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# Performance Evaluation of the Health Systems Strengthening (HS-STAR) Project

## Mid-term Evaluation Report

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**May 2013**

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Karine Boyakhchyan and Susanna Onanyan through Social Impact, Inc.

*Cover Photo: Courtesy of HS-STAR Project, May 2012.*

# HEALTH SYSTEMS STRENGTHENING PROJECT (HS-STAR): MID-TERM PERFORMANCE EVALUATION

## EVALUATION REPORT

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Evaluation of Five USAID/Armenia Activities

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# ACRONYMS

BBP	Basic Benefit Package
CME	Continued Medical Education
CPG	Clinical Practice Guidelines
COP	Chief of Party
DEC	Development Experience Clearinghouse
ECA	Europe Central Asia
FP	Family Planning
FY	Fiscal Year
GOA	Government of Armenia
HS-STAR	Health Systems Strengthening Project
LOE	Level of Effort
LMI	Low Middle Income
MCH	Maternal and Child Health
MIDAS	Medical Information Data Analysis System
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NOVA	Innovation in Support of reproductive health
NCD	Non-Communicable Disease
NTP	National TB Program
PD	Project description
PHC	Primary Health Care
PHCR	Primary Health Care Reform
PMP	Performance Management Plan
PPP	Public Private Partnership
QA	Quality Assurance
QI	Quality Improvement
RFA	Request for Application
RH	Reproductive Health
SHA	State Health Agency
SOW	Statement of Work
TB	Tuberculosis
TOT	Training of Trainers
USAID	U.S. Agency for International Development
WHO	World Health Organization

# EXECUTIVE SUMMARY

## EVALUATION PURPOSE AND QUESTIONS

In September 2012, Social Impact, Inc. was awarded a contract by USAID/Armenia to evaluate five projects in the Mission's portfolio. Among them was the Health Systems Strengthening Project (HS-STAR), aimed at addressing key constraints in Armenian health financing, leadership and governance, human resources and information systems that were perceived to limit delivery and access to quality health care services.

The purpose of this mid-term evaluation is to inform USAID's determination on whether the set programmatic goals and targets are being achieved, and whether the initial project designs are still valid in fostering the achievement of the original objectives. Findings from the mid-term evaluation must inform future work plans of the relevant projects, as well as designs of similar future activities. The evaluation findings will be used primarily by USAID/Armenia, the respective implementing partners, and by interested government entities where applicable. The responsible Mission and project staff will develop plans for incorporation of relevant recommendations from the evaluations in their future work plans.

This document is the HS-STAR evaluation report requested by the Mission. It is formatted around the five questions that were posed by the Mission in the scope of work (SOW) for the evaluation. The team's findings and conclusions were achieved through the triangulation of information collected to answer the following evaluation questions:

- To what extent is the project on track in achieving its expected results of a) establishing transparent and accountable health financing and governance; b) institutionalizing a system of continuous improvement of the quality of provided services; c) building the capacity of the national Tuberculosis (TB) program; and d) enabling civil society to exercise their health rights and responsibilities?
- Are the project implementation approaches relevant to the current state of health reforms in Armenia?
- How did the implementer perform in terms of project management?
  - Were the project leadership and the management structure appropriate for its implementation?
- What internal and external factors delayed the organization of procurement and training processes?
- Is there evidence that project interventions will be sustainable beyond the project's timeframe?

## PROJECT BACKGROUND

HS-STAR is a three-year activity currently in the second year of its implementation period with a budget of \$9.6 million. The project aims to address key constraints in health financing, leadership and governance, human resources, and information systems that impede access to and delivery of quality health services. The project aims to strengthen the health system while improving the quality of care and increasing population knowledge in priority service areas including maternal and child health, reproductive health and family planning, TB, non-communicable diseases, and emergency medicine. HS-STAR aims to significantly enhance local capacity to design, implement and monitor reform interventions to foster future sustainability. HS-STAR provides technical assistance to the Government of Armenia

(GOA) through program components such as health financing and governance, quality improvement (including Maternal and Child Health (MCH), TB, Reproductive Health/Family Planning (RH/FP), and the adoption of proactive health care seeking behaviors through civil society engagement.

## **EVALUATION DESIGN, METHODS AND LIMITATIONS**

The evaluation team used a mix of qualitative and quantitative methods, including a review of key documents, formal and informal relevant research materials, government statistics, key informant interviews, site visits, and structured observations. Data collection tools used included a survey (namely with final beneficiaries), in-person semi-structured interviews, and structured anonymous short questionnaires. As preferred by HS-STAR project staff and stakeholders, the team's most often-employed technique was semi-structured and in-person interviews.

The evaluation team, consisting of one international and one local evaluator, spent two weeks in the field, Yerevan, for the interviews with key informants and HS-STAR project team. Due to time constraints, the evaluation team could only interview 26 (13 male and 13 female) main stakeholder/beneficiaries and 12 HS-STAR staff. Discussions were also held with USAID staff. Two site visits were made to poly-clinics in Yerevan, which were chosen according to their performance indicators chosen from a list proposed by the HS-STAR project staff. The main limitations encountered during the evaluation were time constraints and a lack of well-defined, consistent data on outputs and outcomes of HS-STAR activities.

## **SUMMARY OF FINDINGS AND CONCLUSIONS**

The evaluation team's key findings are summarized as followed:

- A majority of interviewed beneficiaries of the Ministry of Health (MOH) and other donors in the Armenian health field indicated confusion and misunderstanding concerning HS-STAR's proposed coverage of activities. They cited USAID's previous projects (e.g. Primary Health Care Reform (PHCR), and Innovation in support of reproductive health, called NOVA), for their efficiency and achievements. The majority of those key informants cited their narrow focus for the success of those prior USAID efforts. They concluded that it would be virtually impossible to achieve similar tangible results from such a large-scale intervention as HS-STAR.
- Seven grant project interventions were found to be pending or delayed for several reasons, such as a lack of clarity in project purpose.
- The evaluation team observed a large gap between the declared activities and their realization, which has contributed to confusion among stakeholders in times of slowly progressing results. It was unclear among respondents what activities had actually been completed and what results were achieved.
- Reform of the TB program is very slow and has been impacted by myriad external factors despite increased donor involvement and growing international pressure.
- The evaluation team noted some communication shortcomings related to the organization and prioritization of interventions, as some project staff were unaware of deliverables developed by other staff in related areas.

- The assessment studies, trainings, and health education efforts have not been implemented in a systematic fashion and the changes in actual health sector performance have been cosmetic at best.
- HS-STAR did not prioritize its interventions by components. The proposed work plan (WP) for Fiscal Year (FY) 2 was largely a duplication of the FY1 WP and did not include information on anticipated milestones and accurate anticipated time frames.
- According to respondents, the procurement process is primarily hampered by its bureaucratic nature; approval must often be received from Armenia's MOH and other decision-makers outside the project team. Project leaders cited an average of three to five months as a typical delay time for major procurements.

The evaluation team arrived at conclusions based on literature review and analysis of findings from key informant interviews. It was identified that the HS-STAR project's implementation of designed activities contained the following strengths and weaknesses:

#### Strengths:

- The project was successful in well-focused and small-scale areas (e.g. one region, one topic, one level, etc.)
- The project was executed satisfactorily when the objectives were well defined and the methods and outcomes are identified (e.g. neonatal reanimation improvement, independent practice provider support etc.)
- The project's successful implementation of pilot programs

#### Weaknesses:

- The project's inability to prioritize and design systematic activities on a large scale
- The project's inability to initiate innovative, adaptable, and feasible interventions with clearly defined, sustainable results
- The project's low flexibility and incapacity to coordinate interventions simultaneously on a large scale
- The project's weak capacity in team-building and team synergy

### **SUMMARY OF RECOMMENDATIONS:**

1. Continue those activities that have been successful in order to tie up effective work needing completion. If the project is to continue for the ensuing months before termination, the Mission should consider seriously restructuring program-level activities with an appropriate management structure.
2. Any new initiative should be jointly agreed upon by the grantee and the MOH through carefully crafted memorandums of understanding (MOUs) and a mutually agreed upon WP.
3. A revised WP must be designed carefully with clearly defined deliverables and milestones. A LogFrame will be appropriate.
4. Project activities should be focused on responsive, results-oriented areas such as the three pilot programs in quality assurance and quality improvement.



5. We strongly recommend expanding the pilots to two other Marz hospitals as efficient intervention areas. The World Bank has expressed interested in this expansion.
6. The project should maintain its commitment to MOH and donors related to the health account, Medium Term Expenditure Framework (MTEF), conducting surveys for Health Performance Assessment Reports, training of emergency care professionals, three independent Primary Health Care (PHC) providers, and E-health.
7. The TB component should not be considered feasible in the context of the current realities in Armenia and low interest by GOA. Any TB initiatives deemed worthy of continuation should be incorporated into other components, such as capacity building or health education.
8. Health education initiatives should be incorporated into components of the activities framework, but sustainable outsourcing of health education initiatives through public private partnership (PPP) should be promoted with the participation of MOH (similar to the social protection system, like the nongovernmental organization (NGO) “Mission Armenia”).
9. Secondment is an artificial organizational phenomenon and should be terminated. It should be replaced by a clear cooperation plan and efficient communication, administered through short-term technical assistance, as needed.
10. The evaluation team strongly recommends including project cost-effectiveness and resource allocation efficiency in the future evaluation exercises, as well as the need to conduct a financial audit.

# PROJECT BACKGROUND

## INTRODUCTION: OVERVIEW OF HEALTH REFORM IN ARMENIA

Health system reform in Armenia began after independence was declared in 1991. Armenia adopted a range of legal acts regulating the health system, such as the law on medical aid and services to the population adopted in 1996, and the introduction of official user charges in 1997. In 1998, the Government of Armenia (GOA) introduced the first state Basic Benefits Package (BBP) and established the State Health Agency for purchasers of publicly financed health care services. Initially, BBP guaranteed free access to basic services for the entire population, as well as broader inpatient and outpatient services free of charge for predefined social groups within the Armenian population. In 2006, the range of free health care services was expanded to include services related to disease prevention in all public poly-clinics.

The health system reform and the GOA health strategy indicated a continuing focus on, "...disease prevention, greater access to primary health care, improved quality and effectiveness, provision of continuous health care, responsiveness to population needs, reduced need for hospital care, increased resource utilization efficiency, and greater community participation in achieving primary health care (PHC) goals. Specific strategies developed to attain these goals included strengthening preventive measures by reducing risk factors and use of early diagnosis, introducing family medicine, providing comprehensive primary care, enhancing the material and technical bases for ambulatory poly-clinic services, and enhancing the diversity of ambulatory poly-clinic services"<sup>1</sup>.

Armenia has made important efforts to restructure the public health system, improve quality service provisions, and improve payment methods for PHC and in hospitals. However, the World Health Organization (WHO) reports that health outcomes and population health indicators are still below Europe-Central Asia (ECA) regional level averages. Armenia is a lower middle income (LMI) country in the Europe and Central Asia (ECA) region with a gross domestic product (GDP) per capita of US \$2,838 (2010). The country has a population of 3,262,600 (1.01.11) of which 36 percent lives in rural areas. The adult literacy rate is 100 percent. Life expectancy at birth is 74 years, slightly lower than the ECA average of 76 years. According to the Armenian Demographic and Health Survey (ADHS), in the past few years the infant mortality rate, as recorded in the 2005 ADS, decreased from 26 deaths per 1,000 live births to 13 deaths per 1,000 live births in 2010. Under-five mortality rates have decreased from 30 deaths per 1,000 live births in 2005 to 16 deaths per 1,000 live births in 2010.<sup>2</sup>

According to official statistics 1.6 percent (2010) of GDP is allocated to government health expenditures, down from 1.8 percent of the GDP in 2009. The allocation of GDP to health services ranks among the lowest in the world, well below WHO-recommended levels of three to four percent of GDP. These scarce health resources are not effectively distributed among health care providers, institutions and regions. Low financing causes a widespread use of informal, out-of-pocket payments, which consisted of 52 percent of household health expenses in 2009, deepening inequalities in health care access and health outcomes. As reported by the ADHS in 2010, access to health care is especially limited among women.

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<sup>1</sup> WHO, Health performance assessment, 2008; Government of the Republic of Armenia, 2003.

<sup>2</sup> Statistical Yearbook of Armenia, pp.12, 234, 2011; ADHS, 2008, p.8

Scarce financing in the health sector contributes to health workers' extremely low average monthly wage compared to the average national income. In 2010, individuals employed in the health sector earned a monthly wage of 68,196 AMD, roughly \$170 USD, which represents a 44 percent difference below the national average income of 102,652 AMD.<sup>3</sup> This phenomenon has created enormous challenges for health care providers in terms of improving the quality of care. These challenges are particularly prevalent and visible in treating communicable TB and non-communicable diseases.

The Armenian Government made a commitment to continue reforming the health system outlined in the strategic health plan of 2008-2013. Currently, the GOA is finalizing an overarching national health plan with the assistance of the WHO and USAID. Meanwhile, the GOA has developed individual strategic plans focused on vertical priorities in TB, PHC, reproductive health (RH), child and mother health, and non-communicable diseases (NCD), all of which will be included in the future national health plan.

“The Global Health Initiative (GHI) Strategy” for Armenia built upon the successes of the United States Government’s (USG) prior health assistance and the priorities of the GOA. GHI identified priority areas to be supported and improved. The HS-STAR project’s main objectives are designated according to the previously mentioned GHI provisions.

## **PROJECT DESCRIPTION AND IMPLEMENTATION**

HS-STAR is a three-year activity currently in its second year implementation. The project aims to address key constraints in health financing, leadership and governance, human resources, and information systems that impede access to and delivery of quality health services. The project aims to strengthen the health system while improving the quality of care and increasing population knowledge in priority service areas including maternal and child health, reproductive health and family planning, TB, non-communicable diseases, and emergency medicine. HS-STAR aims to significantly enhance local capacity to design, implement and monitor reform interventions to foster future sustainability. HS-STAR provides technical assistance to the GOA through program components such as health financing and governance, quality improvement (including MCH, TB, RH/FP), and the adoption of proactive health care seeking behaviors through civil society engagement.

The HS-STAR project, implemented by Abt Associates in January 2011, is a cooperative agreement with USAID totaling \$9.6 million USD. Over the first 22 months, the disbursement rate was 39.7 percent of the amount anticipated to be spent. HS-STAR was designed and informed according to the lessons learned and accomplishments of USAID's Primary Health Care Reform (PHCR) and NOVA 2 projects. The overarching strategy of HS-STAR covers broad issues such as health financing, governance and leadership, quality services, human resources and IT support. Each element of this strategy can be assessed as a separate component of health reform in Armenia, each one of them requiring continuous systematic changes, political will, and innovative approaches. For instance, the project commitment on the health financing rubric has three directions: (i) improvement of accountability by increasing efficiency of allocated financial resources at the PHC and hospital level, (ii) proposing efficient financing methods for PHC and hospitals (performance-based, global budget), (iii) develop and support to the new financing mechanisms.

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<sup>3</sup> Statistical Yearbook of Armenia, p.234

The original HS-STAR Program Description (PD) covers the main directions of the Armenian Health Strategy for 2008-2013. In it, the grantee proposed an overarching strategy of horizontal, vertical, and “diagonal” dimensions. The HS-STAR program chose a diagonal approach for implementation that “improves vertical service delivery for MCH/RH/FP/TB/NCD services while strengthening the horizontal health system and removing health systems barriers to improving services and institutionalizing improvements”. The program targets all levels of health services ranging from family doctors, to PHCs, to hospitals. The project description clarified that “facility-level interventions will not be implemented without ...creating an enabling environment to implement and sustain interventions.” Consequently, the project intervention will not be a single cosmetic action. The project also focused on sustainability, and will “...not initiate an activity unless that activity has a place in a long-term health sector policy framework and it is linked to a local institution or entity assigned to implement it.”

HS-STAR is organized by four components with an assigned contribution rate to level of effort (LOE) of Request for Application (RFA):

1. Establish transparent and accountable health financing and governance system (45 percent)
  - a) Strengthen PHC provider payment systems (15 percent)
  - b) Test additional health financing and risk-pooling mechanisms (10 percent)
  - c) Support MOH to redefine BBP (10 percent)
  - d) Support independent PHC providers (10 percent)
  - e) Strengthen health workforce planning and contribute to pre-service and in-service capacity building efforts (no percentage LOE assigned in RFA)
2. Institutionalize a system of continuous improvement of the quality of provided services (35 percent);
  - a) Establish mechanisms to monitor provider performance against selected indicator (five percent)
  - b) Promote supportive supervision and feedback on PHC provider performance (five percent)
  - c) Link quality improvement (QI) and quality assurance (QA) and continue to discuss decentralizing MOH QA functions (15 percent)
  - d) Develop and implement an emergency care CME, training package (10 percent)
3. Build the capacity of the National TB Program (NTP) (10 percent)
  - a) Provide support to GFTAM to implement key program efforts that improve TB and MDR (multi-drug resistant) TB prevention and treatment (five percent)
  - b) Refine provider payment system for TB services
  - c) Support MOH and NTP to strengthen TB infection control (IC) practices in facilities providing TB services (five percent)
4. Enable civil society to exercise their health rights and responsibilities (10 percent)
  - a) Strengthen government health education and promotion capacity
  - b) Support innovative PPPS
  - c) Mobilize patient groups and communities to take ownership of their health
  - d) Rehabilitate health facilities
  - e) Continue public education activities on health reforms

Eighty percent of targeted interventions concern accountability, new financing mechanisms, resource allocation efficiency and quality service provision. The TB program and civil society strengthening in the public/health education activities share 20 percent of LOE.

Project outputs/deliverables and progress are reported on a quarterly/annual basis. The HS-STAR project progress reports involve information on interventions by components, the challenges, a summary on budget spending and a Performance Management Plan (PMP). Quarterly Project Reports repeat much of the same information and include activities already mentioned in the previous reports. The PMP indicates project achievements against given targets and the project outcome/output indicators, by components.

In October 2012, the PMP recorded positive accomplishments in training activities, especially in the MCH/NCD areas (except the TB training activity). The following are other indicators by components:

- Component 1- Workforce planning: two tools developed (against two targeted)
- Component 2- A recommendation on licensing suggested (against one targeted)
- Component 3- Two TB policy papers drafted (against three projected) and the development of infection control for seventy-three TB facilities (against twenty targeted)
- Component 4- Rehabilitated five health facilities (against two targeted) and two public education materials developed (against five projected)

The project interventions were conducted through working groups, seminars, discussions, trainings, and direct advice to the beneficiaries. HS-STAR conducted assessment studies and working papers covering priority health areas that were aimed at identifying potential intervention areas and methods. The project produced conceptual assessment studies covering the project focus areas, and sought to analyze existing situations in the HS-STAR planned intervention areas.

Project outcome studies are:

- “Review of health care financing in Armenia”, conducted by HS-STAR project consultant Sheila O’Dougherty

The main objective of this study was to outline and refine the hospital-level provider payment system improvement mechanisms through support to the State Health Agency.

- “New Financing Mechanisms for Tuberculosis: Incentivizing the Stop TB Strategy in Armenia”, conducted by STTA M. Borowitz

The main objective of this study was to outline the shortcomings of the current TB strategy and developed HS-STAR intervention plans.

- “Recommendations: Based on the Findings of the Feedback Study to Assess Implementation of the Quality of Care Processes Introduced with Support of PHCR and NOVA/NOVA 2 Projects.”

The main objective of this study was to analyze feedback from the PHCR and NOVA/NOVA2 projects’ QA initiatives. The project identified HS STAR intervention areas in the improvement of MIDAS3, PHC performance based payment and quality services within SHA and regional level.

- “Situation Assessment and Improvement Strategy of Emergency Care and Ambulance Services in Armenia”, conducted by STTA Ross I. Donaldson

This study was requested by the MOH and provided a comprehensive view of the emergency care reform strategy in Armenia. The recommendations outlined focus areas to be potentially supported through HS-STAR and other USAID programs. For instance, the study recommended

that HS-STAR support should be focused on the training of emergency care professionals by international standards, and using a training of trainers (TOT) model.

- “Workforce Planning at Primary Health Care (PHC): Issues and Approaches”,

The findings of this study provided a summary of evidence regarding excess human resources in PHC.

- The HS-STAR second year activities in the three pilot regional hospitals were supported and assessed by STTA expert Dr. Nigel McCarley.

The consultant produced three progress reports on project implementation in the three pilot sites.

Other objectives of HS-STAR are to promote public-private partnerships, to strengthen community empowerment and health education as well as quality health service delivery in the priority areas of MCH, RH/FP, and chronic disease, TB, and emergency/ambulance services. In terms of an implementation approach, the HS-STAR project chose grants and has announced eleven RFAs covering the above mentioned priority areas. HS-STAR also developed a grants management manual in accord with Abt home office requirements. Eleven requests for proposal (RFPs) were announced, covering health education and MCH/NCD CPGs. The announced duration of grant-projects varied from two to five months, with potential grant amounts of US \$5,000 to US \$9,000. Almost all the grant announcements occurred by last June. To date, however, only two grant-projects have been awarded (Annex F, Grant Table).

HS-STAR proposed another key capacity building strategy, which was to embed the project staff within local institutions to mentor and groom counterparts on a continuous basis, both in specific content areas and in general program management and implementation skills. There are six seconded staff, who are responsible for licensing, certification, and accreditation, quality of care/quality improvement, health financing/risk pooling mechanisms, workforce planning, TB control, and health education areas.

# EVALUATION PURPOSE AND METHODOLOGY

## EVALUATION PURPOSE

The purpose of this mid-term performance evaluation is to inform USAID's determination on whether the set Health Systems Strengthening Project (HS-STAR) goals and targets are being achieved, and whether the initial designs of the projects are still valid. Findings from the mid-term evaluation are intended to inform future work plans of HS-STAR, as well as designs of similar future activities.

The evaluation questions, as laid out in the HS-STAR evaluation SOW, are:

- To what extent is the project on track in achieving its expected results of a) establishing transparent and accountable health financing and governance; b) institutionalizing a system of continuous improvement of the quality of provided services; c) building the capacity of the national TB program; and d) enabling civil society to exercise their health rights and responsibilities?
- Are the project implementation approaches relevant to the current state of health reforms in Armenia?
- How did the implementer perform in terms of project management?
  - Is the project leadership and management structure appropriate for its implementation?
- What internal and external factors slow down organization of procurement and training processes?
- Is there evidence that project interventions will be sustainable beyond the project lifetime?

## EVALUATION METHODOLOGY & LIMITATIONS

Data collection methods that were combined in this evaluation include a review of key documents, formal and informal review of relevant literature and government statistics, key informant interviews, site visits, and structured observation. Data collection tools used included discussions with key informants, a mini-survey (namely with final beneficiaries), in-person semi-structured interviews, and structured anonymous short questionnaires. The team's most often-employed technique was semi-structured and in-person interviews. The evaluators determined that by conducting interviews, they could gain valuable qualitative information from knowledgeable people on wide range of topics pertinent to the evaluation questions. . The open-ended design of the questions allowed and encouraged respondents to express their views in their own words and gain additional insights not accommodated by a more structured format.

The findings and conclusions were derived from the triangulation of the information collected. Evaluation techniques were adapted to each specific question in order to gain relevant, useful data (for example, for each individual group of stakeholders, the team developed specific questions (see Annex B, Evaluation Methodology), or, using the same methodology, undertook highly-focused key informant in-person interviews. Although telephone interviews are less desirable than in-person, the use of the phone

allowed the team to interview key individuals, (e.g. in poly-clinics throughout Armenia,) without needing to spend additional time traveling far distances.

The evaluation was conducted by Social Impact's evaluation team, comprised of Senior HS-STAR Evaluator, Dr. Karine Bouvry-Boyakhchyan and Local HS-STAR Evaluator, Dr. Susanna Onanyan, with supervision from the overall Team Leader, Dr. John H. Sullivan. The evaluation team spent two weeks in the field in meetings and interviews with the key informants. Interviews were conducted by the two evaluators. The team attempted to conduct as many of these interviews as possible together in order to gain a diverse range of perspectives on the issues; however, it was not possible to interview all of the identified key informants due to limited availability of both the interviewers and prospective interviewees. On a limited number of occasions, the team members conducted separate, simultaneously conducted interviews in order to collect as much data as possible. In these cases, each evaluator used the same interview protocol and all of the responses were analyzed jointly during rigorous debriefing sessions. This process helped to validate the coherence of the interview process. A tentative key informant list was suggested by the Mission and was adjusted by the evaluation team as needed. For example, in addition to the list provided by the Mission, the HS-STAR reached out to related department chiefs of the MOH, including the MOH Chief of Personnel as well as the Public Health Education and Public Affairs Departments at MOH. The team also contacted the directors of HS-STAR's three pilot hospitals and three regional primary health centers). Phone interviews were conducted, as appropriate, depending on location and time constraints. For example, the directors of the three regional pilot hospitals and three key informants from regional PHC were interviewed by phone.

The team also organized two site visits to poly-clinics. The purpose of these visits was to commission feedback on performance-based payment from high- and low-scored poly-clinics and to assess the impact of health service quality in the particular facility. The team used careful selection criteria for its poly-clinic visits. PHCs were chosen on the basis of their low and high scores on established MOH criteria and on their geographical location: one in the center of the metropolitan capital and the second in an administrative district just outside the capital. Ultimately, the team selected poly-clinic number 7, a poly-clinic with a low score situated in the center of Yerevan, and poly-clinic number 19, a unit with a high score located in the Malatia district.

The evaluation team organized mini-surveys and structured discussions with patients, health facility directors, and doctors about the quality of services. Given the limited time, the team determined that it was impossible to conduct one-on-one interviews or to organize focus groups with final beneficiaries in order to discuss the quality of primary health services. As a result, the decision was made to use site visits to observe and discuss service quality with site patients and staff. Respondents for the patient discussions and mini surveys were not able to be sampled randomly; rather, respondent selection was based on the availability of patients waiting for appointments during the site visits. The team found that patients were responsive and readily shared opinions concerning service quality. Trends of the responses are detailed in the "Findings" section of this report. The mini-surveys asked respondents about their reasons for choosing the particular poly-clinic, the timing of their visits, and their views regarding the quality of service received.

A total of 26 stakeholders and 12 HS- STAR project staff were interviewed during a series of in-person key informant interviews. The gender distribution of the key-informants was divided equally among 13 men and 13 women.

The HS-STAR project staff interviewed included 12 of the 17 project-funded technical staff (including the Chief of Party, his Deputy, component leads, and technical staff randomly selected from each component). The criteria chosen for selecting the staff interviews was to give preference to the



technical advisors, nearly all of whom the team was able to interview. The team also interviewed the projects grant manager. In addition to in-person interviews, the teams used a combination of structured and open-ended discussion with additional staff. The team interviewed a few staff members that were concerned about reprisals for speaking freely on an anonymous basis.

The limitations encountered during the evaluation were:

- Constrained timeframes;
- Time constraints for sites visits;
- Key informant availability;
- Lack of data on project deliverables (excessive time was spent on their identification and clarification);
- Time limitations on assessing project deliverables in terms of content quality and their sustainability;
- Time limitations on assessing grant projects' content and selection procedures;
- Limited access to project financial data (information on project spending efficiency by components could not be obtained);
- Limitations related to analysis and clarification of contradictory information from project reports and beneficiaries;
- Limitations in using focus group interviews, due to the project's large scope and few deliverables.

In summary, the evaluation was limited by two main types of constraints to the team's ability to gather useful data: limited time and the difficulty of eliciting timely and accurate information on project outcomes and results. The purposive sampling strategy used in this evaluation lent itself to the potential for selection bias, as respondents were not necessarily representative of the population as a whole. As a result, the findings are not generalizable to a larger population. Recall bias is also a factor in data collected from interviews; to mitigate recall bias, the evaluators sought to glean information from as many different sources as possible under the circumstances.

Annex B summarizes the evaluation design and methodology by evaluation questions.

# FINDINGS & CONCLUSIONS

## EVALUATION QUESTION #1

To what extent is the project on track in achieving its expected results of a) establishing transparent and accountable health financing and governance; b) institutionalizing a system of continuous improvement in the quality of provided services, c) building the capacity of the national TB program and d) enabling civil society to exercise their health rights and responsibilities?

### FINDINGS

To answer this question, the evaluators analyzed the project description and program activities by components. The response is based on documents, studies, reports reviews, key informant interviews, and mini-surveys.

Over the past 15 years, healthcare reform policy in Armenia has targeted issues related to HS-STAR's proposed intervention; however, tangible results have been slow and significant challenges to reform have persisted (see Annex D). This raises the question of whether the project implementation strategy was realistic or effective enough to overcome all barriers and challenges in the proposed large-scale effort to provide sustainable health results over a three-year project life period. A key question to consider is: could HS-STAR be expected to achieve results in three years that were not realized over the entire span of the Armenian health reform effort? The strategy was indeed ambitious in its attempt to intervene and strengthen all levels of health facilities and to improve the governance of the health system in Armenia. Additionally, it proposed improving priority health service quality development in the MCH/FP/RP/NCD/TB/emergency care areas. In summary, proposed HS-STAR activities aimed to support reform throughout the entire health system by increasing the affordability, accessibility, financing efficiency, accountability and monitoring in the provision of health services to the Armenian population – all to be accomplished in the period of 36 months.

The HS-STAR project, as proposed by the implementing partner, established ambitious goals that were unclear in their practical application for a majority of stakeholders. This ambiguity was confirmed in the review of project documents, which revealed that the project's design made significant assumptions about the operating environment that were not adequately addressed by the risk mitigation strategy. For example, the project description (PD) cited a “lack of financing commitment and mechanisms to realize institutionalization of reform activities” as one of its main shortcomings and challenges of the Armenian health sector, and by extension, a risk to HS-STAR. The mitigation strategy, however, proposed to “continue to advocate for increased health sector financing.” Such additional funding was crucial to achieving the goals of HS-STAR, yet the framework of the project showed no path to remedy the financial gaps necessary to realize the project's objectives. The solutions posed in the PD were unclear to respondents and questions arose as to the project's strategy for achieving desired outcomes. Several respondents wondered whether the project should suspend implementation until there appeared sufficient pressure to increase health sector financing.

The evaluation team was made aware of the above concerns by nearly all stakeholders and representatives of other donors. A characteristic comment was “the project is everywhere and cannot finalize or produce tangible deliverables/outcomes because it has no particular focus area.” The team heard similar views from representatives of Armenia's MOH, SHA, WHO, and UNICEF, among others.

Sixty percent of key informants interviewed in the MOH and other donors in the Armenian health field indicated confusion and misunderstanding concerning HS-STAR's proposed coverage of activities. They cited the efficiency and achievements of USAID's previous projects (namely, PHCR, NOVA) because of their narrow focus, and concluded that it is impossible to achieve a tangible result from such large-scale intervention. Key informants, including some of the HS-STAR staff interviewed, shared concerns over a lack of systematic approaches and strategic vision for interventions. They believed these shortcomings hindered the development of sustainable outcomes. A substantial number of respondents commenting on various components of HS-STAR suggested that the outcomes produced were little more than cosmetic changes.

The evaluation team attempted to assess the project's outcomes and outputs against contribution rates by component, which were provided to the evaluation team. However, due to the lack of clarity in defined framework results (except the results framework for NCD/MCH/RP/FP), it was difficult to obtain reliable, documented evidence on project achievements that may have provided complementary, quantitative data to the team's key-informant interviews.

A key finding revealed that the Project Management Plan (PMP) failed to include important information; the team's review of the plan determined that 60% of the indicators related to project outputs and milestones were missing from the document. At the time of in-country data collection, the implementer had not yet completed a project PMP containing all of the necessary data against indicators and set targets. A completed PMP was produced and made available to the evaluation team after the conclusion of the data collection period, during the writing of the draft report. This occurred, however, only after the submission of the initial draft of this evaluation report to the Mission, in which concerns about a lack of information were discussed. The team's document review calls into question whether the data is routinely collected and recorded for use in making timely management decisions.

The document review found significant gaps among the Project Description, Work Plan (WP), and quarterly reports. Although the WP structure by components and sub-components is similar to what was proposed in the PD, the activities did not, in some instances, follow the proposed objectives. Moreover, the results and outputs mentioned in reports were not effectively tied to project inputs and activities. For example, listed under "Other Provider Payment System" (WPFY1, Comp.1, unit 19-22) and "Test additional health Financing and risk-pooling mechanisms" (Comp 1, sub-comp.1.3) are activities resulting from quarterly performance reports and studies on TB financing, hospital payment, co-payment, etc. (see Annex D: Data Sources). However, the WP mentions activities under these sub-components when no other results or outputs were achieved, giving the impression that objectives were indeed achieved.

Quarterly reports frequently reported on "outputs," even if they were not the result of a project's on-going intervention. Moreover, the reports made no clear distinction between "final" or "intermediate" outputs; therefore, it was unclear from a comprehensive review of the project documents if HS-STAR consistently produced new outputs, or simply the same output in each reporting period. Examples of insufficiently defined outputs include: interventions in the emergency care area (dispatch emergency IT); PHC performance payment (feedback on PHC performance); "cervical and breast cancer" study; and TB monitoring indicators ("chaporoshichner"). Quarterly reports mentioned outputs on a "cumulative" basis, adding only limited information on what had occurred specifically within the three month period being covered.

The evaluation team's appraisal of the planned activities listed in the WP compared to the PD components is provided below under each evaluation question. The team identified a number of PD prescribed activities that failed to be followed or expressed in subsequent work plans, and therefore

produced no recorded result (PD, pp. 10;18-21). Among those PD activities “dropped” with no explanation of the rationale for omission from subsequent reporting were the following:

- Support counterparts to conduct a feasibility assessment on social health insurance and voluntary health insurance
- Provide technical assistance to help GOAM formalize population co-payments under BBP
- Solidify mechanisms for national pooling of funds
- Outpatient drug benefit
- Frame the structure of BBP copayments
- Build capacity in MDR TB diagnosis and treatment
- Refine provider payment system for TB services

It is not uncommon for a project to modify plans during implementation, as planned project activities in the proposal and contract stage may ultimately prove infeasible. However, it is standard USAID practice to require the implementing partner to make a formal request to the Mission and to proceed accordingly if a written approval is obtained, creating a paper trail. Although there may be written records of the changes to the official project outputs, the team was not made aware of them.

Moreover, the project did not prioritize its interventions by components. Work plans for FY1 and FY2 contained considerable duplication. The WPs did not include information on anticipated milestones for their respective time periods. For example, activities related to PHC performance payment, emergency care (dispatch service improvement), or feedback study on PHC performance payment and hospital payment/copayment were largely duplicated from one year to the next with no clear indication of which milestones had been met within the subcomponent or component.

The WPs by implementation status (completed/partially completed/not completed/delayed/on-going/cancelled) did not provide consistent information concerning project result-oriented interventions. Indeed, sometimes the document in question provided conflicting information between the first and the second years. For example, the first item of the WP FY1 states that dialogue with stakeholders on issues of health financing and provider payments issues had been conducted in FY1. However, in FY2, this activity was still documented as on-going. Another example involves the differentiated capitation method. The FY1 document reports that this subcomponent was both “started” and “completed” in FY1, yet in FY2, the activity is listed as “cancelled.” There was no subsequent explanation for this discrepancy in the plan.

The review of project documents also raised questions concerning the reliability of the project work plans to document completed and future activities, especially for planned activities that were ultimately terminated (See Annex G: WP by Implementation Status). For example, per WP FY1, component 2 (2.1.subcomp., items 3-6) planned to conduct an assessment feedback study on QI issues at the PCH level. The study was projected to last for three months and reported as completed. For the following two months, however, HS-STAR intended to support the MOH implementation of the QI improvement activities that were to be based on the findings of the study. This activity could not be completed because the MOH failed to express an interest in the study or its recommendations. In effect, this QI/PCH activity, a key HS-STAR intervention, lasted five months with no evident result. In another example related to the differentiated capitation study, the activity was cancelled after seven months of HS-STAR support. An apparent question is whether these activities were agreed upon with the MOH

before the interventions started and whether the MOH made firm commitments to their ultimate implementation.

In sum, the analysis of project documents found that by the second year of implementation, 42 percent (42 of 99) of HS STAR proposed activities had either been delayed, partially completed, or cancelled (See Annex G). The breakdown of activity statuses is as follows:

- Cancelled: 9 activities (9%)
- Delayed: 15 activities (15%)
- Partially completed: 18 activities (18%)

Because HS-STAR also included a fourth “ongoing” category in its WP, its meaning should not be construed as “partially completed”, as partial completion suggests a designation requiring some further explanation in order to more fully understand what was accomplished and why full completion was not achieved.

To date, by their own admission, HS-STAR staff members have not shared work plans with local counterparts. The reason provided was that doing so was forbidden by USAID. Upon subsequent inquiry to USAID, it was denied that any such order had been given. On the contrary, it is customary for the PD and work plans to be shared with beneficiaries. Consequently, there was no opportunity for the project to coordinate its work plans with the needs and priorities of Armenian counterparts. This omission raised elicited dissatisfaction and confusion from beneficiaries. For example, MOH respondents (Departments of NCD and MCH) cited that there was no need for several proposed studies, since some studies, such as the reproductive cancer study, had already been conducted by previous USAID projects, or had been started by other donors. Sharing of work plans presumably could have reduced the possibility of a duplication of effort.

The evaluation team found that work plans did not include sufficient information on key milestones and deliverables. Moreover, the evaluation team observed a large gap between declared activities and their realization, which caused some stakeholders to question the project’s slow progress toward results. Examples of activities cited by respondents for gaps in realization were 1) improvement of the population open enrollment-based PHC financing activity, 2) improvement of PHC performance payment efficiency, 3) the TB sub-account, 4) NHA institutionalization, and 5) medical personnel register system and regulatory framework.

#### **a) Establishing transparent and accountable health financing and governance**

This sub-question was addressed using a review of quarterly reports, studies, interviews with MOH, SHA, directors of three pilot hospitals, donors, and the NTP director, as well as two site visits (See Annex D for list of interviewees). This sub-question is related to the HS -STAR Component I activities (with an estimated 45 percent LOE).

According to FY2 WP, only 56 percent of the activities were recorded as completed or ongoing, with 44 percent noted as delayed, partially completed, or cancelled<sup>4</sup>. The original project description included many activities under the transparency and accountability component; a review of project documents

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<sup>4</sup> This calculation based on implementation status rough data. Content of proposed activities was not considered in this calculation (See Annex G: WP by Implementation Status).

found that only 20 percent of activities had been implemented to date. As a result of the team's inquiry, it was determined that the following elements of the project were meant to achieve beneficiaries' satisfaction and stated project goals:

1. Reviewing and improving the mid-term expenditure framework for the Health Ministry and the health budget formation process, and national health accounts, with a survey firm supporting the development of the Health System Performance Assessment (HSPA) 2011 report. This activity was requested by MOH in coordination with the World Bank (WB). However, the survey organization is delayed.
2. Assessment analysis on health financing issues (outcome studies-TB: enrollment based; hospital payments).
3. Supporting independent PHC providers in cooperation with WB. Implementation is still ongoing, but already assessed as successful by MOH.
4. Financial support to the Medical Information Data Analysis System (MIDAS) operating system and information technology (IT) support to the three pilot hospitals targeted for operational improvement, including accounting and reporting.

Analysis of respondent interview data (e.g. MOH, SHA key informants) revealed inefficiency of some interventions and shortcomings in implementation:

- Long delays in the establishment of MOH working groups on different health improvement issues (national account, HSPA 2011 report's survey firm, PHC payment indicators-improvement of form 002, etc.), due to the use of inefficient means of financial compensation of working group members, creating conflict with USAID compliance.
- No sustainable financial mechanisms were proposed for further operation of MIDAS (PD proposed outsourcing to private business). HS-STAR continued passive financing of MIDAS maintenance by subcontracting (as shown in PD, WPs, and quarterly reports).
- No observable results concerning improvement in MIDAS data analysis. Weak practice of evidence-based analysis in the improvement of the payment for services scheme (PD proposed improvement of PHC payment using copayments).
- Feedback on QoC process at PHC revealed that HS-STAR experienced serious shortcomings in data reporting through MIDAS at the PHC level, but follow-up improvement was not recorded or analyzed (evidenced through surveys and unannounced site visits, mentioned in the PD).

Interviews with PHC directors during the two site visits revealed that there was neither an improvement in feedback mechanisms from SHA according to their performance indicators, nor a decrease in paperwork burden. PHC directors specifically indicated their lack of comprehension of performance calculation mechanisms. One SHA interviewee expressed dissatisfaction with HS-STAR's untimely interventions in the IT network improvement.

The evaluation failed to find records describing HS-STAR's follow-up on the application of project-produced studies on hospital financing, TB hospitalization payment, TB financing within additional health financing, and risk pooling mechanisms. The recommendations of HS-STAR STTAs do not appear to have been into consideration in subsequent work plans.

## **b) Institutionalizing a system of continuous improvement in the quality of services provided**

Findings are based on literature reviews and reports, as well as interviews with MOH, three pilot hospitals, WHO, WB PIU, poly-clinics, and patient groups.

This sub-question is related to HS-STAR component two activities (with 35 percent of LOE). The main objective of this component was to increase the capacity of the GOA to establish a system of sustainable quality improvement (QI) processes in targeted health areas.

According to the FY2 work plan, 68 percent of activities were reported as completed/ongoing and 44 percent delayed/partially completed/cancelled; however, when compared against activities listed in the original PD, only 40 percent of stated activities (PD, Box2. p.14) were shown to be completed/ongoing, and 30% of activities delayed/partially completed/cancelled (MCH/FP/RP/NCD result framework: 14 activities, table 2, p.15).

The assessment of outcomes against proposed targets proved challenging for this component since some activities commenced and are continuing on a small scale (in three Marzs' pilot hospitals and not system-wide, as promised). Or, as was the case for NCD, it was only planned to develop CPGs in two topics through grant projects.

Respondents/beneficiaries cited project success in the following areas:

1. Quality assurance (QA) monitoring in the three Marzs' pilot neonatal rehabilitation hospitals and PHCs and supporting rehabilitation of quality improvement (QI) units, including capacity building and refresher training for personnel. The choice of pilots and intervention scope were suggested by MOH in cooperation with UNICEF.
2. Provision of training opportunities to medical and paramedical professionals.
3. Capacity building and curriculum development strengthening in the National Institute of Health and Yerevan State Medical University.
4. Strategic paper on emergency care reform, requested by the MOH, and upcoming training of trainers (TOT) for emergency care providers.

However, MOH respondents indicated skepticism regarding the sustainability and quality of some interventions. An example is the development of clinical practice guidelines (CPGs) and the establishment of a national standard CPG/job aid development methodology, which raised concerns over whether interventions through grant projects could lead to an anticipated result. Particularly, interviewees from MOH, MCH and NCD were very critical and cited the following shortcomings:

- Low quality and outdated training packages, or duplication of past USAID project packages, especially those related to TOT.
- No systematic interventions were planned or implemented, specifically in the areas of NCD and MCH. A translation of a WHO manual into Armenian was done through HS-STAR, but its adaptation was delayed without any reason being given by the Project.
- Slow progress in the QA capacity building and institutionalization.
- Weak communication, particularly, the absence of joint cooperative planning (no prior agreement with MOH appropriate departments.) For example, cardiovascular and cervical and

breast cancer studies were performed by PHCR, but were not implemented due to financing issues. One interviewee speaking anonymously stated that HS-STAR had duplicated past efforts, particularly studies. This informant contended HS-STAR did not take into account past lessons learned and failed to express the changing needs of MCH on these issues. Subsequent discussions with other informants tended to validate these concerns.

- Duplication of certain NCD CPG topics (for example, “Review of the existing guidelines on the screening and early detection of cervical cancer and development of clinical protocols for the early detection of breast cancer” and “CPG and management of emergency cardio-vascular conditions” had already been addressed by previous projects.
- Long delays of four to five months or more, in some cases. To date, seven project components are delayed. These delays occurred at the implementation phase of grant projects and interventions (e.g. adaptation of a WHO manual for school age children nutrition). Additional examples in the areas of “cervical and breast cancer” and “cardiovascular areas” were cited as studies to be undertaken throughout the first and second year WPs and in almost all quarterly reports, but in reality, none had been implemented at the time of the evaluation (See Annex F: Grant Table).

PHC directors and patients cited their dissatisfaction with existing performance tools, which were put in place in accordance with HS-STAR’s first study on “Feedback on QoC process at PHC”. For example, both patients and doctors from poly-clinics noted:

- Current performance indicators are decreasing the quality of services, due to health providers having to spend more time in writing/reporting than in the examination of patients.

“My poly-clinic is showing [a] high-performance score because I replaced my secretary with an IT skilled one who is entering data-sets, so please tell me what quality indicators we [mean], doctors, or secretary services?”

“Then I heard that government is going to increase the number of performance indicators from 10 to 30. Is that your (donors/technical assistance projects’) idea? If, yes, how you could suggest [such an] inefficient thing?” - Respondent from poly-clinic # 19)

- Poly-clinics are providing free services, but services are not considered to be of high quality.

“If I am sick, I am trying to find good professional from hospitals. I come here because I don’t have much money to pay for and here is free. You know, poly-clinics are for the “poor” population.” - Respondent from poly-clinic # 19

The Project PMP recorded high output indicators on training activities, but respondents from MOH, namely from MCH/NCD, cited their dissatisfaction with the quality of TOT activities (explained as “essentially the same package and same trainer as a previous project”) and medical/paramedical training packages (cited as “outdated” and “duplicative” from previous training projects).

After the interview with the chief of the MOH personnel department, the evaluation team found that MOH prioritizes the monitoring of health providers’ professional development, rather than improving personnel policy with workforce planning tools and/or licensing. Particularly, the MOH personnel chief believed that most health facilities are private institutions and “business units” should not concern themselves with their staff/doctors’ professional development. He concluded that all doctors are personally responsible for their professional development; otherwise, the MOH could disqualify them. HS-STAR reports noted updated support for IT resources in the licensing agency, which is intended to



improve workforce planning throughout the health system. This raises the question of whether weak IT capacity is the true reason for a lack of MOH health workforce and planning capacity. The chief of the MOH personnel department was pleased with HS-STAR's suggested draft list of health specialties, which could be cited as a "serious" outcome.

### **c) Building the capacity of the national TB program**

This sub-question is related to the HS-STAR component three activities (with 10% of the LOE). The main objective of this component is to assist in implementing priority activities that improve infection control measures in TB facilities and improve prevention, diagnosis, and treatment for MDR TB cases.

Findings are based on a review of studies, reports and interviews with MOH, NTP, WHO and a seconded HS-STAR LT expat adviser. The TB-specific WP is agreed upon by MOH and NTP.

To date, HS-STAR deliverables are:

1. Working paper/concept note on "New Financing Mechanisms for Tuberculosis: Incentivizing the Stop TB Strategy in Armenia". The recommendations have not yet been taken into consideration by HS-STAR or the GOA.
2. The TB country strategy draft, currently under review, and the elaboration of clinical guidelines, which are now in progress.

The Project Summary of HS-STAR FYI report recorded a substantial list of TB outputs, such as assistance to national and MDR-TB guideline development, improvement of monitoring indicators ("chaporoshichner"), a gene-expert introduction, an E-TB data management system, and a TB financing study. The evaluation team found the same outputs reported in subsequent quarterly reports. The project has hired two long-term TB experts; therefore, it is not clear when and how these outputs were delivered and implemented by NTP.

Based on document review and respondent interviews, reform of the TB program was found to be slow due in part to external complications, despite the addition of donor involvement and growing international pressure. Meanwhile, HS-STAR interventions are faced with important challenges, such as the coordination of all donor efforts, avoiding overlapping efforts with other donors (e.g. the duplication of assessment studies performed by WHO and HS-STAR STTA expert), MOH persistence on outdated prevention and treatment practices, and poor political will. For instance, an interview with the Director of the NTP indicated that extensive use of donor support is not accompanied by GOA's strong commitment to reform the TB program. (See "TB Financing..." study conducted by HS-STAR STTA, Annex D: Data Sources). The NTP Director stressed the need for a long-term International TB expert to be on staff every day, but an interview with the expatriate HS-STAR TB expert herself revealed her belief that she could not have effected great change even if she had achieved the project targets for onsite presence, due to the current political situation regarding TB care.

Analysis of the PD, WPs, quarterly reports, and interviews with WHO and others revealed that HS-STAR efforts were not significant in the areas of TB capacity building, increasing MDR TB cases payment, management of primary cases of TB, and improving the quality of TB and MDR TB areas. Respondents reported problems of prioritization of interventions in the TB area as well. For instance, HS-STAR's TB expert was not informed of existing reports or studies written by other HS-STAR STTAs and WHO experts, and was already producing another similar one. This observation was also validated by a review of relevant documents. The TB expert also pointed out the weak capacity at NTP and primary TB centers. Nevertheless, HS-STAR project reports failed to mention the need for capacity building

activities in the TB area. When the evaluation team asked the TB expert why this was the case, she responded that “no one asks” her [to hold trainings].

#### **d) Enabling civil society to exercise their health rights and responsibilities**

This sub-question corresponds with the HS-STAR project component four activities (10% of LOE).

The main objectives of this component are to empower individuals and communities to exercise their health rights and responsibilities and to explore ways to better institutionalize these efforts through increased government ownership and innovative public private partnerships (PPPs).

According to reports, this component has seen much progress in the implementation of the following activities:

1. Health education capacity building (some of it is delayed)
2. Promotion of the private business CSR (through health messages)
3. Public education activities by grant programs (delayed)
4. Capacity building activities with journalists/media on health issues, TV programs, etc.

This cross-cutting component was aimed at providing complementary actions to intervention areas of other components. As cited by MOH (MCH and NCD) respondents, despite the growing need for health education, they had not noted many activities. Respondents from Health Education and PR departments did not inform the team of any social contracting between MOH and HS-STAR grantees (two grants project were still in the implementation process) or any MOH active involvement in the grant issuing and monitoring processes.

Grant projects generally have shown shortcomings in regards to their sustainability. For example, within the framework of the WHO “Healthy School” initiative, HS-STAR announced an RFA for a grant project to be accomplished within two months, and another RFP on “patients’ and providers’ rights and duties in healthcare services delivery” for five months. While both grant projects were delayed in their implementation, larger questions remained, such as: What will happen after two months? Who will take over? Is the government making any commitment to cooperate with the NGO/CSO grantee, for example, to outsource this particular health initiative?

In general, respondents noted serious concerns with the grant projects and cited the following shortcomings:

- Inapplicability of the grant manual
- RFA did not provide realistic requirements
- Inappropriate selection indicators (e.g. price versus budget) (cited by the Public health Department chief)
- Small grant size did not appeal to many potential grantees

HS-STAR developed a grants manual, but many respondents (MOH MCH/NCD, Health Education Department) expressed a common lack of understanding concerning the manual contents (“too complicated”) and its incompatibility with the Armenian context. For instance, the manual suggested “not to purchase any single item that has a useful life over one year and an acquisition cost of \$5000 USD, or more” (Grants Manual, p.13). This figure, nearly equal to the amount of grant funding, raised questions among respondents. Projects awarded grants also experienced significant start-up delays; seven of the announced nine grant projects were pending or delayed in award at the time of the

evaluation team's data collection. Interviews with MOH respondents and HS-STAR staff revealed several reasons for delay, including:

- Armenian professional associations did not show much interest in bidding due to conditions outlined in the RFP conditions (cited by DCOP and MOH),
- The topics were duplicative: "School-age child nutrition clinical protocols" appears to have already been completed by UNICEF.
- Review of existing guidelines on the screening and early detection of cervical cancer and the study on the development of clinical protocols for the early detection of breast cancer had already been completed by a past project. As a result, according to our Ministry respondents, MOH failed to express an interest in the study or see a need for its application. Further, the selected NGO declined the award.
- The cardiovascular emergency condition management study duplicated a study from a previous project, according to respondents.

In general, interventions within this component were within the framework of the PD, but the team noted some discrepancy between actual targeted rehabilitation efforts (health education resource centers) and another PD proposed area of attention (PHC or other medical facilities rehabilitation; PD, p.22). It was unclear from documents or interviews the extent to which health facilities' rehabilitation needs were assessed by MOH, and whether HS-STAR proposed support in this area to MOH.

## CONCLUSIONS

1. The review of documents and responses from the majority of key informant interviews reveal that the goal of a more transparent and accountable health financing system has not been met in any appreciable way since the project's inception. HS-STAR project implementation approaches are inefficient and not results-oriented (As evidenced by working groups and delays in grant implementation).
2. The team's review of current government policy and practice indicates that over the course of 22 months, the grantee has not institutionalized a system of continuous improvement in Armenia. The document review and interview respondents indicated that little progress toward this goal has been achieved. (For example, MIDAS institutionalization was not implemented as proposed by the PD, as evidenced by NIH, YSMU, Licensing Agency, QI department of MOH.)
3. The HS-STAR interventions in the pay for performance area used mechanisms that are not efficient enough to contribute to health sector performance improvement, despite the project's initially ambitious commitments and evidence-based analysis, patient survey, mysterious patient, etc.). An exception is the passive support provided to MIDAS maintenance.
4. The team's analysis revealed that project interventions also did not make efficient changes to the PHC service quality "performance indicators" improvement area. Despite existing evidence on PHC providers' dissatisfaction and low-quality perception of PHC services by the general population, the "performance indicators" as a quality monitoring tool remained difficult to comprehend and implement by those expected to make use of them.
5. HS-STAR outputs and outcomes have not been particularly productive or constructive for workforce planning, professional development, or licensing issues. The team's analysis found that the establishment of an electronic registry for health professionals and/or a process for entering data on

licensing would have had minimal effects on the problem of excess human resources management in the health field, or in adjunct professional development areas.

6. HS-STAR's contribution to the desired changes in PD target areas was minimal. The health reforms identified in the PD cannot be affected within the project life and resources. Realistically, significant reform in the Armenian health sector requires new financing mechanisms (e.g. performance-based PHC financing (with transparent and efficient accountability), TB program financing, and workforce planning, and quality services), which are notably absent in HS-STAR.
7. Improvement of the priority MCH/NCD/FP/RP health services was not significant, due in large part to long delays, inadequate quality, and flawed implementation strategies.
8. The project produced one high quality report on TB, but did not follow-up vigorously enough to ensure that the recommendations were taken into serious consideration by the stakeholders. As a result, MOH commissioned the same work from another source, and the report produced by the project remained underutilized.
9. The TB program's long-term expatriate consultant, provided by the project to help produce tangible results, was not able to overcome the project's larger deficiencies.
10. The project showed measurable progress in the areas with more focused, clearly defined objectives that are externally proposed and coordinated (MOH, WB, MOH, UNICEF, and MOH). Examples include three pilot hospitals, three regional Independent PHC practices, MTEF, Health Account, health performance assessment report, and elements of the MIDAS system update.
11. Key informant interviews and document review indicate there has been little or no change in the ability of civil society to advocate their health rights and responsibilities; however, a solid conclusion is difficult to draw from the available data because these result areas were not directly measured. There were a limited number of grants targeted specifically toward civil society activities. Prioritization of interventions and focus areas were ignored. There remains significant confusion concerning the nature of PPPs.

## EVALUATION QUESTION #2

Are the project implementation approaches relevant to the current state of health reforms in Armenia?

### FINDINGS

Findings are based on review of Armenian strategic papers, interviews with MOH officials, and directors of the SHA and NTP.

The project design and the initial PD were developed with the active involvement of the Ministry of Health; MOH officials readily admitted active participation. They further confirmed that the project is generally appropriate for the MOH health reform guidelines; however, it was reported that implementation approaches and work plans/activities have been less efficient for improving health sector performance than originally anticipated. The question of relevance applies mainly to the level of implementation achieved, where results are less clear. The assessment studies, trainings and health education efforts have not been implemented in a systematic way so as to effect significant changes in actual health sector performance, which have been cosmetic at best. An exception to this, however, is the three pilot projects in Armenian neonatal reanimation hospitals, which represent a positive step.

Discussions with beneficiaries, both in and out of the health system, largely indicate dissatisfaction. Some stakeholders with whom the team spoke are willing to be patient through the initial months of the project in the hopes that implementation will improve. Others are of the view that the project in its current structure has inherent problems and that its goals essentially are not feasible in the Armenian context. For instance, 83 percent (10 out of 12) of the respondents concluded that the project should narrow its intervention by focusing on one or two areas, as in previous USAID projects.

Many respondents expressed dissatisfaction with grant issuing methods, HS-STAR's efficiency in managing the establishment of working groups, follow-up delays (for example, not following up on adaptation of the translated WHO manual for teenager nutrition, as was agreed in the MCH/NCD area). Other examples cited by respondents include: inappropriate use of grants for the CPGs, tardiness in the forming of working groups, long delays in MIDAS improvement (mentioned specifically by a SHA officer), and poor communication with stakeholders.

The project produced high-quality studies (See Project Description section), but further application was not followed up and effective application failed to occur. WPI indicated that application of some studies was eliminated at the request of stakeholders, (See: feedback study on PHC QoC (WP FY1); PHC doctors-Workforce planning tools (HS-STAR Quarterly report, Third Quarter, FY, 2012, pp. 38-39); PHC open enrollment payment method, or/and Hospital payment, TB financing, TB hospital care improvement). The question remains: What is the cause of the government's lack of interest?

HS-STAR lead project staff reported that the project's low efficiency in achieving anticipated results could best be explained by the project leaders' dependence on USAID and ABT rules and regulations. For instance, the DCOP suggested that the project could have reached more targets if USAID had allowed them to have direct meetings with the Health Minister. The evaluation team's interviews with USAID and MOH officials revealed that bi-monthly meetings with the Deputy Minister at MOH were initially planned, but over time, failed to occur. Once more, the stakeholders estimated (MOH, WHO, UNICEF) that perhaps a narrower focus for the project could target activities more effectively to

produce “a visible change”, and cited the implementation of hospital QoC in the pilots as an example of a successful implementation practice (confirmed by MCH interviewees).

## **CONCLUSIONS**

1. The project goals are generally aligned with the main strategies of Armenian health sector reform. However, chosen implementation approaches have failed to harness the ideals of this reform.
2. The project implementation approaches were not always efficient, because they had not been adopted in a way that insured prior stakeholder interest and commitment. This was particularly true for major elements of HS-STAR that required Government of Armenia ministerial agreement and ultimate reform actions.
3. HS-STAR at times has failed to use flexible, mutually accepted, realistic approaches to project implementation.
4. Although the project proposed a series of ambitious, large-scale activities, implementation has been delayed and slow. Some of the fault, but not all, lies in the slow pace of the Armenian government’s own efforts at health reform. In light of this fact, the expectation to fulfill the ambitious HS-STAR agenda in three years was not entirely realistic.

## EVALUATION QUESTION #3

How did the implementer perform in terms of project management? Were the project leadership and the management structure appropriate for its implementation?

### FINDINGS

To answer this question, the team reviewed initial and current project management structures, project staff professional profiles, interviewed 12 staff (technical advisors) in person, and 22 staff by anonymous structured questionnaire. The project management structure was composed of three home office staff, five key personnel and 20 non-key personnel, for a total number of 28 persons (gender distribution is 19 females and 9 males). Over 50 percent of current staff came from previous USAID projects (e.g. PHCR and NOVA).

The evaluation assessed management structure appropriateness vis-à-vis project activities. The project structure differed markedly from that described in the PD. However, the PD structure itself contains shortcomings in that, for instance, it failed to delineate a position for a grants manager, although the project anticipated the issuing of grants, but designated three non-key positions for financial/administrative tasks. Although the COP is mandated to supervise field personnel, he reported his inability to control some internal management problems with local administrative staff, the expressed cause being “Abt rules”. The COP reported a lack of full decision-making authority, citing “having limited power” and the fact that “everything is decided by Abt”.

The receptionist for HS-STAR doubles as the grants manager, although there is no evidence of her being trained in such a complex and demanding job. In addition, the position of training coordinator has overlapping responsibilities with the Component Two advisors, whose main duties relate to training coordination (moreover, many training activities were outsourced to YSMU), the position of Health Information Specialist (who is a medical doctor by training), and an IT Specialist consultant, despite the fact that that the MIDAS system and all IT support is outsourced to an IT company). Throughout the review, questions of roles and responsibilities, workload distribution, and intra-staff coordination and cooperation were consistently raised by HS-STAR staff. Interviews revealed serious shortcomings reported in project leadership: weak teamwork, frequent delays, lack of communication and transparency, and duplication of tasks.

Both the COP and DCOP cited Abt as providing inefficient home office support and management of HS-STAR requests and requirements, which was blamed for the delay in implementation and obtaining timely results. Testimony from respondents revealed that a significant number of project staff do not view current project leadership as transparent. Four of eight Component Two staff interviewed reported that relevant information is neither shared vertically nor horizontally (e.g. whether particular activities are cancelled, delayed). Some HS-STAR component advisors (4 of 8 respondents) seemed largely unaware of grants that had been issued under the rubric of their component and were not involved in the awards process or in further monitoring activities. Concern was expressed about cross-cutting issues that involve more than one component, and a culture of sharing information in these related areas was seen as weak. For example, a grants manager was monitoring two issued grant projects alone, without a field advisor/MCH/NCD specialist.

Furthermore, respondents also indicated that tension exists within components concerning coordination and task distribution, with conflicts arising that suggest a lack of overall leadership. The respondents also

cited conflicts occurring between technical advisers and financial/administrative staff that caused further delays in activity implementation.

Deputy Chief of Party's sister was hired as non-key personnel on the project despite respondents challenging her credentials for the position. Even though project managers and Abt's HR department took steps to ameliorate the situation to avoid being perceived as nepotism, the question still remained about a staff member reporting directly to a sister at times when the latter assumed COP responsibilities in the absence of the COP for extended periods of time. In addition, project managers failed to distinguish between salary supplements and honoraria for government employees. In one instance, proposed compensation for one senior government official was disproportionate to the projected duration of employment, and was subsequently rejected by USAID.

Eighty-six percent of respondents of the structured anonymous questionnaire reported that project management was efficient, while simultaneously reporting project leadership as an critical area of inefficiency. Project staff was very hesitant about changes to project management - 81 percent of respondents opposed it. Meanwhile, 70 percent of the respondents did not mention any shortcomings or recommendations.

The following shortcomings were expressed in anonymous questionnaires:

- Delays in decision-making and home office approvals.
- Low or non-involvement of relevant staff.
- Personal bias and preferences, and unjustified promotions for less qualified supervisors.

The following recommendations were made by respondents:

- Increase transparency, more USAID involvement in decision-making.
- Improve communication with staff to solicit their feedback. Hold mid-term progress meetings and status observations from counterparts.
- To streamline the process of acquiring approvals from external management, provide clear guidance on processes (for example, approval timing).
- Give precise tasks to subordinate employees.
- Be polite to employees.
- Do not blame employees in the event of problems with task accomplishments.
- Be more consistent and insist on the promotion of project deliverables for implementation at the MOH senior management level.
- Improve coordination with MOH.
- Reform the hiring policy.

## CONCLUSIONS

1. Project management is a particularly weak point of this project. Top project management – specifically, the Chief of Party and Deputy Chief of Party – acknowledged managerial problems (especially delays), but maintained that such problems were external, such as the Abt Associates home office and regulations, as well as the strict protocols of USAID.
2. The project management structure fails to operate as an organic whole with each part contributing its designated efforts in collaboration with other components.



3. Some existing positions are seemingly redundant, as they appear to duplicate the work assigned to other positions. Moreover, although the notion of crosscutting issues that required special attention from the HS-STAR staff was highlighted in the PD, little has been done on the personnel front to apply those synergies.
4. The failure of project management is a major contributor to the lack of tangible results for this project, and the project's structure does not appear to contribute to project efficiency.
5. Project team-building has failed and a culture of information sharing is absent. Moreover, the project staff's unhealthy work environment detracted from project success.

## EVALUATION QUESTION #4

What internal and external factors slow down organization of procurement and training processes?

### FINDINGS

Findings are based on reports, WP implementation status, grant manual review and analysis, as well as interviews with the Deputy COP and COP.

According to respondents, the procurement process is primarily hampered by its bureaucracy. If approval must be received from Armenia's MOH and other decision-makers outside the project team, the delays are often lengthy. Project leaders cited an average of three to five months as a typical delay time for major procurements. Small local procurements, on the other hand, were reportedly capable of being executed within two to three weeks.

Another often cited issue was the policies and procedures of the Abt Associates home office staff in approving procurements and training events. The HS-STAR COP reported being seen as unsuccessful in efforts to spur swifter action when urgent issues and deadlines were arose. Other factors contributing to delays and slow progress cited by respondents were long lags in ministry decision-making, USAID approval procedures, and the inability of subcontractors to work rapidly.

The processing of grant projects is another lengthy procedure – three months from the RFA announcement to award. To date, of the nine grant projects announced, only two were in the implementation process, with others either pending or delayed. The establishment of working groups for the some activities was delayed three to four months. The DCOP cited the persistence of external rather than internal problems, which are listed above and throughout the report.

### CONCLUSIONS

The project experienced long delays in the implementation of activities and failed to implement flexible, rapid methods to push procedures forward. Project management failed to demonstrate a clear understanding of grantee regulations and procedures to avoid long delays in procurement and long-term pending of approvals. Project leaders also failed to gain necessary independent decision-making power and move rapidly toward accomplishing procurement and training objectives.

## EVALUATION QUESTION #5

Is there evidence that project interventions will be sustainable beyond the project lifetime?

### FINDINGS

While the evaluation team agrees that certain HS-STAR project activities have been valuable, it is difficult to assess the sustainability of all activities as a group; each individual project intervention must be assessed on its own.

The project PD stated its intent to focus on institutionalization by “a narrow or more targeted short-term impact and activities...” As noted above, respondents expressed concern over the project’s broad focus contributing to slow progress in its institutionalizations efforts. Reported exceptions were: the three poly-clinic pilot projects, the EMB library improvements, and the NIH status upgrade. Regarding the latter, the newly approved MOH Minister changed the status of the NIH, and seemingly strengthened its capacity, namely in the framework of assistance given to the MTEF and national health accounts. Notably, HS-STAR assistance was considered successful and worthwhile by respondents.

In light of the current economic and political situation in Armenia, the attitudes of the MOH, and the ability to demonstrate to stakeholders that a specific intervention is highly desirable, it is generally understood that some interventions may prove unsustainable due to Armenia’s shifting political structure, strategy, and replacement of high-ranking officials. Respondents’ perceptions surrounding the term “sustainability” in the context of HS-STAR’s interventions included responsiveness to particular priorities of MOH, project continuation, replicable activities, and effectual leadership. To date, the MOH MCH Department, three hospital directors, deputy minister, and HS-STAR ST international experts demonstrated favorable support for the three pilot projects in the field of neonatal reanimation care in Gyumri, Kapan and Vandazor, as well as TOT activities within MCH and emergency care, citing these interventions as a step toward “sustainable change”. Respondents noted the need for further improvement in the area of sustainable intervention continuation.

Respondents were not in favor of some capacity building/training activities, based on outdated training packages (MCH/NCD), and duplicative studies (NCD/MCH CPGs). Respondents noted the project’s incapacity to create a culture of outsourcing certain services (e.g. the area of health education or CPGs,) at MOH, or MIDAS funding through using of social contracting/PPPs. Particularly, no efforts or activities were planned and or implemented for the institutionalization of MIDAS funding. PD commitments for this task appeared to have been ignored.

### CONCLUSIONS

During the past 22 months, HS-STAR implementation performance has not measured up to the goals and accomplishments expressed in the PD. Time has proven that the feasibility of achieving HS-STAR objectives is low, and unfortunately, the generously proposed reform activities have largely remained ideas on paper. Many of the activities cited in the PD have not been accomplished, nor are they on the way to accomplishment.

In general, the development of strategic papers and clinical guidelines are valued as important and sustainable interventions, but it remains difficult to assess their applicability, which depends on the country’s political will. This point is also relevant to the recently drafted national TB strategy.

Institutionalization of the QoC process at three pilot regional hospitals was a noteworthy example of an intervention assessed as sustainable by stakeholders and worthy of replication.

Table I below provides a summary of HS-STAR project strengths and weaknesses.

**TABLE I: SUMMARY OF THE HS-STAR PROJECT'S STRENGTHS AND WEAKNESSES**

Strengths	Weaknesses
<ul style="list-style-type: none"> <li>• The project's success in well-focused and small scaled areas (one region, one topic, one level, etc.)</li> <li>• The project executive's satisfactory skills, if the objectives are well-defined, and the methods and outcomes are identified (neonatal reanimation improvement; independent practice provider support)</li> <li>• The project's use of pilots</li> </ul>	<ul style="list-style-type: none"> <li>• The project's inability to prioritize and design large scale, systematic activities</li> <li>• The project's incapacity to initiate innovative, adaptable and feasible interventions, with clearly-defined, sustainable results</li> <li>• The project's limited flexibility in coordinating interventions simultaneously on a large scale</li> <li>• Team's weak capacity in team-building and team-work</li> </ul>

### **Gender Considerations**

The HS-STAR SOW has integrated gender considerations into the design, as well as implementation, of all project activities. It must be understood that the Armenian health workforce is comprised mainly of women. Moreover, some HS-STAR activities were exclusively directed to the health needs of women and children, for example, MCH /NCD service quality improvement, monitoring of pre- and post-natal clinic visits, and neo-natal reanimation hospitals (three pilots). As indicated in the training statistics (as well as PMP), nearly all training participants were women as well. The evaluation noted a gap between the PD, which dealt with gender considerations, and the Quarterly reports or WP, which provided no specific information on gender in the process of implementing the project. The evaluation team emphasized gender issues in its questioning of respondents; statistics of these responses are provided in the Evaluation Methodology section.

# RECOMMENDATIONS

1. Continue those activities that have been successful in order to tie up impactful work needing completion. If the project is to continue for the ensuing months before termination, the Mission should consider seriously restructuring management organization of program-level activities.
2. Any new initiative should be jointly agreed upon by the grantee and the MOH through carefully crafted MOUs and a mutually agreed upon WP.
3. The WP must be carefully designed with clearly defined deliverables and milestones. A LogFrame will be helpful and appropriate.
4. Project activities should be focused on responsive, results-oriented areas, such as the three pilot programs, for continued quality assurance and quality improvement.
5. We strongly recommend expanding to two other pilot Marz hospitals as efficient intervention areas. (The World Bank has expressed interested in this expansion.)
6. The project should maintain its commitment to MOH and donors related to the Armenian health account, MTEF, conducting surveys for Health Performance Assessment Reports, training of emergency care professionals, three independent PHC providers, and E-health.
7. The TB component should not be considered feasible in the context of the current realities in Armenia and low interest by GOA. Any TB initiatives deemed worthy of continuation should be incorporated into other components, such as capacity building or health education.
8. Health education initiatives should be incorporated into components of the activities framework, but sustainable outsourcing of health education initiatives through PPP should be promoted with the participation of MOH (similar to the social protection system, like the NGO “Mission Armenia”).
9. Secondment is an artificial organizational phenomenon and should be terminated. It should be replaced by a clear cooperation plan and efficient communication, administered through short-term technical assistance, as needed.
10. The evaluation team strongly recommends including project cost-effectiveness and resource allocation efficiency in the future evaluation exercises, as well as to conduct a financial audit.

# LESSONS LEARNED

1. At the design and approval stage, the Mission should pay greater attention to the feasibility of the project and realities of local contexts. The scope of work submitted by Abt Associates may have initially been seen by USAID as unrealistic, particularly given the slow pace of health reform in Armenia. A more modest and focused design might well have had more success, such as those enjoyed by earlier USAID projects.
2. In order for a project to succeed, the project SOW must have a clearly defined results framework and/or formal LogFrame for designed interventions, a narrative illustrating a clear link between project activities, outputs, and outcomes.
3. HS-STAR was awarded to Abt Associates, without competition, under a Leadership with Associates grant. While that mechanism is faster than a full and open competition, it also severely limits a Mission's options for implementation and probably should only be used in situations where the project strategy is fairly simple and straightforward. HS-STAR was not that kind of project; it was highly ambitious and, in effect, promised to be an instrument for putting in place virtually every reform that the Armenian government had indicated on paper -- but may not have actually committed itself to effectuating.

# **ANNEXES**

**A. EVALUATION SOW**

**B. DRAFT WORK PLAN AND METHODOLOGY**

**C. SAMPLE DATA COLLECTION TOOLS**

**D. DATA SOURCES**

**E. HS-STAR ORGANIZATIONAL CHART**

**F. GRANT TABLE**

**G. WORKPLAN BY IMPLEMENTATION STATUS**

**H. DISCLOSURE OF ANY CONFLICTS OF INTEREST**

## ANNEX A. EVALUATION SOW

### Background:

USAID/Armenia requires performance evaluations of the following activities: Health Systems Strengthening Project (HS-STAR), Civil Society and Local Government Support Program (CSLGSP), Alternative Resources in Media Project (ARM), Assistance to the Energy Sector to Support Energy Security and Regional Integration Program (ESRI), and Pension and Labor Market Reform Project (PALM). The purposes of this Task Order are to evaluate the success of these projects in their relevant technical areas and to assess the overall effectiveness of the projects in achieving set programmatic goals and USAID/Armenia's strategic objectives. Three of the five planned evaluations are designed as mid-term performance evaluations (HS-STAR, CSLGSP, and ARM), while the remaining two are designed as end-of-project performance evaluations (ESRI and PALM). The purposes of the mid-term evaluations are to inform USAID's determination on whether the set programmatic goals and targets are being achieved, and whether the initial designs of the projects are still valid in leading to the achievement of the original objectives. Findings from the mid-term evaluations must inform future work plans of the relevant projects, as well as designs of future similar activities. The purpose of the end-of-project evaluations is to assess the effectiveness of resources spent and to inform design and development of future strategies and projects. The evaluation findings must be used primarily by USAID/Armenia, the respective implementing partners, and by interested government entities where applicable. The respective project AORs/CORs will develop plans for incorporation of relevant recommendations from the evaluations in their future work plans.

### SI Responsibilities and Projects:

The evaluation should measure and analyze the accomplishments or the progress toward achievement of the results of the activities, guided by the evaluation questions formulated for each individual activity. **Each evaluation question must be answered empirically, relying on factual evidence, and must be addressed distinctly in the final reports.**

- To what extent is the project on track in achieving its expected results of a) establishing transparent and accountable health financing and governance; b) institutionalizing a system of continuous improvement of the quality of provided services; c) building the capacity of the national TB program; and d) enabling civil society to exercise their health rights and responsibilities?
- Are the project implementation approaches relevant to the current state of health reforms in Armenia?
- How did the implementer perform in terms of project management?
  - Were the project leadership and the management structure appropriate for its implementation?
- What internal and external factors slow down organization of procurement and training processes?
- Is there evidence that project interventions will be sustainable beyond the project lifetime?

### HS-STAR- Jan 2011-Jan 2014, \$9.6 million

This is a three-year activity in the second year of its implementation. The project aims to address key constraints in health financing, leadership and governance, human resources, and information systems that impede access to and delivery of quality health services. The project relies on an approach that simultaneously aims to strengthen the health system while improving the quality of care and increasing population knowledge in priority service areas, including maternal and child health, reproductive health and family planning, tuberculosis, non-communicable diseases and emergency medicine. HS-STAR aims to significantly enhance local capacity to design, implement and monitor reform interventions to foster sustainability. To this end, HS-STAR provides technical assistance to the Armenian government through program components of health financing and governance, quality improvement (including MCH, TB, RH/FP), and the adoption of proactive health care seeking behaviors through civil society engagement.

- Conduct a comprehensive review of performance reports and other materials and identify data gaps.
- Identify data collection methodology to provide the best possible evidence to answer the evaluation questions, also considering feasibility issues.
- Identify informants and stakeholders, samples and/or other relevant data sources.
- Prepare a field work plan.



- Conduct field research in Armenia.
- Analyze data and compile key findings, conclusions and recommendations.
- Revise the draft reports addressing comments by USAID and submit final reports to USAID/Armenia for acceptance.
- Address implementing partner comments within one week as necessary after USAID/Armenia shares the final reports with implementing partners, and if partners choose to submit “Statements of Differences”.

The proposed methodology should address the need for data collection from qualitative and quantitative sources, and provide the best possible combination of methods, given the evaluation questions and the available resources and timeline. All evaluation questions need to be answered empirically; therefore the data collection methods should be tailored to ensure that adequate evidence is collected to answer each of the questions in a definitive manner. There is no preference for any particular method. The ability of particular method(s) to properly answer the evaluation questions is important. Data should come from facts, rather than be based on anecdotal evidence. Conclusions should be based on findings received from multiple sources, and strengths and limitations of the methodology should be explicitly communicated. All people-level data should be disaggregated by sex to allow analysis of findings by sex. Baseline data for all projects is available from their monitoring data. A sample of indicators used for monitoring of each of the projects is provided in the Annex. Some of the baseline data sources include surveys, official statistics, automated information systems, and project records.

## ANNEX B. DRAFT WORK PLAN AND METHODOLOGY

### HS-STAR Performance Evaluation USAID/Armenia

#### I. Work Plan

Week	Location	Key Activities/Deliverables
Week 1 (Oct. 2 – Oct.9)	U.S., other sites and Armenia	<ul style="list-style-type: none"> <li>• Team is reviewing documents on HS-STAR provided by Mission.</li> <li>• Team Planning Meet held by Social Impact with HS-STAR Evaluation team leader, with participation by Armenian team member and Overall Team Leader.-Oct.2</li> <li>• Discussion of work plan and evaluation design, including the prospect for constructing a well-matched comparison groups that could make strong inferences about project impacts to date.</li> <li>• SI Quality Control based on USAID policy and methods is exercised.</li> <li>• Work plan and evaluation design document sent to Mission for approval prior to arrival of the team.-Oct.3</li> <li>• HS-STAR evaluation senior evaluator leaves for Armenia.-Oct.9</li> </ul>
Oct. 10-13)	Yerevan	<ul style="list-style-type: none"> <li>• <u>Day One:</u> HS-STAR evaluation team meets with appropriate personnel in Mission. Discussion of work plan and evaluation design. Adjustments made as required, taking into account extremely short timeframe and urgency of decision making on HS STAR future implementation directions. The rapid assessment technics privileged.</li> <li>• Specific discussion of the substantial evaluation data that has been developed under HS-STAR, project management, outcome sustainability observed and recorded shortcomings and warnings were mentioned by Mission appropriate personnel. The list of potential key-informants were discussed.</li> <li>• The HS-STAR evaluation team, with the SI local logistics assistant, begin process of arrangement of appointments with key-informants.</li> <li>• <u>Day Two:</u> Meet with HS-STAR implementers. Request documents that have not been previously supplied. Interview with HS-STAR team on project managements. Discuss on components activities effectiveness and efficiency. Team with help from implementers and SI logistics assistant makes appointments. Summarized and analyzed each Interview. Made modifications in the Work plan and Evaluation methodology Draft.</li> <li>• <u>Day Three:</u> HS-STAR key informant semi-structured interviews with</li> </ul>

		<p>Ministry of Health appropriate personnel according to USAID suggested list. Regularly Intra-team meeting to assess the progress of the evaluation and revision of meetings.</p> <ul style="list-style-type: none"> <li>• <u>Day Four:</u> Saturday is used to make Interviews with Health facilities as key- Informant by telephone.</li> </ul>
Week 2 (Oct. 15 – Oct. 20)	Yerevan	<ul style="list-style-type: none"> <li>• Day One and Day Two: Evaluation Team site visits continue. Analyzing of Interview progress, reviewing potential key- informants list, site visit.</li> <li>• Day Three: Progress debriefing with Mission, discussion on process, problems, clarify some important data/ information issues concerning Mission and HS-STAR relationship. Evaluation Team site visits continue afternoon.</li> <li>• Day Four: Evaluation Team site visits continue. Intra- team special meeting to assess done work and arrange new appointments</li> <li>• Day Five: Assessment day: Has all necessary information for the evaluation been obtained. If not this day is used to tie up any “loose ends.”</li> <li>• Day Six: HS-STAR evaluation team prepares Mission debriefing. This will serve as a basis for the draft report. Overall Team Leader assists with quality control.</li> </ul>
Weeks 3 (Oct. 22 – Nov. 13)	All Sites	<ul style="list-style-type: none"> <li>• Day One: HS-STAR Evaluation team provides Mission with oral briefing. Receives feedback. Final HS-STAR Evaluation team meeting. Overall Team Leader attends. Set schedule and responsibilities for draft report.</li> <li>• Day Two: HS-STAR Evaluation team leader departs. HS-STAR Evaluation Team prepares Draft Report.</li> <li>• Submitted to Social Impact Quality Assurance Group.</li> <li>• Suggestions from Group incorporated by team in draft.</li> <li>• Submission of draft report to Mission by Nov. 13</li> </ul> <p>[Mission consideration]</p>
(2 weeks after receiving Mission comments)	All Sites	<ul style="list-style-type: none"> <li>• Mission comments received.</li> <li>• Additions, corrections, revisions made by HS-STAR Evaluation Team.</li> <li>• Sent to Social Impact for final editing and formatting.</li> </ul>

Note: This work plan is subject to such changes as may be directed by Mission personnel or by circumstances as they are encountered by the HS-STAR Evaluation Team. The actual timing of the several evaluation methodologies will be affected by a variety of circumstances that will require day by day adjustments.

## II. Methodology

The evaluation study will be done by using a mixed-method, including rapid appraisal evaluation techniques, combining two or more techniques or methods to collect the data needed to answer one or more evaluation questions. This method will be appropriate to given time constraints and could provide feasible assessment /evaluation report (see below risk assessment). Some of the different data collection methods that might be combined in an evaluation include a review of key documents, formal and informal relevant research materials, government statistics; key informant interviews; focus groups, and structured observations. As collection tools might be used of mini-surveys (especially for beneficiaries), interviewing using comparison groups to analyze and identify findings and to develop conclusions. The triangulation of the collected data will strengthen findings and conclusions. The SOW for the evaluation provides five specific questions to be answered. Evaluation technics will be adapted to the each specific question. Below is a description of the proposed methodologies to answer these questions.

### **Key evaluation questions:**

- *To what extent is the project on track in achieving its expected results of a) establishing transparent and accountable health financing and governance; b) institutionalizing a system of continuous improvement of the quality of provided services; c) building the capacity of the national TB program; and d) enabling civil society to exercise their health rights and responsibilities?*

As primary evidence will be the reports, performance monitoring indicators produced and submitted by USAID to the GOA and health survey data. Interviews with the relevant key stakeholders – the Ministries and state agencies, NGOs, if possible also final beneficiaries will provide information comparison, whether Project activities resulted expected impact and were reliable and cost-efficient. The purpose is to identify successful interventions or/and failures, shortcomings, potential for further improvements in the scope of each component.

**Method:** Key informant interviews; document review, mini surveys, focus group interviews and group discussions, site observations

**Source:** Relevant USAID program reports; relevant stakeholders, survey data analysis.

- *Are the project implementation approaches relevant to the current state of health reforms in Armenia?*

The memorandum/agreement between USAID HS-STAR and GOA will be assessed and project state-the-art will be compared with Armenian health reform priorities and current state. Project work plan and impact of each implemented activities will be analyzed.

**Method:** Key informant interviews; document review, focus group interviews and group discussions, site observations.

**Source:** Relevant USAID program reports; relevant stakeholders, project documents, survey data analysis.

- *How did the implementer perform in terms of project management? Were the project leadership and the management structure appropriate for its implementation? HS STAR project management reports and management structure will be analyzed. The question of project human professional capacity will be reviewed. The appropriateness of project each component to scope of work will be assessed. Project team members will be interviewed person to person and by anonymous Questionnaire.*

**Method:** document review, structured and semi-structured interviews, open discussion, observations.

**Source:** Initial SOW, project management structure, position specification, result of interviews.

- *What internal and external factors slow down organization of procurement and training processes?*

Analyze of project organizational reports and timeframe, schedule of capacity building activities will be used for revealing of shortcomings in organization. Group and individual discussions will be used with stakeholders, especially Project team, Mission.

**Method:** Key informant interviews; document review, semi-structured interview.

**Source:** Relevant USAID program reports; project team, subcontractors

- *Is there evidence that project interventions will be sustainable beyond the project lifetime?*

Government statistical baseline data and stakeholders (including beneficiaries mini surveys) interviews will be basis for the assessment of sustainability of implemented activities and capacity building procedures.

**Method:** document review, mini surveys, focus group interviews

**Source:** Relevant USAID program reports; relevant stakeholders-MOH, health facilities, survey data analysis

**Risk mitigation to Evaluation Design:**

The feasibility and implementation of the above evaluation methodology is determined by the availability and quality of relevant program reports, research and health statistical data, that supposed to be complementary and overcoming to proposed interviewing technics known disadvantages and limitations given extremely short timeframe. Another risk could be the availability and participation of key informants for interview and focus groups on short notice. The evaluation team will attempt to mitigate mentioned risk items by triangulation analysis, better targeting groups/subjects and contacting as early as possible, with assistance from the Mission, at the time of the HS-STAR Evaluation team in-brief. Evaluation team is anticipating Mission and HS-STAR project team large assistance. A local logistician will also aid in the timely scheduling of appointments and overall evaluation-related logistics.

## ANNEX C. SAMPLE DATA COLLECTION TOOLS

### III. Evaluation Protocol and Interview Guide

The evaluation study will make use of qualitative as well as quantitative methods, comprising the review of relevant project documents and literature, cited in the “Sources” section above, informal as well as semi-structured interviews with key-stakeholders and informants at national and governorate level and focus group discussions at primary/final beneficiaries’ level. Evaluation team in order to overcome and best adapt to the extremely limited timeframe will use formal and informal interviewing common technique that might be employed from person to person (conversational interviews) or from person to group (structured or semi-structured interviews following with identical closed-ended and/or open-ended questions.

Research questions clearly address to SOW evaluation key questions/issues. It proposed that a focus group comprised of 6-12 participants for a session of 60-90 minutes. The location should be amenable but free of distractions. As far as possible the participants should be heterogeneous for age and gender but not for status (as higher hierarchical differences – or likewise the presence of a foreigner - would tend to inhibit the free expression of opinion). There should always be an over-recruiting of at least 2 attendees to compensate for possible non-shows. During the session not more than 10-15 questions can be covered, as far as applicable the same as in the person-to-person interviews. Current interviewing Guide is subject of changes and modifications due to real situation / need, and timeframe.

The target groups of the evaluation study are defined a priori as:

1. USAID itself
2. HS-STAR project team
3. MOH, SHA, NTP
4. Health facilities- out- and in-patient care
5. Other Donors- UNICEF, WB PIU, UNFPA, WHO
6. Relevant civil societies expressing interest of final beneficiaries and if possible, also final beneficiaries

Below are illustrative interview questions for different target groups covering Missions SOW evaluation five main questions. It is worth mentioning, that each questions will be relevant to participants profile and could be revised depending on circumstances and needs.

#### **Interview questions for GOA – MOH, SHA, out- and in-patient care providers:**

1. What is the nature of your organization? What functions does your organization undertake? By what mandate?
2. Are you aware of the USAID and particularly, HS-STAR project? If yes, what is your relationship with USAID and particularly HS-STAR project?
3. What has been the nature of the assistance being provided? Is assistance relevant to Health System current needs and priorities, or is it more than less useful?
4. Do you find the assistance relevant in light of the current regulatory and legal environment in Armenia?
5. What have been the results to date? Do you think that assistance is implementing in the timely manner and effective?
6. How satisfied are you with the experience with the USAID assistance and particularly HS-STAR project? How would you rate your level of satisfaction on a scale of 1 – 10 (10 highest)?
7. How effective do you view the USAID contractor’s work of implementing the USAID assistance? What kind of relationship do you have with contractor-beneficiary, or? Can you provide comments about the experience, qualifications, and effectiveness, of the contractor team?
8. Can you provide the evaluation team with information to help us understand the LT and ST impact of the assistance on your activities? And impact on final beneficiaries?
9. How sustainable are the impacts of the assistance? Do you anticipate that your organization will continue with the same practices after the USAID assistance has finished?
10. What, in your opinion, is the main constraint acting on USAID assistance in Armenia?

11. What, if any, kind of training, or other capacity building assistance have you received? Do you think the training or/ and capacity building activities relevant to your professional needs and had impact on your activities.
12. What you think about effectiveness ( relevance to set objectives) of the USAID/HS-STAR assistance? Could you provide some shortcomings, if any?
13. In your opinion, how could the assistance be improved?
14. What other types of assistance could be offered by USAID to the Health sector in Armenia?
15. Do you have a specific recommendation and lesson learned that the evaluation team could provide to USAID to help it improve future assistance? In light of your experience, what advice would you give USAID?

**Interview questions for other stakeholders/health care facilities :**

1. Can you please summarize your mandate for assistance to the Armenian health sector?
2. Are you aware or/ and involved in health sector assistance projects in Armenia? What are they? And within USAID?
3. Are you aware of HS-STAR project and in what extent is your involvement?
4. In your view, how appropriate is the USAID assistance in the health sector? Are any improvements needed?
5. Do you think, USAID, particularly HS –STAR, health sector assistance is meeting GOA current objectives? And in light of the current regulatory and legal environment in Armenia? Do you believe it fits well within the desired development strategy for Armenia?
6. Do you consider assistance implementing is efficient, or just money and time wasting?
7. Could you mention main impact of assistance that you observed in your everyday work?
8. How sustainable are the assistance impact? Will the changes continue once the assistance has ended?
9. Do you think, that USAID assistance is more, enough, not significant in the Armenian Health sector? If not enough, what areas might be included in the assistance?
10. What, in your opinion, is the main constraint acting on USAID assistance in Armenia?
11. Should any new, follow-on assistance be designed any differently than the present one? Please explain in detail.
12. Does your component of the project(s) have a human capital development component or an institutional strengthening component? If not, in your opinion, should there be?
13. Can you recommend any individuals, groups, or organizations in Armenia the evaluation team should be sure to contact?
14. On a scale of 1 – 10 (10 highest), how would you rate USAID assistance to the Armenian health sector?
15. Do you have a specific recommendation that the evaluation team could provide to USAID to help develop similar assistance in the future? In light of your experience, what advice would you give USAID?

**Interview questions for HS-STAR team ( in-person):**

1. How long you worked in the HS-STAR and what is your role?
2. How effective you consider implementation of Project objectives?
3. How you describe your professional relationship with main client/beneficiaries and USAID Mission?
4. Could you mention internal and external factors that constrain project activities implementation?
5. On a scale of 1-10 how you evaluate Project Internal management in the implementation of project objectives, USAID Missions assistance/requirements?
6. In your view, has Project management impact on assistance implementation ? Positive? Negative?
7. What kind of external factors misleading assistance timely implementation? Procurement? Financing delays. In your view, how these shortcomings should be eliminated?
8. What are your recommendations concerning improvement of the Project management?
9. What are your recommendations to USAID Mission for the future project design?
10. What are your recommendations for the assistance improvement?

**Interview questions for USAID:**

1. How does USAID/Armenia anticipate using this assessment? What are the special areas of concern? What should the assessment be sure to cover?

2. Can you briefly summarize USAID’s past involvement in Armenia’s economic development and its specific plans for the future?
3. What is a rough estimate of the amount of annual funding that might possibly be available for USAID’s future health sector development programs in Armenia?
4. Are there policies or other issues that presently cause disagreement between USAID and GOA?
5. What are the respective roles and responsibilities of USAID/Armenia, USAID/ Washington, and the Armenia implementing agencies in terms of project implementation? What were the respective roles in the design of each of the projects?
6. Can the evaluation team obtain a timeline of the cost summary of the project-to-date?
7. How do the individual components fit with USAID’s development strategy and priorities for Armenia?
8. Can you please provide the evaluation team with the performance monitoring plan for each of the project’s components with the targets for these indicators, and the latest reports on how well the targets have been achieved?
9. Can you please provide the evaluation team with copies of the original SOW for contractor, technical reports produced by the project?
10. In your view, how sustainable are the changes brought about by the projects?
11. How effective are the projects’ contractors? How effective are the targeted recipients of the assistance? What, in your opinion, are the main constraints in effectively implementing the assistance?
12. How important is health sector assistance to USAID’s overall portfolio in Armenia and its proportion?
13. In your opinion, does the project have a sufficient human capital development component or an institutional strengthening component? If not, should these support activities be increased?
14. What kind of strategy is using for the increasing sustainability of assistance in the health sector now and in the future.
15. Who are the key organizations or people in Armenia that USAID feels that the evaluation team should meet while conducting the evaluation?

**Mini-survey questions for final beneficiaries/patients:**

1. What you do and whom you apply when you have troubles in health?
2. Why you come policlinics? Because, you seek to get first qualified help? Or?
3. Are you satisfied from policlinics doctors’ services? Did you feel any changes in the quality of services?
4. Is it long waiting time for getting doctor’s services?
5. Please, describe how doctor proceed medical examination? Do you think doctors spend more time in “writing” while conducting medical consultation?

**STRUCTURED QUESTIONNAIRE FOR THE HS-STAR PROJECT TEAM**

Please fill out this anonymous questionnaire and feel free to express your opinion.

- 1.How long you are working in the HS-STAR Team?  
Year
2. Do you have managerial position?, If yes how many person you managed?  
Yes    No
- 3.Do you have your functions well designed?  
Yes    No
- 4.How you can describe your manager style?  
a.Efficient  
b. average  
c.inefficient
- 5.How you evaluate your contribution in the project activities?  
a.According to my work tasks  
b.Overloaded



c.Under-loaded

6.How you evaluate your clients?

- a. cooperative
- b. difficult to get agreement,
- c. impossible work with

7. How you evaluate project management impact on the program progress

- a. Efficiently
- b. in efficiently

8.Do you think change in project management will positively impact on project?

- Yes
- No

9.What kind of shortcomings you can mention in the project management?

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10. What recommendations you have for the improvement of the project management?

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## ANNEX D. DATA SOURCES

### List of Persons Interviewed

#### 1. HS-STAR -

- 12 staff were interviewed in-person and 22 staff answered an anonymous questionnaire

#### 2. MOH

- Sergey Khachatryan Deputy Minister of Health
- Ruzanna Yuzbashyan Head of Health Program Department of MOH
- Gayane Avagyan Head of Maternity and Reproductive Health Care Department -
- Nune Pashayan Head of Children Health Protection Division, MCH department, MOH
- Karine Saribekyan Head of Mother and Child Health Care Department of MOH
- Anahit Haytayan: Health minister's press secretary of MOH
- Armen Hayrapetyan, Director, TB NTP
- Sogomonyan Armen- chief of personnel management department Nelson
- Alexander Bazarchyan, head of Public Health department, MOH
- Anahit Haytayan: Health minister's press secretary

#### 3.SHA

- Saro Tsaturyan General Director of SHA
- Samvel Kharazyan, the head of Health Services Purchasing and Information division of SHA
- Stella Kushkuyan Polyclinic # 7, -Director
- Hakob Harutyunyan Polyclinic # 19 , - Director
- Minisurvey of patients in Polyclinics # 7 and #19
- Smbat Orbelyan Director of Kapan Hospital- by telephone
- Vanadzor Hospital (Medical Center)
- Ashot Kurghinyan director of Gyumri Austrian MC Hospital
- 10 Gohar Israelyan Head of Kapan Medical Center (outpatient)(MIDAS training)
- 11.N.Igityan, Head of Oshakan Medical Ambulatory (MIDAS training)
- 12.A.Tadevosyan, Head of Agarak Medical Ambulatory (MIDAS training)
- 13.Discussion with physicians who came regular (once for 3 years?) trainings on the TB issues
- 14.Gayane Ghukasyan Head of WHO office in Yerevan - TB, MCH, NCD
- 15.Hayrapetyan Susanna- World Bank Armenian country office, health programs senior specialist
- 16.Zulumyan- Head of WB PIU
- 17.Ervand Elibekyan FM Development Component coordinator, PIU
- 18. Liana Hovakimyan, MD, MPH, Programmers Officer, Health and Nutrition Section UNICEF.
- 19. Mher Bisharyan, Vice dean, CME department of YSMU

### List of Documents Reviewed

1. Health Systems 20/20. 2007. Health System 20/20 and Governance. Project Brief. Bethesda, Maryland: Health Systems 20/20, Abt Associates Inc.
2. Health Systems 20/20. 2008. Health Systems Database <http://healthsystems2020.healthsystemsdatabase.org/>
3. Scope of Work- HS-STAR Program Description
4. HS-STAR SUMMARY ANNUAL REPORT, FYI 2011 (JANUARY 27, 2011 – SEPTEMBER 30, 2011)
5. HS-STAR PMP Final for USAID

6. HS-STAR Quarterly Report FY11 Q2 [04-20-11]
7. HS-STAR Y02 WP and budget 08 12 11 with final changes for USAID
8. HS-STAR Year I Work Plan Revised 05-23-11
9. HS-STAR Year I Work Plan Tables Revised 05-23-11
10. HS-STAR FY12 I Quarter report-02 2012 FINAL
11. HS-STAR FY12 II Quarter report-04 2012-final
12. HS-STAR FY12 III Quarter report
13. HS-STAR IV Quarter report 31.10.11
14. HS-STAR Y02 III Quarterly report 14 08 12-final
15. OE based financing simulation model October 7, 2011 Armenian Final report
16. Summary analyses of plans PHC
17. OE based financing simulation model October 7. 2011 Armenian, HS-STAR
18. OE based financing and workforce planning simulation model 24 January-
19. Armenia health care quality framework, HS-STAR
20. MOH regulation on clinical standards
21. Barriers to establishing family medicine in Armenia (urban areas)
22. Amended Decree 420
23. RA Health Care service Quality assessment concept paper
24. Summary analyses of plans PHC-2.08, HS-STAR
25. Improving TB Financing in Armenia 2011, HS-STAR, M.Borowitz
26. QoC Feedback Study PHCR NOVA Final Report 09.11.2011, HS-STAR
27. Recommendations after QoC Feedback Study 09.11.2011, HS-STAR
28. Review of Health Care Financing in Armenia. HS-STAR,
29. Workforce Planning at PHC: Issues and Approaches. HS-STAR
30. Armenian Health Strategy 2008-2013
31. Health Performance assessment report, WHO, 2009
32. Armenia: non-income dimensions of poverty, 2011, Poverty Snapshot
33. Armenian Demographic and Health Survey 2010
34. The Achievability of the Millennium Development Goals (MDGs)
35. Global Health Initiative Strategy, ARMENIA
36. USAID Evaluation Policy

## ANNEX E. HS-STAR ORGANIZATIONAL CHART

### Management of HS-STAR Project

HS-STAR four components are:

Health Financing and Governance: Establish transparent and accountable health financing and governance systems

Quality Improvement: Institutionalize a system which promotes/rewards ongoing services quality improvements

Tuberculosis: Build the capacity of the NTP to manage its programs with a focus on limiting the spread of MDR-TB.

Civil Society Engagement: Empower individuals and communities to exercise their health rights, responsibilities and institutionalizes these efforts through increased government ownership and innovative public-private partnerships.

### Monitoring and Evaluation expert

Technical field team consists of 18 members (12 female and 6 males).

Administration team staff 7 members (5 females and 2 males).

Robert Hagan is the Chief of Party of HS-STAR project. He is a M. S. graduate of the first class in Health Systems Analysis and Planning from the School of Industrial and Systems Engineering at Georgia Institute of Technology.

### Health Financing and Governance

Gayane Gharagebakyan is the Deputy Chief of Party and Team Leader for Health Governance & Finance Team at HS-STAR project. She has graduated the Yerevan State University and holds a PhD degree and has completed several certificate courses in UK, Hungary and Armenia.

Gayane Igitkanyan is the Health Financing Advisor at Health Governance & Finance Team at HS-STAR project. She has a degree in Organization Economics and Management, certificates from trainings in Accounting, Business, Health Planning, Human Resource Management in Health Care, Rational Use of Medicines.

Davit Khachatryan is the HIS Advisor at Health Governance & Finance Team at HS-STAR project. He graduated Yerevan State Medical University.

Naira Davtyan works as the Health Financing Advisor, assisting with the planning and implementation of the project's health financing activities. She has completed several certificate courses on health finance, economics, accounting, resources and strategic budgeting in the U.S., Latvia, UK, Austria. She also holds a Master degree in Finance and Accounting from the Yerevan State Institute of National Economy.

Garnik Harutyunyan is the Health Financing Advisor at HS-STAR. He has graduated the Yerevan State Polytechnic Institute, the Moscow Institute of Economics and Statistics, the Moscow State University.

Narek Kosyan is the Communications Specialist at HS-STAR project. He holds an MA degree in Communication Studies from the University of North Carolina at Charlotte, USA, Master's degree in Political Science from the American University of Armenia and Bachelor's degree in Journalism from the Yerevan State University.

### Quality Improvement

Karine Abelyan is the Quality Improvement Team Leader/ Non-Communicable Disease/Preventive Adviser at HS-STAR project. She holds an MD degree from the Yerevan State Medical University.

Karine Gabrielyan is the Quality of Care Adviser at HS-STAR. She holds an MD degree from the Yerevan State Medical University.

Murad Kirakosyan is the Healthcare Quality Advisor at HS-STAR project. Murad holds an MD degree and has completed several certificate courses in Canada, U.S. and UK.

Gohar Panajyan is the Maternal/Child/Reproductive Health/Family Planning Advisor at HS-STAR project. She holds an MD degree from the Yerevan State Medical University and also holds a Master of Public Health degree from the American University of Armenia.

Gohar Jerbashian is the Health Financing/Workforce Planning Advisor at HS-STAR. She holds MS in Mathematics and MBA Degrees, received respectively from Yerevan State University and American University of Armenia.

Vigen Tatintyan is the Emergency Care Specialist at HS-STAR. He has graduated the Yerevan State Medical University and National Institute of Health Named after Academician Avdalbekyan in Yerevan.

#### Tuberculosis:

Laura Gillini is the TB advisor at HS-STAR project. She has completed several epidemiology courses at Johns Hopkins University, Baltimore, MD-U.S.A. and at the London School of Hygiene and Tropical Medicine. She has graduated the Infectious diseases residency of the Università Cattolica del Sacro Cuore, Rome and holds a Ph.D. degree from the same university.

#### Civil Society Engagement

Narine Beglaryan is the Civil Society Engagement Team Leader at HS-STAR. She has graduated with honor from the Yerevan State Medical University with MD degree and has passed postgraduate residency program on OB/GYN at National Institute of Health.

Susanna Mkrtchyan is the Health Education advisor at HS-STAR. She holds a Master's degree in Public Health from the American University of Armenia and MS in Biology from the Yerevan State University.

Hripsime Nazaretyan is Civil Society Advisor at HS-STAR. She has graduated Yerevan State Institute of Foreign and Russian Languages after V.Brusov, department of English and German languages and Yerevan Polytechnic Institute, faculty of social professions.

#### Monitoring and Evaluation expert

Zaruhi Mkrtchyan is the Project Monitoring and Evaluation Expert. She has post-graduate degree in Public Health from the American University of Armenia and Public Health Informatics from the University of Illinois.

#### Administration team

Koryun Sargsyan is the Senior Financial and Administrative Manager at HS-STAR.

Anahit Papoyan is the Administrative & Office manager of the project. Anahit has graduated from the Yerevan State Pedagogical Institute and holds a certificate in English language from the American University of Armenia. She also has completed the ACCA accounting courses.

Vahram Martinyan is the IT Specialist at HS-STAR project. He holds a Master's degree from the State Engineering University of Armenia and a certificate from Cisco Networking Academy.

Lilit Manukyan is the accountant of the project. She has graduated from the State Engineering University of Armenia and holds a certificate in English language from the American University of Armenia.

Marina Vardanyan is a translator at HS-STAR. She graduated from Yerevan State University.

Hasmik Sahakyan is the Project Assistant / Receptionist. She holds a Master's degree in International Relations from the Yerevan State University.

Mara Yeghiazaryan is the Training Coordinator/Project Assistant. She has graduated Yerevan State Veterinary Institute.



## ANNEX F. GRANT TABLE

Announced Grant Title:	"Health policy advocacy" Grant	"Capacity building of neonatal and pediatric intensive care unit medical staff" Grant	"Development of clinical protocols on screening and management of depression, assessment and management of generalized anxiety disorders for PHC Providers and development of related public education materials" Grant	"Patient's and provider's rights and duties in healthcare services delivery" Grant	"School age (6-18 years of age) child nutrition clinical protocols and public education materials development" Grant	"Development of national pre-hospital emergency care protocols" Grant	"Development of emergency medical dispatch guide cards" Grant	"Healthy school promotion" Grant	Review of the existing guidelines on the screening and early detection of cervical cancer and development of clinical protocols for the early detection of breast cancer Grant	
#	Activity	Timeline	Timeline	Timeline	Timeline	Timeline	Timeline	Timeline	Timeline	
1	Grant announcement	12-Jun-12	18-Jun-12	19-Jun-12	22-Jun-12	25-Jun-12	27-Jun-12	3-Jul-12	9-Jul-12	July 10, 2012 Renounced
2	Pre-proposal briefing session	20-Jun-12	21-Jun-12	26-Jun-12	27-Jun-12	29-Jun-12	3-Jul-12	10-Jul-12	13-Jul-12	7/12/2012 2nd: 10 August, 2012
4	Grants application submission deadline	28-Jun-12	2-Jul-12	11-Jul-12	6-Jul-12	16-Jul	17-Jul-12	23-Jul-12	1-Aug-12	7/31/2012 2nd: 22 August, 2012
5	Revision of grant applications	4-Jul-12	9-Jul-12	30-Jul-12	20-Jul-12	10-Aug-12	9-Aug-12	15-Aug-12	20-Aug-12	8/17/2012 2nd: TBD
6	Grant awards	RDRC 01-Spt-12; Confidence 11-Spt-12	15-Aug-12	TBD	TBD	TBD	TBD	TBD	TBD	TBD
8	Award Duration	5 months	3 months	2 months	5 months	5 months	3 months	2 months	2 months	5 months
9	Applicant organizations and scores by GEC	1. "Armenian Center for Health Initiatives" NGO - 71.25; 2. "Helsinki Citizens' Assembly - Vanadzor/HCAV" - 76.25; 3. "Regional Development and Research Center" NGO, - 84; 4. "Confidence" Health NGO -79; 5. "Health for all" NGO - 43.5	1. Armenian Association of Neonatal Medicine - 83	1. "Armenian Psychiatric Association" - 84.25; 2. "Kidney" NGO for Renal patients support, education and care - 64.25	1. "Fund for Armenian Relief Inc." (FAR)- 77.8; 2. "Armenian Center for Health Initiatives" NGO - 57; 3. "Center for Health and Social Rights Protection" NGO - 80.8	1. "Armenian Public Health Organization" - 87.8; 2. "Armenian Pediatric Association" - 86.8; 3. "Health for All" Health NGO - 58.2	1. "Ambulance Association" NGO - 83.4; 2. "Kidney" NGO for Renal patients support, education and care - 50.6	1. "Ambulance Association" NGO - 83.8	1. "Armenian Public Health Organization" - 74; 2. "Armenian Pediatric Association" - 84.2	1. Public Health Training and Research Center - 84.5
10	Grant Proposals Selected by GEC and Grant Amount Proposed by Applicant	1. Organization name: Confidence Health NGO Project title: "Campaign supporting the adoption of the draft law "Breastfeeding promotion and regulation of infant food marketing" Project duration: 4 months Grant Amount: 2.979.600 AMD (HS-STAR) + 400.000 AMD (NGO) = 3.379.600 AMD (Total) 2. Organization name: RDRC NGO Project title: "Obstetrical Care Voucher" Project duration: 5 months Project total cost: 3.876.000 AMD Contribution of NGO: 890.000 AMD Amount requested from HS-STAR: 2.986.000 AMD	1. Organization name: Armenian Association of Neonatal Medicine Project Title: "Improvement of skills in neonatal and pediatric emergency departments" Project duration: 3 months Project total cost: 4.865.075 AMD Contribution of NGO: 932.000 AMD Amount requested from HS-STAR: 3.933.075 AMD	1. Organization's legal name: "Armenian Psychiatric Association" Project Title: "Development of clinical protocols on screening and management of depression, assessment and management of generalized anxiety disorders for PHC Providers and development of related public education materials" Project duration: 2 months Project total cost: 3.367.000 AMD Contribution of NGO: 1.370.000 AMD Amount requested from HS-STAR: 1.997.000 AMD	1. Organization's legal name: "Center for Health and Social Rights Protection" NGO Project Title: "Patient's and physician's rights and responsibilities during service provision" Project duration: 5 months Project total cost: 4.593.000 AMD Contribution of NGO: 610.000 AMD Amount requested from HS-STAR: 3.983.000 AMD	1. Organization's legal name: "Armenian Public Health Organization" NGO Project Title: "School age child nutrition clinical protocols and public education materials development" Project duration: 4 months Project total cost: 4.450.000 AMD Contribution of NGO: 1.610.000 AMD Amount requested from HS-STAR: 2.840.000 AMD	1. Organization's legal name: "Ambulance Association" NGO Project Title: "Development of national pre-hospital emergency care protocols" Project duration: 3 months Project total cost: 4.435.000 AMD Contribution of NGO: 445.000 AMD Amount requested from HS-STAR: 3.990.000 AMD	1. Organization's legal name: "Ambulance Association" NGO Project Title: "Development of emergency medical dispatch guide cards" Project duration: 2 months Project total cost: 2.236.000 AMD; Contribution of NGO: 240.000 AMD Amount requested from HS-STAR: 1.996.000 AMD	1. Organization's legal name: "Armenian Pediatric Association" Project Title: "Improving capacity of the schools of Armenia to promote health and development of children at school settings" Project duration: 2 months Project total cost: 2.590.000 AMD Contribution of NGO: 639.250 AMD Amount requested from HS-STAR: 1.950.750 AMD	1. Organization's legal name: "Public Health Training and Research Center" NGO Project Title: "Review of the existing guidelines on the screening and early detection of cervical cancer and the development of clinical protocols for the early detection of breast cancer" Grant Project duration: 4 months Project total cost: 3.330.000 AMD Contribution of NGO: 320.000 AMD Amount requested from HS-STAR: 2.980.000 AMD
11	Awarded Grant Proposals with Revised Grant Award Amount	1. "Confidence" Health NGO - 2.960.600 AMD (HS-STAR) + 400.000 AMD (NGO) = 3.360.000 AMD (total) (duration is 4 months) 2. "RDRC" NGO - 2.986.000 AMD (HS-STAR) + 890.000 AMD (NGO) = 3.876.000 AMD (total) (duration is 5 months)	Armenian Association of Neonatal Medicine - 3.675.543 AMD (HS-STAR) + 738.800 AMD (NGO) = 4.414.343 AMD (duration is 3 months)							
12	Status of Grant Applications							GEC have decided to postpone the implementation of grant project and it will be renounced later		The selected NGO has declined the grant

## ANNEX G. WORKPLAN BY IMPLEMENTATION STATUS

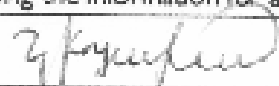
### List of HS STAR WP FY2 delayed activities by components and sub-components

WP fiscal year 2 activities	
A	<p><b>Component 1</b></p> <p><b>1.1. Strengthen Healthcare Provider Payment Systems (15%) Support to Strengthen and Institutionalize HIS</b></p> <p>1. 19. Support MOH with the emergency dispatch information system development and implementation</p> <p><b>1.2. Test Additional Health Financing and Risk-Pooling Mechanisms (10%)</b></p> <p>2. Support MOH/SHA and NTP with development of improvements to TB financing system to promote a public health approach to TB and reduce unnecessary hospitalizations</p>
	<p><b>Component 2</b></p> <p><b>2.1. Establish Mechanisms to Improve and Monitor Provider Performance against Selected Indicators (5%)</b></p> <p>3. 4. In collaboration with the CS&amp;PE team develop leaflet for patients informing and inviting to visit PHC service for preventive measures</p> <p>4. 6. Support MOH efforts to address PHC provider compliance issues with cervical cancer screening</p> <p>5. 11. Support series of 5-day trainings on NCD prevention and management of most common CVDs for 150 PHC providers, poly-clinic cardiologists, quality coordinators in marzes (1-2 facilities with poor performance indicators per marz). Consider participation of Marzpetaran Health Department, Marz SHA and SHAI representatives in trainings</p> <p>6. 13. Develop clinical guidelines on nutritional aspects of children 6 - 18 years of age and on factors contributing to NCDs among children, coordinate with Component 4 for PE material development</p> <p><b>2.3. Link QI and QA and Continue to Discuss Decentralizing MOH QA Functions (15%)</b></p> <p>7. 6. Award grant to professional associations for adaptation/development and implementation of new EMB based clinical guidelines (primary focus on cardio-metabolic risk assessment and management guidelines) involving MOH in selection of association, circulation of draft guideline and approval of final version</p> <p>8. 8. Support MOH to initiate process of developing treatment protocols for priority NCD topics (e.g., CVDs, diabetes) at hospitals by organizing workshops with professional associations and/or health providers from leading hospitals</p> <p>9. 10. Award grant to professional associations for development of guidelines on depression screening, referral and management at PHC level</p> <p><b>2.4. Develop and Implement Emergency Care CME Course (10%)</b></p> <p>10. 6. Support translation of training materials into Armenian as needed</p> <p>11. 7. Support trainers to develop plan to roll-out training</p>
	<p><b>Component 4.</b></p> <p><b>4.2. Support Innovative PPPs</b></p> <p>12. 4. Award and facilitate social partnership program in collaboration with MOH, Private sector and other grants making international organizations (health policy watchdog and advocacy grant)</p> <p><b>4.5. Continue Public Education Activities on Reforms and Priority Health Issues</b></p> <p>13. 4. Collaborate with MOH (including legal department, licensing agency, SHAI, SHA, Mother and Child health protection department) and Marz health departments to design and disseminate public information about health reforms, Basic Benefits Package (BBP), patient and health worker rights, licensing processes, preconception care, NCDs, TB, and other priority health topics</p> <p>14. 6. Support development of MOH and MOE joint program on Healthy School Promotion (exact timing TBD by results of workshop in December)</p> <p>15.</p>



	7. Support NGOs to conduct public education activities
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## ANNEX H. DISCLOSURE OF ANY CONFLICTS OF INTEREST

<b>Name</b>	BOUVRY-BOYAKHCHYAN Karine
<b>Title</b>	Dr.
<b>Organization</b>	SOCIAL IMPACT Inc.
<b>Evaluation Position?</b>	<input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member
<b>Evaluation Award Number</b> <i>(contract or other instrument)</i>	Contract No: AID-RAN-I-00-09-00016 Task Order No: AID-111-TO-12-00002
<b>USAID Project(s) Evaluated</b> <i>(Include project name(s), implementer name(s) and award number(s), if applicable)</i>	Health Systems Strengthening Project (HS-STAR)
<b>I have real or potential conflicts of interest to disclose.</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p><b>If yes answered above, I disclose the following facts:</b></p> <p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> <li>1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.</li> <li>2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.</li> <li>3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.</li> <li>4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.</li> <li>5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.</li> <li>6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.</li> </ol>	
<p>I certify: (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.</p>	
<b>Signature</b>	
<b>Date</b>	03 October, 2012

<b>Name</b>	Susanna Onanyna
<b>Title</b>	Health specialist
<b>Organization</b>	Social Impact, Inc.
<b>Evaluation Position?</b>	<input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member
<b>Evaluation Award Number</b> (contract or other instrument)	Contract No: AID-RAN-I-00-09-00016 Task Order No: AID-111-TO-12-00002
<b>USAID Project(s) Evaluated</b> (Include project name(s), implementer name(s) and award number(s), if applicable)	Health Systems Strengthening Project (HS-STAR)
<b>I have real or potential conflicts of interest to disclose.</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>If yes answered above, I disclose the following facts:</b></p> <p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> <li><i>1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.</i></li> <li><i>2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.</i></li> <li><i>3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.</i></li> <li><i>4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.</i></li> <li><i>5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.</i></li> <li><i>6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.</i></li> </ol>	Despite having previously sought employment with the implementing agency, it not believed to present a conflict of interest with the evaluation or bias the findings and conclusions in any way.

## **ANNEX I. STATEMENT OF DIFFERENCES FROM ABT ASSOCIATES**

Following the submission of Social Impact's draft evaluation report to USAID/Armenia, the HS-STAR contractor, Abt Associates, was given an opportunity to respond. Abt's immediate comments were closely reviewed and carefully considered, and changes and additions were made where deemed appropriate by the evaluators. In the meantime, the Mission terminated the HS-STAR project. Abt was then provided a second opportunity by USAID/Armenia to formally address its stated differences from the findings and conclusions of the evaluators. The evaluators believe that concerns expressed in the below Statement of Differences have been adequately addressed, and offer no further rebuttal.

### **ABT ASSOCIATES RESPONSE TO HS-STAR MID-TERM EVALUATION REPORT: STATEMENT OF DIFFERENCE**

5/3/2013

Abt respects and appreciates the input and feedback of partners, counterparts, and beneficiaries regarding the Health Systems Strengthening in Armenia (HS-STAR) Project as reflected in the mid-term evaluation report dated February 2013. By the time of the evaluation, HS-STAR had succeeded in influencing 14 laws, policies, regulations, or guidelines, including 3 strategies/plans in tuberculosis control, and increasing the capacity of the Ministry of Health and a number of national health sector institutions. The project supported the establishment of 5 independent PHC practices and helped the government introduce pay-for-performance in 100% of PHC facilities throughout Armenia. The project trained 1,104 health care professionals in reproductive, maternal and child health, non-communicable diseases (e.g., hypertension), and emergency care and also trained 1,046 people in non-clinical topics, such as behavior change communication and public private partnerships, through 105 capacity building events. HS-STAR built the capacity of health NGOs in advocacy, developed 7 public education materials, and reached an estimated 1,000,000 people with radio messages on reproductive health topics.

We agree with the finding of the evaluation team that the scope of work for the project (which was developed in response to an RFA issued to Abt Associates by USAID) may have been overly ambitious for the given timeframe. Overall, however, we are concerned that the evaluation report does not provide an accurate and sufficiently robust description of the accomplishments and achievements of the project in meeting its objectives at its mid-point or a balanced reflection of stakeholder comments. We are particularly concerned that:

- The evaluation methodology lacked sufficient rigor to adequately measure project performance;
- The report contains a number of inaccuracies, omissions, anecdotal statements, and assertions that did not appear to be confirmed or triangulated with other parties involved or the project team.

These key points of concern are discussed in detail below in two sections: comments on the evaluation methodology and responses to the findings and conclusions under each evaluation question.

#### **I. COMMENTS ON EVALUATION METHODOLOGY**

Abt is concerned that the 26 stakeholders interviewed as part of the evaluation constitutes an insufficient sample size for this type of evaluation, particularly for a project with such a large number and variety of activities, counterparts, and beneficiaries. Furthermore, Abt is concerned that some of the individuals interviewed by the evaluation team may not have been appropriate key informants as they were only indirectly linked to project interventions. It can take time to derive the benefits (e.g., perceived improvements in the quality of care) from interventions of health policy and reform projects

such as HS-STAR. Therefore, Abt questions the value of responses from patients in focus groups (p. 19) regarding the quality of services at polyclinics in assessing HS-STAR's performance.

The evaluation team does not seem to have considered the project's performance against its Performance Monitoring Plan (PMP), which was developed in collaboration with USAID to assess and report the project's progress according to key indicators. Abt feels this omission resulted in an incomplete and inaccurate picture of performance. Since the evaluation team's visit coincided with the end of the project's annual reporting period, the project was still collecting and analyzing data for the PMP during the visit. Unfortunately, the evaluation team did not attempt to triangulate any of its in-country findings with the PMP upon receipt of the document from Abt shortly after the in-country visit. The evaluators allocated only three hours to discussing the project with staff; nearly all of that time was spent only with the Chief of Party (COP), Deputy Chief of Party (DCOP) and the Resident TB Advisor. On one occasion, much of the discussion was conducted in Armenian, which the COP could not follow. The team did not meet with the other two component team leaders, nor was Abt home office staff contacted by the team which is a standard practice of such evaluations. Abt is concerned that this limited time with staff did not enable the evaluation team to develop an accurate understanding of the project's activities and performance.

There is no evidence provided in the report that information collected was adequately triangulated – the evaluation team did not follow up to validate or clarify findings with other relevant stakeholders or the project team prior to finalizing its findings and conclusions. The report does not consistently distinguish between issues and themes that may have been raised by a single informant versus those that may have been shared by several informants.

## **II. COMMENTS ON EVALUATION QUESTION SECTIONS**

### **A. Comments on Evaluation Question #1**

Abt Associates does not agree with the findings and conclusions regarding Question #1, as we would view the project as being on track according to two main measures of progress: the approved work plans and the PMP. In this section, we summarize the project's progress in completing work plan activities and meeting targets for indicators set forth in the PMP. We also address some of the specific findings and conclusions described in pages 13-23 of the evaluation report.

#### HS-STAR Progress: Year 1 and Year 2 Work Plans

The evaluation team's findings regarding the project's progress according to the approved work plans differs substantially from Abt's assessment. One explanation for this discrepancy is the treatment of cancelled activities. The evaluation team treated cancelled activities as activities that the project had failed to achieve. However, the project had notified USAID of these changes to the work plan through weekly meetings with the Mission, which the evaluation team would have discovered through follow-up with the project or USAID. We take as a lesson from this exercise that it would have been best to formally document these cases. Excluding activities that were cancelled and activities that spanned more than one year, Abt concludes that the project accomplished the vast majority of approved work plan activities in each component for Years 1 and 2. Of 89 planned activities in Year 1, 90% were completed and 10% were partially completed by the end of the year. Of 221 planned activities in Year 2, 80% were completed and 9% were partially completed by the end of the year.

#### HS-STAR Progress: PMP

The HS-STAR PMP was developed in consultation with USAID specifically to measure the project's performance. Unfortunately, the evaluation report only links one of its findings to the project's PMP. In light of this oversight, Abt conducted an analysis of HS-STAR's progress in meeting the targets for the indicators listed in the project's approved PMP. Of the 26 indicators directly linked to project activities,

by the end of Year 2, the project had exceeded or met the targets for 20 indicators, was on track to meet the targets for four indicators in Year 3, and did not meet the targets for two indicators. The project's PMP is available upon request.

#### Responses to Specific Findings and Conclusions Regarding Question 1

On page 16, the report states that "To date, by their own admission, HS-STAR staff members have not shared work plans with local counterparts" and on page 18 mentions "Weak communication, absence of joint cooperative planning (no prior agreement with MOH appropriate departments)." While it is true that the project work plan in its entirety was not formally shared with counterparts in agreement with the project's first AOR, component activities and work plans were discussed with counterparts in the MOH and adjusted with counterpart input and feedback. The statement that sharing of work plans was "forbidden by USAID" is a misquote of the project's COP, who stated to evaluators that HS-STAR has both developed and shared the work plan on a component level with MOH counterparts; however, in agreement with USAID, we have not shared the complete work plan with the Minister of Health.

On page 16, the report states: "MOH respondents (Departments of NCD and MCH) cited that there was no need for several proposed studies, since some studies, such as the reproductive cancer study, had already been conducted by previous USAID projects, or had been started by other donors." This statement is not true. HS-STAR reviewed all activities related to reproductive cancer implemented in Armenia and worked closely with the MOH in the design of the study. HS-STAR's study gathered data beyond what had been previously gathered and analyzed. No other donor had initiated this activity.

On page 17, the report states: "Long delays in the establishment of MOH working groups on different health improvement issues (national account, survey organization, PHC payment indicators, etc.), due to using inefficient and unacceptable means..." Abt's response to Question 3 below provides an explanation for these delays and corrections to the evaluators' understanding of these events.

On page 16, the report mentions five activities that were "cited by respondents for gaps in realization." This finding is not true. Through proper triangulation with project staff, the evaluation team would have discovered that the project had in fact achieved or been on track to achieve all five of these activities in close coordination with government counterparts.

On page 18, the report states: "Low quality and outdated training packages, or duplication of past USAID project packages, especially those related to TOT." In fact, the project reviewed existing national and international training materials to inform revision of the training packages used, vetted all training packages with Ministry counterparts (email correspondence and other written approvals are available), and received feedback that the project's TOT packages were well received by the teaching faculty of NIH and YSMU. Furthermore, on the very same page, the evaluation report lists "provision of training opportunities to medical and paramedical professionals" as one of the areas in which "respondents/beneficiaries cited project success."

On page 20, the report states "HS-STAR efforts were not significant in the areas of TB capacity building, increasing MDR TB cases payment, management of primary cases of TB, and improving the quality of TB and MDR TB areas." While Abt agrees that policy changes around TB were slow to come, Abt does not agree with this conclusion regarding HS-STAR's efforts in these areas, given the many contributions of the Resident TB Advisor, including: building the capacity of the NTP; supporting the development of a number of key TB guidelines and strategies; introducing a new monitoring system; developing the roll-out plan for GeneXpert; developing facility drug calculation tables; and developing an algorithm for the selection of candidates to receive MDR-TB treatment.

On page 23, the report indicates that “there has been little or no change in the ability of civil society to advocate their health rights and responsibilities.” Abt does not agree with this conclusion given the project’s significant achievements in working with NGOs to conduct policy/advocacy activities. As reported in the project’s progress reports and website, the project facilitated a health NGO working group in preparation for and during the Legislative Agenda Advocacy Day (LAAD) 2011, which served as a forum for civil society to present priority health issues to senior parliamentarians. As a result of these efforts, four of the proposals presented by health NGOs were reflected in relevant legislative documents in 2012. This major success demonstrates a substantial improvement in the ability of civil society to exercise its health rights as a result of project technical assistance.

## **B. Comments on Evaluation Question #2**

While Abt respects the input of beneficiaries on our performance and agrees that HS-STAR may have benefited from a more narrow focus, we respectfully disagree that the project’s implementation approaches failed to harness the ideals of the Armenian health reform. The significant changes in health policy and financing mechanisms that were called for by both the reform agenda and the project’s SOW take time to design and implement. Many reforms that have been discussed through ongoing advocacy efforts and policy dialogue, such as enrollment-based financing for PHC and establishment and functioning of independent PHC practices, are only now coming to fruition after many years of technical assistance and investment from USAID and other development partners.

In fact, the implementation approaches employed by the project are typical for this type of technical assistance project and were determined by the project and MOH to be appropriate for Armenia. The approaches were coordinated with and accepted by Armenian counterparts for the vast majority of activities, and also were flexible as the policy and reform environment shifted, e.g., rapidly responding when the new Minister reconstituted the National Institute of Health (NIH). These approaches included:

- Assessments and studies on topics of interest agreed with the MOH, including analysis of past quality improvement efforts, the emergency care system, health financing issues, reproductive cancer screening, and household health spending and health system performance perceptions;
- Advocacy efforts, including creating and sharing data for decision-making and policy recommendations and empowering NGOs to advocate to the MOH and Parliament;
- Policy reform, including facilitating explicit changes to health legislation and policy;
- Clarifying roles and functions and increasing the organizational capacity of more than ten MOH Departments and related agencies and organizations;
- Competitively awarded subcontracts and grants for HIS system design, clinical training, guideline development, and public education activities – ensuring that the task was completed but also building local expertise and capacity to implement;
- Short-term technical assistance from international experts to supplement local expertise in areas including emergency medicine, health financing, evidence-based medicine, facility-level quality improvement, health information systems, behavior change communication, and TB;
- Development/adaptation and implementation of training and capacity building programs for health policymakers, clinical educators, health facility staff, physicians and nurses, professional associations, and health NGOs, using local or regional experts as trainers whenever possible; and
- Support to improve clinical care through development and implementation of evidence-based guidelines through training programs, supportive supervision, and follow-up monitoring.

Abt agrees that a limited number of the project’s implementation approaches were less successful and regrets that the limitations of these approaches were not recognized and managed by Abt and the project team earlier in the process. The project hoped that it might make these mechanisms work in order to meet the expectations of counterparts that had requested our support in these areas. These approaches included seconding project staff in the MOH, working groups that involved government

employees and policymakers, and grants to professional associations either headed by or staffed with government employees.

### **C. Comments on Evaluation Question #3**

Abt respects the input of both partners and project staff on how project management could be improved. Abt regrets that the report's Recommendations did not provide more concrete and constructive recommendations for management improvements, and that Abt did not have a chance to make improvements prior to the project ending.

Abt is confused by statements made by the evaluation team in this section regarding the project structure. The project organizational chart at the time of the evaluation did not in fact "differ markedly" from the organizational chart included in the project scope of work. Existing positions may have seemed duplicative to the evaluation team at first glance, but upon further review of job descriptions or discussion with the project team, job duties and functions would have become clearer.

Abt is concerned by the evaluation team's incorrect interpretation of two issues: the hiring and supervision of the Workforce Planning Advisor, who is the sister of the DCOP, and discussions surrounding payments for government employees participating in working groups.

Regarding the first issue, Abt does not tolerate nepotism or conflicts of interest and has a specific company-wide conflict of interest policy, which was followed in the hiring of the Workforce Planning Advisor. The interviewing, selection, and hiring of both the DCOP and Workforce Planning Advisor were conducted through competitive selection processes by home office employees. It was agreed with Abt's HR Department that the two positions would both report to and be supervised by the project's COP to maintain neutral reporting relationships on the project and avoid any potential conflict of interest. The Workforce Planning Advisor position was shifted from the Health Financing and Governance component to the Quality Improvement component, further preventing any potential conflict of interest among members of the same component team.

With respect to the second issue, HS-STAR did not attempt to make inappropriate payments to government employees. In response to a request from the MOH, HS-STAR tried to identify a mechanism for the project to provide financial support to National Health Accounts (NHA) and Health Systems Performance Assessment (HSPA) working groups. HS-STAR immediately raised concerns with USAID about its ability to pay government employees as working group members. A potential mechanism to support these members through an honorarium or reduced fixed payment was identified and discussed further with USAID. In the end, however, despite a no objection received by USAID, Abt concluded that it could not find a way in fact to make this mechanism work and comply fully with broader USAID guidance and local laws. Thus, the project revised its strategy entirely and focused efforts on institutionalizing support for these working groups as part of the rehabilitated NIH.

Overall Abt finds the feedback from project staff to be quite positive: "Eighty-six percent of respondents of the structured anonymous questionnaire reported that project management was efficient, while simultaneously reporting project leadership as a critical area of inefficiency. Project staff was very hesitant about changes to project management - 81 percent of respondents opposed it. Meanwhile, 70 percent of the respondents did not mention any shortcomings or recommendations." However the evaluation team seems to dwell on negative comments of a relatively small number of respondents. It is also important to note that HS-STAR project staff expressed confusion regarding the wording of many of the questions which they felt was unclear, and felt their feedback and input was misinterpreted or incorrectly generalized in some instances in the report.



#### **D. Comments on Evaluation Question #4**

Abt acknowledges that several activities were delayed and had been discussing these issues with USAID, including developing new timelines for their implementation. It is important to note that only 5 activities out of 221 planned activities in Year 2 faced significant implementation delays. The delays in these particular cases were primarily due to ensuring the appropriateness and quality of goods and services to be provided in conjunction with the MOH or other counterparts, achieving maximum value for USAID's investment, or identifying mechanisms to satisfy requests of the MOH within USAID regulations and guidance. These issues were not investigated in-depth by the evaluation team either with project leadership, the project's finance and admin team, or Abt's home office representatives.

#### **E. Comments on Evaluation Question #5**

Abt Associates finds the findings and conclusions of the draft evaluation report related to evaluation Question #5 inadequate. The project has many examples of institutionalization and sustainability of activities and interventions within the MOH and related agencies, Parliament, and local NGOs, such as:

- Helping to develop a National Health Financing Concept that will guide changes in provider payment systems for PHC facilities and TB services (currently under review by the Government).
- Increasing capacity of MOH staff in annual health sector budget development linked to the Medium-Term Expenditure Framework.
- Supporting the State Health Agency (SHA) to implement a national pay-for-performance system in 100% of the country's PHC facilities, after nearly 8 years in development.
- Building the capacity of the SHA to update, maintain, and use a national health information system; increasing the capacity of a local IT company to support SHA in maintaining the system.
- Building the organizational and institutional capacity of the Licensing Agency.
- Supporting the establishment, development, and licensing of 5 independent PHC/family medicine practices, increasing patient choice of provider and stimulating competition among PHC facilities in urban areas to improve quality of care.
- Institutionalizing a national Quality Improvement concept and clinical practice guideline (CPG) development process.
- Supporting the ability of the new Evidence-based Medicine Center to lead CPG development.
- Supporting strengthening of the new Scientific Center of Nosocomial Infection Prevention.
- Helping to develop/refine roles and responsibilities of reconstituted NIH.
- Institutionalizing working groups for NHA and HSPA in NIH.
- Building capacity of local training organizations, including government training providers and professional associations, giving health care providers increased choice of training providers.
- Building capacity of NTP staff, including marz-level staff working in TB.
- Institutionalizing changes in TB clinical practices and monitoring.
- Establishing an institutional home for health education activities at the national level and in marzes.
- Institutionalizing the coordination of public-private partnership (PPP) activities at the MOH.
- Institutionalizing behavior change communication training within the State Hygiene Anti-epidemic Inspectorate (SHAI).

Given the project's achievements summarized throughout this response and documented in the project's PMP, Abt disagrees with the evaluation team's conclusion on page 30 that "Many of the activities cited in the PD have not been accomplished, nor are they on the way to accomplishment." Abt feels that after 2 years of implementation, the project made significant progress in achieving its objectives in close coordination with the Government and in institutionalizing these initiatives and interventions whenever possible.

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