Project HOPE

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

Cooperative Agreement No: FAO-A-00-99-00026-00

Project Duration: September 30, 1999-September 29, 2003

Final Evaluation
Phase I

September, 2003

Preface

At the beginning of my career several decades ago, I made an intentional choice to work with NGOs. At that time it seemed to me, and still does, that our power is in being able to try out new, innovative ideas on a small scale, and then, using use our community base, and international stature recommend what works at scale. Many projects are framed in this way: a pilot portending practical lessons for replicability at scale. In the case of the Navoi Child Survival Project, this really happened.

The old cliché "hindsight is 20-20 vision" is the privilege and potential pitfall of the evaluator. How easy it is to see what could, should and might have been from the vantage point of historical reflection. The greater challenge is to learn the lessons of the past and refocus on a clearer vision of a way forward into the future. The Project HOPE Uzbekistan team is fully up to this challenge. They are as enthusiastic as they are capable, and as ready to learn as they have been to share and teach. They work as a team, but each one of them brings something special to the collective task. It was my privilege to be part of this team for a brief time, and I thank them for their hospitality, openness, and insights.

I would also like to thank Dr. Bettina Schwethelm, previous Project Manager and Dr. Diaa Hammamy, Project HOPE Director for Central Asia, for inviting me to undertake this evaluation. It has been my great pleasure to work with them both on this and other projects.

While two of the four person team—Dr. Mavzhuda Babamuradova previous Project Director and Dr. Abdunabi Kuchimov, current Project Director know the Project and the context intimately, the other two members, Ms. Sarah Porter, new Project HOPE Project Manager and myself were on a steep learning curve. The time in the field—just under two weeks—was short, intense, and as always, never enough. As such, there are, I am sure, mistakes of fact and interpretation in this report. The Project HOPE Navoi team have had a chance to read it (albeit not in their own language) as has Ms. Porter and Dr. Hammamy. Nonetheless, major findings and recommendations are my own and I hope, mostly accurate and helpful.

I commend the Project to USAID and the approval of a four-year extension.

Laurie Zivetz
Washington, D.C.
September, 2003

Table of Contents

Tables

Annexes

Acronyms

ARI	Acute Respiratory Infection
ADB	Asian Development Bank
DIP	Detailed Implementation Plan
DOTS	Directly observed therapy short-course
HFA	Health Facility Assessment
HIS	Health Information System
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
KPC	Knowledge, Practice, Coverage
MCH	Maternal and Child Health
MOH	Ministry of Health
MNC	Maternal and Neonatal Care
NGO	Non Governmental Organization
PEPC	Promote Effective Perinatal Care
RH	Reproductive Health
SM	Safe Motherhood
TOT	Training of Trainers
UNICEF	United Nations International Children's Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Develop
WHO	World Health Organization

Executive Summary

This report documents the final evaluation of the Project HOPE's 1999-2003 Uzbekistan Child Survival Project, carried out in August 2003. The evaluation considers the Project in its role as a field laboratory for testing new innovations in maternal and child health in terms of impacts and lessons learned in the two pilot rayons of Navoi Oblast, as well as influences on broader thinking, practice and policy in the country and the region.

This Project arrived at the historical and institutional confluence of a number of trends in Uzbekistan and appears to have gauged the situation and timing quite accurately in its design. With a well-established health delivery system hungry for new information and knowledge, and only a limited tradition of community-based public health outreach, the Project began with the delivery system, moving out to the community once it had the confidence of public sector leaders. Every new activity began with foundation-laying partnership dialogue. The fact that Project HOPE was the only international agency working in health in the Oblast, the physical location of the Project office inside of the Oblast MOH, and the collegial style of the team, all helped to build trust and a partnership with the MOH that propelled the Project forward. Strong, entrepreneurial leadership within the Project and a big-picture, positive "never say no" attitude extended the purview and impact of the Project well beyond the Oblast.

The cascade approach to provider in-service training, and in particular the way master trainers were identified and trained, proved highly effective. Although courses focused on specific topics—breastfeeding, IMCI, reproductive health and safe motherhood—the cumulative impact of the adult learning, client-oriented, public health approach, appears to have catalyzed new behaviors in provider-client and supervisor-subordinate relationships.

Community outreach activities have grown in an organic way from service-delivery focused capacity building activities. While issues-based *makhalla* competitions have stimulated interest and enthusiasm, clinic-based community mobilization volunteers and the dissemination of IEC materials offer the most promise for widespread and sustainable impact at scale.

The Project's health information system provided only limited data for comparing or measuring change or impact. In the next phase, as the Project continues to position itself as a laboratory for testing innovations in maternal, child and adolescent health, strengthening this aspect of the program merits greater attention.

Key findings and recommendations are summarized here:

Safe Motherhood

Findings: 1. Use of the partograph and changes in rooming-in, breastfeeding and delivery room procedures represent important achievements.

2. Baby friendly hospitals in both pilot rayons have become the flagship for change in maternal and neonatal care (MNC).
3. Safe Motherhood activities related to emergency obstetric care and IEC were delayed.
4. Maternal nutrition, particularly addressing the high rates of anemia, was anticipated in the DIP but not directly addressed in project activities.

Recommendations: 1. Safe motherhood should be prioritized in the extension project.

2. The planned establishment of a Safe Motherhood Center in Navoi should provide a focal point for training, monitoring and IEC outreach.

Integrated Management of Childhood Illness (IMCI)

Findings: 1. Probably the most important impact of the Project on national policy and practice was in the area of IMCI.

1. Navoi was designated a pilot site for IMCI under the MOH's health reform initiative.
2. Project HOPE participated on the national IMCI task force, and made significant contributions to IMCI protocols, now used throughout the country.
3. Impact beyond the target rayons is significant, with integration into preservice curricula at two prominent medical schools in the country.

Recommendation:

Quality and sustainability will depend on further attention to institutionalizing monitoring and supervision systems and ensuring a consistent drug supply.

Breastfeeding

Findings: 1. Exclusive breastfeeding in the first 4-6 months rose from 9% at baseline to 78% in final evaluation.

2. Fifty-three TOTs in Navoi and Medical Institutes. And IEC materials widely distributed.

Reproductive Health

Findings: 1. The Project has made significant strides in creating a context in which providers and clients *expect* choice.

2. A total of 387 providers trained in RH issues.
3. Formative research was conducted to inform the development of IEC outreach for key RH decisionmakers.
4. Contraceptive availability hampers efforts to offer a range of options to clients.

Recommendations: 1. More information on household spending patterns on contraception, would inform the design of appropriate social marketing mechanisms for contraceptives.

2. User pay drug schemes should include contraceptives.

Adolescent Reproductive Health

Finding: The extension project will add a component focusing on adolescent reproductive health. The Project is strategically poised to undertake this initiative, with widespread community interest and support.

Recommendations: 1. Use adolescents to collect data on adolescent knowledge, behaviors and preferences; establish an adolescent advisory committee.

2. Peer networking would be an effective way to disseminate information.
3. Good supervision is important to ensure correct information is being disseminated.

Monitoring and Evaluation

Findings: 1. Despite the fact that the Project collects a lot of data, information management and use was one of the weakest parts of the program.

2. The KPC and HFA in particular provided little in the way of longitudinal reliability because of poorly articulated indicators and a lack of consistency and rigor with the instrument.
3. Despite these drawbacks, the Project has been able to make the case for its approach at national level. In a playing field with few other voices, this was possible.

Recommendation: For the Navoi project to continue to play the role of laboratory for innovative new approaches in MCH, RH and related areas, information management will have to be significantly strengthened.

Training

Findings: 1. Training was a major Project activity, a method of capacity building and institutionalizing new skills in the delivery system.

2. A total of 1483 providers were trained by the Project.
3. A total of 106 TOTs have been trained (32 in the pilot rayons; 62 in the oblast).
4. The Project has followed the national practice of awarding a certificate to individuals when they complete a training course.

Recommendations: 1. On certificates: provide trainees with a letter of thanks for attending Project courses. Award certification after at least 3 monitoring visits (including written tests) ascertains a pre-established level of mastery.

2. On maintaining quality training: the role of the IMCI, RH and soon to be established SM Centers in Navoi should include monitoring, to enable identification of refresher training needs.

Quality

Finding: Initial delays in implementation did not allow the Project to implement originally planned Quality Assurance activities.

Recommendation: Supervision systems that enable continuous reinforcement of QA approaches are critical to ensure sustainable institutionalization.

Drug Supply

Finding: 1.Unavailability of many essential drugs means that in fact consumers are forced to buy them from private pharmacies.

2. Over the life of the Project, Project HOPE donated a total of $641,934 in pharmaceuticals. While this filled some gaps in availability, it does not solve the long-term problem.

Recommendation: Pilot community-based cum clinic-based revolving drug scheme approaches in the extension Project.

Community mobilization

Findings: Although community mobilization activities only got underway in the second half of the Project, the last year saw significant activity, including

- Community Competitions
- Makahalla committee involvement and strengthening
- Breastfeeding support group motivators
- Patronage nurse outreach workers
- Hotline for postpartum women
- Support groups

Specific recommendations about each of these approaches are provided.

Recommendations: 1. Develop an integrated community mobilization/IEC strategy with specific targets.

2. Establish an inquiry framework to monitor and measure the relative and synergistic impacts of various approaches.

Communications and materials for behavior change

Finding: The printed materials produced by the Project appear to have been of good quality, used by both providers and clients, and widely distributed.

Capacity building

Findings: 1. The Project successfully catalyzed paradigm shift at MOH, facility, and community levels through training, exposure, and partnerships supported by the project. 2. It also served as a fulcrum for connecting national and local stakeholders in ways that built capacity and aligned perspectives through jointly initiated activities.

Impact on national policy and programming

Findings: 1. The Navoi Project design became a model for a project covering two entire Oblasts in the country.

2. Project staff participation on national task forces related to IMCI and reproductive health brought lessons from the project to bear on policies being conceived in the context of health reform.
3. Training of trainers and staff from other Oblasts and medical schools multiplied exposure and practice to key MCH practices.
4. Donors, government and international NGO representatives have visited the project site or learned about it through interaction with project staff, borrowing ideas, curricula, and materials.

Recommendations: The DIP for Phase II should proactively anticipate the Project's strategic, national role as a laboratory by allocating human resources and designing M&E systems and dissemination mechanisms to promote specific, targeted issues.

Sustainability

Several aspects of the program portend well for sustainability and scale up:

- The Oblast MOH has embraced all of the new MCH approaches.
- Oblast officials are invested in health issues.
- Oblast-based TOT's are able to independently plan and deliver training. They are in demand from within and outside of the Oblast.
- Baby Friendly hospital certification set the standard for other facilities and demand sustainability of best practice.
- Local leadership has experience organizing around public health issues.
- Communities in the target rayons have been saturated with information about key issues.

Factors that may constrain or hinder sustainability of project interventions include:

- The absence of a supervision and monitoring system which can support quality and consistency in new practices.
- The inconsistent supply of drugs and contraceptives.
- Provider "migration" to private sector opportunities because of low pay from government service.
- MOH lack of budget to reproduce IEC materials.
- Lack of cogent data demonstrating impact of key interventions.

I. Introduction

This report documents the final evaluation of the Project HOPE's Uzbekistan Child Survival Project, carried out in August 2003. The report looks not only at impact and lessons learned in the two pilot rayons of Navoi Oblast[1] but considers also the influence and impact of the Project on broader thinking, practice and policy in Uzbekistan. The Project's models and lessons have already been used in the design of USAID's "Healthy Family" bilateral program covering two other oblasts in Uzbekistan and one oblast in Tajikistan, as well as a "sister" child survival Project in Kyrgyzstan being implemented by Project HOPE. Because the current Project has been granted a 4-year extension to consolidate current activities and scale up into two additional rayons, the evaluation process was simultaneously retrospective and prospective in its inquiry. The report follows the outline format recommended by USAID, with some additional sections to consider these aspects of the program. A Scope of Work is provided in Annex B.

Recommendations pertinent to specific findings are included in the relevant sections to make it easier for the reader to follow the rationale.

A. Methodology

The findings and perspectives in this report rely heavily on in-depth interviews and focus group discussions with key stakeholders during the field portion of the evaluation (August 21-29, 2003). A KPC and HFA was undertaken at the launch, midterm and evaluation points, but much of the data is problematic as discussed in Section II.A.1. below. Quarterly, annual, and mid-term evaluation reports as well as technical consultant trip reports were reviewed prior to the fieldwork. Interviews with Project HOPE/US staff, previous consultants, and donor representatives no longer in Uzbekistan with knowledge or previous involvement in the Project were undertaken by phone and email. A formal debrief with Project HOPE/Navoi was conducted prior to the Team Leader's departure.

Annex A includes a list of people contacted prior to and during the fieldwork. Interviews in the field were organized to capture a crossection of representative stakeholders in order to effectively triangulate perspectives and information on specific issues. Broadly, these stakeholders included:

- Project HOPE U.S. staff and former consultants
- Project HOPE Navoi staff
- Project HOPE staff on the "Healthy Families" and Kyrgyzstan Child Survival projects
- Tashkent-based donor agency representatives active in MCH

[1] [1] The *oblast* is equivalent to a district that is divided into smaller *rayons*. The Project was implemented in the rayons of Navoi and Kiziltipa in Navoi Oblast.

- Technical Institute representatives (including medical schools) that had participated in the Navoi Project
- Ministry of Health representatives at national, oblast, and rayonal levels[2]
- Senior Oblast Leaders
- A cross section of providers
- Clients
- Community leaders
- Community-based volunteers
- Community members—women, men, adolescents
- Project HOPE/Navoi staff

Where possible, at least three representatives of each of these groups was interviewed, and in some cases many more.

The interview instrument included in Annex D served as a starting point as much to share priorities and perspectives by email in advance of the field work, as a guide to data collection on the ground. As trends and issues surfaced—overall or in the context of a specific conversation, additional questions were added and pursued.

B. Team composition

The formal team was comprised of

- Team Leader, external consultant, Dr. Laurie Zivetz
- MCH Program Manager, from Project HOPE/US, Ms. Sarah Porter
- Project Director, Project HOPE/Navoi, Dr. Abdunabi Kuchimov
- Previous Project Director and currently Project Manager of the Project HOPE "Healthy Family Project", Dr. Mavzhuda Babamuradova

Other Project HOPE/Navoi staff also participated in some interviews, and all Project HOPE/Navoi staff was actively involved in the planning and discussion process during the course of the evaluation itself.

The field team was ably supported by translator Dr. Bakhodir Rakimov, who provided not only excellent translation, but perspectives on the medical system and broader socio-cultural context as well. Ms. Gulza Khalimova also provided translation support in Navoi.

C. The Context

On September 1, 2003 Uzbekistan celebrates its 12th independence day since the demise of the former Soviet Union. At its height in the early 15th century, capital city, Tashkent, was the center of a major empire under Amur Timerlane (Timur the lame) stretching from what is now Turkey to parts of India and north into modern day China. Borders have changed, but newly independent Uzbekistan is today a country with enormous natural wealth and an educated,

hard working population. Although economically struggling following independence, the country has very little absolute poverty. A republican, Uzbek government has replaced former punitive system once enforced from Moscow, and change continues to take place on the basis of edicts—*prikaz*--from on high. The status of women, high by international standards, may be eroding in the context of a shrinking job market and rising Islamic influences in the country[3].

1. The health delivery system

A major health reform initiative, underwritten by the major multilateral banks and supported by UN and bilateral agencies, is attempting to streamline an antiquated, inefficient system with a greater emphasis on integration of now disparate services through a network of primary health care sites. Health professionals are enormously underpaid (Rural doctors make $25/month with the per capita GDP at $2500) as a result of which most have private, parallel practices to their government employment. Health reform research being carried out by USAID-funded Z'drav Plus is investigating the structural and cost options of various public/private sector alternatives. In the context of health reform, Navoi was selected by the MOH as a pilot site for Community IMCI, based on Project HOPE's early work in the Oblast.

Cut off from innovations in medical best practice until the 1990s, providers are eager to learn and adapt international approaches in medicine and public health. The context is ripe for change, and doctors seem willing to cede some of their traditional monopoly on information, to a population not only educated but eager to learn more about public health issues that are relevant to their lives.

At the time of this evaluation, active discussions were underway among key donors, technical agencies and the MOH about *prikaz* 155, which mandate some fairly traditional approaches to maternal and newborn care. Under the *prikaz*, a pregnant woman is required to see her doctor no less than 14 times during her pregnancy and to enter the hospital 2-3 weeks before her delivery date.

The Project cycle coincided with presidentially proclaimed Year of the Healthy Generation (2002) and Year of the Community (2003), giving additional profile to Project activities.

2. Navoi

Navoi was selected by USAID and MOH because of the relatively high infant and mortality rates in the oblast relative to the rest of the country. MMR was estimated to be 58/100,000 compared to a national level of 28/100,000 MMR[4]. In

[3] See Cooper, Belinda and Isabel Traugott, *Women's Rights and Security in Central Asia*, a paper for Advocacy

[4] This statistic is taken from the original proposal, based on 1999 government estimates. Both national and oblast-level statistics have been dropping since then.

an Oblast that generates 46% of GDP with less than 1 million people in a country of 23 million, this was clearly an embarrassment.

In addition to the sixth largest gold mine in the world, Navoi is home to significant chemical, pesticide and herbicide industries. Forty-six percent of the cement from the Former Soviet Union was produced in Navoi. With this level of industrialization, air and water pollution are significant public health issues. Interestingly, however, the Oblast Governor (*Hokim*) reportedly subsidizes national contributions to the health delivery system through mandatory "contributions" from these factories. According to the Deputy of the Navoi Ministry of Health, 84% of the annual Oblast budget for health (some $1 million) comes from local contributions. Project inputs and humanitarian assistance are in addition to this amount. At the present time, Project HOPE appears to be the only International agency with a program in the Oblast, though ADB and the World Bank loans will provide infrastructure support in the near future.

The pilot rayons of Navoi and Kiziltepa, selected in consultation with the Oblast MOH, are more accessible than others in the oblast, and proved a good starting point for the Project.

II. Results and Impact

A. Overview

This Project arrived at the historical and institutional confluence of a number of trends in Uzbekistan and appears to have gauged the situation and timing quite accurately in its design. With a well established health delivery system hungry for new information and knowledge, and only a limited tradition of community-based public health outreach, the Project began with the delivery system, moving out to the community once it had the confidence of public sector leaders. Every new activity began with foundation-laying partnership dialogue—a multi-agency Steering Committee that vetted workplans on a regular basis, orientation meetings on new technical approaches with senior decisionmakers, community-based "makhalla" committee meetings to consider new outreach mechanisms. In addition, the fact that Project HOPE was the only international agency working in health in the oblast, the physical location of the Project office inside of the oblast MOH, and the collegial style of the team all helped to build trust and strong partnership that propelled the Project forward. Strong, entrepreneurial leadership within the Project and a positive, "never say no" attitude to requests for inclusion in training and other activities, effectively extended the purview and impact of the Project well beyond the Oblast.

The cascade approach to provider in-service training, and in particular the way master trainers were identified and trained, proved highly effective. Although courses focused on specific topics—breastfeeding, IMCI, reproductive health—

the cumulative impact of all of these trainings appears to have affected systemic changes, particularly related to provider-client and supervisor-subordinate relationships. The fact that so many MOH staff benefited from this training, and that the Oblast became a focal point for training for other Oblasts and Medical Institutes brought further kudos to the Navoi MOH and enhanced the partnership.

Community outreach activities have grown in an organic way from this partnership, seemingly without any government resistance. It also sets the stage for an extension in which strategies to address more sensitive issues such as adolescent reproductive health, and the involvement of men and grandmothers, and potentially support to local NGO's tackling domestic violence can be launched.

This section reviews results of specific technical foci of the Project based on available data and information gathered in the context of the evaluation. The goals, objectives, and intervention mix is provided in Annex F. Table 1 summarizes data from the baseline, midterm and final KPC and HFA's based on indicators from the Detailed Implementation Plan (DIP). For sampling methodologies, during the most recent final surveys (July 2003), including clusters (makhallas, and health facilities surveyed) please see Annex C.

Table 1. Project HOPE/Uzbekistan Navoi CS-16 Program – Key Results

Indicator	Baseline April 2000	Mid-term March 2002	Final July 2003	DIP Target	Source	Notes
A. Maternal and Newborn Care						
1. % of health staff in target area using protocols for delivering quality antenatal and post-services	0%	100%	100%	80%	Project HIS	"Protocol" was interpreted as *prikaz*—govt. edict—so that it was assumed that 100% of providers were following the *prikaz*. Although there is a protocol (algorithm) inside, this was not what was understood.
2. % of pregnant women screened for priority STDs	61%	N/A	84%	80%	HFA	Data shows the % of pregnant women screened for syphilis.
3. % of deliveries managed with partograph	0%	0%	100%	70%	HFA	Random sample of records collected from the 3 Baby Friendly hospitals in pilot rayons where the partograph was introduced after the mid-term review.
4. % of providers following other established protocols for delivery and newborn care	0%	100% for BF	100% for BF	70%	Project HIS	Same as #1- interpretation of protocol as *prikaz* At the present time there are no *prikaz* for Safe Motherhood, only breastfeeding.
5. % of health facilities using brochures for health education	0%	30%	IMCI: 100% SM: 54% BF: 92% RH/FP: 92%	100%	HFA	"Health facility use" interpreted as "availability of health brochures in clinic" based on HFA observation. At the baseline, only the Only limited SM IEC materials were available for distribution. The midterm only covers availability of Mother Reminder Materials (IMCI)
6. % of health facilities providing classes for pregnant women and their partners and new parents	N/A	N/A	66%	50%	HFA	If either the mother, or mother and a partner (husband or mother in law), attended a class, they were counted. No prenatal classes were offered before the midterm.
7. % of women report improved nutrition during pregnancy and lactation	a. 58% b. 50% c. 20%	N/A	a. 82% b. 44% c. 45%	50%	HFA a. Client exit interview b. Provider observation c. Provider observation	The questions in the HFA focused on whether correct nutritional advice had been provided, as a proxy for improved nutritional status.

Indicator	Baseline April 2000	Mid-term March 2002	Final July 2003	DIP Target	Source	Notes
B. Breastfeeding						
8. % of women in baby-friendly hospitals breastfeeding within an hour of delivery	50% within 1-8 hours	89%	87%	75%	KPC	The question changed from the baseline, which asked about breastfeeding within 1-8 hours. In the mid-term and final the question specified 1 hour after delivery. Also, respondents in the final survey were all from Baby Friendly hospitals.
9. % of women breastfeeding exclusively for the first 4-6 mo's	9% (<4m)	58% (<4m) 42% (<6m)	78% (<4m) 74% (<6m)	30%	KPC	Interviewed women with children under 2 years
10. % of women with children <6m that report breastfeeding on demand	N/A	99%	99%	50%	KPC	The question was not asked in the baseline. Significant achievements in this regard are based on intensive provider training and community IEC.
11. % of women still breastfeeding at 20-23m	N/A	55%	63%	50%	KPC	The question was not asked in the baseline. Significant achievements in this regard are based on intensive provider training and community IEC.
12. # of maternity hospitals with UNICEF baby friendly certification	0	2	3	2	HIS	
13. # of health providers trained to provide lactation counseling	0	194	390	60	HIS	
14. # of breastfeeding support groups (motivators)	0	16	32	20	HIS	32 active "motivators" working in 4 hospitals (3 maternity houses and one children's hospital) and communities. To date, 10, 915 post-partum women have been counseled in BF in hospitals alone.
C. Child Spacing						
15. % of facilities in target area providing three or more FP methods	0%	N/A	86%	80%	HFA	At baseline, three or more contraceptive methods in facilities did not exist. At midterm, this subject was not observed.
16. % of women receiving FP/child spacing counseling during an antenatal visit and/or post-partum hospital stay	42% (Antenatal Visits) 50.7% (Post-partum stay)	96%	82% (Antenatal Visits) 97%(Post-partum stay)	70%	HFA	Midterm averaged antenatal and post-partum visits. The mid-term HFA results include "health provider discussed the issue of FP/contraception" (results=96%); "health provider explained different contraceptive methods" (result=87%)
17. % of unmet demands decreased	N/A	17%	24%	30%	KPC	Measurement refers to knowledge of providers. Definition of "unmet need" refers to an increase in the practice of providers to counsel women on her needs for contraception. So: at the mid-term, 24% of women were

Indicator	Baseline April 2000	Mid-term March 2002	Final July 2003	DIP Target	Source	Notes
						"told" what to choose, and 76% were able to make an informed choice. The mid-term KPC captured responses from Baby Friendly hospitals only. The Final evaluation included women delivering in all facilities in the pilot. Measurement refers to knowledge of providers. The mid-term KPC captured responses from Baby Friendly hospitals only. The Final evaluation included women delivering in all facilities in the pilot.
D. IMCI						
18. % of trained providers at SVPs and polyclinics following IMCI protocols for sick children a) all danger signs assessed b) prescribed antibiotics when not needed c) nutritional status assessed d) children's vaccination card checked e) caretakers were told when to return for follow-up	 2% 38% 23% 16% 51%	 91% 0% 81% 86% 92%	 74% 0% 88% 32% 63%	80% for each indicator	HIS	18b) is problematic in the way it was formulated given the 80% target. Also, data collection and the formulation of questions varied for each survey. 18a) and e) may have spiked at the mid-term because this fell immediately after IMCI trainings.
19. C-IMCI materials in use by pediatric and maternity hospitals, SVPs, polyclinics, community outreach staff, and caretakers	0	30%	100% in Health facilities. 98% use of caretakers.	N/A	HFA KPC	Use of Mothers' Reminder Materials
20. % of children aged 12-23 completely immunized (including Hep. B vaccine)	N/A	N/A	82%	80%	HFA	Did not measure at baseline or midterm. Staff feels that final survey number would be much higher if Hep B were not included in indicator.
21. % of diarrhea cases among children <2 treated with ORS and/or recommended home fluids	29%	N/A	41%	60%	HFA	Sample size due to seasonality gave insignificant results—not enough children with diarrhea. Also, community outreach in this area is relatively recent, only starting in December, 2002.
22. % of children under 2 with diarrhea in the last 2 weeks who receive same or more amount of solids	5%	77%	79%	60%	KPC	The number of actual diarrhea cases identified during all surveys was very low due to seasonality, hence the results may be invalid.

Indicator	Baseline April 2000	Mid-term March 2002	Final July 2003	DIP Target	Source	Notes
23. At least 50% of caretakers provide additional meals to children while recovering from diarrhea/pneumonia, and other diseases	4%	24%	52%	50%	KPC	At baseline, took average of diarrhea and pneumonia cases. At midterm, only examined diarrhea because there was an insignificant sample of pneumonia cases. For final evaluation, combined both diseases. No "other diseases" were ever tracked.
24. Mothers reporting 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)	50.9%	N/A	83% (2 practices) 73% (3 practices) 48% (4 practices)	N/A	KPC	Indicator not in DIP, but nonetheless a proxy for IEC impact.
25. Mothers reporting improved feeding practices for children under five, including Vit. C, Vit. A, and iron-rich foods	N/A	N/A	63%	N/A	KPC	Indicator not in DIP
26. % of mothers who are able to list danger signs for diarrhea and pneumonia: a) high fever *b) fast or difficult breathing* c) sickness getting worse d) not breastfeeding or drinking *e) blood in stool of children*	N/A	 86% 43% 59% 38% 23%	 89% 5% 48% 16% 29%	 70% for each indicator in this category	KPC	Although indicators "fast and difficult breathing"" or "blood in stool of children" are not considered danger signs under evidence-based protocols they were included in IEC materials to give mothers more information about symptoms.

KPC: Knowledge, Practice, and Coverage; HFA: Health Facility Assessment; HIS: Project HOPE tracking system

1. Data issues

The data presented in Table 1 is problematic in terms of accurately describing Project impact. Some of the indicators were either not clearly articulated or misunderstood by staff, respondents, or both. The wording of questions changed over time and in some cases completely new questions were inserted for some indicators. Data was not collected at the mid-term for a number of indicators. Many indicators are actually two indicators rolled into one. All of these factors make a longitudinal assessment of change challenging if not impossible.

The right-hand column of Table 1 highlights specific issues with each indicator, including caveats to analysis. This has been extensively reviewed with Project HOPE Navoi staff. A number of additional indicators, drawing data from the Project HIS, have been added to supplement the DIP indicators at the end of Table 1.

These findings highlight a number of weaknesses in project planning and implementation which internal stakeholders acknowledge merit attention in the extension. Specifically:

- Indicators were not clearly articulated or understood by local staff
- KPC and HFA instruments were not carefully pre-tested, or translated (and back translated) to ensure accuracy in meaning
- The link and correlation between specific indicators and data points from the KPC, HFA as well as the plethora of other HIS data being collected in Navoi was not clearly established at the outset
- Project HOPE Navoi staff received insufficient technical assistance in Project monitoring to enable them to maximize the use of data for decisionmaking.

Having said this, the data in Table 1 is accurate in parts, and, taken in tandem with the triangulation of other data sources gives some indication of trends, if not impact. Training data, provided in Tables 4 and 5, give an indication of the depth and breadth of training activities, which absorbed a significant amount of Project attention and resources. The use of formative research mini studies (on awareness and practices related to maternal, infant and child health and danger sign recognition, contraception and father's participation on pregnancy, among other topics) though methodologically uneven, was nonetheless critical in deepening and detailing understanding of knowledge and behaviors related to key interventions. This research was, arguably more important in shaping IEC materials than statistical data generated from other sources. Unfortunately, because it was formative in nature with only tenuous links to the KPC or HFA, it provided little in the way of a baseline for monitoring the impact of IEC materials.

Feedback from the evaluation focused attention on the pilot nature of the Project, which will continue to rely on accurate, compelling data to understand the potential for new innovations from the Navoi "laboratory" for oblast or national

replication at scale. Project HOPE Navoi staff fully grasps this, and it will be up to Project HOPE/US to support them in refining systems and skills for better data collection and management in the extension period.

Recommendations for the extension:

1. Project HOPE should prioritize the provision of technical assistance for data management. Technical assistance support should begin with but not be limited to DIP development, and should focus on refining and redefining indicators and corresponding KPC and HFA and Project HIS instruments. TA should ensure that systems, tools and skills within the Project maximize the opportunity to measure the impact of specific interventions (in terms of results and cost).
2. Both quantitative and qualitative systems, approaches and skills should be supported in this regard and all staff, not just the HIS expert, should participate.

B. Results of specific interventions

In hospitals with Baby –Friendly Certification, new mothers and infants room-in, and infants are fed on demand --a radical departure from the past.

1. Maternal and Newborn Care MNC (35%)

Although the Project made significant impacts in aspects of Newborn care, particularly related to clinical and client practices during and immediately post-partum, Safe Motherhood interventions were only getting started towards the end of the project. In part, this may have reflected the absence of Safe Motherhood *prikaz*, which were only issued towards the end of the Project's life.

Orientation and training, particularly for providers in maternity facilities, has clearly precipitated a significant shift in thinking from traditional ways which over-

medicalized pregnancy and childbirth. The UNICEF-certified Baby Friendly facilities in both pilot rayons have become the flagship for change in MNC practice. Use of the partograph (introduced by the Project) is universal in these facilities, and doctor's attribute improved outcomes from labor with their use. Similarly, doctors and clients in these facilities attribute drops in mortality among infants to new rooming in and breastfeeding practices, which have been extremely well received and easily adopted in all facilities.

The Project was able to help three maternities transition to Baby Friendly status in a way that was appropriate and sustainable. This was in part possible because existing infrastructure was relatively well established and well maintained (although water availability was an issue in one place that was visited). The donation of rubber balls and foam mats to aid in delivery, and a small budget for decorating the labor room, transformed otherwise sterile, doctor-centered environments into more welcoming rooms. The legs of cribs have been sawed off to allow eye contact with mothers in the wards, and rooming-in is the new norm.

Traditional restrictions on partners in the labor room have eased significantly with an understanding about the need for "clean" versus "sterile" environments for delivery, and there is much talk and interest in husbands coming into the labor room. Interestingly, doctors and women seem more enthusiastic than husbands about this prospect. Several doctors mentioned that with the husband in the room, there is less likely to be unfounded blame for unforeseen complications affecting the mother or the infant. Another advantage, cited by both women and providers, is the respect and bonding that sharing this experience evokes. At present, mothers'-in-law are more likely to attend a birth, though there is definitely a trend towards husbands in attendance. Women also reported that providers are more friendly and sympathetic during labor than they were in the past. All of these factors are directly attributable to the Project.

The Chiefs of both the Kiziltepa and Navoi Rayonal maternity hospital provided similar statistics, reflecting a drop in infant mortality and morbidity since IMCI activities began. Both attribute this to new technical knowledge and client awareness. The Chief of the Kiziltepa hospital remarked: "It is good to train the common people rather than control them". Observers also acknowledge that new approaches save money. Doctors used to over-proscribe hormones, vitamins and unnecessarily long hospital stays.

Table 2. Infant morbidity and mortality in Central Rayonal Hospitals

Year	Babies in ICU--Navoi	Infant mortality--Kiziltepa
2000	N/A	14%
2001	103	12%
2002	83	12%
2003	34	7%

During year 3, over 200 neonatologists and OB/GYNs were trained in Promoting Effective Perinatal Care (PEPC) based on WHO guidelines. Nine TOT's were also trained. During this period, a neonatologist from the region conducted an in-depth assessment of training needs and some initial training in these areas[5]. To date, 7 TOT's have been trained in Promoting Effective Perinatal Care (PEPC) and others have had some exposure in this area. It is not clear how much follow up has been provided, or is available. IEC on these topics has been delayed, and the extent of awareness of danger signs in pregnancy among women and their families is unknown.

The other urgent area that received insufficient attention over the life of the Project was maternal nutrition, particularly related to anemia, estimated by some to be as high as 80% among pregnant women[6]. Questions to mothers and providers at all levels during the course of the evaluation corroborates the HFA data (Indicator 7) that providers in particular lack correct information about which locally available foods are iron rich.[7] This is an urgent need, and, given the credibility of the Project among providers and communities alike, an informational campaign about maternal nutrition is like to have rapid and maximum impact.

Addressing the issue of anemia through reliance on iron pills, on the other hand, may be problematic. Although these drugs are supposed to be free to pregnant women, the supplies are so sporadic that in most places they are only available at a cost, which is beyond the reach of most families.

The DIP also anticipated interventions to "introduce the provision of one megadose of vitamin A to women immediately post partum and promote the use of iodized salt with iodine deficient pregnant women." No data is available about either of these interventions and neither were they mentioned in interviews in the field.

The Project took some steps towards addressing the punitive approach to maternal mortality review that plagues the health system and prevents learning. This is clearly a "current" issue, in which Project staff has participated. Most staff and observers describe the system as one in which Doctors are (tacitly) encouraged to falsify information because of the unnecessarily severe

[5] National level trainers were brought in for the first round of trainings after which TOT's were trained, including 2 doctors and 1 nurse midwife.
The 5-day Ob/GYN training covers antenatal care, partogram management, postnatal care and delivery management.
The 4-day neonatologist training includes: newborn care (sick and healthy), asphyxia, newborn resuscitation, and breastfeeding. A one-day course for neonatologists and neonatal nurses on breastfeeding was carried out previously.

[6] Personal conversation, Ihtiyar Ochilov, Chief of the Kiziltepa rayonal maternity (a Baby-Friendly hospital)

[7] Questions to providers and mothers in the very small sample of evaluation respondents revealed a better-informed clientele than doctors.

punishments incurred by maternal deaths. A briefing on the topic by the Deputy of the Oblast MOH described a process in which patient rights were being protected by this review that, in her view, only recommended cases for further investigation where the medical review panel considered the health provider to have demonstrated blatant neglect to higher authorities. Clearly, more work needs to be done to rectify practice and protocols in this regard.

Recommendations:

1. Safe motherhood--particularly upgrading emergency neonatal and obstetric care practices, prevention for primary care providers, IEC about danger signs among pregnant women and their families, and nutrition education for pregnant women—require immediate attention in the extension project.

2. The planned establishment of a Safe Motherhood center in Navoi should provide a focal point for training, monitoring and IEC outreach.

2. IMCI (35%)

Probably the most important impact of the Project on national policy and practice was in the area of IMCI. Early in the Project, Navoi was designed one of three pilot sites for IMCI under the MOH's health reform initiative. According to the Director of the National Pediatric Research Institute, (who chairs the national IMCI task force), Navoi is the only site where all three components of the IMCI protocol (upgrading provider skills, improving delivery systems and community awareness) were developed. Project HOPE participated on the national IMCI task force, and made significant contributions to the adaptation and translation of IMCI manuals and protocols, now used throughout the country.

Local impact was also significant, based on a combination of provider training and IEC materials dissemination. With a focus on primary care units (SVPs), a total of 145 providers were trained in the target rayons, including 11 master trainers (TOTs)[8]. The Project helped to establish and resource an IMCI Center in Navoi City which hosts training, including training for providers and TOTs from other oblasts and medical institutes.

Providers report a transformation in attitudes towards clients, a sentiment echoed by the Deputy of the Oblast MOH who recalled how in the past infant diarrhea was cause for hospitalization. The IMCI approach helped usher in greater client control over knowledge, prevention and care.

Formative research conducted by Project HOPE in collaboration with the National Pediatric Research Institute helped to inform the production of a 31 page illustrated booklet with information on breastfeeding, child nutrition, home treatment of child illnesses and danger signs requiring medical attention. These "mother reminder" materials were co-financed with a global grant from

[8] TOT, generically training of trainers, is used in the Navoi Project to refer to the PERSON who has received training and certification to train trainers.

GlaxoSmithKline, and appear to have been widely disseminated and read in the target rayons. The booklet doubles as a take-home record of the child's vaccination and height/weight history, with prompts for the mother about the timing of necessary vaccinations. Companion posters were also developed

Impact beyond the target rayons is significant, considering it was not in the original planning. IMCI has been integrated into preservice curricula at Samarkand and Bukhara Medical Institutes—two prominent medical schools in the country. Twenty-eight TOTs remain in place in these two institutions, offering the 11-day IMCI training as an adjunct to the normal medical school course, until such time as further integration is nationally mandated.

Providers were unanimous in their enthusiasm for the IMCI approach. One clinic even suggested that despite the onerous government reporting requirements already in place, they appreciated the IMCI protocols (provided by the Project) so much that they were concerned they would run out of forms before a new *prikaz* made them available from the government.

Although the Project has been instrumental in promoting a paradigm shift in thinking and practice at service delivery and policy levels, two issues will need to be addressed to ensure quality and sustainability:

1. Monitoring and Supervision: IMCI requires not only a shift in thinking about prevention and treatment, it requires providers to add new facts to their knowledge base, and new approaches to their client interaction repertoire. This is never an overnight proposition for adults with entrenched habits, or systems with traditional, firmly established ways of operating. Monitoring on-going supervision and refresher mentoring or training are essential if this new approach is to maintain consistent quality.

   The data in Indicator 18a) in Table 1 is instructive in this regard. Many of the providers were trained immediately prior to the midterm, which may account for the spike in recognition of danger signs (91%). The Project's protocol specifies that TOT's make supervision and monitoring visits at 1 and 6 months after their 11-day course. This is an opportunity for trainees to get feedback (based on observation) and for TOT's to collect data on information retention (based on written tests). It is noteworthy that by the final evaluation, two years after much of the training, and over a year since the last monitoring visit, proper assessment of danger signs had dropped to 74%. This is still a good outcome, but foreshadowing, perhaps, a further decline in quality and consistency. The need to integrate monitoring and supervision for IMCI as well as other new approaches in a way that supports, encourages and reinforces new practices, is essential. See Section IIIC. for more on this.

2. Drug supply. IMCI relies on availability of 12 essential drugs. While donations from Project HOPE supplemented availability of many of these

drugs, they were not all available during the life of the Project and the situation is likely to get worse as donations stop. Systemic alternatives to ensuring drug availability are being piloted in the context of broader health reform that anticipates a user pay system, as described in Section IIID. below.

The flipside of the drug issue is the fact that over-proscription of antibiotics to treat diarrhea and other childhood illnesses has waned significantly (see Indicator 18). Though data being collected Z'drav Plus will estimate exact figures, this cost savings to the MOH and parents alike is reportedly not insignificant.

3. Breastfeeding promotion (10%)

A significant impact of the Project has been on breastfeeding awareness and behavior. Exclusive breastfeeding in the first 4-6 months rose from 9% at baseline to 78% (<4m) at the final evaluation. Nearly 250 providers have received formal training in the pilot rayons, and an equal number in non-pilot sites. Seventeen master trainers are now available in Navoi. Maternities have been proactive in training *all* staff in the fundamentals of breastfeeding. In tandem with Baby Friendly certification, this seems to have catalyzed a transformation in business-as-usual in these facilities.

The Project produced effective IEC materials for breastfeeding promotion. Many of the Maternities visited during the Project displayed innovative posters—created by clinic staff--exhorting viewers to recognize the advantages of breastfeeding. In line with UNICEF requirements, all baby friendly hospitals have established hot lines to encourage post partum women or their families to ask questions after they leave the maternity. The phone numbers are posted in every ward.

Probably the most innovative aspect of the Project's community outreach strategy is the female breastfeeding volunteers—described in more detail in Section III E. below. A unique aspect of this approach has been the meaningful way in which volunteers have become part of the clinical team, offering regular breastfeeding seminars for immediately postpartum women. A series of community competitions—including dramas, music and informational quizzes--have generated additional interest and enthusiasm, engaging a crossection of the population in the target rayons.

IEC interventions appear to have raised awareness far beyond the traditional targets (women and men in their reproductive years). Older men who were interviewed in the evaluation were unshy about identifying specific advantages of breastfeeding with impressive accuracy. The introduction of these "new" breastfeeding approaches coincides with a resurgence of cultural re-identification in Uzbekistan. Many older informants commented that breastfeeding is recommended in the Koran, but that it was "forgotten" during the Soviet time when artificial feeding was the norm. The importance of approval from this older

cohort cannot be underestimated, and may be a factor in the rapid acceptance of this behavior.

4. Child Spacing

The Project has made significant strides in creating a context in which providers and clients *expect* choice, and expect to discuss choice based on the individual needs and preferences of each client. This is an important development in a context in which the IUD and induced abortion[9] were considered the only options.

Despite the fact that the government offers significant incentives for additional children—subsidizing two years of maternity leave for an unlimited number of children—birth rates have been dropping nationally for a decade. Community members acknowledged this trend, attributing it to the cost of raising a child in these tight financial times. Nonetheless, the head of the Navoi Rayonal Hospital credits the Project's reproductive health initiatives with some of this drop, noting that in 1996 there were 2600 births/year compared to today's 1600 births/yr[10]. Based on available data, it is impossible to substantiate this view. Nonetheless, there is no doubt that the Project has expanded the opportunities for informed choice.

The Republican Reproductive Health Center carried out formative research on attitudes and preferences, which informed the preparation of a flyer on contraceptive options. In total, 387 providers were trained in RH issues (228 in the pilot rayons), about half of them midwives. Last year, the Project arranged for 13 OB/GYN's to receive training in minilap procedures, and provided minilap kits to oblast and rayonal hospitals[11]. Some facilities have also undertaken training for patronage nurses who do home visits. HFA data indicates that 86% of facilities now offer three or more methods. During the project, a UNFPA donation of IUD's, injectables and pills, significantly increased availability, though not sufficient to meet demand.

The Project has been proactive in seeking to understand and engage with key RH decisionmakers—husbands and mothers in law. Consistent with changes in provider-client relations Project-wide, not only has contraceptive counseling increased for ante and postnatal women, but partners have been encouraged to participate in these sessions. The forthcoming formative research on the role of mothers in law in decisionmaking on reproductive health and maternal and child

[9] According to Dr. Feruza Tulaganovna Fayziev, Director of the Republican Reproductive Health Center, there are some 217,000 abortions/year in Uzbekistan. According to the DHS (2002), abortion is actually on the rise—at 0.9/woman in 2002, compared to 0.7/woman in 93-96. The DHS (2002) reports 52% of contracepting women using the IUD.

[10] A senior midwife from one Kiziltepa primary clinic (SVP) also attributed Project inputs to the dramatic drop in birth rates from 300 in 1999 to 205 in 2001.

[11] There is some concern that Drs. may be promoting sterilization, as an alternative to IUD's without given women enough information on this and other options. More investigation is necessary to ensure this is not happening.

health decisionmaking more generally will help to target these important household "gatekeepers" in supporting appropriate client choice.

Despite Project efforts, it appears that the IUD is still the contraceptive of choice if not least resistance for both providers and clients. Women leaders talk about it as the "cheapest and easiest" method, and admit that doctors are still promoting it. They prefer a heavy period to none (with the injectable), and most appear not to understand the connection with endemic rates of anemia.

One of the DIP objectives was to increase the percent of women who purchased a contraceptive method. While this is probably happening irrespective of the Project, due to inconsistent availability in government facilities, the reality is that contraceptive pills cost the equivalent of half a month's salary. If the Z'drav Plus cost survey reveals trends in this regard, the Project may be able work with the Navoi MOH to incorporate these findings into their planning, including piloting creative solutions to contraceptive availability.

Recommendations:

1. Contraceptive availability will continue to hamper efforts to offer a range of options to clients. Offering information does not necessarily lead to changes in consumer behavior unless costs are reasonable. More information on household spending patterns on contraception, particularly in light of the drop in desired family size, would enlighten the design of appropriate social marketing mechanisms for contraceptives.
2. User pay drug schemes should include contraceptives.
3. Side effects of different methods should be stressed, particularly the implications of heavy bleeding on anemia for women entering their reproductive years.

C. Adolescent reproductive health

The extension project will add a component focusing on adolescent reproductive health. Funding from Project HOPE/Switzerland will help to do the formative research to get this started. The Project is strategically poised to undertake this initiative, and communities appear ready to grapple with it as well.

As in most parts of the world, young men and women are growing up in a socio-cultural environment that is very different from their parents. Based on interviews with parents and grandparents—many of whom are formal and informal community leaders--during the evaluation, the resistance to change that is typical from the older generation was surprisingly absent. Adults understand that young people need more information and guidance before marriage, and appear to welcome an outside agent of that information. Indeed, one community leader lamented: "Adolescents are 10% of the community, but they are our major headache." To explain, he mentioned that there were not enough cultural things to do, that because of large families, adolescents went out without much

restriction, and were difficult to control. Anecdotal information indicates that premarital sex is on the rise.

At present the schools offer 5-8 hours/year on health issues[12], which touch on anatomy and related topics in the teen years. Yet adults and adolescents alike acknowledge that reproductive health is not a topic parents and children discuss, and adolescents say they prefer to talk to one another about topics that feel more intimate.

Conversations with young people reveal a generation of aware and interested youth, thirsty to know more about their peers in other countries, and inform themselves about about issues that concern them. Some of the key findings from the evaluation that may help in designing the adolescent reproductive health strategy are noted here, including several related recommendations:

- Adolescents want to talk to one another—they prefer to get information about reproductive health from peers.
- Location is important: adolescents feel more comfortable outside of the clinic or school.
- Adolescents read, but they also like to learn from video and movies.
- Some topics that are of particular interest include:
  - Contraception
  - Safe sex
  - Mood swings
  - Relationships with family
  - Relationships with opposite sex
  - Taking care of children
  - Issues facing adolescents in other countries
  - Rape
  - Domestic violence
  - Drugs

Recommendations:

1. Use adolescents to collect data on adolescent knowledge, behaviors and preferences.
2. Peer networking would be an effective way to disseminate information.
3. Be sure to build referral information and good supervision into the strategy to ensure correct information is being disseminated.
4. Appoint an adolescent advisory committee to help in rolling out the strategy, and link this committee to the Project Steering Committee. Link also with makhallas.
5. Generate good IEC materials for adolescents. Use humor.
6. Pilot approaches, measure outcomes, document processes, share learning.

[12] In forms 1-4 this is taught by the PE teacher; in forms 5-9 it is taught by the biology or chemistry teacher.

III. Crosscutting Issues

A. Health Information System

The mid-term review made a number of specific recommendations, many of which were not addressed in the second half of the Project.
Recommendation 10A: "…provide additional training to HIS staff in survey methodology." Project intern Gal Frenkel has a number of HIS objectives in her scope of work. Her six-month internship appears to have been only partially effective due to language constraints and the press of other demands. In addition, the HIS expert who received the bulk of her attention, transferred to the "Healthy Family" Project in Year 3 of the Navoi Project, with little transfer of skills to the new designate.
Recommendation: 10B: "Prepare indicators and questions for the final evaluation in order to ensure comparison of key indicators with baseline and/or midterm survey results." Still problematic, as shown in Table 1.
Recommendation 10C: "…Specifically define indicators to monitor deliveries and quality of antenatal and post-partum care." No evidence this was done.
Recommendation 10D: --- "Change …'20 breastfeeding support groups' to '20 makhalla establish regular meetings with women's support groups'." The Project did not adopt this strategy, but neither did it change the indicator (until prompted by this evaluation, to make it consistent with the approach that it *did* adopt. See Recommendation 10A.

---"Refine the first IMCI indicator to track performance on a set of key IMCI protocols" Problem remains.

Despite the fact that the Project collects a lot of data, information management and use was one of the weakest parts of the program. As discussed above, the KPC and HFA in particular provided little in the way of longitudinal reliability because of poorly articulated indicators and a lack of consistency and rigor with the instrument.

The Government demands a lot of information, placing enormous pressures on clinical staff that is required, in some cases, to fill out myriad forms for individual patients or procedures. MOH officials and facility supervisors alike appear to have data on hand, and to use it for supervision and decisionmaking. The introduction of new ways of data collection—the partograph, the IMCI checklists for instance--have added to not replaced the already onerous information gathering system. The situation is likely to change as innovations in Maternal and newborn care become nationally mandated, with accompanying changes in the national Health Information System.

Although post-training monitoring relied heavily on the Project HIS, and in fact this data was probably more reliable and more useful than the KPC and HFA in terms of planning, it is not clear that the enormous effort of collecting and compiling this data set was optimized. This data *has* been used by the Project to point up areas in need of additional attention in *specific* clinical contexts. The

extent to which it has been used more systemically to identify rayon-wide or Project wide trends, or to find mechanisms for strengthening MOH HIS or supervision systems is questionable.

Special studies, including formative research, were used deepen understanding of community attitudes and behaviors to inform new interventions. These proved more successful than the KPC and HFA, and the data was used to promote Project HOPE's approach at the national level as well. Specific formative studies conducted to date include:

1. Population knowledge level of child health care (n=239)
2. New fathers' research (n=44)
3. Postpartum services assessment for new/first mothers (n=219)
4. Grandmother's role in MCH decisionmaking (qualitative).

The concept of formative research is valid, and appropriate for this pilot Project. Methodologically, the studies are rather uneven, however, and it is unlikely that staff would be able to design their own formative study independent of external TA.

Despite these drawbacks, the Project has been able to make the case for its approach at national level using data drawn from all of these sources. In a playing field with few other voices, and few competing studies on new approaches, this was possible. For the Navoi project to continue to play the role of laboratory for innovative new approaches in MCH, RH and related areas, information management will have to be significantly strengthened.

Recommendations:

Stress the pilot nature of the Project in DIP formulation of the Project. Specifically, the HIS (which includes but is not restricted to the KPC and HFA) should be designed to:

- Monitor impacts and learn lessons from new interventions such as adolescent RH
- Monitor the process of Oblast-level scale up of key activities and extract lessons for national programming
- Identify key data collection approaches and data points which could be effectively integrated into MOH HIS systems to cost effectively support facilitative supervision *and* track systemic performance.

B. Training

Training was a major Project activity, a method of capacity building and institutionalizing new skills in the delivery system. As shown in Table 2 providers from Project rayons as well as other oblasts and other institutions all received training over the life of the project. The type of provider trained is shown in Table 3. In all

- 4 health providers passed 4 different courses
- 57 health providers passed 3 different courses
- 207 health providers passed 2 different courses
- 1215 health providers passed 1 course

The total absolute number of trained providers is 1483.

The column marked “monit” indicates the number of trainees who were monitored—by MOH or Project staff—following the training.

Table 3. Number of trained health providers and conducted monitoring (20.08.03yy.)

Rayons and health facilities	RH			IMCI			Breastfeeding			SM/obstetrics			SM/Neonatoligist			?-IMCI			newborn resuscitation
	trained	monit	TOT	trained	monit	TOT	trained	monit	TOT	trained	monit	TOT	trained	monit	TOT	trained	monit	TOT	trained
Kiziltepa rayon	118	21	3	85	81	6	147	43	4	40	0	2	37	0	1	235	182	6	1
Navoi rayon	110	31	6	49	43	5	98	39	4	30	0	4	17	0	1	137	109	5	1
Total in pilot	228	52	9	134	124	11	245	82	8	70	0	7	54	0	2	372	291	11	**2**
Nurata rayon	12	0	0	20	0	0	9	0	0	0	0	0	0	0	0	0	0	0	1
Kanimeh rayon	23	0	0	4	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Total non-pilot	35	0	0	24	0	0	9	0	0	1	0	0	0	0	0	0	0	0	**2**
Samarkand Med.Institute	0	0	0	36	0	18	13	0	0	0	0	0	0	0	0	0	0	0	1
Bukhara Med.Institute	0	0	0	22	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0
Total in Med.Institutes	0	0	0	58	0	28	13	0	0	0	0	0	0	0	0	0	0	0	**1**
Oblast Maternity House	24	3	9	0	0	0	58	13	3	32	0	2	33	0	0	0	0	0	2
Oblast Children Hospital	0	0	0	1	0	2	89	0	2	0	0	0	20	0	0	0	0	2	1
Navoi city	31	10	0	23	20	7	19	0	1	7	0	0	0	0	4	27	20	7	0
Total other health facilities in Navoi city	55	13	9	24	20	9	166	13	6	34	0	2	53	0	4	27	20	9	**3**
Other rayons	67	0	0	67	0	0	15	0	0	4	0	0	0	0	0	0	0	0	3
Other oblasts	0	0	0	34	0	3	2	0	1	1	0	0	0	0	0	0	0	0	1
Project HOPE staff	2	0	2	2	0	2	2	0	2	0	0	0	0	0	1	0	0	0	1
Total	**387**	**65**	**20**	**343**	**144**	**53**	**452**	**95**	**17**	**115**	**0**	**9**	**108**	**0**	**7**	**399**	**311**	**20**	**5**

Table 4. Trained health providers by discipline

Health providers	target	other	total	target	other	total	target	other	total	target	other	total	target	other	total	target	other	total	target	other	total
Obstetrician/gynecologist	33	52	85	1	2	3	30	28	58	8	1	9	30	41	71						
Pediatrician				52	44	96	10	29	39												1
General practitioner	37		37	60	48	108	20		20												
Internist							7	4	11				1		1						
Infection prevention specialist				2	1	3															
Midwifes	120	125	245				48	50	98		1	1	28	30	58						
Nurses	38		38				76	185	261	40	39	79				369	24	393			
Feldshers				36		36															
Neonatologist				1		1	7	17	24	5	14	19							2	9	11
Other specialists							7	18	25							3	3	6			
Total trained	**228**	**177**	**405**	**152**	**95**	**247**	**205**	**331**	**536**	**53**	**55**	**108**	**59**	**71**	**130**	**372**	**27**	**399**	**2**	**9**	**12**

Trainees were typically chosen by the MOH, ordered via *prikaz*. As trainees participated in a given course, Project HOPE and other trainers observed them, selecting those they felt would make good trainers. These individuals were then given several days more training in adult learning techniques, to give them the skills of a TOT. Project staff regularly drops in to trainings to give feedback, but are co-facilitating less and less. TOT's interviewed seem confident and capable of planning and delivering training independent of Project staff. TOTs have pretests already prepared that help them plan, based on trainee knowledge, and posttests are also in place. TOT's are also responsible for monitoring at regular intervals after the training. Project staff continue to conduct monitoring visits in conjunction with TOTs.

As shown in Table 4, the overwhelming majority of trainees were doctors, most of them specialists. Because of the current structure of the health delivery system, this is not surprising. However, the leaner and more prevention-oriented system of the future is likely to rely on lower level staff, and in particular nurses and midwives to provide basic education, counseling and primary services. Although some of the trained specialists have made an effort to pass their new skills to these staff, the Project should make them a priority as well.

Table 5 provides a snapshot of the numbers and levels of training provided to TOTs. TOT's are scattered throughout participating facilities, and, in addition to performing their usual jobs, they are called to deliver training. A total of 106 TOT's were trained.

Table 5. Master Trainers (TOT's) Trained by the Project

	Number of TOTs who passed….				
Rayon	**1 TOT course**	**2 TOT courses**	**3 TOT courses**	**4 TOT courses**	**Total TOTs**
Kiziltepa rayon	15	-	2	-	17
Navoi rayon	13	1	1	-	15
Total in pilots	28	1	3	-	32
Navoi city	21	3	2	-	26
Other non-pilot rayons	4	-	-	-	4
Other oblasts	42	-	-	-	42
Project HOPE's staff	-	-	-	2	2
TOTALS	95	4	5	2	106

Much has already been said about the impact of training—in terms of technical updates and changes in supervision systems and client relations. The introduction of adult learning techniques appears to have altered attitudes and approaches both inside and outside of preservice training institutes.

1. Certification

Providers who have successfully completed a training course are awarded a certificate. Many have hung them proudly in their examining rooms and offices. While it is certainly important to let colleagues and clients know that a given provider has received special training, the extent to which these certificates are being used as certification of *achievement* is problematic. Passing a course is not the same as mastering a skill. Indeed, IMCI trainees receive no less than 3 monitoring visits in the first year to ascertain retention and correct practice of new skills. And often, because many of the Project's courses introduce new information and require new behaviors, more training, coaching and mentoring is required before genuine certification of mastery is actually appropriate. This is a national issue, not isolated to the Project. It has significant implications for quality. The current system, in which a final certificate is awarded before practical application is observed, sends a message that taking a course is sufficient to acquire the new skill. This is an unfortunate message.

Recommendations:

1. Nurses, midwives and general practitioners should be prioritized for future training in preventative and primary skills.

On certificates:

2. Provide trainees with a letter of thanks for attending Project courses. Award certification after at least 3 monitoring visits (including written tests) ascertains a pre-established level of expertise.
3. Make the certificate time bound, and award higher certificates for providers who attend refresher courses.

On maintaining quality training:

4. The role of the IMCI, RH and soon to be established SM centers in Navoi need to be clearly defined for the future. At present they host training. However, they should also enable TOT's to get refresher updates by maintaining rosters of master TOT trainers in Uzbekistan and the region and organizing courses with them. The Centers should also monitor new developments in their respective fields and have budget to disseminate this information through a newsletter or other means.

C. Supervision

Initial delays in implementation and the press of other demands did not allow the Project to implement Quality Assurance activities, which were originally planned. As a result, while skills and supervision systems have had benefited from training, supervision systems remain more or less as they were, and the institutional framework for reinforcement and support of new practices—both technical and supervisory—fragile at best. Indeed in one SVP, probing questions about supervision of patronage nurses revealed lingering punitive attitudes towards supervision. Staff reported that when a patronage nurse is found to be falling short in performance they ask her to "stand up and morning conference so we can tell her not to do it." Clearly, while the good intentions are there, theory has not penetrated consistently or completely.

Recommendation for health facilities:

Receptivity at all levels of the health delivery system to a new approach to supervision is high, and QA interventions are likely to be quickly absorbed and adapted. Supervision

systems that enable continuous reinforcement of QA approaches are critical to ensure sustainable institutionalization.

D. Drug supply

Table 6 provides information on Gifts in Kind donations provided by Project HOPE over the life of the Project

Table 6. Gifts in Kind from Project HOPE to Navoi Oblast MOH

Item	$ Equivalent donation
Books	300
Pharmaceuticals	641,934
Medical supplies & equipment	198,774
Other	1,568
Total inventory	841,009

Some of the interventions introduced by the Project rely on a steady supply of drugs to maximize their impact. IMCI, for instance, requires some 12 different drugs. Treatment of micronutrient deficiencies requires iron folate, vitamin A and other drugs. Greater contraceptive choice implies availability of methods. Consistent availability was reported as problematic. Although most drugs are supposed to be free to children under 5, women of reproductive age and others consistent availability of all of these categories of supplies was reported as problematic. Patients are currently paying for iron folate, for instance, because supplies are insufficient. The upshot is that only the small number of those who can afford these drugs have access. In addition, several Project Steering Committee representatives suggested that too much emphasis has been placed on stocking hospitals at the expense of Primary Care Units.

Although many drugs are supposed to be free of charge in the current system, unavailability of many essential drugs means that in fact consumers are forced to buy them from private pharmacies. In the Navoi case, “donations” leveraged from commercial investors, Project HOPE, and, in the case of contraceptives, UNFPA during the last 4 years have also helped fill the clinic shelves. Over the life of the Project, HOPE donated a total of $641,934 in pharmaceuticals. While this filled some gaps in availability, and was highly appreciated, it does not solve the problem.

The system is likely to change with health reform initiatives. A soon to be released study on willingness to pay for drugs conducted by Counterpart International indicates that people are indeed willing to pay for drugs to ensure availability. Counterpart is piloting an approach to clinic-based village pharmacies in Karakalpakstan Oblast. Save the Children has piloted a revolving drug scheme in Tajikistan that is slated to be piloted in Uzbekistan under Project HOPE’s Healthy Family Project.

Recommendation: Review alternative models for ensuring drug availability to support Project interventions, and consider piloting community-based cum clinic-based revolving drug scheme approach in the extension Project.

E. Community mobilization

As capacity in the health delivery system has been upgraded, community outreach activities have built upon a solid foundation of trust with the MOH, local and community leaders, and well-designed IEC materials. The Deputy MOH cited community engagement and awareness of health issues as the most important change resulting from the Project.

In some senses, the provider training launched the community outreach program, as providers began to see their role in informing, advising and educating clients. Adult learning methodologies, which underpin all trainings, offered a new participatory, problem-solving framework for behavior change.

At the midterm not much community outreach activity was observable in the Project. The last year saw significant activity in this regard. At the end of the Project, the community mobilization strategy includes a number of intertwining approaches, each of which bear additional investigation in the extension to assess their appropriateness for scaling up.

In the Oblast level final competition, women perform a skit highlighting home-based care of diarrhea.

1. Competitions

To raise the profile of key issues with the community, the Project used a popular event format for disseminating its message. Uzbeks seem to revel in competition, and panel quizzes on various informational and academic topics are a familiar and fun activity. Using the Mother Reminder booklet as the informational basis, the Project sponsored a tiered approach to competition, starting at the makhalla (community) level up through the rayon to the oblast level. In all, 19 pre-qualifying competitions were held before the final. The competition included dramas and fact quizzes. The final, oblast level competition was judged by a panel from the Project, MOH and Oblast governor's office. The prizes: a TV set for the winner and tape decks for 3 runner's up—all will be housed in community buildings.

The competition as an approach appears to have been a high profile, popular event. What is less clear is how far its impact has reached, how many people actually engaged in the process, and what kind of lasting impact it has had on awareness and behavior change. Before replicating it with other messages, in other places, this should be considered in the extension.

Recommendation about competitions:
Conduct a quick analysis of the cost and outcomes of competitions based on KPC and Project budget data to assess whether this is a viable strategy for replication at scale.

2. Makhalla Committees

Consistent with the design of many community health projects, the Project identified an existing community leadership structure to help garner support and establish legitimacy at the community level. The Makhalla is a multi-tiered structure in which community representation is elected at the grassroots that then nominates representatives to rayonal and then oblast levels. The community makhalla is responsible for oversight of social issues—from dealing with alcoholism to managing major religious events, as well as oversight of community infrastructure (water, roads etc), and playing a welfare function with poorer families.

In year 3, the Project held seminars to brief the makhalla about key messages. Project TOT's delivered nine seminars for some 128 "makhalla activists" in the pilot rayons. Reflecting the sentiments of many older respondents about the Project, one Makhalla member commented: "Project HOPE brought some knowledge that our grandparents had. They just presented it in a scientific way."

In addition to "blessing" Project activities and the informal networking that individual members may do, the makhalla has helped mobilize activities. Some members of the makhalla, as well as other senior community members, have been recruited as so-called IMCI organizers. They gather people together to listen to presentations given by doctors or patronage nurses about IMCI related topics. (See below for more about patronage nurses). Most of these organizers are older, respected men with the time to be able to do this organizing function. There is no information about how many such meetings have been held and to what extent these meetings have contributed to community awareness or behavior change. Anecdotal information indicates that 10-12 "couples" or came to a meeting in one site.

The fact that makhallas committees at every level are about 99% male[13] has it is up and down sides: on the one hand, male support for Project initiatives models interest and engagement by male leaders. On the other hand, and arguably more importantly, by supporting the male-dominated makhallas, the Project may be reinforcing the idea that men should drive community decisionmaking.

Other health issues that makhalla members want information about include:

- Family planning/contraceptives--more
- Healthy baby—more
- Environment, esp. water supply
- Dealing with alcoholism

Recommendations about makhalla committees:
1. Clarify their roles

[13] Nearly all of the female representatives on the makhallas contacted were designated "secretaries". Only one makhalla was headed by a woman in an elected position, and this was the most grassroots level of makhalla.

2. Provide incentives, or at very least positive profiling for female leadership in the makhalla committees
3. Continue to keep makhallas informed and engaged, feature them at events, but do not expend enormous resources for outreach through this mechanism.

3. Breastfeeding support group motivators

This approach is arguably the most innovative, exciting and sustainable. Like community health volunteers in traditional community health projects, "mature" women leaders were recruited to disseminate information that reinforced Project messages. In most analogous projects, the link between the volunteer network and the health delivery system is tenuous or not well defined. In the Navoi Project, the volunteers are very much part of the clinical team, spending between 1-3 hours/month on average in the maternity setting where they share breastfeeding information with new mothers. Their role in the clinic gives volunteers added credibility, access to information, and strengthens referral links. The volunteers also disseminate information through informal networking in their neighborhoods, and, by their own reports, are seen as a resource and support for pregnant women and new mothers. To date, breastfeeding motivators have not been asked to keep a record of the nature and frequency of community-based contacts, and it was difficult to get a sense of the extent of this function in terms of spread and impact.

Training for motivators has, to date, depended on the clinic they are attached to. In some cases, volunteers received only one hour of briefing about breastfeeding. In other clinics, they get regular, quarterly updates. All have access to written materials, and are literate. Volunteers want (and need) training, not just about breastfeeding but also about other related health issues. Issues mentioned include: how to care for newborn, childcare, how to deal with their husbands.

Like health volunteers in other parts of the world, the breastfeeding support motivators are motivated as much by the desire to help other women with vital information, as they are the accolades that accrue to them for the service they provide. Several recounted with considerable fervor how the experience and knowledge about exclusive breastfeeding had transformed their lives—and the health of their children. The desire to share this experience and information with other women was powerful. In addition, many clinics offer volunteers priority treatment in appreciation for their services.

Recommendations about community volunteers:

1. Standardize volunteer training and make it more frequent, adding new topics and refreshing old ones. Provide reference materials.
2. Develop simple matrices to allow volunteers to record their networking activities.
3. Open a "drop in" counseling "room" in a strategic location that can be staffed by volunteers and serve as a focal point for education and dialogue on health issues for pregnant women and new mothers (as well as adolescents at different times?). The center could also stock basic drugs, vitamins and even contraceptives. This idea was proposed by a volunteer and echoed by a member of the Steering Committee.

4. Patronage nurses

An established part of the health delivery system, patronage nurses have been the traditional link between the clinical and household setting. When a woman goes home with her new baby, she can expect a visit from the patronage nurse on a daily or biweekly basis.

The patronage nurse—who functions somewhat like a barefoot doctor--is not only a source of information and advice, but in the past was also responsible for checking on the hygiene of the household. Typically, one patronage nurse is responsible for 50 households. In addition to their house-to-house role, patronage nurses have given community seminars and been very involved in supporting local makhallas in preparation for Project-sponsored competitions.

Patronage nurses have received 3 days of training in reproductive health, and 3 days in basic IMCI. There is a plan to provide a similar module for Safe Motherhood. Patronage nurses are armed with Project brochures that they distribute to each household.

Recommendations about patronage nurses:

1. Patronage nurses have an important role to play in community health education. They should be given more training to upgrade their skills in specific health messages, counseling, and basic home based treatments of childhood illnesses.
2. The link between community volunteers and patronage nurses needs to be clarified in the context of overall health reform that may redefine the role of the patronage nurse. Patronage nurses may, for instance, be the first referral link in some cases that volunteers come to know about. Patronage nurses may also supervise and support volunteers with information.

5. Hotline for postpartum women

Every baby friendly hospital has opened a hotline for women after they go home with their new babies. The phone numbers are posted in all maternity wards. An average hotline receives 250 calls every year. Hotlines may prove a useful component for the adolescent reproductive health strategy.

6. Support groups

Using its own initiative to reach out to the community, the Kiziltepa regional hospital has established support groups for adolescents and one for DOTs patients (in TB treatment). Fifty volunteers organize these meetings. Although this initiative appears to have predated the Project, the head of the hospital reports a change in presentation methods (from lecture to participation) based on learning's from the Project.

7. Summary and recommendation about Community Mobilization

Although the Project started community outreach activities late, it has generated a number of interesting models. Since community health is so new in Uzbekistan, these have already attracted considerable attention. Community engagement is high at the moment, including MOH and makhalla leadership support. Maintaining, monitoring and institutionalizing this level of engagement remain a challenge for the Project.

As a next step, the Project needs a coherent community mobilization/IEC strategy with specific targets. Since this is a pilot, it will be important to establish an inquiry framework including, possibly, control sites, indicators, and simple information collection systems that can monitor and measure the relative and synergistic impacts of various approaches. Cost and human resource considerations should be factored into this inquiry framework. It should generate data and lessons that allow the Project to adjust approaches *and* make national-level recommendations over time.

IEC Materials had a significant impact on the highly literate population

F. Communication and materials for behavior change

The printed materials produced by the Project appear to have been of good quality, used by both providers and clients, and widely distributed. The Mother's Reminder Booklet referenced above was available in maternities and distributed to every household with a pregnant or new mother. It serves as a reference and record for mothers, and a point of discussion between providers and clients.

The leaflet on reproductive health was available in primary clinical and maternity house settings and was distributed to households by patronage nurses. With a highly literate population with little to read, these materials appear to have been read not only by women in their reproductive years, but by partners, grandmothers, and adolescents.

A poster competition between participating clinics and hospitals helped to reinforce breastfeeding, reproductive health and IMCI messages, and generated some very innovative, creative posters that now adorn the walls of the clinics and hospitals where they were produced. Posters created by the Project also brighten the halls of clinics and hospitals.

New materials on MCH-related issues are being generated in many parts of Uzbekistan, underwritten by a number of donors. To date, there is no one standard set of IEC materials for any of the technical areas covered by the Project. The Project has made some important attempts to network with the other agencies that have produced alternative materials, and reciprocal review processes have helped maintain quality if not a measure of healthy competition.

1. Mass media

As shown in Annex F, the Project received attention in major local and national newspapers, due, in large part to proactive placement by Project staff. The use of mass media for dissemination of key messages has been hampered by bureaucracy constraints. While the Project has gotten some TV airtime, it seems like this was mostly “talking heads” and not a major part of the IEC strategy.

Recommendations:

1. Sustainability: looking to national impact, scale, and the inevitable question of covering the recurrent costs for reproducing IEC materials beyond the life of the Project, continued liaison with other Projects and the MOH will be essential.

2. Since mass media is a part of most people's lives, and an inexpensive way to disseminate information widely, the extension should prioritize investigation of print, television and radio to place key IEC messages. Creative, humorous approaches should be considered.

F. Capacity building

Much has been said above about the paradigm shift, which the Project has achieved at MOH, facility, and community levels. The Project has also served as a fulcrum for connecting national and local stakeholders in ways that built capacity and aligned perspectives through jointly initiated activities. For a small Project like this, this is no minor feat. The Project set out in the DIP to build the capacity of six key groups of stakeholders and stakeholder agencies:

- The Navoi Project management team
- The cadre of TOTs
- The health care system as a whole—particularly related to quality
- The Oblast MOH—particularly related to problem solving
- Agencies currently or potentially linked to the MOH
- Local NGOs—still nascent at the time of the DIP

This section considers the extent and nature of the Project's impact on these and several other institutions and stakeholder groups, as well as Project HOPE itself. More details on the Project HOPE teams in Navoi and the U.S. are included in Section IV.

1. Project HOPE/US

Project HOPE launched a number of Child Survival initiatives during the period 1999-2003, but this was its first and by many accounts its most successful. The Project gave HOPE an opportunity to reach into new sectors including maternal and newborn care, and gave the agency greater depth of understanding and valuable networks in Uzbekistan. The design has informed other Projects including the larger bilateral Family Health Project in Uzbekistan and Tajikistan, as well as the Kyrgyzstan Child Survival initiative, which began a year after Navoi. The cluster of programs in Central Asian Republics (which also includes a major TB eradication program) also enabled Project HOPE to standardize personnel and other procedures for the region.

There has been a total turnover of staff from the Project HOPE side, with regional and deputy regional managers as well as the technical manager all changing over the life of the Project. Despite this, field staff appears to feel that Project HOPE has been supportive of their efforts.

Project HOPE Navoi Staff with Evaluators
1st row Laurie Zivetz, Sarah Porter, Dilorom Allabergenova, Ravshan Alimov, Abdunabi Kuchimov; 2nd Row Nasiba Bozorova, Nigora Muratova, Mavzhuda Babamuradova, Lilya Djelilova, Nuriddin Shaimanov, Liza Bogovich, Vicky Bulatova, Komiljob Boboyev

2. Project management team

All old and new staff acknowledge how much they have learned and grown (and enjoyed the process) as a result of their work on the Project. Not only were technical areas new, but the style of working (introduced primarily through the efforts of Dr. Babamuradova) as well. Learning can be seen in two major areas—a) technical—all staff have gained new knowledge and skills in key Project areas through training, monitoring and application, and b) management--Navoi staff remarked that they have never worked in such a collegial way before. Staff has understood and internalized fundamental principles of participation, ownership and partnership in the way that they conduct themselves as a team, implement their program, and relate to partners.

Significant turnover among the local staff has also occurred, much of in the last 6-8 months. New staff has been smoothly integrated, vouching for the strength of the team norms and management systems for application.

Most of the members of the Navoi team demonstrate solid leadership skills in their own areas of responsibility, but there is also a team ethic (which may be cultural as well) to respect and follow the broader leadership of the Director. This, coupled by a dynamic leader for the last 2.5 years, has allowed the team to operate at a highly functional level, where each member of the team shined and felt at the same time supported by colleagues and a leader.

3. MOH

The Project appears to have struck just the right balance in its partnership with the MOH. Several factors contributed to this:

- The introduction of new training topics was preceded by orientation briefings at every level—oblast, rayon, and makhalla before the training was undertaken[14].
- The fact that the Project office is housed within the MOH contributed to daily, collegial interaction.
- The Project actively sought to inform and engage senior political officials at the Oblast level.[15]
- The Project kept MOH informed and actively sought senior decisionmakers' input via monthly Steering Committee meetings.
- MOH staff was involved in all monitoring activities.
- The Project spotlighted Oblast MOH achievements through its participation on national level task forces.

Says Professor Dilbar Makhmudova, Direct of the National Research Institute of Pediatrics, "Usually the Ministry of Health would like to take full credit for achievements, but in the case of the Health Authority in Navoi, they give credit to Project HOPE." Indeed, Project staff report that even the Chief of the local health authority has been known to contribute to seminar preparation efforts, staying with the job until it was finished. MOH staff does likewise.

The Project leave behind a cadre of MOH master trainers who even now are in demand outside of Navoi (see Tables 3 and 4). The Deputy of the Oblast MOH reports that the oblast has started using the "Project HOPE" methodology to train providers in other places, and appears confident that the MOH could continue to replicate training independently in future.

4. National Institutes

The Project did an outstanding job of linking with several national level institutes, thereby multiplying the impact on capacity manyfold. Agencies like the National Institute for Pediatric Research and the Reproductive Health Institute benefited significantly by being part of the inception of the strategies relevant to their sectors. Partnerships with key national Institutes also paid off in terms of the Project's potential for policy impact. Subcontracts were provided to conduct formative research provided financial and logistical support for national level academics to get into the field, and participate in a grassroots-level laboratory at a time of significant national level programmatic change.

Samarkand and Bukhara Medical Institutes benefited significantly from the Project as well. In all, nearly 100 staff were trained, including 28 TOT's. IMCI is now part of preservice training in both Institutes as a result of the Project. The exposure to participatory adult learning techniques has also had an impact on teaching styles.

[14] In the early days of the Project, HOPE sponsored a study tour for senior MOH officials to the Ferghana Valley where Z'drav Plus was implementing baby friendly IMCI approaches. This appears to have given the initial impetus for change. Interestingly, Navoi has now become such a study tour destination as well.

[15] The deputy Governor, the most senior woman in the Oblast, participated on the porject steering committee, and as a judge in oblast-level Project-sponsored competitions.

While the DIP did not anticipate training beyond the target rayons, there is no doubt that by including providers from these Institutes, and indeed supporting training on site there, the Project significantly extended its impact and sustainability. Training built and multiplied capacity. The Bukhara Medical Institute, for instance, trains 150 students/year. Fifty of the 1500 questions on the state test in Samarkand are now directly related to IMCI. The relationship with these Institutes helped establish the Project's credibility, which is in no small measure responsible for the national profile of the Project and Project HOPE. Says Professor Karimova, President of the Association of Ob/GYN's and based at Samarkand Medical Institute: "It is easier to work with Project HOPE than other agencies. They never say 'no'."

5. Health facilities and health workers

Health workers interviewed during the evaluation were universally and unequivocally effusive about training they had received during the Project and the transformations they attribute to Project interventions. Starved for up-to-date information in their specialty areas, the Project infused the system with new ideas and energy.

Participating facilities have strengthened their links with communities through their involvement in outreach activities described above, as well as more sympathetic attitudes towards clients. The visual impact of the Project on maternities in particular is tangible, with posters and displays on breastfeeding produced by maternity staff adorning walls and tables. Head of the Navoi Rayonal MOH, Dr Ergashev Yusef says that breastfeeding training was so important that they insisted all maternity hospital staff, including cleaners and drivers, have exposure to the key messages.

Importantly, supervisors and staff all report significant changes in the way they relate to one another and clients, as mentioned above. The Chief Doctor in one primary clinic (SVP) says he divides his work life into two parts—before and after Project HOPE. Staff in this clinic talked openly about how the training they received transformed the way they work as a team—the supervisor doesn't feel the need to be right every time, but can problem solve with other staff. The group also talked about the way they treat their patients, mentioning that now they consider psychological factors as important to diagnosis and treatment.

In addition to the public sector service delivery system, the Project invited representatives of the better-endowed mining company system to briefings on IMCI and safe motherhood. The mining company, with its head office in Navoi and 57,000 employees nationwide, offers private service to its employees. The chief pediatrician indicated an interest in procuring training for mining company doctors from the project, or Project trained TOTs.

6. Local NGOs

When the Project began in Navoi, there were very few NGOs and those that existed were young, and fragile. Today, there are 46 NGOs in the Oblast, and an NGO newsletter. One of the lead NGOs is active on issues related to women's employment and advocacy on domestic violence and trafficking. The Director of this agency credits the growth and development of local NGOs in large measure to the Project HOPE Project. In the early days of the Project, HOPE supported an NGO exhibition in which local agencies were able to talk

about their programs with local officials and talk about public-private sector partnerships. The project gave this event legitimacy as the only INGO. Project HOPE has continued to participate in NGO events and has invited NGOs to Project briefings and trainings.

The project has been instrumental in lending its credibility and resources to strengthen ties between Navoi-based NGOs and the local government. As community activities take off in the extension, these linkages and Project HOPE's continued support will be critical.

Recommendation about local NGOs:
The Project needs to partner with local NGOs on community activities as mutually appropriate. Collaboration should be designed to strengthen local NGO capacity, and affirm relationships with government.

G. Impact on national policy and programming

Much is said in other parts of this report about the project's impact on national policies and programming. The Navoi Project design became a model for a project covering two entire Oblasts in the country. Project staff participation on national task forces related to IMCI and reproductive health brought lessons from the project to bear on policies being conceived in the context of health reform. Training of trainers and staff from other Oblasts and medical schools multiplied exposure and practice to key MCH practices. Donors, government and INGO representatives have visited the project site or learned about it through interaction with project staff, borrowing ideas, curricula, and materials.

The DIP does not anticipate any activities related to national policy or health reform. Indeed it is questionable whether the objectives that remain unaddressed could have been achieved had not attention been focused solely on Navoi. The IMCI expert, for instance spent an entire six months translating the curriculum from Russian into Uzbek. While this went a long ways towards meeting the broader objective of introducing an important new approach into the country (not to mention creating a positive, collaborative relationship with donors and the MOH), the question of whether this was the best use of project resources is there.

Recommendation:
1. The project is in a strategic position to continue to impact on government programming in the context of national health reform. This should be proactively anticipated in the DIP by allocating human resources, designing M&E systems, dissemination mechanisms to promote specific, targeted issues.
2. In particular, the Project should find ways of regularly networking with other agencies working on MCH-related issues (National Research Institutes, Z'drav Plus, Counterpart International, the Healthy Family Project, the World Bank and ADB projects[16]) in the context of task force work and outside. Networking should not only serve to share lessons from Navoi, but enhance Navoi activities through lessons from other places.

[16] All of these projects have manyfold times more resources, including technical professionals who may be of assistance to the Project.

I. Sustainability

Several aspects of the program portend well for sustainability and scale up:

- The Oblast MOH has embraced all of the new MCH approaches piloted by the Project, and is already implementing many in non-Project rayons.
- MOH officials, as well as individual providers appear empowered by new approaches.
- Oblast officials are invested in health issues.
- Oblast-based TOT's are able to plan and deliver training without assistance from the Project.
- TOT's are in demand from within and outside of the Oblast.
- Baby Friendly hospital certification carries a lot of pride with it. To maintain certificate status, maternities must maintain best practice. Baby friendly hospitals set the standard for other facilities.
- Oblast MOH and local NGOs appear to have forged good avenues for dialogue and cooperation.
- Local leadership is well informed about some issues, and has experience organizing around public health issues.
- Communities in the target rayons have been saturated with information about key issues—breastfeeding, danger signs, and, to a lesser extent, contraceptive choice. This information may seep down to younger people, and across rayonal lines.
- IEC materials, particularly the Mother Reminder Booklets, are in the possession of many households, and can be used and read by the whole family.

Were the Project to stop today, much would remain behind that would continue have an impact for this generation at very least.

Factors that may constrain or hinder sustainability of project interventions include:

- The absence of a supervision and monitoring system that can support quality and consistency in new practices.
- The inconsistent supply of drugs and contraceptives.
- Provider "migration" to private sector opportunities because of low pay from government service.
- MOH lack of budget to reproduce IEC materials.
- Lack of cogent data demonstrating impact of key interventions.

A note on the Sectoral Centers that the project established is relevant here. To date, the Project has resourced the establishment of IMCI and RH training Centers in the Oblast, with plans to support the establishment of a Safe Motherhood Center in the next phase. While these Centers are well equipped for training, they appear to be understaffed and underutilized, with an equal number of trainings being conducted inside of facilities. Center Directors liase with and support project activities.

The Centers were established with the blessing of the Oblast MOH. However, the evaluation did not explore to what extent the Oblast MOH is committed to supporting the on-going, recurrent costs of maintaining the Centers, or, most importantly, what they envision as the Centers' role in the future. This report argues that the Centers have a role to play as focal points for technical excellence, if they house libraries, disseminate new information, employ staff who do spot technical "audits" (to compliment on-going monitoring), identify

training and refresher training needs, and organize TOT and provider courses etc. Before investing in more stand-alone Centers, however, the Project will need to clarify the roles and resource requirements of such Centers and the commitment of MOH to agree to both.

Although some of the constraining factors are not directly within the extension Project's purview, they are issues that the Project can address in Oblast and national level fora where the broader context for health reform is considered.

IV. Program Management

Many of the management issues related to Project HOPE's partnership with MOH, facilities, National and local Institutes, NGOs and community groups have been covered in the previous section. This section focuses on the management of the Project by HOPE and the local Project HOPE team. While all of the findings and recommendations relate specifically to the extension Project, many of the recommendations are generic and may also apply to other Projects in the Central Asian Republic region or globally.

A. Background

The Project got off to a rocky start under the leadership of an expatriate Team Leader from Bangladesh. Following some administrative and fiscal irregularities, he was terminated in August, 2000. There was then a lapse of some 5 months during which time not much happened, although two Peace Corps Volunteers located in the Project office and did provide some support in this interim period. At the end of 2000, Project HOPE hired Dr. Mavzhuda Babmuradova who had previously represented EngenderHealth (then AVSC) in Uzbekistan. Dr. Babmuradova started work in January 2001. Her arrival rapidly boosted the low morale and lagging staff momentum, and by all accounts propelled the Project to where it is today. In recalling that time, veteran staff talk about how they learned about working as a team, began a genuine partnership with the MOH, and took hold of their individual technical responsibilities. MOH, National Institute informants and providers across the spectrum similarly credit Dr. Babmuradova's leadership and vision as instrumental in achieving the Project's considerable results in such a short period of time.

In September 2002, with Project HOPE's successful bid for the USAID bilateral Health Family Project, Dr. Babmuradova was invited to move to this program. There began a search for a replacement for Navoi, resulting in the hiring of Dr. Abdunabi Kuchimov, then the international relations manager for the GP training program at Samarkand Medical Institute. After a two-week handover in Navoi, Dr. Babmuradova moved to Tashkent, continuing to contirubte15% of her time to the Child Survival Project. During this period she provided both technical and administrative support to the new leadership, ensuring its smooth transition in the final Project period.

None of the original staff from Project HOPE/U.S. are still with this Project, most of them having left the agency. Continuity in technical support from Dr. Bettina Schwethelm who was involved in the inception and left Project HOPE in early 2003 was a critical element in its success. About half of the Navoi staff is new, many having been hired in the last 12 months.

Despite the considerable changes and late de facto start up of the Project, a retrospective look reveals quite significant accomplishments given the time and resources available to the Project. In addition to numbers of people who directly benefited from training, materials, and

activities, the Project has effected a transformation in thinking and practice among MCH providers and their clients that has permeated beyond the pilot rayons into the target Oblast and beyond. It has impacted on national policy and programming through targeted interventions and modeling innovation. This is due in large measure to the hard work, and solid management of a highly committed, motivated team in the field. Importantly, the leadership and functioning of the team modeled the cooperative, participatory, respectful problem solving approach that it promoted in the field. In short: the team *walked the talk* in terms of the way the Project was implemented.

B. Planning

Staff who were involved in the development of the DIP report using this framework for planning their specific activities. Sound planning is reflected in the sheer number of activities carried out by the Project by the relatively small cadre of staff.

Project activities were carried out in a way that maximized participation of stakeholder agencies. The role of the Steering Committee—with senior representatives from key participating agencies--was critical in achieving cooperation of major gatekeepers. The input of key national Institutes in planning major components of the Project was similarly critical in garnering a sense of joint ownership of Project outcomes.

C. Staff training

There is no doubt that every staff member has acquired valuable, practical new skills as a result of the Project. All professional staff have upgraded their technical and training skills. All of the veteran staff have had English and computer training. However, several, newer staff lack these skills.

Like everyone in the health system in Uzbekistan, Project HOPE staff have squeezed every opportunity—whether a training, a consultant visit, the intern or Peace Corps volunteer who were with the Project for several months, or seminars in Tashkent—to expand their skills base. Most training was on the job, informally structured, or a brief mentoring relationship with a short-term consultant. Interestingly, although Navoi drew international and national observers, only one staff study tour (to the other IMCI pilot in Ferghana valley) was reportedly conducted during the Project. A recommendation put forward in this regard from the mid-term review is still pending, and important. Similarly, no staff aside from the Director attended conferences or trainings outside of Uzbekistan.

As the Project begins to institutionalize, scale up and broaden its focus in the extension, staff urgently need training and exposure in some very specific areas related to:

1. Monitoring and evaluation/data for decisionmaking
2. Community mobilization
3. Maternal nutrition
4. Safe Motherhood
5. Time management.

Recommendations:

1. For the extension phase: all staff have access to English and computer skills and all professional staff be required to achieve a certain level of proficiency in both areas.

Project HOPE earmark funds to enable quality training for staff in this regard (a local NGO offers both types of courses).

2. TA and study tours be organized to enhance staff skills in key areas. Specifically:
   - TA: Priority should be placed on the identification of regional (Russian speaking) TA providers. This will maximize impact for non-English speaking staff as well as partners, and is, obviously, more cost and culturally effective.
   - Study tours should be organized in such a way that staff have a chance to meet counterparts in and observe analogous programs in Uzbekistan and the region. They should be structured to encourage critical thinking about adapting existing models to the Navoi context.

3. Staff be supported to participate in international conferences or training, as appropriate to their jobs.

D. Human Resources and Staff Management

The mid-term report observes that the "technical staff, administrative staff and drivers are all actively involved in a team approach which provides strong cohesion and motivation." This remains the case. Three issues related to human resource management merit mentioning:

1. Leadership

As discussed above, outstanding Project management and leadership—from Project HOPE and in Navoi-- was a major factor in the Project's success. Both Dr. Schwethelm and Dr. Babmuradova adopted a style that was collegial, trusting and encouraged hard work and creativity. They led by example. Dr. Babmuradova, commenting on the support she received from Dr. Schwethelm, said: "She always gave me options but let me make the decision. I never felt my hands were tied or that I did something wrong." This approach appears to have permeated all levels of the Project.

This kind of leadership was possible in large part because all professional staff are educated, trained health providers (and all but one a doctor). Nonetheless, it marked a significant departure from the traditional, punitive, top-down management style of the government that staff were used to.

The recent transition to new leadership in the Project inevitably marked a change in style. It has taken some time for the team to make the transition and begins to trust themselves and their instincts, having depended in a myriad of ways on Dr. Babmuradova for vision and direction.

2. Time management

The mid-term evaluation raises the issue of staff burn out in the context of the targets ahead of the Project and its momentum at that point in time. Although there has been some staff turnover since that time, the issue remains a relevant one. Staff work long hours and weekends without complaint or compensation. Morale is high and there is no doubt that efforts have paid off in terms of results and impact. Staff cohesion and a team spirit is palpable in the office—an oft heard comment was that that although individual staff have jobs, they could count on one another for help, and that often they work together on one another's jobs. What is not as clear is whether the long hours are a result of too few staff stretched too thin, or inefficiencies in work style. On the other hand, perhaps staff are trying

to do too much for the MOH, and not letting go of key functions at opportune moments? These points bears further investigation, and more attention going into the extension phase.

3. Job Descriptions and contracts

Although job descriptions exist for each position, they appear to be outdated and do not serve as a baseline for performance review[17]. There is a fairly comprehensive staff manual, which was prepared for all offices in the CAR. Missing from this manual, however, is discussion of how performance is appraised, how salary raises are calculated, and whether an appeals process is available to staff.

Although staff sign government mandated agreements which are sent to the Ministry of the Interior when they are initially employed, these contracts do not appear to be linked to work scopes or transparent salary markers.

4. Skills mix

At the present time, all of the professional staff are trained doctors with the exception of one midwife. In addition, most of the staff, trainees, researchers and other participants in the project are MOH employees by virtue of the system that still remains where all professionals work for the State. Both of these factors limit the potential diversity of disciplinary perspectives on the team, and possibly the opportunities for team creativity and innovation. As the project moves more into community activities, medical degrees may be less important than they have been when technical training was the major emphasis of the project.

Recommendations:

1. Consider staffing levels against targets and activities in the development of the DIP for the extension.
2. Prioritize time management training in upcoming technical assistance or training for staff.
3. Review all job descriptions before the extension begins, based on requirements of the DIP.
4. Project HOPE should generate and disseminate a clear policy for staff performance appraisal, and salary increases.
5. New hiring should focus on diversifying the skills base within the staff.

E. Financial Management

Each Project HOPE project is staffed with an administrator/accountant at the field level who is responsible for compiling and reporting the local currency expenses vis-à-vis approved budgeted line items to the Project Director.

1. On site audits

In the spring of 2001 Project HOPE made some changes to its accounting system, which slowed the process for a period of time. To that point, financial information had been sent directly to Millwood. Following the changes, a financial monitor was installed in Project HOPE's regional office Almaty, and reports were sent to her and checked before forwarding them to Millwood. This does not appear to have had a significant impact on efficiencies one way or another from the Project's point of view.

[17] The job description for the driver, for instance, drafted in the time of the first Team Leader, notes that when the driver is not performing his duty as a driver he should sit and read the paper!

Navoi was lucky to have a competent person in this position, who managed the books in a meticulous way. Regional oversight from a skilled Project HOPE Manager has also provided closer support and oversight. A cursory review of financial systems raise a number of broader, generic issues which are put forward here for consideration[18].

What is anomalous is the fact that following the termination of the first Team Leader and the efforts involved in untangling fiscal issues in the wake of this termination, that Project HOPE did not take steps to adjust its system to be able to catch such issues earlier. It raises questions about whether an on-site audit, or the anticipation of such, might have precluded some of these difficulties?

2. Fiscal planning

Although not a chronic problem, in the final months of the Project, the Director was advised that he had less money in the budget than he'd previously understood. While this is likely to be more the result of transitions in headquarters staff than a pattern, it nonetheless raises concerns about how budgets are interpreted and how information is shared with the field.

3. Reporting systems

It was noted that the Project accountant keeps two sets of manual ledgers in addition to the Project HOPE international Quickbooks system, which is backed up on a zip drive. It is not clear whether the hard copy steps are necessary or mandatory in the current system.

Finally, the mid-term review anticipated a new system in which "field staff (could)…interact with the central database through Internet links for real-time processing, analysis, and performance feedback." (pg 26). There was no evidence that this objective had been achieved.

4. Remuneration for MOH or Institute professionals

As with many Projects, striking a balance between engaging good professionals from within a government system and remunerating them in a way that is both fair and sustainable was a challenge for this Project. This was particularly challenging since nearly all professionals are employed by the government. Project HOPE's commitment to sustainably institutionalizing a training capacity within the MOH made it important to establish a cascade training system that could, eventually, function on its own steam.

Project HOPE has been meticulous in establishing guidelines that disallow Project funds to be paid to professionals who are already salaried with the government. When Project HOPE Navoi recruited TOT's (all employees of the MOH or National Institutes) to implement research or training in the Project area, no salary was paid in the early days of the project. Later on a per diem was given. When TOT's and other TA providers were recruited to work in other Oblasts (and other countries—for instance, for the CS Project in Kyrgyzstan) a letter was sent to their office requesting their services for a specified period of time. It was assumed in this case that the person's salary would be cut for the requested time, so that

[18] Financial issues are always extremely sensitive. These observations and recommendations are based entirely on interviews, and in no way reflect a comprehensive review of HOPE's financial systems that was beyond the purview of this evaluation and indeed the evaluator's skills.

Project HOPE could remunerate the person for both time and per diem. The services of a 50% time IEC specialist from the Institute of Pediatric Research was negotiated in this way.

Project HOPE is to be commended for this approach which is at once pragmatic, transparent, and ultimately more sustainable. A good indication of this, is the fact that many of the project's trained TOT's continue to provide training on behalf of MOH and Medical Institutes without any external funding.

Recommendations:

1. Project HOPE should consider instituting an on-site audit at least once in a Project cycle.
2. The local Project Director needs to have complete and consistent information about the Project budget and anticipated spending timetables.
3. Since the current Navoi-based accountant will be leaving the Project this month, it might be a good moment for Project HOPE to review the manual entry practice and recommend whether the extra steps are necessary.
4. Project HOPE should continue its current approach to requesting the services of Government employees.

F. Logistics

Project HOPE has decades of experience in the distribution of humanitarian assistance, which appears to have been handled effectively in the case of Navoi. The contribution of pharmaceutics and equipment were acknowledged and appreciated by the Oblast MOH and facility representatives.

The Project has its own vehicle and rents other vehicles as needed. Coordination of vehicles—often a challenge to implementation for a complex Project like this one—appears to run smoothly.

G. Information Management

Information management is arguably the weakest technical skill among Project staff, and, based on the data collected since the Project's inception appears to have been an Achilles heal since then. While staff understand MOH procedures, none are statisticians or social scientists (which in any case are few and far between in the countries of the Former Soviet Union). The KPC and HFA were not only foreign tools, the concepts behind them were equally unfamiliar. Technical assistance from Project HOPE appears to have fallen short of what was necessary to conceptualize useful indicators, collect and track data, and particularly analyze data in a meaningful way for decisionmaking.

Recommendations:

1. Project HOPE provide immediate, intensive support to strengthen staff capacity in the design, collection and analysis and use of quantitative and qualitative studies for Project management and design. Training should also help staff make use of data to promote Project innovations.
2. Local, mentoring support be identified to enable this process (e.g. M&E advisors with the Healthy Family or Z'drav Plus projects).
3. The extension continues to use the formative research approach to explore new issues (adolescent reproductive health, safe motherhood) but intentionally build local capacity (staff and local NGO) in the process.

H. Technical and Administrative Support

A number of the external technical inputs provided over the life of the Project have been referred to in previous sections. Table 7 lists the TA provided by consultants to the Project. Project HOPE staff Dr. Bettina Schwethelm, and Juan Carols Alegre provided technical inputs as well.

Table 7. External Technical Assistance

Topic	Person	Dates
Investigations on SM/MCH/Childcare in facilities	Erika Latchis	May, 2000
Staff training in Epi-Info	Gal Frenkel	January-July 2002
Postpartum services assessment for new/first mothers	Stella Aslanyan	August, 2002
Assessment of neonatal and perinatal care	Dr. Andro Shilakadze	March, 2002
Assessment and training in emergency obstetric care	Dr. Erika Latchis	May, 2002
Minilaporotomy training for 13 providers	Dr. Makenjian Musuraliev	June, 2002
Essential newborn care and Newborn Resuscitation course	Dr. Andro Shilakadze	June, 2002
Training Oblast OB/GYNs in antenatal care	Dr. Frank Anderson, U of Michigan	May, 2002
EFM, partograph and prenatal education training	Dr. Erika Latchis	January, 2003
Grandmothers and other actors in MCH decisionmaking	Judi Aubel	June, 2003

As mentioned above, all of the TA appears to have been highly useful as the Project developed. The use of volunteers certainly represented cost savings to the Project.

Annexes: Final Evaluation Report

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

Annexes

A. Persons contacted
B. Scope of Work for the Evaluation
C. Sampling methodology for KPC and HFA
D. Evaluation protocol
E. DIP Matrix
F. Items in the Mass Media about the projects

Annex A
Persons Contacted

Outside of Uzbekistan

Bettina Schwethelm, Former Project Manager, Project HOPE/US
Diaa Hammamy, Regional Manager, CAR, Project HOPE/US
Debbie El Anani, Deputy Regional Manger, CAR, Project HOPE/US
Juan Carlos Alegre, M&E, Project HOPE/US
Judi Aubel, Consultant
Erika Latkis, Project HOPE Women's Health Advisor
Anara Doolotova, Project HOPE CS Manager, Kyrgyzstan
Susan Youll, USAID
Aigul Kuttumaratova, WHO/Europe

Project HOPE Navoi Staff

Abdunabi Kuchimov	Program Manager
Nigora Muratova	OB/GYN specialist
Dilorom Allabergenova	Pediatric specialist
Nuriddin Shaymanov	HIS specialist
Lilya Djelilova	IEC specialist
Nasiba Bozorova	Midwife
Lisa Bogovich	Administrator
Vicky Bulatova	Secretary
Komil Boboev	Driver
Ravshan Alimov	Driver

Steering committee members

1.Abdurahmon Nosirov	Chief of the Oblast Health Department
2.Musallam Ibragimova	Deputy of the Oblast administration
3.Yunus Avezov	Deputy of the Chief of Oblast Health Department
4.Tanzila Ravshanova	Deputy of the Chief of Oblast Health Department on MCH and Head pediatrician
5.Muazzam Bozorova	Head OB/GYN
6.Orif Jumaev	Chief of the Kiziltepa Central Rayon Hospital
7.Yusuf Ergashev	Chief of the Navoi Central Rayon Hospital
8.Gulyam Aslonov	Chief of the Navoi Oblast Maternity House
9.Nizam Sidikov	Chief of the Navoi Oblast Child Hospital
10.Gulsin Karimova	Chief of the Navoi Oblast RH Center
11.Nurmuhammad Alhamov	Director of the IMCI training Center, Deputy of the Chief of Oblast Child Hospital
12.Project HOPE technical staff	

Tashkent
Klara Yadgarova, Deputy Director, MOH
Andreas Tamberg, USAID/Uzbekistan
Prof. Dilbar Makhmudova, Director, National Pediatric Research Institute
Doug Palmer, Bahtiyar, Yuldosh, Fahriddin, Healthy Family Project
Feruza Tulaganovna, Director, National Reproductive Health Center
Zakir, WHO

Asta Maria Kenney and Ulugbek Buriev, Z'drav Plus
Andro Shilakadze, UNICEF
Farkhad Fuzailov, World Bank

D. Navoi

Bahriddin Murtazaevich Ruziev, Governor of Navoi Oblast
Tanzila Ravshanova, Deputy Oblast Health Dept.
Ergashev Yusuf, Chief, Navoi Rayon Central Hospital
Istat Himmatova, Deputy, Navoi Rayonal Hospital (MCH)
Nurmatova, Chief Navoi rayon Baby friendly hospital
Gulom Aslanov, Chief Baby friendly hospital in Navoi Oblast
Orif Jumaev, Chief, Kiziltepa Central rayonal hospital
Dilbar Akramova, Deputy Chief Doctor, Kiziltepa Rayonal hospital
Ihtiyar Ochilov, Chief Kiziltepa Baby friendly hospital
Ramine Bahrambegi, Program Director, Counterpart International's Child Survival Project, Karkalpakstan
Olga Sashina, Navoi NGOs
Sabohat Salmova, Deputy Chief, Mining Co. hospital
Mariyana Bahrieva, Chairwoman, Red Crescent, Navoi Oblast
Prof. Nodira Juraeva, Chief GP training center, Bukhara Medical Institute

In addition, providers, TOTs and outreach workers and makhall committee members as follows:

SVP Madaniyat
SVP Zarafshan
SVA Ibn-Sino
Malikrabod policlinic
Yangi-arik makhalla
Argun makhalla. Navoi rayon
Ok-oltin village. Kiziltepa rayon
SVP Zarmetan. Kiziltepa rayon
Vangozi village. Kiziltepa rayon

E. Samarkand

Prof. Karimova, President, Association of OB/GYNs
Klara Dilmuradova, Dean, Samarkand Medical Institute

Annex B
SCOPE OF WORK

PROGRAM: Child Survival Project, Navoi, Uzbekistan

POSITION: Final Evaluation Consultant

POINT OF CONTACT: *Project HOPE Center*: *Program Manager*, *Russia Eurasia*
On-site: Program Manager, Navoi CS

PURPOSE: Conduct Final Evaluation for Child Survival Project in Navoi, Uzbekistan

Activities Prior to arriving in Uzbekistan

- Review background documents and baseline
- Design pre-evaluation inquiry for Navoi Team
- Design evaluation instruments with feedback

Specifically, the evaluation will look at the following aspects of the project:

- impact in target sites
- potential for sustainability in target sites
- impact of project on national programming/policy direction
- replication/scale within the project period
- groundwork laid for extension/scale within the Oblast
- groundwork laid for added components anticipated in the cost extension
- community mobilization, and particularly appropriateness and capacity building of CBOs and sustainability of CBOs
- availability and appropriateness of technical and IEC materials for impact, cost, replicability, and scale
- training and supervision, particularly related to quality and scale up
- quality of care
- HIS

SPECIFIC OBJECTIVES:

1. Provide methodology and conceptual framework for final evaluation of Navoi SC project.
2. Lead inquiry and evaluation team.
3. Write the final evaluation report.
4. Ensure final evaluation focuses on lessons learned and sustainability and potential for scale in terms of institutional and community commitment, capacity, cost, and the integration of project components into planning at the community, Oblast, and national levels.
5. Carry–out 2 stakeholders meetings to brief participants on the preliminary results of the final evaluation for local stakeholders in the Navoi Oblast and national stakeholders in Tashkent.

Annex C

Sampling Methodology

Knowledge, Practice, and Coverage (KPC) Survey
Universe: 190,294 inhabitants in Kiziltepa and Navoi Rayons
Sampling size: A simple random 30-cluster sampling method was used. For the purpose of the KPC survey, one cluster equals one makhalla. Ten interviews per cluster were obtained. In addition, parallel sampling was used to better understand the knowledge, practices, and coverage of mothers with children aged 0-23 months, women of fertile age (15-49), and youth aged 16-18 years old. Thus, slightly different questionnaires were used for each group. The sample sized used gave a total of 300 interviews per age group, or a grand total of 900 interviews for the total area of the project (Kiziltepa and Navoi Rayons).

The following makhallas were included in the sampling methodology for the KPC Survey:

Rayon	Makhalla	Population
Kiziltepa	Kalayiazizon	2319
	Uzlishkent	2725
	Khasancha	2642
	Gamkhur	3556
	Mayta	2612
	Khusharti	1999
	Khamrabod	2500
	Bulakrabod	3323
	Kasrishurak	2715
	Ayronchi	2764
	Pakhtaobod	1848
	Okmachit	3006
	Khavkarien	3172
	Zarmetan	3547
	Vorazun	2816
	Khusbidin	2924
	Konsurun	3070
	T.Khamid	2340
	Gulzor	2265

Rayon	Makhalla	Population
Navoi	Vark	2,902
	Katta machit	3,013
	Shibzon	3,839
	Allon	2,371
	Umarov	4,130
	Pakhtaobod	3,011
	Dustlik	3,920
	Khoncharvok	2,496
	Yangiobod	2,828
	Degaran	2,011
	Azamat	2,188

The above makhallas (30) were randomly selected out of all makhallas in each rayon. The random selection was based on population size for each makhalla.

Health Facility Assessment (HFA)
The sampling frame and survey sample for the Navoi Oblast is the following:

Navoi Oblast

Sampling Frame for Navoi Oblast

Health Facility	Kiziltepa	Navoi	Total
Central Rayon Hospital	1	1	2
Central Rayon Hosp. branches	2	--	2
Central Rayon Child Polyclinic	1	--	1
Central Rayon Polyclinic	1	1	2
SVP	21	14	35
SVA	5	1	6
Baby-friendly hospitals	--	2	2
Total	**31**	**19**	**50**

Survey Sample for Navoi Oblast

Health Facility	Kiziltepa	Navoi	Total
Central Rayon Hospital	1	1	2
Central Rayon Hosp. branches	1	--	1
Central Rayon Child Polyclinic	1	--	1
Central Rayon Polyclinic	1	1	2
SVP	4	4	8
SVA	2	1	3
Baby-friendly hospitals	--	1	1
Total	**10**	**8**	**18**

A total of 18 health facilities were assessed in the two pilot rayons. All Central Rayon Hospitals were surveyed, along with all Polyclinics. Four SVPs in each rayon, and a total of three SVAs (two in Kiziltepa and one in Navoi) were also surveyed. In addition, one of the baby-friendly hospitals in Navoi City was also included in the sample.

Annex D: DIP Matrix

Interview questions for key stakeholders: Navoi CS Evaluation

Tashkent

Question	Notes
Donors, MOH, Other development agencies	**These are one on one interviews**
1. What do you know about this project?	
2. Have you visited Navoi?	
3. What aspects of the project have informed your work?	Probe for specifics
4. How do you think this project has impact on national programming in health? Are there aspects that have been adapted at scale?	
5. How has it impacted on national policy in health?	
6. What role has project HOPE played in the development of national programs or policies in health?	Probe for specifics
7. Are you using any of HOPE's training or IEC materials in your program?	
8. Are there aspects of the program that you would suggest could be improved?	
9. Are there specific issues related to the implementation of the project that you would like more information about?	
-For MOH (**in addition to the above)**	
1. Do you perceive a change in the way the Navoi MOH performs as a result of this project? How?	
2. How do you plan to interface with this project in future?	
-For other PVOs/development agencies (in addition)	
1. What type of technical cooperation have you had with Project HOPE over the last 4 years related to the Navoi project?	
2. Looking back, what have been the key benefits and challenges?	
3. What if any type of cooperation do you envision in the future?	

Navoi

Question	**Notes**
Project Steering Committee	Focus group
1. Let's do a short history of the project. What were the most important events in the project, and what changes did they make?	Historical timeline (4 yrs) with key events and changes in the project and in the oblast. Paper with years drawn on it. Stickies with key events and then draw arrows to *why, how, who.*
2. What do you see as the most important achievement of the project?	Individual responses then pass to front and read.
3. What do you think your biggest success as a Steering Committee has been?	
4. If you could go back in time and change one thing about the project, what would it be?	
5. If you could change one thing about the Steering Committee what would it be?	For 2-5: make 2 columns on the flipchart: one for each language (so 2 scribes will be good)

Oblast and Rayon Chiefs	Individual interview
1. What have been the major achievements of this project in your oblast/rayon? -in terms of changes in health status or practices -	One on one interviews Probe for changes in health status, management, and MOH 'culture'
2. What have been your biggest challenges?	
3. What do you see as your biggest challenges to keep achievements on course in the future?	
4. What role do you think this project plays in national policy or programming in the health sector?	
5. What other projects or agencies play an important role in health delivery in your oblast/rayon? What role do they play? How does the HOPE project interface with them?	
6. Ask about any anomalous changes in key indicators from the KPC or HFA…	TBD based on data
7. Iron and folate supplementation?	
8. How is health information data collected? How do you use statistical data to make decisions? Is this different from the past?	
Oblast stat. Dept/Rayon stat chief (?)	Individual interview
1. Describe how data is collected analyzed and shared in the oblast and rayons and with the national MOH.	
2. Has this changed during and as a result of the project? If so, how?	DIP anticipates "data for action", computerization and analogous approaches at oblast and rayon levels.
3. Can you suggest 3 things you would like to do to further improve the Health Information System in Navoi?	
Heads of baby friendly hospitals	**One on one**
1. Size of hospital, services, no. staff, no. of deliveries, pop served etc.—basic stats.	
2. How did your hospital come to be a baby friendly hospital—history?	
3. What have been the biggest changes you had to make for this hospital to become a baby friendly hospital?	Note: DIP anticipated: -breastfeeding edu during mothers' stay -home visits in lactation support -removal formula cans from facilities -mother's cards
4. Which changes were easiest?	Probe—why?
5. Which were most challenging?	" "
6. How have project interventions changed the way staff are supervised inside the hospital and in tertiary facilities?	Following 4 and 5, probe using 6-10 if these issues are not naturally raised.
7. What protocols are you using? How do you ensure staff are following them?	
8. Has the project changed the way the hospital views and interacts with patients and their families? How?	
9. How do you know whether your patients/clients are satisfied with your services?	
10. What are the most important skills that hospital staff have gained as a result of project inputs?	
11. As a result of the project, have you changed the way you collect or manage	

data?	
12. Looking back, what would you advise an administrator of another hospital that wants to achieve baby friendly status to do and not to do in this process?	
Heads of non baby friendly hospitals	One on one
1. What do you know about the project?	
2. What benefits has your hospital received from the project—training, materials, equipment, medicines?	
3. Do you expect more? If so, from where? If not, how will you sustain these inputs in years to come?	
4. Have supervision procedures changed in your hospital since the project started? How? What was the best thing about this change? What was the most challenging?	
5. What protocols are you using for maternal and neonatal care? How do you ensure staff are following the ones you are using?	
6. What have been the most important skills that the project has provided staff at the hospital through training? How do you ensure that your staff are using these new skills? Do you have plans to train other hospital or clinic staff in these skills?	
7. How do you know whether your patients/clients are satisfied with your services?	
8. Do you plan to apply to be registered as a baby friendly hospital? If so, why? What will you need to do to get this registration? What systems will you have to change?	
Supervisors/TOT's	Can be one on one interviews, but if there are 3-4 in one place, I've designed a short exercise we could also carry out (see 2. below)
1. What is your position? Has this changed since before the project started in Sept 1999?	
2. What kind of training did you receive? What were the 3 most important things you learned in the training? What were the 3 most challenging things you learned?	If this is in a focus group, could write on paper individually and then post/share and discuss.
3. How do you plan training now? How do you identify training needs? Select trainees? Organize training's? Evaluate? How many training courses have you done without project support? Does the MOH support you on this?	" "
4. How do you define Quality? What are 3 indicators/ways of knowing or measuring quality in the health system according to you?	Same process, post, cluster, list across top of a flipchart (column heads) then ask 5.
5. What does the health system have to do to achieve and maintain these aspects of quality?	Same process, cluster responses for rows, then ask 6.
6. Using a scale of 1-10 with 10 outstanding and 1 terrible, how would you rate yourselves (oblast/rayon) at the moment?	Participants fill in the boxes. Important to probe for *why*—in terms of why they scored that and causal factors. In this discussion, the conversation is as important as the score.
7. Have supervision procedures changed in your area since the beginning of the project? If so, how? What have been the biggest successes in this regard? What has been the most challenging?	Address this if it has not already come up in the previous discussion.

8. Do you use a supervision checklist? What do you do with the information?	
Providers	One on one interviews as well as observation when the opportunity presents itself
1. What is your job?	
2. What kind of training or other support have you received as a result of the project?	
3. What were the 3 most valuable things you learned in the training?	Ask this Q if the person has received training
4. What has been the most challenging thing you learned to actually implement?	
5. Has your relationship with your supervisor or the way you are supervised changed since the project started? If yes, how? How do you get feedback on your performance?	Probe for details.
6. Have you changed the way you communicate or relate to your patients/clients changed since the project started? If yes, how?	" "
7. What protocols do you use for maternal and infant care? Where do you go if you have a question about these protocols? Who supervises you?	
8. What do you think are the 3 most important changes in the health system as a whole in Navoi since the project started?	Details
EXPLORE some of the findings from the HFA and KPC as appropriate here.	
9. What important issues do you think remain to be addressed in the health system in Navoi in future?	Details

Navoi (community)

Question	Notes
Makalla committees	**F. Focus group discussion**
1. What is your function in the community?	
2. Venn part 1: who are the most important decisionmakers with respect to the health of a mother and child? List all of the decisionmakers on individual stickies. Place them near the picture of the mother and child based on how important they are. Then draw arrows between those who may interact in ways that also benefit the mother and child.	Draw a mother and child in the middle of a large piece of paper. Participants place stickies around it. Be sure that the health system is broken down into component parts—hospital, clinic, specific types of providers etc, not put up as one large unit. For key decisionmakers, ask *how?* And note on the paper. Help participants to think about the connections between decisionmakers, and draw arrows where appropriate.
3. Venn part 2: looking at this diagram, which decisionmakers has the project helped make more informed decisions or improved services to women and children? How?	Talk about what the project has done for key decisionmakers (providers, fathers, the committee itself, mothers) and note this on the flipchart near the name of the decisionmaker.
4. What has been your role as a committee in the project?	If this did not come up in 3., raise it and add.
5. What do you see as your role in future?	

Red Crescent Visiting Nurses	Focus group or 1:1. I would like to talk with the head of the Red Crescent in Navoi (oblast and/or rayon) as well.
1. What is your job?	
2. Has your job changed as a result of the project? If so, how?	
3. What training or other inputs did you receive?	
4. What have been the best parts of this new work?	
5. What have been the most challenging parts?	
6. How do you interface with the health system?	
Breastfeeding support group volunteers	Focus group
1. Background on individuals, work, no. kids, age.	
2. Who organized this group and what is its role? How long have you been meeting? How many women have you reached?	
3. Where do you get information? Where do you go if you need information?	Note: we could also do the Venn exercise, as above.
4. What other types of information do you think would be helpful to pass along to pregnant women or women with infants or young babies?	
Community members: female	NOTE: NEED TO REVISE THIS BASED ON GROUP COMPOSITION, SEE MY Q ABOVE.
1. Background on individuals: age, work, no. children, where children delivered (BF or not).	
2. Did you notice any differences in your experience in x hospital this time than previous deliveries? IF so, what were they?	For women who delivered at BF hospitals. Brainstorm and make list on flipchart.
3. What do you know about hospital x and the procedures for birthing and postpartum care? What do you think about that?	For women who did NOT deliver at BF hospitals.
4. Venn exercise part #1.	Note: could also do the Venn exercise, as above.
5. What kind of contraception do you use? Where do you get it? Is this your method of choice?	
Explore some of the findings from the KPC and HFA as appropriate.	
Community members: male	Focus group
1. Background as above with females.	
2. Venn exercise part #1.	Probe particularly on role of fathers in decisionmaking.
3.	
3. What new information, if any, have you learned about pregnancy, birthing, infant or child health over the last 4 years? From whom?	
4. What additional information would you like on these topics?	
Community members: adolescents	
1. What was the most valuable thing you learned in the training?	
2. What would you like more information about?	

Navoi (NGOs)

HOPE staff	
1. Timeline of major events	Probe for how's and why's
2. What have been the major successes of this project? Challenges?	Individual and then list/cluster
3. What would you do differently in the extension?	
4. Partnerships	Venn for how important to project meeting its objectives: role of each in; probe for why?
5. What has surprised you the most in your experience in this project?	
Individual interviews: HOPE	
1. What has been your role?	
2. Most gratifying; most challenging part.	
3. What changes have you seen in the MOH system over the life of the project in your area?	
4. What have you learned that has been most valuable?	
Explore data	
HIS: 5. How has project monitoring data been collected over time? How is it used?	
6. Describe the MOH HIS system. Has it changed as a result of the project? How? Is data being used in a different way now than it was before?	
IEC: 7. How did you develop the msgs for your materials?	
8. Who pretested and how?	
9. Intermediate measures of impact?	
10. Distribution? Sustainability?	
11. Use of mass media and challenges?	
Red Crescent management	
1. Overview of visiting nurses program.	
2. How has this worked in the Navoi program?	
3. What do you think has been the major achievement of your program in the context of the HOPE project?	
4. What lessons have you built upon for the larger program?	
5. Has this collaboration built capacity in your organization? If so, how?	
Mining company	
1. Describe your health facilities and its relationship, if any to the MOH.	
2. Do you do any public health education in addition to the clinical services you provide?	
3. How much do you know about the HOPE project?	
4. What has been your relationship with the project?	DIP expected provider participation in technical updates.
5. Have you received any benefits from the project?	
6. Do you think your organization has contributed to the success of the project or any transformations in the MOH health delivery system? How?	

7. What is your policy on rooming in for newborns?	
8. Do providers give mothers information on breastfeeding? Care of diarrhea in young children? Danger signs?	
9. What kinds of contraception do you provide?	
Navoi NGOs	
1. Background on the NGO and their overall program.	
2. What has been your relationship with the project?	
3. What have been the 3 most important contributions you have made?	
4. How has your organization benefited from this project or this association?	
5. What were the 3 biggest challenges you faced?	
6. What do you think your greatest contribution to maternal and child health can be over the next 3-5 years?	

Outside Navoi

HOPE staff in new rayons	
1. What is your current job?	
2. What was your role in the previous project, if any?	
3. How much do you know about the previous project?	
4. What are the major elements of the new project that are similar to the previous one?	
5. What are the main elements that are new?	Probe on partnerships, community outreach, IEC.
6. What do you expect to be the biggest challenges to implementing the new project?	
7. How will you maintain achievements in the old rayons while launching in the new ones?	
8. What do you see as your role in national policy making?	
9. What do you see as the role of the new project in the HOPE MCH/RH project? Other HOPE projects?	
10. What is your relationship with MOH Navoi?	
Explore data—their ideas.	
MOH Rayonal Director in Extension Rayons	
1. What has your involvement in the previous project been?	
2. What do you know about the previous project?	
3. What were the most important accomplishments from the previous project?	
4. What do you think the most important lessons were—what to do this time, and what not to do?	
5. What do you expect to be the benefits in your rayon of the new project?	Probe for specifics--components
6. How do you expect these benefits to be sustained over the longer term, after the project is finished?	
7. What do you anticipate as your biggest challenges?	
TOT"s from non-project rayons	
1. What is your job?	
2. What kind of training did you receive?	
4. What were the 3 most important things you learned in the training?	
3. What kind of training have you delivered?	

4. What have you found most challenging in delivering the training?	
5. What other types of training would help you?	
6. Are you doing supervision in addition to training?	
7. How has that changed as a result of project training?	
8. Have you faced any challenges in the rayon in implementing the training?	
9. Where do you go if you have questions about subjects covered in the new training?	
Medical school reps from Bukhara and Samarkand	
1. What contributions has the project made to universities?	
2. Why did you approach HOPE for these inputs?	
3. How effective have they been?	
4. What other aspects of the program that you know about would you like to see incorporated into your curriculum?	

U.S.

Bettina Schwethelm	
1. Contact info for WHO/Copenhagen and who is best to talk to?	
2. Abt? WB? Unicef?	
3. Steering committee—role anticipated; role played?	
4. Most successful aspect of community component?	
5. Most successful aspect of natl policy work?	
6. Relationship with Kyrgestan CS project?	
7. Most challenging aspect of the training of providers?	
8. How have supervision systems in the project changed as a result of the project?	
9. HIS?	
10. Role of U. of Michigan? Worth talking to?	
11. Special studies—which, where?Who determined what special studies to do? Who conducted? Available in English?	
12. How has this project strengthened the capacity of HOPE/US or HOPE/Uz?	
13. Management issues: reasons? impact?	
14. Most important changes in MOH capacity as a result of the project?	
15. Challenges of institutionalizing aspects of the project—e.g. midterm says govt. not "claiming responsibility" for providing IEC materials.	
16. What 3 things would you do differently or will you do differently in the extension?	
Debbie El Anani	
1. Historical perspective on management issues.	
2. How did the Navoi project inform development of the Kazakhstan design?	
3. What other projects has it informed?	
Anara, Kyrgestan CS Project	
1. How has the Navoi project informed or influenced the design and implementation of the Kyrgestan CS project. Can you give me specifics and details.	
2. Are there specific lessons learned in Navoi that influence the way you are implementing your project?	
3. What kind of contact has there been between the staff of each project?	
4. Is there anything you would like to know more about the Navoi project that would help you in your project, that we could investigate in the evaluation?	

Erika Latkis	
1. What was the role of U. of Michigan?	
2. What impact did they have on thinking and practice in the Oblast? Nationally?	
3. What have been the most impt. Changes in the areas of safe motherhood in terms of practice in the oblast? Nationally?	
USAID	Sent to Susan Youll who agreed to circulate to relevant people in USAID/DC; will also contact Andreas Tamberg in Tashkent
1. Can you give me some background on your involvement of and knowledge about this project? What was the period of your involvement? How often did you meet with HOPE staff during the Project's implementation? Have you visited the project in the field?	
2. This project formed the basis of the larger MCH/RH bilateral initiative for Uzbekistan and Tajikistan, also being implemented by a consortium led by Project HOPE. In your view, what were the key aspects of the CS project that recommended it for replication and scale up?	
3. Aside from these factors, what would you say have been the major achievements of this project? To what do you attribute these successes?	
4. What would you say have been the major challenges in implementing the project, and to what do you attribute these challenges?	
5. Are there any issues, or themes you believe are particularly important for investigation or individuals or stakeholder groups who may merit particular attention in the upcoming fieldwork phase of the evaluation (August 21-29)?	

Other doc's to review and items to check on

G. Special studies	**H. Sarah and Bettina will gather/send**
Mid term recommended curricula and protocols covering essential and emergency obstetric and newborn care in Russian/Uz—done?	
Mothers' cards and any other IEC materials	
I. Oblast IMCI Center	
J. Drug availability	

Annex E
Items in the Media about the Project

Name of newspaper	Edition	Date of edition	Name of article	Short description of the article	Author of the article
Salomatlik	Oblast news-paper	06.02.2001	"Project HOPE's new plans"	Seminar concerning Breastfeeding, Reproductive Health and IMCI in collaboration with Oblast Health Department was conducted.	
Dustlik bayrogi	Oblast news-paper	20.03.2001	"For health of your child"	Project HOPE in collaboration with Oblast Health Department conducted an Orientation meeting on Breastfeeding, Work with population, Creating of a working group.	
Dustlik bayrogi	Oblast news-paper	12.04.2001	"The first steps"	Project HOPE – an international organization working in Navoi Oblast. Its activity directed on improvement of mother and child care. Project HOPE is working with health providers on improvement of health staff's training.	
Dustlik bayrogi	Oblast news-paper	12.04.2001	"If newborn baby feels thirsty or it's no need to give a child a nipple".	Breast milk is one of the most important components for growth and development of a child. Some useful vitamins like A, B, C, iron and other you can find in breast milk. It is necessary to breastfeed a child till 4-6 months not giving boiling water, tea, juice. Health providers do not recommend to give a nipple to child because nipple can be a cause of different gastrointestinal	Babamura-dova M., Muratova N.

				diseases, wrong development of jaw and different infectious diseases.	
Salomatlik	Oblast news-paper	16.04.2001	"Project HOPE's purposes"	Project HOPE's purposes and main directions were discussed during meeting with NGOs of Navoi Oblast.	Khotamov J.
Znamya drujbi	Oblast news-paper	01.06.2001	"Project HOPE in action"	Monitoring on usage of health items and after training were conducted. New direction of the Project. Orientation meeting on IMCI that took place on May 2001.	Babamura-dova M.
Dustlik bayrogi	Oblast news-paper	14.09.2001	"Humanitarian assistance"	Project HOPE rendered a technical assistance on amount of $105 thousands – medicines.	Oybuvi Ochilova
Dustlik bayrogi	Oblast news-paper	01.01.2002	"Basis of Baby-friendly status"	Talk with chief of maternity department in Navoi CRH – Oybibi Nurmatova. She told about preparation of maternity complex to "Baby-friendly" certification . Health providers were trained on seminar about Breastfeeding with assistance of Project HOPE.	Oybuvi Ochilova
Salomatlik	Oblast news-paper	01.01.2002	"Happy New Year"	Interview with Oblast Health Department's chief Nosirov A.M. about getting of UNICEF/WHO "Baby-friendly" certificate in 2 CRHs of Kiziltepa and Navoi rayon. Congratulations on getting "Baby-friendly" certificate.	
Oyla Jamiyati (Family society)	Republic an news-paper	23.01.2002	"A child have to grow with mother's love"	Interview with chief of department in Navoi rayon CRH's – Oybibi Nurmatova. The clinic is preparing for "Baby-friendly" certification. Maternity House has 115 beds. Women conducting talks about meaning of Breastfeeding.	Oybuvi Ochilova

				Assistance is rendering with technical assistance of Project HOPE.	
Oyla va jamiyat (Family society)	Repub-lican news-paper	23.01.2002	"A child growing with mother's love".	The article about getting of "Baby-friendly" certificate by Navoi rayon's clinic.	Oybuvi Ochilova
Dustlik bayrogi	Oblast news-paper	01.02.2002	"IMCI"	Some activities on IMCI on WHO's program were conducted. Since 2001 training of health providers on IMCI is taking place in Navoi Oblast. Opening of IMCI Center.	Babamura-dova M.
Dustlik bayrogi	Oblast news-paper	15.02.2002	"People's health"	An Orientation meeting on IMCI in Buchara Medical Institute. The article about conduction of a round table with health workers of Buchara Medical Institute and Oblast Health Department. Nodira Sharipova – representative of GP faculty.	Oybuvi Ochilova
Salomatlik	Oblast news-paper	01.05.2002	"Concerning to Project HOPE's program"	In Toshrabod of Kiziltepa rayon was conducted "The best nurse" competition. On the 5th of April competition on Breastfeeding was conducted where 7 health nurses took a part. The article describes the competition conduction and talks with population also.	
Dustlik bayrogi	Oblast news-paper	21.05.2002	"Safe Motherhood"	Creating of IMCI Center, technical support to the Center. Program on Reproductive Health. Conduction of seminars on Breastfeeding, Reproductive Health, IMCI. Preparation to meeting on Safe Motherhood.	Oybuvi Ochilova
Health System in Uzbekistan	Republic an news-paper	23.07.2002	"Analyses of health knowledge on main skills on child care".	The article about conduction of population's interviewing on childcare. Conduction	Babamura-dova M.

				of meetings in focus groups and conduction of researches among Population.	

Vestnik of NGOs	Oblast news-paper	01.10.2002	"Project HOPE in Navoi Oblast"	The article contents a short story about general activity of Project HOPE and about done work of Project HOPE since 2000.	I.Alek-sandrova
Znamya drujbi	Oblast news-paper	19.11.2002	"Keeping the most valuable"	The article contents interview of Project HOPE's coordinator-Abdunabi Kuchimov. He told about Project HOPE's program, tasks, achievements for the last time. He also noted that our "Child Survival" program directed to improvement of Child's and Mother's health condition. Project HOPE's main directions are: Safe Motherhood, Reproductive Health, Breastfeeding, prophylactics of child's diseases. Project HOPE's staff is realizing the program by conducting training seminars, monitoring and preparing of trainers from health providers and nurses and also organizing different meetings with makhalla activists, pregnant and women having children under 5. During Project HOPE's activity 2 hospitals got "Baby-friendly" status.	I.Tudvasev
Dustlik bayrogi	Oblast news-paper	14.01.2003	"On the way to recovering of population"	On November 2, 2002 a joint meeting with Oblast Health Department's collaborators and working group on work with population. The meeting was headed by Oblast khokim's deputy Ibragimova M.A. On the	O.Mu-Rodullaeva

				meeting was created a plan on work with population in 2 pilot rayons. Mavzhuda Babamuradova and Abdunabi Kuchimov told about Project HOPE's activity.	
Salomatlik	Oblast news-paper	16.01.2003	"Oblast Maternity complex got "Baby-friendly" status"	Collaborators of Oblast Maternity complex carefully prepared to getting of Baby-friendly status. Their knowledge and efforts were evaluated by an international experts. Project HOPE rendered a great assistance to Oblast Maternity complex in getting of Baby-friendly certificate. During handing the certificate Oblast khokim's deputy Ibragimova Musallam Adizovna and Oblast Health Department's chief Abdurakhmon Nosirov, chairwoman of "Red cross" Oblast society Bakhrieva M.A. and Mavzhuda Babamuradova.	J.Akhtamov
Dustlik bayrogi	Oblast news-paper	14.02.2003	"Increasing of health knowledge among population"	Orientation meeting on IMCI - third component (Work with population) was conducted in Kiziltepa and Navoi rayons. Oblast khokim's deputy Ibragimova M.A. emphasized necessity of introducing "Work with population" program in prosperity year for makhalla. Kuchimov A. told about purposes of the program and got acquainted participants with introductory steps of the program to population.	O.Mu-rodullaeva
Dustlik bayrogi	Oblast news-paper	28.03.2003	"Health generation – health future"	During Steering meeting on Safe Motherhood conduction was discussed issue on creating of Oblast Center on Safe	O.Mu-rodullaeva

				Motherhood.	
Dustlik bayrogi	Oblast news-paper	18.04.2003	"That a child to be healthy"	The article is about conduction of competitions on makhalla level on topic "That a child to be healthy" in 2 pilot rayons.	O.Mu-rodullaeva
Navoi avozi	Rayon news-paper	30.05.2003	"Such a wonderful brochure"	Population of Navoi rayon approved issuing and creating of "That a child to be healthy" brochure.	Kenjaeva N.
Dustlik bayrogi	Oblast news-paper	05.06.2003	"Purpose – creating of a healthy family"	Steering meeting was conducted in Navoi Oblast and programs "Organization of Reproductive Health in health facilities" and "Issues of creating a healthy family on makhalla and family level" were made out	Namozova D.
Salomatlik	Oblast news-paper	12.06.2003	"Purpose – creating of a healthy family"	Collaborators of Project HOPE and Oblast Health Department organized meeting where Reproductive Health issues were discussed. On the discussion were collaborators of Health Ministry of Uzbekistan K.Yadgarova and Oblast Health Department's chief Abdurakhmon Nosirov.	Namozova D.
Khamshira	Oblast news-paper	06.2003	"Is it important consulting of patients?"	All 8 pages of the newspaper are devoted to consulting on Reproductive Health and family planning.	M.Murodova
Dustlik bayrogi	Oblast news-paper	17.06.2003	"Project HOPE's collaborators in kindergarten"	Project HOPE's collaborators on Children defense holiday visited kindergartens in 2 pilot rayons. Due to the holiday children got presents and Project HOPE conducted meeting with kindergarten's collaborators and mothers on topic "Health generation-health future" also.	O.Mu-rodullaeva
Tumaris	Oblast	07.2003	"Opinion of Mrs.	In many makhallas of	Sh.Zoirova

	news-paper		from America”	pilot rayons were conducted meetings with Judi Aubel. Judi Aubel highly evaluated traditions of our people, relationship of young and old generation, role of grandmothers in family.	
Dustlik bayrogi	Oblast news-paper	21.08.2003	“People’s health – Country’s health”	in the article is written about Project HOPE’s activity and development of Project HOPE from starting the project and about Breastfeeding week and final evaluation	O.Ochilova