Application for:
Health System Strengthening in the Republic of Armenia

March 2008

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Abbreviations and Acronyms

AEFI	Adverse Events Following Immunization
APR	Annual Progress Report
BBP	Basic Benefit Package
BCG	Vaccine against Tuberculosis
cMYP	Comprehensive Multi-Year Plan for Immunisation
CSO	Civil Society Organisation
CDC	Center for Disease Control
DHS	Demographic and Health Survey
DTP	Diphtheria Pertusis Tetanus vaccine
FAP	Health Post
GoA	Government of Armenia
GDP	Gross Domestic Product
GNI	Gross National Income
HS	Health system
HSCC	Health Sector Coordination Committee (highest level group in-country coordinating the development, implementation and monitoring of the GAVI HSS proposal)
HSS	Health system strengthening
HepB	Vaccine against Hepatitis B
ICC	Interagency Coordination Committee for immunization
IMCI	Integrated Management of Childhood Illnesses
INGO	International Non-Governmental Organisation
IRC	Independent Review Committee
LDC	Least Developed Country
Marz	Province (regional level administrative area)
MCH	Mother and Child Health
MOFE	Ministry of Finance and Economy
MOH	Ministry of Health
MTEF	Midterm Expenditure Framework
NGO	Non-Governmental Organisation
NNGO	National Non-Governmental Organisation
NSS	National Statistical Service
NIP	National Immunization Programme
PH	Public Health
PHC	Primary Health Care
PHCR	USAID-funded Primary Health Care Reforms Project
PRSP	Poverty Reduction Strategy Paper
RA	Republic of Armenia
SHA	State Health Agency
SHAEI	State Hygienic and Anti-Epidemic Inspectorate
VRF	Vishnevskaya-Rostropovich Foundation
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency of International Development
WG	Working Group
WHO	World Health Organisation
WB	World Bank
VPD	Vaccine Preventable diseases

Executive Summary

After intensive consultation with major stakeholders and reviewing key strategic documents the following barriers to PHC and Public Health services, that are not currently addressed were identified

1. Insufficient knowledge and skills of PHC/PH providers
2. Lack of physical access and/or availability of human resources in remote, mountainous, and near boarder areas
3. Lack of appropriate delivery system for PHC supplies, including vaccines
4. Irregular and low quality supportive supervision of primary and public health services
5. Weak surveillance systems for communicable diseases, including VPD and adverse events following immunization (AEFI)

The following goal and objectives were formulated in order to address the mentioned barriers.

Goal:

The goal of the GAVI HSS Application for the Republic of Armenia is to improve quality and responsiveness of Primary Health Care (PHC) and Public Health (PH) services, with special attention to population groups living in remote and border areas.

Objectives:
In order to achieve this goal the following main objectives have been identified:

1) Development of health (PH and PHC) workforce by training 1800 health care professionals by 2010
2) Establishment of integrated supportive supervision of primary and public health services, by training marz and district level 240 professionals, and establishing 44 teams for supportive supervision by 2010
3) Improvement of access to PHC and PH services in remote, mountainous, and near border areas by establishing 5 outreach teams for 5 marzes (Shirak, Syunik, Tavush, Vayots Dzor, Gexarkunik**)** by 2010
4) Strengthen the surveillance of communicable diseases, including VPD by training 900 specialists and providing operational support (printing of reporting and case investigation forms, providing transportation support for case investigations, specimen transportation and active surveillance in areas needed) to implementation of surveillance systems by 2010.

The following chart aims to demonstrate the links between the Barriers, Objectives/Components, Intermediate objectives, and the overall goal of the proposed activities to be supported by GAVI HSS.

3. BCG – DTP3 drop out rate at national level (%)	3,6%	2006	< 3%	2010
4. Under five mortality rate (per 1000)	15.8	2006	≤ 12	2010
5. Number of annual average PHC contact per person	2,3	2005	3	2010

Source NSS (Appendix XVIII)

GAVI HSS Application Development: The Minister of Health's office with the Legal Adviser to the Minister as the person in charge led the application development process. The WG developed this application with technical support from the WHO/EURO, WHO country office, in close consultation with WB, UNICEF, and USAID.

The Health Policy Board of the Ministry of Health, Ministry of Health, Ministry of Finance, WHO, WB, UNICEF, USAID, Vishnevskaya-Rostropovich foundation reviewed the draft application and provided comments/suggestions that were incorporated in the application. Local NGOs were also consulted and comments on the draft application were received.

Section 1: Application Development Process

1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):

Health Policy Board of the Ministry of Health of the Republic of Armenia

……

HSCC operational since: 13/07/2005 (see Appendix IV)

……

……

Organisational structure (e.g., sub-committee, stand-alone):

Stand-alone committee in the Ministry of Health reporting to the Minister of Health

……

……

Frequency of meetings:[1]

At least once a month

……

See the meeting minutes in the Appendix IX

……

Overall role and function (functions and responsibilities):

a) Development of MOH strategy (including reforms) and general health policy, as well as field strategies and priorities, trends in the health sector and presentation of conclusions on the drafts of relevant legal acts
b) Coordinating implementation of all health projects implemented by the MOH if there is no any written coordinating mechanism in the agreement between MOH and donor organization.
c) Ministry of Health annual budget planning, discussion and adoption of the Financial Policy of the MOH; and adoption of Draft Legal Documents
d) Development of indicators for the implementation of MOH policy, projects and field reforms, and the estimation of their actual effect. Review of the indicators.

……

[1] Minutes from HSCC meetings related to HSS should be attached as supporting documentation, together with the minutes of the HSCC meeting when the application was endorsed. The minutes should be signed by the HSCC Chair. The minutes of the meeting endorsing this GAVI HSS application should be signed by all members of the HSCC.

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

The Minister of Health's office with the legal Adviser to the Minister as responsible officer directly led the application development process.

Who led the drafting of the application and was any technical assistance provided?

The WG developed this application with technical support from the WHO country office in close consultation with the colleagues from UNICEF, WB, USAID, and VRF. The WG identified all HS barriers to immunization and MCH services and potential solutions, areas of work and activities. WHO expert team provided experience from alternative approaches in solving the identified barriers and commented on the activities suggested by the WG, guided the drafting of the proposal and provided feedback before the submission.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

The application development process was conducted in a fully participatory approach with a WG of 6 people led by the Minister's legal Adviser and representing Mother and Child Health (MCH) and PHC departments at the MOH, the State Hygiene and Anti-Epidemic Inspectorate (SHAEI) and State Health Agency (SHA) of the MOH. The MOH in collaboration with the WHO country office did the preparatory work during January through May 2007. The WG conducted a series of half-day meetings in early June. It used a log frame approach to identify the main HS barriers to immunization and MCH services, the possible causes of these barriers and project activities to mitigate them. The WHO staff supported the WG in this identification exercise. Consultative meetings with other stakeholders (including the major donor organizations and relevant NGOs) were conducted between the WG meetings.

When the main areas of work were identified, a broader stakeholder workshop was conducted in early June to create a census and ownership of needed interventions among a broader health community. The WG team leader was the chair of this workshop. All WG members, representatives from the SHAEI regional branches and regional health authorities were among the participants of this workshop.

The WG continued working on the draft application during July, August and September months.

In order to provide technical assistance for the preparation of the application and regional peer review, the Division of Country Health Systems of the WHO Regional Office for Europe invited 4 members of the WG and the Local Consultant to participate in the Workshop on GAVI HSS Proposals Preparation in Kyrgyz Republic from July 29 to August 1. The Workshop provided tailored support, and the WG revised the draft application.

The draft application, developed by the WG with support from WHO, was submitted to the Minister of Health and the main donors in August, followed by a Health Policy Board meeting to review the draft.

Health Policy Board discussed the draft application, provided comments and suggestions, based on which the WG revised the application.

In mid and late August 2007, the WG had everyday meetings to finalize the GAVI HSS application. The WG has also discussed the application and comments on the application from the major stakeholders including the MOH and the Health Policy Board. The WHO representatives were usually invited to these meetings. The WG members met and had phone

conversation with the representatives from USAID, UNICEF, Vishnevskaya-Rostropovich Foundation and WB. In September the Health Policy Board had a meeting to discuss the final version of the application and endorsed it. After that endorsed version of the proposal was sent out for regional peer review to WHO country office, WHO Euro, WHO HQ, UNICEF Regional office, WB country office, GAVI Alliance, as well as to national counterparts and donor organizations. By the end of September the comments and suggestions were received incorporated in the proposal and the proposal was finalized and signed by the Minister of Health and Minister of Finance.

Who was involved in reviewing the application, and what was the process that was adopted?

The Health Policy Board of the Ministry of Health, Ministry of Health, Ministry of Finance, WHO, WB, UNICEF, USAID, Vishnevskaya-Rostropovich foundation, some NGOs reviewed the draft application and provided comments/suggestions, which were incorporated in the application. Moreover, the application was also reviewed in the scope of the regional peer review in July-August at Issyk-Kul workshop and in September by the members of the HSS task Force (via GAVI Secretariat).

Who approved and endorsed the application before submission to the GAVI Secretariat?

The Health Policy Board approved the final version of the application. The MOH and the Ministry of Finance, WB, WHO, VRF, USAID, and UNICEF endorsed the application.

Actions taken after the Conditional Approval in November 2007.

Initially the proposal was submitted to the GAVI Secretariat in October 2007. The proposal was conditionally approved in November 2007. The IRC send a report which outlined the conditions to be met and the needed clarifications to the MOH Armenia in December 2007.

The Working Group thoroughly discussed the IRC recommendations, as well as the comments and the recommendations of in-country partners and external consultants. Several changes were maid in order to meet the IRC conditions and the requested clarifications.

Afterwards the Members of the Republic of Armenia (ROA) Ministry of Health (MOH) Council on Policy Issues discussed the changes made and approved the revised proposal for submission to GAVI Alliance Secretariat (Appendix XXI).

For the complete list of IRC conditions and requested clarifications and the corresponding actions taken by Working Group please see Appendix XX.

1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Harutyun Kushkyan	MOH/ Minister	Yes	Coordinates the development of the policy in the field of public health services and approves GAVI HSS application form
Hayk Darbinyan	MOH/First Deputy Minister	Yes	Coordinates the sector of medical services
Abraham	MOH/Deputy	Yes	Coordinates the financial sector

Manukyan	Minister		
Tatul Hakobyan	MOH/Deputy Minister	Yes	Coordinates Drug Policy and International Affairs
Alexander Gukasyan	MOH/Deputy Minister	Yes	Coordinates realization of policy of licensing of medical establishments
Gagik Sayadyan	MOH/ Head of Staff	Yes	Coordinates job of the employees of the ministry
Suren Krmoyan, Legal Adviser to the Minister of Health	MOH, Legal Department	Yes	Coordinator of the activities of the Working Group and International Experts: responsible for development of the application
Artavazd Vanyan	MOH/Head of the State Hygienic and Antiepidemic Inspectorate	Yes	Participates in the implementation and monitoring activities of the GAVI HSS application
Sergey Khachatryan	MOH/Head of the "Health Project Implementation" Unit	Yes	Provides implementation of the WB financed project
Ara Ter-Grigoryan	MOH/Head of the State Health Agency	Yes	Responsible for financing of the State Health programmes
Vahan Poghosyan	MOH/Head of the Division of Health Provision	Yes	Responsible for implementation of the State financed programme in the Primary Health Sector
Narine Beglaryan	MOH/ Head of the International Relations Department	Yes	Ensures coordination and cooperation among the implementing partners
Eduard Margaryan	Head of the staff of the MOH Department of Pharmaceutical Activity Organisation, Drug and Technology Provision	Yes	Ensures coordination and cooperation among the implementing partners
Tigran Sahakyan	MOH/ Head of the Education Department	Yes	Coordinates the training component of the programme
Armen Karapetyan	MOH/Head of the Economy Department	Yes	Coordinates budget formulation of the programme
Izabel Abgaryan	MOH/ Head of Legal Division	Yes	Responsible for legal component of the programme
Mher Ghazaryan	MOH/Head of the Licensing Division	Yes	Responsible for the licensing of medical establishments to be involved in the programme

Zhora Asatryan	Ministry of Finance and Economy of the RA/ Head of Financial programming of budget expenditure Division	Yes	Consultant: responsible for the conformity of the GAVI HSS proposal financial components to financial reforms in the RA
Nara Davtyan	Ministry of Finance and Economy of the RA/ Specialist of Financial programming of budget expenditure Division	No	Consultant: responsible for the conformity of the GAVI HSS proposal financial components to financial reforms in the RA
Elizabeth Danielyan, Head of WHO Country Office for Armenia	WHO Country Office for Armenia	Yes	Coordinates of the activities of the International Experts
Ruben Jamalyan, Health Project Management Specialist	USAID	Yes	Ensures synchronization of GAVI HSS activities with USAID health projects
Sheldon Yett	UNICEF/Representative	Yes	Ensures that GAVI HSS activities comply with UNICEF policy and complement Unicef initiatives
Susanna Hayrapetyan, Senior Health Specialist	WB	Yes	Ensures that GAVI HSS activities comply with WB health reform interventions, approved the application
Ruzan Gjurdjyan, Representative	Vishnevskaya-Rostropovich Foundation	Yes	Ensures that GAVI HSS activities comply with VRF supported activities, approved the application
Gayane Sahakyan, Coordinator of Immunization Programme of the Ministry of Health of the RA	MOH, Immunization Program, SHAEI	No	Member of the WG: provides WG members with information on Immunoprophylaxis, as well as with statistical and other professional data, is responsible for development of indicators, list of required equipment and final financial assessment of the proposal.
Lilit Avetisyan, Head of the Department of Infectious and Non-infectious Disease Epidemiology	MOH, Department of Infectious and Non-infectious Disease Epidemiology, SHAEI	No	Member of the WG: Responsible for formation of the public health part of the proposal, description of the barriers contributing to the expansion of infection diseases and baring Immunoprophylaxis.

Karine Saribekyan, Head of the Mother and Child Protection Unit	MOH, Mother and Child Protection Division	No	Member of the WG: responsible for identification of barriers to immunization coverage and MCH services, formation of measures aimed at removing barriers to lead to a reduction of mother and child morbidity and mortality.
Ruzanna Yuzbashyan, Head of Primary Health Care Unit	MOH, PHC Division	No	Member of the WG: responsible for identification of barriers to immunization coverage at the PHC level, formation of measures aimed at removing barriers.
Samvel Kharazyan, Head of the Unit of Health Services Procurement and Information	MOH, Unit of Health Services Procurement and Information, SHA	No	Member of the WG: responsible for the preparation of GAVI proposal financial components ensure consistency with on-going financial reform activities.
Varduhi Petrosyan, Director of the Centre for Health Services Research and Development	American University of Armenia, Centre for Health Services Research and Development	No	Local Consultant: responsible for finalizing the application in accordance with the GAVI guidelines.
Jens Wilkens, Health Financing Analyst,	Health Systems Financing, WHO/EURO	No	Consultant: advises on the financial components of the application and integration of immunization programme into performance based financing schemes
Martina Pellny, Programme Officer on Primary Health Care,	Primary Health Care Unit, WHO/EURO	No	Consultant: Renders advices integration of immunization services into primary health care services
Elina Manjieva, Policy Analyst	Centre for Health System Development, MOH of Kyrgyz Republic	No	Consultant: advises on improvement of disease surveillance and monitoring system, as well as on financial sustainability of the programme
Niyazi Cakmak, Consultant for Vaccine Preventable Diseases and Immunization Programme	WHO/EURO	No	Consultant: advises on integration of immunization services into primary health care services, improvement of vaccine management system, improvement of timely coverage at all levels and immunization information system
Nazik Aslanyan	"Development Appropriate" Non governmental organization	No	Consultant on problems of children and vulnerable groups of population

Davit Petrosyan	"Human Health Care" Non governmental organization	No	Consultant on monitoring activities in the field of Public Health Services
Hovhannes Margaryants	"Armenian Public Health Union" Non governmental organization	No	Consultant on methods of informing the population about Primary Health Care Services

1.4: Additional comments on the GAVI HSS application development process

As indicated above, non-governmental organizations working in the field of Public Health were also invited to comment on the draft GAVI HSS Application. Three representatives from the NGOs listed below took part in the discussion and GAVI HSS application development process.

1. Nazik Aslanyan

Consulted on problems of children and vulnerable groups of population in Armenia; "Development Appropriate" Non governmental organization

2. Davit Petrosyan

Consulted on monitoring activities in the field of Public Health Services; "Human Health Care" Non governmental organization

3. Hovhannes Margaryants

Consulted on methods of informing the population about Primary Health Care Services; "Armenian Public Health Union" Non governmental organization

Section 2: Country Background Information

2.1: Current socio-demographic and economic country information[2]

Information	Value	Information	Value
Population	**3 219 200** (Source: NSS RA on 01.01.2006)	**GNI per capita**	**US$ 1524 (Source NSS.2005)** (US $1470, WB 2005, US $1930, WB 2006)
Annual Birth Cohort	**37857** (Source: NSS RA 2005)	**Under five mortality rate** (2000-2005)	**15.8‰ (Source NSS 2006)** (30 / 1000 (Source: DHS 2005))
Surviving Infants*	**37499** (Source: NSS RA 2005)	**Infant (0-1) mortality rate** (2000-2005)	**13.9‰ (Source NSS 2006)** (26 / 1000 (Source: DHS 2005))
Percentage of GNI allocated to Health	**1,39 % (MTEF 2007-2009)**	**Percentage of Government expenditure on Health**	**8,0% (MTEF2007-2009)**

* Surviving infants = Infants surviving the first 12 months of life

2.2: Overview of the National Health Sector Strategic Plan

In the framework of the Biennial Collaborative Agreement 2004-05 between MoH and WHO, the MOH developed a draft of a National Policy paper as a single comprehensive health sector strategy. Though the latter was presented for broad discussions twice it is yet to get finalized and current plans foresee that the World Bank-funded project on Health System Modernization is to take the draft forward.
Against this background the GAVI HSS proposal is based on the several strategic documents which complement and enforce each other, including the Primary Health Care Development Strategy (2003 – 2008), the Strategy for Maternal and Child Health (MCH) (2003 – 2015), the Poverty Reduction Strategy Paper (2003 – 2015) as well as the Medium Term Expenditures Framework (MTEF) (2007 – 2009) (for details see Appendixes VIII, XI, XII, XIII respectively). As outlined in these strategic documents, the key objective of the Health Care system of the country is to ensure financial protection, accessibility of the health care services and the proper quality of the provided services for the entire population. In this context a particular focus is laid on regions with high poverty rates which need the strengthening especially of primary health care services.

As a result of the dramatic economic decline and political turmoil in the region that followed the collapse of the Soviet Union, the health sector has been severely under-funded. It was recognized that the inherited hospital-based, resource-intensive system was no longer affordable. So far in many instances the financing gap has been filled by out-of-pocket payments, which by 2005 constituted 62% of total health expenditure. Acknowledging the need to address these issues, the

[2] If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested.

Government of Armenia (GoA) developed its first PHC strategy in 1997 and several external donors and technical agencies supported its implementation. Based on the completed work, the GoA developed a new PHC strategy in 2003 (see Appendix XIII) which defines the following priorities: (1) to continue integration of currently separate PHC functions (e.g. children's and adults' polyclinics) into family medicine practice, and strengthening the role of the preventive services in the primary health care level (2) to complete (re)training of family physicians and nurses, (3) to introduce incentives for good quality services, particularly in remote areas, (4) to raise awareness among the population about its rights in regard to service provision, (5) to increase the share of public expenditures allocated to PHC services, and (6) to streamline and optimize PHC and hospital networks.

According to the Mother and Child Health Strategy in Armenia 2003-2015 (Appendix XII), Armenia has mid levels of under 5 mortality rates by WHO classification. In 1990-2003 the UMR has shown definite trends of decline (1990- 23.7‰, 2002- 16.5‰). However during the last years both the Infant Mortality rates and the Under 5 Mortality rates tend to increase. (see the table below)

Source NSS (Appendix XVIII)	2004	2005	2006
1. Infant Mortality Rate‰)	11.6	12.3	13.9
2. Under 5 Mortality Rate - ‰	13.0	13.7	15.8

These trends can be explained by the newly adopted legislation regarding the births and infant and child mortality, and the improvement of their registration. However, it is possible also, that due to the impact of different factors the rates are really increasing. The identification of those factors and the measures taken to overcome them are one of the priorities of the MCH strategy.

The MCH Strategy (Appendix XII) emphasizes also the need to ensure full immunization coverage as well as to improve antenatal and obstetric care for pregnant women especially in poor rural areas. Moreover, the document stresses the importance of improving the nutritional status of women and children.

The strengthening of PHC services together with more effective public health services that work in close partnership with each other are considered the main instruments for achieving these objectives.

The PRSP (2003 – 2015) (Appendix XI) finally recommends a significant increase in state-financed health expenditure, particularly on the primary health care level as this is considered the key instrument to ensure physical and financial access to health services for the entire population, especially the poor.

Thus, the share of health expenditure in the total state budget expenditure has increased from 6,3% in 2003 to 8,2% in 2006 and by 2015 is planned to further increase to 11,9%. Moreover, by 2015, the share of health expenditure for primary care from public sources is planned to increase to 50% (in 1998 e.g. this share was only 19%).

MCH services are described as a separate program priority in the PRSP and emphasize the importance of achieving the Millennium Development Goals (MDGs). The implementation of Integrated Management of Childhood Illnesses (IMCI), ensuring full immunization coverage for children, improving the nutritional status of women and children, and providing increased public financing for obstetric care at all levels are seen as important tools for achieving these goals.

The MTEF (2007 – 2009) (Appendix VIII) takes full account of the priorities and spending targets outlined in the PRSP.

However, regardless of increased levels of financing for the sector as a whole and for PHC in particular, there has been limited progress toward building a health system that provides financial protection and access to good quality services for the entire population; it is projected that by 2012 government health expenditure will be slightly over 2,2% of the GNI. The detailed assessment of strengths and weaknesses of the system is provided in the next section.

Section 3: Situation Analysis / Needs Assessment

3.1: Recent health system assessments[3] - (see Appendixes I, II)

Title of the assessment	Participating agencies	Areas / themes covered	Dates
Public Expenditure Review of the Health Sector	World Bank	• Review of sector development agenda and levels and trends of total health expenditures, including out-of-pocket payments • Analysis of government health expenditures, health service delivery system, and health outcomes • Regional distribution of government expenditures • Impact of reforms on household financial burden and equality of utilization patterns • Impact of reforms on efficiency of resource use through linkages to facility restructuring • Impact of reforms on transparency of resource flows and on the practice of informal payment.	Issued: 2005 Covers: 2000-2004
Health Systems in Transition: Armenia Health System Review	European Observatory on Health Systems and Policies and WHO Regional Office for Europe	• Detailed description of organization, financing and delivery of health services • Comprehensive review of institutional framework, content and implementation challenges of key health policies • Brief analysis of main challenges facing the implementation of reforms and improving the health status of the population.	Issued: 2006 Covers: 1992-2005
Immunization Program Management Review	WHO, UNICEF, US CDC, WB, MOH, SHAEI, NCDC of the RA	• Comprehensive review of the immunization program, including (i) management, coordination and service delivery; (ii) immunization strategies, policies, and schedules; (iii) immunization coverage and monitoring; (iv) disease surveillance; (v) immunization quality and safety; (vi) advocacy and communication; (vii) financing and sustainability. • Analysis of strengths and weaknesses of each of seven components • Program and policy recommendations.	Issued: 2006 Covers: 2001-2005
Armenia Demographic	USAID, MOH, NSS,	Survey-based estimates of child	Issued 2005

[3] Within the last 3 years.

and Health Survey 2005	ORC Macro	health and immunization coverage, and a number of other indicators relevant for meeting the MDGs.	Covers: 2002-2005, mid estimates
Integrated Assessment on Immunization Quality and Safety, May 2006,	WHO	Assessment revealed significant supply interruptions/stock-outs at sub-national levels and health facilities at various times in 2005 and 2006 – this especially with regard to OPV and in some places for HepB and DTP vaccines due to: • low capacity of calculating required levels of vaccines (no standardized manual for recording and calculation of stocks has been adopted yet) • logistical problems in the supply chain (the current distribution is working as a collection system run by the regional level causing co-ordination problems) • heavy administrative (double-) structure on the inspectorate level and the lack of quality cold chain equipment.	Issued: 2006 Covers: 2005-2006

3.2: Major barriers to improving PHC and PH services identified in recent assessments

1. High out-of-pocket payments due to under-budgeting of the health system and fast expansion of the Basic Benefits Package

In 1997, the Government of Armenia introduced the Basic Benefits Package according to which a number of services, mostly at primary level and certain services provided by outpatient specialized care, were to be provided free of charge to the entire population, i.e. officially no co-payments were to apply when using BBP services. Moreover, a list of vulnerable groups that were to be exempt from fees at all levels was published. The Health Systems in Transition, Armenia, Health system Review 2006 (Appendix XVII) estimates that these groups represent 15.5 % of the total population.

Due to budgetary constraints and political pressures the content of the BBP has been revised on an annual basis. Currently, it covers all family medicine services (PHC), including the costs of home visits; antenatal and post natal care (provided by gynaecologists, family doctors or their nurses); a large part of dispensary outpatient care, e.g. such infectious diseases as tuberculosis; oncology services, psychiatric care, as well as a selection of services provided by narrow specialists.

Over time the cost of the Package has been increasing through increasing the number of groups exempt from any fees as well as expanding the range of services offered under the Program.

Although government spending for health has increased significantly over the last few years, there has been little increase in reimbursement rates resulting in high out-of-pocket payments. According to the World Bank Public Expenditure Review (2005), reimbursement rates cover only 30 to 50% of the total cost of services, leading to patients, including the poor, having to make informal payments. Thus, in 2005, 62% of total health expenditures in the hospital sector were out-of-pocket expenditures (PER 2005).

2. Lack of awareness among the public about their right to free PHC

The World Bank Public Expenditure Review in 2005 suggested low awareness among the population regarding services offered free-of-charge based on the under-spending of the budget covering recurrent costs for PHC services together with the observed low utilization rates (According to National Statistical Service (Appendix XIX), in 2003 there were 2.1 outpatient contacts per year, and in 2006 there were 2.8 outpatient contacts). The little increase in the number of outpatient contacts can be explained by the fact that the population is not informed about their rights. The BBP has been changing almost annually either, in terms of services covered and/or in terms of exemption categories. According to a UNDP survey carried out among those eligible for full exemption, 43 percent of those not aware of their eligibility did not seek care because they assumed that they would have to pay (UNDP/Government of Armenia "Social Monitoring and Analysis Project", 2005 quoted in WB PER, 2005). The situation improved a bit when the PHC services became for free in 2006. About 81.5 % of adult population heard about free primary health care, more than half of the respondents who heard about the free services had sought PHC; however for 28.8 % of them the services were not actually free (Primary Health Care Reform Project. *Household Health Survey: Baseline Evaluation. 2006.* Submitted by: Emerging Markets Group, Ltd. Submitted to: United States Agency for International Development (USAID), http://www.auachsr.com/publications_reports2006.php). Moreover, 27.9% of the population did not visit a PHC facility in the last two months even when there was a need. The main reasons for not using PHC services were lack of money/too expensive healthcare (49.7%), lack of trust in PHC providers/their qualification (16.7%), and lack of time (10.8%).

ARM DHS 2005 (Appendix XIX) shows that in 68% of cases of diarrhea among children, their mothers did not refer to the Primary Health Care Services/ medical workers.

Moreover, it seems that the Armenian population is still oriented toward curative rather than preventive services. People forego PHC services and turn directly to services at secondary level, even if they are costlier (Appendix XVII). Although mothers in Armenia are aware about the general need to immunize their children, they do not fully understand the importance of timely and full immunization, which contributes to high drop-out rates and delayed immunization. The DTP1-DTP3 drop-out rates are as high as 55.6% in some marzes and only 42% of children nationwide are considered to be fully immunized (Immunization Program Management Review, 2006, Appendix II).

3. Insufficient knowledge and skills of providers

Lack of knowledge or persisting stereotypes regarding the quality of certain medical supplies depending on their country of origin and safety of certain types of supplies, including vaccines, lead to lower utilization of MCH services. For example, in 2005, 37% of Armenian children aged 6-59 months suffered from anaemia. However, only 2% of them were taking iron supplements and 18% were given de-worming medication (DHS 2005, Appendix XIX).

According to the recent Immunization Program Management Review (Appendix II), there is a widespread belief among the Armenian health workers that vaccines produced in Western countries are of better quality than UN pre-qualified vaccines from countries such as India (example for DTwP). Hence, they provide inaccurate information to parents regarding safety of these injections and advise them to come back when they have better quality vaccines. Changing these stereotypes requires not only providing information to parents directly but also and perhaps even more importantly to change perceptions of PHC providers through specific trainings and supportive supervision.

In addition to negative stereotypes among the general population and health providers, the observed delays and dropouts are due to a high rate of reported contraindications. According to

the results of the survey conducted by UNICEF and WHO, 32% of vaccination failures are due to either wrong contraindications (24%) or fear of side effects (8%).

According to the Immunization Programme Management Review (2006) (Appendix II), there is a need to include into in-service training courses for nurses, family doctors and paediatricians topics such as “Immunization in Practice”.

These issues relate not only to lack of knowledge and necessary skills among health providers but also it leads to lack of awareness among the general population about important public health issues. PHC Providers are the first point of contact that deals with the population (including parents), and besides providing medical services they must have the necessary patient counselling skills and knowledge to counsel on such important public health issues as healthy behaviour and nutrition, as well as immunization. However, PHC providers do not possess the necessary knowledge and skills to fulfil this responsibility. Therefore, training them on public health issues and patient counselling skills would be important interventions.

4. Lack of physical access and/or availability of human resources in remote, mountainous, and near boarder areas

According to the GoA Resolutions N 713 (November 17, 1998) and No.1017-N (July 14, 2005) about the approval of the list of near border communities of Republic of Armenia, there are 181 villages and towns in 9 marzes of 10 which are defined as a remote and near border areas (see Appendixes VI and VII).

The following facilities deliver PHC services in Armenia: policlinics in urban areas (PHC physicians, some narrow specialists and nurses); rural health centres and rural medical ambulatories (PHC physicians and nurses); nurse midwifery centres (FAPs) (only nurses). There are rural health and rural medical ambulatories in 283 rural communities and nurse midwifery centres (FAPs) in 617 rural communities in Armenia.

Anyway, despite of the geographical coverage of the ambulatory services, the rural facilities are lacking enough specialists, due to the absence of financial incentives to work in rural areas.

According to the recent Immunization Program Management Review (2006) (Appendix II), regardless of the relatively developed health infrastructure and overall high rate of immunization coverage, there are areas where physical access to health services including immunization countinues to remain an issue, thus leading to low utilization rate of basic health services. The share of fully immunized children in some marzes such as Syunik and Tavush is only around 30%, whereas in marzes such as Vayots Dzor and Gegarkunik it is about 52-55% (UNICEF-WHO Immunization Coverage Survey, 2006). Moreover, the timely valid coverage (by 12 months of age) for DTP3 varies from 68% in Vayots Dzor Marz to 42% in Syunik Marz. Moreover, in 2005 in Gegharkunik marz, only 74% of mothers received antenatal care from a health professional and only 71% of births were assisted by a doctor (DHS 2005). The DHS 2005 suggested that the large proportion of home deliveries (14%) in Gegharkunik could be due to greater distances to health facilities.

Currently, 617 small villages (with population less than 2,000) are served only by FAPs (Feldsher Ambulatory Posts) that are run by nurses, midwives, and/or feldshers. Officially, FAP staff is responsible for very basic interventions, and in order to access higher levels of PHC, people in these villages have to travel to larger villages and towns that have ambulatory facilities and polyclinics (Poletti & Balabanova 2005 quoted in HiT 2006). Moreover, there are 41 communities in 7 mazes of Armenia without any medical facility (Appendix V), and health care services in those communities are provided through the FAPs and ambulatories of the neighbouring community.

These 41 communities face even more severe barriers to physical access to PHC physician services. FAPs are to be supervised by doctors from nearby polyclinics and ambulatory facilities.

However, for many years FAPs have been left on their own with FAP staff forced to deliver services for which they are not appropriately trained. Recently, the Government introduced a new payment scheme for doctors by which, they receive additional payments for visiting FAPs on a regular basis, but not less than twice a month. However, discussions with Ministry of Health officials and representatives of local health services reveal that these payments on their own are not sufficient to ensure that population groups living in remote, rural areas have access to timely and good quality services.

5. Lack of appropriate delivery system for PHC supplies, including vaccines

A weak vaccine management and delivery system contributes to delays in immunization and dropouts. According to the 2006 survey on immunization coverage, 29% of vaccination failures are

Although there is revised National Surveillance Standard on communicable diseases and trainings for epidemiologists have been conducted previously in cascade method (district, marz and national levels), the Immunization Programme Management Review (Appendix II) revealed that there are weaknesses in the communicable disease Surveillance System. The Surveillance structure has been changing but no deep analysis of the functional responsibilities of each newly created or changed institution was conducted. This created confusion and lack of clear mechanisms for conducting surveillance (for example, since the creation Expertise Centres as separate agencies from SHAEI there have been disputes regarding their functional responsibilities). Secondly, the existing package of indicators for disease surveillance is out-of-date and hence, the statistical data provided by the country is not comparable to international data. Also, there are no indicators for monitoring the performance of the surveillance system itself. Thirdly, physicians in PHC facilities and hospitals, and epidemiologists in Expertise Centres and SHAEI do not possess knowledge and skills for effective surveillance of communicable diseases. This leads to inaccurate diagnosis where cases are not confirmed by laboratory analysis, misreporting of cases, and incorrect epidemiological analysis.

AEFI surveillance is also weak due to the following: (i) There are no implementation mechanisms and legal regulations for the new guidelines; (ii) there are no systematic training programs for PHC doctors on immunization and to date there was only one general training conducted at the central level.

3.3: Barriers that are being adequately addressed with existing resources

1. High out-of-pocket payments due to under-budgeting of the health system and fast expansion of the Basic Benefits Package

One of the key issues in ensuring financial protection and access to the basic health services in Armenia is full public financing of the Basic Benefits Package and avoidance of unfunded mandates or expansion of services provided for free without first ensuring adequate funding for these. The projects financed by the World Bank and USAID are addressing this problem. The State Health Agency, the single purchaser in Armenia, with the technical support provided by this project has started costing of the BBP in order to estimate more accurately fiscal implications of the current BBP as well as any future changes. USAID funded PHCR project is currently working with MOH and State Health Agency on establishing performance indicators under BBP and initiate performance-based reimbursement mechanisms for primary care providers. PHCR project has been providing support to develop reform-oriented management skills and competences at the primary care facilities. This includes helping PHC directors develop skills in and distribution and identification of hiring needs, labour contracting, financial planning and budgeting, costing of PHC services, tax accounting and reporting, quality monitoring, and strategic planning. National Health Accounting, developed by working group including State Health Agency (SHA), Ministry of Finance and Economy (MOFE), National Statistical Service (NSS) and the USAID founded PHCR project, are based upon a review and allocation of expenditures from four basic data sources: (1) Government Accounts, (2) Survey of Donor contributions, (3) Household survey, (4) Health care facilities survey.

The increased public financing for the health sector as reflected in MTEF will also help in ensuring a proper match between the available resources and the volume of services guaranteed by the state. However, in order to ensure that the expansion of the BBP does not outpace the increases in the level of available resources in addition to initial costing of the BBP, it is necessary to conduct systematic evaluations of the changes in out-of-pocket payments, utilization patterns, and quality of services provided under the BBP.

As the increased financing of the health sector in recent years and the MTEF for 2007- 2009 show, the political commitment to the health sector has been strengthened (for specific figures see

previous sections). Moreover, the share of health expenditures for PHC in total health expenditures has been growing and is projected to increase further. This is mainly due to strong advocacy efforts of the Ministry of Health and its international partners.

2. Lack of awareness among the public about their right to PHC

UNICEF in cooperation with the MOH is conducting a wide range of advocacy and information campaigns targeted at mothers specifically and communities in general regarding the benefits of timely immunization of children. These activities are included in the annual joint UNICEF-MOH work plan and include printing of mother immunization cards, parental booklets on advantages of immunization, production and broadcast of video spots and TV programme series with special programmes on immunization. In addition to this, the USAID supported Primary Health Care Reform Project has a Public Education component that is involved in enhancing awareness about PHC services offered; improving understanding of open enrolment and acceptance of family medicine providers; promoting healthy lifestyle and health-seeking behaviour. This component also covers healthy lifestyle promotion and community mobilization campaigns to encourage health-seeking behaviour. To that end, the Project also provides trainings and small grants to health promotion NGOs in Yerevan and marzes. Through local NGO's, PHCR is also distributing Health Education messages to the population. The PHCR project Health Education initiative includes a module on child Immunization with clear message to the population why Immunization is important for children, what the national timetables for immunization are and what the possible/potential dangers of controlled infections are. Thus, there is already active involvement of UNICEF, USAID, and WHO in raising public awareness on issues regarding MCH, including immunization.
Currently MOH added a regulation, noting that health workers must inform pregnant women and mothers of children about their rights for the free medical services, and the women have to sign a document as verification.

3. Insufficient knowledge and skills of providers

To improve the knowledge and skills especially of PHC service providers, several donors and technical agencies offer various types of trainings. The World Bank and USAID e.g. have been active in pre-service training of family doctors and nurses: the large-scale training of family physicians which was begun in the first phase of the Health Sector Modernization Project (HSMP) and will continue in the second phase, aims to ensure the (re)training of 1650 physicians and an equal number of nurses. This in turn will provide the whole population with access to teams of retrained PHC providers in a ratio of one team per 1700 to 2000 population (WB HSMP PAD). More specifically, the project is now financing: (i) the training of physician trainers; (ii) the tuition fees & stipends for 600 family physicians and 720 family nurses (with the lodging provided by the GOA); (iii) technical assistance for the improvement of pedagogic skills in communication and counselling; and (iv) technical assistance for the sub-component management and evaluation of quality of the training.
Moreover, several agencies, including UNICEF, WHO and USAID, are planning to review the training needs and design a training module for PHC staff on MCH services to complement the existing trainings on Family Medicine.
However, several of the issues described in the previous section, such as the need to overcome/ eradicate wrong stereotypes, improve the knowledge on broad public health issues, etc are not yet addressed but crucial for improving the health outcomes of children in Armenia. Interventions to that end will be described in the following section.

4. Lack of physical access and/or availability of human resources in remote, mountainous, and near boarder areas

The issue of physical access to PHC services and availability of human resources, in remote rural areas is being addressed through several activities. International agencies and charity organizations are financing variety of outreach activities. For example, between 1999-2006 under the World Bank financed project 90 of polyclinics and ambulatory facilities across the country have

been provided by vehicles. These vehicles should allow doctors to conduct more regular visits to FAPs which are in their catchments areas. World Vision Armenia has 8 mobile outreach teams (MOT) working in 4 marzes of Armenia (Gegharkunik, Lori, Syunik and Tavush). Since 2004, they have been serving 123 rural communities and the program ends in February 2008. During the monthly visits these MOTs have never provided immunization services.

Moreover, the Government of Armenia, in an attempt to ensure access and better quality services to population groups living in remote rural areas, has recently created a scheme by which a doctor in a PHC facility responsible for FAPs receives a certain bonus payment for conducting regular visits to the FAPs. A bonus payment system is being introduced by the MOH for those health providers who work in remote rural areas.
Despite these activities, pockets of under-coverage remain and in order to ensure equity in access it is necessary to provide targeted assistance that will ensure physical access to basic PHC services for all children in Armenia.

5. Lack of appropriate delivery system for PHC supplies, including vaccines

Weak vaccine management and delivery system contributes to delays in immunization and dropouts. According to the 2006 survey on immunization coverage, 29% of vaccination failures are accounted by vaccine stock-outs (UNICEF - WHO, 2006). This is supported by the findings of the recent Immunization Program Management Review, according to which, staff are not trained in vaccine requirement calculations, distribution, stock management and reserve stock management leading to significant vaccine supply interruptions and stock-outs at sub-national levels and health facilities at various times during 2005 and 2006. Vaccine requirement calculation methods are not standardized and staff is not able to project the expected actual stock balance to be in hand at the date new vaccine stocks would arrive, or the additional needs for “catch-up” vaccination if stocks in fact would have run out before the arrival of new supply (Immunization Management Review 2006) (Appendix II).

In addition to the need to increase the capacity of staff, there is also a need to review the existing vaccine delivery system and cold chain equipment. Currently, the country does not have a centralized distribution system and each facility is responsible for collecting their share of vaccines using cold bags. This is contributing to stock-outs and wastage due to improper storage during transportation. To address these problems a recent review by a WHO team recommended the purchase of a small truck with refrigerator to ensure timely distribution of vaccines and to keep them from spoiling. However, as a prerequisite, it is necessary to first conduct a review of the current distribution system and develop a new one based on the findings of the review.

6. Irregular and low quality supportive supervision of primary and public health services

In order to improve the coordination mechanisms between PHC and PH services (e.g., coordinated outreach and delivery of supplies), the MOH, in cooperation with the WHO and UNICEF, plans to develop a system of supportive supervision. So far this process has not been started and no operational support has been provided by any of the donors. In collaboration with USAID founded Primary Health Care Reforms (PHCR) project, MOH works also on establishing quality monitoring and assurance mechanisms at PHC facility, marz (regional) and national levels.

7. Weak surveillance systems for communicable diseases, including VPD and adverse events following immunization (AEFI)

The MOH, with WHO support will review and revise existing surveillance systems for communicable diseases, with special emphasis to case definitions and, detecting, reporting and case investigation procedures based on which guidelines and regulations defining implementation of both surveillance systems in line with WHO recommendations will be developed.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

1. Insufficient knowledge and skills of PHC providers

A key health system barrier to quality MCH that requires additional resources is insufficient knowledge and skills of PHC providers. This includes the following elements: (i) lack of knowledge on public health issues, including immunization, child care and prevention and (ii) lack of patient counselling skills.

As Family medicine is established and is empowered currently, and mostly (if not all of) those who are retrained as family doctors are the former therapevts (or district therapevts) who did not provide services to children previously (especially immunisation) they need to be retrained in mentioned topics.

The issue will be addressed through support from GAVI HSS. Some persistent stereotypes among the population are directly related to lack of knowledge on certain issues among health providers. To address this issue the PHC providers will be trained in certain public health and MCH issues, including healthy nutrition and healthy behaviours, and Mid-level Management and Immunization in Practice modules developed by WHO.

2. Lack of physical access and/or availability of human resources in remote, mountainous, and near boarder areas

Some part of GAVI HSS grant will be used to support to solve the issue of lack of physical access in remote, mountainous, and near boarder areas.
According to the GoA Resolutions N 713 (November 17, 1998) and No.1017-N (July 14, 2005**)** about the approval of the list of near border communities of Republic of Armenia, there are 181 villages and towns in 9 marzes out of 10; which are defined as a remote and near border areas (see Appendixes VI and VII).

Outreach teams will be established for 5 marzes (Shirak, Syunik, Tavush, Vayots Dzor, Gexarkunik) with such villages where people do not have physical access to PHC services beyond those provided by FAPs because they are too far or difficult to travel to for PHC doctors' services assigned to them. Moreover in these areas there is lack of supervision due to absence of certain professionals (epidemiologists, paediatricians and etc.) In these remote poor areas providers often do not have vehicles or budgets to cover operational costs such as fuel and maintenance, to provide FAPs with visits by doctors.

These activities would compliment the existing efforts of the MOH to ensure human resource availability in the remote rural areas by providing financial incentives for working in these sites or making frequent outreach visits.

As the HSS financial recourses are limited and can not cover all needs, HSS funds will be useful for those marzes which are remote, mountainous and a few number of organizations are working there.

3. Lack of appropriate delivery system for PHC supplies, including vaccines

This is another area that requires GAVI HSS resources in addition to those that are already being provided by the Government of Armenia, UNICEF, Vishnevskaya-Rostropovich Fund, World Bank and WHO. It is envisioned that in the near future vaccines will be distributed from the central to the marz and then district level using a single vehicle on a regular basis rather than being collected by each facility individually at various intervals. Currently, the MOH in cooperation with WHO is

planning to review the existing vaccine distribution system that has been identified as one of the barriers to effective immunization services. However, the new system cannot be implemented unless a new small truck with a refrigerator is purchased for the centralized distribution.

Another gap that has been identified in vaccine management and delivery system is the lack of skills at marz and district level for vaccine requirement calculations, stock management etc. While there are limited international training opportunities provided by WHO for central level staff, there are no such opportunities for marz and district level staff. Training of district and regional (marz) level Program Managers (epidemiologists and family doctors/ paediatricians) on Mid Level Management and Rational Drug Use is necessary.

4. Irregular and low quality supportive supervision of primary and public health services

GAVI HSS funds in this respect will serve as catalytic funds that will initiate the process of building the capacity for high quality supportive supervision in the country. Thus, as a result of the process of development of the GAVI HSS plan, MOH has made a commitment to review existing institutional arrangements and content for supportive supervision and define clearly roles and responsibilities of supervisors. These have been identified as key elements for building effective supportive supervision. However, a comprehensive approach to addressing this barrier requires a whole set of activities that have not been addressed yet: developing standardized and quantifiable supervision checklists and manuals covering selected public health programmes; training marz and district level public health managers on supportive supervision with specific emphasis to programme management and reporting; and providing partial operational support (per diems and fuel) for supervisory visits.
The 44 teams for supportive supervision will be created at the marz level within the Public Health Service system (Marz Expert Centre) and will be mobile. These teams will include a physician-epidemiologist from the expert centre and a PHC provider (a paediatrician or family physician). The marz Expert Centre and Marz Health Department will manage the mobile teams of supportive supervision.

5. Weak surveillance systems for communicable diseases, including VPD and adverse events following immunization (AEFI)

GAVI HSS funds in this respect will be used to support the skill transfer trainings of the marz and district level staff responsible for surveillance using the WHO integrated surveillance training module and operational costs of surveillance system implementation. GAVI HSS Support is needed to develop and print standardized and quantifiable supervision checklists and manuals to these checklists. And finally, initial operational support to cover per diems and fuel is necessary.

Section 4: Goals and Objectives of GAVI HSS Support

4.1: Goal and intermediate objectives of GAVI HSS support

The goal of the GAVI HSS proposal for the Republic of Armenia is to improve quality and responsiveness of PHC and public health services, with special attention to population groups living in remote and border areas.

In order to achieve this goal the following intermediate objectives are set up:

1. Improved knowledge and skills of PHC/PH providers
2. Improved quality of PHC/PH services
3. Effective linkages between PHC and PH services

4.2: Objectives of GAVI HSS Support

The following main objectives, which will help to achieve the goal through mentioned above intermediate objectives, have been identified:

1. **Development of health (PH and PHC) workforce by training 1800 health care professionals by 2010**

This objective relates to the priority 1 identified in the GAVI HSS Guidelines 2007. Through this objective it would be possible to strengthen the public health knowledge and patient counselling skills of 1800 health providers, as it was identified in a PHC strategy(Appendix XIII) as an issue that is in need to be addressed. Additional workforce development activities would include training of 420 public health professionals by 15 one day trainings in 2009 and 20 one day training in 2010 (35 trainings totally) in vaccine supply and delivery, 480 program managers (epidemiologists and family doctors/paediatricians) in Mid Level Management and supportive supervision by 20 trainings in 2009 and 20 training in 2010 (40 trainings totally) and 900 participants will be trained on surveillance of communicable diseases, by 30 one day trainings in 2009 and 45 one day trainings in 2010 (75 one day trainings totally).

As the trainings aim to enhance the knowledge of the health professionals, it is projected that after these trainings health care workers will better inform the population referring to them (about their rights, PHC services, immunisation etc).These activities will lead to better awareness of the population, fight against existing stereotypes regarding the quality of medical supplies, and generating demand for immunization and other services at the PHC level.

2. **Establishment of integrated supportive supervision of primary and public health services, by training marz and district level 240 professionals during 20 two day trainings and establishing 44 teams for supportive supervision by 2010**

This objective relates to the priority areas 1 and 2 as identified in the GAVI HSS Guidelines 2007. The lack of integrated supportive supervision of primary and public health services was recognised as one pf major weaknesses of PHC and Public Health sphere in a PHC strategy (Appendix XIII), and in the Immunisation Programme Management Review (Appendix II).

This can be done through developing standardized and quantifiable supervision checklists and manuals covering selected public health programmes; training marz and district level 240 (out of 1800) public health managers on supportive supervision with specific emphasis to programme management and reporting; and providing partial operational support (per diems and fuel) for supervisory visits. It is planned to have 10 trainings in 2009 and 10 trainings in 2010.

The 44 teams for supportive supervision will be created at the marz level within the Public Health Service system (Marz Expert Centre) and will be mobile. These teams will include a physician-

epidemiologist from the expert centre and a PHC provider (family doctor/paediatrician responsible for the district). The marz Expert Centre and Marz Health Department will manage the mobile teams of supportive supervision.

This objective will also help to strengthen the interface between the public health and the PHC services at the service delivery level – the supportive supervision of PHC staff. This activity will be organized by MOH and USAID founded PHCR project.

3. **Improvement of access to PHC and PH services in remote, mountainous, and near border areas by establishing 5 outreach teams for 5 marzes (Shirak, Syunik, Tavush, Vayots Dzor, Gexarkunik) by 2010**

This objective relates to the priorities 2 and 3 as identified in the GAVI HSS Guidelines 2007.
Several strategic documents, such as Immunisation Program Management Review (Appendix II), PHC strategy (Appendix XIII) and the ARM Coverage Survey (Appendix I) identified lack of access to PHC and PH services as one of the major weaknesses of the Armenian Health Care System in general and of the PHC in particular.

Physical access to PHC and PH services in remote areas will be strengthened via establishing 5 outreach teams for 5 marzes (Shirak, Syunik, Tavush, Vayots Dzor, Gexarkunik) with villages without PHC facilities and services beyond those provided by FAPs because they are too far or difficult to travel to get PHC doctors' services assigned to them. Also it is planned to train 60 outreach staff members, during 3 day trainings. It is planned to have 5 trainings in 2009 and 5 trainings in 2010; so there will be 10 trainings totally within this activity.

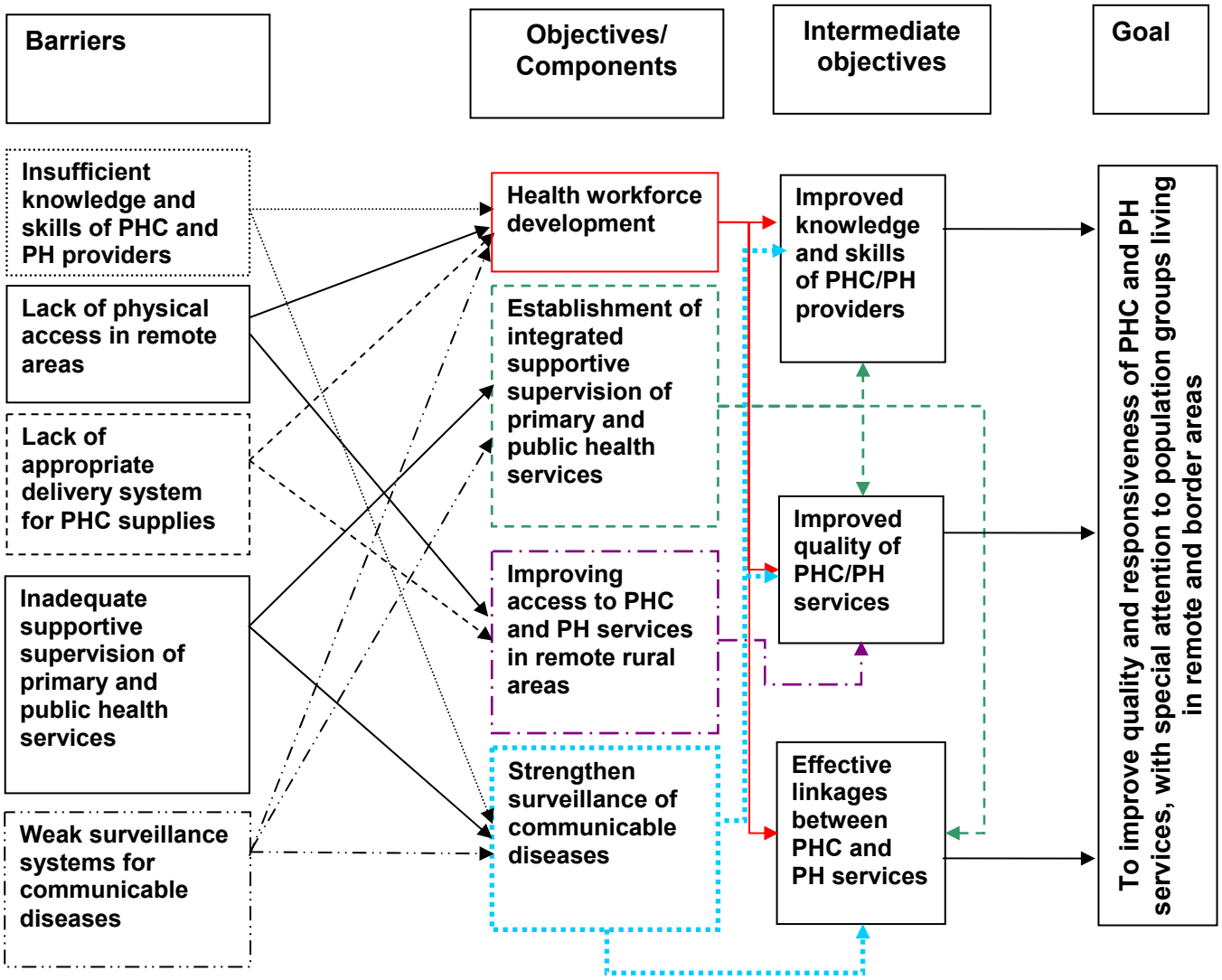
In addition to this, this GAVI HSS application proposes to purchase a refrigerated vehicle to transport vaccines and support the centralized, timely, and quality delivery to the marzes, particularly remote areas.

4. **Strengthening the surveillance of communicable diseases, including VPD and adverse events following immunization (AEFI) by training 900 specialists, by 75 one day trainings and providing operational support (printing of reporting and case investigation forms, providing transportation support for case investigations, specimen transportation and active surveillance in areas needed) to implementation of surveillance systems.**

This objective relates to the priority 2 identified in the GAVI HSS Guidelines 2007.
Immunisation Program Management Review (Appendix II) and the ARM Coverage Survey (Appendix I) recognised the need to strengthen the surveillance of communicable diseases via strengthening the surveillance system

The surveillance system for communicable disease will be strengthened through training marz and district level programme staff responsible for surveillance using WHO's integrated surveillance training module; training reporting site (hospital and health facility) staff on surveillance using marz and district level trained staff as trainers; providing operational support (printing of reporting and case investigation forms, providing transportation support for case investigations, specimen transportation and active surveillance in areas needed) to implementation of surveillance systems. Totally 900 specialists, out of initially indicated 1800 will be trained under the activities planned in this component. It is planned to conduct 30 one day trainings in 2009 and 45 one day trainings in 2010 (75 one day trainings totally).

The following chart aims to demonstrate the links between the Barriers, Objectives/Components, Intermediate objectives, and the overall goal of the proposed activities to be supported by GAVI HSS.



**The Chart reflects only 5 of the barriers out of 7 identified in the Application; these 5 barriers will be addressed through additional support from GAVI HSS.*

Component description

Component 1: Health Workforce Development

This component will address barriers 1 and 5 identified in the Section 3.2, and aims to improve health workforce performance.

These trainings will lead to a stronger involvement of PHC staff into Mother and Child health promotion and prevention. This is particularly important since Armenia is still facing high prevalence of anaemia among women and children, as well as high-level of malnutrition among young children (DHS 2005). Additional trainings include training of public health professionals in vaccine supply and delivery, supportive supervision and surveillance of communicable diseases.

This application proposes to carry out assessment of training needs and design a training module for PHC staff on MCH and PH services including the latest WHO recommended immunization practices and other public health programs to compliment the existing training program on family medicine (in-service training). This will be done in close collaboration with the WB, USAID and UNICEF that are leading the efforts in implementing unified family medicine curriculum in medical education institutions in Armenia and trainings of family physicians and family nurses.

Additionally, refresher-trainings of PHC staff on maternal and child health issues, public health issues, and patient counselling skills is an urgent requirement for those doctors and nurses who have been trained before the year 2000. This would also be carried out based on the established training system supported by the World Bank, USAID and UNICEF, as well as in line with their training strategies.

It is projected that the activities of the Component 1 will be carried out by a close collaboration of the MOH Primary Health Care Unit, Education Department, Mother and Child Health Unit and the State Anti-epidemiological Inspection.

Component 2: Establishment of integrated supportive supervision of primary and public health services

This component will address the barrier 4 identified in the section 3.2.
Currently, the supervisory visits of public health staff to PHC facilities are conducted on an irregular and unstructured basis by underpaid and insufficiently trained staff. This function is restricted to mainly epidemiologists and some paediatricians or family physicians. This component suggests re-organizing the supervision system to broaden its mission from supervision of immunization services to all public health services to be carried out on the primary health care level. Moreover, the nature of supervisions should be changed to supportive nature by giving on-site trainings and working hand in hand with family doctors and nurses to establish effective information exchange. This will also improve the reporting system.

This re-organisation requires a number of activities which are addressed in the plan of work, e.g., to legally define the new supportive supervision system and the eligibility of other specialists to carry out this managerial function (would be funded by the Ministry of Health), to compile standardized and quantifiable supervision checklists which are available free of charge from WHO but need to be compiled into one document and adapted to the local context (will be funded by GAVI HSS Grant), to train the respective public health staff on this (will be funded by GAVI HSS Grant) and to provide operational support for its implementation (mainly expenses for replacements which will be covered by GAVI funds for the first two years and than be taken over by the government of Armenia). Finally, the evaluation of the impact of such an integrated supportive supervision (including child nutrition, growth and development, IMCI, also monitoring of IMR indicators, etc) and the dissemination of the findings will be carried out by external

reviewers funded by UNICEF.

As components 3 and 4, this component aims to improve the interface between public health and primary health care services.

The implementation of the activities proposed under the Component 2 will be carried out by MOH Primary Health Care Unit, the State Anti-epidemiological Inspection, the State Health Agency and the Economy Department of the Ministry of Health.

Component 3: Improving access to PHC and PH services in remote, mountainous, and near border areas

Component 3 aims to address barriers 2 and 3, identified as not adequately addressed barriers currently (Section 3.2).

This component tries to tackle the pockets of low coverage complementing the ongoing significant efforts towards PHC development in Armenia supported by International Agencies, mainly by the World Bank, USAID, UNICEF and others. All these projects have components on improving general access to health services and quality issues at the PHC level. However, the activities proposed in the GAVI HSS application – in close co-ordination with the mentioned projects – will try to cover the unmet needs. In some "remote, mountainous, and near boarder" areas (see the Government Definition), the population is still experiencing access problems which will be covered establishing well-organized outreach teams with appropriate transportation means (which will also be used in parallel for supervisory visits – see Component 2).

The members of established outreach teams will also go through the trainings or refresher-trainings (see the Component 1 for the details about the trainings).

The main aim here is to strengthen the supply distribution and its maintenance.

District and regional (marz) level Programme Managers (epidemiologists and family doctors/paediatricians) will go through training of on MLM (see the Component 1 for the details about the trainings) to improve estimations of necessary vaccine supplies. Additionally, the purchase of a small refrigerated truck will allow a more co-ordinated medical supply distribution system from the central level – and which is not yet available in the country.

Component 3 will be implemented by the close cooperation of such Ministerial bodies as Primary Health Care Unit, the State Anti-epidemiological Inspection, the State Health Agency and the Economy Department of the Ministry of Health.

Component 4: Increase the capacity of the surveillance systems for communicable diseases, including vaccine preventable diseases and AEFI

This component aims to strengthen the surveillance system for communicable diseases to address the weaknesses the Immunization Programme management Review (2006) identified as a barrier 5 in the section 3.2 of this proposal.

This will allow Armenia to timely respond to disease outbreaks in order to prevent epidemics, reduce numbers of hospitalisations and ultimately reduce the burden on the health system. It will as well enable the health system to timely notify and investigate adverse events, and enhance the capacity to take necessary actions to correct programmatic errors and/or improve safety of immunization.

Although the structure has been changed over the years, functional responsibilities of each newly created or changed institution (Expertise Centres, Inspectorate/ SHAEI, CDC) are not clearly outlined which produces much confusion and frustration among the public health staff. Secondly, the existing reporting system needs to be enhanced: This includes revision of the Epidemiological Standards approved by the Ministry of Justice, which contain out-dated reporting forms. In

addition to this, those standard forms for monthly/ quarterly surveillance are physically difficult to get and only randomly used in practice – meaning that no standard form is actually used nation-wide. Furthermore, health facilities are not retaining copies of reports sent to higher levels. And finally, physicians in PHC facilities and hospitals, and epidemiologists from Expertise Centres and SHAEI are in dire need to be retrained: there is a lack of understanding of the standard case definition and a high percentage of cases are reported without laboratory tests – especially for measles. Consequently, areas which are proposed to be funded by the GAVI HSS grant are as follows (other activities mentioned under this component will be carried out by WHO under their regular country support or by the MOH itself): 1) existing guidelines and training materials will be revised in line with WHO recommendations for surveillance of communicable diseases, including VPDs and AEFI. 2) PHC-staff and mid-level program managers will be trained in order to improve the full range of functions of a surveillance system: detection, reporting, case investigation, specimen collection, case confirmation, feedback and action taking. 3) And finally, it is planned to contribute financially to the operational support through e.g. the printing of surveillance reporting forms or the support to specimen transportation.

The activities included in the Component 4 will be carried out by the Primary Health Care Unit of the Ministry of Health and the State Anti-epidemiological Inspection,

Section 5: GAVI HSS Activities and Implementation Schedule

5.1: Sustainability of GAVI HSS support

The sustainability of the proposed activities in this application has been carefully assessed both from a general HS sustainability perspective, and the pure financial sustainability of the proposed activities, i.e. the ability of the government to take over funding and build on the results obtained by the GAVI support.

Financial Sustainability

All components have activities funded directly by the government and other donor agencies, which mean none of the activities, are solely dependent on GAVI HSS support. Several of the activities in each component are targeted directly to creating sustainability. The training modules and materials to be developed within the component 1 will all be used after the time of the project. Since all the trainings will be conducted based on already existing training institutions and facilities, it will produce not only trained staff, but also contribute to the development of existing training institutions (capacity building).

For some activities, GAVI funds will be used during the first and second year of the activities, and the government will increasingly take over funding, most importantly operational support like per diems and running costs of vehicles.

The proposed indicators in the monitoring package can, after the GAVI funding has ended, still be used by the Government as “dash board” indicators in monitoring the performance of immunization. It will be feasibly to continue monitoring a limited number of indicators.

In addition, the overall financial framework in which this support is given is favourable from a sustainability perspective and makes it possible for the government to take over the proposed activities, (see chapter 2.2). Although Armenia has a very low level of public spending on health, health expenditure related targets in the PRSP from 2003 have been met. With the increase in GDP over the last years, this has meant a substantial increase in absolute public funding of health. Expenditure on PHC as share of total health spending has increased from 19% to 32% from 1998 to 2004. By 2015, it is envisioned that 50% of public expenditure on health will be allocated to PHC. With increasing GDP, increasing priority to health, and increasing focus on PHC, Armenia is able to address HS barriers in collaboration with donors and increasingly take over the responsibility.

Technical Sustainability

All the activities proposed in the ARM HSS proposal will be implemented by using the existing resources. There is no need for the external technical support, for the implementation of any activity.

The proposed activities are mostly trainings, developing of training manuals and guidelines, establishment of supportive supervision and outreach teams, and those kinds of activities are currently implemented by the Health Care System without any external technical assistance. The activities included in the proposal are mainly directed to strengthening the existing capacities of the system and covering the pockets that are currently out of coverage (due to different factors already described in corresponding section (Section 3, points 3.2 and 3.4)).

The 5 outreach teams that will be established with GAVI support will continue to operate after the end of the support, as Government of Armenia will further support their operation. Moreover, to ensure that the Government of Armenia will be able to take that responsibility, during the third year of support the outreach teams will be 50% financed by the Government of Armenia.

All the training manuals and modules that will be developed in the scope of GAVI support will be integrated into existing training courses for health professionals, thus ensuring the sustainability and continuity of this component as well.

5.2: Major Activities and Implementation Schedule

Components and Major Activities	Financing agency	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Component 1. Health Workforce Development													
Activity 1.1. Reviewing training needs and designing a training module for PHC staff on MCH services to compliment the existing trainings on Family Medicine (in-service)	WB, USAID, WHO, UNICEF												
Activity 1.2. Conduct trainings on MCH services, including Immunization in Practice (TOT) (WHO)	WHO, WB, USAID												
Activity 1.3. Training of 480 district and regional (marz) level Programme Managers (epidemiologists and family doctors/pediatricians) on MLM (40 trainings, each trainig group -12 participants)	GAVI												
Activity 1.4. Integrate current public health programme trainings into continuous medical education (CME) system	MOH												
Activity 1.5. Upgrade pre-service training according to the needs identified in Activity 1.1 (e.g., public health issues and patient counselling skills)	GAVI												
Activity 1.6. Training of 60 outreach staff members during 3 days trainings on maternal and child health using IMCI, Safe Motherhood, Immunization in Practice and Reach Every District training modules (10 trainings)	GAVI, UNICEF												
Activity 1.7. Conduct 35 one-day trainings of 420 specialists at marz and district level responsible for supplies management and delivery	GAVI												
Activity 1.8. Train marz and district level programme staff 240 members during 20 two-days trainings responsible for surveillance using WHO's integrated surveillance training module	GAVI												
Activity 1.9. Train reporting site (hospital and health facility) staff 900 members during one-day trainings on surveillance using marz and district level trained staff as trainers (75 trainings, each training group -12 participants)	GAVI												
Activity 1.10. Train marz and district level 240 public health managers during one-day trainings on supportive supervision with specific emphasis to	GAVI												

Components and Major Activities	Financing agency	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
programme management and reporting (20 trainings)													
Component 2. Establishment of regular and high quality integrated supportive supervision for primary and public health services													
Activity 2.1. Develop a system of supportive supervision that clearly defines the process and its content as well as roles and responsibilities of supervisors	MOH, WHO & UNICEF												
Activity 2.2. Develop and print standardized and quantifiable supervision checklist accompanied by manuals covering selected public health programmes	GAVI												
Activity 2.3. Provide operational support (per diems and fuel) for supervisory visits, excluding Yerevan, for 2 years. 3rd year 50 % GAVI funded, conditioned that in the 3rd year, the GoA provides 50% of total budget needs	GAVI, plus GoA												
Activity 2.4. Monitor and evaluate integrated supportive supervision and disseminate findings with decision makers and partners	MOH, partners												
Component 3. Improving access to PHC and PH services, including immunization, in remote, mountainous, and near boarder areas													
Activity 3.1. Establish outreach teams to deliver basic health services (maternal and child health services) in remote, mountainous, and near boarder areas) and procurement of 5 vehicles to support outreach activities in selected poor performing and remote districts	GAVI												
Activity 3.2. Provide operational support (per diems and fuel) for outreach teams	GAVI, MOH												
Activity 3.3. Bonus payments of health providers working in remote, mountainous, and near boarder areas	MOH												
Activity 3.4. Review and revise the existing supply management and delivery system to ensure continuous availability of safe supplies and supplies at the point of use as a follow up of 2006 assessment	WHO, UNICEF, USAID												
Activity 3.5. Procure a refrigerated-truck to be used for vaccine and supplies delivery to sub-national levels	GAVI												

Components and Major Activities	Financing agency	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 3.6. Prepare guidelines and regulations defining implementation of revised vaccine management and delivery systems	MOH												
Component 4. Strengthening the surveillance systems for communicable diseases, including vaccine-preventable diseases (VPDs) and adverse events following immunization (AEFI)													
Activity 4.1. Review and revise existing surveillance systems for communicable diseases, with special emphasis to case definitions and, detecting, reporting and case investigation procedures	WHO												
Activity 4.2. Prepare guidelines and regulations defining implementation of surveillance systems in line with WHO recommendations	MOH												
Activity 4.3. Provide operational support (printing of reporting and case investigation forms, providing transportation support for case investigations, specimen transportation and active surveillance in areas needed) to implementation of surveillance systems	GAVI												
Activity 4.4. Conduct regular assessments to evaluate performance of the surveillance systems	MOH, WHO												

Section 6: Monitoring, Evaluation and Operational Research

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value[4]	Source[5]	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)	MOH, NIP	86,8%	MOH, NIP	2006	95%	2010
2. % of districts achieving ≥80% DTP3 coverage	MOH, NIP	(35/51) 69%	MOH, NIP	2006	100%	2010
3. BCG – DTP3 drop out rate at national level (%)	MOH, NIP	3,6%	MOH, NIP	2006	< 3%	2010
4. Under five mortality rate (per 1000)	NSS	15.8	NSS	2006	<=12	2010
5. Number of annual average PHC contact per person	MOH, SHA	2,4	NSS	2005	3	2010

[4] If baseline data is not available indicate whether baseline data collection is planned and when
[5] Important for easy accessing and cross referencing

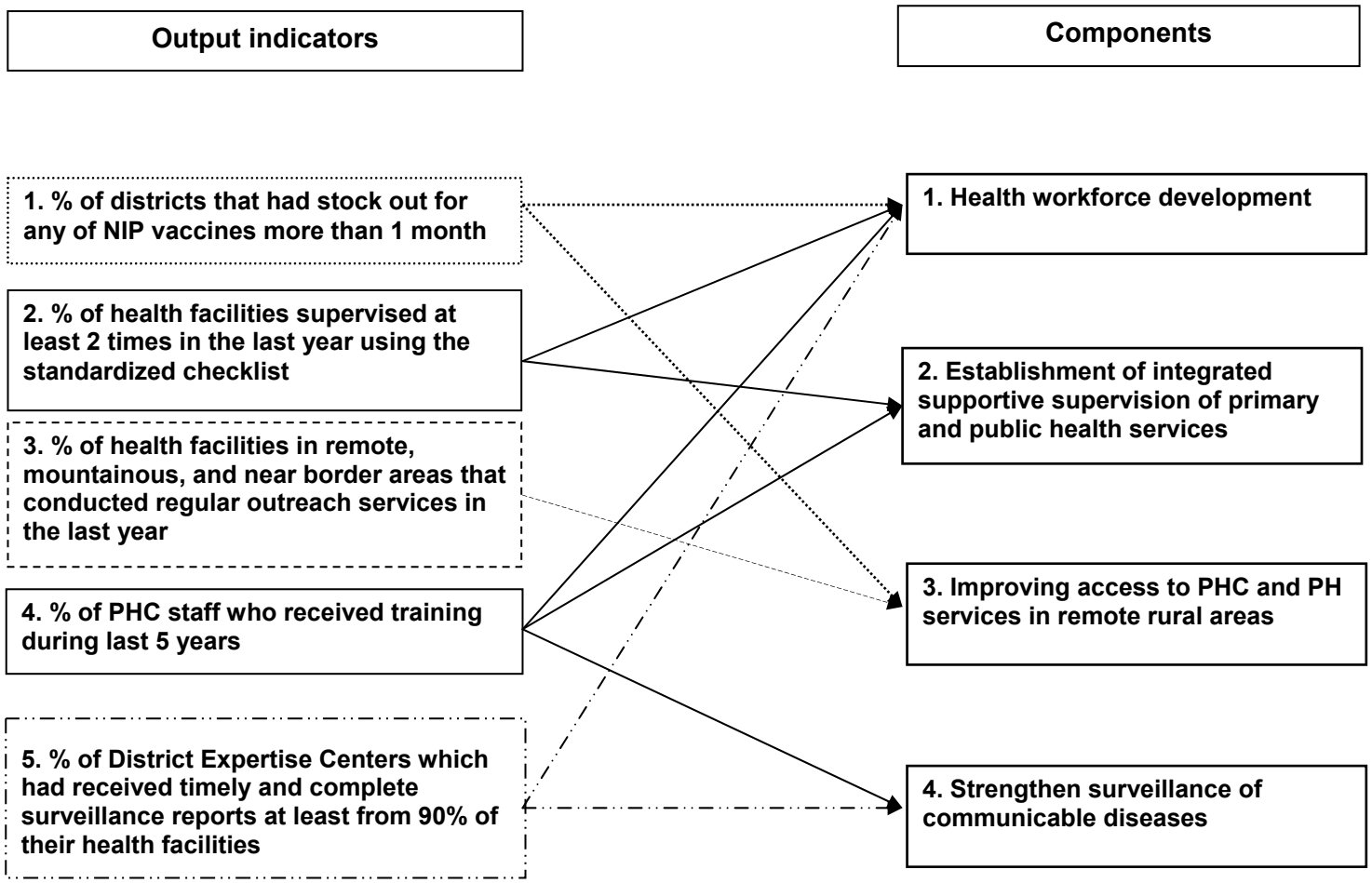
6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value[4]	Source	Date of Baseline	Target	Date for Target
1. % of districts that had stock out for any of NIP vaccines more than 1 month	Number of districts that had stock out for any of NIP vaccines more than 1 month in the last year	Number of districts that deliver vaccines to PHC facilities in their territory (44 + 7 = 51)	Supervision checklists	100%	NIP records	2006	5%	2009
2. % of health facilities supervised at least 2 times in the last year using the standardized checklist	Number of health facilities supervised at least 2 times in the last year using the standardized checklist	Number of operational health facilities (facilities with staff) in the last year	Supervision checklists	0% (baseline value taken as 0, as the standardized checklist is not introduced yet and supervisions are not supportive)	MOH	2006	90%	2010
3. % of health facilities in remote, mountainous, and near border areas that conducted regular outreach services in the last year	Number of health facilities in remote, mountainous, and near border areas that conducted regular outreach services (at least once a month per village) in the last year	Number of health facilities in remote, mountainous, and near border areas that have villages / localities in their catchment areas to serve other than where the health facility is	Supervision checklists	4% *	MOH (estimate / collection of baseline data before submission of application)	2006	50%	2010

		located						
4. % of PHC staff who received training during last 5 years	Number of PHC staff who received training on public health programmes in the field of MCH, including immunization	Total number of PHC staff	Supervision checklists	40%	MOH (estimate / collection of baseline data before submission of application)	2006	90%	2010
5. % of District Expertise Centres which had received timely and complete surveillance reports at least from 90% of their health facilities	Number of districts which had received timely and complete surveillance reports at least from 90% of their health facilities in the last year	Total number of districts (44 + 7 = 51)	MOH, NIP (reports produced by marzes)	0%	MOH, NIP (reports produced by marzes) (collection of baseline data before submission of application)	2006	90%	2010

* Only World Vision 8 mobile teams currently provide regular monthly outreach services in rural, mountainous areas.

**The Chart reflects the link between Output indicators and Components.*



6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	Through existing monthly routine reporting system (using reporting form no P1). No additional measures needed to collect required data. Flow of reporting; health facilities → district SHAEI → marz SHAEI → national CDC	Monthly at district level by District Expertise Centres; Quarterly at regional level by Marz Expertise Centres; & at national level by National CDC Monthly/quarterly coverage / drop out rates are calculated at all levels based on predetermined denominators. Performance is assessed according to pre-set coverage / drop out rate targets. Performance of marzes and districts are rated, reflecting their performance.	Quarterly feedback provided to sub-national levels by CDC and low performing ones will be requested to respond, together with actions taken for improvement and/or additional inputs needed. Analyzed data will be presented at semi annual HSCC meetings and recommendations of HSCC will be forwarded to the MOH to take/implement necessary actions. Annual progress reports will present analyzed data and recommendations to share the implementation progress with all stakeholders.
2. % of districts achieving ≥80% DTP3 coverage			
3. BCG – DTP3 drop out rate at national level (%)			
4. Under five mortality rate (per 1000)	Mortality data is collected through (DHS and/or MICS) surveys conducted every 5 year. Next one is scheduled for the year 2010 and will be funded by international partners.	Mentioned surveys provide only mortality data at national level. It provides overall information on the impact of interventions targeting reduction of child mortality. Therefore, no specific data analysis is planned on mortality reduction before the year 2010.	Mortality data that will be obtained from the year 2010 survey will be used in final evaluation (completion report) of HSS Plan implementation at national level.
5. Number of annual average PHC contact per person	Data needed for this indicator is collected on annual basis to monitor impact of newly introduced family medicine system at PHC level. No additional measures needed to collect required data.	Number of annual average PHC contact per person reflects utilization rate at PHC level. Rate is expected to increase gradually. Utilization trend at PHC level will be analyzed on annual	Annual average PHC contact per person will be presented at the annual HSCC meetings to assess utilization trend of PHC services. MOH will use this statistics to take/implement

		basis.	necessary actions, if needed. Annual progress reports will present analyzed data and recommendations to share the implementation progress with all stakeholders.
Output			
1. % of districts that had stock out for any of NIP vaccines more than 1 month	The data needed for these indicators are not collected through routine reporting system. Second component of GAVI HSS Plan is on establishing a regular and high quality supportive supervision documented by standardized and quantifiable checklists. Facility, district and marz levels will be supervised at least 2 times a year. The proposed checklist will cover the data needed for these indicators. Based on the assessments of supervision through filled checklists, district and marz Expertise Centres will be requested to report annually to National CDC on these indicators.	Reported data will be analyzed at marz and national level, by converting data into indicators. Feedback reports will be issued by National CDC annually. Performance at district and marz level will be assessed according to pre-set targets. Low performing districts and marzes will be requested to provide additional information on reasons of failure and measures taken to improve performance and additional inputs needed to implement those measures, if necessary.	These indicators will be used in monitoring implementation performance of planned interventions of the GAVI HSS Plan in the field of vaccine management & delivery, supervision, outreach services and training. Reasons for poor performance will be discussed at HSCC meetings held prior to annual progress evaluations to identify constraints and measures needed to improve performance to meet the set targets. Recommendations of HSCC will be forwarded to MOH to take/implement necessary actions. Annual progress reports will present analyzed data and recommendations to share the implementation progress with all stakeholders.
2. % of health facilities supervised at least 2 times in the last year using the standardized checklist			
3. % of health facilities that conducted regular outreach services in the last year			
4. % of PHC staff who received training during last 5 years			
5. % of District Expertise Centres which had received timely and complete surveillance reports at least from 90% of their health facilities	This indicator is already within the existing reporting system, therefore no additional measures needed to collect required data. District and Marz Expertise Centres are responsible from monitoring timeliness and completeness of surveillance reports	Monthly at district level by District Expertise Centres; Quarterly at regional level by Marz Expertise Centres; & at national level by National CDC Monthly/quarterly rates are calculated at all levels based on predetermined denominators, which	Quarterly feedback provided to sub-national levels by CDC and low performing ones will be requested to respond, together with actions taken for improvement and/or additional inputs needed. Analyzed data will be presented at semi

	and reporting this data monthly to National CDC.	is total number of reporting units to that level.	annual HSCC meetings and recommendations of HSCC will be forwarded to MOH to take/implement necessary actions. Annual progress reports will present analyzed data and recommendations to share the implementation progress with all stakeholders.

6.4: Strengthening M&E system

Monitoring and evaluation system for the GAVI HSS Plan is structured in a sustainable manner, aiming not to create additional burden on the existing reporting system. Therefore, most of the indicators can easily be reached using data collected by the existing reporting system. Besides the existing reporting system, proposed regular and high quality supportive supervision using quantifiable checklist will contribute to provision of additional information to decision-making levels on quality, accessibility, availability aspects of PHC services provided.
In other words, level of existing reporting system is capable of providing most of the needed data to monitor implementation and performance of the GAVI HSS Plan.

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	Responsible unit- Project Coordination Committee under the Policy Board of the Ministry of Health Responsible person- Gagik Sayadyan, head of Staff of the Ministry of Health
Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	All project activities will be reported to the Health Policy Board which will also be responsible for · monitoring and evaluation of implementation to ensure timely implementation of planned GAVI HSS activities, · ensuring coordination and cooperation between technical units responsible for implementation and monitoring, · ensuring coordination between GAVI HSS activities and non GAVI HSS activities in order to harmonize implementation of country wide HSS activities, · taking decisions on actions needed to improve implementation of the GAVI HSS Plan, · serving as approval body for decisions that will have impact on GAVI HSS implementation, · serving as a coordination mechanism for disseminating information on implementation (progress achieved & remaining challenges) to all HSS related stakeholders, · Communicating with GAVI Secretariat on issues related to GAVI HSS implementation.
Mechanism for coordinating GAVI HSS with other system activities and programs	Coordination between GAVI HSS Plan activities and other HSS programs and/or activities will be established through the HSCC. The functions of the Health Policy Board are not limited to GAVI HSS. HSCC is established to coordinate all HSS related activities within the country. Health Policy Board will be convened monthly to coordinate HSS activities among all HSS related stakeholders within the country.

7.2: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Harutyun Kushkyan	MOH/ Minister	Yes	Coordinates the development of the policy in the field of public health services and approves GAVI HSS application form
Hayk Darbinyan	MOH/First Deputy Minister	Yes	Coordinates the sector of medical services
Abraham Manukyan	MOH/Deputy Minister	Yes	Coordinates the financial sector
Tatul Hakobyan	MOH/Deputy Minister	Yes	Coordinates Drug Policy and International Affairs
Alexander Gukasyan	MOH/Deputy Minister	Yes	Coordinates realization of policy of licensing of medical establishments
Gagik Sayadyan	MOH/ Head of Staff	Yes	Coordinates job of the employees of the ministry
Suren Krmoyan, Legal Adviser to the Minister of Health	MOH, Legal Department	Yes	Coordinator of the activities of the Working Group and International Experts: responsible for development of the application
Artavazd Vanyan	MOH/Head of the State Hygienic and Antiepidemic Inspectorate	Yes	Participates in the implementation and monitoring activities of the GAVI HSS application
Sergey Khachatryan	MOH/Head of the "Health Project Implementation" Unit	Yes	Provides implementation of the WB financed project
Ara Ter-Grigoryan	MOH/Head of the State Health Agency	Yes	Responsible for financing of the State Health programmes
Vahan Poghosyan	MOH/Head of the Division of Health Provision	Yes	Responsible for implementation of the State financed programme in the Primary Health Sector
Narine Beglaryan	MOH/ Head of the International Relations Department	Yes	Ensures coordination and cooperation among the implementing partners
Eduard Margaryan	Head of the staff of the MOH Department of Pharmaceutical Activity Organisation, Drug and Technology	Yes	Ensures coordination and cooperation among the implementing partners

	Provision		
Tigran Sahakyan	MOH/ Head of the Education Department	Yes	Coordinates the training component of the programme
Armen Karapetyan	MOH/Head of the Economy Department	Yes	Coordinates budget formulation of the programme
Izabel Abgaryan	MOH/ Head of Legal Division	Yes	Responsible for legal component of the programme
Mher Ghazaryan	MOH/Head of the Licensing Division	Yes	Responsible for the licensing of medical establishments to be involved in the programme
Zhora Asatryan	Ministry of Finance and Economy of the RA/ Head of Financial programming of budget expenditure Division	Yes	Consultant: responsible for the conformity of the GAVI HSS proposal financial components to financial reforms in the RA
Nara Davtyan	Ministry of Finance and Economy of the RA/ Specialist of Financial programming of budget expenditure Division	No	Consultant: responsible for the conformity of the GAVI HSS proposal financial components to financial reforms in the RA
Elizabeth Danielyan, Head of WHO Country Office for Armenia	WHO Country Office for Armenia	Yes	Coordinates of the activities of the International Experts
Ruben Jamalyan, Health Project Management Specialist	USAID	Yes	Synchronizes GAVI HSS support and USAID health portfolio projects
Sheldon Yett	UNICEF/Representative	Yes	Ensures that GAVI HSS activities comply with UNICEF policy and complement Unicef initiatives
Susanna Hayrapetyan, Senior Health Specialist	WB	Yes	Ensures that GAVI HSS activities comply with WB health reform interventions, approved the application
Ruzan Gjurdjyan, Representative	Vishnevskaya-Rostropovich Foundation	Yes	Ensures that GAVI HSS activities comply with VRF supported activities, approved the application
Gayane Sahakyan, Coordinator of	MOH, Immunization Program, SHAEI	No	Member of the WG: provides WG members with information on Immunoprophylaxis, as well as with statistical and other professional

Immunization Programme of the Ministry of Health of the RA			data, is responsible for development of indicators, list of required equipment and final financial assessment of the proposal.
Lilit Avetisyan, Head of the Department of Infectious and Non-infectious Disease Epidemiology	MOH, Department of Infectious and Non-infectious Disease Epidemiology, SHAEI	No	Member of the WG: Responsible for formation of the public health part of the proposal, description of the barriers contributing to the expansion of infection diseases and baring Immunoprophylaxis.
Karine Saribekyan, Head of the Mother and Child Protection Unit	MOH, Mother and Child Protection Division	No	Member of the WG: responsible for identification of barriers to immunization coverage and MCH services, formation of measures aimed at removing barriers to lead to a reduction of mother and child morbidity and mortality.
Ruzanna Yuzbashyan, Head of Primary Health Care Unit	MOH, PHC Division	No	Member of the WG: responsible for identification of barriers to immunization coverage at the PHC level, formation of measures aimed at removing barriers.
Samvel Kharazyan, Head of the Unit of Health Services Procurement and Information	MOH, Unit of Health Services Procurement and Information, SHA	No	Member of the WG: responsible for the preparation of GAVI proposal financial components ensure consistency with on-going financial reform activities.
Varduhi Petrosyan, Director of the Centre for Health Services Research and Development	American University of Armenia, Centre for Health Services Research and Development	No	Local Consultant: responsible for finalizing the application in accordance with the GAVI guidelines.
Jens Wilkens, Health Financing Analyst,	Health Systems Financing, WHO/EURO	No	Consultant: advises on the financial components of the application and integration of immunization programme into performance based financing schemes
Martina Pellny, Programme Officer on Primary Health Care,	Primary Health Care Unit, WHO/EURO	No	Consultant: Renders advices integration of immunization services into primary health care services
Elina Manjieva, Policy Analyst	Centre for Health System Development, MOH of Kyrgyz Republic	No	Consultant: advises on improvement of disease surveillance and monitoring system, as well as on financial sustainability of the programme

Niyazi Cakmak, Consultant for Vaccine Preventable Diseases and Immunization Programme	WHO/EURO	No	Consultant: advises on integration of immunization services into primary health care services, improvement of vaccine management system, improvement of timely coverage at all levels and immunization information system
Nazik Aslanyan	"Development Appropriate" Non governmental organization	No	Consultant on problems of children and vulnerable groups of population
Davit Petrosyan	"Human Health Care" Non governmental organization	No	Consultant on monitoring activities in the field of Public Health Services
Hovhannes Margaryants	"Armenian Public Health Union" Non governmental organization	No	Consultant on methods of informing the population about Primary Health Care Services

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country	It is proposed that the funds provided by the GAVI HSS window are channelled through the already established procedures for external health funding within the budget system. There is existing extra budgetary account, held by the Ministry of Health. Specifically, the funds would flow directly into an extra budgetary account that was opened at the **Central Treasury of The Ministry of Finance and Economy.**
Mechanism for channelling GAVI HSS funds from central level to the periphery	GAVI HSS funds would flow into the special account of the Ministry of Health. This account will be used only for HSS project.

Mechanism (and responsibility) for budget use and approval	GAVI HSS funds are allocated to activities through one channel in an agreed and specified manner. The channel is through the Ministry of Health. The GAVI HSS funds would flow in the same manner following the same rules. Specifically, once the HSS funds are deposited in a special account managed by the Ministry of Health, These funds should be used for financing the activities envisioned under the Components. The funds, are managed according to the standard budgetary procedures of the country
Mechanism for disbursement of GAVI HSS funds	MOH Department of Economy and Finance
Auditing procedures	The Internal Auditor of the MOH is responsible for auditing at least once a year health facilities and other organizations that are under the MOH and MHIF. All audit reports are to be provided to Joint Financiers, including GAVI, not later than six months after the reporting period.

7.4: Procurement mechanisms

The Project Coordination Team under the Policy Board of the Ministry of Health will be responcible for the Project implementation. In this team a procurrement ofiicer, public health specialist, lawyer, economist and a primary health care specialist will be involved.
The Ministry of Health will procure goods and services for the project. A Procurement Officer involved in Project Coordination Team will maintain close working relations with other departments of the Ministry of Health as well as with Donor organizations.
WHO and WB will provide advice on procurement issues. In case of GoA funding, all the procurement procedures and arrangements will be carried out in accordance with the Law on Procurement of the Republic of Armenia. In case of GAVI HSS and WHO funds, the procurement policies and procedures set forth by the WB Procurement Guidelines will be applied.
The Health Policy board will coordinate relevant procurement matters. Ministry of Health have necessary capacity to conduct Procurement and Supply Management.
Procurement of goods will be conducted by the Ministry of Health using the Shopping Procedures based on a minimum of three quotations as the maximum estimated cost per contract under the subject Project is below USD 100,000 threshold (the justification of application of “Shopping” procedure is that according to the loan/credit agreements of the WB supported projects that are currently under implementation in Armenia, the threshold for applying the “International Competitive Bidding” procurement method is above USD 100,000 per contract).
The Law of the Republic of Armenia **“On Public Purchases”** endorsed by the Decree of the President of the Republic of Armenia dated 06.12.2004 is in force for all purchases carried out by governmental organizations (institutions) and other entities. These regulations apply also to the grants and credits received by the Government. The Law promotes transparency and competition and provides explicit evaluation and award criteria that guarantee efficiency and value for money. Procurement of goods and services under the HSS grant will follow provisions of this Law and will comply with the HSS requirements and established practices of other international organizations.
The Project Coordination Team will develop a written procurement plan, which will be adopted by Health Policy Board with detailed descriptions of the procurement dates.
Selection of consultants will also be implemented in accordance with the WB’s Guidelines for Selection and Employment of Consultants.

7.5: Reporting arrangements

The Project Coordination Team under the Policy Board will prepare **Annual Progress Reports.** The progress reports will include the same components as the application, clearly describing the progress made through the outcome and output indicators. In addition to financial audit, the Policy Board will approve the report before submission. This way all international organisations participating in this proposal will be responsible to GAVI for the accuracy of the yearly progress report. **Annual Progress Reports** will be developed based on annual and quarterly reports, coming from local level to the central level. In the development process will be engaged all departments of MOH, especially MCH department, PHC department, Health financing and Accounting department, SHAEI, SHA, as well as international organizations, such as UNICEF, WHO.

7.6: Technical assistance requirements*

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
-	-	-	-
-	-	-	-
-	-	-	-

*All activities will be conducted by MOH staff in order to build institutional capacity and ensure sustainability. There is no need for the external technical support, for the implementation of any activity. The proposed activities are mostly trainings, developing of training manuals and guidelines, establishment of supportive supervision and outreach teams, and those kinds of activities are currently implemented by the Health Care System without any external technical assistance.

Section 8: Costs and Funding for GAVI HSS

8.1: Cost of implementing GAVI HSS activities

Area for support	*Cost per year in US$*			
	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL COSTS**
	2008	2009	2010	
Activity costs				
Component 1	***$3 600***	***$61 550***	***$64 350***	***$129 500***
Activity 1.1	$0	$0	$0	***$0***
Activity 1.2	$0	$0	$0	***$0***
Activity 1.3	$0	$12 800	$12 800	***$25 600***
Activity 1.4	$0	$0	$0	***$0***
Activity 1.5	$3 600	$9 000	$400	***$12 600***
Activity 1.6	$0	$2 100	$2 100	***$4 200***
Activity 1.7	$0	$8 850	$11 800	***$20 650***
Activity 1.8	$0	$6 400	$6 400	***$12 800***
Activity 1.9	$0	$17 700	$26 550	***$44 250***
Activity 1.10	$0	$4 700	$4 700	***$9 400***
Component 2	***$7 700***	***$3 950***	***$2 950***	***$14 600***
Activity 2.1	$0	$0	$0	***$0***
Activity 2.2	$6 000	$1 500	$500	***$8 000***
Activity 2.3	$1 700	$2 450	$2 450	***$6 600***
Activity 2.4	$0	$0	$0	***$0***
Component 3	***$74 500***	***$5 700***	***$5 400***	***$85 600***
Activity 3.1	$50 000	$0	$0	***$50 000***
Activity 3.2	$4 500	$5 700	$5 400	***$15 600***
Activity 3.3	$0	$0	$0	***$0***
Activity 3.4	$0	$0	$0	***$0***
Activity 3.5	$20 000	$0	$0	***$20 000***
Activity 3.6	$0	$0	$0	***$0***
Component 4	***$4 500***	***$13 000***	***$28 900***	***$46 400***
Activity 4.1	$0	$0	$0	***$0***
Activity 4.2	$0	$0	$0	***$0***
Activity 4.3	$4 500	$13 000	$28 900	***$46 400***
Activity 4.4	$0	$0	$0	***$0***
Support costs	***$4 000***	***$5 500***	***$5 500***	***$15 000***
Management costs	$3 000	$3 500	$3 500	$10 000

M&E support costs	$1 000	$2 000	$2 000	$5 000
Technical support	$0	$0	$0	$0
TOTAL COSTS	***$ 94 300***	***$89 700***	***$107 100***	***$291 100***

8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation	**Allocation per year (US$)**				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL FUNDS**
	2007	2008	2009	2010	
Birth cohort	38,734	38,928	39,122	39,318	
Allocation per newborn	$ 0	$ 2.5	$ 2.5	$ 2.5	
Annual allocation		$ 97,320	$ 97,805	$ 98,295	**$ 293,420**

Source and date of GNI and birth cohort information:

GNI: **$1 524 in 2005, NSS**
$ 1470 in 2005, WB
$ 1930 in 2006, WB

Birth cohort: National Statistical Service of the Republic of Armenia and Demographic Health Survey Armenia 2005 (NSS data is adjusted with applying IMR of DHS)

Total Other: .....

When the Working Group was preparing the proposal it used 2 main documents as a baseline for the main figures (such as GNI, outpatient contacts etc.); National Statistical Service (Appendix XVIII) and the Demographic and Health Survey Armenia (Appendix XIX). Currently all baseline figures and data are taken from National Statistical Service as it is considered to be an official data source for the Ministry of Health. And it was required from the IRC that the country should use the data source which is official and is used in the official documents.

8.3: Sources of all expected funding for health systems strengthening activities

Funding Sources	**Allocation per year (US$)**			
	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL FUNDS**
	2008	2009	2010	
GAVI	**$94 300**	**$89 700**	**$107 100**	***$*291 100**
Government	$130 320	$130 320	$132 080	***$ 392 720***
World Bank	x	x	X	***X***
USAID	$3,500,000	N/A	N/A	$3,500,000

UNICEF	$120 000	$125 000	$130 000	***$375 000***
WHO	$118 300	$100 000	$100 000	***$ 318 300***
Vishnevskaya-Rostropovich-Foundation	x	x	x	***X***
TOTAL FUNDING	$3 269 290	$445 020	$469 180	***$4 877 120***

Source of information on funding sources:

GAVI: GAVI HSS Plan,

Government: State Budget of the RA allocated for MOH.....

World Bank .....

USAID .....

UNICEF .....

WHO Biennial Collaborative Agreement (BCA)

Section 9: Endorsement of the Application

9.1: Government endorsement

The Government of the Republic of Armenia commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Health:	***Ministry of Finance:***
Name: Harutyun Kushkyan	Name: Vardan Khachatryan
Title / Post: Minister of Health of Republic of Armenia	Title / Post: Minister of Finance and Economy of Republic of Armenia
Signature:	Signature:
Date: 4 October 2007	Date: 4 October 2007

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on 10 of September 2007 .The signed minutes are attached as Annex 1(see Appendix IX)

Chair of HSCC (or equivalent):

Name: Harutyun Kushkyan	Post / Organisation: Minister of Health, Ministry of Health of Republic of Armenia
Signature:	Date: 4 October 2007

9.3: Person to contact in case of enquiries:

Name: Mr. Suren Krmoyan	Title: Legal Adviser to the Minister of Health of Republic of Armenia
Tel No: + 374 10 56 43 20	Address: 3 Government building, Yerevan, Armenia
Fax No. +374 10 56 27 83	
Email: gencounsel@moh.am	

ANNEX 1 Documents Submitted in Support of the GAVI HSS Application

To the applicant:

- *Please number and list in the table below all the documents submitted with this application.*

Note: All supporting documentation should be available in English or French, as electronic copies wherever possible. Only documents specifically referred to in the application should be submitted.

Attachment Number	Document (with equivalent name used in-country)	Available (Yes/No)	Duration
Appendix I	**ARM Coverage Survey July 16-2006**	Yes	July 16, 2006
Appendix II	**ARM Immunisation Programme Management Review**	Yes	October, 2006
Appendix III	**cMYP**[6]	Yes	2007-2010
Appendix IV	**MOH Decree Dated 23. 07. 2007**	Yes	July 23, 2007
Appendix V	**List of RA communities where health institutions do not operate**	Yes	-
Appendix VI	**RA Government, Resolution No.713**	Yes	November 17, 1998
Appendix VII	**RA Government, Resolution No.1017-N**	Yes	July 14, 2005
Appendix VIII	**MTEF**[7]	Yes	2007-2009
Appendix IX	**HSCC minutes, signed by Chair of HSCC**	Yes	August 08, 2007
Appendix X	**List of districts with the lack of Epidemiologists**	Yes	-
Appendix XI	**PRSP**[8]	Yes	2004-2015
Appendix XII	**Mother and Child Health Strategy in Armenia 2003-2015**	Yes	2003-2015
Appendix XIII	**Primary Health Care Strategy of the Republic of Armenia (2003 - 2008)**	Yes	2003-2008
Appendix XIV	**Information about stakeholders who were sent Armenian Health System Strengthening draft application form in the scope of regional peer-review and the comments provided by them**	Yes	-
Appendix XV	**ARM Immunization Quality and Safety assessment, April, 2006,**	Yes	April, 2006,
Appendix XVI	**Armenian HSS Budget brake down**	Yes	2008-2010
Appendix	**Health Systems in Transition, Armenia, Health system Review**	Yes	2006

[6] If available – and if not, the National Immunization Plan plus Financial Sustainability Plan
[7] if available please forward the pages relevant to Health Systems Strengthening and this GAVI HSS application

XVII			
Appendix XVIII	**The Demographic Handbook of Armenia http://www.armstat.am/Arm/Publications/2007/Demos_07/index-eng.html**	Yes	2007
Appendix XIX	**Demographic and Health Survey Armenia** http://www.measuredhs.com/pubs/pub_details.cfm?ID=634	Yes	2003-2005
Appendix XX	**Actions taken in response to IRC Conditions**	Yes	March 2007
Appendix XXI	**Minutes of the meeting of Ministry of Health (MOH) Council on Policy Issues**	Yes	March 2007
Appendix XXII	**Minutes of the meeting of the Interagency Coordinating Committee**	Yes	December 2007
Appendix XXIII	**Decree of the Minister of Health on the approval of cMYP**	Yes	March 2008