovernmental organizations (NGOs), and the public about the substance and process of social sector reforms
- Establish mechanisms for resolving conflicts and building consensus about reforms.

Box 2. Sample Social Assessment Findings About Health

Issue	Finding
Access	• Access to hospital and inpatient services is limited by high informal payments required by doctors prior to consultations, diagnostics, and treatment.
Utilization	• Patients go to hospitals for inpatient care (47 percent of visits), outpatient care from a specialist (39 percent), and consultations or diagnostic tests (14 percent). • Reasons for polyclinic visits include patient's initiative (52 percent), need for immunizations (27 percent), follow-up or other visits initiated by a physician (15 percent), and to obtain free drugs (4 percent).
Quality	• More than 75 percent of survey respondents were satisfied or highly satisfied with their practitioner's expertise, attitude toward patients, and duration of waiting time. • Patients were most dissatisfied with the availability of medicines and the physical condition of facilities. Focus groups said that health facilities rarely distribute free medicines, even with a prescription. The groups did not trust doctors because they felt doctors are motivated by profit.
Cost and coping strategies	• The mean cost of a polyclinic visit is US$8; the mean cost of a hospital stay is US$70. There is little opportunity to negotiate prices. • Informal payments are less common in polyclinics than in hospitals. Respondents do not know if fees are official and legal, which limits their ability to claim free care. • Medical costs are financed with current income, savings, and above all the sale of assets (44 percent). Some patients borrow money to cover immediate costs until assets can be sold. • People without assets are reluctant to borrow money and likely to avoid or discontinue treatment. • When care is too expensive or initial treatment is unsuccessful, Armenians turn to folk healers and elders who are compensated based on the patient's willingness to pay.
Problems and recommendations	• People believe that prices will be more transparent and doctors will be more accountable for service quality if fee recommendations are formalized. Overall costs will increase, however, because informal fees will continue.

Box 3. Sample Social Assessment Findings About Education

Issue	Finding
Utilization	• Nearly 90 percent of respondents support kindergarten attendance yet only 39 percent of children 3 to 7 years old attend kindergarten. • Nearly 5 percent of school-age students, most of them outside the capital, do not attend school. • Enrollment is stable for grades 1 through 8; after grade 8 enrollment drops. • More than one-third of students attend school sporadically, and 90 percent of absences last from 10 to 30 days. Among students absent for more than 10 days, 67 percent cited health reasons and 17 percent cited the poor physical condition of schools as the main cause.
Quality	• Rural schools are perceived as being of lower quality than urban schools. • Parents perceive education as geared toward higher education and not toward developing marketable skills. Technical and vocational schools are not widely available.
Cost and coping strategies	• The cost of textbooks dramatically exceeds most parents' willingness to pay. The average cost is 500-800 drams; parents are willing to pay 360 drams. • The mean cost for one child in kindergarten is 554 drams a month. The mean rate respondents are willing to pay is 903 drams a month. • Parents contribute 100-200 drams a year toward school repairs and supplies, as well as labor and fuel in rural areas. Those unable to contribute are not penalized. • To meet education expenses, rural households barter or sell crops early at disadvantageous prices. • School/parent councils take action on issues such as textbook problems, physical condition of schools, and heating.
Recommendations	• To attract male teachers skilled in subjects in high demand to remote, small schools, parents recommend reinstating the law exempting them from military service. • Parents also recommend adjusting the public transport schedule to the school schedule to reduce tardiness among students traveling from nearby villages.

The ministry working groups responsible for planning and implementing reforms were involved in the SA from the design stage. The SA team included local and international experts who combined quantitative and qualitative methods over a three-month period.

Household survey. Local researchers and State Department of Statistics staff, who were proficient with Livings Standards Measurements Survey methods, surveyed a representative sample of 1,000 households to explore utilization rates, access, expenditures, and attitudes.

Participatory rapid appraisal methods. Focus groups, semistructured interviews, and participant observations were undertaken in a sample of villages and urban areas to explore issues that could not be easily captured by the household survey. This field work was supervised by an international consultant and conducted by local teams that had been trained for Armenia's participatory poverty assessment.

To formulate focus group and interview discussion guides, researchers from Armenia's National Institute of Health observed patients at selected health facilities. Their observations, along with existing studies and reports on health and education, informed the survey questionnaire. The questionnaire and discussion guides were also revised based on discussions with an education consultant responsible for advising the government on financing and delivering textbooks. In addition, the ministerial working group on education met with parents and headmasters in Armenia's 12 administrative districts. These meetings proved to be an excellent way for parents and headmasters to voice their concerns and influence the education reforms.

Stakeholder workshops. The household survey and participatory rapid appraisal work were followed by a national stakeholder workshop to discuss findings (see Boxes 2 and 3) and consider lessons from reforms in other countries. Separate days were devoted to health and education. Nearly 75 representatives came from different regions, levels of government, service providers, donors, United Nations agencies, and NGOs.

Continuous feedback. To continue the process of sharing information and gathering feedback, the two projects that grew from sector reform plans—the Health Financing and Primary Health Care Development Project and Education Financing and Management Reform Project—will hold systematic, regularly scheduled regional workshops. The main tool used at the workshops will be the strategic logframe, an approach that assists stakeholders in assessing issues and developing clear priorities or action plans.

Funding for the social assessment came from the Japanese and Dutch governments. The household survey, participatory rural appraisal report writing and translation, and stakeholder workshop cost about US$150,000.

Box 4. Practice Pointers

Local capacity is key. Armenia's SA team benefited from working with local people trained in sampling procedures and questionnaire development. When local capacity is lacking, SA teams should budget additional resources, time, and supervision to build this capacity.

Costs versus coverage. This SA covered two different sectors at one time, in an effort to keep costs down. Household survey and rapid appraisal activities were carried out when schools were out of session. This enabled the SA team to interact with full families, but made it difficult to gather first-hand information from teachers and school management, or to observe community involvement in schools. Separating the education from the health social assessment would have given the SA team flexibility to explore education issues on a more appropriate schedule, but costs would have at least doubled.

Value Added

Baseline data. As a result of the SA, a wealth of data is now accessible on health and education in Armenia. These data form the baseline against which projects will monitor changes in attitudes, access, utilization rates, and expenses, as well as reveal the impact of the projects. Funds were set aside in both projects to finance surveys and workshops for continuous monitoring and learning.

Project component design. The SA found that only 30 percent of children have access to all of their textbooks—much less than reformers had estimated. The SA also found that parents support a revolving textbook fund, but they are reluctant to change pedagogical methods and approaches and do not want to assume greater responsibility for managing schools. Education components were designed based on such findings.

Similarly, health sector findings provided a rationale for reforms to support preventive health care through primary care, which is less expensive than hospital-based curative care. Under the health project, the government will develop the training and retraining capacity of primary health care providers, rehabilitate and equip primary care facilities, and develop primary care guidelines.

The SA highlighted weak communication between health and education ministry professionals, and the general public. As a result, project budgets for information and consultation activities were increased to improve dissemination and generate discussion and feedback about proposed changes.

In addition, both projects will establish funds for pilot activities to test ways of divesting social infrastructure to communities, protecting access by the poor, and developing incentives for professionals to improve service delivery.

Policy formulation. Ministry officials continue to cite findings from the social assessment to justify sectoral reforms. Quantitative data underscored the scale of problems in health and education, while qualitative data explained the reasons behind the demand for some changes and resistance to others.

Participatory process. The assessment also helped the government meet the social development needs of Armenia's Structural Adjustment Credit, which requires ministries to identify the stakeholders in reforms and establish a process for consulting and exchanging information with them.

Social Development Notes are published informally by the Social Development Family in the Environmentally and Socially Sustainable Development Network of the World Bank. For additional copies, contact Social Development Publications, The World Bank, 1818 H Street, NW, Washington, DC 20433, USA, Fax: 202-522-3247, E-mail: sdpublications@worldbank.org.

Printed on Recycled Paper