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PROJECT NOVA: MID-TERM ASSESSMENT

PROJECT NOVA IS DESIGNED TO IMPROVE THE QUALITY OF AND ACCESS TO REPRODUCTIVE, MATERNAL AND INFANT HEALTHCARE IN RURAL AREAS OF ARMENIA

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MID-TERM ASSESSMENT

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CONTENTS

TABLE OF FIGURES..... 5

ACKNOWLEDGEMENTS..... 6

PROJECT SUMMARY 6

ACRONYMS 7

EXECUTIVE SUMMARY 8

I. INTRODUCTION 10

 A. COUNTRY CONTEXT..... 10

 B. PURPOSE AND SCOPE OF THIS ASSESSMENT 10

II. THE DEVELOPMENT PROBLEM AND USAID’S
RESPONSE 11

 A. THE PROBLEM STATEMENT 11

 B. OVERVIEW OF PROJECT NOVA’S DESIGN AND
 IMPLEMENTATION STRATEGY 14

III. RESEARCH DESIGN AND EVALUATION
METHODOLOGY 15

IV. ASSESSMENT OF PROJECT NOVA 16

 A. ASSESS THE EXTENT TO WHICH PROJECT
 NOVA HAS MET, NOT MET, OR EXCEEDED ITS
 OBJECTIVES..... 16

 B. ADDRESS STRENGTHS AND WEAKNESSES OF
 THE OVERALL PROGRAM STRATEGY,
 STAFFING AND MANAGEMENT..... 23

C. INFORM THE DECISION TO CONTINUE WITH THE OPTION YEARS	26
VIII. THE ANNEX.....	27
ANNEX A. PROJECT NOVA MID-TERM ASSESSMENT SCOPE OF WORK (SOW)	27
ANNEX B. REFERENCES AND BIBLIOGRAPHY OF DOCUMENTS REVIEWED.....	32
ANNEX C. LIST OF PERSONS INTERVIEWED	33
ANNEX D. RESPONSES TO SPECIFIC QUESTIONS IN THE SOW	34
ANNEX E: PROJECT NOVA COMPLIANCE WITH CONTRACT TASKS.....	43
ANNEX F: ARMENIA RH/FP/MCH PHC NETWORK.....	54
ANNEX G. PROJECT NOVA ORGANIZATION CHART....	55
ANNEX H: DESCRIPTION OF PRIME II.....	57
ANNEX I: FOUR LEVELS OF HEALTH CARE IMPACT	57
ANNEX J. DATA COLLECTION INSTRUMENTS: INTERVIEW QUESTIONS AND SITE VISIT CHECKLISTS.	58
ANNEX K. TOPICS INCLUDED IN THE NOVA MANAGEMENT HANDBOOK.	63
ANNEX L. PROJECT NOVA PERFORMANCE MANAGEMENT PLAN (PMP).	66

TABLE OF FIGURES

Figure	Page
Figure 1. Map of Armenia's marzes. Source: U.S. Central Intelligence Agency, courtesy the University of Texas, Perry Castaneda Library's online map collection.	1
Figure 2. Project NOVA Mid-Term Assessment Objectives	2
Figure 3. Comparison of the 2000 results and 2005 preliminary results of the Armenian DHS	3
Figure 4. Project NOVA Technical Areas	5

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PROJECT SUMMARY

Project NOVA (Innovations in Support of Reproductive Health)

Original title: Rural Reproductive Health/Maternal and Child Health Program – Phase II.

Supports USAID/Armenia Strategic Objective 3.2: “Increased Utilization of Sustainable, High-Quality Primary Healthcare Services.”

Contract Number: GHS-I-802-03-00031-00; Order Number: T.O. 802

Life of the project (LOP) and Project Funding:

5 years (2 years plus a total of 3 option years). Total Ceiling Price: \$7,432,924.00

Base Period: October 1, 2004 – September 30, 2006. Ceiling Price: \$2,827,806.00

Option Period 1: October 1, 2006 – September 30, 2008. Ceiling Price: \$3,418,134.00

Option Period 2: October 1, 2008 – September 30, 2009. Ceiling Price: \$1,186,984.00

Implementing Partners: Emerging Markets Group, Ltd

Sub-contractors: IntraHealth International, Save the Children.

ACRONYMS

AMD	Armenian Dram (currency)
ALSP	USAID-funded Armenia Legislative Strengthening Program
ASTP	USAID-funded Armenia Social Transition Project
BBP	Basic Benefits Package
BMC	Basic Medical College
CBL	Competency-Based Learning
CO	Contracts Officer
COP	Chief of Party
CTO	Cognizant Technical Officer
CTS	Clinical Training Site
DE	Distance Education
DFID	Department for International Development (Great Britain)
DHS	Armenia Demographic and Health Survey
EMG	Emerging Markets Group, Ltd.
FCMC	Family Centered Maternity Care
FAP	Feldsher Acoucher Punkt (Russian)
FM	Family Medicine
FP	Family Planning
GOAM	Government of Armenia
HAG	Health Action Group
IR	Intermediate Result
IUD	Intrauterine Device
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-governmental Organization
OB/GYN	Obstetrician/Gynecologist
PHC	Primary Healthcare
PMP	Performance Management Plan
PPIC	Postpartum Infant Care
RH	Reproductive Health
RH/FP/MCH	Reproductive Health/Family Planning/Maternal Child Health
RMC	Regional Medical Colleges
SHA	State Health Agency
SOW	Scope of Work
SRH	Sexual and Reproductive Health
SPL	Self-Paced Learning
STI	Sexually Transmitted Infection
TO	Task Order
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
U.S.	United States
USAID	United States Agency for International Development
USG	United States Government
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

USAID/Armenia asked a USAID/Washington team to carry out a mid-term assessment of Project NOVA, Innovations in Support of Reproductive Health. Project NOVA seeks to improve the quality of and access to reproductive health and family planning (RH/FP) and maternal and child health (MCH) care, especially in Armenia's rural regions.

The assessment team was asked to:

1. Assess the extent to which Project NOVA has met, not met, or exceeded its objectives.
2. Identify key strengths and weaknesses of the program activities, strategy, and staffing and management.
3. Make recommendations to strengthen the program and address any areas of concern.
4. Inform the decision to continue with the option years of the project.

During the assessment, the team was impressed by Project NOVA's results in improving the access to and supply of health services for rural populations and in involving and motivating local communities. However, with the benefit of hindsight, two years of program implementation experience, and new preliminary data from the 2005 Armenia Demographic and Health Survey (DHS), the team had questions about the original project design which focuses interventions almost exclusively at the health post, the lowest level of health service delivery. In some cases this focus results in overlapping service delivery systems in close proximity, disregards the high cost of maintaining health posts within the current Armenian health care system, and limits NOVA's ability to improve the quality of primary health care services once a client is referred up the lengthy chain of intermediaries. While many parts of the project were first rate, particularly the training of nurses and the work with community health action groups, progress was not consistent across all project components. In summary, the team has four primary recommendations:

1. Exercise the contract option years to extend the project for the full remaining three years if there can be mutual agreement on the emphasis, elements and expected results for this period and if there are no contractual obstacles. Additionally, instead of dedicating a full fifth year to Monitoring and Evaluation (M&E), all three option years should focus on M&E as well as program implementation.
2. Review and adjust Project NOVA's Project Management Plan (PMP) and M&E methodology and indicators to better capture relevant data and illustrate compelling Project results.
3. Adjust NOVA's objective to focus on use of services. The evaluation team recommends the following new objective: "To increase use of appropriate and safe RH/FP/MCH services and practices in rural areas." This modification necessitates renegotiating the contractual requirement that NOVA work in 90 percent of rural facility networks.
4. Increase emphasis on Technical Areas One and Four and significantly reduce the level of effort in Technical Area Two (management training) and Technical Area Three (policy formulation and implementation). Specifically:

- a. Strengthen site selection criteria, reduce the number of health networks¹ chosen and deepen interventions in those selected within **Technical Area One** activities. Expand NOVA interventions to include training content and participants that will improve the overall care women receive during pregnancy and delivery at each point of contact in the health network (versus just health posts).
- b. Select one or more of NOVA's clinical training sites that have already received training, equipment, and renovation during the base period and pilot the family-centered maternity care (FCMC) model as a new activity within Technical Area One. This model should be linked with NOVA's improvements in the primary health care (PHC) network beginning with the FAP nurse providing ANC and ending with the maternity center and the delivery of the baby.
- c. In **Technical Area Two**, NOVA should retain the Quality Improvement (QI) activities with increased emphasis on achieving counterpart buy-in and use of the NOVA-developed QI tools. All other activities within this component should be discontinued under NOVA.
- d. Determine if it is appropriate now to engage in a full and open dialogue with the national government and other key leaders and opinion-makers on reproductive health/family planning (RH/FP) needs and services in the context of maternal health and, if not, diminish project activities related to RH/FP policy reform in **Technical Area Three**.
- e. If the decision to diminish RH/FP policy reform is reached, maintain only those policy reform efforts that promote the legal recognition and role of FAP nurses.
- f. Standardize community education and outreach activities in **Technical Area Four** to ensure consistent application of the approach.
- g. Increase the investment in FAP renovation to improve the quality and completeness of the renovation and increase investment in the health action groups.

The findings and analysis which led to these recommendations, as well as the substance of the recommended changes, are discussed in some detail in the chapters that follow.

Finally, like all outsiders who participate in assessments of complex programs within a brief time period, the team believes that the findings and recommendations require greater scrutiny by those who are more extensively involved in program assistance in Armenia. The team hopes that these recommendations and observations will be useful to those managing and implementing this project directed at the important health needs and the empowerment of rural communities in Armenia.

¹ Health networks are defined as health facilities linked both by ownership structure and referral patterns. A NOVA health network could be, for example, a FAP, a Polyclinic, and a Maternity.

I. INTRODUCTION

A. COUNTRY CONTEXT²

The Republic of Armenia is a landlocked, mountainous country located in the southern Caucasus region, covering an area about the size of the state of Maryland. It is bordered by Georgia, Azerbaijan, Iran, and Turkey. Armenia became independent from the former Soviet Union in 1991. According to the census conducted by the National Statistical Service of the Republic of Armenia in October 2001, the population is estimated at just over three million people. Ninety-five percent of Armenia's population is reported as Armenian, two percent as Kurd, and the remaining three percent as Russian, Greek, or other.

Armenia is administratively divided into eleven regions including the capital city of Yerevan. These regions are called “marzes” (or “marz” in singular) and are headed by regional governors appointed by the President. Armenia is a sovereign, democratic state with an Executive, Legislative, and Judicial branch. The heads of Ministries are appointed by the Prime Minister and each Ministry has several deputy ministers. At the marz level there are regional department heads leading, for example, the Department of Health and Social Affairs.



Figure 1: Map of Armenia

B. PURPOSE AND SCOPE OF THIS ASSESSMENT

Project NOVA (Innovations in Support of Reproductive Health) is a key activity in the health portfolio of USAID/Armenia. The project targets the lowest level of primary health care facilities in Armenia's rural areas, and seeks to improve the quality of and access to reproductive, maternal and infant care. The project will complete the initial contractual base period of two years on September 30, 2006. The USAID Armenia Mission must decide now whether to exercise its option to extend the project.

² The team used the excellent background materials provided by USAID/Armenia both for this description of the country context and most of the section that follows on the problem statement.

USAID/Armenia asked a USAID/Washington team to assess Project NOVA’s performance in meeting its objectives (see Figure 2); key strengths and weaknesses in project implementation, staffing and management; and to make recommendations on the continuation of the project and any changes in the requirements (See Figure 2). In addition, the team’s scope of work (see Annex A) included 37 specific questions on the performance in each of NOVA’s four technical areas. For a complete list of these questions and responses, please see Annex D.

This report is structured to respond to each of these objectives and includes both findings and recommendations in each topic area.

Figure 2: Project NOVA Mid-Term Assessment Objectives

- ❖ Assess the extent to which Project NOVA has met, not met, or exceeded its objectives.
- ❖ Identify key strengths and weaknesses of the program, including specific activities, overall program strategy, and staffing and management.
- ❖ Make recommendations to strengthen the program and address any areas of concern.
- ❖ Inform the decision to continue with the option years of the project, including specific recommendations for program areas, budget, and staffing.

II. THE DEVELOPMENT PROBLEM AND USAID’S RESPONSE

A. THE PROBLEM STATEMENT

As part of the Soviet Union, Armenia’s healthcare system was a planned public service provided by the state, with all healthcare personnel hired as state employees. The system was highly centralized and standardized with free services provided in state-owned facilities. All healthcare services were provided through a network of healthcare institutions: Feldsher-Accoucheur posts (FAPs, or rural health posts), rural ambulatories, regional polyclinics and hospitals, and maternity and other specialized hospitals. See Annex F for a diagram of the type and hierarchy of Armenia’s health facilities. While this system was generally successful in providing access to comprehensive services for the majority of the population, it required substantial and continuous state budgetary support and management.

Figure 3: Comparison of the 2000 results and 2005 preliminary results of the Armenian DHS

Sample Profile	Year of DHS	
	2000	2005
F = Female, M = Male, U=Urban, R=Rural.		
Interview Sample	F: 6,430; M: 1,719	F: 6,566, M: 1,447
Residence	U: 61.3%, R: 38.7%	U: 63.9%, R: 36.1%
Reproduction		
Total fertility rate (TFR)	1.7	1.7
Urban fertility	1.5	1.6
Rural fertility	2.1	1.8
Total abortion rate (TAR)	2.6	1.8
Urban TAR	2.1	1.5
Rural TAR	3.4	2.2
Contraception (currently married women)		
Overall use (any method) by married women	61.0%	53.1%
Modern contraceptive use methods	22.0%	19.5%
Traditional contraceptive use methods	37.0%	33.6%
Maternal Care		
Antenatal Care by health professional	92.0%	93.0%
Urban		95.6%
Rural		89.2%
Delivery by a health professional	97.0%	>97.5%
Delivery in a health facility	91.0%	>95.7%
Child Health (estimates from 5 yrs preceding survey)		
Neonatal mortality (per 1000 live births)	19.5	17
Infant mortality (per 1000 live births)	36.1	26
Child mortality (deaths per 1000 surviving to age 1)	3	4
Under 5 mortality (per 1000 live births)	39	30
Percent of children between 12 to 23 months of age who received all basic WHO-recommended vaccinations	75.7%	59.7%

The breakup of the Soviet Union, the subsequent collapse of Armenia's command economy, and the economic blockade imposed by Turkey in the early 1990s all contributed to severely depressed economic conditions and directly affected social service provision, including healthcare. Without adequate financing over the past decade, many healthcare facilities fell into disrepair and workers' wages went unpaid for up to 18 months at a time. Current health services continue to be characterized by antiquated facilities and a vertical, highly specialized, non-integrated approach to care. Even more disquieting, information systems and providers' skills have not been updated and community outreach services have been neglected or even halted. Moreover, the Soviet legacy of an authoritarian, top-down approach to healthcare administration has discouraged individual initiative and stifled PHC management and institutional development at the regional and local levels. As a result, both access to and the quality of health care decreased across the country in both urban and rural areas.

Among the most neglected health care services are RH/FP and MCH care. The 2001 Armenian Census reported a total of 900,861 women of reproductive age (15 – 49 years) residing in Armenia, with approximately 33 percent of these women living in rural areas. Armenia is facing a decline in overall population due to emigration and a fertility rate below replacement level. With an infant mortality rate in 2005 of 26 deaths per 1000 life births, Armenia's rate is higher than all Eastern European countries and Belarus, Moldova, Russia, and Ukraine but lower than in the neighboring countries of Azerbaijan and Georgia. Most infant deaths occur early and can be associated with the condition of the mother, the delivery itself and post-birth care. Despite this data, the Government of Armenia (GOAM) has done very little to improve RH/FP and MCH services and care.

At first glance the preliminary data from the 2005 DHS seem to indicate that most Armenian women in both rural and urban areas are receiving antenatal care (ANC). A high percentage of women reported receiving ANC from a health professional at least once (95.6 percent in rural areas; 89.2 percent in urban areas), almost all women report that their delivery was attended by a health professional (98.7 percent of urban women and 98 percent of rural women) and that the birth took place in a health facility (98.6 percent of urban women and 93 percent of rural women). However, successful outcomes for mothers and children also depend on the timing, frequency and quality of ANC as well as safe delivery and good post partum care for the mother and child. In reality, many expectant mothers access ANC either inconsistently or of varying levels of quality. While final data from

the full 2005 DHS is still being analyzed, it is expected that there will be significant and negative rural-urban differences in access to health care, as shown in the 2000 DHS, on important MCH variables such as the timing and number of ANC visits and other pregnancy and labor/delivery-related information.

In addition to poor MCH services, many women are either unaware of or do not have ready and affordable access to RH/FP methods. Particularly alarming is that already low use rates of effective modern methods of contraception continue to decline. The overall contraceptive use rate, both modern and traditional methods, has declined from 61 percent reported in the 2000 Armenian DHS to 53.1 percent reported in the 2005 DHS. Because women cannot access quality RH/FP services, many resort to abortion as their primary family planning method. According to the preliminary results of the 2005 DHS, Armenia's total fertility rate is 1.7 children per woman (1.8 rural vs. 1.6 urban women). When the total fertility rate is compared to Armenia's high abortion rate of 1.8 abortions per woman, it means that Armenian women have approximately the same average number of abortions as births. While 1.8 is a significant decrease from the total abortion rate of 2.6 in the 2000 DHS, it still remains among the highest in the region. Additionally, complications as a result of abortions are a leading cause of maternal mortality and morbidity throughout the E&E region³. Armenia is no exception. WHO estimates Armenia's maternal mortality rate (MMR) at 55/100,000, nearly triple that of the developed world MMR of 13/100,000⁴. This elevated rate is exacerbated by Armenia's high abortion rate. Finally, secondary infertility as a result of unsafe or frequent abortions is also common.

Access to affordable, high quality, MCH and RH/FP services is a significant gap in the Armenian health care system. The consequences of these gaps are far reaching. Neonatal and child mortality rates are among the highest in the region and abortion as a predominate method of family planning persists. Elevated maternal mortality and morbidity rates, often as a result of abortions and poor ANC or delivery practices, are particularly troubling. In order to address these gaps and improve both access to and quality of MCH and RH/FP services, USAID/Armenia designed Project NOVA.

USAID/Armenia's Health Portfolio

USAID support to Armenia's health sector began in the 1990s. The current USAID/Armenia health portfolio is focused on strengthening Armenia's PHC system to achieve USAID/Armenia's Strategic Objective 3.2: "Increased Utilization of Sustainable, High-Quality Primary Healthcare Services." USAID/Armenia programs work to expand and enhance services at the PHC level; to improve PHC management and administration of services; and to increase consumer-driven demand for PHC services. Program activities address health system reform, pharmaceutical management, and maternal, child, and reproductive health. USAID places considerable emphasis on cooperation between the various implementing partners to ensure that these programs are coordinated to provide a comprehensive approach to strengthen the healthcare system at both the institutional and service delivery levels.

The major activities of the current USAID/Armenia health portfolio include:

- Project NOVA (NOVA): a five-year, \$7 million project to improve the quality and access to RH/FP/MCH care in Armenia, and the subject of this mid-term assessment report. The prime partner is Emerging Markets Group.
- Primary Healthcare Reform Project (PHCR): a five-year, \$17 million project to support the health sector reform efforts of the Ministry of Health. The project includes six key components: 1)

³ Kantner, Andrew and Pinar Senlat. An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern Europe and Eurasian Region. December 2004. (Poptech).

⁴ http://www.euro.who.int/eprise/main/WHO/Progs/CHHARM/cismortality/20060120_1

Primary healthcare reform; 2) Family Medicine; 3) Open Enrollment; 4) Quality of Care; 5) Healthcare Financing; and 6) Public Education. The prime partner is Emerging Markets Group.

- **Mobile Outreach Team (MOT):** a five-year, \$5.2 million program focused on improving access to primary health care for rural and hard-to-reach populations and strengthen the capacity of state health care facilities to provide quality primary health care. The prime partner is World Vision.
- **Bringing Sight to Armenian Eyes:** a three-year Global Development Alliance (USAID contribution: \$750,000) working to integrate ophthalmological care into the primary healthcare framework and reducing rates of preventable blindness through four main intervention strategies: 1) epidemiology; 2) education and training; 3) public communication; and 4) outreach services for vulnerable populations.
- **Armenian American Wellness Center (AAWC):** a four-year Global Development Alliance (USAID contribution: \$1 million) to expand the scope and capacity of the AAWC’s provision of quality medical services.

B. OVERVIEW OF PROJECT NOVA’S DESIGN AND IMPLEMENTATION STRATEGY

Project NOVA Design

Project NOVA is a five-year, \$7.4 million national program designed to build on the success of the USAID PRIME II project (see Annex H for a description of PRIME II). NOVA began operating in Armenia in October 2004. The contract provides for an initial two-year base period, an option to extend for two more years and a second option to extend for a final fifth year. This final option for the fifth year is designed to focus on monitoring and evaluation. NOVA is managed by Emerging Markets Group (EMG) in collaboration with IntraHealth International and Save the Children. NOVA has a field team of approximately 28 people based in Armenia, including three funded by EMG, five by Save the Children, and the rest by IntraHealth (See Annex G for Project NOVA’s organizational chart). The project is also supported by headquarters staff of EMG in Virginia, and IntraHealth International in North Carolina. USAID provides project oversight through USAID/Armenia’s Contracting Officer (CO), Cognizant Technical Officer (CTO), and health team technical advisors.

The goal of Project NOVA is to “improve quality in 90 percent of rural facility networks offering basic reproductive and maternal health care in Armenia. [NOVA] will improve quality of care, increase utilization of services, increase client satisfaction, improve the policy environment, and increase community demand for quality services.”⁵ Project NOVA’s contract proposes an integrated approach based on four main technical areas (see Figure 4 above): improved service delivery at rural facilities; strengthened management and supervision; improve RH/FP/MCH policy; and increased consumer demand.

Figure 4: Project NOVA Technical Areas

Area One: Improve RH/FP/MCH performance of rural health facilities through training and equipment provision.

Area Two: Strengthen management and supervision of rural RH/FP/MCH services.

Area Three: Improve RH/FP/MCH policy formulation and implementation.

Area Four: Increase consumer demand for high-quality services through community education and mobilization.

⁵ Contract Number GHS-I-802-03-00031-00 between USAID and Emerging Markets Group, Ltd. Page 13, Section A.2 PROGRAM BACKGROUND AND GOALS.

Project NOVA Implementation

While NOVA has key activities and approaches within each of the four technical areas, the program was designed to use an integrated approach which linked these four components. The activities designed to achieve Technical Area One goals are to: reinforce national and marz-level training capacity by creating a national training team and strengthen clinical training sites within each marz; develop training modules and conduct clinical training targeting FAP nurses and ambulatory nurses and physicians; and equip the health posts of the trained FAP nurses with a set of basic equipment and supplies.

The two major activities addressing Technical Area Two are the development of a management handbook and corresponding training for facility managers and the development and implementation of QI activities. Technical Area Three components include contributing to national government efforts to update laws and clinical protocols in RH/FP/MCH, improve national-level healthcare regulatory activities, and establish appropriate protocols for monitoring and oversight. Area Three is also designed to support the other technical areas of the project. Finally, Technical Area Four activities focus on selecting participating communities and then engaging those selected in addressing local problems such as health facility quality and access.

III. RESEARCH DESIGN AND EVALUATION METHODOLOGY

The mid-term assessment took place in Armenia from July 24 – August 8, 2006. Additional review and analysis occurred in Washington prior to and after the field assessment. The assessment was a rapid evaluation of the project's major interventions to determine the extent to which Project NOVA has met, not met or exceeded its objectives. The evaluation findings are limited to the information obtained through 1) document review (see Annex B for a list of documents); 2) direct observation during four full days of field visits to health facilities; and 3) interviews with key informants including headquarters staff at EMG and IntraHealth International, USAID/Armenia staff, NOVA field staff, NOVA trainers, local and national level government officials, Health Action Group and Marz Advisory Committee members, nurse and physician participants in NOVA training (see Annex C for a list of interviewees).

The Project NOVA field staff provided extensive data to the evaluation team including PMP baseline and follow-up data and NOVA staff are making a good-faith effort to collect, analyze and share data according to their PMP indicators. In many cases, however, the USAID-approved PMP indicators for NOVA do not accurately or sufficiently measure intended project outcomes and/or were not annotated or analyzed appropriately to allow for easy assessment of Project NOVA's development impact. For example, data collected on indicators meant to measure improvement in provider performance included all practitioners in a marz and the data is not disaggregated to show the Project's impact on performance improvement.

The team's cost analysis was constrained by incomplete data as well. For example, though the team received rough estimates showing allocation by the four broad technical areas, the evaluators were limited in their ability to evaluate whether budget allocations were appropriate and the activities cost effective because EMG headquarters staff was unable to provide detailed or precise cost estimates at the activity level.

The assessment team supplemented their analysis of Project NOVA with national level data from the 2000 and 2005 Demographic and Health Survey (DHS) statistics specifically related to RH/FP/MCH and with data from the 2001 Armenian National Statistical Survey. The data from the 2005 DHS is still preliminary; a final report is due in January 2007.

IV. ASSESSMENT OF PROJECT NOVA

A. ASSESS THE EXTENT TO WHICH PROJECT NOVA HAS MET, NOT MET, OR EXCEEDED ITS OBJECTIVES

- **Overall, NOVA has met or is on track to meeting the objectives outlined in its contract for each of the four technical areas. However, not every individual task included in the contract has been completed or, in some cases, initiated.**

NOVA's performance was strongest in Technical Areas One and Four, and less successful in Areas Two and Three. In **Technical Area One** FAP nurses and other primary health care providers received training in RH/FP/MCH care and FAPs equipped with basic supplies and equipment. NOVA received the most accolades for the community mobilization component of **Technical Area Four**. This activity has been extremely successful and the strategy used for community mobilization is an excellent model that could be copied by other assistance projects being implemented in Armenia and elsewhere. In **Technical Area Two**, NOVA developed a management handbook, and provided these handbooks in training for supervisors. However, the quality of the management training is not sufficient. **Technical Area Three** faces the most impediments. Improving the policy environment is a significant challenge for NOVA. While accomplishments in this area, such as NOVA's contributions to the National Law on Health, are notable, many other activities have not been initiated or fully-implemented including, but not limited to, engaging the private sector in public-private partnerships and in policy reform and strengthening the role of professional associations.

Detailed findings and recommendations for each technical area follow below.

TECHNICAL AREA ONE

IMPROVE RH/FP/MCH PERFORMANCE OF RURAL HEALTH FACILITIES THROUGH TRAINING AND EQUIPMENT PROVISION

Key Findings for Technical Area One

- Building on earlier work performed under Prime II, NOVA has provided excellent training in RH/FP/MCH. The protocols and training materials are widely known and used not only by NOVA-trained FAP nurses, but by other RH/FP/MCH health providers as well.
- All gathered data and outside assessments indicate that NOVA training and equipment inputs are high quality, but the PMP indicators are not adequate impact measurements.
- The health impact of current RH/FP interventions, in particular, is limited by the policy environment. FAP nurses can only provide counseling and referrals. They cannot prescribe contraceptives, take samples for STI testing or pap smears to screen for cervical cancer or carry out breast examinations.
- MCH interventions do not significantly impact health services beyond the FAP level or deliberately improve the quality of care at maternity centers or other key PHC points in the network.

NOVA training effectively improves FAP nurse knowledge. Clinical training materials are excellent and consistent with World Health Organization (WHO) requirements and protocols. External testing of

training participants⁶ and the assessment teams' field visits confirm that NOVA's training programs are transferring RH/FP/MCH clinical information to the FAP nurses and family physicians. Project records indicate increased patient visits to health outposts where FAP nurses have been trained and facilities improved. Unfortunately, current records do not note whether the visits were necessary or whether they reflect more visits by more individuals or more visits by just a few individuals. Evidence collected by the evaluation team also indicates that record keeping by nurses improved after they received training. However, this information is not sufficient to show that RH/FP/MCH performance in rural health facilities improved as an outcome of NOVA training. Performance indicators in the project's PMP are for entire marzes, not specifically for NOVA intervention sites and thus they do not specifically measure change in provider performance due to NOVA interventions.

The self-paced distance learning design of the training program for nurses contributes directly to the success of the program. Distance learning not only costs less than classroom-based training but also allows nurses to improve their skills outside of work hours. This approach makes it possible for more nurses to participate in the training with supervisor support. NOVA staff estimates that the cost per nurse trained is \$550 for six month distance learning course, and the cost per doctor for a one to two week seminar is approximately \$31. NOVA plans to incorporate the Safe Motherhood Training for nurses into the pre-service training at basic medical colleges. This would institutionalize the NOVA protocols and contribute to sustainability.

The uncertain legal status of FAP nurses is one threat to the sustainability of NOVA training. NOVA helped draft the FAP nurse job description which, if authorized, provides legal recognition of the role of FAP nurses. On October 14, 2005, Order No. 940 was issued by the Ministry of Health that authorized two separate job descriptions for Family Nurses (FN) and FAP Nurses. The order was then sent to the Ministry of Justice, which approved the FN job description in August 2006. However, the FAP Nurse job description was not approved because it included an allowance for FAP nurses to work on community outreach which was not acceptable to the Ministry of Justice. Consequently, the job description was returned to the Ministry of Health for further review and revision. NOVA staff anticipates that the job description will be approved by the end of the year, but there is no guarantee that agreement will be reached in this time period. NOVA needs to redouble its efforts to promote the legal status of the FAP nursing cadre. Legal recognition of the FAP nurse cadre is essential to the success of NOVA activities and, ultimately, the ability of the Armenian health care system to provide access to quality health care in a cost-effective manner.

RH/FP/MCH Performance

The assessment team believes that while NOVA training is appropriate for improving MCH care, it may not be a sufficient intervention to improve RH/FP care. Since FAP nurses (some claim Family Medicine Doctors also) are only able to counsel and refer patients and not provide other vital services such as carrying out breast examinations, taking vaginal and pap smears and prescribing contraceptives or antibiotics, NOVA activities are unlikely in themselves to have much if any impact on RH/FP practice or on reducing cervical or breast cancer or sexually-transmitted infections. A combination of a lack of national policy and political will and the Armenian health care system's over reliance on specialists has limited NOVA's ability to increase access to quality RH/FP care. The 2005 DHS preliminary results actually show a decline in some key RH/FP variables such as the rate of use of traditional and modern contraceptives. In addition the total abortion rate is still high and it is almost equal to the low fertility rate.

⁶ The use of Armenian Ministry of Health and other key national health leaders in the testing has had the important advantage of proving to these influential individuals that the nurses are capable of learning and mastering important MCH tenets of care. One project staffer told the team that one of the initial FAP training classes was tested three times because the senior testers could not believe the results. This public mastery also strengthens FAP confidence in their own knowledge and capability.

Current NOVA RH/FP interventions are insufficient to significantly and attributably impact these important behaviors. Despite these obstacles, NOVA is viewed by national working group counterparts as the voice for RH/FP and MCH issues and is credited with good cooperation with international partners such as UNICEF, OXFAM, and World Vision.

Recommendations for Technical Area One

- RH/FP: Review the objective to work in RH/FP and reduce activities pertaining to RH/FP in technical area one if appropriate (outside of including RH/FP content as a component of MCH training).
- MCH: Shift focus to provide some MCH and ANC support for services at levels above that of the health post including increased interventions at the marz maternity center level (such as Family Centered Maternity Care) to increase health impact and ultimately improve key maternal and infant health indicators. Work with *networks* of primary health care sites providing RH/FP/MCH/ANC care rather than isolated health posts.
- Include all medical professionals (i.e. FAP nurses, midwives, OB/GYNs etc.) involved in pre- and post-natal care as well as labor and delivery in training programs. This may necessitate a review of all training curricula to ensure that each cadre is trained at the appropriate level.
- Implement expanded training in marzes NOVA has already worked in and offer training to an expanded participant base (i.e. midwives, OB/GYNs) at these sites.

Review Reproductive Health Activities

USAID/Armenia needs to review the NOVA objective to work in RH/FP considering the current policy and program environment. In order to have an impact on RH/FP, NOVA would need to implement a broader set of RH/FP interventions including addressing the policy environment. This may not be feasible under NOVA's budget, and therefore NOVA may need to delete or severely limit RH/FP interventions and activities to where it adds value to developed NOVA training curricula.⁷

Mother and Child Health: Increase interventions at secondary care facilities

NOVA has equipped clinical training centers in each of the 5 marzes served, and will be developing several more in the remaining marzes. Each training center is linked to a maternity center that is usually located in a regional hospital. The assessment team recommends that NOVA concentrate its efforts in selected networks, rather than on an individual FAP. Training, equipping, and organizing the entire network as an integrated system will, ultimately, increase the number of interventions at the maternity center level. In addition, improve ANC testing and care, safe delivery and post partum care for mothers and infants in a limited number of PHC networks which have already received some upgrading and demonstrated a capacity to use assistance well.

Concentrating activities in selected health care networks will also allow NOVA to support system integration programs focusing on appropriate referrals, rapid and timely transfer of information between

⁷ In order to have an impact on RH/FP, NOVA would need to implement a broader set of RH/FP interventions which must include working with PHCR on activities to influence key opinion leaders and policy makers and could include other activities like expanding the demonstration "experiment" in pediatrician provided family planning that is being piloted in Ijevan and integrating RH/FP/MCH approach at Maternity Centers. Family-centered maternity services have provided a successful means for improving RH/FP in other countries in the region, particularly in Russia but also in Ukraine and Georgia.

MCH providers and integration of ancillary services (laboratory, transportation, tertiary care) into an actual system.

The evaluation team also recommends piloting family-centered maternity care (FCMC) and delivery in a limited number of settings. FCMC-initiatives have proven effective in reducing neonatal mortality throughout the region.⁸ Furthermore, by introducing FCMC into NOVA curricula, it provides a pathway through which to introduce NOVA expertise into the labor and delivery process and into the care and treatment of both mother and child during the birthing process itself. Implementing FCMC interventions builds upon NOVA's strong reputation in the Armenian MCH community, and it offers NOVA as a partner and facilitator to the OB-GYN and midwifery communities. It also allows NOVA to build training modules around the actual labor and delivery process into the larger curricula.

Finally, in order to ensure that mothers and infants receive quality care before, during and after delivery, providers (midwives and OB/GYNs) involved in the pregnancy and delivery process should receive NOVA trainings. Since FAP nurses are not allowed to deliver babies or provide ANC beyond very basic services, it is essential that providers who are assisting mothers in making decisions regarding their RH/FP and pregnancies and/or are involved in the actual delivery receive training.

TECHNICAL AREA TWO

STRENGTHEN MANAGEMENT AND SUPERVISION OF RH/MCH SERVICES

Key Findings for Technical Area Two

- Management training is insufficient for supervisors and does not address concrete management skills.
- Many quality improvement activities specified in the contract are incomplete.
- Anticorruption has not been measurably integrated into NOVA's activities.

Management Training

NOVA has met contract requirements by training 83 participants from the first five marzes (representing at least one manager from each target facility that manages a NOVA FAP), but the training does not concretely address management skills required of these individuals. While the training fills an important void of information for rural managers on updated legislation, policies, and suggested procedures, it does not introduce management techniques and tools that the facility managers need to operate a health facility. The project proposal suggested more appropriate and targeted management topics including, but not limited to, strategic planning and budgeting, human resource management, managing satellite facilities including ambulatories and health posts, maintaining material resources, monitoring service quality and use, and working with community structures. However, the NOVA-developed handbook does not include many of these critical topics (see Annex K for a list of topics included in the NOVA management handbook).

⁸ Russia Maternal and Child Health Study, Sept 2003-2006; John Snow International

Quality Improvement

Technical Area Two QI component results are limited. While NOVA developed impressive QI tools, many tasks listed in the contract related to QI remain incomplete or even uninitiated. Examples include integrating key STI indicators into the QI program; developing QI and supervisory tools to include STI risk assessment; promoting condoms and taking samples; and strengthening AUA and NIH management training programs.

NOVA piloted QI systems in Tavush and Shirak in 25 supervisory facilities; however, follow-up data shows that only 10 facilities have operational QI systems. The target for Kotayk and Gegharkunik was reduced to 9 facilities and only a total of 3 sites will be selected in the remaining five marzes. In addition, there are no concrete activities focused on developing local capacity for monitoring and evaluating the QI or management systems. NOVA staff underscored that institutionalizing a quality management system is very challenging and heavily dependent upon individual facility managers. The benefits of QI are not immediate or tangible and it has been difficult for the Project to obtain buy-in from the managers and physicians.

Integration of Anti-Corruption Activities

NOVA's integration of anti-corruption activities has been limited to increasing public awareness on available free services through publishing and disseminating posters and brochures; advocating for increased remuneration for nurses; initiating a FAP costing study to determine the cost of services provided at the FAP; and incorporating transparency and accountability concepts into the management handbook and training. An analysis of the social and legal justification of maintaining FAPs, "FAP Review," is the only recommendation implemented by NOVA included in the *Armenian Reproductive Health System Reviews* Study implemented to date.

Recommendations for Technical Area Two

- End investment in management training activities.
- Place greater emphasis on QI measures in subsequent five marzes by better utilizing NOVA's QI tools and obtaining beneficiary buy-in. Merge QI activities into Technical Area One.
- Provide the framework from the costing study to PHCR to be incorporated into PHCR's on-going health financing activities.
- Discontinue anti-corruption activities under NOVA.

As NOVA rolls out activities in the next five marzes, the project should reduce their activities and corresponding staff time and budget allocation in Technical Area Two. Although the handbook is not adequate as a management training tool, it does contain useful information on health legislation and protocols, in addition to other topics needed by facility managers. Consequently, the evaluation team recommends that the training seminar content and management handbook be modified, placed on a cdROM, and distributed to clinics.⁹ Finally, classroom management training seminars should be

⁹ PHCR and the World Bank are providing computers to all hospitals, ambulatories, and polyclinics in Armenia that can be used for using the management cdROMs.

eliminated from NOVA's activities. The responsibility for this type of training will remain with PHCR under PHCR's existing scope of work.

As stated earlier, Technical Area Two QI component should be emphasized and merged with Technical Area One. QI should be built into all NOVA training modules.

Anti-corruption is an issue better addressed by a macro-level reform project such as PHCR. NOVA should continue to provide relevant data and experience to PHCR in the RH/FP/MCH context and only retain increasing public awareness of the Basic Benefits Package (BBP) in its activities.

TECHNICAL AREA THREE:

IMPROVE RH/FP/MCH POLICY FORMULATION AND IMPLEMENTATION

Key Findings for Technical Area Three

- Policy activities are significantly behind schedule.
- NOVA has done a good job collaborating with key government officials, donors, and NGOs on what policy work has been done.
- Ambiguity remains regarding the legal authority of FAP nurses in critical technical areas related to NOVA's activities.

NOVA is significantly behind schedule on many of the policy activities outlined in the contract, such as completing a work plan for policy reform, expanding the role of the private sector in RH/FP/MCH policy formulation, and providing technical assistance to strengthen the advocacy capacity of associations. Though NOVA is seen as a major voice on RH/FP/MCH issues and is widely represented on national level working groups, most policy efforts may be better accomplished under PHCR's existing scope of work in this area.

NOVA's successes in this area includes working well with members of MOH, SHA, other donor organizations and NGOs and encouraging them to participate in working groups on RH/FP/MCH policies; developing Infection Prevention Protocols which have been adopted by the GOAM; developing a training curriculum on STI Integrated Care Management that includes the protocol for treating STIs; contributing to the job description for community/health post nurses (Ministerial Decree No. 940 10/14/2005) that is now pending with the Ministry of Justice; and providing valuable contribution to the law on health in coordination with USAID's Armenia Legislative Strengthening Project.

Recommendations for Technical Area Three

- Limit policy work to promoting the legal recognition and legitimizing the role of FAP nurses.
- Reduce emphasis in Technical Area Three and transfer resources to other Technical Areas.

NOVA's primary policy emphasis must be on obtaining legal recognition and government approval for the FAP nurse job description. Legalizing the FAP nursing profession is essential to the overall success of NOVA. By limiting and/or removing all policy reform activities but policy advocacy for nursing from NOVA's contract, the project will be able to increase efforts in the more successful activities under Technical Areas One and Four. Additionally, NOVA's involvement in health financing and costing should be limited to collaboration with PHCR on only a few specific RH/FP/MCH issues.

TECHNICAL AREA FOUR:

INCREASE CONSUMER DEMAND FOR HIGH-QUALITY SERVICES THROUGH COMMUNITY EDUCATION AND MOBILIZATION

Key Findings for Technical Area Four

- The community mobilization strategy is very successful with outstanding performance by Save the Children. This “Armenian Model” for community mobilization is recognized internationally by USAID and others as uniquely effective.
- Component Four is the foundation of Project NOVA and affects the success of the other components of the project.
- Results vary in the success of community education activities depending on community interest.

Overall, the community mobilization component of Project NOVA’s Technical Area Four is one of the greatest strengths of the project. Save the Children utilizes an effective community mobilization strategy that engages key community members by forming health action groups (HAGs). HAGs successfully promote community involvement and ownership of health activities at any entry point of the health system. By utilizing a collaborative, transparent process to engage and involve the community in renovations, HAGs generate community ownership of health facilities and services and also promote a democratic partnership between key community leaders and members. The community mobilization strategy is cost-effective because it engages communities and successfully encourages them to commit their own resources to NOVA renovations. The collaborative mobilization process is essential for sustainability even if it is not always the easiest or “cheapest” method of refurbishing FAPs. In addition to motivating the FAP nurse and the community, the improved facilities attract other health resources, e.g. increased visits by doctors, private contribution, and provide a venue for other community events and projects.

While the community mobilization efforts are strong, the community education component is considerably weaker and results vary among health posts. In some cases, the FAP nurse and health action groups (HAGs) are actively engaged in community education activities, including school health talks, classes for expecting parents, and “maternity schools” for young mothers. In other cases, little or no educational activities are being conducted.

Recommendations for Technical Area Four

- Document the model of community mobilization used by NOVA so that it can be replicated by other projects in Armenia and elsewhere.
- Increase assistance focused on the sustainability of HAGs. Link them with other civil society projects and extend the action plans to include other health-related community projects that continue after the date of completion of the FAP renovation.
- The educational and outreach activities should be more consistently implemented across sites by the HAGs and/or other health providers (i.e. FAP nurses).
- Determine available resources and needs at the field level and maintain or increase funding for activities in Technical Area Four with continued implementation by Save the Children.

NOVA has created a strong foundation for engaging communities through the HAGs. Future activities should build on the HAG model as well as identify means for promoting greater sustainability of the groups. Community action plans, for example, could include developing a schedule and funding/labor source for regular on-going maintenance of FAPs and steps for restocking basic supplies. Plans could also incorporate strategies for tackling other health community projects.

Finally, education is key to promoting healthier lifestyles. The project should place greater emphasis on community education and on implementing education initiatives consistently and thoroughly across all sites. Fundamental to NOVA's success in administering education materials is ensuring trained educators exist and have the support necessary to use the materials to educate patients. FAP nurses and HAG members are natural selections for educators. The evaluators recommend strengthening efforts to build the capacity of selected health educators as well as developing and distributing educational materials of high quality in all NOVA sites. Additionally, NOVA should ensure that there are no legal impediments to FAP nurses acting as health educators.

By reducing activities in Technical Areas Two and Three, additional funding can be allocated to Technical Area Four activities.

B. ADDRESS STRENGTHS AND WEAKNESSES OF THE OVERALL PROGRAM STRATEGY, STAFFING AND MANAGEMENT

Program Strategy

Project NOVA was built upon the successes and lessons learned from the implementation of its predecessor, PRIME II. The project addresses the lowest and most underserved level of the primary health care system, the FAP. With two years of implementation experience, and additional data available from the 2005 Armenian DHS, now is an opportune time to make mid-term adjustments in the NOVA contract, strategy and project activities. By focusing on strengths and moving away from less effective activities, NOVA can more strategically improve both the quality of and access to RH/FP and MCH care in Armenia.

The NOVA contract and implementation plan quite naturally correspond closely with the original USAID/Armenia-designed request for proposal (RFP). The objective formulated in that RFP was set low (see Annex I: Four Levels of Health Impact) and worded in a way that could result in ineffective approaches with limited if any impact on health status. By requiring 90 percent coverage and mandating that the work in each marz would not last more than a year, project impact may have been lessened. Changing the objective and the corresponding contractual requirements will allow NOVA to provide comprehensive technical assistance to fewer, but more strategically selected networks.

A particularly critical issue is the sustainability of Project NOVA's activities. The evaluation revealed that insufficient attention has been paid to sustainability in the base period. Gaps in ensuring sustainability include:

1. Project NOVA is contractually obligated to create sustainability plans for each marz before phasing out activities in that location. To date, no sustainability plans have been drafted or approved.
2. Individual NOVA-associated FAPs lack sustainability plans. For example, there is currently no plan for restocking FAP supplies provided by NOVA (pregnancy tests, prenatal vitamins, etc). Many nurses interviewed believed that when the FAP ran out of these supplies that NOVA would replenish the stock.

3. While NOVA proposes to integrate its *Safe Motherhood Training* into the Basic Medical College curriculum, a great step towards sustainability, the project has not considered how FAP nurses trained by NOVA's in-service training will receive updated training and skills after the initial NOVA training.

The evaluation team is not suggesting that NOVA in and of itself becomes sustainable, but rather that the project's interventions lead to sustainable changes in communities, the health system and/or health seeking behavior. As such, sustainability must be a priority and addressed in the option years.

Recommendations for Adjusting NOVA Program Strategy

- Adjust NOVA's objective to focus on use of services: "Project NOVA's objective is to increase use of appropriate and safe RH/FP/MCH services and practices in rural areas."
- Adjust corresponding activities and indicators, reallocate resources and renegotiate targets according to the newly defined objective and focused strategy (for example, reduce the 90 percent national coverage requirement and revise the one-year implementation limitation).
- As stated in earlier Technical Area recommendations, NOVA should strategically identify a limited number or network of promising PHC facilities, building upon already selected clinical training sites, to strengthen and expand the training participant base to include health care providers providing care at every point in and through a pregnancy.
- Increase attention to sustainability: complete the sustainability plans for marzes as proposed in the contract; continue working with the MOH to integrate FAP nurses into the health system; reexamine mandate, performance and role of marz advisory boards to see how they can contribute to more realistic and sustainable programming.

Monitoring and Evaluation

Generally, the assessment team found the USAID-approved NOVA PMP lacking. The current indicators and gathered data do not always tell a compelling or, in some cases, accurate story. In its present state, the NOVA PMP is unable to adequately assess the impact of project activities on the health status of Armenians. The NOVA PMP can be found in Annex L.

Notable examples include;

1. While the training of FAP nurses resulted in increased patient referrals, and in an increase in the trainees' RH/FP/MCH knowledge (as shown through testing), the PMP indicators do not show whether the referrals have been more appropriate, or that the protocols taught in the training are being used in practice. To address this, data from the quality improvement self assessment form, for example, could be included in the PMP and used to show change over time in how nurses assess themselves in technical competence.
2. PMP indicators do not adequately measure whether the manager appropriately applies any skills learned in that training. Instead, the indicators measure only an increase in the number of supportive supervisory visits at health posts and the percentage of facilities that have "at least one" NOVA management handbook.
3. Despite the success of Technical Area Four, it is difficult to determine the change in consumer demand and use of services. Indicators for this Technical Area include 1) the number of communities actively involved in improving HC provision as measured by the existence and

implementation of Community Action Plans, 2) the percentage of clients aware of free health services, 3) the utilization of a village drug revolving scheme measured by the number of people involved and the amount of money spent in the scheme, and 4) the percentage of clients satisfied by program area and target facility as measured during client interview surveys. None of these indicators directly measure an increase in demand for or use of RH/FP/MCH services.

4. When measuring the impact of the HAGs, NOVA should use the new indicator proposed by NOVA. More specific indicators measure the number of health talks and discussions conducted in the target facilities and more accurately track educational activities and check for inconsistency between health posts.
5. In order to assess the trends in consumer demand for services, an indicator could be added to the PMP to measure the number of referrals made by the FAP nurses each month. The NOVA team already collects data that could be used for such an indicator.

Recommendations for Adjusting NOVA PMP

- Evaluate and revise all project indicators.

Staffing and Management

Project NOVA's greatest resource is the capable, motivated, and dedicated local team. The team is very technically qualified with most staff members trained as medical doctors or otherwise credentialed professionals in public health. One challenging factor has been the long absence of a Chief of Party (COP). The search for a new COP began in December 2005 and has only recently resulted in agreement on a candidate who began residing and working in Armenia at the end of August 2006.

Despite a highly-motivated and hard-working acting COP, overall project vision, administration and flexibility for innovation was limited because she was not fully delegated overall leadership responsibilities for the direction of the program. While the acting COP maintained on-going activities, critical decisions could not be made in the field due to this lack of authority. For example, Project NOVA missed local payroll and other payments on occasion because the acting COP did not have signature authority with the bank. In addition, according to interviews with USAID/Armenia staff in different offices at the Mission, the lack of an official COP has placed additional administrative, management, and technical burdens on USAID. Finally, turnover within the USAID/Armenia Mission has meant that NOVA has been managed by several CTOs since launching, which may have also contributed to difficulties in program administration.

The need to replace the COP revealed a less than ideal working relationship between EMG, the prime partner, and IntraHealth, a sub partner. This seems to have contributed to the very substantial delay in selecting a new COP. With the COP position now filled, senior leadership at both organizations have expressed a renewed commitment to moving forward and working together for Project NOVA's success.

The reporting and communication path between Project NOVA's field and headquarters staff and USAID seems unnecessarily complicated and has resulted in delays in decisions and information sharing. For example, reports are drafted in the field, then sent by the COP to IntraHealth headquarters for editing, next sent to EMG headquarters for final edits, and finally submitted by EMG to USAID/Armenia. IntraHealth staff mentioned that they do not always know when the final report is submitted, and do not always see the text of the final report. EMG and IntraHealth should work to devise a simplified reporting pattern that maintains EMG's control over the final product while also increases IntraHealth's inclusion in information sharing.

Finally, as stated earlier, it was difficult to assess the cost-effectiveness of each activity and Technical Area since EMG was unable to cost out the various components.

Recommendations on Staffing and Management

- Review staffing pattern and use of resources in light of the revised program and objective with shifts in allocation by technical areas.
- Once COP is in place, renew the practice of delegating responsibility and authority to the field.
- As soon as new COP is on board, Project NOVA should initiate a collaborative process between USAID and all NOVA implementing partners to review and update the program implementation strategy, monitoring, and targets to reflect those changes recommended in this report that are endorsed by USAID/Armenia.

C. INFORM THE DECISION TO CONTINUE WITH THE OPTION YEARS

The evaluation team recommends that the Mission exercise the option years for the remaining three years of the project contingent upon successful revision of program objectives, targets, and action plans and also taking into account the contractual procedures and preferences at USAID/Armenia. Continue implementation into the final, fifth, year of the project, and integrate Monitoring and Evaluation activities throughout the remaining three years.

VIII. THE ANNEX

ANNEX A. PROJECT NOVA MID-TERM ASSESSMENT SCOPE OF WORK (SOW)

STATEMENT OF WORK

USAID/Armenia

Project NOVA Midterm Assessment

Date: July 2006

Location: Yerevan, Armenia

INTRODUCTION

The United States Agency for International Development in Armenia (USAID/Armenia) seeks to obtain an assessment team to carry out the midterm evaluation of Project NOVA, a five-year national program designed to assist in the achievement of USAID/Armenia Strategic Objective 3.2: "Increased Utilization of Sustainable, High-Quality Primary Healthcare Services" by developing sustainable high-quality rural RH/FP/MCH service provision to improve the quality of and access to reproductive and infant health care.

The evaluation is expected to require a total of 18 working days for the full team in Yerevan, Armenia, including fieldwork and report preparation. The team leader will require an additional 3 days in Washington to complete the final report. This timeline anticipates a six-day work week.

BACKGROUND

General

Armenia is a small, landlocked mountainous country with few natural resources, covering an area of 29,800 square kilometers. It is situated in the Southern Caucasus, bordered by Georgia, Azerbaijan, Iran, and Turkey. According to the census conducted in October 2001, the population is estimated at just over three million people. Armenia is administratively divided into 10 regions called "marzes," which are headed by regional governors appointed by the President, plus the capital city of Yerevan. It is one of the most ethnically homogenous countries in the world (Armenian 95 percent; Kurd 2 percent; Russian, Greek, and other 3 percent). Armenia has had a troubled relationship with some of its neighbors, including an ongoing conflict with Azerbaijan over the ethnic Armenian enclave of Nagorno-Karabakh, which is located in the territory of the former Soviet republic of Azerbaijan. Although a cease-fire has been in place since 1994, Armenia continues to face closed borders with Azerbaijan to the east as well as Turkey to the west, including an economic blockade.

Healthcare

As part of the Soviet Union, Armenia's healthcare system was a planned public service provided by the state, with all healthcare personnel hired as state employees. The system was highly centralized and standardized with free services provided in state-owned facilities. All healthcare services were provided through a network of healthcare institutions: Feldsher-Accoucheur posts (FAPs, or rural health posts), rural ambulatories, regional polyclinics and hospitals, and maternity and other specialized hospitals. This system was generally successful in providing access to comprehensive services for the majority of the population, but required substantial and continuous state budgetary support and management.

The breakup of the Soviet Union, subsequent collapse of Armenia's command economy, and the economic blockade imposed by Turkey in the early 1990s all contributed to the worsening of the overall economic conditions and directly affected social service provision, including healthcare. Without adequate financing over the past decade, many healthcare facilities have fallen into disrepair, workers' wages have gone unpaid for up to 18 months, information

systems and providers' skills have not been updated, and community outreach services have not been maintained. Moreover, the legacy of an authoritarian, top-down approach to healthcare administration has discouraged individual initiative and stifled management and institutional development at the regional and local levels. Current RH/FP/MCH health services are still characterized by antiquated facilities, and a vertical, highly specialized, non-integrated approach to care.

The 2001 Armenian Census reported that as of 2001, a total of 900,861 women of reproductive age (15 – 49 years) resided in Armenia (approximately 33 percent in rural areas). According to the preliminary results of the USAID-sponsored 2005 Demographic and Health Survey, Armenia's total fertility rate is 1.7 children per woman (1.8 rural vs. 1.6 urban women). Induced abortion continues to be the main method of fertility control, with a total abortion rate of 1.8 per woman (decreased from 2.6 in 2000), and modern contraceptive use has continued to decline. Infant mortality is estimated to be 26.0 per 1,000 live births (decreased from 36.1 per 1,000 live births in 2000). Finally, while antenatal care by a health professional is uniformly high, at an estimated 93 percent (95.6 percent rural; 89.2 percent urban), the needs for education for overall MCH remain.

USAID/Armenia Health Portfolio

USAID support to Armenia's health sector began in the 1990s. The current USAID/Armenia health portfolio is focused on strengthening Armenia's primary healthcare system and ultimately increasing the population's utilization of adequate and affordable health services. Programs address health system reform, pharmaceutical management, and maternal, child, and reproductive health.

Project NOVA (Innovations in Support of Reproductive Health) is one of the key activities in the health portfolio, and builds on the success of the USAID PRIME II project. NOVA is a five-year, \$7.4 million national program designed to improve quality of and access to reproductive and infant health care in rural areas. The five-year NOVA program began in October 2004, and includes two option years. Thus, this evaluation is scheduled to take place at the middle of the base period of the program.

NOVA is managed by Emerging Markets Group (EMG) in collaboration with IntraHealth International and Save the Children. NOVA staff in Armenia includes a team of approximately 28 people, including three funded by EMG, five by Save the Children, and the rest by IntraHealth.

The four main components of the program include:

- Area 1: Improve reproductive health/maternal and child health performance of rural health facilities through training and equipment provision.
- Area 2: Strengthen management and supervision of rural RH/FP/MCH services.
- Area 3: Improve RH/FP/MCH policy formulation and implementation.
- Area 4: Increase consumer demand for high-quality services through community education and mobilization.

The reported progress to date includes:

- Completed RH/FP Program in 3 marzes, including renovation of FAPs, training (clinical, management, supervision), supplies and equipment, and community mobilization activities;
- Reinforced national and marz clinical training capacity, including a team of 21 national and 16 regional trainers;
- Trained a total of 318 PHC providers, including 80 nurses and midwives during the "Safe Motherhood Clinical Skills" 6-month long training and 58 PHC physicians during specialized trainings; and
- Strengthened management & supervision of rural RH/FP/MCH services through the development, distribution, and training of a management handbook.

In addition to Project NOVA, the major activities of the current USAID/Armenia health portfolio include:

- Primary Healthcare Reform Project (PHCR): a five-year, \$17 million project to support the health sector reform efforts of the Ministry of Health. The project includes six key components: 1) Primary healthcare reform; 2) Family Medicine; 3) Open Enrollment; 4) Quality of Care; 5) Healthcare Financing; and 6) Public Education. The prime partner is Emerging Markets Group.
- Mobile Medical Team: a five-year, \$6.2 million program focused on improving access to primary health care for rural and hard-to-reach populations and strengthen the capacity of state health care facilities to provide quality primary health care. The prime partner is World Vision.
- Bringing Sight to Armenian Eyes: a three-year Global Development Alliance (USAID contribution: \$750,000) working to integrate ophthalmological care into the primary healthcare framework and reducing rates of preventable blindness through four main intervention strategies: 1) epidemiology; 2) education and training; 3) public communication; and 4) outreach services for vulnerable populations.
- Armenian American Wellness Center (AAWC): a four-year Global Development Alliance (USAID contribution: \$1 million) to expand the scope and capacity of the AAWC's provision of quality medical services.

These programs are coordinated to provide a comprehensive approach to strengthen the healthcare system at both the institutional and service delivery levels to achieve USAID/Armenia Strategic Objective 3.2: "Increased Utilization of Sustainable, High-Quality Primary Healthcare Services."

SCOPE OF WORK

PURPOSE

The purpose of this evaluation is to provide USAID/Armenia with a midterm evaluation of Project NOVA. The key objectives of this evaluation are for the team to:

- Assess the extent to which Project NOVA has met, not met, or exceeded its objectives;
- Identify key strengths and weaknesses of the program, including specific activities, overall program strategy, and staffing and management;
- Make recommendations to strengthen the program and address any areas of concern;
- Inform the decision to continue with the option years of the project, including specific recommendations for program areas, budget, and staffing.

DETAILED TECHNICAL REQUIREMENTS

In order to respond to the key objectives listed above, the final report should respond to questions including, but not limited to, the following:

General:

1. What are the objective, measurable indications that access, utilization, and quality of health services have increased due to Project NOVA? What are the continued areas of need?
2. To what extent has Project NOVA accomplished the following:
 - a. Expanded successful RH/FP/MCH programs to the majority of the country
 - b. Increased client utilization of target facilities
 - c. Improved rural RH/FP/MCH quality of care
 - d. Provided both local and national level sustainability mechanisms
3. How have the four areas of Project NOVA been integrated to provide a comprehensive RH/FP/MCH program?
4. What strategies are used by NOVA to promote sustainability of the results? Analyze the capability and commitment of communities and health facilities to sustain project achievements.
5. What are the current and potential future constraints facing the project?
6. What are the current linkages, potential duplication, and potential additional areas of collaboration with other USAID/Armenia health activities?
7. How effective is the current management and staffing structure for the achievement of project goals?
8. How cost-effective is the program? Is the current budget appropriate for project completion?
9. What are the specific recommendations to strengthen the overall program?
10. Given the project implementation to date, should USAID/Armenia utilize the option years of the project?

- a. Should all four program areas be included in the option years? What are the continued areas of need in each area that should be addressed?
- b. Will the project be at a technical point after the base period so that a bidding process does not disrupt program activities?
- c. What are the recommendations related to any financial and/or management factors that should be considered in the decision?

Area One: Improve RH/FP/MCH performance of rural health facilities through training and equipment provision

11. What are the objective, measurable indications that RH/FP/MCH performance of rural health facilities has been improved through Project NOVA training and equipment?
12. What is the total number of healthcare providers who have received NOVA training, and in what areas?
13. To what extent has NOVA training been cost-effective, appropriate, and effective?
14. How have the grant recipients benefited from the financial and technical resources provided by NOVA? Are the dollar amounts sufficient to achieve the proposed results?
15. What are the current linkages, potential duplication, and potential additional areas of collaboration with other USAID/Armenia training activities?
16. What are the policy and institutional management constraints related to the training participants utilizing their skills covered in training, and how have they been addressed by NOVA?
17. What are the lessons learned and best practices in this area?
18. What are the continued areas of need to achieve this objective?

Area Two: Strengthen management and supervision of rural RH/FP/MCH services

19. What are the objective, measurable indications that management of rural RH/FP/MCH services has been strengthened by Project NOVA?
20. To what extent has NOVA institutionalized a quality management system for rural RH/FP/MCH services?
21. To what extent has NOVA developed local capacity for monitoring and evaluation?
22. How has NOVA incorporated anti-corruption strategies? Has this been successful?
23. How has NOVA contributed to the improvement of quality of care?
24. What are the policy and institutional management constraints related to management training, and how have they been addressed by NOVA?
25. What are the lessons learned and best practices in this area?
26. What are the continued areas of need to achieve this objective?

Area Three: Improve RH/FP/MCH policy formulation and implementation

27. What are the objective, measurable indications that RH/FP/MCH policy formulation and implementation has been improved by Project NOVA?
28. What are the lessons learned and best practices in this area?
29. To what extent has NOVA improved healthcare financing/budgeting systems for rural RH/FP/MCH services?
30. What are the lessons learned and best practices in this area?
31. What are the continued areas of need to achieve this objective?

Area Four: Increase consumer demand for services through community education and mobilization

32. What are the objective, measurable indications that consumer demand for services has been increased by NOVA community education and mobilization?
33. To what extent has Project NOVA engaged community participation, including local leaders and community members?
34. To what extent has NOVA institutionalized community RH/FP/MCH education activities?
35. How has NOVA utilized private sector/community resource leveraging?
36. What are the lessons learned and best practices in this area?
37. What are the continued areas of need to achieve this objective?
- 38.

The team's analysis should take into account the opinions of the USAID health team, NOVA staff, rural beneficiaries of the NOVA project (including NGOs, staff of health facilities, training participants, communities, and MOH) as well as a review of the project's agreement, operational policies and procedures, reports and other technical documents, and organizational structure.

SUGGESTED TEAM COMPOSITION

USAID/Armenia recommends that the team consist of five members including:

- 3 international consultants, 1 of whom is the team leader
- 1 local professional
- 1 translator/administrative assistant

The team should possess the following expertise and skills:

- Expertise in reproductive and maternal health in rural settings
- Experience in the former Soviet Union
- Management experience
- Experience with primary healthcare reform
- Experience with USAID/W Global Health contracting mechanisms
- Excellent oral and written communication skills
- Fluency in English; Armenian/Russian is desirable

TANGIBLE RESULTS/DELIVERABLES

- Outline of the final report: due mid-way through the fieldwork
- Draft of final report due before the departure of the team leader from Armenia
- USAID/Armenia will review the draft and provide comments within five working days
- Final report due three working days after receipt of comments from USAID
- Debriefing meetings with USAID and Project NOVA to present key findings and recommendations
- Report of key findings and recommendations, in English

LOE AND PERIOD OF PERFORMANCE

The proposed LOE for this assessment is as follows:

- Team leader: 21 total working days, including 18 working days in Armenia for fieldwork and draft report preparation, and 3 days in the U.S. for final report completion
- International consultants and local professional: 18 working days in Armenia for fieldwork and draft report preparation
- Translator: 20 working days in Armenia, including 18 working days in the field, and 2 days that will be dedicated to planning and organizing the logistics for the field visits prior to the arrival of the rest of the team

ILLUSTRATIVE BUDGET

To be completed.

ANNEX B. REFERENCES AND BIBLIOGRAPHY OF DOCUMENTS REVIEWED

Blue, Richard and Molly Hageboeck, "Constructing an Evaluation Report." Management Information Systems for USAID, April 14, 2006

Central Intelligence Agency, *The World Factbook 2006*

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Crigler, Lauren, "Project NOVA Reproductive Health/Maternal Child Health Quality of Care Concept Paper" August 2006.

Pereira, Alisa, Anna Benton, Gohar Jerbashian, and Rebecca Kohler, "Armenian Reproductive Health System Review: Structure and system inefficiencies that hinder access to care for rural populations." Emerging Markets Group, Ltd. For USAID. May 2005.

PRIME II Armenia. "End-of-Project Reports Draft." IntraHealth International. July 2004.

Project NOVA "Annual Workplan October 2005 – September 2006."

Project NOVA "Facilitator's Guidebook to the Self-Directed Approach" February 2005.

Project NOVA "Instructions on Organization and Implementation of Preventive and Anti-Epidemic Activities at Obstetric Inpatient Health Care Facilities" 2004.

Project NOVA "Integration of Reproductive Health into Family Medicine Training Curriculum" 2004.

Project NOVA "Management Guide for Primary Healthcare Managers" 2005.

Project NOVA. "Project Performance Management Plan" Accepted November 15, 2004.

Project NOVA "Quality Improvement Self Assessment and Action Planning Tool" August 2005.

Project NOVA "Safe Motherhood Clinical Skills Training Curriculum."

Project NOVA "STI Integrated Care Management Training Curriculum."

ANNEX C. LIST OF PERSONS INTERVIEWED

Name	Title	Organization
Anna Benton	Former Project Manager for NOVA	EMG
Sara Espada	Project Manager for NOVA	IntraHealth
Andy Dijkerman	Chief Executive Officer	EMG
Tim Clary	Proposed Project Manager for NOVA	EMG
Leslie Flinn		EMG
Rebecca Kholer	former COP for Project NOVA, Director of Program Development	IntraHealth
Miriam Daldabanyan	Finance Director, NOVA	
Harutjun Shahumyan	Management Information Systems, NOVA	
Zara Mkrtchyan	Monitoring and Evaluation Officer, NOVA	
Lusine Ghazaryan	Acting COP, Program Manager, NOVA	
Gohar Jerbashyan	Policy Formulation, Implementation, NOVA	
	Health Post Review Advisory Group	
	Village mayors, health post supervisors, nurse trainees, management trainees, community action group members, advisory board members (not every type of stakeholder was interviewed in each of the three marzes)	Villages in Shirak, Gegharkunik, and Tavush marzes.
Karine Saribekyan	Management Training Facilitator, NOVA Technical Working Group member, Head of Mother and Child Protection Unit for the MOH	
Sam Tornquist	PHCR COP	
John Vartanian	PHCR DCOP	
Gohar Panajyan	RH/FP Advisor for Project NOVA	
Lilit Hovakimyan	Clinical Manager for Project NOVA	
Iren Sargsyan	Community Advisor, Gender Specialist, NOVA	
Irina Saghoyan	Country Director	Save the Children
Geghanush Stepanyan	President	Armenian Nursing Association
Grigor Nazinyan	Head of Center, NOVA training facilitator, technical working group member	Ijevan Mother/Child Health Center, Tavush marz
Anahit Gevorgyan	President of Martuni Women's Community Council, community outreach participant	Martuni Women's Community Council
Karina Baghdasarova	Quality Improvement Team Member	Quality Improvement Site, Ddmashen Ambulatory
Nancy Nolan	Senior Health/Social Sector Advisor	USAID/Armenia/DSRO
David Brown	Contracting Officer	USAID/Armenia
Razmik Abrahamyan	RH/FP advisor to MOH, Director of the Center of Perinatology, Obstetrics, and Gynecology (CPOG), editor in chief of all major NOVA publications	Center for Perinatology Obstetrics, and Gynecology (CPOG)
Gayane Avagyan	NOVA training facilitator, technical working group member, Chief MOH specialist on RH/FP/MCH	Center for Perinatology Obstetrics, and Gynecology (CPOG)

ANNEX D. RESPONSES TO SPECIFIC QUESTIONS IN THE SOW

DETAILED TECHNICAL REQUIREMENTS

The Scope of Work for the Project-NOVA mid-term assessment asked the evaluation team to respond to the following questions. While many of the answers to these questions will be addressed in greater detail in the content of the report, this annex addresses each question individually.

General:

1. What are the objective, measurable indications that access, utilization, and quality of health services have increased due to Project NOVA? What are the continued areas of need?

Increased access has been demonstrated by:

1. Increased use of FAP services and renovated facilities.
2. Increased referrals to physicians.
3. Increased supervisory and specialist visits to FAPs.

Increased quality has been demonstrated by:

1. Improved knowledge and skill sets of trained nurses and physicians.
2. Patient satisfaction surveys.
3. Improved timeliness and appropriateness of referrals.
4. Decline in maternal and infant mortality rates in rural areas.

Continued areas of need:

1. Expanded role in MCH/RH/FP for FPs and nurses in primary care
2. Integration of FAP nurses into primary care programs
3. Improved QI reporting and activities

2. To what extent has Project NOVA accomplished the following:

a. Expanded successful RH/FP/MCH programs to the majority of the country

On schedule with project expanded to 4 marzes plus Lori. NOVA still planning on adding the additional 5 marzes over the next two years.

b. Increased client utilization of target facilities

Number of visits increased, however, unclear if number of individual patients increased.

c. Improved rural RH/FP/MCH quality of care

- All evidence points to excellent clinical training materials consistent with WHO
- Effective training process
- Process of external testing – important both for trainees and for program credibility
- Have less information on how that translates into improved quality of care through the PHC network

d. Provided both local and national level sustainability mechanisms

Sustainability has been neglected. Some work has been successful at the local level with Health Action Groups however more support is needed, such as training in fundraising, for these groups to be truly sustainable. At the national level, NOVA has good working relationships with partners, but unclear whether changes will outlast project. Sustainability plans for each marz are not in place.

3. How have the four areas of Project NOVA been integrated to provide a comprehensive RH/FP/MCH program?

Not well-integrated. Areas 1 (training of nurses and equipping FAPs) and 4 (community mobilization) have been most successful. Some integration attempted by addressing same topic (such as community outreach) in training of nurses (area 1), training of supervisors (area 2) and community mobilization (area 4). Area 3, which focuses on policy and should support integration of the other components, has not been that successful, and therefore integration is suffering.

4. What strategies are used by NOVA to promote sustainability of the results? Analyze the capability and commitment of communities and health facilities to sustain project achievements.

Sustainability will depend upon

1. *Legislating the role of FAP nurses*
2. *Integration of FAP services into the organizational framework of rural health*
3. *Unless secure financing is obtained the gains evident in the high achieving villages will not be sustained. However the active involvement of international agencies, local MD supervisors, and the developing integration for referral and educational systems, all lay a groundwork that could be sustainable*

5. *What are the current and potential future constraints facing the project?*

- Role of FAP nurses is too narrow (restricted to counseling and referrals) and not legally defined
- No secure legitimate funding
- Current mandate for Project NOVA to roll out to 90 percent of the health posts in Armenia and the one-year per marz restriction.

6. *What are the current linkages, potential duplication, and potential additional areas of collaboration with other USAID/Armenia health activities?*

- Active linkages with World Vision mobile clinics & good patterns of cooperation.
- Little evidence of successful coordination or collaboration with PHCR – important joint policy, financing activities are not apparent. There is a risk of considerable duplication or overlap and possible diminishment of results if PHCR continues with the plans we were told about by the COP to train 700 FAP nurses with special priority to those already trained under NOVA

7. *How effective is the current management and staffing structure for the achievement of project goals?*

- Highly-qualified and dedicated field staff
- Current management and reporting structures (for example: quarterly reports flow from Project NOVA field staff to IntraHealth headquarters to EMG headquarters then to Mission) seem to impede effective clear communication with USAID, between implementing partners, and delay reporting.
- Substantial delays in replacing COP raise concerns about staffing structure especially since the current acting COP will leave in September.

8. *How cost-effective is the program? Is the current budget appropriate for project completion?*

- Achievements in management training (Area 2) and policy (Area 3) do not appear cost effective based on the share of the budget provided to these areas. The project staff were not able to provide the evaluation team with sufficient information on the costs or level of effort associated with key components of the four major program areas to enable the evaluation team to assess adequately cost effectiveness.
- One critical area where the budget appears inadequate is the community action and renovation activities carried out through Save the Children. This is exacerbated by declines in the dollar purchase value and the increase in construction/renovation costs. This past year Save staff reallocated \$8,000 out of salary to support renovation – most of the money they are allocated under the five year budget has already been spent.

9. *What are the specific recommendations to strengthen the overall program?*

- Adjust NOVA's objective to focus on use of services: "Project NOVA's objective is to increase use of appropriate and safe RH/FP/MCH services and practices in rural areas."
- Adjust corresponding activities and indicators and reallocate resources and renegotiate targets according to the newly defined objective and focused strategy (for example, reduce the 90 percent national coverage requirement and revise the one-year implementation limitation). NOVA should strategically pick a limited number of promising PHC networks (building upon already selected clinical training sites) to strengthen the chain of PHC facilities and reach health care providers that actually deliver babies.
- Engage in more focused and strategic interventions; more interventions with fewer, carefully selected, facilities.
- Increase attention to sustainability: complete the sustainability plans for marzes as proposed in contract; continue working with MOH to integrate FAP nurses into the health system; Reexamine mandate, performance and role of marz advisory boards to see how these can contribute to more realistic and sustainable programming.

10. Given the project implementation to date, should USAID/Armenia utilize the option years of the project?

- Yes. Exercise options for a three year continuation contingent upon successful revision of program objectives, targets, and action plans and also taking into account the contractual procedures and preferences at USAID/Armenia. Continue implementation into the final, fifth, year of the project, and integrate Monitoring and Evaluation activities throughout the remaining three years.
- Wrap up management training component by creating a computer based learning program from the handbook and curriculum.
- Merge Technical Area One and the Quality Improvement portion of Technical Area Two.
- Limit policy work to gaining legal recognition for the FAP nurse role.
- Decrease investment in Technical Areas Two and Three according to recommendations, and shift those resources to Technical Areas One and Four.
- Develop integrated implementation and evaluation plan for the full remaining period as opposed to ending implementation and only working on M&E activities in year five.

a. Should all four program areas be included in the option years? What are the continued areas of need in each area that should be addressed?

- Area 1 (training of nurses and equipping FAPs) and Area 4 (community mobilization) should continue.
- The Quality Improvement component of Area 2 (training of supervisors) should be merged into Area 1. The supervisory training should be brought to a conclusion. An up-to-date version of the Management Handbook could be put on CD and a computer training course developed, but otherwise the training in this area should end.
- Limit work in Area 3 (policy) to promoting the legal recognition of the role and job description of FAP nurses. Any health financing and provider payment activities should be limited to collaboration with PHCR on key RH/FP/MCH issues.
- Take resources saved from reducing work in Areas 2 and 3 to shift them to Areas 1 and 4.

b. Will the project be at a technical point after the base period so that a bidding process does not disrupt program activities?

Assuming a bidding process resulted in a new awardee, then there is a Potential for disruption due to handover and possible staff turnover and any delays associated with negotiating a new contract.

c. What are the recommendations related to any financial and/or management factors that should be considered in the decision?

- Review staffing pattern and use of resources in light of the revised program with shifts in allocation by technical areas and a revised objective.
- Once COP is in place, renew the practice of delegating responsibility and authority to the field.
- As soon as new COP is on board, initiate collaborative process between USAID and all NOVA partners to review and update program implementation strategy, monitoring, and targets to reflect those changes endorsed by the USAID mission.
- Costing study – put that all into PHCR – don't spend more on this in NOVA – NOVA doesn't have capacity.
- Change 90 percent coverage requirement

Area One: Improve RH/FP/MCH performance of rural health facilities through training and equipment provision

11. What are the objective, measurable indications that RH/FP/MCH performance of rural health facilities has been improved through Project NOVA training and equipment?

- External testing of training participants and the assessment teams' field visits confirm that NOVA's training programs are transferring RH/FP/MCH clinical information to the FAP nurses and family physicians.
- Project records indicate that there are more patient visits to health outposts where FAP nurses have been trained and the facilities improved. Unfortunately, the current records can not tell whether the visits were necessary and reflect more visits by more individuals or more visits by just a few individuals.
- Evidence collected by the evaluation team also indicates that record keeping by nurses improved after they received training.

- This information is not sufficient to show that RH/FP/MCH performance in rural health facilities has improved as an outcome of NOVA training. Performance indicators are for entire marzes, not specifically for NOVA intervention sites and they do not adequately measure change in provider performance. NOVA is equipping FAPs with basic supplies and medical equipment, despite facing some delays in local procurement.

12. What is the total number of healthcare providers who have received NOVA training, and in what areas (technical skills)?

Marz	FAP nurses trained	FAPs that have at least one nurse trained	Percentage of FAPs with a trained nurse versus the total number of FAPs in marz.
Gegharkunik	50	49	84.5%
Kotayk	30	31	100%
Lori	27	22	26.5%*
Shirak	45	45	45.9%
Tavush	34	30	69.8%
TOTAL	186	177	56.5%
*Lori marz received assistance under PRIME II, and NOVA training in Lori has therefore been less than in other marzes.			

13. To what extent has NOVA training been cost-effective, appropriate, and effective?

The self-paced distance learning design of the training program for nurses is an important factor in the success of the program. Distance learning not only costs less than classroom –based training but also allows nurses to improve their skills outside of work hours. This makes it possible for more nurses to participate in the training with supervisor support. NOVA staff estimates that the cost per nurse trained is \$550 for six month distance learning course, and the cost per doctor for a one to two week seminar is approximately \$31.

14. How have the grant recipients benefited from the financial and technical resources provided by NOVA? Are the dollar amounts sufficient to achieve the proposed results?

The benefits have been substantial in terms of renovation of accessible, quality, delivery sites and availability of technical health resources in small villages. The dollar amounts are barely sufficient to do minimal renovations, but will be under considerable pressure with the fall in the value of the dollar.

15. What are the current linkages, potential duplication, and potential additional areas of collaboration with other USAID/Armenia training activities?

Linkages include the use of renovated FAPs by Word Vision, UNICEF, Mobile Outreach Teams.

Collaboration with PHCR has begun, but it has the potential to be even more effective, especially when training family practitioners and family medicine nurses.

Duplication is minimal. Some potential in training of health providers and facility development that are minimized by continued coordination on the part of Project NOVA and other donor projects

16. What are the policy and institutional management constraints related to the training participants utilizing their skills covered in training, and how have they been addressed by NOVA?

Limitation of the role of FAP nurses can mean that some skills covered in training (such as baby delivery) can only be used in an emergency and are not a legitimate part of the FAP nurses regular duties.

NOVA works on legitimizing the role of the FAP nurse. To address institutional management constraints, NOVA also trains FAP supervisors.

17. What are the lessons learned and best practices in this area?

- Training aligned with national orders and protocols (concern about rate of decreasing competence when skills not used and training that is focused on skills that are prohibited from being used)

- Consensus of national experts should be obtained (need to work through working groups, use of high level tech expertise, use of study tours)
- PHC physicians need more frequent follow-up supportive supervision and technical feedback to apply their newly gained knowledge and skills in RH/FP.
- Competency based learning for rural nurses and PHC physicians should be expanded (need Lusine's expansion on this thought)
- The SMCS training course should be introduced into basic education through integration into the nursing school curricula (issue of sustainability, evidence based medicine, capacity building)
- The integration of the FAP RN is a systems issue and must be approached through systems planning that incorporates the entire approach to primary health care nationwide.
- It is important to focus resource use and to be strategic in the allocation – vertical vs. horizontal resource allocation

18. What are the continued areas of need to achieve this objective?

- RH/FP: Review the objective to work in RH/FP and reduce activities in this area if appropriate.
- MCH: Shift focus to provide some support for services at levels above that of the health post including increased interventions at the marz maternity center level.
- Design indicators and collect data which measure change over time in provider performance. These could draw upon the excellent quality improvement self assessment data already being collected.

Area Two: Strengthen management and supervision of rural RH/FP/MCH services

19. What are the objective, measurable indications that management of rural RH/FP/MCH services has been strengthened by Project NOVA?

- (presentation) NOVA has trained 83 participants from the first 5 marzes which represents at least 1 manager from each target facility that manages a NOVA FAP. The contract limits the project to 15-20 managers per marz. NOVA statistics meet the contract requirements.
- There is no measure of success or follow-up assessment of the manager's use of the skills learned in NOVA management training other than the following:
 - (presentation): # of Supportive Supervisory Visits at Health Posts in Tavush and Shirak: baseline .7 visits/month after NOVA, 1.5 visits/month
 - (detailed PMP): 21 percent of facilities in Shirak & Tavush have "at least one" NOVA management handbook.

20. To what extent has NOVA institutionalized a quality management system for rural RH/FP/MCH services?

- a. Piloting QI System in "select" facilities. Detailed PMP indicates that 30 sites total will be included, but they expect 25 to have functioning QI systems by the end of the project. Target for Tavush & Shirak was 25 and follow-up data shows that only 10 are operational. Next two marzes, Kotayk and Gerharkunik's target went down to 9. Why? The June report indicates that only 3 sites total will be selected for the new marzes. What was the rationale for the drastic reduction in participating facilities from the first zone to the third? NOVA's response:

At the initial stage of the QI initiative it was decided to involve two MA/HC from each marz (Shirak, Tavush and Lory) with 2-4 FAPs attached to each (figure 25 in the PMP is based on the following calculation: 6 MA/HC + 2-4 attached FAPs per each MA/HC). At the end of implementation FY1 an external assessment was conducted for evaluating Project NOVA QI sites. One of the goals was to identify the facilities that had made progress during the pilot program in order to continue the QI initiative implementation in these sites. In the weakest MA/HCs the project didn't continue for the next FY. So, the three strongest QI sites from our first year target marzes continue to be involved in the project, while the other 3 dropped out. Three MAs/HCs from new marzes (Gegharkunik, Kotayk) were added to the existing 3 (from Lory, Shirak and Tavush). So in total currently there are 6 QI sites (MA/HC) in five marzes. To assure consistency in the calculations and avoid the confusion on the PMP, we will only include the legal PHC facilities in the count for the QI sites (in other words the number of FAPs won't be mentioned). One QI system is a MA/HC with all FAPs attached to it.

- Increase in quality of care is done by facility self assessment. Baseline for the first two marzes was 60 percent; target was 80 percent, follow-up 84 percent. Self assessment includes a) access to care, b) community involvement, c) management, d) infrastructure, 3) technical competence.
- The staff underscored that institutionalizing a quality management system has been very challenging and heavily dependent upon the managers. Quality is difficult for doctors and facility managers to grasp and the benefits are not immediate or tangible.

21. To what extent has NOVA developed local capacity for monitoring and evaluation?

- The staff highlighted how difficult it is for NOVA staff to monitor this component much less the beneficiaries. There has not been any concrete activity focused on developing local capacity for monitoring and evaluating the QI or management systems.

22. How has NOVA incorporated anti-corruption strategies? Has this been successful?

- Management training touches on anti-corruption (transparency, accountability, etc). No measurement of success
- Only one recommendation from the Health Systems Review Study has been implemented. The staff indicated that there is no specific reason why other recommendations had not been implemented other than they just had not gotten to it yet.
- NOVA has integrated anti-corruption in to its activities in the following ways:
 - Increased public awareness on available free services (i.e.: publishing the BBP poster and brochures)
 - Advocating for increased remuneration for nurses
 - Initiating the FAP costing study
 - Incorporating transparency and accountability into the management handbook

23. How has NOVA contributed to the improvement of quality of care?

- The presentation says that NOVA's QI process helps achieve the MOH quality criteria including reducing maternal and infant mortality, increasing the number of women who have all four ANC visits, Increasing the number of women who have first ANC visit during the first trimester, and reducing the number of pregnant women with premature delivery. The only data available related to NOVA intervention on QI is:
 - Percentage of women receiving ANC in first trimester (for Shirak & Tavush): 57.7 percent baseline, 60 percent target, 53.8 percent follow-up.

NOVA's Explanation:

As indicated in the definition of this indicator "percent of pregnant women receiving ANC visit within the first trimester", it is calculated as percent of pregnant women, who received ANC visits within their first trimester in relation to all pregnant women receiving ANC visits. The baseline assessment for Project NOVA year one marzes was conducted in March 2005 and the follow-up assessment was conducted in April 2006. Taking into account the assessment methodology, according to which we interview a randomly selected sample of women, who delivered within the preceding 6 months from the date of survey, the women who were interviewed during the follow-up assessment did not have an opportunity to be influenced by Project NOVA interventions. More specifically, women who were interviewed in April 2006 were the ones who delivered during October 2005-March 2006, who were in their first trimester beginning from February-April. As Project NOVA nurse training, which would have the biggest impact on this particular indicator, during our first year of implementation in Shirak and Tavush marzes began in May, 2006, it appears that some women who were assessed as part of the follow-up time-wise were left out from our intervention. Unfortunately, our records weren't collected in a way, so that we'd be able to adjust our calculations basing it on a sub-sample of women who were in their first trimester during April-June only, to be able to demonstrate at least partial impact of our interventions.

- Percentage of facilities with adequate record keeping: 55 percent baseline, 79.8 percent follow-up

24. What are the policy and institutional management constraints related to management training, and how have they been addressed by NOVA?

- NOVA has not experienced any policy or institutional constraints related to management training. Facility managers are requesting the training as Marz level officials and other facility staff.

25. What are the lessons learned and best practices in this area?

- Reinforcement of the paperwork indicating that the RH/FP/MCH services for pregnant women are free
- Introduction of the supportive supervisor basic skills
- Theory and the real picture “provided” during the training
- Involvement of marz health authorities in the training
- QI helps to realize the strength of the QI team

26. What are the continued areas of need to achieve this objective?

- Reduce investment in management training activities and hand this component over to MOH and/or PHCR
- Place greater emphasis on Quality Improvement, and merge this component with Technical Area One.
- Hand over anti-corruption activities to PHCR.

Area Three: Improve RH/FP/MCH policy formulation and implementation

27. What are the objective, measurable indications that RH/FP/MCH policy formulation and implementation has been improved by Project NOVA?

- Infection Prevention Protocols developed by NOVA have been adopted by the GOAM.
- 80 percent of all facilities in the zone 1 marzes are using updated RH/FP/MCH protocols that were developed under PRIME II and updated and approved by the MOH under NOVA.
- STI Integrated Care Management training curriculum developed by NOVA that includes the protocol for treating STIs.
- NOVA contributed to the job description for community/health post nurses (Ministerial Decree No. 940 10/14/2005) that is now pending with the Ministry of Justice.

28. What are the lessons learned and best practices in this area?

- Consideration of the roles and interests of all stakeholders
- Close involvement of key national counterparts at all stages of the protocol/guidelines development
- Strong partnership with other implementing partners
- Very difficult area to work in

29. To what extent has NOVA improved healthcare financing/budgeting systems for rural RH/FP/MCH services?

- NOVA is undertaking a costing study on services provided at health posts including an analysis of the supervisory facility budget. This activity is on-going. NOVA expects to use the findings of the study to develop a policy “push” for improving financing of the FAPs. Further thought needs to be given to how NOVA will use the data itself versus pushing it up to PHCR.

30. What are the lessons learned and best practices in this area?

It is going to be very difficult for NOVA to make a major improvement in the healthcare financing/budgeting systems for rural RH/FP/MCH because of the nature and narrow focus of the program.

31. What are the continued areas of need to achieve this objective?

NOVA's primary policy emphasis must be on the legal recognition and government approval of the job description for FAP nurses. NOVA's involvement in health financing should be limited to collaboration with PHCR on only a few specific RH/FP/MCH issues. In total, NOVA should reduce emphasis and level of effort in this component and transfer freed resources to technical areas one and four.

- Limit policy work to promoting legal recognition and the role of FAP nurses
- Limit activities in health financing and provider payment policies to collaboration with PHCR on a few key RH/FP/MCH issues
- Reduce emphasis in this component and transfer resources to other technical areas.

Area Four: Increase consumer demand for services through community education and mobilization

32. What are the objective, measurable indications that consumer demand for services has been increased by NOVA community education and mobilization?

- During the site visits, the team heard many anecdotal reports of increased demand and use of services after NOVA activities, specifically after FAP renovation and equipment provision. In one FAP, a nurse mentioned that community members were scared to come for services before the renovation activities took place. Although this is not directly related to community education, the renovations are a result of community mobilization activities and community contributions (both in-kind and financial)
- While the amount of the community contribution varies, NOVA has done an excellent job in promoting ownership of the health posts.
- There is not a direct indicator that measures consumer demand. The only related indicator is “percent of clients satisfied with services by program area and target facility.” This is measured using a client satisfaction survey to measure client satisfaction with 6 fields: (a) quality of care, (b) privacy/confidentiality, (c) attitude of personnel, (d) affordability of services, (e) level of comfort in getting information, and (f) cleanliness. While it may be helpful for clients to feel that their satisfaction is important, the baseline value for the year one marzes was already 81.6 percent, with a target of 90 percent. It seems that a more direct indicator, such as the number of referrals made by the FAP nurse each month, would be a more useful measure.

33. To what extent has Project NOVA engaged community participation, including local leaders and community members?

- NOVA has done an excellent job engaging community participation. The Project successfully creates health action groups (HAGs) in each of the target marzes, and involves them in all aspects of project activities in the respective communities. The members of these groups include the head of the supervisory health facility, community mayor, FAP nurse, local teacher, community council members, and other community members. These HAGs are active participants in the community assessments, identification of health needs, and development and implementation of the community action plans. During the site visits, all of the HAG members seemed engaged and excited about the project. Communities contribute to FAP renovation through both financial and in-kind donations, creating greater ownership of the health posts. NOVA also includes community education in their training sessions.
- There is a 50 – 80 percent contribution of the community in FAP renovation.
- Once the HAGs have been established by NOVA, in some cases, the groups have continued to exist, and to be utilized for other community activities. For example, in one target facility, after completing the renovation of the FAP, the HAG has participated in the restoration of a historic monument in the community, a water pipeline project, and a drainage project. This is an excellent example of the potential for sustainability of these groups. In addition, the HAGs clearly understand that they are responsible for the ongoing maintenance of the FAPs once Project NOVA completes its activities.
- The current indicator that is used to measure community participation is the percentage of the financial contribution made by the community for healthcare. A new proposed indicator is the number of community health action groups developed, with a target of 30 per marz.

34. To what extent has NOVA institutionalized community RH/FP/MCH education activities?

- While NOVA has promoted community RH/FP/MCH education activities through trainings, there does not yet appear to be institutionalized activities in all communities. The number of activities seem to vary by community, with some FAP nurses engaged in a variety of activities, while others simply provide NOVA brochures.
- Currently, NOVA records the percentage of clients aware of free RH/FP health services during an annual facility assessment. In year one marzes, the baseline value was 30 percent, and the follow-up value was 48 percent. The target of 60 percent was not reached. Thus, in the year two marzes, the target value was lowered to 55 percent. While the NOVA staff explained that the target was lowered after the first year target was not met, NOVA introduced its posters and brochures with information on the Basic Benefits Package and rights of free services during year two. Therefore, it seems that the year two target should be higher, with the assumption that these posters and brochures will raise the awareness of free services.
- NOVA has proposed a new indicator of the “number of health talks, discussions conducted in each marz,” that would help to measure the educational activities in each community.

35. How has NOVA utilized private sector/community resource leveraging?

- In the communities in which NOVA works, there is a requested community contribution (financial or in-kind) for FAP renovation activities. The PMP has a target of 45 percent for the community contribution in Gegharkunik and Kotayk.
- In addition to this contribution, NOVA also engages private individuals with small businesses in the community, who often make donations to help with community activities.

36. What are the lessons learned and best practices in this area?

- Strong, replicable models of community mobilization from Save the Children

37. What are the continued areas of need to achieve this objective?

- Greater emphasis on community education activities
- Greater emphasis on sustainable community activities with the HAGs
- Potentially increase funding in this area to allow for better quality construction materials

ANNEX E: PROJECT NOVA COMPLIANCE WITH CONTRACT TASKS

Technical Approach Overview and Overall Goals of Project NOVA (Section A "Overview" and Section B "Expansion Strategy" in contract).			
Tasks	Complete/ Ongoing	Incomplete	Notes
Improve quality in 90 percent of rural facility networks offering basic reproductive and maternal healthcare in Armenia.	√		On target for this, though depends on how "rural facility networks" are defined; coverage statistics vary by marz.
Sign MOU with MOH outlining the ways in which the project and MOH will work together	√		
Conduct intensive data collection using simple checklist to map all primary health care facilities, determine their functioning status, and relative need for improvements	√		NOVA conducts facility/community mapping to select 30 communities per marz to implement the program as part of Area 4.
Use GIS software to develop strong monitoring system	√		GIS software used and system in place, but indicators, data collection, and data analysis need improvement.
Work with marz leaders to complete the action plans and transition to sustainability plans that require minimal additional support.		√	Action plans have been developed, but sustainability plans have not been done, even in Year One marzes
Provide technical assistance to key national institutions (MOH, marz officials, BMC, NIH, NGOs, medical professional associations) in each of the four technical areas to strengthen their programs and services	√		Technical assistance was provided to the key national institutions through their participation in a 3-day technical information-sharing workshop for the national team of trainers in order to upgrade the team on specific RH/FP clinical skills transfer, clinical practice supervision, and professional feedback and coaching skills.
Create network of "champions" with members such as marz health directors or mayors from each marz	√		
AREA ONE: Improve RH/FP/MCH performance of rural health facilities through training and			

equipment provision.			
Tasks	Complete/ Ongoing	Incomplete	Notes
Bring together a team of 30 national and regional trainers to form a "national RH/FP/MCH training team"	√		
Identify three senior-level midwives and nurses from Basic Medical College faculty to join the team	√		
Seek "accreditation" for all members of the training team	√		
Training and curricula			
Provide intensive TOT for government marz-level FM training centers and preceptors for all 37 [rural or partially rural] rayons		√	NOVA conducted trainings in the FM training center (Shirak marz), but has not provided intensive TOT
Use PRIME II training materials (8-module distance learning, 10-day RH/FP curriculum for FM, 5-day STI training)	√		
Update PRIME II training materials for rural nurses to incorporate counseling and STI referral	√		
Conduct five-day STI training program for physicians and nurses in target facilities	√		
Disseminate approved job aids and algorithms for health care providers		√	NOVA has developed BBP posters and brochures, and training modules, such as the Safe Motherhood Clinical Skills training, includes checklists and job aids, but NOVA has not disseminated approved job aids or algorithms for health care providers.
Incorporate updated curricula into pre-service curricula for nurses and physicians	√		NOVA has engaged Basic Medical College to incorporate NOVA curricula into nursing medical college's pre-service curricula.
Include anti-corruption components in all provider training		√	Anti-corruption is mainly addressed through providing information on the BBP. While it is discussed during management training, there

			is not a specific component focused on anti-corruption in NOVA training.
Address gender issues (empower female providers; sensitize providers; ensure gender-sensitivity; cultivate female leaders; develop gender tools)	√		NOVA has received TA focused on gender, and has plans to incorporate gender into all areas
Work to incorporate gender training into WB retraining, BMC nursing curriculum, and BMC distance learning		√	
Marz implementation			
Determine inventories at each facility, doing needs assessment and cost estimates for procuring desired supply	√		
Strengthen at least 3 clinical training sites in each marz: Central Maternity Hospital, centrally located outpatient RH/FP/MCH facility, nationally accredited FM training center	√		
Prepare clinical sites for training	√		
Introduce updated service protocols, train staff, select trainers and preceptors, provide training equipment; technical updates on national protocols	√		
Facility mapping			
Visit each facility in the marz and determine a quality score	√		This is done in each PHC facility, including FAPs
Create a user-friendly visual database to track (geographic locations, conditions, data on outcome indicators)	√		Website: http://www.nova.am/Maps/200/index.html
During last 3 years of project, transfer database to MOH for management	√		On target: In process with MOH and discussing possible technical assistance to ready MOH for database transfer.
Training of ambulatory and HP providers			

Year one: train approx. 10 additional ambulatory physicians and nurses, and 20 HP nurses in Lori	√		In Lori, Project NOVA trained 23 FAP nurses and 5 ambulatory nurses in Safe Motherhood Clinical Skills and 6 physicians in management training.
Year one: Conduct 10-day FM training for ambulatory physicians and nurses in Shirak and Tavush	√		10 FP trained in Tavush and Shirak marzes using two 10-day courses
Train up to 45 HP nurses in each marz using distance learning	√		Implemented distance learning for 45 nurses in Shirak, 35 in Tavush, 50 in Gegharkunik, and 30 in Kotayk.
Train additional nurses through 37 FM clinical preceptors		√	
Equip health posts using the established set of minimum equipment and supplies	√		Mostly completed, with some delay of distribution due to local procurement delays. 99 health posts equipped in year one, and an additional 80 in year two.
National Capacity Building			
Collaborate with WB retraining of 950 physicians and nurses to incorporate strong RH/FP clinical skills component		√	This is in process.
Update skills and curriculum used by NIH nursing faculty			NOVA provided STTA that included a clinical skills TOT workshop for selected members of the nursing working group, including NIH nursing faculty representatives and faculty from the Gyumri State Medical College. Following this activity, a newly established working group drafted a curriculum to integrate the Safe Motherhood Clinical Skills training program into the pre-service basic education. This first draft is currently under peer revision by the Yerevan State Basic Medical College faculty. The next steps include involving Ministry of Health officials in the recognition and support for piloting the implementation of this newly-created curriculum in the program of Gyumri State Medical College.

Work with Basic Medical College to test the incorporation of distance-learning in 3 marz-level medical colleges	√		Working group convened to review regional medical college curriculum and to integrate CBL program. Proposal to be submitted for USAID and MOH approval.
AREA TWO: Strengthen management and supervision of rural RH/FP/MCH services.			
<u>Tasks</u>	Complete/ Ongoing	Incomplete	Notes
Management handbook and training	√		
Year One: Establish a national working group of central and marz experts to create a PHC management handbook, including gender issues	√		
Distribute handbook to all PHC managers	√		The handbook is being distributed to training participants, and mailed to other health facilities as NOVA does training in the zones (mailed handbooks are not counted in the number distributed when NOVA reports on performance management indicators). Current project thinking is that the Mgt Handbook working group (that includes representatives from the SHA and the MOH) will update the handbook and turn it into a computer-based training course. The World Bank and PHCR will be providing facilities with computers on which the facility staff could take the NOVA training course. Long-term sustainability in terms of updating has not been seriously considered yet, but the current thinking is that the handbook will eventually be handed over to either the MOH for updating and distribution after NOVA.
Include accountability and transparency measures in the management handbook and modular training courses	√		Management training touches on anti-corruption; however, there is no measurement of success.
Conduct management and leadership modular training for 15 - 20 leaders in marz health system based on	√		Total number trained for 5 marzes is 83 so it satisfies the average of 15 – 20

management handbook			
Quality Improvement			
Pilot practical RH/FP/MCH quality improvement methodologies in selected facilities in each marz	√		Pilot includes self-assessment, action planning, and monitoring.
Address issues such as poor indicators in antenatal or postpartum care use, home deliveries, low client volume for RH/FP services, poor vaccination rates.		√	These issues are not addressed by NOVA. Currently, NOVA only uses one indicator relevant to these issues: the "percentage of women receiving ANC in first trimester." However, even this indicator is not measured in a way to assess the impact of NOVA interventions.
Involve community leaders, clients, and marz level officials	√		Quality Team includes head of Ambulatory, medical staff and a community representative. All members are clients/residents of the target area.
Incorporate key indicators related to STI services into quality improvement programs		√	There is no STI indicator in QI self assessment/monitoring.
Develop QI and supervisory tools, including checklists to assess STI risk assessment, condom promotion, and sample taking.		√	Condom promotion was carried out in QI target sites as part of the family planning, but NOVA staff had never heard of this requirement and it has not been done.
Conduct intensive capacity-building of marz-level officials to understand and accept new QI methodologies.	√		NOVA creates marz advisory boards that include marz-level officials and undertake detailed situational analysis, allowing marz-level officials to become comfortable in QI methodologies. The success of these interventions is heavily dependent on the participation and will of the officials.
National capacity building			
Collaborate with NIH and AUA to reinforce existing management training programs		√	Nova collaborates with NIH and AUA on many aspects of NOVA, but the staff said that they have not worked to reinforce existing management training programs in

			these institutions.
Explore the possibility of establishing marz-level computer-based distance learning programs (with Project Harmon)	√		2005 – 2006 Quarter 3 report says it is under exploration
AREA THREE: Improve RH/FP/MCH policy formulation and implementation.			
Tasks	Complete/ Ongoing	Incomplete	Notes
Influence national policy development			
Provide guidance and development of specific policies and protocols	√		Infection Prevention Protocols adopted, 80% of facilities are using updated RH/FP/MCH protocols developed by NOVA, NOVA also contributed to the job description for community/health post nurses (Ministerial Decree No. 940 10/14/2005)
Identify and work with MOH to develop legislative reform "champions"	√		Done for individual policy activities (i.e.: includes MOH representatives in the FAP Review working group)
Establish small working groups ("think tanks with authority"), including MOH, to draft policies and protocols, including: clinical training guidelines, STI practice guidelines, and guidelines on what RH/FP skills can be practiced by a family physician	√		In each case a working group including the MOH, NGOs, donors, and other relevant parties participated in the development of the protocols/guidelines. The terminology "think tanks with authority" was not used, but the concept was upheld.
In collaboration with the 'think tank with authority':			
Create a Policy Review Working Group (collaborate with public and private sector, other donors, other policy makers)	√		A Policy Review working group was established for the health post review. It included other donors, the MOH, SHA, and the Nursing Association.
Review current legislation and government orders and compare to real	√		
Conduct analysis to recommend additional policy reform activities required	√		a) Armenian RH/FP Sector System Review, b) Health Post Review, c) Costing Study
Develop a work plan for policy reform and work with Working Groups to design recommendations		√	This has not been done. It could be done if necessary in the next phase of the project.

Build capacity at the local level			
Develop marz-level capacity to develop, sell, implement, and monitor homegrown solutions to reform problems		√	
Involve public and private sectors in reform and implementation		√	
Engage the Private Sector			
Conduct strategic planning exercises for private-public sector partnerships (<u>in first 3 months of project</u>)		√	
Strengthen the role of Armenian Association of FM and Association of Nurses, and Assoc of Midwives.		√	NOVA collaborates and supports each of these associations, but has not provided TA to strengthen them.
Engage the private sector in policy reform regarding insurance		√	The World Bank has halted the process because it does not feel that the country is ready for mandatory health/medical insurance.
Improve national-level healthcare regulatory activities			
Legal reforms (draft Health Law)	√		Presentation indicates that NOVA contributed to the Law on Health
Strategic planning and regulatory reform	√		NOVA contributes technical advice on RH/FP/MCH issues.
Partners with USAID Armenia Legislative Strengthening Project	√		ALSP published the draft law and NOVA helped distribute it. NOVA also commented on the health law via ALSP and participated in the hearings.
Ensure that the draft health law and other legal initiatives reflect RH/FP/MCH needs of rural families	√		NOVA provided extensive comments through ALSP on the health law and attended all relevant hearings
Sponsor joint activities (e.g.: sponsor RH/FP/MCH hearings, educate Deputies etc.)		√	
Empower marz and local stakeholders to demand effective regulatory development in service quality, licensing and accreditation, management and		√	

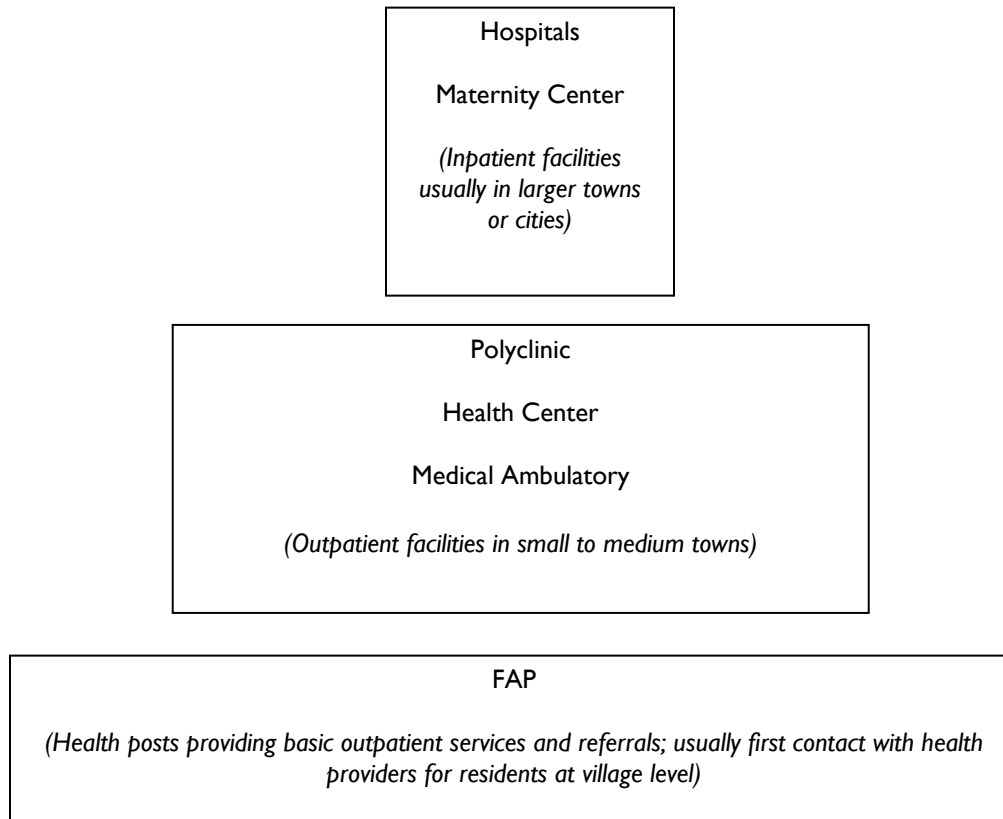
supervision, and anti-corruption.			
Enhance the role of medical association in policy development		√	NOVA coordinates with the associations, but has not done anything specifically to enhance the roles.
Advocate for higher pay and benefits for nurses (to reduce bribes)		√	Contributed to the FAP nurse job description "package" that is with the Ministry of Justice for approval. While this job description does not include a request for increased salary the NOVA health post review has a specific section on Cost and Compensation that may contribute to this activity.
Incorporate gender equity into policy formulation and the regulatory environment			
Incorporate gender equity into policy formulation and the regulatory environment		√	NOVA just completed the gender training that included marz level authorities, partners, and policlinic heads. There was a delay in the gender training which has resulted in delays in all of the gender activities.
Target national and local levels		√	
Analyze and address gender issues for both service delivery and service utilization		√	
Adapt and use IntraHealth gender tool to raise awareness		√	
Incorporate gender analysis into tools developed by the "think tank with authority"		√	
Additional policy/protocol activities			
Strengthen clinical management protocols, specifying how services should be offered, by whom and to whom.	√		The presentation says that 80% of the facilities are using updated RH/FP/MCH protocols that were updated by NOVA (developed under PRIME II). NOVA contributed to job description outlining the legal role for FAP nurses that is currently with the Ministry of Justice.

Work at the marz level to develop innovative dissemination approaches, including algorithms and pocket guides.		√	NOVA has produced brochures for patients. No algorithms or pocket guides for facility staff related to protocols.
Ensure that final MOH regulations are updated and made available to the end users (e.g.: STI treatment guidelines)	√		NOVA makes the protocols and guidelines they contribute to available to end users.
Collaborate with other donor-funded efforts to ensure that policy reforms related to healthcare finance are developed		√	Participate in PHCR meetings. No policy reforms have been developed by PHCR so this has not been accomplished.
Support performance-based contracting by SHA, using ASTP standards		√	Activities need to be done in coordination with PHCR and at the request of PHCR.
Serve as a technical resource and advocate for broadening the official role of family physicians, nurses, and HP providers	√		Contributed to the job description that broadens the role of nurses
Monitoring and Oversight			
After development of protocols, work w MOH to establish appropriate oversight monitor institutions		√	
Involve marz representatives in "think tanks with authority" to develop monitoring & oversight		√	
AREA FOUR: Improve consumer demand for high-quality services through community mobilization and implementation.			
<u>Tasks</u>	Complete/ Ongoing	Incomplete	Notes
Assess the level of perceived corruption through informal surveys		√	
Communicate the rights to free services	√		BBP posters and booklets at each facility; also conduct annual facility assessments during which they record the % of clients aware of free health services. The targets are low (60% and 70%), and differ for each marz
Create health action groups (HAGs) to: (a) Solve local problems of health facility quality and access; and (b) advocate to marz authorities for transparent and	√		Project NOVA has emphasized the importance of transparent and accountable services from referral facilities in collaboration with marz

accountable services from referral facilities			health authorities.
Ensure gender equity in Health Action Groups	√		
Educate women about their rights during community meetings	√		
Marz implementation			
Assess communities for potential involvement using selection criteria	√		
Conduct an assessment of health provider and community perspectives on health and quality care needs (focus groups)	√		
Facilitate joint community and provider stakeholder meetings to review data from assessment	√		
Develop an action plan with each community/facility group, including tasks and responsibilities	√		
Implement action plans (may include: renovation, community health education activities, suggestion boxes, HAG training, community-based health financing schemes)	√		
Provide ongoing TA and monitoring of community action plans	√		Yes, but usually ends with completion of FAP renovation
Work with local marz-based NGOs (RH/ & MCH) to create replicable models for reaching communities	√		
Conduct education activities based on community interest (may include: local health education volunteers, distribution of materials, out-of school youth activities, men)	√		Occurs, but not consistently in all communities; depends on community interest

ANNEX F: ARMENIA RH/FP/MCH PHC NETWORK

Health Facilities and Hierarchy up to the Marz Level



RH/FP/MCH PHC Network in Armenia* (excluding Yerevan)

RH/FP/MCH PHC Network in Armenia* (excluding Yerevan)

Maternity Houses, Departments: 41

Polyclinics/women's consultations: 50

Health Centers: 33

Ambulatories attached to Polyclinics: 102

Independent ambulatories: 101

Family Medicine centers: 69

**from Project NOVA's Contract, Technical Approach Overview*

ANNEX G. PROJECT NOVA ORGANIZATION CHART

(PDF FILE)

ANNEX H. DESCRIPTION OF USAID PROJECT PRIME II.

From PRIME II website: <http://www.prime2.org/prime2/section/60.html>

USAID funded global project PRIME II

The USAID-funded global initiative, PRIME II, ended on September 30, 2004. PRIME II worked in over 25 countries and provided technical leadership in areas such as Performance Improvement, Post abortion Care, Responsive Training and Learning, and Family Planning and HIV/AIDS Integration, and implemented activities in reproductive health focus areas.

PRIME II in Armenia

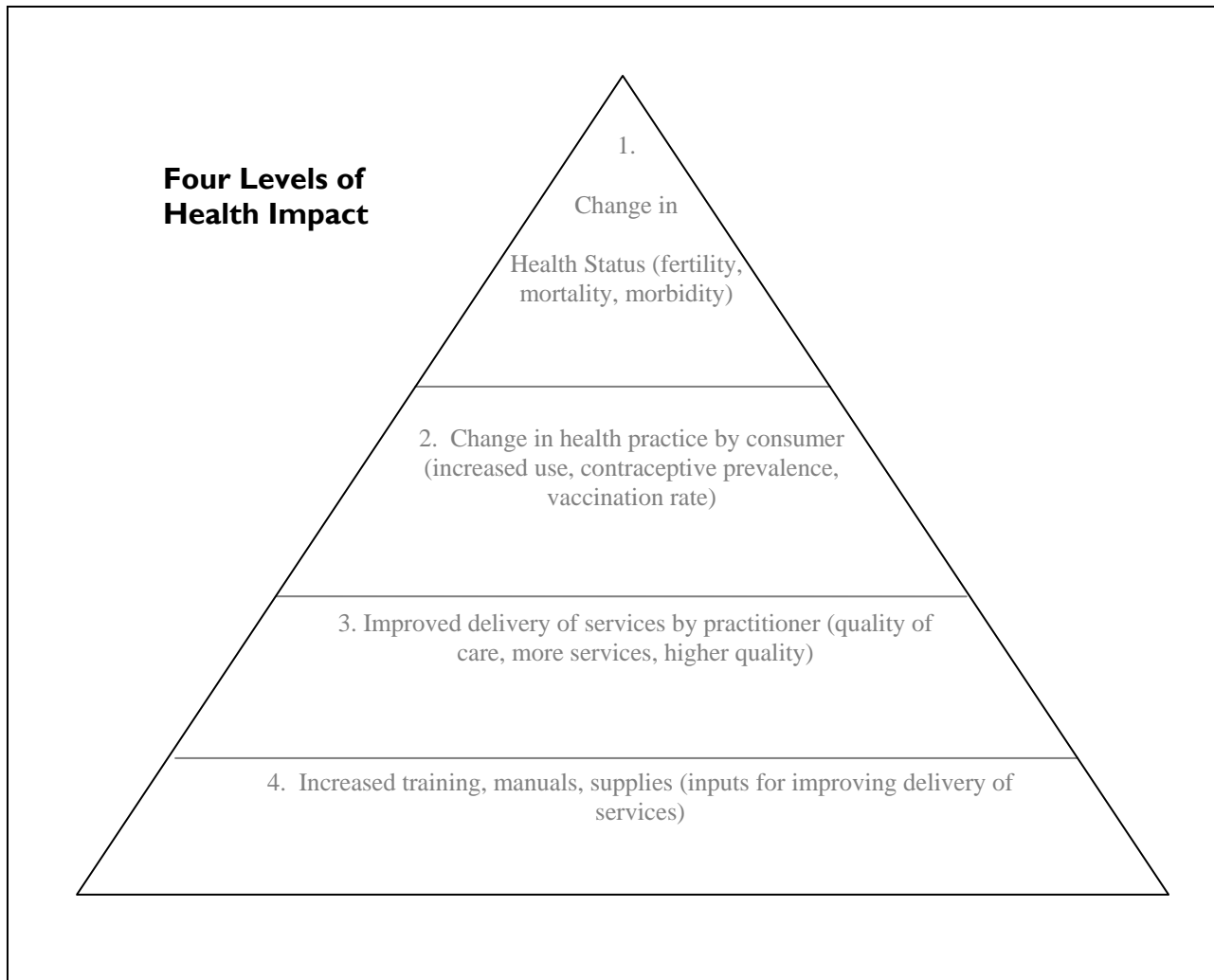
PRIME II's work in Armenia focused on health sector reform, with an emphasis on improving primary-level reproductive health (RH/FP) care. PRIME assisted the Ministry of Health (MOH) to guide the primary healthcare system toward client-focused service delivery. PRIME concentrated on building national capacity through updating policies and guidelines and improving training and human resources, and on demonstrating new models of enhanced service delivery in targeted primary care facilities in Lori, one of Armenia's most populous provinces.

PRIME II's Armenia program encompassed four integrated components: Improving the Performance of Rural Facilities and Providers; Integrated Management of Sexually Transmitted Infections; Strengthening Family Medicine Training; and Improving Provider Response to Violence against Women.

For more information, go to

<http://www.prime2.org/prime2/pdf/PRIME%20II%20Final%20Report.pdf> to read the report [Improving the Performance of Primary Providers in Family Planning and Reproductive Health: Results and Lessons Learned from the PRIME II Project, 1999-2004.](#)

ANNEX I: FOUR LEVELS OF HEALTH CARE IMPACT



ANNEX J. DATA COLLECTION INSTRUMENTS: INTERVIEW QUESTIONS AND SITE VISIT CHECKLISTS.

Contractor HQ Interviews

Project NOVA Evaluation

DRAFT July 2006

As part of the assessment, the team is arranging interviews with Project NOVA management and oversight staff at Emerging Markets Group (EMG), IntraHealth International, and Save the Children. During these interviews, the team hopes to get an understanding of each organization's role in implementing Project NOVA and the general management policies.

Possible Interview Questions

1. Describe your role for Project NOVA.
2. In general terms, please describe the management structure of Project NOVA and how management responsibilities are divided between the field and headquarters, and between EMG, IntraHealth International, and Save the Children.
3. What are the names of other people at your organization who are managing Project NOVA?
4. Describe your understanding of the current working relationship between EMG, IntraHealth International and Save the Children and also the relationship between EMG and the USAID/Armenia Mission.
5. What is your understanding of the factors that led to the delay in recruiting a Chief of Party for Project NOVA?
6. In your opinion, how would you assess project NOVA so far – what's working well, what could be improved, any corrections that have been made, and current challenges and successes.
7. Is there anything else you'd like us to know?

Client Checklist
Project NOVA Evaluation
DRAFT July 2006

1. Frequency to clinic

- When was the first time to clinic?
- How often are the visits (has this altered?)
- Anyone accompany you to clinic?

2. Have you noticed a change in services in the last two years at this clinic?

- Availability of products
- Counseling services provided
- Clinical services
- Knowledge of staff increased
- More options offered
- Facility's appearance
- Provider to client relationship altered

3. Satisfaction of services being provided at facility-anything to improve?

- Questions answered
- Knowledge increased
- Desired health outcomes achieved (preferred FP method, healthy pregnancy)

Facility Visit Checklist

Project NOVA Evaluation

DRAFT July 2006

- 1. Facility Characteristics:**
General atmosphere, layout of facility, maintenance, area of privacy for counseling

- 2. How has this facility been improved since this project began? Are these upgrades sustainable?**

- 3. Facility Infrastructure:**
Electricity supply, heating system, water supply, refrigerators, toilets, sterilization area

- 4. Supplies Available:**
Examination gloves, first aid kit, pregnancy test, contraceptives, drugs, infection prevention (containers to dispose of syringes/soiled linens, antiseptics), a system to monitor supplies

- 5. Equipment Available:**
Infant/adult scales, examination tables, record keeping (client records, registers)

- 6. With what you currently have, is there anything essential that is needed to continue?**

Provider Checklist
Project NOVA Evaluation
DRAFT July 2006

1. **What is your current job at the clinic?**

2. **Do you know what roles and tasks you have to carry out at work? What are your duties?**

3. **What motivates you to work at this clinic? Is your work challenging? Satisfying?**
Non-monetary incentives, ambitions

4. Training Provided

- Which training programs have you participated in?
- When was the first time you received training?
- When was the last time you received this training?
- How long is the typical training?
- How often do you receive training?
- How useful do you find the trainings to be?
- How frequently do you utilize the training you receive in your daily work?
- Do you think you need additional training? On what? How often to maintain the current skills level?
- Has this training affected your relationships at work? With patients?
- Do you see improved health in the community? In what areas?

5. Organizational Support Provided

- Does your supervisor support your career development through the trainings?
- Co-workers supportive of trainings?
- Have you ever attempted to change a policy at work?
- Tools available to continue to learn on own time?
(Nurse/midwife training modules, materials on health education, UNFPA materials, literature, posters, guidelines-ask to see *these*)

ANNEX K. TOPICS INCLUDED IN THE NOVA MANAGEMENT HANDBOOK.

Organizational Structure

What is the definition of primary health care?

What are the functions of health care delivery system at different levels?

How is the rural primary health care system organized?

The main types of PHC facilities and their main characteristics

How is the reproductive health care implemented?

How is pregnancy care organized in rural areas?

Do pregnant women have rights for free antenatal care?

Appendices

Appendix 1: The Framework of Reproductive Health Responsibilities for Midwives, FAP Nurses, OB/GYNs and Family Physicians

Appendix 2: The content of laboratory diagnostic examinations for pregnant women of low and high risk groups

Appendix 3: Home-Based Antenatal Care Card

Appendix 4: Prenatal Care and Referral Card

Quality Improvement

What is the definition of quality of care?

How is quality of care measured?

How can managers undertake quality improvement activities at their facilities?

Quality Improvement Main Stages

What tools exist to assist in improving quality of reproductive and child health care?

What are the necessary conditions for successful quality improvement?

Appendices

Appendix 1: QI self assessment and action planning tool

Appendix 2: Client feedback card

Appendix 3: National indicator monitoring by team

Supportive Supervision

What is the definition of supportive supervision?

What are the essential components of the supervision system?

How do you conduct a supervision meeting (visit)?

Financial Management

What is the definition of financial management?

What is the structure of financial flows in primary health care system?

What is budgeting?

What are the types of expenses and their priorities?

What is the volume of the “State guaranteed free primary health care at ambulatory/policlinic levels”?

What is the scheme for reimbursement of expenses by the government?

How are the costs and revenues of health facility formulated?

What are the main types of taxes paid by a facility?

Appendices

Appendix 1: Content Outline for the Contract on State Guaranteed Free Health Care

Appendix 2: Income Tax Calculations

Appendix 3: Rates of Social Contributions Paid by Employers for the Employees

Legislative Environment

What is the legal basis for health protection?

How is the provision of health care regulated?

Legal responsibilities for unofficial health care provision to population?

What are the regulations in the sphere of Family and Reproductive Health?

What are the main issues of the new draft Law “On Health Care”?

What is organizational ethics and why it is important?

How are the internal relations within health facility regulated?

Which are main supervisory bodies of health facility?

How are conflicts regulated in the facility?

What bodies defend Human Rights prior to the plea process?

Appendices

Appendix 1: Contract termination terms by the employer

Appendix 2: Conditions when employment contract termination is illegal

Appendix 3: Eligibilities of Control Chamber

Training of Health Care Managers in the Republic of Armenia

RA National Institute of Health

How is the training of health care managers in RA National Institute of Health implemented?

What is the structure of the faculty?

How is the graduate and post-graduate training of nursing managers (chief and senior nurses) implemented?

Health Management and Administration programs at NIH

Where to apply for training?

American University of Armenia

How is the training of health care managers implemented in American University of Armenia?

Who is eligible to apply to the training courses?

Training courses

Where to apply for training?

ANNEX L. PROJECT NOVA PERFORMANCE MANAGEMENT PLAN (PMP).