PROJECT HOPE

Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan

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MID-TERM EVALUATION

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Submitted by:
Project HOPE –
The People-to-People Health Foundation, Inc.
Millwood, Virginia 22646
Tel: (540) 837-2100
Fax: (540) 837-1813

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Contact person:
Bettina Schwethelm, PhD, MPH, Director, Maternal & Child Health Programs
Mavzhuda Babmuradova, CS Project Director, Navoi, Uzbekistan

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Report prepared by:
Linda Tawfik, MSc, PhD candidate
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Mid-term Evaluation Team:

Linda Tawfik, MSc, PhD candidate
Team Leader/External Evaluator

Bettina Schwethelm, PhD, MPH
Director, Maternal and Child Health Programs, Project HOPE/USA

Mavzhuda Babamuradova, MD
Project Director, Child Survival Program, Project HOPE/Uzbekistan

Fakhruddin Nizamov, MD
National Pediatrics Research Institute and
Child Survival Program, Project HOPE/Uzbekistan

Dalia Shodieva, MD
Head of Center of Adolescent Reproductive Health, Navoi Oblast MOH

Darshana Vyas, MSW, MPH
Director Health Programs, Counterpart International/USA

Nuriyah Elgondieva
Project Manager, Counterpart International/Uzbekistan

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Attachments

ACRONYMS

ARI	Acute Respiratory Infection
CA	Contracting Agency
CAR	Central Asian Republics
CDC	Center for Disease Control
CDD	Control of Diarrheal Disease
CRH	Central district hospital
CS	Child Survival
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
FAP	Feldsher midwife post
FP	Family Planning
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
KPC	Knowledge, Practice, Coverage
MCH	Maternal Child Health
MOH	Ministry of Health
MSF	Medecins sans Frontieres
NGO	Non-Governmental Organization
NIS	Newly Independent States
OR	Operations Research
ORT	Oral Rehydration Therapy
PEPS	Promote Effective Perinatal Care
PHC	Primary Health Care
PVO	Private Voluntary Organization
QA/QI	Quality Assurance/Quality Improvement
RH	Reproductive Health
STD/STI	Sexually Transmitted Disease
SUB	Rural community hospital
SVA	Rural physician ambulatory
SVP	Rural physician post
TOT	Training of Trainers
UDHS	Uzbekistan Demographic and Health Survey

1. Summary

The goal of Project HOPE's child survival and maternal care services project in Uzbekistan is to decrease maternal and child morbidity and mortality by improving quality of health care. The strategy has been to focus on three key interventions—breastfeeding, reproductive health, and IMCI—at the oblast level through capacity building of providers and at the community level in two pilot rayons of Navoi Oblast (Kiziltepa and Karmana). Summary descriptions of the project outlined in the DIP appear in Attachment A.

Data sources for the mid-term evaluation include baseline assessments, periodic surveys, and the mid-term survey completed in March 2002. The mid-term evaluation team conducted interviews with providers at hospitals and clinics, observed provider-client interactions, and held exit interviews with mothers at primary and tertiary care facilities. Discussions were held with inpatients in post-natal care departments of maternity hospitals and with breastfeeding support group members. The evaluation team observed IMCI training and debriefing sessions, as well as a "Best Nurse Competition" and reproductive health "Poster Competition."

The findings of the evaluation indicate that the project is extremely successful. It has been able to produce cost-effective outcomes in a short time due largely to close collaboration with its partners—oblast and rayon Ministries of Health offices and their health facilities; national institutions such as the Pediatric Research Institute and Ob/Gyn Research Institute in Tashkent; reproductive health centers; international agencies such as USAID, UNICEF, WHO, the World Bank; contractors such as Abt Associates; and local and international NGOs such as Counterpart International. The Ministry of Health at the national level is in regular contact with the project. HOPE has been able to establish national and even regional acclaim in Central Asia with its IMCI initiatives. The current leadership of the Project Hope field office in Navoi and the very supportive relationship of the director for the project at U.S. headquarters provide high morale and serve as a catalyst for positive results.

Highlights of key measures of effectiveness provide evidence of the project's success to date. A comparison of results from the baseline and mid-term surveys show areas of strength and future emphasis. Although the survey methodologies varied, one may infer that the high degree of knowledge and behavior change documented in the mid-term survey is predominantly due to the project.[1] In the baseline, 8.7% of women said they exclusively breastfeed their child. In the mid-term survey conducted in intervention areas, the figure rises to 58.2% for exclusive breast-feeding during the first 4 months. In May 2000, only 34.7% received postnatal consultation from a health provider on STIs and 41.7% on contraception. The mid-term survey indicates 90.5% reported receiving a consultation on STIs and 95.8% on contraception. While availability of contraceptives has been an issue, 93.8% of women surveyed in the mid-term are currently using a method of contraception. Over ninety-five percent (95.8%) of the women said the health provider discussed the issue of contraception with them and 87.2% received an explanation from the provider regarding contraceptive methods. Another indicator measured by both surveys was the degree to which women were providing or would provide some or more food to sick

[1] The baseline KPC survey was comprised of a cluster sample, with 30 clusters of 10 respondents each of mothers with children under two years of age in Navoi oblast. The mid-term randomly selected a total of 393 women from the total group of women who gave birth in the intervention area "Baby-Friendly" clinics from March 2001 to March 2002; 309 interviews were actually conducted in the mid-term survey per availability.

children.[2] At baseline, 4.7% reported they provided some/more food to their sick child. In the mid-term survey in the intervention areas, 47.3% of caretakers said they would increase breastfeeding; 24.4% who would offer more food; and 61.3% who would offer more fluid to their child during a diarrhea episode. The mid-term suggests that provider knowledge on IMCI has increased significantly. Danger sign assessment was completed in 91.0% of cases observed. Nutritional assessment was done in 80.6% of cases and counseling in 88.9%.

To verify findings in the mid-term survey and more fully understand operational issues, the mid-term evaluation included site visits in both intervention rayons to maternity hospitals, poly-clinics, SVPs, reproductive health centers and the new IMCI center. Mothers interviewed by the evaluation team in the post-natal department of the maternity centers claimed a high degree of satisfaction with the services they were receiving currently, but bitterly complained about separation from newborn prior to "Baby Friendly" facilities. Women interviewed by the evaluation team reported immediate breastfeeding after delivery and all were rooming in with their newborns. Providers were using colorful flipcharts to explain alternative contraceptive methods during counseling sessions. Historically, the consistent availability of a sufficient method mix has been an issue due to shortages and interruptions in contraceptive supplies. UNFPA has been a key donor. At the writing of this evaluation plans were underway by the German donor KFW to donate large quantities to Uzbekistan. Observations by the evaluation team revealed that randomly selected physicians, trained by the project, are following IMCI protocols for diagnosing and treating a sick child. The only question omitted by the trained providers from the WHO's checklist dealt with the health of the mother. For a project which initiated its first IMCI course only 6 months ago, this is a major achievement.

Since impact is a function of effectiveness and coverage, the project's progress in scaling up is very important. While the program has been careful to stay on track in terms of improving quality of care and health outcomes, it has been able to expand upward through national level institutions and outwards across non-intervention rayons and other oblasts. Financial sustainability is an area to focus on as the project continues. Its capacity-building function with the oblast health department, local government, NGOs, and makhalla committees has been a major step forward sustaining achievements.

2. Assessment of Progress Toward Achievement of Program Objectives

2.1 Technical approach

2.1.1 Overview of the project

This 4-year project aims to improve the quality of child survival and maternal care services in Navoi Oblast, with a population of about 769,000, in the central economic region of Uzbekistan. The ethnically diverse population, consisting of Uzbeks, Kazaks, Tajiks, and Russians has one of the highest maternal and mortality rates in Uzbekistan, despite being characterized by sufficient

[2] For questions concerning childhood diarrhea, the baseline survey asked, "Was (child's name) offered less than usual to eat, about the same amount, or more than usual to eat?" Due to the limited number of diarrhea cases during the mid-term survey, mothers were asked if their child would have diarrhea, "Do you offer less than usual to eat, about the same amount, or more than usual to eat?"

numbers of medical staff and relatively good access to health services of limited quality. Navoi's population density is very low, and close to 60% of the population is rural, including some nomadic Kazakhs.

At the request of the oblast MOH, the project was initiated in Navoi City and the rayon (district) of Kiziltepa. Rich in metals, industry is a major contributor to the GDP of the Navoi oblast, followed by agriculture. Navoi City was build several decades ago by the Soviet regime to exploit its mineral resources and develop chemical industries. Kiziltepa is one of the eight rural rayons of Navoi Oblast and is located between Navoi and Bukhara Oblast. It is approximately 60 kilometers from Navoi City. Most of the people live close to the center of the rayon, the northern and eastern parts of which are desert and difficult to access. The majority of the population is Muslim, but religious beliefs and practices are not easily observable in daily life.

The Navoi Oblast inherited the traditional Soviet health system managed by the public sector. It has parallel and vertical systems to manage certain diseases and conditions (e.g. TB, STIs, maternity). At the outset of the project, preventive health services and health promotion were minimal. Providers did not use modern protocols and lacked essential equipment.

The project is focusing on maternal and newborn care, breastfeeding, child spacing, integrated management of childhood illnesses (IMCI), and capacity building. Major activities include:

> Training of health providers in maternal care, lactation counseling, family planning counseling, and IMCI, as well as training health facility representatives in QA/QI methods.
>
> Development and introduction of protocols and tools to improve quality of peri/neonatal care and IMCI.
>
> Developing IEC materials for the community/household level on prenatal and postpartum care, breastfeeding, danger signs and home management of childhood illness.
>
> Capacity-building through establishing a project steering committee of counterpart representatives, training of trainers and providers, and supporting the establishment of NGOs and other formal and informal entities in project activities.

2.1.2 Progress report by intervention area

Intervention areas. The aims of the project are to: (1) decrease maternal and child morbidity and mortality, (2) promote exclusive breastfeeding, (3) improve sick child management, (4) increase women's knowledge of family planning and (5) develop local capacity.

Activities. The project has organized its activities into five areas: (1) maternal and newborn care, (2) breastfeeding, (3) child spacing, (4) IMCI, and (5) capacity building. The initial strategy was to focus on activities which could be most readily implemented to ensure success, such as breastfeeding and then to develop the more complex interventions. The project initiated breastfeeding activities first in the rayons and then at the MOH oblast level. Reproductive health training was started throughout the entire oblast and surgical equipment, such as 14 mini-lap kits,

was purchased and training in female surgical contraception is planned for Year 3 of the project. The more technically complex area of IMCI was undertaken through a series of activities with multiple partners in order to introduce the concept at the national, oblast, and rayon levels, train providers, and engage the community.

There has been a delay in implementing several maternal and newborn care activities (e.g. introduction of newborn and delivery care protocols, conducting of a TOT course in peri/neonatal care) according to the original workplan. However, the strategy has been to concentrate on quality throughout the project and to systematically introduce new activities. The minor cost in speed of implementation for maternal and newborn care activities has been more than offset in terms of project impact. Maternal and newborn care activities are currently high priority with technical assistance being provided within the coming months.

The progress in implementation of activities is noteworthy given initial staffing delays. The initial delay in hiring the first Project Director, and thus hiring of local staff, was compounded by having to replace him due to administrative reasons. To overcome this constraint, at the end of 2000, HOPE hired a well-respected local Project Director with expertise in Reproductive Health and experience in managing externally funded projects.

Progress towards intermediate objectives. Table 1 on the next page shows that the project is making excellent progress towards program objectives. The table lists indicators of and progress towards specific program objectives, along with their baseline values and end-of-project targets. Clearly, several end-of-project targets have already been met for those indicators where complete data currently exist. Maternal and newborn care will be a focus of the remaining project life in order to meet the original objectives by September 29, 2003. Key activities for reaching the maternal and newborn care objectives are programmed for years 3 and 4.

The information system needs to be refined to measure progress towards all the original objectives.

Project effectiveness to date. Data sources also include baseline and mid-term evaluations, interviews with providers at hospitals and clinics, observations of provider-client interactions, exit interviews with mothers, interviews with mothers in post-natal care departments of maternity hospitals, discussion with members of a breastfeeding support group, and observation of IMCI training and debriefing sessions.

Highlights of key measures of effectiveness provide evidence of the project's success to date. A comparison of results from the baseline and mid-term surveys show areas of strength and future emphasis. The survey methodologies varied, however, one can infer that the changes are predominantly due to the project.[3] The mid-term survey is attached as a special report.

In the baseline, 8.7% of women said they exclusively breastfeed their child during the first four months of life. In the mid-term survey conducted in intervention areas, the figure rises to 58.2% for exclusive breastfeeding. Another indicator measured by both surveys was the degree to which women were providing, or would provide, some or more food to sick children. At baseline, 4.7% of mothers reported they provided some/more food to their child with diarrhea. In the mid-term survey, 47.4% of caretakers said they would increase breastfeeding; 24.4% would offer more food; and 61.3% would offer more fluid to their child during a diarrhea episode.

Provider knowledge on IMCI has increased significantly. Data from the mid-term survey indicates danger sign assessment was completed in 91.0% of cases. Nutritional assessment was done in 80.6% of cases and counseling in 88.9%/

Baseline data indicate that in Navoi Oblast in May 2000, only 34.7% of surveyed women with children under two years received postnatal consultation from a health provider on STIs and 41.7% on contraception. By comparison, the mid-term survey indicates that in the project area 90.5% reported receiving a consultation on STIs and 95.8% on contraception.

To verify findings in the mid-term survey, monitor providers' technical competence, and assess client satisfaction, the mid-term evaluation included site visits in both intervention rayons to maternity hospitals, polyclinics, SVPs, a reproductive health center and the new IMCI center.

Observations by the evaluation revealed that physicians trained by the project are precisely following IMCI protocols for diagnosing and treating a sick child. The only question omitted from the WHO's checklist dealt with the health of the mother. For a project which initiated its first IMCI course only 6 months ago, this is a major achievement.

Mothers interviewed in post-natal departments of the maternity centers in both intervention rayons articulated a high degree of satisfaction with care at these "Baby-Friendly" hospitals. They all reported immediate breastfeeding after delivery and were observed rooming in with their newborns. The evaluation also specifically identified several multi-parity women who had received delivery services for earlier births prior to the project. This was to compare client

[3] The baseline KPC survey was comprised of a cluster sample, with 30 clusters of 10 respondents each of mothers with children under two years of age in Navoi oblast. The mid-term randomly selected a total of 393 women from the total group of women who gave birth in the intervention area "Baby-Friendly" clinics from March 2001 to March 2002; 309 interviews were actually conducted in the mid-term survey per availability.

TABLE 1. ***Indicators of and Progress towards Program Objectives***

TOPIC	INDICATOR [DIP]	EOP TARGET	BASELINE VALUE	AT MIDTERM EVALUATION
1. Maternal and Newborn Care	- target area use protocols for delivering quality antenatal and post-partum services;	80%	Not available.	To be addressed in years 3 & 4
	- 80% of pregnant women screened for priority STDs;	80 %	Not available. To be obtained from oblast health dept.	To be addressed in years 3 & 4
	- At least 70% of deliveries managed with partograph;	70%	0%	To be addressed in years 3 & 4 Plan exists to begin training of providers. EOP target to be changed to 80% of trained providers in 2 central rayon hospitals of the original pilot areas will be trained to use partograph.
	- 70% of providers follow other established protocols for delivery and newborn care;	70%	Not available. General resuscitation protocols exist. Basic treatment protocols for asphyxia, hypothermia, jaundice	To be addressed in years 3 & 4 Redefine this indicator with neonatal consultant and determine what the Project can achieve.
	- Health brochures available at all health facilities and used for education;	100%	0% (Very limited and lots of variability between facilities)	Variety of brochures (RH, FP, BF, STIs, Adolescent health) are currently available in 100% of health facilities in pilot rayons. Maternal nutrition posters are available in > 90% hospitals. Formative research on danger signs in pregnancy has been completed by Ob/Gyn Institute but brochures on the topic are limited.
	- 50% of health facilities provide classes for pregnant women and their partners and new parents;	50%	0%	50% of facilities in pilot rayons provide classes for pregnant women (mothers' schools).
	- 50% of women report improved nutrition during pregnancy and lactation;	50%	Not available.	Not yet assessed.

TOPIC	INDICATOR [DIP]	EOP TARGET	BASELINE VALUE	AT MIDTERM EVALUATION
2. Breastfeeding	- 75% of women in baby-friendly-hospitals breastfeeding within an hour of delivery;	75%	0% (Baby-friendly hospitals did not exist at Project outset.)	89.1% of women in baby-friendly hospitals breastfeeding within an hour of delivery (Midterm survey)
	- 30% of women breastfeeding exclusively for the first 4-6 months;	30%	< 4 months: 8.7% (Baseline KPC survey)	<4 months: 58.2% <6 months: 41.6% (Midterm survey)
	- 50% of women with children < 6 months that report breastfeeding on demand;	50%	Not available.	98.6% of mothers delivering in "Baby-Friendly" hospitals breastfeed on demand (Midterm survey)
	- 50% of women still breastfeeding at 20-23 months;	50%		Not yet assessed (Midterm survey sample did not include children 12 – 23 months).
	- 2 maternity hospitals with baby-friendly policies;	2	0	2 "Baby Friendly" hospitals established
	- 60 health providers trained to provide lactation counseling;	60	0% (Not available regarding lactation counseling)	169 health providers trained to date on lactation counseling
	- 20 breastfeeding support groups established;	20	0	12 women in Navoi rayon trained 17 women in Kizeltepa rayon trained.
3. Child Spacing	- 80% of facilities in the target area provide three or more different methods;	80%	Not available for this indicator. In exit interviews with mothers: 23.2% use no method 58.0% use IUD 7.2% use oral pill 1.4% use condoms 10.2% use other methods (Baseline KPC survey)	Midterm evaluation team was told at facilities visited in Navoi rayon that supplies were available for at least 3 contraceptive methods. UNFPA had just received a shipment which had been distributed. 93.8% of mothers who had given birth in baby-friendly hospitals since March 2001 were using a contraceptive method, including LAM, to avoid pregnancy. (Mid-term survey)

TOPIC	INDICATOR [DIP]	EOP TARGET	BASELINE VALUE	AT MIDTERM EVALUATION
	- 70% of women will receive FP/child spacing counseling during an antenatal visit and/or the post-partum hospital stay;	70%	41.7% of mothers reported receiving FP/child spacing counseling during antenatal visit (Baseline KPC survey)	87.2% of mothers reported receiving counseling from the health provider regarding contraception. (Mid-term survey)
	- By project end, unmet demand has decreased by 30%;	30% decrease	83% in program site who do not want another child in the next 2 years, or are not sure, are using a modern contraceptive method (Baseline KPC survey)	Not yet assessed, since midterm survey focused on women who had delivered in Baby-Friendly hospitals during the past year.
4. IMCI	- 80% of trained providers at SVPs and polyclinics will follow IMCI protocols for sick children;	80%	2% of children were assessed by provider for all danger signs when seeking treatment for ARI, diarrhea, or fever; 17% of assessment tasks were completed by providers for diarrhea cases; 26% of cases with simple diarrhea received ORS and 38% received an inappropriate antibiotic; 41% of assessment tasks were completed by the provider for ARI cases and only 19% in case of fever; 16% of children had vaccination card checked; 24% of children were weighed; 23% had their nutritional status assessed; 25%-40% of caretakers were counseled on the importance of giving fluid and	91.0% of cases observed had danger signs assessed; 91.7% of providers examined the child for malnutrition/anemia; 100% of cases were correctly assessed for use of antibiotics and no (0%) of inappropriate antibiotics were prescribed; 86.1% of providers checked child's vaccination status and completed weight assessment; 80.6% of cases were "assessed" and in 86.1% of cases providers "inquired" about the child's nutritional status. 86.1% of caretakers were counseled on the sickness and given guidance on home treatment (83.3% on when/how to give fluids, 97.2% on food, and 44.4% on medication.)

TOPIC	INDICATOR [DIP]	EOP TARGET	BASELINE VALUE	AT MIDTERM EVALUATION
			food at home; 51.4% of caretakers were told when to return for follow-up; 37.6% received nutrition advice; 42.8% of caretakers were advised on how to prepare ORS. (Baseline KPC and Health facility assessment survey)	94.4% of caretakers were told when to return immediately to the health facility but only 50% were informed of danger signs. (Mid-term survey)
	- Community-based IMCI materials in use by pediatric and maternity hospitals, SVPs, polyclinics, community outreach staff, and caretakers;		0% IMCI had not been introduced at baseline.	In process of development . On basis of formative research, Mother Reminder Tools are being prepared by HOPE in collaboration with the Pediatric Research Institute for mother with children <5. Plans are underway to distribute these materials through the maternities and the excellent patronage nurse system and train parents to 1) use the brochure, 2) identify danger signs and seek care of a provider. Posters on danger signs and referral to be placed in pilot rayon facilities. Agencies involved nationally in IMCI (including HOPE), have decided among themselves which agency is responsible for what type of community IEC materials. The agencies update each other on progress made

TOPIC	INDICATOR [DIP]	EOP TARGET	BASELINE VALUE	AT MIDTERM EVALUATION
				and receive input from their partners, so the tools can be used nationally. This maximizes available resources and promotes consistency in messages across Uzbekistan.
	- 85% of children 12 - 23 months completely immunized (including hepatitis B vaccine);	80%	Not available for this indicator. (Baseline KPC measured only knowledge about immunization.)	Not yet assessed, since the sample did not include children 12-23 months.
	- Vaccination drop-out rates reduced half by reducing missed opportunities;	50% decrease	Not available.	86.1% of IMCI-trained providers checked immunization status.
	- 60% of cases of diarrhea in children under two treated with Rehydron (oral rehydration salts) and/or recommended home fluids.	60%	28.5% mothers gave ORS during a diarrheal episode; 33.7% had correct knowledge on ORS preparation. (Baseline KPC survey)	Due to an insufficient number of diarrheal cases during the midterm survey this indicator could not be measured. This should be determined during the diarrheal season for the final evaluation.
	- 60% of children receive the same/more solids;	60%	4.7% of mothers provided more food than usual (during a diarrhea episode) (Baseline KPC survey)	47.3% of caretakers said they would increase breastfeeding; 24.4% would offer more food to their child; and 61.3% would offer more fluid (during a diarrhea episode). (Midterm survey)
	- At least 50% of caretakers provide additional meals to children while recovering from diarrheas, pneumonia, and other serious	50%	Not available.	Not yet assessed.

TOPIC	INDICATOR [DIP]	EOP TARGET	BASELINE VALUE	AT MIDTERM EVALUATION
	diseases.			
	- Mothers will report improved hygienic practices at the household level (use of clean water for consumption, hand washing, appropriate use of latrines, proper disposal of stools of young children);		Household hand washing practices: 39.3% before food prep 42.0% before eating 44.6% before feeding children 77.7% after using toilet 28.6% had soap present (Baseline KPC survey)	Not yet assessed.
	- Mothers will report improved feeding practices for children under five, including vitamin C, vitamin A, and iron-rich foods;		45.4% of children under two had consumed meat, eggs, fish or poultry during 7 days preceding survey 18.6% of children over 6 months of age were given food 3 or more times per day (Baseline KPC survey)	Not yet assessed.
	- 70% of mothers will be able to list danger signs for diarrhea and pneumonia;	70%	Not available. (The baseline KPC survey asked about the dangers signs of a newborn baby. 12.7% of women surveyed knew these signs. 8.3% of mothers counseled during the postpartum period knew danger signs of infant illness.)	Mother's knowledge of danger signs: 86.2% High fever/fever not going down 43.4% Fast or difficult breathing 59.2% Sickness is getting worse 37.5% Not breastfeeding or drinking 23.0 % Blood in stool (Mid-term survey)
	(1) Develop local project management skills; (2) Develop a core group of trainers in the oblast; (3) Develop a commitment to quality in the health care system;			Cooperative workplanning, implementation, monitoring, and evaluation within HOPE and with its partners continues to develop local project

TOPIC	INDICATOR [DIP]	EOP TARGET	BASELINE VALUE	AT MIDTERM EVALUATION
	(4) Improve critical analysis and problem-solving skills of counterparts; (5) Increase the number of informal and formal organizations working with the MOH on project activities; (6) Promote the development of local NGOs;			management and problem-solving skills. Number of TOTs established at the oblast/ rayon level to date: 12 for Breastfeeding, 11 for IMCI, 8 for RH Provider and client satisfaction articulated during the midterm evaluation and improved measures of selected indicators suggest a commitment to quality in the health care system. HOPE is enhancing links between the MOH and makhalla. MOH conducts most makhalla trainings. HOPE is working with 4 NGOs that have emerged since the development of the DIP. Two are health NGOs with branches in pilot rayons. With the Bukhara Association of Pediatricians and Counterpart Consortium in Bukhara. HOPE supports the establishment of new NGOs and builds capacities through proposal/grant writing, workplanning, etc.

*The Knowledge, Attitude, and Coverage (KPC) Survey and Health Facility Assessment Survey in Navoi Oblast were completed in April 2000. The Mid-term Survey was completed March 2002.

satisfaction now with the past, when the national protocol was to withhold contact between mother and newborn for the first three days after birth.

Providers were using colorful flipcharts to explain alternative contraceptive methods during counseling sessions. Historically, the consistent availability of a sufficient method mix has been an issue due to shortages and interruptions in contraceptive supplies. There appears to be a changing scenerio as the German donor KFW plans to donate massive quantities to the country. Since impact is a function of effectiveness and coverage, the project's progress in scaling up is very important. The program has been careful to stay on track in terms of improving quality of care and health outcomes. It has simultaneously been able to expand upward through national level institutions and outwards across non-intervention rayons and other oblasts. The project has been very effective in its capacity-building functions, as indicated in Table 1. The close coordination with partners and the transfer of technology, management and technical skills is having a clearly demonstrated impact in terms of cost-effectiveness and sustainability.

Changes in the technical approaches outlined in the DIP and rationale. There have been few changes in the plan as presented in the DIP. The most significant change is the increase in the number and high level of involvement of local partners. Besides the original partners outlined in the DIP, the project has gone beyond Navoi Oblast involving trainees from oblasts and rayons beyond the original pilots. In Bukhara, it has tapped into a network of NGOs because there are strong medical NGOs there which do not exist in Navoi. Also, HOPE is working with the Medical Schools in Bukhara and Samarkand, charged with pre-service education and training of general physicians on how to integrate IMCI into the training curricula. The rationale for involvement of additional new partners and broad networking has been to meet an unmet demand with positive health impacts at no extra or minimal cost to the project.

Another highlight which was not planned for in the DIP is the establishment of the new oblast-level IMCI center. The request for such a center came from within the MOH. A church was converted with financial resources for refurbishing coming from HOPE and the MOH. The rationale was to fulfill an unmet need for strengthening and expanding IMCI in Navoi and the neighboring oblasts.

A foreseeable modification articulated during the mid-term evaluation is the need to reassess the concept of breastfeeding support groups. There is interest from these volunteers to learn more about broader areas of child health. The rationale for reassessing their role is that: 1) these women may have greater impact if they are linked with the makhallas at the community level rather than maternity hospitals where women have good breastfeeding support from trained providers, and 2) with more technical knowledge about child health they may have greater impact.

Special outcomes, unexpected successes or constraints. The dynamic nature and strong leadership of the project has created a strong interest from several partners within Uzbekistan (e.g. the National Pediatric Institute) and within Kazakhstan for the project to serve as a model in IMCI. The translation and technical review support of IMCI materials into Uzbek in cooperation with Abt Associates has been a major success for meeting the mandates of all actors (e.g. World Bank, WHO, MOH, etc.) to introduce IMCI into the national health system.

A systemic issue which potentially affects the project's child spacing objectives is the documented inconsistent availability of contraceptives throughout the republic. Qualitative interviews conducted during the evaluation revealed that a moderate level of contraceptives were available at the sites visited in Navoi rayon, including at the SVP level and Baby-Friendly Hospital.

Next steps. Based on the results of the mid-term survey, the next steps by technical area are to:

Reproductive Health

- More deliberately integrate LAM into "Baby-Friendly" clinics and breastfeeding trainings to increase effective use of this child spacing method
- Translate materials related to emergency contraception and integrate them into reproductive health trainings
- Increase the knowledge of health providers on women's physiology as a natural contraception method
- Underscore the need to counsel women and give them the opportunity to make an informed choice regarding contraception
- Stress the need to better inform women on protection methods for STIs
- Conduct focused activities and trainings to further enrich provider knowledge and practices. Focused trainings planned for 2002 include: STI, antenatal care/safe motherhood, emergency contraception, LAM (potentially with Linkages), female sterilization (minilaporotomy)

Breastfeeding

- Integrate antenatal care/safe motherhood and LAM trainings/sessions to further increase provider knowledge
- Establish two additional "Baby-friendly" clinics in 2002 on the oblast level
- Conduct monitoring in the "Baby-friendly" clinics every 6 months
- Initiate community activities to promote the knowledge and practice of exclusive breastfeeding
- Further disseminate knowledge and utility of women support groups and link with the makhalla

IMCI

- In trainings, further emphasize the importance of counseling caretakers on home treatment and danger signs
- Produce and distribute Mother Reminder Materials and educate caretakers on danger signs
- Encourage health providers to produce their own informative material
- Promote various IMCI issues on the national level

Maternal and Newborn Care

- Orient the Oblast Health Department and health providers to the Safe Motherhood Initiative
- As a member of the National PEPS working group, take part in the WHO guidelines adaptation, planning, and implementation process
- Conduct TOT on antenatal, perinatal, and postnatal care and on neonatal care
- Improve the skills of health providers of two pilot rayons using locally adapted guidelines and standards for the management of pregnancy and childbirth
- Implement health education and promotion activities for improving family and makhalla attitudes and practices with regard to pregnancy and childbirth

A detailed discussion of recommendations in section 5 provides next steps in terms of the overall project direction.

2.1.3 New tools and approaches

Coordination and networking. While coordination is not a new approach, rarely has it been undertaken with such powerful results as seen in Navoi. Its networking approach to link project activities with organizations at all levels has been a strategy to maximize the impact of each intervention. For example, through the leadership of Project HOPE the country is in the process of scaling up IMCI nationally and regionally. The National Pediatric Institute, which also works closely with WHO and Unicef, has been able to translate IMCI materials into Uzbek with Project HOPE and Abt's technical and financial support. HOPE has also conducted the formative research for community-level education materials (Mother Reminder Tools) and is in the process of developing first draft tools for testing and validation. The Institute and HOPE will now be able present the Uzbek facility and household materials at the regional IMCI meeting in Kazakhstan. It continues to incorporate IMCI training into its ongoing activities through close coordination with the project.

Collection and translation of training materials. The project has compiled a valuable collection of various training materials in Russian and Uzbek. The Uzbek translation of WHO's IMCI modules has been exceptionally useful to many agencies engaged in implementation of child programs in Uzbekistan.

Obstetric and newborn care standards. This is HOPE's first child survival program with a major focus on obstetric and newborn care. To address these technical issues and build headquarters capacity, HOPE has established partnerships with the University of Michigan Medical School as well as individuals that are assisting with secondary and tertiary obstetric and pediatric programs in the past.

Innovative interventions. Simple interventions like cutting the legs of baby cribs, so that newborns are at the same level of the mother when rooming in, provide evidence of the openness to innovation and an inexpensive way to enhance the bonding between newborns and mothers.

Special studies. Special studies mentioned in section 3.7 have been utilized to guide the project in focusing its inputs.

2.2 Cross-cutting approaches

2.2.1 Cross-cutting activities used by the project. "Cross-cutting approaches" refer to project activities that further the achievement of many or all of the objectives. These include institutional capacity building, training, planning, supervision, information management, and behavior change.

The outstanding reputation of the project at all levels, from national to community, has been a major accomplishment. The National Pediatric Institute utilizes the knowledge and materials shared with the project to replicate IMCI at the national level. Training of trainers courses, and technical trainings in IMCI, reproductive health, and breastfeeding have improved the knowledge of multiple providers to effectively deliver quality services. The cascade approach to training has resulted in a diffusion of skills to areas beyond Navoi and Kizeltepa because trainers were invited from other oblasts such as Sardaria. The supervisory practices established by the project are implemented through the oblast Ministry of Health. Data is collected and shared by Project Hope in cooperation with its partners. This collaboration means that project objectives can be achieved while building institutional capacity. The child survival program has received the trust and support of all partners involved, including doctors, nurses, and mothers in the intervention areas; Ministry of Health staff; donors, international and bilateral agencies. Project HOPE is currently looking at ways to expand working with medical schools such as the Samarkand Medical School and the Medical Institute in Bukhara to further meet project objectives.

2.2.2 Community mobilization

Community mobilization activities are in a nascent stage and gaining momentum. The project has trained 12 women in Navoi rayon and 17 women in Kizeltepa rayon to serve as the foundation for 4 Women's Support Groups for breastfeeding mothers. On the basis of formative research, the project is in the process of developing community-based brochures in the Uzbek language for women with children under age five. These "Mother Reminder Tools" are part of a 9-country activity being undertaken with funding from Glaxo-Smith Kline and technical support from BASICS II and CHANGE. Sessions are held with makhalla to keep communities abreast of new health information. Poster competitions are periodically held to communicate key health messages.

There was a limited presence of health NGOs in Navoi Oblast at the writing of the DIP. The Red Crescent Society, with about 8,000 volunteers at that time, had worked in schools and makhallas. Healthy Generation, supported by the state, had a small clinic and ambulatory unit in Navoi with some community outreach and women's groups. In the past, the government stance towards such organizations and the weak financial base to establish them had been barriers. The project has spurred NGO development through roundtable meetings of emerging organizations from Navoi and Bukhara Oblasts. Several health NGOs now exist in Navoi Oblast as the total number in all sectors has increased to 27. According to Olga Sashema, Director for Social Adaptation, "Project HOPE's influence in the community is well-felt…The first meeting was only thanks to Mavzhuda." By involving the Bukhara Association of Pediatricians in IMCI training (an oblast with a well-developed establishment of 120 NGOs), the project has helped to catalyze the NGO community into forming networks with those from Navoi.

There are several other contextual factors will likely contribute to community mobilization in the long-run. First, the project is following national health policy guidelines established by the President under the Cabinet. This written policy is followed uniformly and contributes positively to project implementation. Secondly, mass media, initially in the form of newspaper articles about the program, has enhanced awareness and acceptance of initiatives. These articles initially only mentioned Project HOPE in Navoi; now they refer to specific MOH facilities or doctors who are doing the work There have been several articles in the national newspaper: coverage about the deputy of a hakim (mayor of the oblast) speaking of an SVP opening, and an article on an IMCI orientation meeting. These favorable promotions support community mobilization and advertise key health messages. Public figures from the government are attending ceremonial events, such as the "Best Nurse Competition" and "IMCI Center Opening". The involvement of political figures demonstrates linkages and support between the MOH and community, thereby serving as a motivational force.

2.2.3 Communication for behavior change

The results of the mid-term survey and mid-term evaluation indicate that the program's approach to behavior change is appropriate and effective. Health workers (doctors and nurses) continue to be the primary source of information for the population and are utilized extensively for this purpose by the project. Community education materials and the media are also receiving increasing support. Providers' and clients' knowledge and skills are improving in pilot rayons as suggested by comparative survey and mid-term evaluation findings presented in section 2.1.2. Highlights of behavior changes are shown in Table 2 below.

Table 2: Key Findings Indicating Behavior Change among Women who Delivered in Baby-Friendly Maternities, Caretakers of Ill Children, and Providers, Midterm Survey, March 2002

Reproductive Health	Breastfeeding	IMCI
80.7% of women take part in decision-making on type of contraceptive to use	92.4% of women giving birth used the Kangaroo method*	Nutritional assessment was conducted in 80.6% of cases and counseling in 88.9% of cases
88.3%-94.5% of women are familiar with LAM but only 40.8% know the 3 LAM criteria	91.4% of women were rooming-in with their newborns within the first hour after delivery*	In case of a diarrheal episode, 47.7% of caretakers would increase breastfeeding, 61.3% would increase fluid intake, and 24.4% would increase food
74.9% of women prefer to have their next child more than 2 years from now	99.7% of mothers who delivered were breastfeeding*	54.7% of caretakers know that tea has a negative effect on iron absorption
93.8% of women (among those who delivered in a baby-friendly facility within the past year) use contraception	41.6% of mothers exclusively breastfeed infants under 6 months of age	Providers assessed danger signs in 91.0% of cases observed

There is a recognized need to link more closely with the makhalla over the remainder of the project. The potential exists to involve them in the use of these data to promote other behavioral changes.

2.2.4 Capacity building approach

i. Sustaining the PVO Organization

Project HOPE in Uzbekistan is actively building its organizational capacity. First, it has created a highly competent and well functioning staff. The Navoi office staff has acquired skills in management, English, wordprocessing, EPI-Info, training, survey research.[4] HOPE headquarters has submitted a proposal to USAID for a child survival project in Kyrgystan which would be mentored and receive technical oversight by the Navoi-based Project Director, Dr. Mavzhuda Babamuradova. Secondly, the office is supported by state-of-the-art systems and procedures as described in section 3 under Program Management. The office has internet access and copy machines which make production of materials in a short period feasible. Thirdly, the increased competence of the field office and partners has laid the foundation for project sustainability. Its reach has also created a high demand within and outside the oblast for involvement in HOPE activities. A most striking indication of the breadth and depth of the organization is the respect earned from all local, national, and international organizations in Uzbekistan.

HOPE headquarters has been gaining experience in the region. The organization is in the process of expanding its consultant base and partnerships to cover obstetric and newborn care because of its Uzbekistan project. Curricula and protocols covering essential and emergency obstetric care and newborn care have been acquired in the Russian language. The project is currently working on approaches, guidelines, and protocols to improve neonatal mortality. This is particularly important for a region with relatively high neonatal mortality rates. HOPE has developed a second child survival project for Kyrgystan based on lessons learned in Navoi. The MCH Director at headquarters, Dr. Bettina Schwethelm, has provided valuable guidance to the project. In the process, she has developed experience in the region which is faced by vastly different health challenges and opportunities than HOPE CS projects in the Americas or Africa along with other headquarters professionals who have provided short-term technical assistance.

2.2.4 Capacity building approach

ii. Sustaining the PVO Organization

Project HOPE in Uzbekistan is actively building its organizational capacity. First, it has created a highly competent and well functioning staff. The Navoi office staff has acquired skills in relevant technical topics**,** management, English, wordprocessing, EPI-Info, training, and survey

[4] All questionnaires for the mid-term survey on RH, BF, and IMCI were discussed with local team in Navoi with input from Project HOPE headquarters. The survey team was comprised of HOPE personnel, RH/BF/IMCI trainers and past RH/BF/IMCI trainees from the Central Rayon Hospital of both Navoi and Kiziltepa rayons. Surveyors were trained and conducted role-plays prior to conducting the survey. Supervisors discussed findings daily with project director. All data were analyzed and entered in Epi-Info version 6.04d.

research.[5] HOPE headquarters has submitted a proposal to USAID to develop a similar CS project in Kyrgystan that would be mentored by HOPE's project in Navoi and with an expanded, more regional role of the current Project Director. Secondly, the office is supported by state-of-the-art systems and procedures as described in section 3 under Program Management. The office has internet access and copy machines which make production of materials in a short period feasible. Thirdly, the increased competence of the field office and partners has laid the foundation for project sustainability. Its reach has also created a high demand within and outside the oblast for involvement in HOPE activities. A most striking indication of the breadth and depth of the organization is the respect earned from all local, national, and international organizations in Uzbekistan.

HOPE headquarters has been gaining experience in the region. The organization is in the process of expanding its consultant base and partnerships to cover obstetric and newborn care because of its Uzbekistan project. Curricula and protocols covering essential and emergency obstetric care and newborn care have been acquired in the Russian language, and the project is expanding its focus on neonatal and maternal care in the remaining months. This is particularly important for a region with relatively high neonatal mortality rates. HOPE has developed and submitted a second child survival project for Kyrgystan based on lessons learned in Navoi. The MCH Director at headquarters, Dr. Bettina Schwethelm, has provided valuable guidance to the project. In the process, she has developed experience in the region along with other headquarters professionals who have provided short-term technical assistance.

ii. Strengthening Local Partner Organizations

The project has excellent working relationships with its partners: the Navoi oblast and pilot rayons MOH, the Center for Reproductive Health in Navoi, health facilities in the two pilot rayons (Navoi/Karmana and Kiziltepa), emerging local NGOs, makhalla committees, the National Institute of Pediatrics and its Center of Reproductive Health, and the Ob/Gyn Research Institute in Tashkent, USAID, Unicef, WHO, the World Bank, Abt Associates, Counterpart International. Certain project interventions aim to strengthen health services and local capacity oblast-wide, while others focus on intense implementation in the pilot rayons.

The Project HOPE office in Navoi is housed in the Oblast Ministry of Health building. All planning and operations in the oblast are undertaken jointly with this partner. This results in direct transference of skills and monitoring of program activities. The program is viewed by the Chief of the oblast MOH as a joint endeavor. On April 6, 2002, the project established an IMCI Center which now serves Navoi and neighboring oblasts as a model resource and training center.

The Center for Reproductive Health was established in January 2001 and started its activities, reproductive health training and service provision for the oblast, in March 2001. HOPE assisted the Center in its planning and by conducting TOT workshops for midwives, ob/gyn's, and general practitioners. HOPE has also served as a bridge between the Navoi Center for

[5] All questionnaires for the mid-term survey on IMCI, RH, and Bf were discussed with local team in Navoi with input from Project HOPE headquarters. The survey team was comprised of HOPE personnel, RH/BF/IMCI trainers and past RH/BF/IMCI trainees from the Central Rayon Hospital of both Navoi and Kiziltepa rayons. Surveyors were trained and conducted role-plays prior to conducting the survey. Supervisors discussed findings daily with project director. All data were analyzed and entered in Epi-Info version 6.04d.

Reproductive Health and the Ob/Gyn Research Institute in Tashkent. The Navoi Center for Reproductive Health delivers workshops for the makhalla with project support. The Center began this year to provide reproductive health training for adolescents. This adolescent training includes use of contraceptives, STI prevention, drug and smoking addiction, gender identity, etc. Their work has reached approximately 70% of students in grades 8-10 in Navoi City, and has expanded to at least three colleges. Because its facilities are limited, the Reproductive Health Center needs additional inputs to upgrade its capacity.

Two "Baby Friendly" hospitals have been established through the project, one in Navoi and one in Kiziltepa. Staff from other pilot rayon facilities (e.g. polyclinics and SVPs) are being trained in IMCI and reproductive health to provide quality services to their respective coverage areas. In addition, HOPE is providing assistance to the oblast maternity to become certified as "Baby-Friendly."

As mentioned previously in section 2.2.2, the project has supported the establishment of local NGOs in Navoi and is networking with those in other oblasts to expand their role.

Project Hope coordinates with all of the key international agencies: WHO, Unicef, and World Bank. WHO has been a key player for all work in IMCI and will be embarking on Safe Motherhood initiative. Unicef has been assisting in the project's breastfeeding activities. The World Bank and HOPE have interfaced on the integration of new curricula into the training of providers and on preparation of materials.

The project is financially supported by USAID/Washington, but regular coordinating meetings are held with the USAID mission. At the local level, the project coordinates closely with two USAID-funded organizations, Abt Associates and Counterpart International. Abt Associates is the contractor for USAID's Health Reform Project. Counterparts International, an NGO with headquarters in Washington, D.C., has its field office in Karakalpakstan Oblast where it is develops its child survival initiatives at the makhalla-level.

Project Hope has taken a lead role in the introduction of IMCI in Uzbekistan through its partnership with the National Pediatric Institute in Tashkent, which also coordinates closely with WHO and Unicef. By June 1999, Kazakhstan and 30 other countries had reached the early implementation phase of IMCI implementation, whereas IMCI was just being introduced into Uzbekistan, Kyrgyszstan, Tajikistan, and Turkmenistan (WHO IMCI Information 1999).

HOPE has supported the Institute in practical IMCI training, the translation of IMCI materials into Uzbek, and the development of baby-friendly health instruments and mother reminder tools. The Institute will introduce IMCI materials developed by Project Hope in Navoi at an upcoming regional conference in Almaty, Kazakhstan.

The key challenge to further capacity building is the size of the Project HOPE staff and the current level of effort needed to maintain ongoing activities. The emphasis on coordination and networking is one means of meeting this challenge.

iii. Health Facilities Strengthening

There are currently two facilities in Navoi which have been certified as internationally recognized "Baby Friendly" hospitals due to the inputs of the project. Training of medical personnel from SVP's and polyclinics in maternal and child health supports and complements these efforts at the tertiary care level.

There are certain other facilities which could benefit from additional financial inputs, namely the Center for Reproductive Health in Navoi. Space is limited and the building needs to be refurbished, or more ideally, changed.

The project has conducted health facility assessments at baseline and at mid-term. Thirty sites were selected randomly for the baseline from a list of SVPs, SVAs, SUBs, polyclinics, and hospitals. Methods included observations of providers and interviews of providers and clients. The project adapted the BASICS HFA and the WHO Reproductive Health Assessment For the midterm survey, 27 facilities were assessed to monitor facilities where doctors had been trained in IMCI and/or Reproductive Health. Results from the midterm health facility assessment indicate that a majority had a functional weighing scale and timer (92.6% and 85,2% respectively), a working refrigerator (88.9%), and an IMCI protocol folder. However, only 66.7% had a separate oral rehydration therapy corner. Most facilities did not have reminder materials or IMCI record forms (only 29.6% and 25.9%, respectively had these forms). Most vaccinations were available (between 88.9% and 96.3%) with the exception of flu and mumps vaccine, neither of which has been available for the last five to six years. IMCI drug availability ranged widely from 0.0% for Gentian violet, 3.7% for Chloramphenicol, to 81.5% for Paracetamol and 92.6% for ORS.

iv. Strengthening Health Worker Performance

The project has devoted major resources to strengthening health worker performance with its cascade approach to training. This has been very effective as shown in the results of the mid-term survey on provider knowledge and skills discussed in 2.1.2. Training has been carried out at all levels of the project including orientation meetings at the national and oblast level, provider training at the oblast and rayon levels and with mothers. Partner organizations have been invited to both TOT and technical courses.

Initially, some technical assistance was received from WHO Kazakhstan for IMCI training. Now all IMCI, breastfeeding, and reproductive health training is done by master trainers from the MOH, HOPE/Navoi, and its partners. Technical assistance in maternal and newborn care will soon be provided by international experts. The evaluation team observed that the training methodology being used for IMCI training was excellent, and the achievement of benchmarks for number of providers trained is high as shown in Tables 1 and 3. Aspects of training activities are discussed further in other sections of this report (2.1.3 and 2.2.2).

The program is establishing new performance standards with the introduction of protocols for each of the technical areas. The continual feedback mechanisms being developed through pre and post-tests, workshop debriefings, and special surveys serve to address any gaps between standards and actual performance. Supervisory checklists are part of the project's routine supervisory system. In addition, special surveys have been conducted to observe and interview

providers and clients in the two target pilot rayons. Specifically, these tools have focused on IMCI for health providers, IMCI for caretakers, IMCI for health facilities, RH and BF for women. Questions were adapted from the KPC 200+ and BASICS tools. The questionnaire included specific program-oriented questions.

v. Training

The training strategy is based on a cascade approach in which master trainers train trainers, who in turn train providers and community members (e.g. breast-feeding support groups). This has been very effective in stimulating the program to expand to oblasts beyond the intervention areas at basically no extra cost. In this way, Pediatric and Ob/Gyn Institute staff are involved in the master training workshops in Navoi and then can transfer the technologies through training of staff in Navoi and other oblasts.

Table 3 provides a list of training of providers and trainers, by technical area, to date.

Table 3: Number of Providers and Trainers Trained in each Technical Area, April 2002

Topic	No. of providers trained	No. of trainers trained
Breastfeeding	194 (from 2/2001)	12
Reproductive Health	162 (from 3/2001)	8
IMCI	72 (from 9/2001)	11

As already mentioned, Table 1 shows how these training activities have contributed towards progress in meeting the objectives. Table 2 indicates that provider and client knowledge and skills have resulted in new ways of doing things due to the project's training.

A consistent need articulated by the partners is for integration of state-of-the-art protocols into medical and nursing schools. While post-graduates are gaining knowledge via training courses, entire cadres of health sector human resources are entering the field. This is a window of opportunity in which the project is already participating in Samarkand and Bukhara.

vi. Sustainability Strategy

All project activities are taking place within the context of a larger health reform in Uzbekistan, with Navoi one of the three pilot oblasts. At the time of this midterm evaluation plans were still underway to reduce the number of providers at the tertiary care level and expand the role of the SVP's to encourage a primary health care approach. Long-term reforms require changes in the curricula of medical institutions and in the certification of medical personnel. Doctors and nurses already in practice need continuous upgrading of skills in the latest child survival and maternal health technologies and protocols. As the World Bank's loan money is been channeled to equip rural points and train teachers from the three pilot oblasts in IMCI, breastfeeding, and pre and post-natal care, HOPE has been assisting by helping prepare for training in Bukhara and Samarkand Institutes.

The evaluation team does believe that if the project were to end, that many of the technical interventions have been institutionalized in the pilot areas and would continue at some level.

An exit strategy has not been formally formulated by HOPE with local partners. All individuals met during the course of this mid-term evaluation clearly prefer the project to continue with more inputs.

The project has not yet implemented programs to build financial sustainability. There is limited local level financing, no cost recovery, and no significant resource diversification or corporate sponsorship for the oblast MOH. The oblast receives its financial support from the government and has not been engaged in fund-raising. Financial contributions to the public sector by corporations would require a major paradigm shift. The oblast MOH had approached several large enterprises such as the chemical factories and mining enterprises but apparently they were not interested in public health care financing. The money from these industries goes directly to the central government, resulting in what one could call a "negative flow" from the oblast for health care financing. Industries are currently not considering funding of public health care beyond their defined coverage targets because they have their own hospitals for their own employees. Sources of financial support from collective farms, mining industries, chemical factories, cement manufacturers, and food industries are estimated to account for only about 1% of the current oblast health budget. In terms of financial sustainability for NGOs, discussions were underway during the mid-term evaluation with NGO's on how the project might assist in organizing grant-writing workshops.

3. Program Management

3.1 Planning

All program planning has been accomplished in cooperation with the major local organizational partners, including the National Institute of Pediatrics in Tashkent, the Navoi oblast MOH, the new Center for Reproductive Health, health facilities in the two pilot rayons (Navoi/Karmana and Kiziltepa), emerging local NGOs, and makhalla committees. There are few individuals not involved and data is shared and analyzed across the project. For example, the Medical Council, an oblast-level Board of Health works with the project to examine each maternal death case in the project area. Together the organizations discuss results and determine recommendations for Project HOPE to conduct its activities.

HOPE interfaces with the various international and bilateral organizations to plan specific activities related to their joint missions.

3.2 Staff training

English language and computer skills have been clear priorities for all staff since the start of the project. With the help of a HOPE intern, the entire team was trained in Microsoft programs and certain staff in EPI info. Instruction in English began for each member of the project team who needed to upgrade their language skills, with instruction being given twice per week. The HOPE/Navoi pediatrician who came to the project with significant clinical neonatal experience is now one of the key trainers in IMCI and breastfeeding at the national level; she has developed research skills through conducting the baseline survey and health facility assessment. The HOPE/Navoi obstetrician with 5 years of clinical experience has expanded her skills in training

in IMCI, reproductive health, and breastfeeding. Project HOPE's physician in charge of the management information system has mastered EPI-info and gained on-the-job training in survey research methodologies. All technical staff attended WHO's monitoring and evaluation course. The Project Director, an ob/gyn by training, came to the position having worked for several international organizations (e.g. AVSC, JHPIEGO) and with strong skills in reproductive health and training. During her tenure on the project, she has expanded her experience in IMCI and program management. She has visited the University of Michigan Medical School for observations and discussions of maternal and neonatal health.

3.3 Supervision of program staff

Supervision of staff by the Director of MCH Programs at HOPE headquarters and by the Project Director in Navoi is exceptional. Staff are enthusiastic about their work and challenged by it. In fact, the key thought to consider for the future is the balance between work and time off. There is a strong team relationship among all members of the project who work long hours. Effort will be required to maintain the current momentum and yet avoid burn-out with the limited size of the team. This will be especially necessary if the role of the Project Director is expanded to include regional responsibilities. The technical staff spend a great deal of time engaged in training activities in the field and working with the partners and often meet afterward at the Navoi office.

The MOH conducts supervisory visits for IMCI trainees according to a project schedule. Currently, trainees are followed up one month and at six months after training. The evaluation team recommends that the supervisory visits needs to be extended and more regular as the project becomes institutionalized. The MOH takes action based on its monitoring and supervisory visits, indicating that a feedback system is in place. Certain technical areas require more emphasis. Supervision of breastfeeding activities at the polyclinics, for example, has not yet been integrated into the supervisory system.

3.4 Human resources and staff management

When the initial project director was terminated, there was a lag time before qualified individuals could be identified to fill all technical and administrative positions. The field office and headquarters worked closely together to examine existing staff qualifications against project needs. Job descriptions were reviewed in January 2001. There were clear needs in the area of information systems and IEC. Given the shortage of qualified human resources for the IEC position, despite advertising Samarkand, Bukhara, and Tashkent medical schools, nobody could be found to fill the position. Ultimately, the Pediatric Institute agreed to share Dr. Fakhruddin with the project 50% time, an arrangement which ultimately facilitates coordination.

Technical staff, administrative staff, and drivers are actively involved in a team approach which provides strong cohesion and motivation. The evaluation team found the administrative systems of HOPE extremely well organized. Human resource management is a high priority. A conscious effort is made to develop staff knowledge, skills, and experience. Job descriptions are written for each HOPE staff.

3.5 Financial management

Each HOPE project is staffed with an administrator/accountant at the field level who is responsible for the compiling and reporting the local currency expenses vis-a-vis approved budgeted line items to the Project Director. Once the monthly Profit and Loss statements and related financial documents are approved by the Project Director, this information is sent to HOPE Center in Millwood, Virginia for review by the Assistant Regional Director of Finance. The Assistant Regional Director, Finance reviews the financial reports and enters the financial data into the General Ledger, provides for imprest reimbursement to the field offices, requests payment from funders, and provide the necessary reports to funders as stipulated in the agreements.

HOPE's commissioned multi-functional Financial Assessment Team in late Spring 2001 made recommendations for re-engineering its financial delivery systems in order to improve decision-making at all levels of the organization. A major focus of this group was improving the accessibility and interactivity of HOPE's financial data base for international field staff in a way that better reflects the organization's desire to increase field responsibility and accountability for program activities. HOPE has already installed a new accounting and reporting system centrally. The focus is now on standardizing and automating the field accounting systems to better capture local data needs, while training field staff to interact with the central database through Internet links for real-time processing, analysis, and performance feedback.

3.6 Logistics

The project has a well-defined logistics system for bringing humanitarian supplies into the country at limited cost to the project. Once medicine and equipment arrive from overseas delivery is within two weeks. A letter is sent to the Cabinet and once a reply is received from Customs, HOPE arranges delivery through its office based in Tashkent. This office manages the logistics of all HOPE goods brought into the country, some of which come to the Navoi child survival project. It coordinates transport of goods to Navoi through the oblast MOH. Project HOPE in Navoi checks inventory with the oblast MOH when it arrives at destination.

The project's Steering Committee invites pharmaceutical company representatives to its meetings to discuss quantities of available supplies and allocations for each rayon. The oblast health department distributes humanitarian supplies according to need, which is determined by various organizations (e.g. the Mining Company). HOPE monitors drug distribution, use, and reporting for donated pharmaceuticals. Humanitarian supplies include drugs such as amoxycillin, penicillin, and multivitamins. Project HOPE/Navoi owns a vehicle and rents additional cars if necessary.

3.7 Information management

The information system for the project includes a system operated by the Ministry of Health and a system within the HOPE field office. The MOH system is comprised of two systems: 1) a medical system, and 2) a civil registration system. The government collects data on a variety of indicators, but for certain ones it follows strict requirements to focus on the project's target

interventions. These indicators include number of deliveries, maternal deaths, perinatal deaths, and infant deaths. Death rate information is sensitive because investigations are made on practitioners whose patients are not surviving. The definition of a live birth is changing from the Soviet system definition to that of WHO. Because the WHO definition of perinatal death is a death which occurs after 28 weeks of pregnancy and within six days of post-delivery, it becomes critical to distinguish between cases of spontaneous abortion, stillbirth, and perinatal deaths and the medical reasons for each. The increased rate of maternal mortality in the oblast has been a red flag for mismanagement during delivery. Punitive measures are taken for practitioners who are judged to be technically questionable or incompetent. For example, measures range from a memo to the files for a first time breach of quality care, to salary cuts, to dismissal.

Information is collected and shared between HOPE and the MOH. Key information system activities are carried out jointly to monitor and evaluate the child survival project. These have included a baseline Knowledge, Practice, Coverage (KPC) survey[6], a health facility assessment, a list of providers trained in each technical area with pretest and posttest scores, and the mid-term survey[7]. The project has also conducted formative research and mini-studies to explore particular issues. In August 2000, technical assistance was provided to conduct a "Postpartum Services Assessment for New/First Mothers in Navoi Oblast, Uzbekistan." In 2001, population surveys and focus group discussions were carried out on IMCI topics in preparation for developing the Mother Reminder Tools to determine knowledge levels and practices among the target population of beneficiaries.[8] Routine data is collected on provider performance using supervisory checklists to make sure the project is on track and to feedback information into training sessions.

3.8 Technical and administrative support

The project has received technical assistance from its partners and outside organizations such as WHO/Kazakhstan. The project anticipates it will need additional assistance in the remaining years in maternal and neonatal health care from institutions such as the University of Michigan Medical School**,** USAID CAs, and independent consultants. The project has received several supervisory and technical support visits per year from persons stationed at Project HOPE's headquarters, including the Regional Director and the Director for Maternal and Child Health.

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[6] KPC instruments were comprised of 58 questions based on a state-of-the-art instrument developed by CORE/CSTS. The instrument was translated into Russian and Uzbek and pretested.

[7] Data for the mid-term survey was collected in the two pilot rayons, including Navoi City, using two methods: 1) observation of providers, and 2) interviews of clients and providers. See attachment 1for complete methodology.

[8] The population survey randomly selected 48 households in Kiziltepa rayon and 42 households in Navoi. A total of 239 individuals (104 from Navoi rayon; 135 from Kiziltepa rayon) were interviewed; 66.9% were women and 33.0% were men. Four focus groups were selected in each rayon and were divided into primary and secondary groups based on their role in family life: 1) mothers with children under five years of age, 2) health providers, 3) men, 4) mothers-in-law and their representatives.

4. Other Significant Issues/Strategic Opportunities

The end of the Soviet control of Uzbekistan coincided with a time period when the influx of new knowledge became limited. While Uzbekistan was part of the Soviet Union, people could move free of charge between the republics for in-service training, refresher training, post-graduate courses. After independence in the early 1990s, the borders opened up but travel became a financial issue. Suddenly state-of-the-art technical materials are beginning to flow into the health sector and people are thirsty for the materials in the Uzbek language. The current era is seen as a window of opportunity to establish new protocols which meet international standards.

Other republics in the region are likely experiencing the similar motivation to absorb the latest in technology and health care advancements. There appears to be a regional interest in sharing materials and lessons learned as the newest medical and health information becomes available.

The experience gained in child survival and maternal care in central Asia by the project offers a unique opportunity to expand lessons learned to other republics. This strategy is being pursued by HOPE for a project in Kyrgyzstan.

5. Conclusions and Recommendations

This section summarizes findings and recommendations, most of which are described elsewhere in the report.

Finding 1: Outstanding reputation of project. The credibility of Project HOPE is exceptionally high with the partner organizations. This is crucial to the support, expansion, and institutionalization of the project at all levels. HOPE's close coordination and the respect it has achieved with each of the partners accounts for the open flow of communication and unified project identity.

> *Recommendation 1A:* Maintain this reputation as project by maintaining quality as new technical interventions are undertaken and as coverage is extended. This may require additional HOPE staff, changes in job descriptions, new or extended networks of NGOs, etc.
>
> *Recommendation 1B:* Continue to provide humanitarian aid.

Finding 2: Well implemented in terms of effectiveness. The project has been largely successful in implementing its workplan. It has already achieved some of its end-of-project benchmarks at midterm and has placed as high priority those activities which were initially delayed.

> *Recommendation 2A:* Continue to implement the program according to the values and management style used to date.

Recommendation 2B: Coordinate with KFW to target RH training to those facilities being supplied with contraceptives.

Finding 3: Well implemented in terms of coverage. Due to the successful implementation in the target areas, particularly with providers at the facility level, emphasis should continue in deepening the roots of the program at the community level. Moreover, a demand for project interventions has been created in other oblasts and rayons who are inspired by the state-of-the art technical protocols and behavior changes.

Recommendation 3A: Extend and replicate the project in other oblasts and rayons which have no foreign assistance or limited inputs. In order to achieve equity, certain geographical areas require project assistance. The decision on where to extend should be based on criteria such as population size, commitment and interest of the oblast/rayon MOH and/or NGOs, cost to the project, potential for impact.

Recommendation 3B: Establish a full-time cadre of master trainers for IMCI in order to scale up. They can be based at the IMCI center.

Finding 4: Community mobilization. Community mobilization activities are in a nascent stage and gaining momentum. The project is making major headway at the community level by supporting the establishment of local NGOs. The political support and attendance of high profile figures at project competitions and ceremonies reinforces awareness and acceptance of new initiatives among the general population.

Recommendation 4A: Place more emphasis on the makhalla as a project resource. For example, link breastfeeding support groups/volunteers to makhalla committees, reach men/fathers through the makhalla, etc.

Recommendation 4B: Reassess the role of breastfeeding support groups in terms of the potential role of this cadre of volunteers. With the influx of additional IEC materials and an interest in broader child health topics, these volunteers could have a greater impact. Discuss the role of the makhalla and formal health system in supervising volunteers.

Finding 5: Limited technical and IEC materials There is a limited supply of technical resources for providers and for communities in the local language. The inadequate availability of reminder tools in health facilities and IMCI record forms emphasizes the fact that nobody has claimed responsibility for their provision. On the national level, Project HOPE is making an effort to improve this situation with the IMCI Steering Committee. On the regional level, HOPE coordinators are urging health facilities to produce their own posters. It is expected that the Mother Reminder Materials being produced by the project will be incorporated in the health facilities. There is a need for audio-visual materials for the central rayon hospitals and communities. Previous attempts at the use of television have been costly and short-term.

Recommendation 5A: To the extent possible, identify more literature in Russian and Uzbek for project-related resource centers and libraries. Produce a HOPE brochure and an annual report in the local language.

Recommendation 5B: Further explore the use of mass media (e.g. radio, television, etc.) to disseminate health messages.

Recommendation 5C: Identify and request donations of audiovisual equipment for each rayon hospital, especially for Central Rayon Hospitals. Find videos from the Central Asian region (e.g. Kazakhstan) which can be utilized in Uzbekistan. Particular topics of interest are well-child care and anemia.

Finding 6: Sustainability. Institutional development has been a cornerstone strategy. For added value, the project can effectively upgrade and replicate its activities through existing and new institutions. Financial sustainability is an area which needs to be addressed further.

Recommendation 6A: Assist the Center for Reproductive Health in Navoi with refurbishment, provision of equipment, and other reproductive health supplies to make it a model center.

Recommendation 6B: Open two more Baby-Friendly hospitals.

Recommendation 6C: Build oblast capacity in (and explore the possibility of establishing a center for) adolescent health.

Recommendation 6D: Have project staff participate in more national and international workshops.

Recommendation 6E: Assist in linking emerging NGOs with donors. Involve the MOH and NGOs in proposal preparation and grant writing and/or coordinate with other organizations for this purpose.

Finding 7: Training and supervision At the policy level, oblast and rayon chiefs need to be oriented to the project's supervision policy in order to upgrade knowledge and skills over the medium- and long-term. The cascade approach to training is successful and there is an interest from oblasts/rayons outside the current project coverage area to participate in training sessions. Within the project area certain providers and technical areas need to be addressed further.

Recommendation 7A: Orient policymakers to the role and techniques of supervision in managing quality services, particularly those involved in IMCI. Hold workshops on effective supervision for managers and trainers.

Recommendation 7B: Invite trainers and providers from areas beyond the current pilot areas to begin training in breastfeeding, reproductive health, and IMCI. Develop criteria for selection so that there is a critical mass of trained providers at each facility and rayon

to develop supervision systems. The approach should be system-wide rather than sporadic training of individuals who will not be supported by the public health system.

Recommendation 7C: Integrate IMCI training into medical schools in neighboring oblasts by working on this issue with the National Pediatric Institute.

Recommendation 7D: Focus more input and attention on training of midlevel providers.

Recommendation 7E: To increase dissemination of state-of-the-art knowledge while motivating high performance, attract international trainers and provide study tours as opportunities and budget allow.

Recommendation 7F: As noted in recommendation 9A below, provide additional training to HIS staff in survey methodology.

Finding 8: Maternal and neonatal care. The project is in need of capacity building in maternal and neonatal care. The disproportionate number of neonatal and maternal deaths in the oblast requires continued investigation into the causes and steps to ameliorate the problem.

Recommendation 8A: Provide technical assistance using experts from abroad in neonatal and maternal care, as planned. The project can then use its existing mechanisms for transferring the knowledge of such medical specializations to national medical institutions and geographical areas beyond Navoi.

Recommendation 8B: Implement international classification of "live birth" with approval from the MOH.

Recommendation 8C: Conduct training for providers in antenatal, postnatal, and neonatal care after upcoming technical assistance consultation by international expert.

Finding 9: Special studies. There are several research topics which need to be studied. In light of new protocols and an unstable, insufficient supply of pharmaceuticals at public health delivery points, there is a need to understand drug availability, use and compliance. The involvement of fathers at the starting point of delivery and post-natal care has been an unexplored area. Currently fathers have extremely limited contact with the newborn, and in fact, spend much of the early days outside the hospital. There is an interest within the oblast MOH to research adolescent reproductive health in Navoi**,** because adolescent pregnancies appear to be on the rise. This topic should be considered for potential research.

Recommendation 9A: Conduct an operations research study on drug availability, use, and compliance related to IMCI.

Recommendation 9B: Conduct qualitative research on the role of fathers during Delivery and during post-natal periods to assess how to involve them in bonding and early child care.

Recommendation 9C: Consider research into adolescent reproductive health issues in Navoi and link it with project objectives.

Finding 10: Utility of health information system. The health information system is critical for measuring project outcomes and gauging impact. There is currently a lack of comparison data between baseline and midterm surveys. In order to maximally evaluate the project during the final evaluation several steps need to be taken. This can also help to improve monitoring and feedback into training and supervisory systems. Indicators for maternal and newborn care have not yet been developed. There is no indicator and no information available for several objectives outlined in the DIP. Staff need additional training in survey methodology to upgrade knowledge and skills.

Recommendation 10A: As noted in recommendation 7F, provide additional training to HIS staff in survey methodology.

Recommendation 10B: Prepare indicators and questions for final evaluation in order to ensure comparison of key indicators with baseline and/or midterm survey results. Collect and/or compile data from existing sources. For the Child Spacing indicator which reads, "By project end, unmet demand had decreased by 30%," in the final evaluation sample women with children under age two for unmet need.

Recommendation 10C: Develop indicators for maternal and newborn care using Safe Motherhood guidelines. Specifically define indicators to monitor deliveries and quality of antenatal and post-partum care.

Recommendation 10D: Redefine indicators as follows—

-- Change last Breastfeeding indicator from "20 Breastfeeding support groups established" to "20 makhalla establish regular meetings with women's support groups."
-- Refine the first IMCI indicator to track performance on a set of key IMCI protocols.

6. Results Highlight

Key findings indicating behavior change from the Mid-term Survey, March 2002, are highlighted in section 2.1.2 in Table 2. The complete Mid-term Survey document is available from Project HOPE headquarters in Millwood, Virginia.

ATTACHMENT A1: *Program Description*

FIELD PROGRAM SUMMARY
PVO/Country: Project HOPE Uzbekistan Program duration (9/1/1999 – 8/31/2003)
Site: Kyziltepa Rayon and Navoi City, Municipality (Total population 252,000)

1. ESTIMATED PROGRAM EFFORT AND USAID FUNDING BY INTERVENTION

Intervention	% of Total Effort (a)	USAID Funds in $ (b)
Immunization	%	$
General Nutrition	%	$
Vitamin A	%	$
Micronutrients (other than Vitamin A)	10%	$
Breastfeeding Promotion	10%	$
Control of Diarrheal Disease	%	$
Pneumonia Case Management	%	$
Control of Malaria	%	$
Maternal and Newborn Care	35%	$
Child Spacing	10%	$
STI/HIV/AIDS Prevention	%	$
IMCI – Health Facility and Community Level	35%	$
Total	100%	$

2. PROGRAM SITE POPULATION: CHILDREN AND WOMEN (C)

Population Age Group	Number in Age Group
Infants (0-11 months)	6,800
12-23 Month Old Children	6,460
12-59 Month Old Children	25,580
Total 0-59 Month Olds	32,380
Women (15-49 years) (d)	60,480

Data collected for UDHS rates and Government of Uzbekistan population data for target sites.

- Estimated annual number of live births in the site 6,800
- Sources of the population estimates above: MOH Oblast Administration

Attachment A2: *Program Goals and Objectives*

OBJECTIVES	MAJOR ACTIVITIES	INDICATORS	MEANS OF VERIFICATION
Child Survival and Maternal Care Objectives			
1. Maternal and Newborn Care (1) Improve the quality of antenatal and postpartum care. (2) Increase the capacity of physicians and midwives to provide quality basic, essential, and emergency obstetric care. (3) Increase the capacity of physicians to provide quality newborn care. (4) Increase provider capacity to diagnose and appropriately treat/refer pregnant and post-partum women and neonates with danger signs. (5) Increase knowledge of families about danger signs during the pre-natal, post-partum, and neonatal period that require immediate and appropriate care seeking. (6) Improve maternal nutrition during pregnancy and lactation. (7) Increase the number of women provided with iron folate during pregnancy and lactation (8) Introduce the provision of one megadose of vitamin A to women immediately post-partum. (9) Promote the use of iodized salt with iodine-deficient pregnant women.	- Review and update the existing mother-baby package and protocols for basic health services; - Train health providers to promote good maternal nutrition; - Provide iodine to deficient women; - Supplement all pregnant and lactating women with iron folate; - Screen and treat pregnant women for STDs; - Supplement all women with vitamin A immediately post-partum; - Train providers in improved management of deliveries; - Train physicians and other providers in basic newborn care (neonatal resuscitation, provision of oxygen, hypothermia, management of asphyxia, prevention and treatment of neonatal infections, and immediate breastfeeding); - Develop health education materials on key topics for women and their partners (maternal nutrition, pregnancy and post-partum danger signs, preparation for delivery, etc.); - Develop curricula and implement classes for pregnant women and their partners and new parents; - Promote the involvement of men during the prenatal, perinatal, and postpartum period; - Conduct ongoing case reviews of all maternal deaths in the target area with key oblast health staff.	- 80% of health staff in target area use protocols for delivering quality antenatal and post-partum services; - 80% of pregnant women screened for priority STDs; - At least 70% of deliveries managed with partograph; - 70% of providers follow other established protocols for delivery and newborn care; - Health brochures available at all health facilities and used for education; - 50% of health facilities provide classes for pregnant women and their partners and new parents; - 50% of women report improved nutrition during pregnancy and lactation;	- KPC survey at baseline and project end; - Provider observations and review of patient charts through ongoing supervision; - Patient exit interviews - annual, - Dietary recall for pregnant and lactating women at project baseline and end;

OBJECTIVES	MAJOR ACTIVITIES	INDICATORS	MEANS OF VERIFICATION
2. Breastfeeding (1) Increase the percent of newborns that are breastfeed within one hour of birth. (2) Increase the percent of newborns that are rooming in with their mothers after birth. (3) Increase the percent of infants under six months that are exclusively breastfed and receive no other liquids or solids, with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines. (4) Increase the percent of women that report breastfeeding on demand; (5) Increase the percent of women still breastfeeding at 20-23 months.	- Assist maternity hospitals in the target area to establish baby-friendly hospital procedures. - Train OB/GYNs, pediatricians, hospital and community health nurses in lactation counseling. - Promote the development of breastfeeding support groups. - Conduct qualitative research on barriers to exclusive breastfeeding during the first six months.	- 75% of women in baby-friendly-hospitals breastfeeding within an hour of delivery; - 30% of women breastfeeding exclusively for the first 4-6 months9; - 50% of women with children < 6 months that report breastfeeding on demand; - 50% of women still breastfeeding at 20-23 months; - 2 maternity hospitals with baby-friendly policies; - 60 health providers trained to provide lactation counseling; - 20 breastfeeding support groups established;	- KPC survey at baseline and project end; - Project Information system - quarterly; - Baby-friendly hospital patient records - quarterly; - Research report (once).
3. Child Spacing (1) Increase women's knowledge about advantages and disadvantages of contraceptives other than the IUD. (2) Increase the number of facilities that provide a range of modern contraceptives. (3) Decrease unmet need for contraception; (4) Increase the percent of women who purchased a contraceptive method.	- Focus group study to determine reasons for contraceptive preferences of women and their partners; - Provide needs-based training to providers in all methods and client counseling; - Include family planning/child spacing education as an essential component during the prenatal and post-partum period; - Train staff in delivery hospitals to counsel women and offer methods during the hospital stay; - Develop/adapt and disseminate brochures for women and men with advantages and disadvantages of all major methods, including surgical contraception and LAM; - Develop materials and IEC approaches that target young women that might be interested in delaying pregnancy.	- 80% of facilities in the target area provide three or more different methods; - 70% of women will receive FP/child spacing counseling during an antenatal visit and/or the post-partum hospital stay; - By project end, unmet demand has decreased by 30%;	- KPC survey at project onset and end; - Provider observations (quarterly); - Client exit and client satisfaction interviews (annually); - Maternity hospital statistics (quarterly); - Special reports.

[9]The UDHS reports exclusive breastfeeding for the first four months. The project will collect information for the first four and the first six months and follow MOH policy.

OBJECTIVES	MAJOR ACTIVITIES	INDICATORS	MEANS OF VERIFICATION
4. IMCI - Improve the integrated management of the sick child (i.e., diarrhea, ARI and severe disease management skills, EPI, and nutrition assessment and counseling skills); - Improve the quality of well-child visits; - Improve the health system's capacity to provide sick and well-child services (logistics, procurement, training and supervision); - Improve family and community child health and nutrition practices.	- Train IMCI trainers; - Assist IMCI trainers in the training of SVP and polyclinic health providers; - Train SVP staff and public health nurses in educating parents about good child health and nutrition household practices; - Train providers in hepatitis B and vaccine application; - Assist the MOH in the development of community-based IMCI materials.(e.g., brochures for new parents on 1. diarrheas (promoting hygienic practices at the household level, knowledge of danger signs, use of ORT, and good nutritional management); 2. ARIs (recognition of danger signs of pneumonia, prompt care seeking, nutritional management, and compliance with antibiotic treatment); 3. EPI (immunizable diseases and vaccination schedule); and 4. Nutrition (good breastfeeding and complementary feeding practices, complementary feeding practices, and essential micronutrients). - Conduct qualitative research on local beliefs and practices related to the recognition of pneumonia and dehydration danger signs, care seeking, and home management; - Assist the MOH to receive low-cost/donated Hepatitis B vaccine for the protection of children under one and health care workers; - With MOH, identify pockets of low vaccine coverage and target promotional efforts to providers and families;	- 80% of trained providers at SVPs and polyclinics will follow IMCI protocols for sick children; - Community-based IMCI materials in use by pediatric and maternity hospitals, SVPs, polyclinics, community outreach staff, and caretakers; - 85% of children 12 - 23 months completely immunized (including hepatitis B vaccine); - Vaccination drop-out rates reduced half by reducing missed opportunities; - 60% of cases of diarrhea in children under two treated with Rehydron (oral rehydration salts) and/or recommended home fluids. - 60% of children receive the same/more solids; - At least 50% of caretakers provide additional meals to children while recovering from diarrheas, pneumonia, and other serious diseases. - Mothers will report improved hygienic practices at the household level (use of clean water for consumption, hand washing, appropriate use of latrines, proper disposal of stools of young children); - Mothers will report improved feeding practices for children under five, including vitamin C, vitamin A, and iron-rich foods; - 70% of mothers will be able to list danger signs for diarrhea and pneumonia;	- KPC survey at baseline and project end; - Health facility statistics (quarterly); - Project HIS (quarterly); - Special reports.

OBJECTIVES	MAJOR ACTIVITIES	INDICATORS	MEANS OF VERIFICATION
Capacity-Building			
(1) Develop local project management skills; (2) Develop a core group of trainers in the oblast; (3) Develop a commitment to quality in the health care system; (4) Improve critical analysis and problem-solving skills of counterparts; (5) Increase the number of informal and formal organizations working with the MOH on project activities; (6) Promote the development of local NGOs;	- Set up project steering committee with counterpart representatives; **- Identify potential trainers throughout the project and provide additional training in adult education;** - Train representatives of health facilities in QA/QI methods and provide support to QA investigations in the oblast; - Teach counterparts in other analytical methods (e.g., COPE, supportive supervision, analysis and use of qualitative and quantitative information, etc.); - Explore establishing a Project HOPE NGO in Uzbekistan; - Actively involve and seek participation of other formal and informal public and private entities in project activities;	- Steering committee meets quarterly and provides input to project; - Oblast MOH office has a list of experienced trainers to draw on for future training; - Providers will report increased concern and involvement in quality of care issues; - MOH actively coordinates with other local entities on MCH issues; - Health facility staff apply analytical and problem-solving skills;.	- Steering committee minutes-quarterly; - Project health information system - quarterly; - Focus group discussions with providers and key informants at project beginning, midterm, and end; - Project final evaluation; - Quality assurance final report.

Attachment A3: *Program location*:

1. Description of the Project Target Area

Project HOPE's Child Survival project is located in the Navoi Oblast of Uzbekistan (see Annex VI.1 for a map of the country, oblast, and rayon). Uzbekistan is the most populated country in Central Asia with a population of about 23.5 million (World Development Report 1999/2000, World Bank 1999) with about 71% of the population being ethnic Uzbeks and 88% Muslim (World Bank OP 3.10 Annex D, June 1997). Life expectancy in 1996 was 67.8 years for men and 72.7 years for women. Literacy rates are very high, with an average of 11 years of schooling, and high secondary and tertiary school enrollment for men and women. According to the UDHS, 99.2% of women 15-49 completed primary education and 78.6% of girls 6-12 are attending school. Water and sanitation services are clearly inadequate in Uzbekistan: Only 22.6% of households have flush toilets or VIP latrines, and 15.2% of the population lives further than 15 minutes from safe water supply (UDHS, 1996). After the pronatalist policies of the former Soviet Union, Uzbekistan has remained the country in the region with the highest fertility rate (TFR = 3.3 children). 41% of the population is under age 15 (UDHS).

All political power in Uzbekistan rests in the hand of the President who appoints all top-level officials in the central government and in the oblast administrations. Staffing changes appear to be relatively frequent. Uzbekistan is also affected by non-convertibility of the local soum, for which there is an official, a bank, and a black market rate, affecting Uzbekistan's ability to assure a consistent supply of pharmaceuticals, medical equipment, and consumables. With USAID's assistance a new law supporting nonpolitical NGOs was issued in 1999, but there are still few international and local NGOs operating in Uzbekistan.

The Navoi Oblast, with a population of about 769,000, is located in the central economic region of Uzbekistan. While one of the largest geographic regions with 8 rayons, more than a third of the land is dessert. Navoi's population density is very low, and close to 60% of the population is rural, including some nomadic Kazakh populations. Rich in metals, industry is a major contributor to the GDP of Navoi, followed by agriculture. Navoi City was built several decades ago by the Soviet regime to exploit its mineral resources and develop chemical industries. Pollution and contamination by these industries are clearly visible throughout the City. Navoi City was linked directly with Moscow with its local airport (currently not operational) and was completely isolated from the rest of the country and off-limits to all outsiders. HOPE's Project Director is only the second expatriate living there for an extended period. A Peace Corps volunteer, teaching economics, and her students have been subjected to much harassment from local officials, and two other Peace Corps volunteers left, because they were unable to live under similar circumstances. Given the strong controls exercised in this region, independent initiative (NGOs, businesses, etc.) have not yet entered this oblast.

The ethnically diverse population, consisting of Uzbeks, Kazakhs, Tajiks, and Russians has one of the highest maternal mortality and infant mortality rate in Uzbekistan. In 1996, 57% of Navoi's health care expenditures were allocated to inpatient care and only 44% to outpatient health services, and the population averaged 7.9 physician visits per year, 42.8% of these to specialists (MOH, UNDP Human Development Report, 1997). The majority of the population is Muslim, but religious beliefs and practices are not easily observable in daily life. In Region 2, (containing Navoi), only 39.7% of women with children under six were working, and their children were cared for in daycare (25.2%), by an older female child (21.5%), or others (UDHS). According to the HOPE KPC survey, mother-in-laws are the most common child care provider when the mother is out of the home (59.6%).

At the request of the oblast MOH, the project will be initiated in the rayon of Kyziltepa and Navoi City. Kyziltepa is one of the 8 rural rayons (district) of Navoi Oblast and is located in between Navoi and Bokhara Oblast. It has borders with Navoi, Navbahaor and Konimeh rayons of Navoi Oblast. It is approximately 60 kilometer from Navoi City and it takes about an hour from the City to the center of the rayon by taxi. Most of the people live close to the center of the rayon. The northern and eastern parts of the rayon are mostly desert. The desert areas are hard to access. The total area of the rayon is 221 square kilometer and the population is 109,819. The density of population is 4.7 per km^2. The rayon has 140 kishlaks (villages). The population is predominantly Uzbek with some Kazakh and Tajik. Most of them

are Muslim. The economy of the rayon is dependent on agriculture. The rayon produces cotton, wheat and fruits. In the desert area, the farmers are engaged in cattle rearing. Like other parts of Uzbekistan the literacy rate is high, with most of the people having primary education. In the rural area women work mostly at home and take care of the children.

Navoi City is the main city of the Navoi Oblast and the center of the Oblast. All Oblast level offices and facilities are located here. It has a population of about 142,000. The city was built in the early sixties by the Soviet when they started mining the region for gold and uranium. The city was built like a small Soviet city with most of the facilities available. The area of the city is approximately 1366 sq.km. The density of population per km^2 is 103.9, the highest density in the region. The population of Navoi City was once predominantly Russians, but they are gradually replaced by Uzbek populations. After the independence in 1991, most Russians left for Russia, and only 10-15% of the total city population remains Russian. The city is divided into 18 units called micro-rayons and has an old and new area. The older part, called Karmana, contains mostly native Uzbek Muslims, and has limited access to water, sanitation and modern facilities, like telephone. The new part contains most of the facilities like shops, schools, park, hospitals, piped hot and cold water, telephone, etc. Most people live in apartments. The city has the following factories: Navoi Mining, Navoi Cement, Navoi Hydro-Electric, Navoi Chemical Factory and Navoi Nitrogen Plant. Approximately 15,000 people are employed in these factories. These factories have their own medical facilities which provide care to their employees and families. Unlike in the rural areas, the lifestyle in Navoi City is more European. Most of the women work and there are no religious restrictions on women's movement or dress.

Given relatively good access to health services of limited quality, within a context of high levels of nutritional deficiencies, the project will target all women of reproductive age and children under five in the rayon and the city.

The Navoi Oblast inherited the traditional soviet health system managed by the public sector. It has parallel and vertical systems (facilities and providers) to manage certain diseases and conditions (e.g., TB, STIs, maternity). Preventive health services and health promotion is minimal. Providers do not use modern protocols and lack essential equipment. The types of facilities and the services they provide are described in more detail further on in the text.

The Navoi Oblast health system is divided into four components: the Oblast Health System of the MOH, the City Health System, the industrial, and the private sector. The MOH provides most of the care in the region while the industrial health system provides health care to their employees. The private sector is a new phenomenon, mostly confined in cities. There are no real NGOs in Navoi. Two semi-public organizations the project will work with include the local branch of the Red Crescent Society and Healthy Generation, a government sponsored agency. Their activities are mostly limited to health promotion, first aid, and humanitarian assistance to poor families, very large families, and/or families with handicapped children.

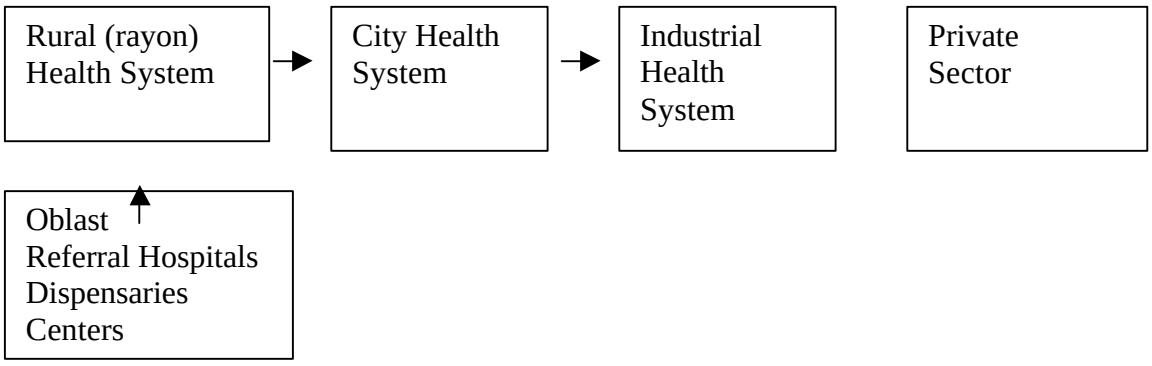

Figure 1. Navoi Oblast Health System

The MOH Oblast Health System is the main health care provider in the rural areas, encompassing the eight rayons. When needed, patients are referred to specialized hospitals and dispensaries in Navoi City. The Oblast Health System provides patient care through 40 hospitals, 135 polyclinics, 40 SVP, 43 SVA and 143 FAP. The hospitals include rayon hospitals, SUBs, regional hospital and specialized hospitals.

There are 1,615 doctors and 6,668 middle medical employees providing medical care in the Oblast Health System. Of them 306 doctors and 2,881 midlevel medical personnel work in urban areas. There are 21 doctors and 85 mid-level medical personnel for every 10,000 population.

Navoi Oblast Health Department. Oblast Health Department plans and implements the national health programs, including preventive and curative services. It works closely with the Oblast Hokimiyat and the Ministry of Health for allocation of funds and its annual plan. The Oblast Health Department operates two specialized hospitals for children, ophthalmology and a General Hospital (also contains Oblast blood transfusion and pathology department, and provides specialized care to the entire Oblast. However, more than 60 percent of the patients are directly from Navoi City. In addition, there are also five specialized dispensaries (oncology, narcology, dermato-venerology, psychiatry, endocrinology), and the Oblast TB dispensary, providing care for TB patients from the entire region.

Rayon Health System. The Navoi Oblast is divided into eight rayons. Each rayon health system provides preventive and curative health care to its population through a network of rural health posts, polyclinics and hospitals.

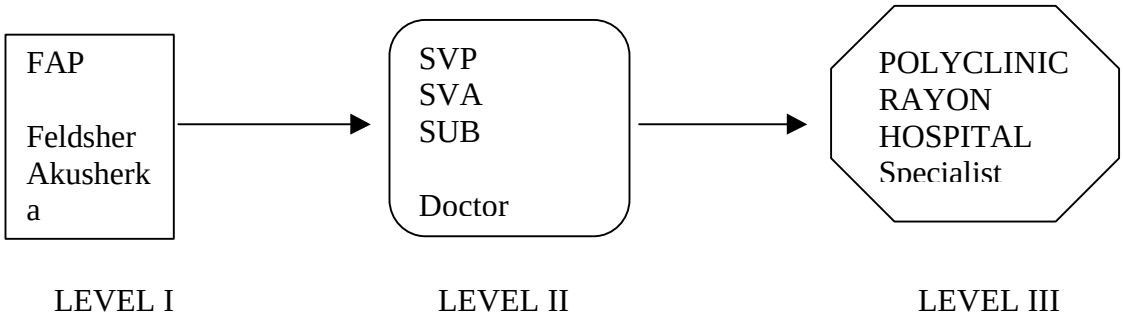

Fig 2. Existing Rayon Health System

The older rural health care system is still in place, with Feldshers at FAPs as the first contact point (Level I). The second level consists of SVP/SVA/SUB (Level II). The health reform supported by World Bank and USAID is planning to replace most FAPs, SVAs, and SUBs with SVP as the primary health care center. However, it is expected that some level I FAPs will remain in Navoi's most rural areas. Some rayons also operate TB dispensaries and infection hospitals.

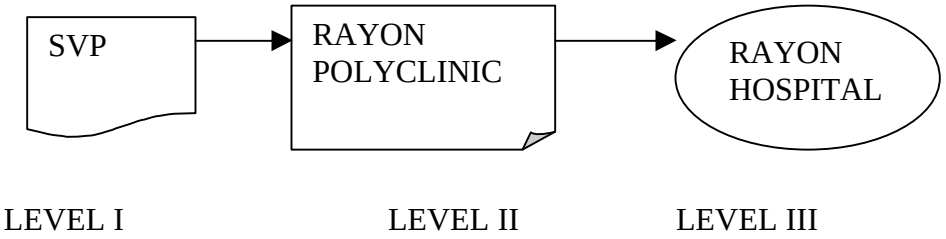

Fig 3. New health system under health reform

Table 1 lists the oblast health facilities by rayons, with Kyziltepa indicated in bold**.**

Table 1. Health facilities by Rayon

Sl. no.	Name of Rayon	Central Rayon Hospital	Rural Hospitals (SUB)	SVAs	SVP	FAP	TB Dispensary	Infection hospital
01.	Navoi	1	0	6	5	0		
02.	Novbohor	1	0	8	5	4		
03.	**Kyziltepa**	**1**	**0**	**11**	**8**	**9**	**1**	
04.	Khatyrchi	1	1	8	9	53		1
05.	Konimeh	1	3	1	3	26		
06.	Nurata	1	5	7	4	9	1	1
07.	Tomdy	1	4	0	3	25		
08.	Uchkuduk	1	5	1	1	17	1	
Total		8	18	43	40	143	3	2

Doctors and mid-level medical personnel. Table 2 gives the total number of mid-level medical personnel in different rayons. Khaterchi has the highest number of personnel followed by Nurata, Navbohor, Kyziltepa, Konimeh, Navoi, Tomdi and Uchkuduk respectively.

Table 2.Mid-level Health by Rayon

Rayon	Number	Percent
Navoi	420	10.2
Tomdi	221	5.3
Uchkuduk	70	1.7
Kyziltepa	**503**	**12.2**
Khaterchi	1214	29.6
Konimeh	434	10.5
Nurata	659	16.0
Navbohor	575	14.0
Total	4096	100

Source: Oblast Health Department (1999)

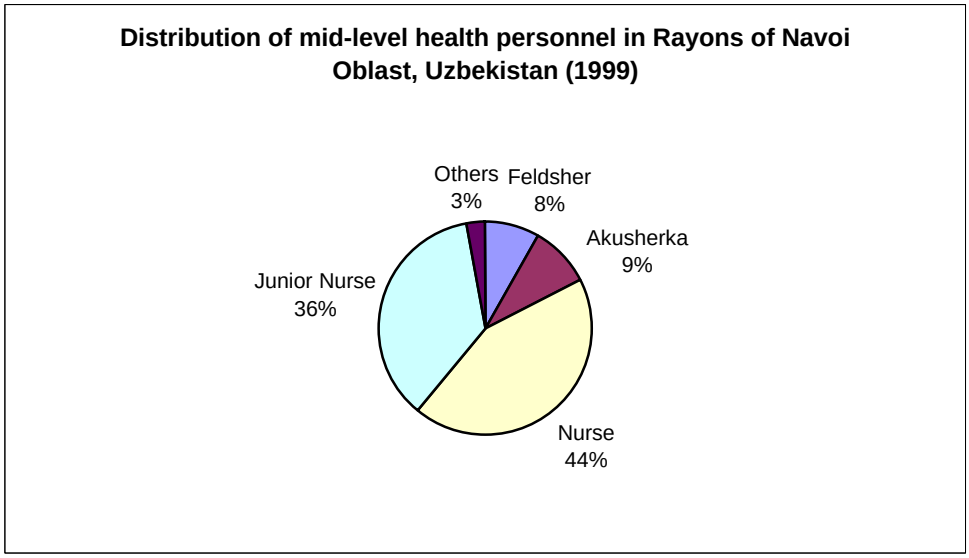

Figure 4. Distribution of health personnel

Figure 4 gives the distribution of health personnel in different health care facilities in the rayons: 45% of all mid-level health personnel are working in hospitals, 22% in polyclinics, and 25% in SVPs/SVAs/SUBs/FAPs.

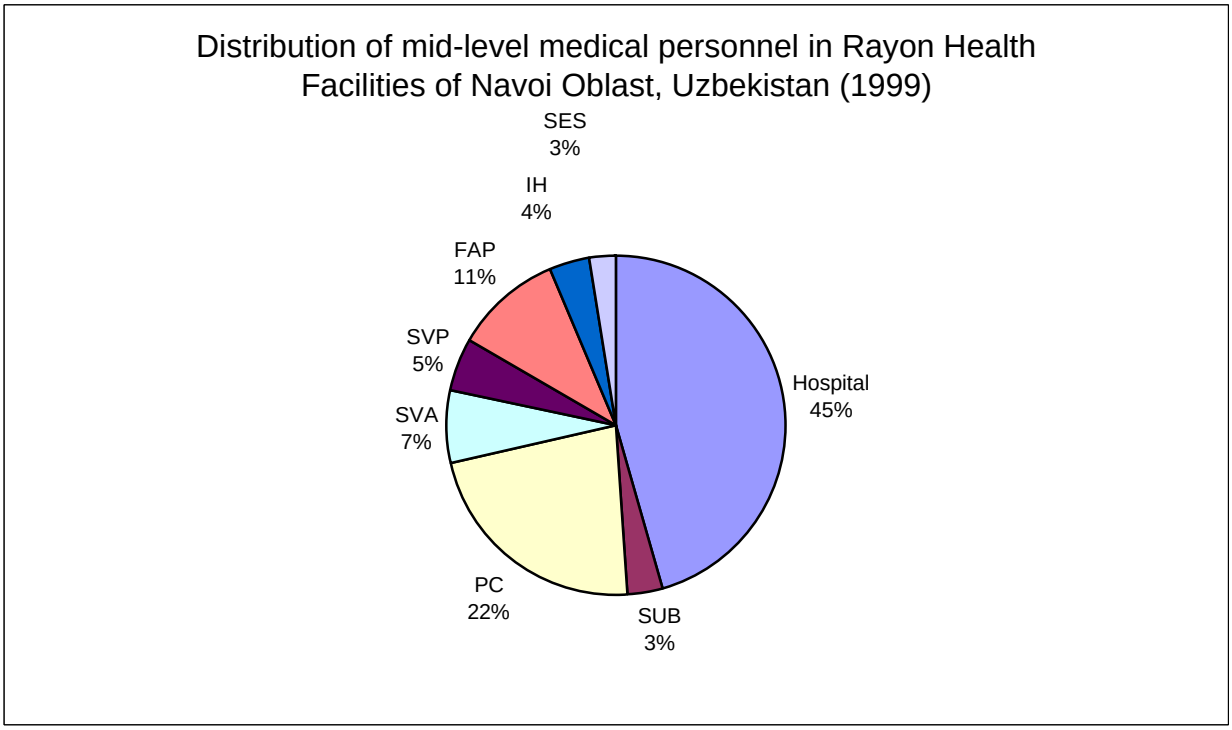

Table 3. Mid-level medical personnel per 1000 population in the Rural Areas of Navoi Oblast (1999)

Specialty	Number	Per 1000 population
Feldsher	343	0.7
Akusherak	371	0.7
Nurse	1776	3.7
Junior Nurse	1492	3.1
Others	114	0.2
Total	4096	8.7

Health System of the City Council (Hokimyat)

The city health system is supported by the city council (Hokimyat). It operates the city polyclinic and the city SES. The Oblast General Hospital is the referral center for the city polyclinics.

Health care institutions of the city council (Hokimyat) in Navoi Oblast

Hospital/clinic	Navoi	Zarafson	Uchkuduk
Polyclinic	5	1	1
City TB Dispensary	0	0	1
SES	1	1	0

In Navoi City there are four polyclinics, and one for skin and STIs. The other three are for children and adults. The city also runs a first-aid ambulatory station, with ambulance service

Industrial Health System

Mining in the Kyzylkum desert started in 1958. Currently, the biggest government company, the Navoi Mining and Metallurgical Complex, popularly known as Gorne Mettullergy Kombinet (GMK), operates four uranium sites and two gold mining sites (including the largest gold producing mine and mill in the world). A plant for processing uranium and gold is located at one end of the city, at the edge of the desert. Apart from GMK, the Newmont Mining Company of USA and another British company are also engaged in gold mining. Navoi also has a plant for production of cut and polished marble.

The GMK employs around 55,000 people and manages a parallel health care system for their employees and their dependents (approximately 130,000 beneficiaries). Its system of polyclinics and hospitals (Medical Sanitary Department, MEDCENCHAS, provides preventive and curative services to children and adults in three cities (Navoi, Zarafson and Uchkuduk). MEDCENCHAS has approximately 1,000 beds in 3 hospitals (400 each in Navoi and Zarafson and 200 in Uchkuduk), 7.6 beds per 1000 population, as well as laboratory facilities in all three locations, with a unit of Sanitary and Epidemiological Station (SES). Although covered under a different decree of the government of Uzbekistan, the GMK medical system works closely with the Oblast Health Department and provides information on a regular basis. The information system of GMK is computerized and produces a wide range of statistics of morbidity and mortality. MEDCENCHAS also assists the Oblast Health Department with medicines, vaccines and equipment.

Other Factories in Navoi City. The other big factory is the Navoi Nitrogen Plant (Navoi AJOT), with 7,000 employees, which operates a polyclinic and a hospital for adults of the employee families. Children under 14 years are served by the city polyclinic. Three other state owned smaller factories, the Navoi Cement Factory, Chemical Plant, and Hydroelectric plant located around Navoi City employ about 10,000

people. They have polyclinics for their employees only, and the employees' dependents are served by the Oblast and City Health System.

Brief Description of Health Facilities

Facility	Services	Provider
	Child Health Maternal Health	
FAP	EPI ANC/PNC FP	Feldsher/Akusherka
SVP	EPI, Curative care ANC/PNC FP	Akusherka/Nurse/Doctor
SVA/SUB	EPI, Curative care ANC/PNC, Delivery FP	Akusherka/Nurse/Doctor
Central Rayon Poly- Clinic	Curative care, EPI, referral ANC/PNC, referral FP	Akusherka/Nurse/General Physician/Physician/Specialists
Central Rayon Hospital	Referral Referral, Delivery	Specialists
Regional Hospital Children, Maternity	Referral Referral	Specialists
Dispensary	Specialized care	Specialists

FAP (Feldsher-Akusherka Station). The FAP is the most basic health care facility in the rayons. Each FAP is staffed by a Feldsher (doctor's assistant), a Akusherka (midwife), a nurse, and a cleaner. They are responsible for about 150-200 households in their catchment area. FAPs provide preventive (e.g., vaccination) and curative services. Akusheraks see mostly women of reproductive age and provide care to pregnant and lactating women, as well as family planning services. They are also capable of providing primary care to the patient. They work in the FAP till lunch and then conduct home visits in the afternoon. About 15-20 patients visit a FAP on an average day.

AKUSHERKA CABINET	**FELDSHER CABINET**	**NURSE CABINET**

The ***SVA*** is the next level of health care. The average SVA is staffed with 5 doctors (2 therapists, 2 pediatricians, and, 1 OB/GYN), 5 nurses, 2 midwives, 2 feldshers, a lab nurse, and 2 cleaners. Each SVA serves an average of 2,000 - 3,000 people. In addition, a pediatrician, a dentist, and two nurses work in the local school. The SVA also generally has ambulance service, with a driver and a nurse available on a 24-hour basis to provide emergency transport.

AKUSHERAK-GYNECOLOGY	PEDIATRICS	LABORATORY	THERAPIST
PROPHYLAXIS (VACCINATION)	PROCEDURE ROOM	REGISTRATION	

ORGANIZATION OF SVA (KHATERCHI RAYON)

The ***SUB*** is a small rural hospital with about 10 beds (5 for women, 2 general medicine, and 3 for children). A SUB is headed by a chief doctor, and staffed with a pediatrician, a dentist, and 14-15 nurses, including three midwives. Each SUB serves approximately 2,000-3,000 people. The SUB also provides vaccinations. There is a small lab that conducts some basic tests. In a day, 50-60 patients are seen, half of them for lab tests.

CHIEF DOCTOR'S CABINET	AKUSHERKA-GYNECOLOGY CABINET	PEDIATRICIAN/ THERAPIST CABINET	DENTIST CABINET
PROCEDURE ROOM	PROPHYLAXIS (VACCINATION) ROOM	BEDS (10)	LABORATORY

EXAMPLE OF A SUB (RURAL HOSPITAL)

The ***SVP*** is the new primary care center established under the Uzbek health reform. The average SUB is staffed by a therapist, a surgeon, a midwife, a dentist, a laboratory technician, a physio-therapy nurse, two nurses for conducting home visits, one nurse for patient registration, a nurse to provide preventive health services, and a nurse for medical procedures. The small lab provides basic tests (blood, urine, stool). The SVP is supposed to serve about 3,000 people within a radius of 20 km. On an average day, approximately 40 patients are seen, 40% for lab tests. Each SVP also has 5 beds for day observation and treatment. The physiotherapy room also has 2-4 beds for treating patients.

AKUSHERKA CABINET	LABORATORY	OBSERVATION BEDS	PROCEDURE ROOM	SURGERY CABINET

DRUG STORE	PROPHYLAXIS (VACCINATION) ROOM	CHIEF DOCTOR'S CABINET	DENTIST CABINET	PHYSIOTHERAPY CABINET

ORGANIZATION OF SVP (KONIMEH RAYON)

Attachment A4: *Program design*

1. Program Description

The project will operate at the oblast and rayon level through capacity building of providers and at the community/household level in the experimental areas through extensive IEC activities and work with muhalla committees, Red Crescent volunteers, and schools.

Oblast level. An overall project steering committee, including the Oblast Health Chief, the Chief OB/GYN, Chief Pediatrician, Chief Nurse and HOPE staff will develop and review the project workplan. This committee will meet quarterly to review progress, adjust the workplan to changing needs and opportunities, and approve training plans. No formal agreements will be developed at this time at the oblast and rayon level, because all agreements would have to be processed and approved at the central level and a "prikaz" law issued.

The project will develop a core team of master trainers/trainer-of-trainers/supervisors at the oblast and rayon level to assure that the MOH will be able to replicate activities developed by the project in the experimental rayon. These trainers will provide regular follow-up and facilitative supervision to the individuals they have trained. Major emphasis will be placed on establishing evidence-based and internationally accepted protocols for managing maternal and child health problems and provider interpersonal communication and counseling skills.

The project will follow following steps in implementing its training and IEC activities to bring about behavior change of the target population:

- need assessment
- recruit trainers/educators
- develop training/IEC materials/curriculum
- conduct TOT
- participatory training courses
- follow-up and on site supervision
- continued education
- quality improvement
- audit/evaluate

Based on the results of the health facility assessment, the project has developed a list of priority interventions/topics that will be addressed by this project:

- Management of high and low-risk pregnancies
- Essential and emergency obstetrics
- Newborn and post-partum care
- Micronutrient deficiencies in women and young children (anemia and iodine deficiency)
- Baby-friendly maternities and exclusive breastfeeding during the first six months
- Integrated management of childhood illness
- Adult education techniques and counseling, and
- Consumer health education and mobilization

For each topic/intervention, project staff will determine whether the information collected to date is sufficient, or whether additional information needs to be collected through focus group discussions, observations, key informant interviews, surveys, OR, or others methodologies. With the support of collaborating public agencies (e.g., the Institute of Reproductive Health, Institute of Pediatrics) and international donors and NGOs (e.g., GTZ, AVSC, UNICEF, Peace Corps), available curricula will be identified and adapted with local consultants and staff.

Several of the listed agencies have assured Project HOPE that they will make their staff available for training, as long as Project HOPE will cover their travel and per-diems. The original trainer-of-trainers

course will involve project staff and 3-4 trainers from the oblast level, and a similar number from the rayon. One of the first courses will cover adult education methodologies, with trainers from Peace Corps, AVSC, JHPIEGO, and other agencies as available. The master trainers at the oblast and rayon level, will be expected to replicate the training activities, at the rayon level with technical and logistical support from Project HOPE. With AVSC support, Project HOPE staff and the local master trainers will also be trained in facilitative supervision by an AVSC consultant. Supervision checklists will be developed for each technical area and assess the extent to which protocols are being followed and clients educated and counseled.

In addition to developing a group of master trainers, HOPE will also strengthen obstetric and neonatal care in the Navoi City referral facilities. After conducting verbal autopsies of maternal deaths and neonatal deaths in Navoi City and Kyziltepa, retrospectively, as well as on an ongoing basis, specific areas to be strengthened will be determined and local/international consultants identified to provide training. Specific areas that might be included are management of pregnancy-induced hypertension, management of obstetric emergencies and post-abortion complications, neonatal resuscitation, management of premature and/or small for gestational age newborns; etc. Protocols and curricula for some of these topics are already available in Russian from HOPE programs in Kazakhstan and Georgia and will be adapted.

Rayon. At the recommendation of the MOH Oblast Chief, Project HOPE will initiate its activities in Kyziltepa, one of the rayons not to be served by the World Bank project. Project HOPE will set up a rayon coordinating committee with the rayon health chief and his chief OB/GYN and pediatrician to plan, implement, and monitor the rayon activities. In this rayon, HOPE will work with health providers at all levels, from the FAPs to the rayon hospital, depending on the specific project intervention. Building on the abundance of health providers in the region, which allows time from problem analysis and OR approaches. QA/QI methods will be introduced at the health facility level. Given AVSC's strong presence in the country and the fact that its director has been trained in COPE, (a QI tool). HOPE is considering requesting AVSC assistance in using COPE for introducing health-facility based problem analysis and problem-solving. In addition, HOPE may also consider experimenting with peer training and role-modeling, using PCI's approach developed for vaccinators in Indonesia. Given that access in the region is not a real issue, the key to reducing maternal and child mortality and morbidity is an increased focus on evidence-based methods and quality.

Navoi City. In Navoi City the project will work closely with the city polyclinic, children hospital and the maternity unit of the regional hospital. A set of core trainers from these institutions will be developed. The maternity unit will serve as the center for reproductive health and the children polyclinic will be the focal point for IMCI activities. The TOTs will be conducted at the city polyclinic and the maternity unit of the regional hospital. Apart from the MOH, in Navoi City the project will also work closely with the mining industry and implement IMCI and maternal health activities in their setting. However, the project will negotiate and examine the feasibility of these interventions beforehand with the medical department of the mining complexes.

Community/Household Level. A further key to health improvements in the region is increasing consumer/client active participation in health. HOPE will work with mahalla committees, schools, and community-based volunteers of the Red Crescent Society. In addition, the project will develop information materials for women of reproductive age and children under five, with an emphasis on increasing knowledge and active consumer participation in healthier lifestyles. Given the importance of other adults (husbands, mothers-in-law, etc.), IEC activities will also target these key decision-makers. As part of a larger project, complementing existing CS projects, HOPE (in coordination with UNICEF, BASICS, PAHO, and WHO) will develop a Mother's Card, providing key information on danger signs necessitating timely care-seeking, home management of basic conditions, and feeding advice. Two cards will be developed, one for the neonatal period, and a second for children under two years of age.

All women of reproductive age and children under five will automatically be part of the target group and accessed through the project and counterpart providers. It is unlikely that more than a small proportion of high-risk families would be missed, given the comprehensive outreach of the local health care system and the vast majority of women delivering within the formal health care setting.

In order to reach the communities a series of advocacy meetings will be held at the rayon and community level (Kishlak level) in Kyziltepa. While in the city these meetings will be held at the microrayon level of the city unit. The existing administrative structure of the Rayon and its various level will be sensitized and mobilized to support project activities.

Simultaneously, the current linkage between household and the health care provider will be strengthened, particularly during prenatal and postnatal visits by the Akusheraks and doctors. Their role will be extended from IPC to form support groups and provide group health education at the community level.

The other existing resource is the school nurse who comes in contact with school children on a regular basis. The nurses will be utilized to promote nutrition, hygiene and the community component of IMCI through children.

Before implementing community interventions, the lessons-learned by the Health Reform Project of Abt/USAID in reaching and mobilizing communities in Fargana will be examined. The project will work closely with the reform project in utilizing its first hand experience.

2. Choice of Interventions and Strategies

Generalizing broadly, the introduction and systematic use of evidence-based modern protocols and active consumer participation in health maintenance and improvement are the two key strategies of the project for reducing unnecessary mortality and morbidity in women of reproductive age and children under five in the target area. Within this context, the following key technical interventions were selected based on health statistics, baseline survey results, and MOH priorities:

- Maternal and Newborn care
- IMCI
- Breastfeeding
- Family planning
- Iron and iodine deficiency

In addition, the project will be responsive to the issue of lack of drugs, supplies and equipment, in great part due to the non-convertibility of the local currency. Project HOPE will work with international donors to improve the availability of basic antibiotics and contraceptives, and assist the oblast with targeted donated product. The drug supply management module developed by Management Sciences for Health will be introduced at the Oblast and Rayon level.

The project will build on the strengths of the local health care system, the abundance of human resources and a strong system of community outreach and visitation.

Project HOPE's local staff is highly motivated, but lacks professional experience in evidence-based protocols and adult education methodologies. HOPE staff will participate in all trainer-of-trainer courses and receive additional in-service education through the Project Director to be able to serve as role models and mentors of counterpart staff.

3. Changes, Additions or Deletions of CS Interventions between the Agreement Program Description and those Discussed in the DIP

As mentioned above, the project is adding a focus on iron deficiency anemia and iodine deficiency, given the importance of these micronutrient deficiencies in the target area.

4. Innovations, New Methods, Strategies, or Materials

Most of the project methods, strategies, and materials are new in the project area. For example, Uzbekistan is still finalizing its facility-based IMCI approach and a community-based approach has not yet been

developed. Project HOPE serves on the national taskforce for the facility-based IMCI and develop materials for community/household IMCI. Modern protocols for managing deliveries (e.g., partograph) or child illness (IMCI) have not been introduced to the target area. In addition, adult teaching/learning methodologies differ significantly from the traditional teaching style of lecturing.

As perinatal makes up a major portion of the IMR, emphasis will be given to case management of newborns and the neonates. Standard protocols on case management of these babies will be introduced following WHO guidelines. All neonatal deaths will be evaluated using verbal autopsy and audit of medical records. Efforts will be made to develop collaboration with American International Health Alliance and US based institutions to utilize expertise in the area of neonatal health.

Facilitative supervision and QI methods at the health facility methods (e.g., COPE) have not yet been used in Navoi. IEC materials at the health facility level are very rare (usually only hand-made posters for the wall with non-standardized health messages are available) and absent for the family/household level. The project will develop a Mother's Card with the major danger signs indicating the need for care-seeking, home-based care advice, and basic child feeding and nutrition information. This Mother's Card will be dove-tailed with the health-facility-based IMCI approach. The developed methods and materials will be shared with the Institutes of Reproductive Health and Pediatrics, as well as other interested organizations in Uzbekistan for replication and scaling-up purposes.

5. Operations Research Activities

Operations questions requiring operations research will be identified throughout the course of the project and may include the following:

- Impact of IMCI training on the appropriate use of antibiotics for ARIs and diarrheas;
- Impact of use of the partographs on the use of C-sections and drug interventions;
- Comparison of various IEC approaches on changes in knowledge and behavior;
- The use of QI methods by health facilities on quality of care.
- Changes in the quality of care of the providers after introduction of protocols for ANC/PNC and newborn care.

The following additional issues will be explored:

Risk factors for not exclusively breastfeeding
Quality of IMCI services at the polyclinics
Effectiveness of ORT campaign in the project area
Barriers to family planning in the target area
Beliefs and practices during pregnancy and postpartum period
Complimentary feeding practices in children 6-24 months
Feeding pattern during illness (ARI, diarrhea and fever)
IUD users and problems associated with IUD use

6. Process Undertaken to Select and Involve Relevant In-Country Organizations in the Design and Implementation of the Program

The project worked with the MOH Oblast Health Chief, the Chief OB/GYN and Deputy Chief of the oblast Health Department in the selection of the priority interventions and to a limited extent in the development of this plan. At their recommendation, the project will strengthen its focus on micronutrients (iron and iodine deficiency), work with community committees (Makhalla committees) and community leaders, the Red Crescent Society, Healthy Generation, teachers, doctors, and other health providers. At the oblast level, the MOH would like to see a core group of master trainers and TA to the oblast and eight rayon hospitals, and increased community participation in health in the experimental rayon.

Increasing the active participation of the oblast and rayon MOH also will be part of the capacity-building component of the project. The experimental rayon was not involved in the development of this DIP, since

the decision that Project HOPE should initiate activities in Kyziltepa was not made by the oblast administration until mid-May. The health facility assessment included exit interviews with clients and the information they provided was taken into account. People in the oblast are not yet accustomed to participate in participatory planning processes and freely provide their opinions or ideas.

In addition, the Project Director has developed a network of professional contacts that will enhance project implementation and technical assistance to the project, including the Institutes of Pediatrics and Reproductive Health of the MOH, Peace Corps, AVSC, GTZ, and UNICEF.

7. Program Fit with the USAID Mission Strategic Objective (SO)

The project has been in periodic communication with the USAID Mission. Cheri Vincent, Health Advisor accompanied Dr. Siddiqi to Navoi on his first trip and has assisted with contacts and recommendations. The project contributes to the CAR Mission's goal of *Healthier Central Asian Populations* and its IR 3.2.3 of *Increased quality of health care* and IR 3.2.4. *Better informed citizenry about personal health care rights and responsibilities.*

USAID Collaborating Agencies. USAID is in progress of negotiating the Central Asia Quality Health Care Project, which includes Uzbekistan, to support technical assistance, training, and limited equipment and commodity to "increase select populations' equitable access to quality primary health care." This project will include health policy inform, the development and replication of existing successful general medicine/family medicine health care delivery models, and consumer awareness raising in preventive health care, health care rights, and responsibilities. The project will be first implemented in Tier I oblast and be replicated in Tier II oblast. Navoi is a Tier II oblast. IMCI and reproductive health are highlighted, among other activities, in the USAID RFA. Project HOPE will coordinate with USAID's contractor to assure that the CS project will link and enhance these new USAID/CAR activities by keeping the contractor apprised of lessons-learned in Navoi and in determining activities that can be replicated in the target area. Other contractors include AIHA, CDC, and Project HOPE (TB activities).

8. Other Bilateral or Multilateral Organizations

Other donors, currently active in Uzbekistan include:

The World Bank (Health One project) with the purpose of 1. Strengthening rural primary health care facilities; 2. Pre- and in-service training of health professionals in general/family medicine; and 3. Strengthening of finance and management system. While Navoi is one of the three oblasts involved in this project, activities have focused on Fergana, and the perceived impact in Navoi is limited. To date, the World Bank has supported the construction of 12 SVPs and a one-year retraining course for 40 doctors in general medicine (ongoing, with assistance from the British Know-How Fund). The training of additional doctors, nurses, and managers of SVP is planned. The World Bank is working in two experimental rayons, Nurata and Konimeh, with Kyziltepa and Khaterchi as controls.

- EU/TACIS started a project in 1999 to complement World Bank and USAID activities to promote preventive health care policies, develop preventive medicine programs, assist in reorganizing the public health care system; and assist in upgrading the management system in the same oblasts.
- The Know-How Fund – retraining of physicians as GPs
- The Peace Corps has assigned a volunteer to share her time between the oblast hospital and Project HOPE and is considering the placement of additional volunteers to support the project activities.
- CDC is working with the USAID Mission and Project HOPE on the implementation of the TB DOTS program. Project HOPE is not currently working on TB in Navoi, because of Mission concerns that two USAID funding sources could be mixed. However, TB is a high priority for Navoi health officials, and HOPE will encourage the Mission to revisit this issue later on.
- MSF/Holland, WHO, and UNICEF, with some support of the Government of Japan, are working in the Autonomous Republic of Karkalpakastan on such areas as TB DOTS implementation, ARI, CDD, IMCI, and iodine deficiency

- GTZ/EPOS, UNFPA, CMS of USAID (recently completed), and UNAIDS are working in different areas of the country on reproductive health issues. GTZ has already shared its reproductive health materials with Project HOPE, and a HOPE trainer participated in GTZ's reproductive health training course in mid-May
- AVSC (supported by UNFPA) has trained providers in family planning and counseling and is willing to share expertise in reproductive health, facilitative supervision, and QI methods (e.g., COPE).

9. Special Health Initiatives in Uzbekistan

IMCI is the major new health initiative in Uzbekistan. According to the Director of the Pediatric Institute, charged with IMCI implementation oversight, IMCI is in the final stages of adaptation. However, in a meeting on 5/12/2000, Project HOPE staff also met a WHO consultant charged with conducting OR for the food box of IMCI. According to the Director, IMCI is currently stagnating due to the fact that the World Bank has not been forthcoming with funding the trip of the two WHO staff from Copenhagen to review the adapted IMCI materials. Given the IMCI experience of Project HOPE's CS Project Director, Navoi was selected as one of the three pilot implementation oblasts sites for IMCI, and the CS Project Director serves on the national IMCI taskforce.

The MOH is conducting surveillance activities on poliomyelitis. Routine immunization with OPV is in place, and the current coverage levels are very high. At present there is no mass campaign like NIDs in place. Last year, no cases of polio were reported in the Navoi region.

10. Participation of Community Leaders, and Community Groups

Given the local environment, community leaders have not yet been included in the design and implementation of activities. Community members participated in the health facility assessment through exit interviews and in the KPC survey. They will also be included in the development of IEC materials through focus group discussions and other qualitative methodologies. In addition, the project will work with the mahallas committees. The Mahalla Committees holds the administrative and political power base at the Kishalak level. They are representatives of their communities and share their concern with the Rayon Hokimyat, which is the highest body in the rayon. These committees are represented by various senior citizens and groups in the community. The project plans to mobilize them for its activities through a series of advocacy meetings with them.

The project plans to explore collaboration with the school system using two strategies, the training of school nurses in RH and CS issues within the context of health provider training, and training courses for teachers in reproductive health. The development of curricula and training of select school teachers will be scheduled in the third year.

11. Local Government Organizations Involved with Primary Health Care

See Section B.2, for a detailed description of the local government involvement in PHC.

12. Other US and International PVOs

There are no other U.S. and international PVOs in Navoi. As described earlier, the project area is still suffering the long term consequences of past isolation. The project has made excellent contacts with other international donors and NGOs located in Tashkent and will bring their expertise to the target area. Counterpart International was recently awarded a CS-XVI grant. The project will provide lessons-learned and explore sharing international TA with Counterpart.

13. Private Sector

The existing private sector in Navoi consists of physicians mostly providing dental care, and care for heart diseases and physiotherapy. These specialists are not providing child or maternal care at present, thus limiting their inclusion in the project activities. However, the project will monitor the private sector and its

development on a regular basis and will look for opportunities to incorporate it within the project activities as appropriate.

14. NGOs

NGO involvement in health care is very limited in Navoi. Healthy Generations and the Uzbekistan Red Crescent are the two organizations outside the main health system providing first aid and health promotion to the population in the region.

The Red Crescent Society provides support mostly through its volunteers in the schools and Mahallas. It has about 8,000 volunteers nationally who are trained in first aid. It also provides food to families in need whenever it receives humanitarian assistance from other countries. The Government of Uzbekistan, International Red Cross and Red Cross Societies of different countries support the Red Crescent. In Navoi, the Red Crescent Society has a staff of seven, and about 3-5 paid individuals in each of the rayons, as well as about 100 volunteers. They work with pensioners and have trained about 500 students and workers in first aid. The volunteers teach school children and recently conducted a competition on hygiene and sanitation. The Red Crescent works with about 3,000 families in Navoi, selected by the mahalla committees, because families are either very large or have a disabled child. In the target rayon, there are 25 volunteers working. The Red Crescent Society is very interested in working with the project and participate in some of the training. In addition, their beneficiary families are clearly at elevated risk for poor health status.

Healthy Generation is a relatively a new organization mostly supported by the state. It has a nationwide network and offices. In Navoi, it operates a small clinic and an ambulatory unit which provides medical care and medicines, mostly free of charge. Healthy Generation also reaches out to the communities and organizes seminars for the women groups on various health issues and publishes health promotion materials for people.

Another organization that works on a very limited scale in Navoi is called ***The Fund for Disabled***. It receives limited support from Save the Children/UK and works with 8,000 children that have lost one or both parents. Their Director indicated her willingness to collaborate, where feasible.

As the Navoi oblast is becoming more open to the outside world, it is expected that existing national NGOs will branch out to this oblast (e.g., women's groups) and that new NGOs will form. The project will be open to developing a working relationships with groups that share common goals or have access to the beneficiary group of the project. This also includes professional groups of medical providers and teachers, as they begin to establish local chapters.

Attachment A5: *Partnerships*

STRENGTHENING LOCAL PARTNER ORGANIZATIONS

1. Local Project Partners

The project will work with the Oblast Health Department (including the health care system of the mining and industrial sector), the Kyziltepa Rayon Health Department, the Red Crescent Society, Healthy Generation, and the mahalla committees.

2. Capacity of Local Partners

The available human resources of the Oblast, city and rural health care system have been described in detail in section B.2 and E. As pointed out in the HFA, facilities at all levels lack essential pharmaceuticals, supplies, and equipment, and often patients are requested to purchase prescriptions in the local pharmacy. The vast majority of health providers have also not participated in training in the project interventions in the previous year and need to be trained in the use of international management protocols and patient education and counseling.

The industrial health care system receives additional resources from its profits. As a result, its facilities are better stocked and equipped. Since providers are paid higher salaries, the industrial health care system draws the brightest and most motivated health care workers. Even at first glance, there are more patients awaiting services at the visited health facilities; providers appear busy and occupied with patient care; and the available equipment is more modern.

However, providers in both types of settings have expressed great interest to participate in technical updates through the program.

With respect to management capabilities, supervision visits do not assess the quality of care provided by individual health workers, with constructive feedback and incentives on how to improve performance. Supply and logistics are driven by the number of population covered, rather than by actual local needs. The current information system is loaded with data that are hardly used. The data collection methods are poor as is the quality of data. The health reform project will be working on the improvement of health information system and develop a population-based computerized data base for the Oblast.

Given national health reform efforts managed by the GOU with the World Bank, USAID, and other partners, the project does not plan to become involved in health care financing issues at this point in time.

3. Program Approach to Strengthening the Capacity of its Partners

Technical Strengthening. The project will develop a TOT team at the oblast and rayon level. This team, with assistance from project staff, will be responsible for the training of all providers involved in reproductive and child health, counseling and patient education, as well as for post-training follow-up and supervision. In addition to technical training, the TOT team will receive training in adult education methodologies and facilitative supervision. Prior to each new technical training, a training needs assessment will be conducted with a sample of the targeted providers, and the findings integrated into the curriculum. In addition, providers at the referral hospitals (rayon and Navoi City) will be trained in essential and emergency obstetric care and newborn critical care.

Since the rayon and city health team has little understanding of primary health care management a one week course on primary health care management spread over a period of 4 months will be developed for the managers of the centers.

Quality Improvement Methodologies. To improve quality of care, the project will strengthen technical and management skills at the health facility level, using a variety of QI methods. Given the current top-down approach of management, the project considers it unwise to introduce more democratic, analytical problem-solving approaches until the latter part of the second year. Introduction to participatory teaching approaches, novel interactive approaches to supervision, and training in customer counseling and education will provide the foundation for health-facility wide analysis and planning, that will involve provider and customer perspectives about current health service delivery and system improvements. The project plans to work with AVSC and other organizations in the region to develop a commitment to QI at the health facility level. A small manageable number of health facilities will be included in the first phase. As these facilities complete their first QI projects, health staff from additional facilities will be invited to listen to their experiences, findings, and improvements. In the second phase, successful health facilities will be invited to send staff to assist in the training of the second group

Information System. The project will work to strengthen the current information system and will introduce the concept of "data for action". The project will work with the Oblast Statistical Department to computerize their data and produce meaningful tables and graphs of the collected data. Similarly, at the Rayon level, the data will be analyzed and presented in a compatible format with the Oblast level. Later on, when the Health Reform Project gets on board, the project will work closely to ensure that the staff managing the health information system in the Rayon and the City get appropriate training like in the other intervention areas.

Coordination. All activities will be made in consultation and coordination at the central level with the MOH and various institutions particularly on IMCI and reproductive health. All development partners will be coordinated through the inter agency health meeting held at USAID on a bimonthly basis. At the local level the project will coordinate on a regular basis with the World Bank Project Implementation Unit, TACIS and the Health Reform Project of USAID.

4. Jointly Developed and Signed Agreements

Project HOPE has a Country Agreement (see Annex III), but does not intend to develop formal agreements with its local partners at this time. All agreements have to go through the central level formal approval process, which would be cumbersome and potentially stall the implementation of project activities. Through the steering committee, the project will developed mutually agreed upon annual and quarterly workplans with its partners. The issue of developing formal agreements at the project level will be revisited periodically and assessed for feasibility.

STRENGTHENING THE PVO

1. Strengthening of Project HOPE

This is Project HOPE's first CS project in Uzbekistan and USAID-funded CS project in the CAR. While HOPE headquarters and field staff can draw on lessons-learned through previous and current activities in the NIS (foremost humanitarian assistance and TB DOTS training and implementation), this oblast partnership to improve child and reproductive health presents new challenges.

At the headquarters level, the program will be managed by Project HOPE's maternal and child health staff and regional team. This team has worked in developing countries in the Americas and Africa and has limited experience in the NIS. This is also HOPE's first CS program with a major focus on obstetric and newborn care. To address these issues and build headquarters capacity, HOPE is developing new partnerships to benefit this CS project (e.g., University of Michigan Medical School, and consultants and HOPE volunteers that have assisted with secondary and tertiary obstetric and pediatric programs in the past). The rigors and M & E activities associated with the implementation of BHR/PVC CS projects will also benefit HOPE's other programs in the region, by increasing knowledge and skill levels of technical and administrative staff in the region for monitoring health programs.

2. Monitoring and Measuring Increased Capacity of HOPE

Current Capacity.

- ♦ No ongoing CS/MCH/RH project in the NIS.
- ♦ Other programs in the region are weak in the areas of formal workplans, results indicators, M & E systems, including external evaluations.
- ♦ HC CS staff lacks experience in the region.
- ♦ Limited headquarters expertise in obstetrics and neonatal care.

Capacity at Project End

- Expanded consultant base to cover obstetric and newborn care needs of CS projects.
- Increased attention to obstetric and newborn care in new CS proposals in regions with high neonatal mortality rates.
- Curricula and protocols covering essential and emergency obstetric care and newborn care in Russian/Uzbek.
- Procedure and guidelines for assessing neonatal mortality through verbal/social autopsies developed.
- A second CS project proposal developed in the region and submitted for funding to a donor, based on lessons-learned in Navoi.
- At least one technical MCH staff with experience in the region.
- M & E strengthened in other projects in the region.

Attachment A6: *Health Information System*

Monitoring:
The program will monitor its progress, both internal and external, by tracking inputs, outputs and activities according to the project workplan. During the forth quarter of the first year project staff will break down the activities in the work plan into sub-activities called "tasks", and assign these to specific members of the project team or to collaborating organization team members as well as setting a schedule for their execution and completion. This will be done in a participatory fashion to produce maximum buy-in by both staff and counterparts. Subsequently project staff will meet monthly to review progress in completing tasks and to modify or adjust schedules as external or internal factors cause changes.

On a quarterly basis, as described in Section 1.E Program Design, the overall Project Steering Committee. including counterparts, will meet to similarly review progress. Staff members and managers will prepare quarterly progress reports using the task completion targets as the basis for those reports. Where external factors had been identified which interfered with completion of tasks, and which were related to Oblast or Rayon health system factors, this quarterly meeting will provide the opportunity to discuss these barriers and to collaboratively plan strategies and related activities to overcome them.

An annual meeting, with the addition of USAID representatives and those of other relevant organizations, will be carried out in similar fashion, but will provide a formal review of the strategy of the project, and allow adjustments to be made as appropriate. This detailed Task-Based Workplan and monthly summaries will provide feedback and reminders to project staff regarding upcoming tasks as well as those in process of implementation. If appropriate, separate meetings will be held with rayon and muhalla leaders and counterpart staff, with the same review and updating of objectives, activities, and tasks relative to the particular rayon/community in mind.

The program will also monitor results of its activities in terms of changes in behavior of providers and households/families/women, and changes in conditions in health facilities. Provider behaviors are expected to become more similar to national/international protocols as the result of training and supervisory follow-up after training. A baseline HFA has provided data regarding patient care practices, including the results of both direct observation of providers giving care to sick children and pregnant and post-partum women, and exit interviews of the clients. Newborn and delivery care will be assessed during the second half of Year 1 and the beginning of Year 2. While a full HFA/Situation Analysis will be repeated only for the final evaluation, observation s and exit interviews will be carried out during post-training supervisory visits. The results of these will be fed back to the providers, in groups and individually, and progress toward behavior change documented.

Quality of care, and quality of other activities such as clinical and adult training, will be monitored and improved using Quality Improvement methods, such as COPE, supervision checklists, and other methods (e.g., participatory definition of standards in critical areas of behavior, self-assessment or mutual assessment of performance, analysis of data and of causes for non-quality performance, development and implementation of interventions, assessment of the effectiveness of the interventions in bringing about improved quality, and replanning as needed for further improvement). These quality improvement activities will be documented using standardized forms based on relevant case management or training guidelines and protocols/algorithms as well as the supervisory checklists being used in an ongoing fashion, and compiled by the project as documentation of progress in improving quality. The QI methodology involves teams of persons involved with particular processes (e.g., pediatric staff at a PHC facility) to be the ones working through problems associated with those processes, hence has the element of participation which is critical to eventual acceptance of changes in the processes under examination.

Changes in conditions in health facilities, for example availability of selected essential drugs, will be monitored by supervisors using a checklist of items including some selected from the overall HFA, as well as by the staff of the facility itself. Supervisors will seek to move toward a facility managed system of ongoing internal supervision and checking to improve the sustainability of these efforts.

The project will facilitate the carrying out of audits of neonatal and maternal deaths, both to determine their medical cause and to explore the steps leading up to the death. A doctor or other provider will be assigned to investigate the death using a standardized form, and the situation will be reported to a group of providers, either at the facility, rayon, or oblast level and discussed with the objective of determining how to avoid similar deaths in the future. The oblast and rayon health systems will be encouraged to make these audits on their own (and include deaths beyond the neonatal period), to allow for sustained improvement activities after the HOPE project is no longer present.

The project will experiment with LQAS type sampling and survey method to monitor changes in maternal knowledge and practices in areas in which the program is known to have carried out activities. Where results of these samples suggest that coverage may be deficient according to targets set in advance (e.g. % of mothers who recognize signs of pneumonia, % of mothers who can recite signs of dehydration, % of mothers who know danger signs in newborns), further investigation will be carried out to more definitively assess the deficiency as well as to determine how to overcome it.

A detailed list of indicators and monitoring/evaluation data gathering methods is listed in Section 1.D of this DIP as part of the table entitled PROGRAM GOALS AND OBJECTIVES. This table would be applicable to both monitoring and evaluation activities.

Evaluation

The project will carry out a mid-term and final evaluation as shown in the workplan. The midterm evaluation will review documents, carry out focus group discussions and in depth interviews, and examine data from the project database. We anticipate that this midterm evaluation will be a slightly more detailed review of progress and activities than the annual monitoring review described above, involving the use of external persons to obtain a more objective view of the project's internal and external relationships and functioning, and providing an opportunity for a more in-depth discussion of possible changes in strategy as needed to reach the project's targets and objectives in the time remaining. Full participation of counterpart staff at oblast and rayon/municipality level will be emphasized for the midterm evaluation (as well as the final evaluation), both to facilitate acquisition of the skills in this kind of assessment as part of capacity development, and to facilitate an active response to the results of the evaluation on the part of local officials and staff. This will facilitate preparation of the Action Plan for implementing the recommendations of the evaluation team, which may well involve changes in both the project and the host country sponsored activities and inputs.

As already noted, the Final Evaluation will involve a repeat of the KPC survey, the HFA for child health activities, and a combination of the Reproductive Health Assessment and the Situation Analysis for delivery and newborn care assessment. In addition the evaluators will carry out focus group discussions, in-depth interviews, and reviews of documents as in the midterm evaluation. The team will involve external consultants, project staff and counterpart staff, and representatives from other relevant agencies in an attempt to include all stakeholders in the project. Instruments will be modified and adapted to answer strategic questions particular to the Uzbekistan and Navoi situations.

Changes in the Project Evaluation Guidelines

Project HOPE proposes that the midterm evaluation be conducted in October of 2,001 to give the project additional time to recover from a slow start-up period and to take advantage of the somewhat cooler months in the fall.

With respect to the Midterm evaluation guidelines, Project HOPE proposes that the external evaluation consultant and HOPE staff spend 1-2 days prior to the evaluation on reviewing the status of the Uzbek health reform. This information should be taken into account when making recommendations about modifications to the workplan for the final two project years.

The final project evaluation should also address the achievements of the project within the context of the larger health reforms, and to what extent the health reform stalled or moved along the project objectives and how project activities have/have not complemented health reform efforts.

Dissemination of Monitoring and Evaluation Results

The project will emphasize the use of results from both monitoring and evaluation in its management, as a learning organization. Monitoring results, as noted, will be shared directly with those involved with the processes, and at the quarterly and annual review meetings these will be used as the basis for consideration of shifts in project emphasis or strategies. Monitoring and evaluation results will also be shared with HQ backstopping staff, who will contribute from their perspective to the planning and replanning which will follow the availability of those results. Evaluation results will be more formally written up in summary or paper fashion, and circulated widely among stakeholder organizations and other partners, as well as prepared for publication as appropriate.

Attachment B: *Assessment Methodology*

This mid-term evaluation report is based on a two week field investigation of the project by the evaluation team and is supported by baseline assessments and periodic surveys. The field investigation occurred April 2-12, 2002. The evaluation team and process was organized by Project HOPE according to the written guidelines for mid-term evaluations provided by USAID. It was a participatory evaluation process that included representatives from the key stakeholders in the project, with an external team leader.

The team was centered in Navoi, Uzbekistan, where the project office is located, and made day trips to many sites where the project is being implemented. Due to the size of the team and the number of people to meet, two sub-teams were sometimes formed. The mid-term evaluation team conducted interviews with providers at hospitals and clinics, observed provider-client interactions, and held exit interviews with mothers at primary and tertiary care facilities. Discussions were held with inpatients in post-natal care departments of maternity hospitals and with breastfeeding support group members. The evaluation team observed IMCI training and debriefing sessions, as well as a "Best Nurse Competition" and reproductive health "Poster Competition." Informal discussions and a meeting were held prior to the end of the evaluation to share and synthesize observations and reports. A final day was spent together developing findings and recommendations.

The entire process was extremely well organized. In offices in Tashkent and Navoi, and at the various facilities the evaluation team was welcomed with enthusiasm and a celebratory atmosphere. The project staff worked very hard and spent long hours to make the time of the evaluation team productive.

Attachment C: List of Persons Interviewed

Tashkent

1.	Dilbar Makhmudova	Director of National Pediatrics Institute
2.	Mekhmon Akhmedov	Deputy of National Pediatrics Institute, Chief of the National IMCI Center, Tashkent
3.	Mark McEuen	Abt Associates, Project Director
4.	Irina Stirbu	Abt Associates, IMCI Coordinator
5.	Farkhad Fuzailov	World Bank Health Project Coordinator
6.	Andreas Tamberg	USAID/Tashkent Health Advisor
7.	Asomidin Kamilov	Deputy Minister, MOH
8.	Vladimir Verbitskiy	Head of WHO Mission in Uzbekistan
9.	Stafania Avanzini	WHO Coordinator for MCH Programs
10.	Feruza Fazilova	Chief of the RH Center, Tashkent

Navoi City

	OBLAST HEALTH DEPT	
1.	Nasirov Abdurakhmon	Chief of Oblast Health Department
2.	Nuriddin Shaymanov	Chief Pediatrician of Navoi Oblast
3.	Bozorova Muazzam	Chief Gynecologist of Navoi Oblast
	TOT TEAM	
4.	Allabergenova Dilorom	Project HOPE Pediatrician/IMCI &BF Trainer
5.	Muratova Nigora	Project HOPE Gynecologist/BF & RH Trainer
6.	Eshankulov Yuldosh	Kiziltepa Coordinator, IMCI & BF Trainer
7.	Gaybullaeva Nigora	IMCI Trainer
8.	Ashurova Lola	IMCI Trainer
9.	Sharapova Solikha	IMCI Trainer
10.	Kalimbetov Ravshan	IMCI Trainer
11.	Ibragimova Ibodat	IMCI Trainer
12.	Karimova Gulsun	RH Trainer
13.	Khamroeva Makhfuza	RH Trainer
14.	Gulyamova Aziza	RH Trainer
15.	Shodieva Dilya	RH Trainer
16.	Khalimova Manzura	BF Trainer
17.	Shaymanov Nuriddin	IMCI Trainer
18.	Bozorova Muazzam	BF Trainer
19.	Kodirova Zarifa	BF Trainer
20.	Ruzikulova Nodira	BF Trainer
21.	Bakirova Anisa	BF & IMCI Trainer
22.	Asadova Gulchekhra	IMCI Trainer
23.	Askarova Dilbar	IMCI Trainer
24.	Bokieva Mavluda	BF Trainer

Chiefs of Hospitals from Other Rayons

1.	Khalilov Shavkat	Chief of Nurata
2.	Norbaev Erdon	Chief of Kanimekh

Local NGO Representatives

1.	Olga Sashina	Women's Adaptation Center
2.	Kamila	Association of RH
3.	Larisa Yurikova	Association of Business Women

Chiefs of Pilot Rayons

1.	Orifjon Jumaev	Kiziltepa Rayon
2.	Askarova Dilbar	Chief Pediatrician of Kiziltepa Rayon
3.	Kuvvatova Oliya	Chief OB/GYN of Kiziltepa Rayon
4.	Ochilov Ikhtiyor	Chief Deputy of Kiziltepa Rayon
5.	Yusupjon Ergashev	Navoi Rayon
6.	Jeliliva Lilya	Chief Deputy of Navoi CRH
7.	Khimmatova Istat	Chief Pediatrician of Navoi Rayon
8.	Nurmatova Oibibi	Chief OB/GYN of Navoi Rayon