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To All TASC2 Global Health IQC Contractors

SUBJECT: Proposed Task Order under TASC2-Global Health IQC, TPR No. 111-05-008, USAID/Armenia Primary Health Care Reform Project

Dear Sir/Madam:

Enclosed is a scope of work for services to be performed under the above proposed task order for a five-year Primary Healthcare Reform Project in Armenia. The project will be implemented under an award that includes a 2-year base period and a 3-year option period. It is anticipated that the first period will run from August 2005 – August 2007, and the second period covers September 2007 – September 2010. The total estimated cost for both task order periods is approximately \$17 million. This estimated LOP amount includes \$550,000 for computer equipment, \$325,000 for small grants to NGOs, \$1 million for health facility renovations, and \$1 million for medical supplies and equipment. The figures should be used as “plug figures” in your cost proposal. This funding are maximum and can be used in either base and/or option period based upon offerors’ proposal. Revealing the cost range for the task order does not mean that Offerors should necessarily strive to meet the maximum amount. Cost proposals shall be evaluated as a part of a Best Value determination for the task order award. The Offeror is to propose the LOE and staffing according guidance provided in the Statement of Work and the Offeror’s approach for achieving results. By the above cited closing date, please provide USAID/Armenia with a proposal for accomplishing the requested services. The proposal should contain the following:

1. A proposed time schedule for the proposed work;
2. A Certification that the proposed personnel were not suggested or requested by USAID;
3. A detailed level of effort estimate. Please provide a separate line item for each proposed individual and identify each by name and by functional labor category as set forth in the contract;
4. A detailed estimate of other direct costs - travel, etc. Please explain the basis for the estimate for each category of cost; and
5. Any proposed changes to the enclosed statement of work.

6. Reporting requirements and deliverables: Task Order reporting requirements should focus on substance and relate progress against Benchmarks and Tangible Results in the Task Order, to be articulated in the Offeror's proposal as "Anticipated Outcomes" for each Project Component (see Statement of Work). Reports must indicate the progress against the Task Order budget and Level of Effort. All reports must be in writing.

At a minimum, Contractor reports shall consist of the following:

a. Quarterly Performance Monitoring Reports - This report is based on the quarterly report described in Section F.9 of the TASC2 IQC. A sample format is attached hereto as Attachment B. The major innovation in the report is that it requires the CTO to add written comments within five working days on the Contractor's version of events and on the Contractor's management, technical performance and progress in achieving Benchmarks and Tangible Results. The Contracting Officer, if he or she wishes, may add comments on any area of concern or identify actions to correct, support or improve Contractor's performance.

b. Completion Report - At the end of each Task Order, the Contractor shall prepare a completion report which highlights accomplishments against work plans, gives the final status of Benchmarks and Tangible Results, addresses lessons learned during implementation and suggests ways to resolve constraints identified. The report may provide recommendations for follow-on work that might complement the completed Task Order work. All reports must be submitted, in hard copy or electronically, to the USAID CTO and CO, and to the TASC2 IQC CTO at their respective addresses.

Instructions to the Offeror for proposal preparation: Detailed information should be presented only when required by specific TPR instructions. Technical proposals are limited to 40 pages (PROPOSALS EXCEEDING 40 PAGES WILL NOT BE EVALUATED) and shall be written in English and typed on standard 8 1/2" x 11" paper (216mm by 297mm paper), single spaced, 10 characters per inch with each page numbered consecutively. Items such as graphs, charts, cover pages, dividers, table of contents, and annexes (i.e., key personnel resumes, past performance report forms) are not included in the 40-page limitation.

The 40-page Technical Proposal should include the following sections: (i) Executive Summary (The Offeror must also provide an Armenian translation of the Executive Summary in an Annex); (ii) Problem Statement, Technical Approach and Rationale; (iii) Management Plan and Approach; (iv) Personnel and Organization (The Offeror should include an organigram, justification of the proposed organizational structure/staffing pattern, and brief summaries of qualifications and job descriptions of key personnel as well as brief job descriptions of other professional-level positions; full resumes and job descriptions of key personnel and job descriptions for all professional-level posts should be included in an Annex); and (v) Past Performance (The Offeror should include summaries of relevant past experiences of the prime contractor and major subcontractors; complete Past Performance References (PPRs) should be presented in an Annex).

The Offeror is requested to submit a proposal:

a. electronically - internet email with up to 3 attachments (2MB limit) per email compatible with MS Word, Excel, Lotus 123 and/or WordPerfect in a MS Windows environment. Only those pages requiring original manual signatures should be sent via facsimile. (Facsimile of the entire proposal is not authorized); or

b. via regular mail - sending 1 original and 4 paper copies of a technical proposal and 1 original and 2 copies of a cost proposal, however the issuing office receives regular international mail only once a

week. All mail is subject to US Embassy electronic imagery scanning methods, physical inspection, and is not date and time stamped prior to receipt by USAID and the Contracting Officer; or

c. hand delivery (including commercial courier) of 1 original and 4 paper copies of a technical proposal and 1 original and 2 copies of a cost proposal to the issuing office.

d. Regardless of the method used the Technical Proposal and Cost Proposal must be kept separate from each other. Technical Proposals must not make reference to pricing data in order that the technical evaluation may be made strictly on the basis of technical merit.

e. The proposal shall be submitted in envelopes marked “TPR No.111-05-008, USAID/Armenia Primary Healthcare Reform Project”, and addressed to:

Contracting Office
USAID/Armenia
1 American Avenue
Yerevan 375082, Armenia

The Offeror is requested to acknowledge receipt of this solicitation. Any technical questions or questions of a contractual nature concerning this TPR must be submitted in writing, no later than June 27, 2005 by COB, Yerevan Time. Questions should be addressed to Armen Yeghiazarian, USAID/Armenia Acquisition Specialist at ayeghiazarian@usaid.gov. Please be advised that you are not authorized to incur costs under the proposed task order prior to the Contracting Officer's signature.

Sincerely,

David Brown
Contracting Officer
USAID/Armenia

Enclosures:

1. Statement of Work
2. Evaluation Criteria
3. USAID/Armenia FSN Compensation Plan
4. USAID/Armenia Primary Healthcare Reform Project 2005 – 2009 -- Annexes

USAID/Armenia Primary Healthcare Reform Project

Statement of Work

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Acronyms

AACA	Armenian American Wellness Center
AECP	Armenian EyeCare Project
ADHS	Armenia Demographic and Health Survey
AIDS	Acute immunodeficiency syndrome
ANC	Antenatal care
ASTP	Armenia Social Transition Program
BCA	Biannual Cooperative Agreement (WHO)
BBP	Basic Benefits Package
CCM	Country Coordination Mechanism (for GFATM)
CDC	Centers for Disease Control and Prevention
CDSTS	Central Drug Supply Tracking System
CIA	Central Intelligence Agency
CIS	Commonwealth of Independent States
CPH	Community Partnership for Health
CQI	Continuous Quality Improvement
DCA	Development Credit Authority
DOTS	Directly Observed Treatment, Short Course
EOP	End of Project
FAP	Feldsher acoucher posts
FM	Family Medicine
FMGP	Family Medicine Group Practice
FSU	Former Soviet Union
GDA	Global Development Alliance
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOAM	Government of Armenia
HIV	Human immunodeficiency virus
IMCI	Integrated Management of Childhood Illnesses
IR	Intermediate result
IRD	International Relief and Development
JICA	Japan International Cooperation Agency
JSI	John Snow, Inc.
LLR	Lower level result
LMIS	Logistics Management Information System
LOP	Life of Project
MCH	Maternal and Child Health
MEDI	Micro Enterprise Development Initiative
MOFE	Ministry of Finance and Economy
MOH	Ministry of Health (Armenia)
MSF-B	Médecins Sans Frontières Belgium
MSH	Management Sciences for Health
NCDI	Noncommunicable Diseases and Injuries
NGO	Nongovernmental organization
NIH	National Institute of Health
NK	Nagorno Karabakh
NOVA	Innovations in Support of Reproductive Health
NSS	National Statistics Service
PCGP	Primary Care Group Practice

PHC	Primary healthcare
PMP	Performance Monitoring Plan
PRSP	Poverty Reduction Strategy Paper
RFP	Request for Proposal
RH	Reproductive Health
RPM	Rational Pharmaceutical Management
SanEpid	State Service of Hygiene and Epidemiological Surveillance
SHA	State Health Agency
SO	Strategic Objective
STI	Sexually transmitted infection
TB	Tuberculosis
UMCOR	United Methodist Committee on Relief
UN	United Nations
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USG	United States Government
USAID	United States Agency for International Development
WHO	World Health Organization
YSMU	Yerevan State Medical University

BACKGROUND

I.1. General

The Republic of Armenia is a small, landlocked, mountainous country with few natural resources. It is situated in the Southern Caucasus and bordered by Georgia, Azerbaijan, Iran, and Turkey. Armenia is a sovereign, democratic, rule-of-law state with executive, legislative (parliament), and judicial branches of government. Administratively, the country is divided into 10 regions, called “marz(es)” which are headed by regional governors appointed by the president, plus the capital city of Yerevan.¹ The 2001 census estimates Armenia’s population at just over three million people. It is one of the most ethnically homogenous countries in the world (Armenian 95%; Kurd 2%; Russian, Greek, and other 3%).

Armenia’s most important natural resource and export, both historical and current, are people. There are as many as five to eight million persons who identify with Armenia but live elsewhere, either temporarily or permanently. “Diasporan Armenians” are generally of two types: “non-emigrant temporary workers and longer-term emigrants,”² the latter including descendants of predecessor generations that fled Turkey in 1915 to find safety, security, employment and a better life, and long ago became citizens of other countries. Approximately 1.4 million of this group resides in the United States.³

As a result of the breakup of the former Soviet Union (FSU), Armenia’s economy suffered tremendous dislocation. Of the FSU countries, the shrinkage of its economy was among the most severe. Nearly half the population currently lives on less than \$2 a day. Some thirteen years after independence, Armenia’s gross domestic output is, despite impressive recent growth, no higher than it was in 1988, before a devastating earthquake. Moreover, the year-to-year fluctuations in many dimensions of the economy have been very large.⁴ Without Diaspora remittances, circumstances would be markedly worse.

In spite of features that suggest relatively high social, political and economic risks of conflict, Armenia is a relatively stable country with low conflict vulnerability. Observed irregularities in the 2003 presidential elections, and relatively large demonstrations protesting the results, suggest that there is some potential for instability. Nonetheless, it appears that USAID and the United States Government (USG) can strongly encourage fundamental reforms, to produce competition in the political and economic system, with little fear that destabilization might lead to violence in the short term.

Nearly all Armenians are literate, with approximately 80% having completed high school. School attendance among primary to middle school-aged children is high in both urban and rural areas and there are no significant differences by gender. As students reach secondary school (15-16 years of age), attendance declines, particularly among males and among the poor, due to problems of cost and access. However, completion rates remain high.

¹ For more information, facts and figures about Armenia, see Annex 1, and visit the CIA Factbook, <http://www.cia.gov/cia/publications/factbook/geos/am.html>; the U.S. State Department webpage, <http://www.state.gov/p/eur/ci/am/>; the Republic of Armenia website, <http://www.gov.am>; and the Armenian Embassy to America website, <http://www.armeniaemb.org/>.

² *Remittances in Armenia: Size, Impact, and Measures to Enhance Their Contribution to Development*, Bryan W. Roberts, Ph.D., et al., BearingPoint, October 1, 2004, p.3; prepared under Task Order #PCE-I-820-98-00012-0.

³ *Ibid.*, Appendix A, Table A.2.

⁴ The transition to a market economy in Armenia has been difficult. Since independence, most industries have ceased business. The labor force sample survey conducted by the National Statistics Service (NSS) of Armenia gives an unemployment level of 33.3% for the first half of 2003 (10.1% official unemployment). Analysis by the World Bank shows total employment fell annually from 1990 to 2001. *Republic of Armenia: Poverty Reduction Strategy Paper*, World Bank, November 2003, Figure 8.2, p. 100.

Many institutes of higher education exist in Armenia, resulting in some 26% of urban women and 29% of urban men having a university education. While literacy rates are impressive, the quality of education and its relevance to Armenia's current economic and political development are questionable. Many members of the labor force have obsolete skills and inflexible attitudes. Others have received strong theoretical training, frequently in narrowly defined, highly specialized fields, but have less skill in practical problem-solving techniques that would help them survive in a competitive marketplace.

Between 1991 and 1993, Armenia suffered a series of economic blows that caused real GDP to contract by 60%. Following major economic reforms in the early 1990s, the composition of output changed drastically, as unproductive sectors, particularly manufacturing, contracted mainly due to the collapse of regional trade and payments agreements with the Baltic countries, Russia and other countries of the FSU. As agriculture gained workers released by industry, the average level of labor productivity in the economy declined after the mid-1990s, because more workers were concentrated in lower value-added activities.

Since 1993, a sound monetary policy has contained previously high inflation. Meanwhile, average real GDP growth of around 6% per year has been the norm. In 2002, real GDP growth reached 12.9%. The Heritage Foundation ranks the economy as the most open of the Commonwealth of Independent States (CIS).⁵ In spite of these positive aspects, the country is not yet showing broad-based growth patterns. The relatively high average real GDP per capita growth in Armenia is explained partly by the catching-up process after the sharp fall in output in the early 1990s. To date, most of these increases have primarily benefited workers in a few relatively small sectors of the economy that employ a small proportion of the labor force.

A six-year war with Azerbaijan over control of Nagorno-Karabakh (NK) ended in a cease-fire in 1994. The NK conflict resulted in Azerbaijan and Turkey maintaining an economic blockade against Armenia. While some highway and rail traffic continues across the Iranian and Georgian borders (and a small amount continues with Turkey through Georgia), the blockade has a large negative impact on Armenia's economy and its prospects for growth. The fact that the country cannot access the larger economic zone within which it operated during the Soviet era reduces access to imports (including inputs needed for industry) and makes exports more costly. It also cost the Armenians significant potential revenues from the oil pipeline from Azerbaijan to Turkey, which bypasses Armenia and instead travels through Georgia.

Corruption is another factor undermining Armenia's economic, political and social reform process. Both "grand" corruption (misuse of political power for private gain) and "petty" (administrative) corruption are common. Corruption is seen in the form of bribes, theft/illegitimate acquisition of assets, patronage, political corruption and conflict of interest. Grand corruption is facilitated by lack of understanding of the role and tasks of the state; the lack of meaningful separation of power among the executive, legislative and judiciary branches of government; ineffective public administration; imperfect implementation of monetary, credit and tax policy; and general weaknesses in the institutions of democracy, including civil society. Tradition, low wages, low tolerance for risk and a weak professional bureaucracy fuel petty corruption.

Despite high rates of economic growth, poverty in Armenia has been persistent. Basic poverty indicators demonstrate little progress during the last few years. The poor were 50.9% of the total population in 2001, with the extremely poor constituting 16%. In 1996, the rates were 55% and 23% respectively. Continuing high rates of poverty during rapid growth highlights a need for an explicit role for poverty reduction in evaluating development efforts. There are significant differences in the

⁵ At present the CIS includes: Azerbaijan, Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Uzbekistan and Ukraine.

territorial dimensions of poverty. Armenia's annual Household Income and Expenditure Surveys, conducted by the National Statistics Service (NSS) with assistance from the World Bank and USAID, show that small- and medium-sized towns are the worst in terms of poverty.

Recognizing the magnitude of the problem, both state and civil society proposed a national strategy to reduce poverty and independent experts were hired to draft a Poverty Reduction Strategy Paper (PRSP). The Government of Armenia (GOAM) approved the PRSP in August 2003. The paper identifies the following main priorities: (i) pro-poor economic growth; (ii) public administration reform and anti-corruption; and (iii) human development, which focuses on issues such as social, education, health, and infrastructure development. Employment generation is viewed as an overarching theme in the PRSP as a means to reduce poverty. At the same time, the PRSP places special emphasis on targeted programs for the most vulnerable populations. In addition, the GOAM has adopted an Anti-Corruption Strategy. USAID/Armenia closely monitors the implementation of the PRSP and Anti-Corruption Strategy and links the Mission's program to these initiatives.

I.2. Armenia's Healthcare System

During the Soviet era, Armenians had the longest life expectancy and one of the best developed healthcare systems of all the Soviet republics. The system was known for impressive health outcomes and a comprehensive range of state-subsidized medical services. However, dire post-independence economic and social conditions presented a new context for service provision. The healthcare system was characterized by weak governmental commitment and financial support; a focus on expensive, tertiary curative care rather than primary and preventive medicine; high out-of-pocket expenditures on health; healthcare providers with inadequate clinical and managerial skills; and overstuffed facilities in disrepair with outdated equipment and insufficient supplies. A scarcity of resources constrained the government's ability to implement reforms. Moreover, the historical legacy of an authoritarian, top-down approach to healthcare administration discouraged individual initiative and stifled management and institutional development at the regional and local levels.

Today, the major causes of death in adults are similar to those in developed countries: cardiovascular disease, cancer, and accidents.⁶ Armenia's infant mortality rate (36 per 1,000 live births) is nearly double that of Russia. ADHS 2000 data suggest that anemia rates among children (24%) may have doubled over the several years that preceded the Survey. Armenia's maternal mortality ratio⁷ is seven times greater than the average for Western Europe.⁸ Total contraceptive prevalence is 61%, but only 22% for modern methods. The total fertility rate is 1.7; the total abortion rate is 2.6. These indicators, especially the infant mortality rate, compare poorly with data from other countries with similar per capita incomes and education status.

Although Armenia is considered a low HIV prevalence country (<0.1%), data indicate a concentrated epidemic among drug users (15%) and prisoners (5.5%).⁹ Prevalence is low in commercial sex workers (<3%), pregnant women (<0.5%), and men who have sex with men (4.5%). Knowledge of HIV transmission is high, yet not reflected by healthy sexual behavior such as regular condom use. Armenia has the lowest incidence of tuberculosis (42.5 cases per 100,000) in WHO's Eastern European region, but underreporting is strongly suspected.¹⁰ All TB rates in the region, including Armenia's, have been on the rise for several years.

⁶ Statistics in this section are from the 2000 Armenia Demographic and Health Survey (ADHS 2000) unless otherwise noted. Preparations for the ADHS 2005 are currently underway, with preliminary results expected in early 2006.

⁷ 48 deaths per 100,000 live births.

⁸ Data for Western Europe, UNICEF 2002.

⁹ USAID/Armenia HIV/AIDS/STI Strategy FY2003-2008, and the National HIV/AIDS Center.

¹⁰ WHO Euro TB statistics for 1999. Armenia's rate is half the average for the region.

Armenia has taken steps to strengthen public health monitoring and surveillance systems in collaboration with the U.S. Centers for Disease Control and Prevention (CDC). Information is collected and managed by a vertical system of 37 centers representing the State Service of Hygiene and Epidemiological Surveillance (SanEpid), and aggregated and analyzed at the national level. Surveillance capacity for noncommunicable diseases and related behavioral health determinants is limited and relies only on ad hoc studies.

Throughout the country, utilization of healthcare services is low. Outpatient visits declined by 42% between 1991 and 2000. The ADHS 2000 found that lack of money was the most frequent reason given by respondents for not seeking healthcare. In rural areas, access to services is further inhibited by geographic barriers, as illustrated by disparities in the use of antenatal (ANC) services. The median number of ANC visits among rural women is three, compared to six by urban women. Between 1996 and 2000, 16% of rural women gave birth at home, compared to 1% of urban women. Among children with acute respiratory infections, only 29% of urban and 19% of rural children were taken to a health professional for care. The national average for stunting in children (low height for age) is 13%, and is three to four times more prevalent in rural areas than in Yerevan.

Ministry of Health (MOH) responsibilities have changed significantly since the health system was decentralized in the mid-1990s. Ownership authority for all but a few tertiary facilities was transferred from the MOH to regional authorities and/or local governments. Health facilities became semi-autonomous state enterprises and more responsible for their own financing. However, regional and local governments were ill-prepared and poorly equipped for their new role and the financial resources necessary to ensure a smooth transition to a decentralized system were not forthcoming. There are no mechanisms that require facilities to be accountable to regional and local authorities. Virtually all pharmacies, the majority of dental services and medical equipment technical support services have been privatized, as well as a number of hospitals in Yerevan.

Today, the central MOH's roles cover health policy and regulatory issues, strategic planning, development of national programs, drug policy, and licensing of medical personnel and facilities. The MOH also retains decision-making authority for the health sector budget, resources allocation, and pricing of services. Regional and local health officials are responsible for operationalizing national programs and enforcing MOH policies and regulations, yet have very limited budget support from the national level and little influence over resource allocation.

The State Health Agency (SHA), created in 1998 to serve as the principal public buyer of health services, is the conduit for 80% of state funds for healthcare. With the establishment of the SHA, a purchaser-provider¹¹ dynamic and healthcare contracting were introduced into the health sector within a quasi-market environment. Over the years, the SHA has developed case-based reimbursement instruments for hospital care (with a capped budget), and capitation-based financing of PHC services that are included under the Basic Benefits Package (BBP)¹². Although national health insurance schemes have been discussed and debated in small circles over the past several years, there are yet no comprehensive plans to develop this sector.

¹¹ The SHA is the purchaser of services, and health facilities are the providers of services.

¹² The BBP is described as "... not based on an elaborate and transparent definition, using cost-effectiveness and public health criteria, but ... more or less rational." Review of health financing and provider payment systems in Armenia – Final Report, HERA, February 2004, p. 9. The BBP was designed to meet the needs of vulnerable groups, and provide select basic services to other categories of citizens. It covers mainly curative and ill-defined services at the PHC level and, with more specificity, certain hospital services; it is subject to periodic changes. In addition, there is no current connection between covered services, their costs, and payments made by the SHA. The HERA report provides a comprehensive review of state budgeting and the public health financing structure in Armenia

State funds for BBP services are transferred from the State Treasury -- upon request from the MOH's purchasing agency the SHA -- directly to health facilities. In principle, the BBP should be provided free of charge to vulnerable groups, but funding shortages mean that even these groups must sometimes pay out-of-pocket. According to a UNDP 2003 household survey, at least half of the population does not know it is entitled to a range of free medical services and consequently avoids healthcare visits. Healthcare facilities generate additional revenues by providing other services (not covered by the BBP) and private care. However, the inefficient management practices that prevailed under the old pre-independence system often continue under the new. Locally elected governments have limited capacity to advocate or fund better services.

Rural health posts, located in small villages, are run by nurses, midwives, and/or *feldshers* and are supervised by staff from nearby polyclinics and ambulatories.¹³ Officially, the role of FAP staff is limited. For example, patients seeking routine maternal and child health (MCH) services are supposed to be referred to physicians. However, FAP personnel are often forced by circumstances to deliver services for which they are not properly trained. The FAPs have also deteriorated since independence, but with a minimum of improvements, they remain a viable option for delivering quality primary healthcare (PHC) to rural populations.

In 2000 the MOH, with the support of the World Bank, developed a "Concept Paper on Health System Optimization" that was approved by the GOAM. In 2001, optimization plans were developed to reduce the numbers of health facilities and hospital beds (through privatization, mergers of hospitals, research institutions and polyclinics) to meet the actual demand for health services. The results of the nine-month optimization plan implementation period in 2001 show that the government saved more than 1.5 billion drams (\$2.9 million) thanks to the privatization process and redirected these funds to health worker salaries and service provision. However, the privatization of hospitals through direct sale to the staff at highly discounted prices (75%) was neither transparent nor organized efficiently. According to the Bank, it did not motivate insiders to develop sound business plans based on a serious consideration of strategic options. The GOAM and the Bank agreed to postpone and re-think the privatization process.¹⁴

PHC was historically provided by a network of urban polyclinics and rural ambulatories, staffed by a mix of therapists, pediatricians, other specialists (who performed basic interventions), *feldshers* and nurses. There were separate institutions dispensing primary care for adults, for children, and for women's consultations. Because of chronic under-funding, the low professional status of PHC providers, and deteriorating infrastructure, the population tended to self-refer to hospital specialist care. PHC service delivery was considered inefficient and of low quality. Within this environment, emergency services began taking over part of the PHC workload.

Between 1996 and 2003, with support from the World Bank, the MOH began its overhaul of the nation's healthcare system. By 2001, the number of hospitals was reduced to 135 from 179 in 1998. In 2003, there were 14,208 hospital beds and 452 polyclinics and ambulatories (outpatient clinics) compared to 23,574 beds and 504 outpatient clinics in 1999. As for physicians, they numbered 12,625 in 1999 and 11,728 in 2003.

It is estimated that about 80% of illnesses in Armenia can be effectively addressed by PHC which is mainly provided through polyclinics staffed by generalists and specialists and through small clinics called ambulatories that mainly serve peri-urban and rural populations. The objective of PHC is to detect, diagnose and prevent illnesses as early as possible. PHC in Armenia includes MCH care, immunization and treatment of common and infectious diseases, the provision of MCH care, and

¹³ Rural health posts are called *feldsher acousher posts* (FAPs). *Feldshers* are mid-level providers.

¹⁴ Hayrapetyan, S., Khanjian, A. "Healthcare in Armenia: Challenges and Prospects," prepared for the Second International AIPRG Conference on "Armenia: Challenges of Sustainable Development," January 17-18, 2004, World Bank.

dispensing of necessary drugs and basic curative care. The majority of polyclinics are owned by local governments (only a few in Yerevan owned by the MOH). Polyclinic BBP services are supposed to be free for everyone.

The National Strategy on Primary Healthcare was approved in late 2003.¹⁵ The Strategy presented the country's vision for PHC reform implementation and service delivery improvement. The main components comprise accessibility, equity, comprehensiveness, continuity of care, and coordination between different levels of the healthcare system. The PHC approach placed a major emphasis on Family Medicine as the preferred organizational method for service delivery. The MOH follow-up PHC development strategy aimed to secure access to quality basic health services, particularly for vulnerable and rural populations.

In 2004, the MOH drafted a ten year National Health Policy document which is currently circulating among key stakeholders. The MOH aims to finalize and disseminate the document in 2005. Most recently, the MOH has been working diligently to facilitate passage of the new Law on Healthcare and the Law on Pharmaceuticals. The former law is currently awaiting hearing in the National Assembly and the latter is expected to be adopted by July 2005. These laws address many critical health sector issues, including optimization of healthcare facilities, continued implementation of PHC reforms, and improvement of service delivery. USAID has provided technical assistance in all of these areas. Additionally, the healthcare sector has been specifically addressed in both the National Poverty Reduction Strategic Program and the National Strategy on Anti-Corruption.¹⁶

Historically, public funds for healthcare have been severely limited (1.6% of GDP in 2001). Funding was slightly increased from 21 billion drams in 2003 (1.3% of GDP) to 24.5 billion (\$49 mln) in 2004, and 32.3 billion drams (\$64.6 mln) in 2005. The MOH projects a 35.5 billion dram national health budget for 2006.¹⁷ A recent Bearing Point study indicated that in 2003 approximately \$0.9 billion per year flowed into Armenia in the form of remittances that were unaccounted for in the GDP.¹⁸ It is not known how much of this money was used for out-of-pocket health expenditures, but historically it is generally agreed that private "informal" payments represent the majority of national healthcare expenditures. In fact, 91% of patients in Armenia report having been obliged to make some payment for hospital services.¹⁹

In 2002, the MOH prepared a proposal and advocated for nation-wide compulsory health insurance. But, given relatively low GOAM revenues, low personal incomes, and a large informal economy, the development of public and private health insurance schemes is unlikely at this time. Nevertheless, the development of health insurance remains a long-range GOAM goal.²⁰

I. 3. USAID Health Sector Projects

¹⁵ Decree No. 1533, December 6, 2003.

¹⁶ Offeror should familiarize themselves with these key documents that can be accessed at <http://www.imf.org/external/pubs/ft/scr/2003/cr03362.pdf> and http://www.gov.am/enversion/programms_9/korup_prog.htm.

¹⁷ 1 USD = 500 AMD.

¹⁸ Remittances in Armenia: Size, Impact, and Measures to Enhance Their Contribution to Development, Bryan W. Roberts, Ph.D., et al., Bearing Point, October 1, 2004.

¹⁹ Figueras J., McKee M, Cain J, Lessof S, eds. Health Systems in Transition: Learning from Experience, p. 60. WHO, 2004 on behalf of the European Observatory on Health Systems and Policies.

²⁰ There continue to be sporadic discussions of national health insurance by top-level MOH officials. GOAM work on this is not likely to begin in earnest until other forms of insurance (e.g., mandatory auto) are firmly established.

USAID support to Armenia's health sector began in the 1990s with a focus on improving the quality of overall care and women's health services through a program that linked premier U.S. healthcare institutions with select hospitals and polyclinics in Yerevan and 4 of Armenia's 10 marzes. U.S. partners leveraged considerable matching funds, instilled new health provider values, and improved the quality and administration of services. In later years, USAID financed efforts to improve primary care at community centers that served the elderly and the handicapped, and mobile medical teams that provided health services to hard-to-reach populations.

In August 2000, USAID began its five-year Armenia Social Transition Program (ASTP) to assist the GOAM to develop, test and implement a series of social protection initiatives including PHC reform. ASTP²¹ will end in July 2005. USAID/ASTP's health sector activities include:

- design and implementation of the organizational and regulatory framework for family medicine as the predominant specialty for PHC;
- development and testing of open enrollment for the population to receive state-funded PHC services;
- support for MOH/SHA and health facility information systems;
- better targeting of vulnerable populations; reducing corruption through transparent contracting, cost accounting and financial management practices;
- and laying the groundwork for sustainable, national PHC coverage.

USAID/ASTP's successes include:

- ASTP pilot sites formally recognized as national health system pilots;
- a new, unified curriculum for family medicine training developed and adopted;
- family medicine departments established; and
- population enrollment and quality improvement programs introduced in pilot sites.

Moreover, the MOH's Primary Healthcare Strategy (for 2003-2008) and the recent National Health Policy draft document (for 2004-2015) incorporate many of the strategies being promoted and piloted under ASTP.

To complement USAID's PHC reform efforts and reinforce Reproductive Health/Mother and Child Health (RH/MCH) programs at the primary care level, in 2001 under the PRIME II project USAID began supporting efforts to improve providers' performance in RH/MCH, and sexually transmitted infections (STIs) including HIV/AIDS prevention.²² PRIME II worked with policy makers at the national level on RH/MCH policy and norms and with local health authorities and primary providers in the Lori region on RH/MCH service quality and organizational issues. The program reinvigorated the delivery of services at the FAPs and second tier PHC facilities (ambulatories, maternity centers, polyclinics). Based on the successful PRIME II work, USAID awarded a five-year RH/MCH project, called NOVA, in October 2004 to roll out the program nation-wide.²³ NOVA has four main thrusts:

- to improve rural RH/MCH PHC provider knowledge and clinical skills and provide basic medical equipment and supplies;
- to develop the capacity of regional health officials and local health facility administrators and practitioners to improve the quality of rural RH/MCH service management and delivery and

²¹ The ASTP prime contractor is PADCO, Inc. The health portfolio is implemented primarily by PADCO's subcontractor, Abt Associates, Inc.

²² PRIME II Project, <http://www.intrahealth.am>.

²³ NOVA is the Armenian acronym for the project title that translates into English as "Innovations in Support of Reproductive Health." LOP is Oct. 2004- Sept. 2009. Prime contractor is Emerging Markets Group (EMG); principal subcontractor is IntraHealth International, Inc.

- ensure sustainability of successful practices by introducing sound management and quality improvement practices at the PHC level;
- to accelerate the momentum of policy change and improve the overall regulatory environment for healthcare services delivery by expanding the range of RH/MCH services that PHC providers can offer; and
- to increase consumer demand for high-quality RH/MCH services and develop community education and mobilization activities using the community partnership for health (CPH) model piloted under PRIME II.

With assistance from the John Snow Inc. DELIVER project, a Central Drug Supply Tracking System (CDSTS) was designed to assist the MOH to better manage drugs supplied by two international NGOs (IRD and UMCOR) as well as MOH centrally procured drugs. The CDSTS tracks pharmaceuticals received by two international NGOs and procured by the central MOH drug warehouse and the distribution of these pharmaceuticals to healthcare facilities. At this time, it only tracks historical data and has no mechanism to track drug distribution to patients. Beginning in May 2005, further assistance in the areas of drug logistics and management will be provided under the Rational Pharmaceutical Management Project (RPM Plus) which is implemented by Management Sciences for Health (MSH).

Since the 1990s, USAID/Armenia has supported initiatives to improve service delivery and management of health programs that directly benefit Armenia's most vulnerable populations. One program, run by World Vision, provides increased access to PHC for over 33,000 people in isolated communities located in four regions (Lori, Tavush, Gegharkunik and Syunik) through mobile medical teams. The program provides nutrition support, strengthens village level health structures, and builds links to district hospitals for improved referrals.

Lastly, USAID has provided matching funds through Global Development Assistance (GDA) grants to two Diasporan organizations, the American Armenian Cultural Association (AACA) and the Armenia EyeCare Project (AACP), to further their respective work in women's cancer screening and blindness prevention. AACA's Yerevan Armenian Wellness Center provides reliable medical screening and diagnosis of breast and cervical cancer and raises public awareness of the benefits of early detection. Quality services are now available outside the capital city at a satellite clinic in Gavar and via regular medical missions to vulnerable regions. AACP focuses on four key intervention strategies: (i) outreach, screening and treatment of vulnerable populations; (ii) medical education and training of regional ophthalmologists, family medicine physicians, and ancillary medical personnel; (iii) public education and communication programs; and (iv) epidemiology.

I.4. Other Donors

Armenia's health sector international collaborators include USAID, the World Bank, WHO, UN Agencies (UNICEF, UNDP, UNFPA), GTZ, JICA, and Médecins Sans Frontières Belgium (MSF-B). Although there is yet no formal MOH mechanism for coordinating donor programs, representatives of donor agencies meet frequently to discuss sector issues, to coordinate and plan respective activities, as is evidenced by the working group for the 2005 ADHS.

The World Health Organization (WHO) is in the second year of its Biannual Cooperative Agreement (BCA) with the GOAM. A needs assessment is presently underway to define the parameters of WHO support for the next 4 years. The current BCA covers nine priority areas including policy development, health systems development (National Health Accounts, PHC), workforce planning, tobacco control, communicable disease surveillance and health information system, maternal and child health (MCH), malaria control, and TB.²⁴ WHO has also been instrumental in elevating the importance

²⁴ See <http://www.who.int/country/arm/en/>

attributed to the policy development process and is currently advocating the establishment of four working groups to consider policy issues related to healthcare financing mechanisms, resource generation, service delivery, and MOH's stewardship role. Both national and international health sector stakeholders will comprise the working groups.

The World Bank's \$10 million Health Financing and Primary Health Care Development Project (1997-2003) focused on improving the quality of PHC and the efficiency of public health expenditures.²⁵ The project promoted community-based PHC and increased access to health services, particularly for vulnerable populations. The Bank's current \$19 million Armenia Health System Modernization Project was signed in June 2004. It is the first of a two-phase, seven-year commitment by the Bank to support broad structural reforms in the health sector.²⁶ About 37% of the funds are devoted exclusively to PHC reform (\$7.1 mln) with additional contributions for training and institution building activities from different project components. The Family Medicine Development component supports training of 980 family medicine doctors and nurses, improving PHC infrastructure beyond the 81 communities supported under the first project, further development of family medicine PHC guidelines, and a small grant program to promote community participation. The Hospital Network Optimization and Modernization component supports the strategic restructuring of selected hospital networks (four in Yerevan, one per region). The third component, Strengthening Government Capacity to Develop and Monitor Effective Health Sector Policies, is designed to strengthen MOH capacity for policy development and implementation monitoring, regulation and oversight of the health sector; it will also strengthen the governance and management structures of healthcare institutions by regional government structures. The project moreover supports development of core monitoring instruments that are needed to inform decision makers (e.g., health sector performance reports, National Health Accounts) and improved surveillance of HIV/AIDS and other public health threats (see Annex 2).

The United Nations Development Program (UNDP) provides assistance for national strategic planning for AIDS prevention, as well as for elaborating HIV/AIDS Situational and Response Analyses through policy advice and direct support to people living with HIV/AIDS.²⁷ In addition, UNDP is building capacity of civil society to participate in anti-corruption initiatives in the social sectors of Armenia. In 1995 the United Nations Population Fund (UNFPA) began stand-alone RH projects in Armenia²⁸ that focused on establishing a network of 77 family planning offices, improving access to and quality of antenatal services and emergency obstetric care, establishing a national reproductive health and reproductive rights legal framework, strengthening the capacity of the GOAM to manage and deliver reproductive health services, improving the awareness of young people in sexual and reproductive health, and fostering partnerships with civil society entities. UNFPA has also been active in formulating broader national development frameworks such as poverty eradication, strategies to achieve the Millennium Development Goals, national reproductive health program, the national strategy on HIV/AIDS, and national action plans to promote gender equality and to address the trafficking of women.

The United Nations International Children's Emergency Fund (UNICEF) program in Armenia aims to improve the quality of and access to PHC services for children, with special emphasis on the remote

²⁵ World Bank, Health Financing and Primary Health Care Development, <http://web.worldbank.org/external/projects/main?pagePK=104231&piPK=73230&theSitePK=40941&menuPK=228424&Projectid=P050140>

²⁶ World Bank News Release No:2004/409/ECA: Armenia Health Systems Modernization Project, <http://www.worldbank.org.am/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/ARMENIAEXTN/0,,contentMDK:20211356~menuPK:301584~pagePK:141137~piPK:141127~theSitePK:301579,00.html>

²⁷ UNDP in Armenia, <http://www.undp.am>

²⁸ UNFPA, Draft Country Program Document for Armenia (unavailable), other publications available at <http://www.undp.am/?page=publications> and http://www.unfpa.org/europe_asia/index.cfm

areas of Armenia.²⁹ Disease prevention for children, prevention of micronutrient deficiencies, improved child developmental screening and Integrated Management of Childhood Illnesses (IMCI) are the key strategies of the project.

World Vision is the principal recipient and implementer of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) grant. This five-year, \$7.2 million program began in July 2003 and aims to reduce the spread of HIV/AIDS among high-risk groups (injecting drug users, female sex workers, men who have sex with men, prisoners, migrants) and to provide better care for people living with HIV/AIDS.³⁰

The German development organization, GTZ, is implementing the Regional Program on Tuberculosis Control in the Caucasus: Armenia, Azerbaijan and Georgia. The aim of this nation-wide program is to reduce tuberculosis morbidity and mortality rates through national and cross-border efforts. The program focuses on DOTS strategy,³¹ training of physicians and laboratory technicians in DOTS methodology, and improving management capabilities at all levels. The current completion date is May 2005, and there are plans to renew the program for an additional two years.

MSF-B currently has programs on tuberculosis and sexually transmitted infections (STI). They work with health authorities in Lori to combat TB using the DOTS strategy as well as train staff and provide public information and education. In Tavush, MSF-B runs an STI/HIV treatment and prevention program.

In October 2004, the GOAM and JICA signed an agreement for a two-year (2005-2007) Reproductive Health Project. The Center for Perinatology, Obstetrics and Gynecology (CPOG) located in Yerevan is the main JICA implementing partner. Project objectives are to promote maternal and neonatal health with a focus on training health professionals in Evidence-based Medicine (EBM); using EBM in service provision during pregnancy, labor and postpartum care; and strengthening the referral system between the CPOG and the maternity hospitals of Gavar and Hrazdan cities. Activities entail assessing health professionals knowledge of EBM; developing web-based and standard teaching materials and a medical library for EBM training; conducting EBM seminars and workshops in Armenia and Japan, including in-service training.

II. STATEMENT OF WORK – Primary Healthcare Reform Project

II.1. Objective

USAID's recent and anticipated activities in health in Armenia support the Mission's Strategic Objective (SO) 3.2, two intermediate results and seven lower level results (LLR) as seen in Table 1.

²⁹ UNICEF, <http://www.unicef.org/infobycountry/armenia.html>

³⁰ Global Fund, <http://www.theglobalfund.org>

³¹ DOTS = Directly Observed Treatment, Short-Course.

Table 1: SO 3.2 Increased Utilization of Sustainable, High-Quality Primary Healthcare Services

IR 3.2.1: Strengthened Institutional Capacity to Implement PHC Reform	IR 3.2.2: Improved Service Delivery in Priority PHC Disciplines
LLR 3.2.1.1: Improved Capacity of Educational Institutions to Prepare PHC Providers	LLR 3.2.2.1: Expanded and Enhanced Services at the PHC Level
LLR 3.2.1.2: Improved PHC Financing Mechanisms and Practices	LLR 3.2.2.2: Improved PHC Management and Administration of Services
LLR 3.2.1.3: Improved Regulatory Environment for PHC Services Delivery	LLR 3.2.2.3: Increased PHC Outreach Services Provided to Vulnerable Populations
	LLR 3.2.2.4: Increased Consumer-Driven Demand for PHC Services in Program Areas

The objective of USAID’s new Primary Healthcare Reform Project is to support health sector reform activities designed to result in increased utilization of sustainable, high-quality PHC services. Achieving the strategic objective will contribute to the improved health of all Armenian families and to a more productive workforce that will be better able to meet the challenges of and contribute to the growing Armenian economy. The Offeror will review USAID’s current health sector performance monitoring plan (PMP) and, if warranted based on Offeror’s proposed strategies and activities, present additional quantitative and qualitative indicators for measuring progress toward achieving the SO and intermediate results (IRs).³²

II.2. Sector Focus – PHC Reform

MOH strategy for health sector reform calls for the strengthening of PHC services through the creation of Primary Care Group Practices comprised of Family Medicine practitioners (called interchangeably either PCGP or FMGP). The vision is for PCGPs/FMGPs to become legally autonomous entities capable of independently contracting with the SHA under an open enrollment system whereby patients choose their own providers. PCGPs/FMGPs may take different forms, including for-profit and non-profit. They may be formed within existing primary care structures (polyclinics, ambulatories) or freestanding entities operating in their own facilities (leased or owned). Other structural models might be envisioned.

The Offeror is requested to propose strategies and activities for implementing PHC reforms at select facilities nation-wide, building upon the results achieved to date under USAID/ASTP and other donor projects. In addition to descriptions of strategies and activities for each project component, the Offeror is requested to discuss measures to be employed over LOP to ensure ownership by host country stakeholders and sustainability of proposed activities.

The selected Offeror is expected to support and help to institutionalize MOH PHC reform goals, policies, norms and standards on a nation-wide scale working within target facilities in each marz and in Yerevan. The selected Offeror will also work closely with regional and local governments and health officials, facility managers, service providers, community leaders and patient stakeholder groups to facilitate and ensure institutionalization and acceptance of PHC reforms including open enrollment and FMGPs either within or independent of existing PHC facilities.

The selected Offeror must remain abreast of other health sector donors’ activities to ensure the

³² See Draft PMP Annex 2. USAID is in the process of working with partners to determine appropriate targets for the lower level results, and the successful Offeror will be expected to contribute to the development and achievement of these results.

complementarity of USAID activities with others, especially the World Bank. The Offeror should propose mechanisms and plans for coordinating donor activities to maximize resources and preclude duplication of effort. The Offeror will be expected to participate in, contribute to, and/or provide advisory services for activities, task forces, and/or committees supported by the MOH, major donors and international organizations (e.g., health policy working groups, GFATM Country Coordination Mechanism [CCM], etc.).

Furthermore, the selected Offeror is expected to participate in regular periodic meetings with USAID and other USAID contractors and to actively look for synergies with other USAID projects, such as Project NOVA that works nation-wide to improve RH/MCH services primarily at the FAP level. Likewise, although work on a national logistics management system (LMIS) and rational pharmaceutical management will be carried out under the USAID Global Health Bureau’s RPM Plus³³ Project, it is essential that RPM Plus and the PHC Reform Project collaborate closely to ensure synchronization of respective activities.

II.3. PHC Reform Project Components

To convey USAID and MOH expectations of the new PHC Reform Project, the project is divided into six (6) components. In reality, the compartmentalization is artificial since all of the components discussed are necessary, integral parts of a coherent reform program and the PHC Reform “model” would not be complete without any one of them.³⁴ Component 1 sets the stage for geographic expansion of the PHC reform in Armenia. Components 2 through 6 present essential elements of the reform program. The Offeror is encouraged to point out and expound upon any perceived critical gaps in this RFP’s conceptualization of PHC reform. In this case, USAID is open to considering additional and innovative strategies and activities that may not be included in the RFP, contingent upon articulation of compelling, evidence-based arguments for their inclusion in the new PHC Reform Project.

The 6 components are:

- 1. Extension of PHC Reforms Nation-wide
- 2. Family Medicine Practice
- 3. Open Enrollment
- 4. Quality of Care
- 5. Healthcare Financing and National Health Accounts
- 6. Public Education, Health Promotion and Disease Prevention

Each of the components will be discussed in this RFP following the same format:

- Name of Component
- 1. Background and Rationale
- 2. Expectations of Offeror
- 3. Illustrative Activities
- 4. Anticipated Outcomes.

³³ RPM Plus work in Armenia is scheduled to begin in May 2005. The work builds on previous interventions done under the JSI DELIVER Project. See <http://www.msh.org/rpmplus>.

³⁴ See Annex 4 for Table of Illustrative Inputs that the Offeror might find useful for proposal preparation. The Table represents a very rough estimate of major inputs to guide the Offeror. Project inputs will be based on the successful Offeror’s vision of, and proposed inputs, for the new PHC Reform Project.

II.3.1. Extension of PHC Reforms Nation-wide

II.3.1.1. Extension of PHC Reforms Nation-wide - Background

While two-thirds of Armenia's population lives in rural areas in small villages and towns, the majority of providers are found in urban areas, particularly in Yerevan. Moreover, the already inadequate supply of PHC providers in rural areas is dropping. They have long failed to receive funding and attention proportionate to their share of Armenia's population. Rural areas have fewer nurses, fewer primary care and fewer specialist physicians than large urban areas. Rural populations have a poorer health status than their urban counterparts.

Since the dissolution of the Soviet Union, many of these circumstances have worsened. Obligatory state service for medical school graduates was a major factor in assuring a flow of health professionals to rural areas, but this obligation no longer exists. Housing and transport allowances for providers in these areas have been rescinded. As the ratio of provider to population has worsened in rural areas, too, has the provider's workload in both scope and volume. And, the real income gap between urban and rural physicians has widened.³⁵ Under such circumstances, it is not surprising that there are proportionately fewer providers in rural areas today than there were 15 years ago.

USAID's Project NOVA provides TA and training to improve the skills and practices of rural health nurses, primarily those in FAPs. NOVA will eventually work nation-wide according to a geographic phase in plan that also includes the renovation of 150 out of a total of 610 FAPs (health posts).³⁶ In addition, a total of 450 FAPs (including the 150 to be renovated) will receive basic equipment and supplies. Since NOVA focuses on reproductive, maternal and child health, additional work is needed to broaden the PHC skills of FAP nurses, and of their supervisory physicians at the FAP referral facilities.

The PHC Reform Project will focus on improving PHC services in the rural areas (villages and small towns), beginning with select FAPs and their reference facilities (ambulatories and polyclinics). Assistance will be provided to a limited number of urban polyclinics and peri-urban ambulatories as well.³⁷

II.3.1.2. Extension of PHC Reforms Nation-wide – Expectations of Offeror

The Offeror is requested to propose a strategic plan for assisting the MOH, regional and local health officials to improve PHC in 100 FAPs, and 200 ambulatories and/or polyclinics nation-wide. Priority should be given to ambulatories and polyclinics that serve as referral facilities (have oversight) for FAPs. The Offeror's plans must take into account both NOVA's strategic plans and the World Bank and other donors' achievements³⁸ as well as target facility selection criteria to be developed by the Offeror in collaboration with stakeholders. The Offeror's plan should include illustrative selection criteria and demonstrate knowledge of both the common and the unique healthcare challenges facing rural and urban areas. The plan should include strategies and activities for working with regional and local governments, health officials, and communities to improve PHC services at the FAPs, ambulatories and polyclinics. The Offeror's experience with GIS mapping of healthcare facilities and optimization of resources should be presented.

³⁵ The most popular and competent PHC physician in a rural area of 1,000 population can make no more from capitation than half the income available to an urban PHC physician who registers 2,000 patients.

³⁶ FAPs are staffed usually by one nurse who is overseen by a physician at a referral facility. Nurses typically have limited training and are often the only source of care for rural residents. NOVA currently operates in Lori, Tavush and Shirak marzes, with tentative plans to expand to Aragotsotn and Gegharkunik in 2006; Kotayk, Armavir and Ararat in 2007, and Vayots Dzor and Syunik in 2008.

³⁷ There are 452 ambulatories and polyclinics in Armenia.

³⁸ Under the previous World Bank loan, 83 ambulatories were refurbished and about 300 physicians and 300 nurses were trained in FM. See Annex 1 and 2 for current World Bank activities.

II.3.1.3. Extension of PHC Reforms Nation-wide: Illustrative Activities

The Offeror is asked to consider the following illustrative activities, elaborate on them, and/or modify them, and/or propose other and additional strategies and activities to ensure the reinvigoration of PHC services at selected FAPS, ambulatories and polyclinics.

Activities may include but are not limited to:

- Development and implementation, in collaboration with all stakeholders, a plan for the upgrading of PHC through the introduction of FM, and quality improvement techniques at selected FAPs, and FM, quality improvement and open enrollment at selected ambulatories and polyclinics.
- GIS mapping of all healthcare facilities in Armenia.
- Development and implementation of training plans to improve the PHC skills of providers from the project's participating FAPs, ambulatories and polyclinics.
- Identification and implementation of plans and measures to increase resources available to rural facilities (working with local governments).
- Design and implementation of training plans covering FM, OE, quality improvement, cost accounting, etc. for appropriate staff at the project's target facilities as well as FM training for FAP nurses targeted under NOVA; activities will include on-the-job and self-directed learning programs and workshops.
- Undertake minor renovation work of up to 100 FAPs, beginning with those associated with the ambulatories renovated by the World Bank, plus up to an additional 130 ambulatories and polyclinics (not previously covered by the Bank or other donors), once the viability of the facilities has been established through a thorough analysis of population needs, services available, client load, other healthcare options, etc.
- Provide basic medical equipment for targeted facilities as necessary.
- Strengthen referral system between FAPs and higher level facilities using innovative technologies, and strengthen links between facilities and SanEpid.
- Policy work with the MOH/SHA, NIH, the Basic Medical College, Project NOVA and other stakeholders to increase the scope of authorized activities of PHC, including FAP, nurses.
- Work with appropriate parties to design and launch continuing professional development courses for PHC nurses at all facility levels, consistent with the FM nursing curriculum.
- Assist the MOH/SHA to develop financial incentive policies and regulations that will address current rural healthcare worker shortages within PHC facilities.

II.3.1.4. Extension of PHC Reforms Nation-wide -- Anticipated Outcomes

Base Period (Sept 2005 – Sept 2007)

- Medical staff from 210 ambulatories and polyclinics and 250 FAPs (includes FAPs targeted by NOVA) benefit from FM and quality of care training, and polyclinic staff benefit additionally from training in cost accounting.
- Establishment, within 6 months of project start up, of a working group to review the current status of rural nursing curricula and to formulate guidelines for the expanded role of rural health nurses (working group comprised of staff from the MOH, regional and local health sector agencies, Basic Medical College, NIH, Project NOVA, etc.).
- Development and launch of an incentive program to attract physicians and nurses to work in the rural areas.
- Completion and launch of an in-service FM for Nurses training curricula within 12 months of project start up.
- In collaboration with the MOH, regional and local health authorities, and other key stakeholders, formulation of a rural health nursing policy that meets the PHC needs of rural populations.

- Synergistic work planning with Project NOVA in regard to FAP renovations and training of FAP nurses.
- Inventory of healthcare facilities nation-wide using GIS completed.

By End of Project (Sept 2010)

- 100 FAPs and approx. 130 ambulatories and polyclinics refurbished and equipped.
- Approx. 150 doctors and 670 nurses trained or re-trained in FM.
- Rural nursing curricula revised, approved and adopted in nursing schools.
- Increased client satisfaction at project's target facilities.
- Increased services utilization rates at target facilities.
- Effective incentive measures in place to attract providers to rural areas.

II.3.2. Family Medicine Practice

II.3.2.1. Family Medicine Practice - Background

In support of PHC and its Family Medicine orientation, USAID has undertaken a wide variety of activities. ASTP began in 2000 and developed the unified Family Medicine curriculum that was officially adopted by the MOH in July 2003.³⁹ Family Medicine training centers for physicians, established within the National Institute of Health (NIH) and the Yerevan State Medical University (YSMU), and the training of Family Medicine nurses at the Basic Medical College of Yerevan make use of the curriculum that incorporates not only infectious diseases, family planning, reproductive health, maternal and child health, but also the major health problems of non-communicable diseases and injuries (NCDIs).

To date, only about 300 Armenian physicians and a similar number of nurses have been retrained in Family Medicine. Under the new World Bank loan project that began in 2004, 980 physicians and 980 nurses will be trained in Family Medicine. Many graduates are expected to return to rural sites where two-thirds or more of the population lives.

The widespread establishment of Family Medicine as a discipline and practice in Armenia is expected to have a significant impact on the way the country conducts its healthcare business in the future.

Currently, PHC BBP services are paid by the SHA as a fixed amount on a per capita basis according to census data. In addition to receiving population-based capitation payments, a polyclinic's specialists bring in additional revenues to the clinic as patients are levied additional fees for specialized services. Historically, the PHC physician has served as an internal referral source to the polyclinic's specialists. The greater the number of client-specialist consultations, the greater the clinic revenues.

Since Family Medicine training and experience enables a PHC practitioner to correctly diagnose and treat about 80 percent of common illnesses and medical conditions, the perceived need to refer clients to specialists might be diminished. This could result in reduced incomes of specialists and in overall clinic revenues. Thus, it is conceivable that incentive schemes to expand the Family Medicine practice on a large scale may lead to resistance to PHC reform by specialists and clinic administrators.

With support from USAID, 12 PHC Family Medicine pilots are well underway in both Yerevan and Vanadzor in Lori Marz.⁴⁰ The pilots are testing a new model of care that incorporates open enrollment, Family Medicine organization and delivery, continuous quality improvement (CQI), and a

³⁹ MOH decree No 613.

⁴⁰ The USAID pilot sites include 9 polyclinics and 3 ambulatories (see www.astp.am).

performance-based capitation payment plan.⁴¹

USAID/ASTP has worked closely with the SHA and the pilot facilities to design and test PHC incentive-based reimbursement approaches that explore the effects of linkages between payment and services rendered to enhance provider quality and productivity. Given the historical context, efforts to spread cost-effective Family Medicine practices could lead to a variety of tensions -- financial, professional and organizational -- within the traditional polyclinic structure. One solution, under consideration by Family Medicine physicians at Yerevan's Polyclinic 17, is for primary care to become wholly autonomous -- even a separate legal entity -- from the cohort of specialists.

The MOH and USAID are open to considering other options for the implantation of Family Medicine, ranging from Family Medicine general practices within a PHC facility to free-standing private sector practices. While a lot has been done, much remains to be accomplished to select and implement a model that is appropriate for Armenia's PHC system. The Offeror is requested to propose as many options as it believes feasible, and articulate how these options would be tested and taken to scale nation-wide, taking into consideration urban and rural differences, and all the developments to date in PHC reform.

II.3.2.2. Family Medicine Practice - Expectations of Offeror

The successful Offeror is expected to maximize use of USAID/ASTP FM and other donors' materials under the new project, refining the materials if necessary over time and/or supplement them with additional materials to fill any. In this regard, the Offeror should expound upon its experience either in Armenia or in other similar countries with Family Medicine. The Offeror should propose plans for increasing the number of FM physicians, taking into consideration World Bank FM training plans and the capacity of current FM pre-service and in-service programs in Armenia. Plans should discuss potential viable short- and long-term mechanisms for addressing the shortage of FM providers such as, for example, the development and implementation of innovative continuing professional development programs for health providers. The Offeror should provide details on all potential mechanisms proposed, including incentive strategies for attracting providers to the field of FM, with a focus on rural and peri-urban areas, as well as measures to ensure the institutionalization and ownership of programs by Armenian stakeholders.

No later than 12 -18 months of project start up, the successful Offeror will be required to study the feasibility of and advise USAID on using USAID's Development Credit Authority (DCA) mechanism to support one or more freestanding FMGPs outside of Yerevan. If the study indicates a good potential for DCA in Armenia, USAID/Armenia will take responsibility for follow up actions with DCA. The Offeror may be requested by USAID to assist in implementation of a resulting DCA activity. Thus, the Offeror is requested to describe any experience they have had with DCA or other credit and loan programs for healthcare providers

II.3.2.3. Family Medicine Practice – Illustrative Activities

The Offeror should consider the following illustrative activities, elaborate on and/or modify them, and/or propose other and additional strategies and activities to further the successful implantation of FMGPs.

Activities may include, but are not limited to:

⁴¹ The model is currently being reviewed and evaluated by the MOH and SHA for possible expansion in Armenia. Variations on the model and methodologies are encouraged and likely necessary as the model is still in its infancy. To date, the CQI protocol has been approved for use throughout the country on a voluntary basis.

- the development and implementation of a training/re-training plan for PHC FM providers (physicians and nurses) to complement World Bank plans (est. no. of USAID-funded trainees: 150 doctors, 670 nurses LOP).
- revision, as necessary, and wide dissemination of USAID-supported PHC FM in-service materials to PHC and FM practitioners.
- development of criteria for the establishment of FMGPs within polyclinic and ambulatories nation-wide .
- establishment of FMGPs (within polyclinics or free-standing) approx. 80 polyclinics/ambulatories.
- development of criteria for the establishment of free-standing FM practices (no. of free-standing practices TBD within 6 months of project startup).
- inventory and evaluation of existing USAID-funded tools and the development of additional tools if necessary (e.g., model business plan, incentives schemes, human resources plans, planning and budgeting) for autonomous and free-standing FM practices.
- provision of a minimum set of start-up equipment and supplies for FMGPs (not to exceed USAID's ceiling price and illustrative equipment list for FMGPs, Annex 5).
- assistance to the MOH and FM training institutions to establish a process for periodic review and revision of the FM curriculum.
- development, promotion and support for a national FM continuing professional development program similar to existing programs within the New Independent States and Western Europe.
- a feasibility study to determine DCA potential for financing start up costs of FMGPs.

II.3.2.4. Family Medicine Practice -- Anticipated Outcomes

Base Period (Sept 2005 – Sept 2007):

- Tools and guidelines refined, supplemented as necessary, approved, published and used for development of autonomous-within-polyclinic and free-standing FMGPs.
- Mechanism in place for the periodic review and updating of FM curriculum.
- FM training practicums established at select sites.
- Approx. 30 new FMGPs functioning.
- Approx. 250 providers begin training/re-training programs in FM.
- Incentive measures developed, approved, and implemented for attracting FM providers to peri-urban and rural PHC facilities.

By End of Project (Sept 2010)

- Development, approval and implementation of standards and guidelines for FM provider licensing.
- Approx. 820 providers trained in and practicing FM.
- Increased no. of FM providers in rural areas and nation-wide (target no. TBD within 2 months of project startup).
- Approx. 80 new PHC FMGPs operating nation wide.

II. 3.3. Open Enrollment

II.3.3.1. Open Enrollment - Background

For decades under the territorial-district principle, the people of Armenia were assigned, with no choice in the matter, to a district polyclinic and a PHC provider. In March 1996, the assignment policy was formally replaced.⁴² Open enrollment was henceforth the policy of the MOH giving citizens the right to choose their PHC provider. This ability to choose represents at once a catalyst and incentive for quality improvement. Providers who do not meet patients' expectations for quality services will lose their clientele. Losing patients, especially in Armenia's capitated system of primary care, directly results in a diminished income for providers. The pilot sites have shown that successful open

⁴² ROA Law on Population Health Care and Service Provision, adopted March 6, 1996.

enrollment goes hand in hand with the establishment of high quality FM practices. Per World Bank loan conditionality, the MOH plans to begin nation-wide rollout of open enrollment in January 2006.

II.3.3.2. Open Enrollment – Expectations of Offeror

USAID is committed to assisting the MOH, and regional and local entities to institutionalize the open enrollment system nation-wide. In this regard, USAID requests that Offeror provide a detailed plan for nation-wide rollout of open enrollment and a discussion of the different challenges specific to urban and rural areas.⁴³ For open enrollment, the successful Offeror will assist national MOH officials and regional health authorities in all 10 marzes and the Yerevan municipality in setting up an open enrollment information system for maintaining and sharing client registration information. Computer hardware and software should be envisioned for about 180 sites including MOH/SHA headquarters, all health district offices, and ambulatories and polyclinics in major towns.⁴⁴ The Offeror should articulate plans for involving and ensuring ownership by regional and local governing entities, communities, medical personnel, as well as plans for training of personnel, public information activities on open enrollment, etc.

II.3.3.3. Open Enrollment: Illustrative Activities

The Offeror should consider the following illustrative activities, elaborate on and/or modify them, and/or propose other and additional strategies and activities to further the successful rollout of open enrollment nation-wide.

The Open Enrollment Component may include, but is not limited to:

- the development, implementation and/or refinement, as necessary, of legal, policy and regulatory, and monitoring and evaluation frameworks for open enrollment (e.g., establishment of policy that articulates the roles, responsibilities, information flow between all parties involved in open enrollment: national and regional MOH entities, local authorities, PHC facility managers).
- facilitating the adoption and implementation of an official rollout strategy, based on strategic targeting or a geographic phase in plan.
- implementation of an open enrollment information system with a database covering clients, providers, and facilities at the MOH national level (SHA) and in all health districts, major cities and large polyclinics (approx. 210 sites).
- design and implementation of public awareness and education activities to inform health sector personnel, professional and NGO groups, government authorities at all levels, community leaders, and the public at large about open enrollment, with appropriate campaigns for different audiences.
- build on and refine if necessary qualitative and quantitative performance indicators for open enrollment (for FM providers).
- identify measures to institutionalize the routine use of guidelines or another framework for documenting facility performance.
- revision of SHA capitation contracts to reflect performance criteria and indicators.

II.3.3.4. Open Enrollment: Anticipated Outcomes

Base Period (Sept 2005 – Sept 2007)

- automated information system in place at new project PHC sites plus at regional and national “control sites” to enable enrollment data sharing, redundancy elimination, and two-way

⁴³ For example, how can one envision open enrollment in areas of the country where there are few facilities and few providers?

⁴⁴ The assumption is that some of the 210 facilities already have IT equipment.

communication and program feedback between MOH national and regional authorities (est. no. 210).

- training curriculum for open enrollment further refined and implemented according to annual training plans.
- public knowledgeable about and exercising open enrollment options.

By End of Project (Sept 2010)

- open enrollment system functioning nation-wide.
- smooth two-way flow of data and information on clients, providers and facilities among the various parties responsible for open enrollment.
- accurate, up to date open enrollment provider and facility-based database and information system institutionalized in the MOH, and at regional and local levels in all 10 marzes plus Yerevan.

II.3.4. Quality of Care

II.3.4.1. Quality of Care – Background

A fundamental gap in Armenia's healthcare system that impacts on the quality of care is the absence of licensing procedures for healthcare workers. In 1996, a system was introduced that required providers to renew their medical license every five years. For reasons that are unclear, the system was subsequently suspended. Ad hoc and voluntary quality improvement measures are not sufficient substitutes for a permanent mechanism that requires providers to regularly update their medical skills and knowledge. Currently graduation from medical school is the only requirement for a license to practice medicine.

In early 2005, the MOH requested that the new USAID PHC Reform Project include assistance for the development of a continuing professional development strategy and programs for Armenia's healthcare providers. And, in April 2005 the MOH proposed the establishment of a Medical Council to address the licensing issue and requested donor assistance in setting up the Council. USAID has agreed in principle to assist the MOH in these endeavors.

In the meantime, the MOH has been addressing quality of care issues by focusing on improving service delivery at the facility level, although currently the application of a rigorous quality of care methodology is voluntary.⁴⁵ Quality improvement activities at the facility level have constituted an essential component of the pilot PHC FM model of care. The model uses the continuous quality improvement (CQI) methodology that entails the on-going scrutiny of services; the identification of strengths, weaknesses and gaps; formulation of lessons learned and measures to improve processes, with active engagement of all staff. CQI establishes quality and performance indicators and criteria for assessing and monitoring provider performance. It provides a methodology for systematically improving every aspect of service delivery, from providers' clinical skills and procedures, to administrators' management and accounting practices.

II.3.4.2. Quality of Care – Expectations of Offeror

The Offeror is requested to present its past experiences with medical licensing and continuing professional development (i.e., continuing education) programs in general, and for FM in particular, in other countries -- experiences that the Offeror believes could be brought to bear in Armenia. The Offeror should articulate a plan for assisting with the establishment of and facilitating the work of the Medical Council in Armenia.

Furthermore, taking into consideration the Offeror's own world-wide quality improvement experiences as well as the CQI work done at the USAID pilot sites in Armenia, the Offeror should

⁴⁵ On October 31, 2002, the GOAM approved the "Concept on Quality Improvement and Management of Health Care Provision to the Population of Armenia" for adoption on a voluntary basis by providers.

propose strategies and activities for institutionalizing a culture of quality care throughout the PHC system in Armenia. The Offeror should specify the number of PHC facilities they intend to target each year of the project. The Offeror should, moreover, articulate strategies and plans for involving regional and local government officials, community leaders, NGOs, professional medical groups and other stakeholders in PHC quality improvement activities.

II.3.4.3. Quality of Care: Illustrative Activities

The Offeror should consider the following illustrative activities, elaborate on them, and/or modify them, and/or propose other and additional strategies and activities to ensure a culture of quality care at PHC service delivery sites.

The Quality of Care Component may include but is not limited to:

- Support for the establishment of a Medical Council in Armenia the principal objective of which is to set norms and standards for medical practice in Armenia.
- Support for the development and implementation of a continuing professional development program and curricula for PHC FM providers and peer group quality improvement mechanisms.
- Work with various stakeholder groups (e.g., MOH, Parliament, professional medical associations, USAID's Armenia Legislative Strengthening Project, WHO and other donors) to develop, refine and implement policies and programs pertaining to workforce planning, medical personnel licensing, facility accreditation, continuing professional development.
- Development of mechanisms to ensure transparency in provider licensing and renewal, and facility accreditation.
- Support for quality improvement mechanisms at select PHC facilities nation-wide (approx. 210 polyclinic/ambulatories and 100 FAPs).
- Facilitating the integration of vertical programs at the PHC level, maximizing existing materials and strategies developed and employed by the MOH and other donors.
- Development of local capacity for monitoring and evaluation using criteria-referenced standards for provider performance.
- Development and/or revision as necessary of evidence-based clinical protocols for treating major communicable and non-communicable diseases in Armenia.
- Development and implementation of hospital referral procedures at PHC project sites.

II.3.4.4. Quality of Care: Anticipated Outcomes

Base Period (Sept 2005 – Sept 2007)

- Basic legal documents drafted, finalized, approved establishing Medical Council.
- Provider licensing requirements and procedures developed and adopted.
- Framework for continuing professional development programs developed and approved.
- Plan for optimizing existing PHC facilities, based on population needs, developed.
- Quality of care methodology and mechanisms incorporated into services at project sites (210 polyclinics/ambulatories, 100 FAPs).
- Clarification and delineation of roles and responsibilities of stakeholders at all levels of the decentralized healthcare system.

By End of Project (Sept 2010)

- Mechanisms for compliance and enforcement of medical licensing institutionalized.
- Healthcare providers in Armenia comply with national licensing requirements.
- Continuing professional development program for PHC FM providers is institutionalized.
- Regional and local management capacity for planning, implementing, monitoring, and evaluation of PHC services is strengthened.
- Increased client satisfaction with PHC services.

- Increased access to PHC services.
- Quality of care methodology and mechanisms incorporated into services at project sites (total 210 polyclinics/ambulatories, and 100 FAPs by EOP).

II.3.5. Healthcare Financing and National Health Accounts

II.3.5.1. Healthcare Financing and National Health Accounts – Background

Another gap in the overall healthcare system concerns financing of services. There are currently no mechanisms or criteria for linking payment of services by the SHA to facility and provider performance. There is no mechanism for ascertaining whether services billed for have actually been performed, let alone for assaying the quality of care.

To remedy this situation, the SHA has been working at USAID’s pilot sites to identify and test incentives to enhance provider productivity, and the quality and cost-effectiveness of services. The SHA is committed to linking reimbursement levels to the volume and quality of providers’ output. To this end, the SHA has developed a database for monitoring and evaluating provider performance -- measured by quality of care indicators and criteria – so that performance becomes an important factor in reimbursement of healthcare services by the SHA.

Moreover, it is estimated that reimbursements by the SHA only cover about 50 percent of the actual cost of BBP services. It is not surprising that the growing volume of evidence suggests that uncontrolled informal payments are endemic in the health sector. The good news is that the MOH is committed to transparency in healthcare financing.

At the USAID pilot sites, administrative staff have been trained in the use of cost accounting techniques and software that enable facility managers to determine the actual cost of services. At the facility level, there is a widespread need for training in this systematic approach for identifying, summing, and reporting the actual costs of services. It takes into account past and future outlays, overhead (oversight and support services) and operating costs.

A small technical Working Group on National Health Accounts (NHA) was established by the MOH in 2004, with the first NHA report anticipated at the end of 2005. The GOAM assigned lead responsibility for NHA development and implementation to the SHA, in cooperation with the NSS. A representative of the Ministry of Finance and Economy (MOFE) is expected to join the group.⁴⁶

NHAs provide a comprehensive, coherent and consistent statistical description of healthcare expenditure. As such, NHAs permit meaningful comparisons over time (as well as across countries). The MOH Finance Department, the SHA, USAID, the World Bank, the NSS, and WHO have been collaborating to implement NHA in Armenia. The Bank is providing technical assistance and training to strengthen the technical and computer capacity at the SHA to do NHAs. USAID has funded consultants to advise the Group, and WHO will provide consultants this year. The Group has a few logistical hurdles to overcome before it becomes truly functional.

Recommendations from the Group will help the GOAM and MOH clarify and optimize fund flows in the health sector. The NHA will capture the flow of both formal and informal funds through the health system, enhance transparency, and enable national health sector officials to better manage health budgets and plan health policies.

As mentioned in the background section of this RFP, development of a national health insurance program is not likely in the near future. However, if the situation evolves during the LOP, USAID is open to considering support for feasibility and strategic planning exercises relative to health insurance.

⁴⁶ Ultimately, the MOFE controls the budget process and has great interest in NHA findings and their implications for future national health sector budgets.

II.3.5.2. Healthcare Financing and National Health Accounts – Expectations of Offeror

The Offeror is requested to describe its experiences with healthcare financing in Armenia, or other countries with similar health sector legacies, and propose plans for ensuring transparent finance practices through the introduction of generally accepted accounting principles and provider accountability at the PHC level. Experiences and schemes that link provider/facility performance with state reimbursement payments are of particular interest to USAID. The Offeror is requested to present strategies and mechanisms for addressing the probable causes that have led to widespread informal payments and discuss appropriate and effective anti-corruption measures. The Offeror should also present its work with NHAs in other countries, and discuss the steps that can be taken to ensure accurate and timely NHA reports in Armenia. And finally, the Offeror is requested to discuss its expertise and experiences with developing and implementing health insurance programs.

II.3.5.3. Healthcare Financing and National Health Accounts -- Illustrative Activities

The Offeror should consider the following illustrative activities, elaborate on them, and/or modify them, and/or propose other and additional strategies and activities to improve healthcare financing mechanisms and practices and to ensure the successful institutionalization of NHA in Armenia.

Activities may include but are not limited to:

- Support for the development of policies and improvement of practices for healthcare financing and budgeting, especially at the regional and local levels.
- Determination of actual costs of PHC in different facilities and settings.
- Provision of computer hardware and finance software (approx. 210 sites), and staff training (about 300 persons).
- Strengthening SHA's capacity as the MOH healthcare purchasing agent to analyze provider performance/quality of care criteria and reimbursement formulas as well as the facilities' ability to comply.
- Design and implementation of a plan to expand quality performance-linked reimbursement practices to PHC target sites.
- Support the work of the NHA Working Group, including identification and implementation of strategies and mechanisms to ensure the regular collection, analysis and publication of NHA data.
- Support the regional NHA training workshops provided through the multi-donor CIS NHA Regional Training Network.
- Feasibility study for a national health insurance program.

II.3.5.4. Healthcare Financing and National Health Accounts -- Anticipated Outcomes

Base Period (Sept 2005 – Sept 2007)

- Performance-based contracting plans finalized by SHA and contracts concluded with participating PHC project facilities.
- Actual cost of BBP PHC services determined.
- Anti-corruption strategy for the health sector formulated and implemented, with specific measures that target PHC services.
- Availability of reliable data in NHA that shows the actual flow of funds in the healthcare system.
- Annual NHAs published, disseminated, and used for planning purposes.

By End of Project (Sept 2010)

- Anti-corruption policies and measures in place and enforced.
- Institutionalization of NHA capability in the GOAM (MOH, SHA, NSS, MOFE).
- NHA reports used by GOAM for more effective health sector budgeting and better-informed health policy decision-making.
- Cost accounting successfully introduced and implemented at approx. 210 project sites.

II.3.6. Public Education, Health Promotion, Disease Prevention

II.3.6.1. Public Education, Health Promotion, Disease Prevention - Background

Public education must be an integral part of any healthcare reform effort. All of the activities envisioned under the new PHC Reform Project will require sustained public education activities over LOP. Public information strategies, campaigns, and materials can raise awareness, sensitize and inform the public and decision-makers about PHC reforms, and promote behavior change among stakeholders as Armenia moves toward an open enrollment system in which Family Medicine dominates at the PHC level.

Currently, about half of the population is unaware that it is entitled to a range of subsidized medical services at the PHC level. These people do not seek medical care for economic reasons even when they are sick. They resort to medical consultations only when their situation becomes quite desperate. This is regretful since for the vast majority of non-communicable diseases and injuries (NCDIs) there are many effective protective measures that lie within the individual's control if the individual is aware of and encouraged to adopt such measures. These include proper diet, good nutrition, regular exercise, limited alcohol consumption, no smoking, occupational safety, etc.

However, fatty diets are too often the norm and exercise rates are insufficient in Armenia. The country has one of the highest rates of smoking in Europe, with nearly 70 percent of males smoking. A study conducted by the MOH in the late 1990s found that 56.4 percent of boys and 20.7 percent of girls between the ages of 14 and 16 smoke.⁴⁷

While the rate of alcoholism in Armenia is not as widespread as in other FSU countries, a study of 8 FSU countries, including Armenia, concluded that heavy episodic alcohol drinking is frequent in males throughout the region (on average 14.5% of men and 1.1% of women). A large majority of respondents in all countries except Armenia believed one should avoid episodic heavy drinking to keep healthy (85% of men and 88 % of women in the 7 countries compared to 28% of men and 30% of women in Armenia). The study recommended the development of effective policies to reduce alcohol-related harm in the region; policies should address hazardous drinking patterns among other issues.⁴⁸

There is a growing awareness and willingness on the part of MOH officials, NGOs and politicians to take up the healthy life style cause. To cite one example, a number of NGOs worked to pass anti-smoking legislation in March 2005 (although many people willfully ignore the law which prohibits the sale of tobacco to minors and restricts smoking in public places). But, sustained culturally appropriate public education campaigns coupled with legislation and compliance and enforcement measures could lead to behavior change in Armenia as it has in other countries.

Other NGOs focus on addressing diet and obesity issues. And, USAID health sector partners stock the waiting areas of PHC facilities with educational brochures that cover topics such as patients' rights, prenatal and well-baby care, diet and nutrition, the consequences of tobacco use and excessive alcohol consumption. But, the demand for good promotional materials on public health issues far outstrips the supplies.

II.3.6.2. Public Education, Health Promotion and Disease Prevention Expectations of Offeror

The Offeror is requested to propose strategies and activities for informing and obtaining the support of different stakeholder groups for PHC reforms in Armenia. Public education activities should promote

⁴⁷ Quoted in Health Financing and Primary Health Care Development Project SAR, Report 16475 AM, p. 2.

⁴⁸ Pomerleau, J., McKee, M. "Hazardous alcohol drinking in the Former Soviet Union: A cross sectional study of eight countries." European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, 2001. Countries studied included Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Ukraine.

FM as a respectable medical discipline and FM providers as well-trained and competent providers qualified to diagnose and treat about 80 percent of health conditions. The Offeror should discuss past experience with drafting and promoting policies and legislation to ensure healthcare reform, and demonstrate an understanding of healthcare policy gaps in Armenia that should be addressed over LOP.

Messages and educational materials about effective preventive measures and interventions should also be developed and promulgated: vaccinations, antenatal care, regular RH checkups for women, family planning and child spacing. Public education activities should also promote open enrollment, patient rights, and quality of care. Messages should vary according to multiple target groups (ordinary citizens, providers, health officials at all levels, community and regional leaders, and NGOs).

In addition to proposing substantial support for FM, open enrollment and quality of care, The Offeror should present public education strategies and activities aimed at promoting good health practices and behaviors. The Offeror is requested to propose plans and strategies, including a small grants program for NGOs, to raise awareness and inform the public about NCDIs and ways to mitigate these through healthy behaviors and life style choices.

II.3.6.3. Public Education, Health Promotion and Disease Prevention – Illustrative Activities

The Offeror is asked to consider the following illustrative activities, elaborate on them, and/or modify them, and/or propose other and additional public education strategies and activities that support and promote FM, FMGPs, open enrollment, patients' rights, quality improvement, and behavior change and healthy life style choices.

- Develop and widely disseminate public education messages and materials in support of FM and FMGPs, open enrollment, patient rights, and quality improvement initiatives.
- Assist the MOH to develop and maintain a database of all health promotion materials available in the country.
- Use focus groups and other strategies to develop culturally appropriate healthy life style promotion and disease prevention messages.
- Provide training in health issues reporting and healthy life style promotion to media personnel (journalists, radio and TV presenters).
- Develop and implement training for PHC personnel in patient rights and interpersonal counseling skills and techniques.
- Work with stakeholders to create effective, culturally appropriate messages and secure radio and TV spots for public service announcements and programs that promote healthy life styles.
- Support and promote inter-ministerial cooperation/collaboration on addressing healthy behaviors.
- Develop and implement a small grants program for NGOs that address public health issues (e.g., health fairs, smoking cessation support groups, school health education campaigns, alcoholics anonymous, etc.).

II.3.6.4. Public Education, Health Promotion and Disease Prevention: Anticipated Outcomes

Base Period (Sept 2005 – Sept 2007)

- Public education messages and materials developed and disseminated for FM, FMGPs, open enrollment, patient rights, quality of care (c. 10 major products/yr).
- Citizens aware of rights and benefits under BBP.
- 25 small grants to NGOs working on healthy life style issues in 5 marzes and Yerevan.
- NGOs capacity to do public education strengthened through information, education and communication workshops (2-3 workshops per year).

By End of Project (Sept 2010)

- Local communities and NGOs involved in disease prevention and healthy life style activities (total of 55 over LOP).
- Wide availability at PHC facilities and other strategic sites of culturally appropriate health promotion and disease prevention informational pamphlets targeting common illness and diseases in Armenia (c. 10 major topics/yr).
- Interesting, tested and age-appropriate disease prevention through healthy life style promotion lessons and materials available in public schools.

EVALUATION CRITERIA (for USAID/Armenia PHC Reform Project Proposals)

The following five general factors will be the basis of evaluation for all proposals.

1. Technical Approach
2. Management Plan and Approach
3. Personnel and Organization
4. Past Performance
5. Cost

TECHNICAL EVALUATION

The technical proposal (containing benchmarks by which progress towards tangible results will be judged) will be scored by a technical evaluation committee using the criteria presented in this Section. The criteria below are listed in descending order of importance, so that Offerors know which areas require greatest emphasis for proposal preparation. Technical Approach and Management Plan and Approach are significantly more important than all other factors combined. Technical Approach and Management Plan and Approach are relatively equal in importance. All other factors are listed in descending order of importance. Cost is of significantly less importance than the technical factors. Based on the assessment of the technical qualities of the proposals, a competitive range will be established.

Proposals will be evaluated according to the following criteria. The Offeror should note that these criteria: (1) Serve as a standard against which all proposals will be evaluated and (2) serve to identify the significant matters which the Offeror should address in its proposal.

Technical Approach and Rationale

The Offeror must demonstrate a thorough understanding of the contextual and socio-cultural work environment, program complexities and expected results. The technical approach will be reviewed for:

- A feasible, yet rigorous, plan for extending PHC reforms and establishing Family Medicine Group Practices throughout Armenia with particular attention to rural areas.
- Innovative methods for transitioning a former Soviet, “top down” health system to a decentralized one that is based on family medicine and patients’ free choice of provider.

- A systematic approach for introducing and institutionalizing continuing professional development programs required for medical licensing renewal with a focus on family medicine; and strengthening the authoritative body responsible for licensing.
- A strategy for addressing health care financing reforms with particular emphasis on improving facility financial management and State Health Agency reimbursement procedures.
- An effective multi-pronged public education program, including small grants to NGOs, for publicizing and gaining support from various audiences (government, public, donor community, etc.) for primary healthcare reform, Family Medicine and open enrollment, and other public health initiatives, including promotion of healthy life styles.
- Anti-corruption strategies and activities to enhance transparency and accountability within the health system.
- Gender sensitivity of approach, incorporating participation of men and women, gender – disaggregation of data, gender analysis of data, and consideration of unintended gender side effects of program implementation, if any.
- Since the program includes renovation of health facilities and the potential management of bio-medical waste, the Offeror is required to indicate in its technical proposal the procedures that will be put in place to ensure that these interventions are clearly identified along with the proposed mechanisms to address relevant environmental assessment requirements.

Management Plan and Approach

The Offeror must exemplify its approach for managing the project including:

- A plan for managing a large, complex project operating throughout Armenia including logistics such as office space, transportation, inventory control, and in-country financing of staff and activities.
- A feasible, yet rigorous, project management plan including a strategy for ensuring full participation in the development and implementation of reform strategies and activities by host country national (HCN) staff working for the successful Offeror as well as HCNs working for the MOH, regional governmental entities and health services, and healthcare facilities.
- A proven monitoring and evaluation approach that tracks performance against indicators and promotes program review and adjustments according to findings.
- An IEC (information, education, communication) approach and demonstrated ability to achieve counterpart and beneficiary support, involvement, and ownership of reform initiatives.
- Experience and organizational ability to undertake health facility renovations and to procure computer hardware, software, medical equipment, and other items in accordance with USAID and USG policies and procedures.

Personnel and Organization

The Offeror must demonstrate clearly how the proposed program organizational structure will support the technical approach to achieve results, including job descriptions for all professional positions (to be included in an Annex). The organizational structure is at the discretion of the Offeror, yet the following points should be addressed:

Key Personnel and Other Staff

- The Chief of Party shall have a minimum of 12 years experience managing large, complex health reform projects (preferably in Former Soviet Union countries), possess superior managerial skills, and a demonstrated ability to interact diplomatically with diverse national and international bodies to promote health reform initiatives. Must be fluent in English; fluency in Armenian or Russian is desirable.
- The Deputy Chief of Party shall have a minimum of 7 years experience in program management with at least 3 years management experience on large donor-financed projects in health reform or other relevant fields, preferably in the FSU region. Must be fluent in English; fluency in Armenian or Russian is desirable.
- Two (2) Senior Positions: A Senior Healthcare Reform Advisor and Financial Management Advisor should be considered as leaders in their respective fields of expertise. Senior Advisors should have a minimum of 9 years experience in their disciplines, including at least 3 years working in FSU countries on large, complex donor-financed healthcare reform projects. Must be fluent in English; fluency in Armenian or Russian is desirable.

The Offeror should propose a team of professionals (long and short-term) with strong technical qualifications and experience in many of the following areas: transitioning health systems from centralized (former Soviet) to decentralized systems (where patients may exercise free choice of provider); reviewing and drafting health legislation; family medicine and primary health care – clinical and managerial; health policy formulation; health financing; quality of care, public health education, health information systems/Information Technology; anti-corruption; facility management (administration, human resource management, ethics, financial management, etc). Preference will be given to a strong team of qualified Armenian professionals.

Past Performance

The Offeror is requested to provide USAID Past Performance References (PPRs) for all projects implemented within the last 3 years. The PPRs should represent projects of similar complexity, scope, and exemplify how the Offeror has addressed the following implementation issues:

- Quality of product or service, including consistency in meeting goals and targets, and cooperation and effectiveness of the Prime Contractor in fixing problems.
- Cost control, including forecasting costs as well as accuracy in financial reporting.
- Timeliness of performance, including adherence to contract schedules and other time-sensitive project conditions, and effectiveness of home and field office management to make prompt decisions and ensure efficient operation of tasks.
- Customer satisfaction, including satisfactory business relationship to clients, initiation and management of several complex activities simultaneously, coordination among subcontractors,

beneficiaries, and other donor activities, prompt and satisfactory correction of problems, and cooperative attitude in fixing problems.

- Effectiveness of key personnel including: appropriateness of personnel for the job; and prompt and satisfactory changes in personnel when problems with clients were identified.
- Record of actual and proposed use of small business concerns as subcontractors in USG contracts. Offers from small business concerns will not be evaluated against this factor.

COST EVALUATION

The total estimated cost for both task order periods is approximately \$17 million. This estimated LOP amount includes \$550,000 for computer equipment, \$325,000 for small grants to NGOs, \$1 million for health facility renovations, and \$1 million for medical supplies and equipment. The figures should be used as “plug figures” in your cost proposal. Revealing the cost range for the task order does not mean that Offerors should necessarily strive to meet the maximum amount. Cost proposals shall be evaluated as a part of a Best Value determination for the task order award.

Cost is of significantly less importance than the technical evaluation criteria. However, where proposals are considered essentially equal from a technical point of view, cost may be the determining factor. Cost proposals will be evaluated on the basis of realism and used in combination with the assessment of technical quality to determine best value from the competitive range.

All schedules necessary to support and explain proposed costs with breakdowns on direct labor, fringe benefits, supplies and equipment, travel and per diem amounts, other direct costs, and indirect costs; personnel costs, allowances and benefits, such as costs associated with resident and short-term personnel; travel and transportation costs, including airfares (destinations and number of trips), per diems amounts, taxis, and car rentals; other direct costs such as rent, equipment, supplies, domestic, and international communications; and indirect costs supported with a Negotiated Indirect Cost Rate Agreement (NICRA) from the cognizant agency, if available. International travel should be identified separately and broken down by destination, number of trips, and number of travelers.

USAID/Armenia may reject any proposal if it is deemed unresponsive.

Evaluation System:

The following adjectival scoring system will be used by the technical evaluation committee to assess each of the technical criteria and sub-criteria and the technical proposal as a whole:

- | | | |
|----------------|---|--|
| “Outstanding” | O | Very significantly exceeds most or all solicitation requirements. Response exceeds a “Better” rating. The Applicant has clearly demonstrated an understanding of all aspects of the requirements to the extent that timely and highest quality performance is anticipated. |
| “Better” | B | Fully meets all solicitation requirements and significantly exceeds many of the solicitation requirements. Response exceeds an “Acceptable” rating. The areas in which the Applicant exceeds the requirements are anticipated to result in a high level of efficiency or productivity or quality. |
| “Acceptable” | A | Meets all solicitation requirements. Complete, comprehensive, and exemplifies an understanding of the scope and depth of the task requirements as well as the Applicant’s understanding of the Government’s requirements. |
| “Marginal” | M | Less than “Acceptable.” There are some deficiencies in the technical proposal. However, given the opportunity for discussions, the technical proposal has a reasonable chance of becoming at least “Acceptable.” (Areas of a technical proposal which remain to be “Marginal” after “Final Proposal Revision” offers shall not be subject to further discussion or revision.) If award is made on the initial offers, there will not be an opportunity for discussions nor a chance to become at least “Acceptable.” |
| “Unacceptable” | U | Technical proposal has many deficiencies and/or gross omissions: Failure to understand much of the scope of work necessary to perform the required tasks; failure to provide a reasonable, logical approach to fulfilling much of the Government’s requirements; failure to meet many personnel requirements of the solicitation. (When applying this adjective to the technical proposal as a whole, the technical proposal must be so unacceptable in one or more areas that it would have to be significantly revised to attempt to make it other than unacceptable.) |

USAID/ARMENIA FSN COMPENSATION PLAN

AMEMBASSY YEREVAN, ARMENIA

AUTHORIZATION: STATE 95558 DATED 06/01/01
LCP DENOMINATED IN USD
PAID IN AMD

EFFECTIVE DATE: 08/12/01

Grade	Step-1	Step-2	Step-3	Step-4	Step-5	Step-6	Step-7	Step-8	Step-9	Step-10	Step-11	Step-12	Step-13	Step-14
12	14,572.00	15,009.00	15,446.00	15,883.00	16,320.00	16,757.00	17,194.00	17,631.00	18,068.00	18,505.00	18,942.00	19,379.00	19,816.00	20,253.00
11	13,248.00	13,645.00	14,042.00	14,439.00	14,836.00	15,233.00	15,630.00	16,027.00	16,424.00	16,821.00	17,218.00	17,615.00	18,012.00	18,409.00
10	11,868.00	12,224.00	12,580.00	12,936.00	13,292.00	13,648.00	14,004.00	14,360.00	14,716.00	15,072.00	15,428.00	15,784.00	16,140.00	16,496.00
9	10,201.00	10,507.00	10,813.00	11,119.00	11,425.00	11,731.00	12,037.00	12,343.00	12,649.00	12,955.00	13,261.00	13,567.00	13,873.00	14,179.00
8	8,997.00	9,267.00	9,537.00	9,807.00	10,077.00	10,347.00	10,617.00	10,887.00	11,157.00	11,427.00	11,697.00	11,967.00	12,237.00	12,507.00
7	8,180.00	8,425.00	8,670.00	8,915.00	9,160.00	9,405.00	9,650.00	9,895.00	10,140.00	10,385.00	10,630.00	10,875.00	11,120.00	11,365.00
6	5,842.00	6,017.00	6,192.00	6,367.00	6,542.00	6,717.00	6,892.00	7,067.00	7,242.00	7,417.00	7,592.00	7,767.00	7,942.00	8,117.00
5	5,312.00	5,471.00	5,630.00	5,789.00	5,948.00	6,107.00	6,266.00	6,425.00	6,584.00	6,743.00	6,902.00	7,061.00	7,220.00	7,379.00
4	4,829.00	4,974.00	5,119.00	5,264.00	5,409.00	5,554.00	5,699.00	5,844.00	5,989.00	6,134.00	6,279.00	6,424.00	6,569.00	6,714.00
3	4,252.00	4,380.00	4,508.00	4,636.00	4,764.00	4,892.00	5,020.00	5,148.00	5,276.00	5,404.00	5,532.00	5,660.00	5,788.00	5,916.00
2	3,865.00	3,981.00	4,097.00	4,213.00	4,329.00	4,445.00	4,561.00	4,677.00	4,793.00	4,909.00	5,025.00	5,141.00	5,257.00	5,373.00
1	3,508.00	3,613.00	3,718.00	3,823.00	3,928.00	4,033.00	4,138.00	4,243.00	4,348.00	4,453.00	4,558.00	4,663.00	4,768.00	4,873.00

Step rates 12, 13, and 14 are longevity step rates, each with a 156 week waiting period.

Effective February 8, 2001, an employee with less than two weeks of accrued sick leave may request up to four hours of excused absence per year in order to participate in preventative health screenings. Excused absence is paid time off without loss of pay or charge to leave.