COUNTERPART

Umir Nuri
Rainbow of Life
Child Survival Program, Uzbekistan

Mid-Term Evaluation Report

Prepared by:
***Umir Nuri (Rainbow of Life)* Child Survival Program**
Counterpart Interntional / Center Perzent / Ministry of Health
Karakalpakstan, Uzbekistan
Cooperative Agreement No.: FAO-A-00-00-00027-00
October 2000 – September 2004

Submitted to:
USAID, Bureau for Global Health, Office of Health, Infectious Diseases, and Nutrition

SEPTEMBER 2003

Written by:
Arvind Kasthuri, MD
St Johns Medical College, Bangalore, India

With editorial assistance from:
Darshana Vyas, MSW, MPH
Director, Health Programs, Counterpart HQ
Washington DC, USA

Ramine Bahrambegi, MPH
Program Director, Umir Nuri Child Survival Program
Karakalpakstan, Uzbekistan

LIST OF ABBREVIATIONS USED

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BFSG	Breastfeeding Support Group
CDD	Control of Diarrheal Disease
CHAP	Counterpart Humanitarian Assistance Program
CS	Child Survival
CSCC	Child Survival Co Ordination Committee
CSTS	Child Survival Technical Support group
DIP	Detailed Implementation Plan
HFA	Health Facility Assessment
HIV	Human ImmunoDeficiency Virus
HMIS	Health Management Information System
IMCI	Integrated Management of Childhood Illness
JDA	Joint Development Associates
KPC	Knowledge Practice and Coverage Survey
LOP	Life of Program
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSF	Medecins sans Frontiers
MTE	Mid Term Evaluation
NGO	Non Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
SCM	Standard Case Management
TOT	Training of Trainers
TTAP	Technical Training Assistance Plan
CSP	(Umir Nuri) Child Survival Program
UNICEF	United National International Children Emergency Fund
UNDP	United Nations Development Program
USAID	United Sates Agency for International Development
VHC	Village Health Committee
VHW	Village Health Worker
Wtp	Willingness to Pay
WHO	World Health Organization

CONTENTS

Dedication

This report is dedicated to the memory of two persons who have left an indelible mark on the Umir Nuri Child Survival Program. Dr Nuriyah Elgondieva was intimately involved with the program from 2001 till her untimely demise in January 2003. Dr Damir Babanazarov helped in seeing the program through its initial planning and preparatory phases, and was a good friend of the program.

Dr. Nuriyah Elgondieva was born on October 7, 1975 in Takhiatash, Karakalpakstan. She graduated from the Samarkand University as a medical doctor with experience in Parasitology, Immunology and Infectious disease.

Nuriyah joined the Umir Nuri Child Survival Program at its inception in 2001 and made invaluable contributions during the start-up of the program and during its subsequent activity including BCC workshops, KPC and HFA surveys. Starting her work in Counterpart Nuriyah as Field Officer in Takhtakupir Rayon, Nuriyah moved on to become Health Education Specialist and finally, Program Manager.

Nuriyah's positive outlook, personal charm, and love for Karakalpakstan was combined with a high level of commitment and competence at the workplace, which served as a model for everyone who worked with her. The UNCSP is coping with her tragic and untimely death by carrying on her work and spreading her ideas throughout Karakalpakstan.

Dr. Damir Babanazarov served as Minister of Health in the Republic of Karakalpakstan. He was a man of high virtues, a well-developed personality who possessed high levels of intellect and talent. He made immense contributions to the Health Care Delivery System of Karakalpakstan. His most notable contribution was in establishing and improving relations with different international agencies and organizations who continue to contribute to the Health of the people of Karakalpakstan. The UNCSP was fortunate in being involved with him in its initial stages and has lost a good friend in his Passing on.

His most notable legacy is the name of the program, which he helped formulate – Umir Nuri, or "Rainbow of life."

Executive Summary

Program Description

The "Umir Nuri" ("Rainbow of Life") Child Survival Program (CSP) is a USAID-supported program located in Karakalpakstan, which is an area of Uzbekistan bordering the Aral Sea. The program is implemented by Counterpart, an international NGO based in Washington, USA, working in partnership with Centre Perzent, a local NGO, and the Ministry of Health in Karakalpakstan. The program was initiated in December 2000, and the detailed implementation plan submitted in April 2001, following baseline assessment. The program is planned over a 4-year duration, till December 2004. A mid term evaluation was commissioned in June 2003.

Goal Objectives Strategies

The program aims to sustainably reduce mortality among children under five years of age in TWO rayons (administrative units) of Karakalpakstan – Nukus and Takhtakupir, and to build the capacity of the partner NGO, Centre Perzent in the area of child survival. The technical interventions of the program are directed at THREE broad issues, Control of Diarrheal Disease (35% effort), Pneumonia Case Management (45% effort) and Promotion of Breastfeeding (20% effort). The objectives of the program are to improve knowledge and practice of mothers and caretakers with respect to the three interventions by improving access to information and services. The main strategies which the program uses include: mobilization of the community by facilitating the formation of Village Health Committees, developing and implementing an effective Behavior Change communication strategy, building its own capacity to train, implement and monitor the program and networking with like minded organizations in the area to enhance effectiveness and play an advocacy role.

Technical Interventions -Accomplishments

In the area of Technical Interventions relating to the Management of Diarrhea disease, Pneumonia Case management and promotion of breastfeeding, ALL KEY indicators (as stated in the DIP) of Knowledge and Practice measured at the mid term are estimated at levels HIGHER than the baseline level. The proportion of mothers of children under two years of age surveyed who knew the danger signs of diarrhea requiring treatment was 87.3% (32.0% at Baseline) and the proportion of mothers who could correctly state the method of preparation of ORS and use it was 84% (42.3% at baseline). The proportion of children who had diarrhea in the two weeks preceding survey and who were treated with an acceptable form of ORT was 70.4% (9.1% at baseline). The proportion of mothers who knew the danger signs of Pneumonia requiring treatment was 96.0% (61.3% at baseline). While no mother surveyed at baseline could state the two danger signs of rapid breathing and chest indrawing as danger signs of pneumonia requiring treatment, 47.0% of mothers surveyed at the mid term could state this correctly. The proportion of newborns breastfed within one hour of birth was 61.3% at the mid term (44.0% at baseline) and the proportion of infants under six months of age who were exclusively breastfed was 70.0% (28.0% at baseline). However, the proportion of mothers whose children showed

symptoms of Acute Respiratory Infection (ARI) in the two weeks preceding the survey and who took the child to a qualified health care provider on the same day was 11.8% (42.9% at baseline).

Partnership

The Partnership of Counterpart with the Ministry of Health and with the NGO Perzent is a positive outcome of the program, with all partners having a clear perception of the program and of their roles. The capacity of the NGO Perzent has been enhanced by the program. This is evidenced by the availability of technically competent staff, the enhanced training ability of the organization and the ability of the organization to independently attract funding in the area of Child survival and Reproductive health. Even though a Health Facility assessment was not a part of the mid term evaluation, the impression from qualitative study was that the health facilities and personnel at the facilities have an increased capacity to deliver care in the areas of diarrheal disease and pneumonia, and in the promotion of breastfeeding.

Community Mobilization

18 Village Health committees (VHCs) have been formed at the community level. The VHCs appear to have a clear perception of the program, and are willing to give time and effort to enhance the reach of the program benefits into the community. Other community-based groups that have been facilitated by the program are breastfeeding support groups, and schools of mothers. At the rayon level, the program has established a Child survival co ordination committee in each of the two program rayons, which is an effective mechanism for enhancing visibility of the program, and for problem solving.

BCC

The program has successfully produced behavior change communication (BCC) materials for use by its beneficiaries and its workers, which is one of its most visible and major accomplishments. The materials have been translated and produced in Karakalpak language, which is used locally. The program uses house visits as an important one-to-one communication strategy. Other innovative methods used include Puppet shows, and street plays.

Staff and Training

The program has had turnover at the level of Project director, and the current incumbent is due to complete a year in September 2003. The program was unfortunate in having lost its dynamic Program Manager, Dr Nuriyah Elgondieva, who died tragically in January 2003. But most of the field staff and support staff at the program office in Nukus have been with the project since its inception. The field staff are an asset to the program, and have developed a good level of competence in delivering messages to the community. Training is an important activity of the program, and a total of 18 training programs have been held since program inception, aimed at a wide variety of audiences, ranging from in-house programs for program staff to programs for personnel of the Ministry of Health at the health facilities. In House trainers have been groomed, and the program can currently handle most of its training on its own.

HMIS

The Health Management Information System (HMIS) has been developed by the program for its own use. The system includes a 6-monthly collection of indicator-level information, and process-related information is collected monthly, as it should be. The staff who manage the HMIS are competent, and could improve with training.

Networking and Advocacy

The Networking and advocacy strategy of the program is founded on monthly interagency and intersectoral meetings, where like-minded organizations come together to discuss matters of mutual interest, and to represent issues of concern at the policy making level. The present program Director has ensured that the program is visible at Karakalpakstan, and in Uzbekistan, and is committed to building a good network which will improve effectiveness.

Village Pharmacies

The Program has done a Willingness-to-pay survey in the area, with the aim of establishing Village based pharmacies. This is based on the observation that often, health facilities do not have stocks of essential drugs, needed for the effective management of Pneumonia and other child health problems. This initiative is an important step in the area, and has the approval of the Ministry of Health.

Sustainability

The sustainability of the program is founded on the following:

- Building the capacity of the NGO Perzent to be able to plan and implement a similar program
- Building the capacity of the Ministry of Health, so that the care and services at the Health facilities continue to be good
- Establishing Village Pharmacies, based on research done which showed that communities were willing to pay for drugs of good quality, if available at their villages
- Establishing a firm Community based organizational network in the form of VHCs and other organizations of women, so that the community takes ownership of the program
- Effectively communicating for behavior change during the life of the program, so that it can be sustained after the program withdraws

There is a need for Child survival activity to be continued in the region. The future of the program, if support for continued Child survival activity is available, may be in the following directions:

- Continuing in the same rayons and expanding the range of issues covered to include other health problems like HIV/AIDS control, and Anemia. Levels of awareness among mothers regarding HIV has been studied at the baseline and mid term, and it shows no change in level over the past two years.
- Expanding into different rayons, replicating the model, with the appropriate local modifications.

In either option, the NGO Perzent could play a larger role in the implementation of the program, with Counterpart providing technical advice and support.

Other important recommendations for the program include:

Recommendations

- The program may need to quickly research the ARI practice issue to find out the reasons for delay in care-seeking and may need to design an appropriate strategy.
- The targets set in the DIP have been exceeded in most cases. Appropriate revision would have to be done for the remaining life of the program.
- The establishment of ORS corners at Health facilities would be a useful step to improve further the practice of ORT during diarrhea since the ORS corners are a popular concept with the Health facility personnel.
- Messages relating to feeding during diarrhea and to handwashing practice for the prevention of diarrhea could be strengthened, since many mothers surveyed did not practice these behaviors appropriately.
- The practice of early initiation of breastfeeding is another area where more input could be given, since many mothers do not practice this.
- Some of the additional areas for strengthening capacity of Perzent include Documentation, Dissemination of information, Lobbying and advocacy to secure support for important issues and the HMIS.
- The program could consider the formation of more womens groups. Following the completion of the life of the program, the continued dissemination of messages to mothers in communities are best done by women, and peers. A Social worker in the program staff could assist in this activity.
- The BCC materials prepared by the project have been well accepted. The production of materials in Karakalpak has been a challenge, which has been successfully handled. Occasionally, there have been delays in the production of materials, due to different interpretations of translated words. Such delays must be avoided.
- The communities met during the evaluation asked that material and methods of BCC have more visual content, like television spots, short films, videos and leaflets with increased graphic content.
- Periodic refresher training especially for new recruits is an important task which must be given the priority it deserves.
- The HMIS staff have developed their own tools, and have adapted them to suit the requirements of the program. However, the program could organize training on HMIS for its staff, to enhance the effectiveness of monitoring.
- The Program could organize scientific conferences / symposiums in the region on issues related to Child survival and Reproductive Health. This would give an opportunity to present its achievements, learn from similar experiences and secure support for the future.

Introduction

Counterpart International (Counterpart) is an international non-profit organization headquartered at Washington DC, USA. It was founded in 1965, working initially in the islands in the South Pacific region. The area of activity and geographic coverage have increased over the years, and Counterpart currently works in over 60 countries, with affiliate organizations in various regions.

The **Core strategy** in Counterpart's activity is to build partnerships and empower local organizations and communities. To this end, Counterpart's work is categorized into the following divisions:

- Humanitarian assistance
- Civil society and governance
- Food security and sustainable agriculture
- Environment and Natural resource
- Small Micro Enterprise
- Health and Child Survival

The **Health and Child Survival Division** of Counterpart implements programs in the following domains

- Child survival
- Reproductive Health
- Primary Health Care
- HIV / AIDS prevention and control

Some of the unique features of the approach adopted by Counterpart include

- The encouragement of micro enterprise to build capacity
- The design of programs based on need and demand
- The building of partnerships with local organizations, aimed at their empowerment.

Counterpart has been present in **Uzbekistan** since 1993, mainly working with Civil Society and Governance, identifying and supporting small NGOs in the region. The strategic vision of the organization perceived that the presence of Counterpart in the Central Asian region was a good foundation for a program aimed at **Child survival**.(CS)

The **Karakalpakstan** autonomous region was identified within Uzbekistan as being an area of need based on high rates of Infant and Child Morbidity and Mortality and relatively little international assistance in Health and Child Survival. At the suggestion of the Ministry of Health in Uzbekistan, it was decided to locate the child survival program in Karakalpakstan.

An effort was then launched to locate **partners** in this area. While the **Ministry of Health in Karakalpakstan** (MoH) was recognized as one partner, a suitable Non Governmental Organization (NGO) was looked for as being the other. Center **Perzent**, an NGO of repute in the region, was identified as the other partner following a process of assessment using, among other methods, the Organizational Assistance Tool and the Technical Assistance and Training Plan (T T A P) tool of Counterpart.

Center Perzent (means "progeny") was established in 1992 as a center for reproductive health by Dr Oral Ataniyazova, a committed reproductive health clinician. The mission of the organization is to improve the health status of the women and children in Karakalpakstan. To this end, Perzent runs a reproductive health clinic, implements environmental education programs, and is engaged in activities which promote safe motherhood. The organization is active in 8 out of 15 rayons in Karakalpakstan.

An intense **period of planning** involving all the partners was then initiated which culminated in the launch of the Child survival program in December 2000. The main **aim** of the program is to **reduce mortality** among children under five years of age in two rayons of Karakalpakstan, Nukus and Takhtakupir, by intervening in three key areas that address the major causes of morbidity and mortality among children in the region:
- The control of **Diarrheal disease**
- **Pneumonia** Case management
- The promotion of **breastfeeding**

The program also aims to **build the capacity** of the partner organization, Perzent, so that the benefits of the program can be sustained in the region.

The program was christened **"Umir Nuri"** or "Rainbow of life", based on discussions had with the former Minister of Health, the community and local Makhalla chiefs.

The program was **unique** in the following dimensions:

- The program is located in **Karakalpakstan**, which is an area of under development within Uzbekistan. Karakalpakstan is the site of the Aral Sea environmental crisis, where the waters of the Aral sea have receded, leading to large areas of unusable and polluted land.

- It represented a **partnership** between an international organization, a local organization and the Ministry of Health. This was a new approach to a health program in Uzbekistan.

- The partnership was based on a written **Memorandum of Understanding** (MoU), which outlined each partner's roles and responsibilities.

- The program **involved the partners** and others including local community leaders, doctors from the rayons, NGO representatives and others, intensively from the stage of planning through implementation and evaluation.

- **Child survival** is in itself a unique area of focus in an NGO-driven program in Karakalpakstan.

- The program, in its goals and objectives aims to **involve the community** as an integral part of the program as opposed to programs which hand out benefits to be passively received by a target group, or others which work directly with health facilities without involving the community.

Program overview

Location

The Umir Nuri Child survival program (CSP) is located in Karakalpakstan which is in North West Uzbekistan, bordering on the Aral Sea. **Infant mortality rates** are estimated to be higher than the nationwide average in Uzbekistan, due in part to the environmental and ecological hazards in the Aral Sea region. In 1997-98, the maternal mortality rate for Karakalpakstan was estimated to be 48.1 per 100,000 live births, while maternal mortality in Uzbekistan was only 31.2 per 100,000. **Health problems** in Karakalpakstan are largely due to the breakdown of health care infrastructure in the region, as well as poor sanitation and hygiene practices. It is estimated that the prevalence of tuberculosis, cancer, anemia, kidney and liver diseases is significantly higher in Karakalpakstan than in other regions of Uzbekistan.

Karakalpakstan administratively comprises 15 rayons (districts, regions, administrative divisions). The Umir Nuri program works in **two** of these rayons – **Nukus and Takhtakupir**, which were chosen based on the high rates of Infant and child mortality, and the commitment of the MoH and the organization Perzent to improve the Primary Health Care system in the area.

The leading **causes of infant mortality**, as well as overall mortality, in Uzbekistan include respiratory illnesses (mainly pneumonia) and diarrheal diseases. Poor nutrition is a risk factor associated with many serious illnesses, including acute respiratory infections (ARI) and diarrheal disorders, as it can exacerbate the effects of these diseases. Due to the unreliability of health data, the rate of ARI, as also the death rate is most likely higher than reported in the official statistics.

Nukus city is the capital of the Karakalpakstan autonomous republic. The Umir Nuri CSP office is located in Nukus city. Some of the health status indicators for the area are as follows:

Table 1: Health status indicators in Karakalpakstan and Uzbekistan

Indicator	Karakalpakstan	Uzbekistan
Area	164,900 sq. km.	447,400 sq. km.
Total population Male Female	1,484,069 712,353 (48%) 771,716 (52%)	23,797,500 11,874,952 (49.9%) 11,922,548 (50.1%)
Density (per sq. km)	12	47

Indicator	Karakalpakstan	Uzbekistan
Number of women of reproductive age (15-49 years old)	378,437 (25.5%)	5,973,172 (25.1%)
Number of children 0-14 years	547,636 (36.9%)	9,233,430 (38.8%)
Live births	31,564	544,500
Birth rate per 1000 population	22.8	29.4
Infant mortality per 1000 live births Urban Rural	24.9 27.8 22.4	45
Maternal mortality per 100,000 live births	48.1	31.2
Hospital beds per 10,000 population	64.7	58.8

Goals

The program has TWO goals:

- To sustainably **reduce the mortality rate** among children under five years of age in the program rayons – Takhtakupir and Nukus
- To improve the **capacity of Perzent** (the partner NGO) to plan, implement and evaluate child survival programs

Objectives

The target group for the program are children under the age of five years residing in the area and their caretakers. The program objectives are directed at improving knowledge and skills of caretakers of children and the capacity of the MoH facilities in the management of **three key interventions:**

- The control of Diarrheal disease
- Pneumonia case management, and
- The promotion of breastfeeding.

Specific objectives of the program include the following:

- To Improve breastfeeding practice among mothers of children under three in the area
- To improve management of diarrhea using an acceptable form of ORT
- To improve knowledge regarding danger signs of dehydration, dysentery, and persistent diarrhea among caretakers of children in the area

- To improve the capacity and performance of caregivers in health facilities in the project area to correctly assess, treat, and counsel caretakers for diarrhea among children.
- To improve knowledge regarding danger signs of pneumonia requiring medical treatment among caretakers of children under five years of age in the area.
- To improve care seeking behavior among caretakers of children showing danger signs of pneumonia
- To improve the capacity of health facilities in the region in the management of diarrhea and pneumonia
- To improve the capacity the NGO Perzent, to sustain activities and programs beyond the four-year duration of the program.

Baseline assessment

The knowledge and practice of caregivers of children under five regarding diarrhea, pneumonia and breastfeeding was assessed by means of a rapid Knowledge, Practice and Coverage (KPC) survey. The survey was done in January 2001 using the standard methodology developed by the Child Survival Technical Support group (CSTS) for use by Child survival projects. A Health facility assessment (HFA) was also done. The detailed reports of these activities are available in the CSP office at Nukus. (See attachment for summary of baseline assessments)

Program strategies

The important strategies which the program planned to adopt in order to achieve the objectives and goals were:

- **Behavior change communication**
  This included
  - the design, development and use of material aimed at improving caretaker knowledge and practice based on the *Behave* framework, and
  - The development and implementation of a training strategy to improve capacity of the MoH health facilities in the three intervention areas

- **Community mobilization**
  The program planned to facilitate the development of organizations at the community level and at the rayon level.

  At the rayon level, **Child survival co coordination committees (CSCCs)** were to be established, with the Chief doctor/pediatrician of the rayon, the Deputy Hakim on women's issues, and other community leaders as its members. These committees would serve as an informal process-oriented mechanism for program review.

At the community level, **Village health committees** would be formed with members drawn from the local makhalla committees, mothers and other interested community members.

- **Capacity building activity**
  Though not stated as a separate strategy, the building of capacity of Perzent, the local NGO partner of Counterpart, was planned as being interwoven into the project activity. The building up of capacity of the MoH, through its Health facilities, was another important activity built into the project.

- **Networking and Advocacy/ Collaboration with other International organizations**
  The Umir Nuri CS program would build upon the excellent relations it has with other international organizations working in the area, such as USAID's mission at Tashkent, Institute of Pediatrics, UNICEF, WHO, Peace Corps, Medecins sans frontiers (MSF), Red Cross, JDA, Project HOPE and others. Many of these organizations had expressed a desire to collaborate with the project, and the Umir Nuri program would explore these collaborations. It would raise issues of common interest with the Ministry of Health and other policy making bodies, and strive to improve the health status of the children in the selected rayons in Karakalpakstan.

The CSP commenced its activity with the submission of its Detailed Implementation Plan (DIP) in April 2001.

The Mid term Evaluation of the Umir Nuri Child Survival Program

The Mid term evaluation of the CSP (MTE) was carried out between May and July of 2003. Dr Arvind Kasthuri, MD, Professor, Department of Community Health, St Johns Medical College, Bangalore, India facilitated the evaluation, at the request of Darshana Vyas, Director, Counterpart Health Programs. Dr Kasthuri has conducted similar studies for other International agencies including the CS programs of Counterpart (India and Turkmenistan), PLAN international and Catholic Relief Services. The participation of the Director, Counterpart Health Programs and of the CSP staff, led by Ramine Behrambegi, the program director, was ensured through the process.

The **Objectives** of the MTE were

- To Assess progress of the programs technical interventions in relation to its objectives
- To Study the strategies used by the CSP in its implementation
- To Identify areas of strength and weakness in the program
- To Suggest possible directions for the future of the CSP

It was ensured that the **method** used was participatory in nature, including a blend of quantitative and qualitative approaches. Specific methods used included:

- Review of documents pertaining to the CSP including the DIP, Annual reports, Quarterly newsletters, Reports of workshops, training programs and Research activity, May – June 2003

- Site visit to the CSP program site in Karakalpakstan, June 2003 which included the following activity:

    - A meeting of all stakeholders of the program on the first day, when the evaluation was introduced, and their concerns listed and discussed. Participants included the program director of the Child Survival program in Navoi, Uzbekistan.
    - A series of group discussions and interviews of Key informants had at the field
    - A Rapid Knowledge, Practice and Coverage (KPC) survey, for which training, implementation and preliminary analysis were completed alongside the qualitative data collection process

(*See attachment 1 for site visit schedule, list of persons met and notes on methodology)*

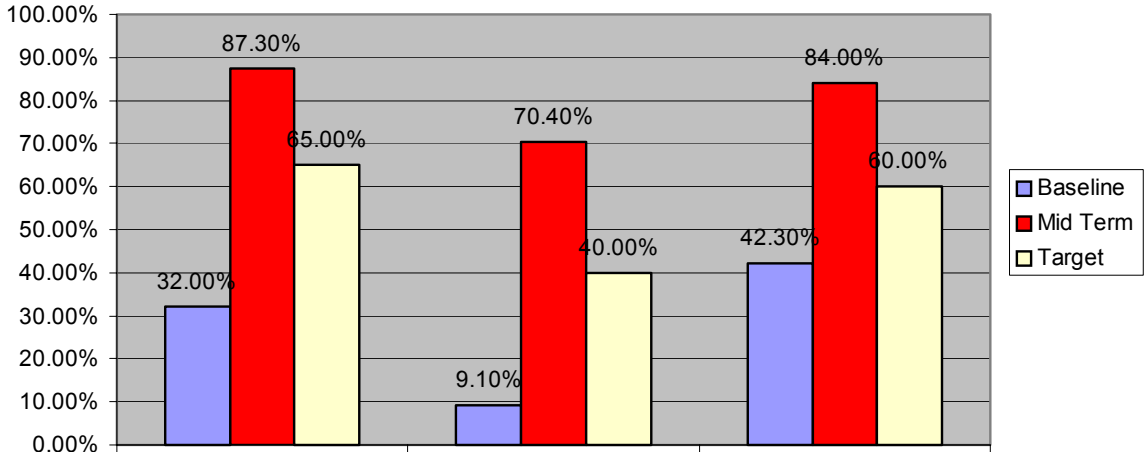
- Development and presentation of the report of the MTE, July 2003, with the CSP office and the Director-Health programs, Counterpart

This document constitutes the report of the evaluation.

Technical interventions

A. Control of Diarrheal Disease

Key Indicators - Diarrheal Disease



	Knowledge- danger signs	Treatment with ORT	Correct ORS use
Baseline	32.00%	9.10%	42.30%
Mid Term	87.30%	70.40%	84.00%
Target	65.00%	40.00%	60.00%

Comparison with Baseline			
KEY INDICATORS (from DIP)			
Indicator	**Baseline (Jan 2001)**	**Mid term (June 2003)**	**Target (Dec 2004)**
Mothers with children under 2 yrs of age who are able to state at least TWO danger signs of diarrhea requiring treatment	**32.0 %**	**87.3 %**	**65.0 %**
Children under two years of age with diarrhea in the past two weeks whose mothers report that they were treated with an acceptable form of ORT	**9.1 %**	**70.4 %**	**40.0 %**
Mothers with children under 2 yrs of age who are able to correctly describe the preparation of ORS and how to use it	**42.3 %**	**84.0 %**	**60.0 %**

OTHER INDICATORS			
Children under two years of age with diarrhea in the past two weeks whose mothers report that they received - same or more liquids than usual - same or more solids / semisolids than usual	 **0.0%** **20.0 %**	 **51.9 %** **53.8 %**	
Children under two years of age with diarrhea in the past two weeks whose mothers report that they sought outside help from a qualified source during their child's diarrhea	**36.4 %**	**48.1 %**	
Mothers with children under 2 yrs of age who say that they wash their hands with soap at all FOUR important times	**3.7 %**	**15.3 %**	

Activity – Control of Diarrheal disease

Activities of the project with respect to Diarrheal disease control include:
The development of educational **material** related to diarrhea including:

a. CDD training module for CSP and MOH staff, June 2001
b. Educational posters and flip charts on all interventions including diarrhea
c. For the MOH staff, VHC members, Mothers, breastfeeding support groups, and other caretakers, periodically
d. Handouts on diarrhea with home management and treatment plans at Health facilities, May 2002
e. "Keep your child from Diarrhea" – leaflet for community distribution, July 2002
f. "What every parent should know about Diarrheal Disease" - a booklet on Diarrhea for the community in addition to MoH HF personnel, available in July 2003

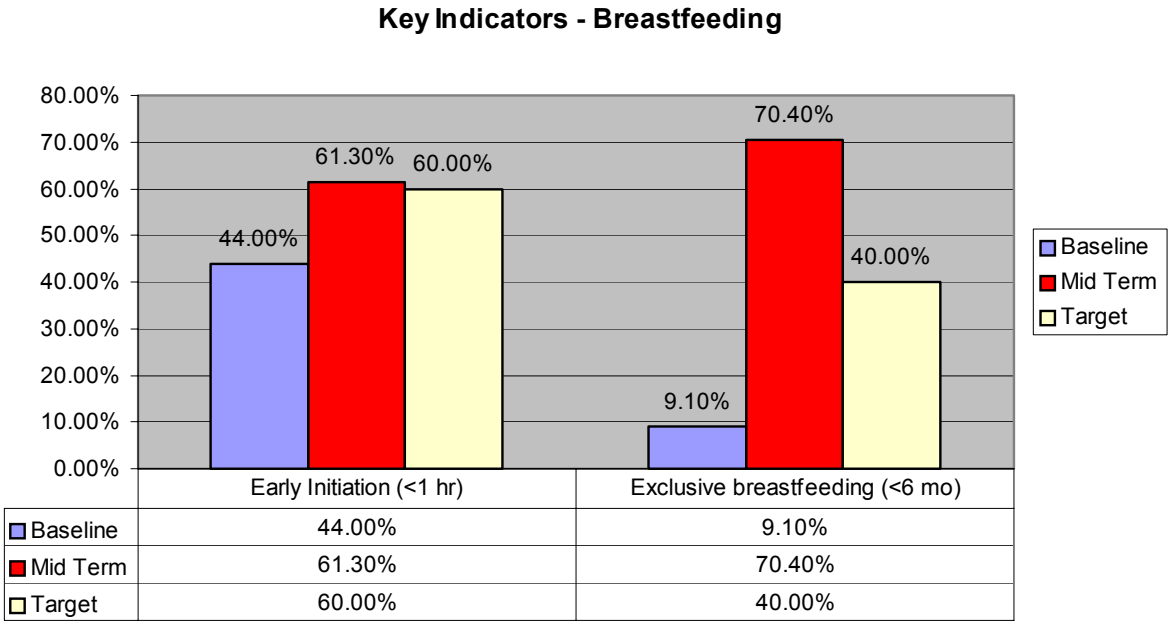
Training programs on diarrhea, including

a. CDD training for staff, especially the Village Health workers of the CSP, February 2001
b. CDD training for 143 participants from the MoH, May 2001
c. Training of trainers for all CSP staff, and for Village Health workers, February 2002
d. Training of trainers for 21 MoH doctors and mid level staff, May 2002
e. Refresher training on CDD incorporating the IMCI guidelines, for CSP staff and Village Health workers, April 2003
f. Training on use of BCC materials for CDD and counseling

Community level educational activities, including

a. Training for VHC members by Village Health workers – where 67 VHC members were trained
b. House visiting at the aul level and 1 to 1 education on diarrhea
c. Education for groups at the aul level like Breastfeeding support groups, Mothers' schools and informal groups of mothers

B. Promotion of Breastfeeding



	Early Initiation (<1 hr)	Exclusive breastfeeding (<6 mo)
Baseline	44.00%	9.10%
Mid Term	61.30%	70.40%
Target	60.00%	40.00%

Comparison with Baseline			
KEY INDICATORS (from DIP)			
Indicator	**Baseline (Jan 2001)**	**Mid term (June 2003)**	**Target (Dec 2004)**
Newborns breastfed within one hour of birth	**44.0 %**	**61.3 %**	**60.0 %**
Infants under six months who are being exclusively breastfed	**28.0 %**	**70.0 %**	**50.0 %**
OTHER INDICATORS			
Mothers with children under 2 yrs of age who say that they gave colostrum to the baby during the first three days	**97.3 %**	**96.7 %**	
Children 20-23 months of age still being breastfed	**58.3 %**	**64.7 %**	

Activity – Promotion of breastfeeding

Activities of the project with respect to Promotion of breastfeeding include:

The development of **material** related to breastfeeding including:

a. Module on "Basics of child care and breastfeeding" for CSP and MoH staff, May 2001
b. Training of trainers handouts for TOT among CSP and MoH staff, February 2001

c. Educational posters and flip charts on Breastfeeding for all stakeholders, from MoH to community, periodic
d. Leaflet entitled "Breastfeed your child" for use by the community, July 2002
e. Handouts for Breastfeeding support groups with instructions and technical information on breastfeeding, August 2002
f. Handouts on comparison of "old" and "new" messages on breastfeeding for community, older persons (decision makers) and MoH, August 2002
g. Handout on "Proper feeding of the child" based on IMCI for CSP staff, September 2002
h. "What every parent should know about Breastfeeding" – booklet on Breastfeeding – available in July 2003

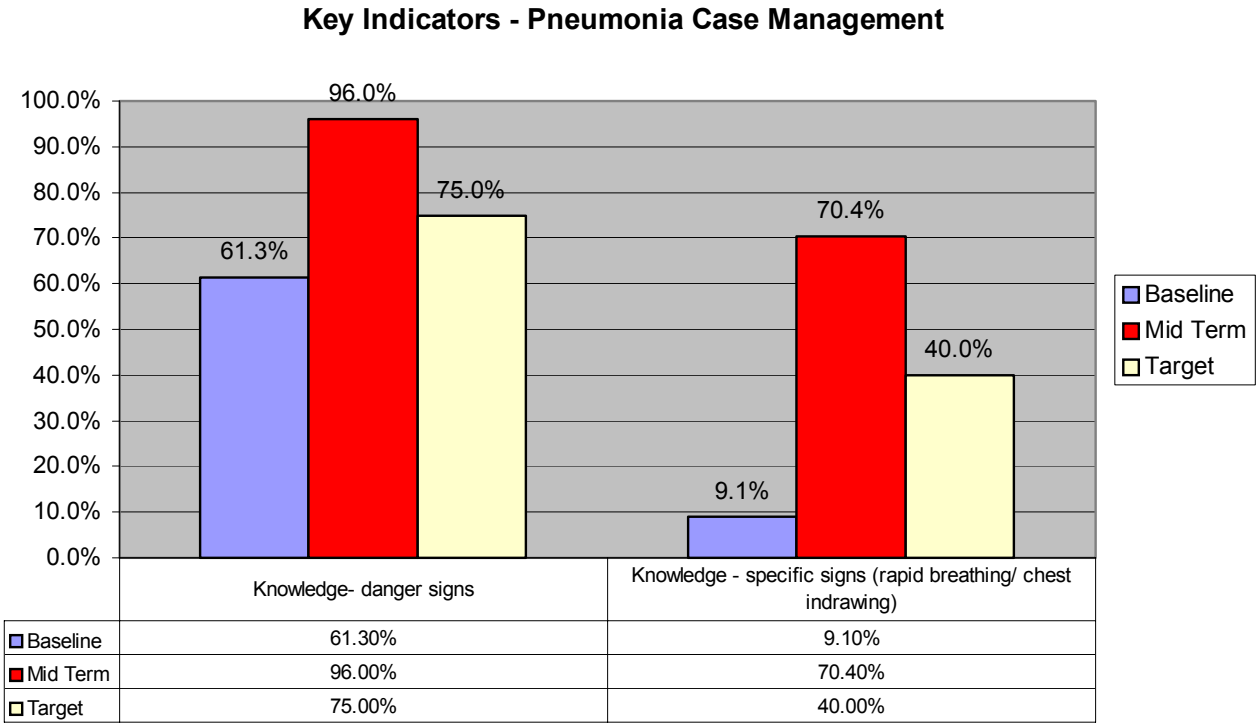
Training programs on breastfeeding, including

a. Training on Breastfeeding for CSP staff, June 2001
b. Training of trainers, CSP staff, February 2002
c. Training of trainers, Village Health workers, February 2002
d. Training of trainers, 21 MOH doctors and mid level CSP staff, May 2002
e. Training on BCC using the *Behave* framework, June 2002
f. Training on breastfeeding for
   - 26 Community nurses
   - 9 midwives
   - 2 Feldshers
   - 6 doctors, and
   - 7 CSP workers – July / August 2002
g. Refresher training on breastfeeding for CSP staff, July 2002

Community level educational activities, including

a. Training for VHC members by Village Health workers
b. House visiting at the aul level and 1 to 1 education on breastfeeding
c. Education for groups at the *aul* level like Breastfeeding support groups, Mothers' schools and informal groups of mothers

C. Pneumonia Case Management



	Knowledge- danger signs	Knowledge - specific signs (rapid breathing/ chest indrawing)
Baseline	61.30%	9.10%
Mid Term	96.00%	70.40%
Target	75.00%	40.00%

Comparison with Baseline			
KEY INDICATORS (from DIP)			
Indicator	**Baseline (Jan 2001)**	**Mid term (June 2003)**	**Target (Dec 2004)**
Mothers with children under 2 yrs of age who are able to state at least TWO danger signs of pneumonia requiring treatment	**61.3 %**	**96.0 %**	**75.0 %**
Mothers with children under 2 yrs of age who are able to state the two danger signs of rapid breathing and chest indrawing as signs of pneumonia requiring treatment	**0.0 %**	**47.0 %**	**25.0 %**

OTHER INDICATORS			
Mothers with children under 2 years of age whose child showed signs of ARI in the past 2 weeks, and who took the child to a qualified health care provider on the same day	**42.9 %**	**11.8 %**	**60.0 %**
Mothers with children under 2 years of age whose child showed signs of ARI in the past 2 weeks, and who took the child to a qualified health care provider on the same day OR the next day	**67.3 %**	**41.2 %**	
Children under 2 yrs of age who showed signs of ARI in the past 2 weeks who were taken FIRST to a qualified Health care provider	**71.4 %**	**91.0 %**	
Mothers with children under 2 years of age whose child showed signs of ARI in the past 2 weeks, and who took the child to a qualified health care provider on the same day or next day	**67.3 %**	**41.2 %**	

Activity – Control of Acute Respiratory Infections/ Pneumonia
Activities of the project with respect to Acute Respiratory Infections (ARI) including Pneumonia include:

The development of **material** related to ARI including:
a. Module on "ARI/Pneumonia case management" for CSP and MoH staff, September 2001
b. Training of trainers handouts for TOT among CSP and MoH staff, February 2001
c. Educational posters and flip charts on ARI/Pneumonia for all stakeholders, from MoH to community, periodic
d. "What every parent should know about ARI" – booklet on ARI/Pneumonia for the Community, VHCs and MoH – January 2003

Training programs on ARI, including
a. Training on ARI for CSP staff, October 2001
b. Training of trainers, CSP staff, February 2002
c. Training of trainers, Village Health workers, February 2002

d. Training of trainers, 21 MOH doctors, and mid level CSP staff, May 2002
e. Refresher training on ARI incorporating IMCI guidelines for CSP staff, October 2002

Community level educational activities, including
a. Training for VHC members by Village Health workers
b. House visiting at the aul level and 1 to 1 education on breastfeeding
c. Education for groups at the aul level like Breastfeeding support groups, Mothers' schools and informal groups of mothers

Conclusions

1. Program effectiveness in terms of interventions

Although information on incidence of disease and mortality in the population was not collected during the Mid term evaluation, the key indicators in the KPC survey would appear to indicate that there has been considerable progress made in the area of technical interventions.

ALL indicators related to Control of Diarrheal disease have improved since baseline, and are currently estimated at levels beyond program targets.

ALL indicators related to Promotion of breastfeeding have improved since baseline except the proportion of mothers with children under 2 yrs of age who state they gave colostrum to their baby during the first three days of life, which remains stable at its pre existing high level. Levels of Key indicators are currently estimated at levels beyond program targets.

The indicators of KNOWLEDGE of mothers regarding signs of ARI show improvement over baseline levels.

However, the indicators of PRACTICE which measure the proportion of mothers taking their child for treatment immediately (on the same day) are lower than baseline levels. This could be because

a. Children with Acute Upper Respiratory Infection can be managed at home, which is a message in the BCC related to ARI. The KPC indicator referred to above measures practice of mothers whose child had ANY kind of ARI, not necessarily Acute Lower Respiratory infections. If messages have been effective, the indicator may actually be reflective of a greater proportion of

mothers who take care of their mildly sick child at home, saving resources for the care of severely ill children.
A study could be done among mothers in the project area to probe this issue and find out the reason for a low proportion of mothers taking their child who shows symptoms of ARI to a doctor on the same day.

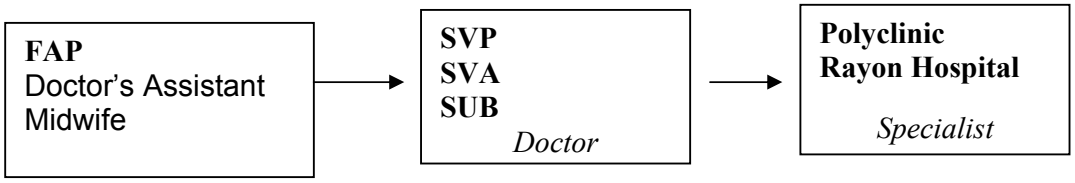
b. *The KPC survey was carried out in summer, when the incidence of ARI is low. The denominator for the indicator is 17, which is an extremely low number. Conclusions drawn based on this number must therefore be viewed with caution.*

2. *Capacity of Health Facilities with respect to Technical Interventions – CDD, Pneumonia and breastfeeding*

The MOH Republican Health System (RHS) is the main health care provider in the rural areas, encompassing the 15 rayons in Karakalpakstan. When needed, patients are referred to specialized hospitals and dispensaries in Nukus City. The RHS provides patient care through 3 Republican hospitals, 3 city hospitals, 15 central rayon hospitals, 42 polyclinics, 30 SUBs, 68 SVAs, 55 SVPs and 388 FAPs (explained below). The hospitals include rayon hospitals, SUBs, Republican hospitals and specialized hospitals. There are 3,930 doctors and 15,245 middle medical employees providing medical care in the RHS. There are 26.1 doctors and 101.1 midlevel medical personnel for every 10,000 people in Karakalpakstan.

*The following diagram illustrates the difference between the **existing** rayon health system and the **new** rayon health system under health reform.*

Existing Rayon Health System.

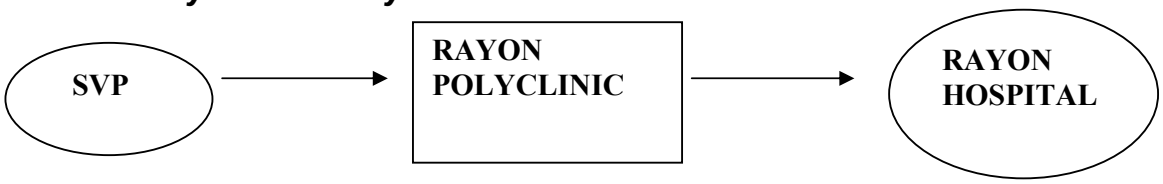


LEVEL I ***LEVEL II*** ***LEVEL III***

The older rural health care system is still in place, with feldshers (doctors' assistants) at FAPs as the first contact point (Level I). The second level consists of SVP/SVA/SUB (Level II). The health reform initiative supported by the World Bank and USAID is planning to replace most FAPs, SVAs and SUBs with SVPs as the primary health care center. However, it is expected that some level I FAPs will remain in most rural areas of Karakalpakstan. Some rayons will

also operate TB dispensaries and infection hospitals. Below is the outline of the new system.

New Rayon Health System Under Health Reform



The qualitative data collected from staff at Health Facilities, from Village Health Committee leaders and from Mothers would appear to indicate that the Health facility staff are currently better equipped to deal with children with Diarrhea and Pneumonia. The concepts of the staff at the facilities regarding breastfeeding have also undergone updating and revision.

Specific areas of increased capacity include:

a. *Updated knowledge on the technical aspects of the interventions, incorporating recent approaches like the IMCI.*
b. *The availability and use of educational material at the Health facility*
c. *Increased capacity as trainers, following the training of trainers programs of the CSP.*
d. *An increase in confidence of the staff at the facilities, based upon their rapport with the community, in those areas where the Health facility personnel have a good rapport with the community, by being VHC members, for example.*
e. *The enhancement of the effectiveness of house visits made by health facility personnel. In the words of a VHC member …" earlier, they were just filling forms, now they talk to us and educate mothers…"*

The Umir Nuri CSP is in the process of conducting a formal Health Facility assessment. The documentation of this will provide more insight on this issue.

3. Key Behavior change – findings from qualitative study

The following were some of the changes in behavior which were cited by the various members of the community / Health facility personnel

a. *Early referral of children showing danger signs of diarrhea*
b. *Use of ORS/ORT in preference to antibiotics or other home remedies, like rubbing ash on the abdomen, or giving tea to children with diarrhea.*

c. *Initiation of breastfeeding, even when mother is at Maternity home*
d. *Taking children who show signs of severe ARI for treatment*

4. ARI Practice

*The **ARI Practice** indicator which measures practice of mothers regarding seeking treatment early when their children show signs of ARI is estimated at lower levels than baseline. However, the indicators of knowledge regarding the danger signs of ARI are estimated at higher levels than baseline.*

Recommendations

1. ARI Practice

Quick research aimed at eliciting the reason for the low level of practice relating to taking a symptomatic child immediately for treatment, by meeting groups of mothers and other key individuals can provide clues as to the reasons behind this. An appropriate strategy can then be planned to improve the indicator

2. Revision of targets

The **targets** for indicators of knowledge and practice related to the interventions indicated in the DIP must be **appropriately revised** since most current estimates exceed target levels. This needs to be done as a joint exercise between the partners, including the inputs of field level staff.

3. ORS Corners

ORS corners at Health facilities are popular with Health workers and Village Health workers. These could be promoted to a greater extent, since the Health facility personnel appear to be comfortable with the concept of ORS corner, have the time and the knowledge to educate mothers and provide them with the right messages, at the ORS corner.

4. Messages – feeding during diarrhea

The **messages relating to** continued feeding, continued administration of liquids, and the feeding of children recovering from diarrhea could be emphasized since the indicators of these practices show that about half the mothers whose children had diarrhea in the 2 weeks preceding survey did not practice the same.

5. Handwashing practice

The estimated level of the indicator of **appropriate handwashing practice** is still low (15.3%), even if it is higher than baseline (3.7%). The project needs to emphasize the prevention of diarrhea in its

messages related to diarrhea management. With the high literacy level, it should be possible for mothers to read posters, leaflets and other material on hygiene. The Poster on hygiene is a good step in this direction – it needs to be built upon.

6. **Breastfeeding practice**
   The indicators of early initiation of **breastfeeding** and exclusive breastfeeding practice show that there are still mothers who do not practice these key interventions. The program has emphasized the importance of correct breastfeeding practice, but needs to do more to ensure that ALL mothers practice these behaviors.

   Since the place of delivery is usually the maternity home, intensive training and support could be provided to staff at maternity homes, specifically on early initiation of breastfeeding.

7. **Breastfeeding support groups**
   The **Breastfeeding support group** initiative was not a part of the Umir Nuri CSP's DIP. The experience of the CS program at Navoi, coupled with the Community's response to the BCC on breastfeeding encouraged the establishment of the BFSGs. There are currently 6 breastfeeding support groups, 3 at each rayon. These could be promoted further, and extended to cover a wider area. Some members of BFSGs are potential trainers themselves and could be included in training of trainers' programs planned for the future.

Cross cutting interventions

The important cross cutting interventions of the Umir Nuri program include:

A. Community Mobilization
B. Behavior Change Communication
C. Organizational capacity
D. Networking and collaboration with other organizations

Community Mobilization

The formation of community-based organizations by NGOs is a relatively new concept in Karakalpakstan.

The *Intent* behind mobilizing the community was

- to serve as an entry point into the community
- to elicit the participation of the community, so that the community is able to identify their needs and act upon them
- to enhance the effectiveness of project staff, by making them part of a community program, rather than an NGO program
- to enhance capacity of the community based organizations to independently establish an identity and attract resources
- build a solid resource base of knowledge and skills to sustain benefits of the program

The Community based organizations, which were formed as part of the CSP included the following:

***Aul* (Village) level**

a. Village Health committee (VHCs)
b. Breastfeeding support group
c. School of Mothers

Rayon level

d. Child survival Co ordination committee (CSCC)

a. Village Health committees

Village Health committees are informal organizations of about 10-20 members. There are 18 VHCs in the CSP till this point in time, against a target of 20 for the mid term and 40 for the end of the program.

VHC members are enthusiastic members of the community, who have expressed interest in assisting the cause of Child survival. The members are generally motivated by the feeling that they are contributing to the cause of their own community and their own children.

The members are usually
- Active mothers, that is, mothers who are interested and able to spend time on educating and motivating others in their own communities
- Local Makhalla leaders
- Health facility personnel – doctors, nurses
- Teachers
- Religious heads – Mullahs
- Traditional healers (some committees)

VHCs have been trained by the CSP. Specific areas of training include the following:
- Behavior change communication regarding the project interventions
- Training on developing project proposals as part of the Community Grants program of the Counterpart Consortium.
- Training on Interpersonal Communication, and
- Training on Conflict resolution, which were facilitated by the Civil society program Division of Counterpart.
- HIV/ AIDS – an orientation

VHCs meet once every month. Their activity includes:
- Discussing activity regarding the CS program
- Educating mothers and other caretakers at social occasions
- Representing issues of interest to the CS program at the Hakimiyat
- Getting groups together for community based activity like group health education

b. Breastfeeding support groups

Breastfeeding support groups (BFSGs) were formed in 2002 based on the experience and sharing of information from the CS project at Navoi. They usually comprise 4-6 women, who are active in the communities and who have the interest and ability to communicate key breastfeeding messages to the young mothers in their community.

There are 6 BFSGs at this time, 3 in Nukus Rayon, and 3 in Takhtakupir rayon.

c. School of Mothers

The schools of mothers is an idea based on the discussions had with members of Village Health committees, where it was suggested that the active women in the community including older women like the mothers in law could be involved in propagating messages related to Child survival.

There are 2 schools of mothers established in Nukus rayon, none as yet in Takhtakupir rayon.

d. Child Survival Co ordination committee

The Child Survival Co ordination committee (CSCC) is a rayon-level organization comprised of the following members:

- Deputy Hakim, Women's Issues
- Chief Doctor, Rayon
- Chief Pediatrician
- Chief of the Sanitation / Epidemiologic department
- Chief of Pharmacy
- Head of the Education department
- Makhalla committee leaders
- Persons from the media

The CSCC used to meet monthly but currently meets quarterly to discuss the issues concerning the CSP. Since many top level officials are members, problems faced at field level, when brought to the notice of the CSCC, can actually be solved.

Problems discussed at the CSCC are not necessarily related to Child Health alone. Discussions surrounding livelihood issues and infrastructure including basic amenities like gas, water and electricity are also discussed.

The Children Defence Day 2003 was celebrated by the CSP on June 1st 2003, with great pomp and gusto. The CSCCs were involved with the organization of the celebrations surrounding this event.

Conclusions

1. ***Role of Village Health Committees***
   The VHCs represent an attempt at empowerment, and this seems to be in evidence as the 18 VHCs of the CSP prepare to play a larger role in their communities. One VHC member said "..The program is causing a Health revolution, akin to the great October revolution…" The members seem to have understood the role which organizations like theirs can play in their communities, and appear to be willing to take on the responsibility. VHC members approach the Hakimiyat on their own for clarification regarding issues concerning the program.

2. ***Community Participation***
   Community Participation is one of the Key principles of Primary Health Care, and the CSP, through its Community mobilization strategy has ensured that the community is not a passive recipient of health messages

which are handed out impersonally, but is an active participant in the process

3. Role of CSCCs

The CSCC appears to be successfully playing the role of a rayon-level supervisory/advisory body. The Deputy Hakim, Women's issues at Nukus Rayon felt that the monthly meeting of the CSCC has now been made quarterly, because "…. The VHCs are now doing their job at the aul/makhalla level…" and the need for a monthly meeting had reduced.

Recommendations

1. Inactive VHCs

It has been reported that there are some VHCs which are not as active as others. The CSP should focus on these poor performers and find out the reasons for poor performance. Attention should be focused on them, in order to build them up to the level of the better performing committees.

2. VHCs – target number

The target for the end of the project is 40 VHCs. In order to ensure quality, it may perhaps be better to identify those areas where committed persons are willing to work for their own communities, and facilitate formation of VHCs in such areas, even if the total number is less than 40.

3. Traditional healers and religious heads

Traditional healers and mullahs (religious heads) play an important role in some communities. While some VHCs have incorporated these individuals in their membership, others have not. It would be useful to identify all traditional healers in the area, and ensure that they are reached with the messages of the CSP. This could be done by

- organizing a training program for traditional healers on key messages and try to get them involved in BCC
- encouraging their membership at VHCs so that they may be reached through the VHC

4. Breastfeeding support groups and School of Mothers

The Breastfeeding support groups and the School of Mothers are useful initiatives. If they grow to the level of community based women's groups, who are not just involved with health, but also social and economic developmental activity like small savings and home based income-generating activity like tailoring, they could be powerful instruments of social change.

A group of women which meets regularly, saves money, and is involved with acquisition of skills among its members which will increase their income, is a group which can sustain itself. It can also serve as an entry point into the community for messages directed at child health, and reproductive health.

The CSP can consider the formation of such groups.

Behavior Change Communication

The Behavior Change Communication (BCC) strategy of the CSP is based upon the *BEHAVE* framework. A five-day BCC training was conducted by the Director, Health Programs based on this framework. Key personnel from the India CS program were invited to share their experiences with the Umir Nuri staff, and this resulted in learning from experiences, which added to the effectiveness of the BCC strategy.
The basic tenets of the BCC strategy of the Umir Nuri CSP are:

a. Technically Updated Messages
b. Appropriate BCC materials
c. Innovative BCC strategies

a. BCC Messages

The Key messages of the CSP relating to the program interventions are as follows:

i. At the level of the MOTHER

Diarrheal disease

- Diarrhea defined as the passage of 3 or more loose stools in a 24 hour period
- Diarrhea can cause dehydration in a child, which can lead to death of the child
- The signs of dehydration in a child
- The child must receive increased fluids during an episode of diarrhea, the nature of which can be any of the accepted forms of ORT
- The child must continue to receive solid, semi solid and liquid food during diarrhea, and during recovery from diarrhea
- The child must be taken to a qualified health care provider when the child shows signs of dehydration

Acute Respiratory Infection/ Pneumonia

- The symptoms of respiratory infection in a child
- The danger signs of respiratory infection in a child
- Home care when the child has no pneumonia
- The child must be taken to a qualified health care provider on the same day that the child shows danger signs of respiratory infection

Breastfeeding

- Breastfeeding must be initiated early, in the first hour of birth
- Pre lacteal feeds must be avoided
- Rooming-in of mother and baby
- Exclusive breastfeeding for 6 months
- Breastfeeding on demand
- Introduction of complementary feeds at 6 months of age

- Persist with breastfeeding till the age of 2 years

ii. At the level of the HEALTH FACILITY

Diarrheal disease

- Manage diarrhea using standard protocol
- Acquire training in SCM of diarrheal disease
- Supervise workers on the SCM of children with diarrhea

Acute Respiratory Infection / Pneumonia

- Manage ARI/Pneumonia using standard protocol
- Check the respiratory rate of children with cough/ difficult breathing
- Supervise workers on the SCM of children with ARI/Pneumonia
- Check stocks of Co-trimoxazole periodically

b. BCC Materials

The steps involved in the preparation of BCC materials produced by the Umir Nuri CSP were

- development of the material based on technical inputs
- translation and back translation to ensure correctness
- extensive pretesting , by involving the personnel from the MoH in the Health facilities, community members and Makhalla leaders. This ensured that they were culturally appropriate and therefore, effective.
- Finalization , production and distribution

The BCC materials produced by the CSP are as follows:

Diarrheal disease

- Educational posters and flip charts on all interventions including diarrhea
  for the MOH staff, VHC members, Mothers, breastfeeding support groups, and other caretakers, periodically
- Handouts on diarrhea with home management and treatment plans at Health facilities, May 2002
- "Keep your child from Diarrhea" – leaflet for community distribution, July 2002
- "What every parent should know about Diarrhea" a booklet on Diarrhea for the members of VHCs, and the community in addition to MoH HF personnel, available in July 2003

Acute Respiratory Infection/ Pneumonia

- Training of trainers handouts for TOT among CSP and MoH staff, February 2001
- Educational posters and flip charts on ARI/Pneumonia for all stakeholders, from MoH to community, periodic
- "What every parent should know about ARI" – booklet on ARI/Pneumonia for the Community, VHCs and MoH – January 2003

Breastfeeding

- Training of trainers handouts for TOT among CSP and MoH staff, February 2001
- Educational posters and flip charts on Breastfeeding for all stakeholders, from MoH to community, periodic
- Leaflet entitled "Breastfeed your child" for use by the community, July 2002
- Handouts for Breastfeeding support groups with instructions and technical information on breastfeeding, August 2002
- Handouts on comparison of "old" and "new" messages on breastfeeding for community, older persons (decision makers) and MoH, August 2002
- Handout on "Proper feeding of the child" based on IMCI for CSP staff, September 2002
- "What every parent should know about breastfeeding" – booklet on Breastfeeding – under preparation, to be ready by September 2003

c. BCC methods

The methods used to inculcate behavior change in the community include the following:

- One- to – one education during household visits where the mother is individually met and educated
- Group education sessions
- Use of flip charts
- Use of Video/ films
- Distribution of leaflets and booklets and follow up
- Innovations like puppet shows, which have been recently introduced at the community level and enthusiastically received

Conclusions

1. BCC strategy

The Behavior change communication strategy of the CSP appears to have conveyed key messages to mothers in the area, as evidenced by the increase in estimated levels of key indicators of knowledge and practice. Of particular interest is the fact that the estimated levels of indicators measuring knowledge of HIV/AIDS, which is not a program intervention, have remained stationary since baseline, while those measuring the program indicators have changed.

Behavior change is difficult to achieve, and the KPC results show that the program has indeed accomplished much in a relatively short time of 2-1/2 years. The Village Health worker, armed with flip charts and posters, has done very well in communicating the BCC messages using appropriate methods, and at appropriate venues. .

2. Ethnic groups

The presence of different ethnic groups within the population, speaking different dialects of Uzbek, Karakalpak, Russian and Kazhakh languages presents a challenge to the communicators of the CSP who have to use the appropriate language when necessary.

3. Translation

The preparation of materials involves their translation into Karakalpak and Russian from English and back translation to check for accuracy. The official stance in Uzbekistan is to promote the Uzbek language, which is not very widely spoken in the program rayons. The CSP, however, has translated most of the BCC materials into Karakalpak, and this would represent the correct decision in the circumstances. The CSP has also translated IMCI guidelines into Karakalpak for use by the MoH.

The translation of BCC materials into the local language has been a major accomplishment of the program. This has resulted in wide dissemination of the messages which they contain, and in the enhancement of the visibility of the program.

4. Innovative approaches

Other innovative approaches suggested towards behavior change are

- Competitions for mothers based on Key Child survival interventions

- Street plays and puppet shows. These methods were learned by the CSP team following an exposure visit to and exchange of information between the CS projects of Counterpart at Ahmedabad, India and the CSP.

A puppet show was staged at the Children's day celebration on June 1st 2003, and despite reservations as to its cultural acceptance, was well received. The CSP plans to use this method to a larger extent in its BCC strategy.

Recommendations

1. BCC material preparation

The production of BCC materials by the CSP, as mentioned above, can be rated as one of its most major accomplishments, and the BCC strategy as being successful. Each step in preparation of BCC materials, from the stage of conception of a message, to developing a draft form, pretesting it with the community, and finalizing it, has been given the importance it deserves by the CSP. The production of materials – design and printing – is not an easy task in Karakalpakstan, and the CSP has done well in this regard.

There has been delay however, in the case of certain materials, and such delays must be avoided in future.

2. BCC Messages

One of the issues repeatedly encountered during discussions at the community level was that messages must be simple and easy to understand by mothers, without sounding too technical, if they had to be effective. The messages given by workers at Health Facilities in the past were cited as examples of complicated messages, while the messages given by the CSP were simple and straightforward, in the language that mothers would understand. Leaflets and booklets were accepted very well in the community, and mothers pointed to the simplicity of the language used as a major reason for such enthusiastic acceptance.

The messages of the CSP must continue to retain their simplicity while not compromising on technical content. This presents a challenge to a communicator.

5. BCC Methods

The methods most preferred by most members of the community who were met as part of the MTE were dynamic visual media like Video, Television and Film. The CSP could explore the possibility of

- creating educational video films based on local culture, with the key messages built in
- Creating television spots, which could be aired at appropriate times, to ensure maximal viewing by members of the target group
- Even leaflets and booklets must have an increased visual rather than textual content in order to be more attractive and appealing.

Other methods which were perceived as being useful were:

- Models, especially the breast model which was used to demonstrate correct breastfeeding technique
- Booklets, which were received enthusiastically by the community. Since literacy levels in the population are very high (above 90%), written material is well received and utilized.

The leaflets were received with a mixed response, with some saying that they were not so useful, and tended to be used as paper containers. Even so, they were on display at almost all the facilities visited as part of the evaluation.

6. BCC to special groups

BCC could be directed towards traditional healers, which is an important group in the context of the CSP. While it is good to involve

them as part of the Community Mobilization strategy by facilitating their membership at VHCs, BCC could also be designed and directed towards this important group.

The other groups which could be focused upon in the BCC strategy are those who are decision makers in child health issues: These include
- Mothers-in-law and other older women
- Fathers and other men

The CSP has succeeded in making contacts with these groups. These are not easy groups to reach and communicate with, but considering the rapport the VHWs of the CSP enjoy at the community level, it could be tried at this stage in the project.

7. Reinforcement and Follow-up

For communication in terms of distributed materials to be effective, it must be followed up by interaction and reinforcement. The VHWs of the CSP have been reinforcing and interacting with the community at every stage, and this is what probably sets them apart from the workers at the health facilities, who were perceived as distributing materials in a more passive manner. This strength of the CSP is an important one, and must be carried forward to the next stage.

The challenge is to be able to get the members of VHCs and the health workers of the MoH to adopt this approach, since it is they who will be there when the project comes to an end. Attempts must be made to inculcate this value into the workers of the Health facilities and to the members of the VHCs.

Organizational Capacity

An important goal of the CSP is to build the capacity of the organization Perzent so as to enable it to plan, implement and evaluate Child survival programs of a similar nature.

The CSP was initiated as a partnership between Counterpart, Centre Perzent and the Ministry of Health in Karakalpakstan. The partnership was founded firmly on a written Memorandum of Understanding (MoU), which is a unique and important document. The staff of the CSP are appointed by Counterpart and Perzent. Capacity has been built into the CSP at all levels, from the management and staff of Counterpart, to the staff of the CSP from Perzent and the health facility personnel of the MoH. Training inputs given to these personnel and to the community has played an important role in this building of capacity.

A. The Partnership

Counterpart envisages partnership as its core strategy in development. In areas where it operates, a suitable partner is identified and capacity of the partner is built up ensuring the sustainability of the program.

The search for a partner was initiated in the Karakalpak area when Counterpart identified Uzbekistan as a potential base for a Child survival program based on need. The Ministry of Health suggested that the program be based in Karakalpakstan, and a suitable partner was required, in addition to the Ministry of Health in Karakalpakstan. Following a process of shortlisting, and application of the Organizational assessment and Technical Training and Assessment Plan tool of Counterpart, Centre Perzent was identified as the partner NGO. All the partners were involved intensively from the stage of planning through implementation and evaluation.

A formal Memorandum of Understanding (MoU) was signed by all three partners prior to the launch of the program.

B. The Staff of the CSP

Recruitment of the staff of the CSP was not easy, considering that the organization was looking for

- Ability to speak/understand English, at least at the Office level.
- Technical competence in the area of child survival

Potential staff were located by contacting other NGOs in the region, through advertisements in the local regional resource center, and by word of mouth.

The program has had changes in leadership since inception, with turnover being an issue. The first Program Director who headed the program was Dr Nizam Uddin Ahmed, a physician with experience in program management. In September 2001, ten months after the inception of the program, Dr Nizam Uddin Ahmed left the organization. Dr Roland Abdullo, who was the Program manager managed the program, when he left to join the WHO. Ms Kshama Singh from India, who was involved with the management of a similar CS program, was then appointed temporarily to manage the project for a period of two months, as technical advisor.

Meanwhile, Counterpart Headquarters was looking for suitable persons to head the program. Two persons who were shortlisted declined the position following the events surrounding the 9th of September 2001 citing security reasons. Dr Nuriyah Elgondieva, who was initially recruited at program inception as Field officer was later promoted to BCC specialist. Following training on program management and finance, she was asked to take on the role of Project Manager which she did, till she left the program in September 2002, to join a position with the WHO. Dr Nuriyah returned to the CSP in December 2002, but tragically died on Jan 1, 2003. Her death created a void in the program, considering that a lot had been done in training her as a program manager.

During this period, Darshana Vyas, the Director, Health Programs at Counterpart Headquarters in Washington who manages the Health and Child Survival program at its HQ level, visited the program periodically and gave constant support and guidance.

Ramine Behrambegi, the current Program Director joined the program in September 2002, and has been guiding its progress since then.

While the project leadership has witnessed some turnover, the program staff and Village Health workers have remained relatively stable.

The staff of the CSP at the time of the MTE are as follows:

Name	**Month/ Year of joining**	**Designation**
Ramine Behrambegi	September 2002	Program Director
Lilya Kim	September 2001	Finance and Administrative manager
Azamat Matkarimov	March 2001	Health Communication specialist
Sagitjan Aitjanov	November 2001	Health Information co ordinator
Nina Nizamatdinova	April 2002	Acting Program Manager

Name	Month/ Year of joining	Designation
Yulia Miroshnichenko	December 2000	Communication officer/ Translator
Bairam Kamalov	January 2001	Driver / Logistics assistant
Sara Utegenova	October 2002	Senior Health Education specialist/Trainer
Gulnara Karabaeva	February 2001	Field Officer
Mirigul Eshmuratova	August 2001	Field Officer
Guljakhan Allambergenova		Village Health Worker
Zulfia Baimuratova	February 2001	Village Health Worker
Kurbangul Omarova	February 2001	Village Health Worker
Makhsud Isakov	January 2003	Administrative assistant/ secretary
Vasilisa Rotalskaya	June 2003	Administrative assistant / receptionist
Kizlargul Esbolova	August 2001	Cleaner / Cook
Rufat Seitimbetov	August 2001	Guard
Jalgas Kalbaev	May 2002	Guard
John Brown	April 2003	Senior Technical Advisor

C. Training

Training has been a major input of the CSP. The organization has identified and utilized the services of trainers from a variety of sources, including the MoH, other NGOs and the international community.

The target audience for training includes:
- The Program staff
- The field staff, including Field Officers and VHWs
- Community based organizations like VHCs and BFSGs
- Active mothers in the community
- Health workers and Personnel of the Ministry of Health

The design of training programs of the CSP are based on assessment of need, by the trainers in the program, especially the senior Health Education specialist. In the case of training for field staff, the actual observation of VHWs performance is also used as an input. VHWs are also formally evaluated by the Health education specialist to find areas of weakness and need.

The training programs conducted by the CSP include the following:

Training Program	Month/ Year	Audience
KPC baseline survey training	January 2001	CSP staff, interviewers
CDD training	February 2001	Village Health Workers

Training Program	Month/ Year	Audience
HFA survey Training	February 2001	CSP staff, interviewers
Training on Counterpart Administrative policy/ procedures	March 2001	CSP staff
CDD training	May 2001	MoH staff – 143 participants
Promotion of Breastfeeding	June 2001	CSP Staff
Training on formation of VHCs	June 2001	CSP Staff`
ARI training	October 2001	CSP Staff
Training of Trainers (TOT)	February 2002	CSP Staff
Training of Trainers (TOT)	February 2002	Village Health workers
Training on BCC framework	April 2002	CSP staff
Training of Trainers (TOT)	May 2002	21 MoH Doctors and mid level staff
Promotion of breastfeeding	July – August 2002	26 Community Nurses, 9 midwives, 2 Feldshers, 6 doctors and 7CSPworkers
Refresher training on breastfeeding	July 2002	CSP staff
Refresher training on ARI incorporating IMCI guidelines	October 2002	CSP staff
Refresher training on Diarrhea incorporating IMCI guidelines	April 2003	CSP Staff
Willingness to pay training	February 2003	CSP staff
KPC Mid Term survey training	June 2003	CSP Staff, Interviewers

Additional inputs in training include the following:

- Exposure / learning visits to other countries, for example, staff were sent to a training program in Cambodia to acquire skills on Behavior Change Communication in January 2003
- The Program Director, Financial Officer and Acting Program Manager visited the Jeevan Daan CS program in India to acquire knowledge and skills and to share lessons learned on program and intervention related issues in April 2003
- The Finance Officer attended a Financial training program at the Counterpart regional office at Almaty, Kazhakstan in July 2001
- Staff are encouraged to attend local conferences, for example the Co ordination meeting on the projects of USAID Tashkent at Charvak in June 2003
- There have been exchange visits of staff working in Counterpart-supported programs between India and Karakalpakstan, and between Turkmenistan and Karakalpakstan The program staff of the CS program of Counterpart in India visited the Umir Nuri CSP and attended a BCC training session organized by the Director, Health

Programs. Also, the India CS program MIS specialist organized a five-day HMIS training with the assistance of the Director Health Programs for the Umir Nuri CSP team.

The staff of the CSP provide training to NGOs and others on request upon topics in which they have gained expertise, like BCC and Epi Info

The monthly meetings of staff of the CSP serve as training opportunities in addition to being monitoring exercises. In-house training is provided to staff in response to needs , either perceived by the program staff, or articulated by the field staff.

D. Monitoring and HMIS

The mechanisms for monitoring program performance which have been built into the program are as follows:

- The Monthly meeting of all staff which takes place in the last week of every month. The monthly meeting is a time to review performance of the past month and plan for the month ahead. An agenda is prepared for this meeting by the Program director, and is chaired by him. Field offices present their reports of activity and the same is discussed.

- Weekly review at the Field offices
  There are two field offices for the CSP, one at Nukus Rayon and one at Takhtakupir rayon. Two field officers look after each of these offices, and they conduct weekly meetings at the Field offices with the VHWs of their rayon.

- Weekly meet of Field Officers with office staff.
  Each week, the field officers of Nukus and Takhtakupir rayons meet with the staff at the CSP office and present their field reports.

The data gathered periodically as part of program monitoring includes the following information, collected as part of the Health Management Information System (HMIS) of the CSP.

- Community Status information, which refers to mothers' knowledge and practice of key behavior regarding the 3 interventions.
- Health Facility data – pertaining to the health facility, collected at the Health facilities of the MoH. The data is collected regarding staff at the facility, equipment, stores and space available, sick child management, and the physical aspects of the facility.
- Selected CS indicators from MOH reporting formats –demographic, mortality-related and morbidity-related data including information on equipment and supplies. This is often not complete, and does not

necessarily match the information collected by the program workers. An example is the information pertaining to diarrheal cases. The definition of diarrhea according to the government includes a stool sample, which must have a positive test result for a pathogen. The program defines diarrhea clinically, based on the occurrence of stools of altered consistency. Hence the number of cases of diarrhea in a given population as reported by the VHW and the health Facility varies.

Rapid assessments of health status and its determinants like caretaker knowledge and behavior have also been done using tools developed indigenously. Rapid assessments have been done in March 2002, August 2002 and May 2003 and they focus on the following aspects:

- Mothers Knowledge/ Practice
- Health Facility assessment
- Epidemiologic data analysis

The reports sent to Counterpart headquarters include:

- Monthly financial reports
- Quarterly progress reports and
- An annual report each year.
- Periodic newsletters are also prepared, giving highlights of the program and important events concerning it.

Feedback is provided by the Director, Health Programs, Counterpart HQ periodically.

Documentation of the CSP processes and activities is evidenced by the reports and documents generated by the program since its inception. The following key documents were available during the MTE

- Baseline assessment reports
  - The KPC survey , Jan 2001
  - The HFA report, March 2001
- The Detailed implementation plan
- Training reports
- HMIS reports
- Quarterly Newsletters and reports
- Reports of studies done, including a brief write-up on the Wtp survey

The **website** of the program (http://cspnukus.freenet.uz) is under construction, and is expected to be updated regularly in the fall of 2003.

E. Finance

The system of finances at the CSP is as follows:

- Funds are received from Counterpart Headquarters by the Counterpart Consortium office at Tashkent
- Funds are transferred physically to the Nukus office from Tashkent every quarter, and are utilized as program expenses
- Financial reports are sent monthly to Counterpart headquarters

Training was received by the current financial and administrative manager, as an orientation and exposure to the finances and system at the CS project at Ahmedabad India, and as formal training at the USAID mission at Almaty. Training was also given to the finance and administrative manager at Perzent, which has helped in clarifying financial aspects of the partnership. All training was given in accordance with the procedures and methods recommended by USAID and Counterpart International.

F. Special Research studies

The following studies have been planned/ executed by the CSP since its inception:

- Baseline assessments
  A. KPC survey, which was done to assess baseline levels of knowledge, practice and coverage of Key Program interventions among caretakers of children under two years of age in the program area in January 2001.
  B. Health Facility assessment survey, which was done to assess baseline levels of infrastructure and practice at Health facilities in the program area

- Periodic rapid assessments
  Rapid assessments have been done in March 2002, August 2002 and May 2003 and they focus on the following aspects:
  - Mothers Knowledge/ Practice
  - Health Facility assessment
  - Epidemiologic data analysis

- Willingness-to-pay Survey
  The CSP has developed survey questionnaires to assess purchase practices and to determine the willingness of residents to pay for medicines**.** This study was done in February 2003 with technical expertise from the Research Triangle Institute (RTI), aimed at giving shape and direction to the establishment of Village Pharmacies in the CSP areas.

  Information about existing pharmacies, needs of population and their "willingness to pay" for select pharmaceuticals such as oral

rehydration salts, *cotrimoxazole, ampicillin, penicillin, amoxicillin,* and other drugs from WHO's essential drugs list were compiled. Additional recommendations from health authorities, local clinics and pharmacies and program staff were incorporated. The end result was two questionnaires – *Household and Exit Interviews* -- reflecting current drug prescription and purchase practices in the region. Training for interviewers including village health workers, field officers and other staff member were conducted during which questionnaires were further revised and samples size for the study were calculated. Furthermore, target communities were defined and schedule of visits were finalized.

During the first phase of survey implementation, 21 field interviewers conducted 802 Household interviews (400 questionnaires in each rayon). During the second phase, 17 interviewers interviewed 320 mothers and caretakers for the Exit interviews (180 questionnaires for each rayon). Due to lack of patient referral in the health facilities, names and addresses of patients who were referred for medical advice in the previous two weeks were collected and interviews were conducted at the household level rather than the health facilities where the interviews were supposed to be conducted. All completed questionnaires were checked at the end of the day by Field Officers and other CSPsupervisory staff. Data from questionnaires were entered into a database designed on Epi-Info 6.04 and converted to SPSS format for data analysis.

The detailed report of the Wtp study is awaited, but preliminary results show that a willingness exists in the residents of the program rayons to pay for essential and important drugs and medications. A presentation on the survey was made at the USAID conference at Charvak in June 2003.

Conclusions

1. The Partnership

It would appear that the Partnership between Counterpart, Perzent and the Ministry of Health in Karakalpakstan has been a successful model. The Memorandum of Understanding which is the written basis for the partnership is a unique document. Some of the features of the MoU which made the process unique were:

a. It was among the first partnerships between an international organization, a local NGO and the Ministry of Health in Karakalpakstan

b. The MoU was a clear basis or understanding of roles and responsibilities of each of the partners.

It outlined the same in unequivocal terms. The Ministry of Health took time to study the MoU before signing it.

c. *The MoU has since served as a set of guidelines as to performance of each partners' role.*
d. *The MoU of the CSP has since been used as a basis for many other partnerships which have developed in the region since the start of the program.*

The partnership is characterized by an intensive level of involvement of all partners. This was initiated form the time of planning, when Perzent contributed considerably to the design of the program and the DIP, in terms of suggestions regarding geographic areas of coverage and the specific issues to be addressed. Suggestions such as these were incorporated into program design, and the ultimate shape of the project was based on consensus.

Initially, there did appear to be problems in the partnership between Counterpart and Perzent. Currently, however, they share an excellent relationship, with the director of Perzent, Dr Oral Ataniyazova admitting that the earlier problems were more due to the style of functioning of the earlier Program director, than system-based.

In the implementation phase, both Perzent and the MoH feel that there is a considerable sharing of information and ideas in the CSP. The Ministry feels that the gap between the Health facilities run by it and the community is being bridged to a great extent by this program. The MoH program is not necessarily need-based and responsive to felt needs, and the MoH feels that the CSP, which works in close partnership with the community, can bridge the gap between peoples needs and program interventions.

The Ministry of Health is perceived by the people as being more interested in indicators, rather than in behavior change. Other problems it faces are in the area of staff turnover and lack of motivation among its workers. The CSP presents a refreshingly different approach, with committed staff who work toward behavior change.

2. *Staff turnover at the level of Program Director*

The program suffered from instability at the level of Program Director, following the exit of the first Program Director, Dr Nizam Uddin Ahmed in September 2001. Staff morale was also apparently affected in this period because of the restrictive management style of Dr Ahmed. The next 12 months, till the appointment of the current

incumbent, Ramine Behrambegi, was a difficult period of time for the CSP.

The factors which assisted the program through this period were the following:

a. *The intense support given by Darshana Vyas, Director of Health Programs from Counterpart headquarters, who made periodic visits to the CSP and gave valuable inputs. Her grasp of the details of the program is commendable, and this has helped even the current Program director establish a pattern of management.*
b. *The contribution made by the late Dr Nuriyah Elgondieva, who was appointed as Field Officer, promoted to BCC specialist and finally Program Manager, was extremely valuable. The various persons interviewed as part of this evaluation rate her as a very dedicated, resourceful person, who was an extremely important and valuable part of the team. The program has indeed lost an important resource in her untimely and shocking demise in January 2003.*
c. *The quality and stability of the staff at the program level and field level ensured that even if the leadership position was vacant, the interventions and strategies of the program were implemented as planned.*

3. Staff Retention

The Program has had turnover of staff, particularly at the level of Program director. But as mentioned above, the field staff and key program staff have remained stable. One of the key strengths of the CSP has been its ability to retain its field staff.

The factors which form the basis of this retention strategy could have been the following:

a. *A basically participatory style of management brought in by the current program director, which presented a refreshing change from the earlier director, whose style was more restrictive.*
b. *Financially remunerative positions, compared to the usual level of salaries in Karakalpakstan*
c. *Empowerment of staff and Incentives in the form of training and exposure visits to organizations overseas*

4. Staff Profile

The Staff of the CSP as of today are a good mix of technical competence, dedication and ability.

The current Program Director, Ramine Behrambegi, has established an open, participatory style of functioning, which has considerably improved staff morale. This is particularly significant considering that

he took over at a difficult stage in the life of the program, with an absence of a Program director for the previous 12 months. His personal style of functioning includes an openness of manner and eagerness to meet with new people and share ideas, which is an extremely useful attribute in a program of this nature. He is focused at this point in time, and has a clear perception that the remaining program period is a crucial one.
However, the balance between task and relationship in dealings with staff must be maintained, and there are times when the program director has to take quick and apparently harsh decisions. This will avoid delays in program functioning in key areas, like, for example, BCC material preparation.

The Senior Health education specialist, Dr Sara Utegenova, is an asset to the program. She is a respected member of the Health fraternity in Karakalpakstan, having come on board the CSP after a stint with the Ministry of Health. She will be a key player in the future of the program, with skills in BCC materials, and in training.

Dr John Brown, the volunteer form the Peace Corps, who will be working with the CSP over the next two years, is another potential asset. Dr Brown has skills in core technical intervention areas, and in the design of material using computers. His ability to focus on a task through to completion must be made use of in the remaining life of the program.

The HMIS co ordinator and Communications specialist , Azimat Matkarimov and Sagitjan Aitjanov have co authored the abstract of the proposed paper on the Willingness to pay study. They are persons with considerable skill in the area of Health information, its collection, analysis and interpretation. Further training on HMIS related issues will enable their skills to be further improved upon.

The acting program manager, Nina Nizamatdinova and the Finance and administration manager, Lilya Kim are other key members of the CSP, who appear to have a good grasp on the program. The support staff of Yulia Miroshnichenko, Communications officer, Vasilisa Rotalskaya, administrative assistant/receptionist, keep the office functional.

The field staff are perhaps the greatest asset of the program. Ably headed by a set of qualified and articulate Field Officers, the village Health workers appear to have made their mark on the community. Judging by the remarks of the various members of the community interviewed as part of the evaluation, the VHWs have played an

extremely important role in the key areas of BCC and Community mobilization.

The Utilization of the field staff in the remaining part of the life of the program must be based on an idea of what the future of the CSP is going to be following December 2004. They could contribute very valuable inputs to any of the possible directions which the program would take

a. *Strengthening the existing program*
b. *Diversification into other strategies in the same area, or*
c. *Applying the same strategies into different areas.*

5. Training

The training inputs given by the CSP have been appreciated by the Ministry of Health and by Perzent as being need based and effective.

The Health workers of the MoH interviewed as part of the evaluation at the Health facilities state that even if they knew about the interventions of the CSP before the program, the training given helped in

a. *Updating knowledge*
b. *Adding a real component to it by associating it with BCC strategies, thereby making it more usable and effective*
   An example given by the pediatrician at Nukus rayon was that she found that the health personnel for Nukus rayon were more aware of the methods to be used in reaching messages to the community than workers from other non program rayons during a meeting of MoH doctors organized by the MoH.

6. Capacity - Perzent

An important goal of the CSP is to build the capacity of the partner organizations to enable them to independently plan, implement and evaluate a Child survival program.

The staff of Perzent who are with the CSP have had the training, the experience and the first-hand acquaintance of the project. Training has been imparted to Perzent staff at Karakalpakstan and by means of deputing them to international training programs. At the end of the CSP, Perzent will therefore have human resource who are technically competent to actually deliver a program directed towards child survival. The Field officers, the Village Health workers and the supervisory level staff member, Mels Kutlimuratov, have expressed confidence in their ability to carry out the interventions and strategies of the CSP.

The measurement of capacity of an organization would probably be based on considerations which include the following:

a. *The ability to independently attract funds by making proposals*
b. *The ability to retain staff who are technically competent*
c. *The presence of Enthused, willing, motivated staff*
d. *The New projects which the organization has developed*
e. *The ability of the organization to expand the scope of its existing activity*
f. *The Presence, within the organization, of trained staff and trainers*

Perzent is currently involved in 8 rayons in Karakalpakstan, and the organization is committed to work in the areas of women's/ reproductive health and the environment. The CSP has given it an orientation to work in the area of child survival, and the partnership has ensured that in addition to the intent, the ability is also present. Perzent has moved to a new and larger office in Nukus, and appears to have the physical infrastructure to be able to handle a program of this nature

7. Capacity - Ministry of Health

The capacity of the MoH is difficult to measure, in the absence of a formal HFA study. The documentation of the HFA study being commissioned by the Umir Nuri CSP will aid in this regard. However, discussions had with personnel at the Health facilities would seem to suggest that the capacity of the health facilities in the 2 program rayons with respect to the program interventions has indeed shown a trend for the better. Specific examples cited were:

a. *Facilities were supplied with drugs (Co trimoxazole) and equipment. This was facilitated by the CSP involving UNICEF and the Counterpart Humanitarian Assistance Program (CHAP)*
b. *The process of filling in health related information in cards during house visits by health personnel has become a more intensive activity, probably because of better communication skills acquired during BCC training.*
c. *Health workers at the facilities now compete with Village Health workers of the project in their community based activities*

The BCC materials and methods used at the health facilities have improved considerably since the start of the project. BCC material relating to the program interventions were found at almost all the facilities. While this was encouraging to note, true empowerment of the MoH facilities will be in evidence when the MoH creates its own BCC materials which are attractive and educational. Even if funds and resources within the MoH are needed for this to happen, the CSP has shown a direction for its partner to take.

Recommendations

1. **Health Management Information system (HMIS)**
   The HMIS could be developed further to make it a sensitive mechanism for detecting areas of need, both in terms of training and in terms of program interventions and activities.

   The HMIS was collecting information pertaining to indicators of knowledge and practice at a monthly frequency. This proved to be a time-consuming laborious exercise, which took time of the VHW away from important, BCC related activity. Following a review of this mechanism, the amount of information collected was reduced and the frequency made once six-monthly, which is a more reasonable frequency for indicator-related information. Process-related information is still collected monthly, as it should be.

   The HMIS staff have developed most of the instruments used themselves, which is commendable. But there is a need for formal training of the HMIS staff on methods designed to make the collection and use of data a more useful and active exercise. Training of the MoH staff on HMIS would further build capacity.

2. **Refresher training**
   The system of periodic assessment of VHW performance by the Health Education specialist is a good basis for designing refresher training. The Rapid assessments which are done by the HMIS staff of the CSP should help identify need for refresher training for the Health facilities as well.

   Motivation and communication skills are two additional areas of need for training of MoH staff.

   Newly recruited staff should receive some form of orientation training so as to make them feel one with the rest of their peers.

3. **Capacity of Perzent**
   Discussions with Dr Oral Ataniyazova, Director, Perzent, would appear to indicate that her organization is expressing confidence in their ability to handle a program of a similar nature. She suggested that in the future, Counterparts role could be more facilitatory and supportive, with Perzent being involved in the actual grassroot level implementation.

   Additional areas where there was a need felt for capacity building in Perzent were the following:

a. Lobbying / advocacy, where skills were required in trying to secure support for issues which need to be addressed
b. Documentation
c. Dissemination of information relating to programs and activities
d. Health Management Information systems

Networking and Advocacy

Counterpart has been an active member of the International NGO community in Uzbekistan since 1993. The work of Counterpart in Uzbekistan ranges from Civil society and governance programs to Health.

Some of the International NGOs with whom the CSP has a relationship include:

- **Medecins sans Frontiers**, which is involved with the DoTS program in Tuberculosis control in all rayons of Karakalpakstan. Initially, MSF was also involved with programs for Diarrheal disease control and Acute Respiratory Infections, but is not involved in these issues since the start of the CSP.

  The CSP has collaborated with MSF in the DoTS program in the two rayons of Nukus and Takhtakupir. The VHWs of Counterpart were involved in the DoTS program. Also, the CSP was involved with Health education on the World TB day, which MSF organized.

- **Project HOPE,** with its Child survival program at Navoi, is involved in similar interventions in another area of Uzbekistan. Collaboration is in the areas of technical information / initiatives exchange. For example, the breastfeeding support groups initiative and the idea of competitions for mothers and health workers on child survival issues.

- **The Progress Educational and Development center**, which is a UK-supported initiative to promote the learning and use of English. The Health Families Club, an initiative supported by UNICEF and the CSP is an area of collaboration.

- **Red Cross**, who is involved with a food distribution program for TB patients. The CSP was involved in the organization of the ceremonies on World TB day in collaboration with the Red Cross and MSF.

- The **Counterpart Consortium** in Karakalpakstan which is involved mainly with civil society and governance-related programs. Even though the parent agency (Counterpart) is the same, the offices of the consortium agency and the CSP are different, and they work as independent bodies. Collaboration has been in the areas of sharing of space, and training facilities. VHC members from the Umir Nuri CSP have been trained on proposal development and management by the Counterpart Consortium, and have received funds from the organization.

- **UNICEF**, with whom the CSP has collaborated in the area of drug distribution to health facilities.

- **Counterpart Humanitarian Assistance Program** (CHAP) in the leveraging of resources, through which the CSP facilitated the equipping of Health facilities in the program rayons with essential infrastructural items.

Formal mechanisms of networking have been established by the CSP. They are:

- **Interagency meetings**, which take place once monthly on Saturdays. These meetings, which are a pioneering initiative by the Umir Nuri CSP, are semi-informal where the various international agencies operating in the Karakalpakstan region get together for a 2-3 hour discussion on issues of common interest at the CSP office.

- **Intersectoral meetings** which are convened at the Ministry of Health, where the agencies meet with the MoH, and get a chance to discuss issues with the government. The intersectoral meetings started following a feeling that the interagency meetings lacked the official backing necessary to actually affect policy. The CSP plays a convener role for both these meetings.

Conclusions

1. ***Networking and advocacy strategy - basis***
   The Networking and advocacy strategy of the CSP is founded on the following principles
   a. *Regular interagency and intersectoral meetings help in getting like- minded organizations together, and in giving them a forum to interact with the Ministry of Health.*
   b. *Excellent public relations, especially with the current Program Director, Ramine Behrambegi, helps in getting people together, and in getting them to articulate their views on issues of common interest*
   c. *Finding common areas of interest and assisting in whatever way possible (for example – World TB day) is a good way of making and keeping friends.*

2. ***Networking and advocacy - benefits***
   Networking and advocacy helps the CSP and Counterpart in the following ways

a. *Deciding and marking out geographic territories of involvement*
b. *Enhancing the visibility of the program and the organization Counterpart in the area and the development community in the region*
c. *Avoiding of duplication of efforts directed at a common purpose by discussing plans and strategies at interagency and intersectoral meetings*
d. *Discovering potential areas of collaboration and partnerships between organizations*
   MSF has discussed possibilities for collaborative research in the future on areas like
   - *Persistent organic pollutants and risk communication*
   - *Anemia, especially in women and children*
   - *Building of capacity of educational institutions in doing research on issues related to environmental health*
e. *Learning from each others experiences which are shared at interagency and intersectoral meetings*
f. *Advocacy for issues of common interest by presenting a stronger voice to policy makers*

3. Donor visibility

The visibility of the donor – USAID – has also been enhanced in the Karakalpak region because of the CSP program, which is the only health program supported by USAID in the region. The CSP enjoys an excellent relationship with the USAID mission at Tashkent.
The US ambassador to Uzbekistan visited the CSP office in May 2003.

4. Support from headquarters

Counterpart Headquarters has also been very supportive to the program, especially through its Director, Health Programs, Darshana Vyas. Specific areas of support and facilitation by Ms Vyas include:

a. *Three training programs, on BCC, ARI and HMIS*
b. *The ensuring of participation in international training programs and seminars to enable upgradation of skills*
c. *The Design of BCC strategy and materials*
d. *The periodic feedback on reports and information sent to Headquarters*
e. *The incentives provided as part of the staff retention strategy*
f. *A two day retreat and training on team building and conflict resolution*

The CSTS unit has helped with technical information and advice when sought.

Recommendations

1. **Scientific Conference**
   The CSP has already taken the lead in organizing interagency and intersectoral meetings on a regular basis. A further step towards emphasizing the identity of the program would be to organize a scientific conference, or seminar, or symposium centered around Child Survival issues of relevance to the region. Besides contributing to the knowledge base on Child survival in the region, it would serve as an excellent platform for all stakeholders – donors, policy makers and communities to come together on a scientific platform and exchange information and views relating to child survival. The achievements of the program could also be presented to the group and their suggestions on future directions be solicited.

Sustainability

What happens after December 2004 ?

The question of sustainability is high on the minds of all stakeholders of the CSP – the donors, the partners, the staff, the community and the network of collaborating organizations among others.

*The **objectives** related to sustainability as stated in the DIP include the following:*

a. *Health facilities improve their skills and quality of care in the areas of CDD, PCM, breastfeeding and interpersonal communication*
b. *Makhalla and village health committees have the capacity to implement health education interventions*
c. *Service – seeking behavior is increased*
d. *Local institutions are established which are capable of sustaining positive changes in behavior*
e. *CS interventions are continued beyond the LOP by instituting alternative funding and cost recovery systems*

One of the major strategies towards sustainability will be the building of capacity of the partner organization, Perzent. This increased capacity could result in the continuation of child survival interventions in the existing rayons, or the expansion of the program into other rayons. The capacity of Perzent and of the MoH has been discussed in the previous section.

Apart from this, evidence that some of these objectives are being fulfilled at the mid term includes:

a. Health Facility/ MoH

Expressions of confidence among personnel at the health facilities met as part of the MTE that they are capable of delivering care in the program intervention areas to mothers in the community. This feeling was also echoed by the members of the Ministry of Health who were met who said that their facilities have benefited from the inputs given by the program and that they are better equipped to deliver intervention-related care

b. Village Health committees

Village Health Committee leaders and members who were met as part of the MTE expressed their satisfaction at the program and expressed willingness and confidence in their ability to talk to mothers in their communities regarding program interventions

In addition to this VHCs have been exposed to the unique Community Grants program, where training was imparted to some of them on the development of project proposals aimed at improving the situation in their communities by means of some development initiative.

VHCs who attended this program have prepared some project proposals directed at common health issues like anemia, breastfeeding promotion and fortification of commonly consumed foods with iron.

This skill imparted to the VHCs will enable them to independently secure funds for their own development, which will pave the way for their independence and empowerment.

c. Care seeking behavior

The KPC indicators which measure care-seeking behavior in diarrhea and in ARI have improved since the baseline. Though the indicator which measured immediate care seeking was estimated at a level less than baseline in the case of ARI, the indicators of seeking care form a qualified health care provider were estimated at levels higher than baseline for both diarrheal disease and ARI.

Recommendations

1. Local institutions – womens organizations

The VHCs are strong community based organizations which have been created by the CSP. Being voluntary bodies, who are not being paid by the program, VHCs will play a key role in the future of the program.

BFSGs, School of mothers and the Village health workers of the CSP who reside in the community can be the starting points to establish solid community based institutions which will continue to exist beyond the LOP. Ideally, organizations of women will be the best source of health related knowledge for newly weds and young mothers. They may be a better source than a VHC, which has an "official" nature as compared to the "woman next door" nature of local women organizations.

The CSP must aim to establish women's groups through the VHCs, BFSGs and Schools of mothers. These groups must receive training from the CSP on the interventions of the program and on social issues, since they will also be social organizations where women can join and discuss social issues of common interest, maybe even start a small savings program.

This can be the source of a revolving fund through which items necessary for women and children at the village such as ORS and drugs can be purchased.

2. **Village Pharmacies**
   The groundwork for the Village pharmacy initiative has been done in the shape of the Willingness to pay study, though this is an initiative which should be accelerated.

   The Village pharmacy promise to be a good legacy to leave behind after the LOP. Since the initiative is based upon solid research, the chances of success are high. In this initiative, it is proposed to establish village pharmacies, which will receive an initial stock of drugs as a grant. Sale of these drugs will lead to the creation of a revolving fund, which will then be used to get more drugs. The management of the pharmacy will be in the hands of the local community. The VHCs could play a role in this, thereby ensuring their continued existence.

3. **Health Facilities**
   The support required for the HF in the remaining part of the program will relate to the following areas:
   - Support with BCC materials and educational aids, and, more importantly, training to enable the MoH to produce and use innovative materials
   - Training for the newly recruited staff and refreshers for the existing staff
   - Creating cadres of trainers by organizing more training of trainers programs..

The Future

The Future of the CSP, if it continues to be supported in Karakalpakstan, could be in one of two broad directions:

1. ***Expanding** the scope of the activity and consolidating the presence of the program in the same rayons.*

   In this scenario, the program will continue o work in Nukus and Takhtakupir rayons, but will expand the scope of activity to include such issues as
   a. *Other Child health issues like Nutrition, Iodine deficiency disorders*
   b. *Reproductive Health issues, particularly anemia*
   c. *HIV/AIDS, which has been reported as being a "silent" crisis in the region*

d. *The building of the capacity of schools and educational institutions, the use of school teachers as potential trainers in the community*

2. ***Replicating*** *the successes of the CSP in other rayons, by initiating similar programs*

   This is the scenario which the MoH would like to see, so that as much of Karakalpakstan, if not the whole of it, receives the benefits of the program interventions.

Either of the possibilities can be actually implemented by Perzent, with Counterpart playing a technical advisory role. Perzent has indicated its willingness and ability to be involved with the grassroot level functioning of any future child survival initiative, with Counterpart providing technical support. The resources of Perzent, in the form of its new office and trained manpower could be used to share costs with the organization in the next phase.

The excellent networking skills of the CSP will result in possible areas of collaborations and areas of cost sharing with other international organizations. MSF has indicated potential areas of collaboration.

The Umir Nuri Child Survival program is a working model which has the potential to improve health status, while empowering local communities at the same time. In the period upto December 2004, the program must consolidate, refocus and plan for the future, which has exciting possibilities.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

A. Technical Interventions

1. Program effectiveness in terms of interventions

Although information on incidence of disease and mortality in the population was not collected during the Mid term evaluation, the key indicators in the KPC survey would appear to indicate that there has been considerable progress made in the area of technical interventions.

ALL indicators related to Control of Diarrheal disease have improved since baseline, and are currently estimated at levels beyond program targets.

ALL indicators related to Promotion of breastfeeding have improved since baseline except the proportion of mothers with children under 2 yrs of age who state they gave colostrum to their baby during the first three days of life, which remains stable at its pre existing high level. Levels of Key indicators are currently estimated at levels beyond program targets.

The indicators of KNOWLEDGE of mothers regarding signs of ARI show improvement over baseline levels.

However, the indicators of PRACTICE which measure the proportion of mothers taking their child for treatment immediately (on the same day) are lower than baseline levels. This could be because

a. *Children with Acute Upper Respiratory Infection can be managed at home, which is a message in the BCC related to ARI. The KPC indicator referred to above measures practice of mothers whose child had ANY kind of ARI, not necessarily Acute Lower Respiratory infections. If messages have been effective, the indicator may actually be reflective of a greater proportion of mothers who take care of their mildly sick child at home, saving resources for the care of severely ill children.*
   A study could be done among mothers in the project area to probe this issue and find out the reason for a low proportion of mothers taking their child who shows symptoms of ARI to a doctor on the same day.

b. *The KPC survey was carried out in summer, when the incidence of ARI is low. The denominator for the indicator is 17, which is an*

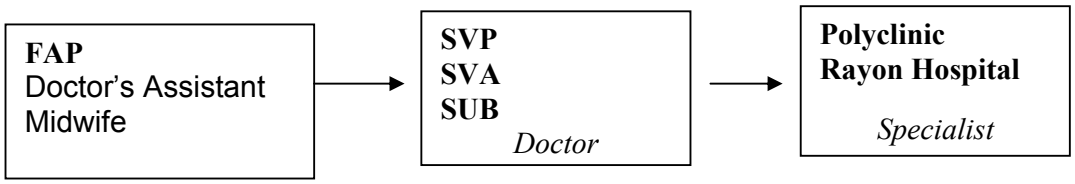
extremely low number. Conclusions drawn based on this number must therefore be viewed with caution.

2. Capacity of Health Facilities with respect to Technical Interventions – CDD, Pneumonia and breastfeeding

The MOH Republican Health System (RHS) is the main health care provider in the rural areas, encompassing the 15 rayons in Karakalpakstan. When needed, patients are referred to specialized hospitals and dispensaries in Nukus City. The RHS provides patient care through 3 Republican hospitals, 3 city hospitals, 15 central rayon hospitals, 42 polyclinics, 30 SUBs, 68 SVAs, 55 SVPs and 388 FAPs (explained below). The hospitals include rayon hospitals, SUBs, Republican hospitals and specialized hospitals. There are 3,930 doctors and 15,245 middle medical employees providing medical care in the RHS. There are 26.1 doctors and 101.1 midlevel medical personnel for every 10,000 people in Karakalpakstan.

*The following diagram illustrates the difference between the **existing** rayon health system and the **new** rayon health system under health reform.*

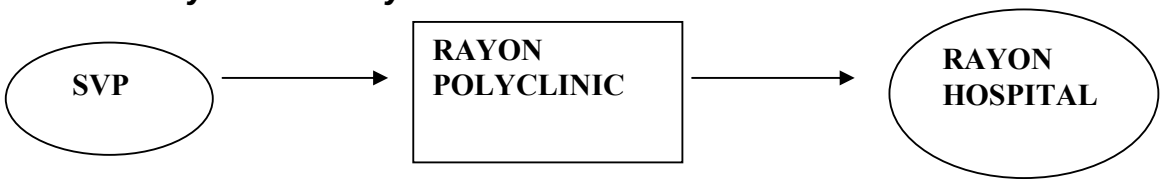
Existing Rayon Health System.



LEVEL I ***LEVEL II*** ***LEVEL III***

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

New Rayon Health System Under Health Reform



The qualitative data collected from staff at Health Facilities, from Village Health Committee leaders and from Mothers would appear to indicate that the Health facility staff are currently better equipped to deal with children with Diarrhea and Pneumonia. The concepts of the staff at the facilities regarding breastfeeding have also undergone updating and revision.

Specific areas of increased capacity include:

a. *Updated knowledge on the technical aspects of the interventions, incorporating recent approaches like the IMCI.*
b. *The availability and use of educational material at the Health facility*
c. *Increased capacity as trainers, following the training of trainers programs of the CSP.*
d. *An increase in confidence of the staff at the facilities, based upon their rapport with the community, in those areas where the Health facility personnel have a good rapport with the community, by being VHC members, for example.*
e. *The enhancement of the effectiveness of house visits made by health facility personnel. In the words of a VHC member …" earlier, they were just filling forms, now they talk to us and educate mothers…"*

The Umir Nuri CSP is in the process of conducting a formal Health Facility assessment. The documentation of this will provide more insight on this issue.

3. Key Behavior change – findings from qualitative study

The following were some of the changes in behavior which were cited by the various members of the community / Health facility personnel

a. *Early referral of children showing danger signs of diarrhea*
b. *Use of ORS/ORT in preference to antibiotics or other home remedies, like rubbing ash on the abdomen, or giving tea to children with diarrhea.*
c. *Initiation of breastfeeding, even when mother is at Maternity home*
d. *Taking children who show signs of severe ARI for treatment*

4. ARI Practice

*The **ARI Practice** indicator which measures practice of mothers regarding seeking treatment early when their children show signs of ARI is estimated at lower levels than baseline. However, the indicators of knowledge regarding the danger signs of ARI are estimated at higher levels than baseline.*

B. Community Mobilization

5. Role of Village Health Committees

The VHCs represent an attempt at empowerment, and this seems to be in evidence as the 18 VHCs of the CSP prepare to play a larger role in their communities. One VHC member said "..The program is causing a Health revolution, akin to the great October revolution…" The members seem to have understood the role which organizations like theirs can play in their communities, and appear to be willing to take on the responsibility. VHC members approach the Hakimiyat on their own for clarification regarding issues concerning the program.

6. Community Participation

Community Participation is one of the Key principles of Primary Health Care, and the CSP, through its Community mobilization strategy has ensured that the community is not a passive recipient of health messages which are handed out impersonally, but is an active participant in the process

7. Role of CSCCs

The CSCC appears to be successfully playing the role of a rayon-level supervisory/advisory body. The Deputy Hakim, Women's issues at Nukus Rayon felt that the monthly meeting of the CSCC has now been made quarterly, because "…. The VHCs are now doing their job at the aul/makhalla level…" and the need for a monthly meeting had reduced.

C. BCC

8. BCC strategy

The Behavior change communication strategy of the CSP appears to have conveyed key messages to mothers in the area, as evidenced by the increase in estimated levels of key indicators of knowledge and practice. Of particular interest is the fact that the estimated levels of indicators measuring knowledge of HIV/AIDS, which is not a program intervention, have remained stationary since baseline, while those measuring the program indicators have changed.

Behavior change is difficult to achieve, and the KPC results show that the program has indeed accomplished much in a relatively short time of 2-1/2 years. The Village Health worker, armed with flip charts and posters, has done very well in communicating the BCC messages using appropriate methods, and at appropriate venues.

9. Ethnic groups

The presence of different ethnic groups within the population, speaking different dialects of Uzbek, Karakalpak, Russian and

Kazhakh languages presents a challenge to the communicators of the CSP who have to use the appropriate language when necessary.

10. Translation

The preparation of materials involves their translation into Karakalpak and Russian from English and back translation to check for accuracy. The official stance in Uzbekistan is to promote the Uzbek language, which is not very widely spoken in the program rayons. The CSP, however, has translated most of the BCC materials into Karakalpak, and this would represent the correct decision in the circumstances. The CSP has also translated IMCI guidelines into Karakalpak for use by the MoH.

The translation of BCC materials into the local language has been a major accomplishment of the program. This has resulted in wide dissemination of the messages which they contain, and in the enhancement of the visibility of the program.

11. Innovative approaches

Other innovative approaches suggested towards behavior change are

- Competitions for mothers based on Key Child survival interventions

- Street plays and puppet shows. These methods were learned by the CSP team following an exposure visit to and exchange of information between the CS projects of Counterpart at Ahmedabad, India and the CSP.

A puppet show was staged at the Children's day celebration on June 1st 2003, and despite reservations as to its cultural acceptance, was well received. The CSP plans to use this method to a larger extent in its BCC strategy

D. Organizational Capacity

12. The Partnership

It would appear that the Partnership between Counterpart, Perzent and the Ministry of Health in Karakalpakstan has been a successful model. The Memorandum of Understanding which is the written basis for the partnership is a unique document. Some of the features of the MoU which made the process unique were:

- *It was among the first partnerships between an international organization, a local NGO and the Ministry of Health in Karakalpakstan*
- *The MoU was a clear basis or understanding of roles and responsibilities of each of the partners.*

- *It outlined the same in unequivocal terms. The Ministry of Health took time to study the MoU before signing it.*
- *The MoU has since served as a set of guidelines as to performance of each partners' role.*
- *The MoU of the CSP has since been used as a basis for many other partnerships which have developed in the region since the start of the program.*

The partnership is characterized by an intensive level of involvement of all partners. This was initiated form the time of planning, when Perzent contributed considerably to the design of the program and the DIP, in terms of suggestions regarding geographic areas of coverage and the specific issues to be addressed. Suggestions such as these were incorporated into program design, and the ultimate shape of the project was based on consensus.

Initially, there did appear to be problems in the partnership between Counterpart and Perzent. Currently, however, they share an excellent relationship, with the director of Perzent, Dr Oral Ataniyazova admitting that the earlier problems were more due to the style of functioning of the earlier Program director, than system-based.

In the implementation phase, both Perzent and the MoH feel that there is a considerable sharing of information and ideas in the CSP. The Ministry feels that the gap between the Health facilities run by it and the community is being bridged to a great extent by this program. The MoH program is not necessarily need-based and responsive to felt needs, and the MoH feels that the CSP, which works in close partnership with the community, can bridge the gap between peoples needs and program interventions.

The Ministry of Health is perceived by the people as being more interested in indicators, rather than in behavior change. Other problems it faces are in the area of staff turnover and lack of motivation among its workers. The CSP presents a refreshingly different approach, with committed staff who work toward behavioral and program goals.

incumbent, Ramine Behrambegi, was a difficult period of time for the CSP.

The factors which assisted the program through this period were the following:

a. *The intense support given by Darshana Vyas, Director of Health Programs from Counterpart headquarters, who made periodic visits to the CSP and gave valuable inputs. Her grasp of the details of the program is commendable, and this has helped even the current Program director establish a pattern of management.*
b. *The contribution made by the late Dr Nuriyah Elgondieva, who was appointed as Field Officer, promoted to BCC specialist and finally Program Manager, was extremely valuable. The various persons interviewed as part of this evaluation rate her as a very dedicated, resourceful person, who was an extremely important and valuable part of the team. The program has indeed lost an important resource in her untimely and shocking demise in January 2003.*
c. *The quality and stability of the staff at the program level and field level ensured that even if the leadership position was vacant, the interventions and strategies of the program were implemented as planned.*

14. Staff Retention

The Program has had turnover of staff, particularly at the level of Program director. But as mentioned above, the field staff and key program staff have remained stable. One of the key strengths of the CSP has been its ability to retain its field staff.

The factors which form the basis of this retention strategy could have been the following:

a. *A basically participatory style of management brought in by the current program director, which presented a refreshing change from the earlier director, whose style was more restrictive.*
b. *Financially remunerative positions, compared to the usual level of salaries in Karakalpakstan*
c. *Empowerment of staff and Incentives in the form of training and exposure visits to organizations overseas*

15. Staff Profile

The Staff of the CSP as of today are a good mix of technical competence, dedication and ability.

The current Program Director, Ramine Behrambegi, has established an open, participatory style of functioning, which has considerably improved staff morale. This is particularly significant considering that

he took over at a difficult stage in the life of the program, with an absence of a Program director for the previous 12 months. His personal style of functioning includes an openness of manner and eagerness to meet with new people and share ideas, which is an extremely useful attribute in a program of this nature. He is focused at this point in time, and has a clear perception that the remaining program period is a crucial one.
However, the balance between task and relationship in dealings with staff must be maintained, and there are times when the program director has to take quick and apparently harsh decisions. This will avoid delays in program functioning in key areas, like, for example, BCC material preparation.

The Senior Health education specialist, Dr Sara Utegenova, is an asset to the program. She is a respected member of the Health fraternity in Karakalpakstan, having come on board the CSP after a stint with the Ministry of Health. She will be a key player in the future of the program, with skills in BCC materials, and in training.

Dr John Brown, the volunteer form the Peace Corps, who will be working with the CSP over the next two years, is another potential asset. Dr Brown has skills in core technical intervention areas, and in the design of material using computers. His ability to focus on a task through to completion must be made use of in the remaining life of the program.

The HMIS co ordinator and Communications specialist , Azimat Matkarimov and Sagitjan Aitjanov have co authored the abstract of the proposed paper on the Willingness to pay study. They are persons with considerable skill in the area of Health information, its collection, analysis and interpretation. Further training on HMIS related issues will enable their skills to be further improved upon.

The acting program manager, Nina Nizamatdinova and the Finance and administration manager, Lilya Kim are other key members of the CSP, who appear to have a good grasp on the program. The support staff of Yulia Miroshnichenko, Communications officer, Vasilisa Rotalskaya, administrative assistant/receptionist, keep the office functional.

The field staff are perhaps the greatest asset of the program. Ably headed by a set of qualified and articulate Field Officers, the village Health workers appear to have made their mark on the community. Judging by the remarks of the various members of the community interviewed as part of the evaluation, the VHWs have played an

extremely important role in the key areas of BCC and Community mobilization.

The Utilization of the field staff in the remaining part of the life of the program must be based on an idea of what the future of the CSP is going to be following December 2004. They could contribute very valuable inputs to any of the possible directions which the program would take

a. *Strengthening the existing program*
b. *Diversification into other strategies in the same area, or*
c. *Applying the same strategies into different areas.*

16. Training

The training inputs given by the CSP have been appreciated by the Ministry of Health and by Perzent as being need based and effective.

The Health workers of the MoH interviewed as part of the evaluation at the Health facilities state that even if they knew about the interventions of the CSP before the program, the training given helped in

a. *Updating knowledge*
b. *Adding a real component to it by associating it with BCC strategies, thereby making it more usable and effective*
   An example given by the pediatrician at Nukus rayon was that she found that the health personnel for Nukus rayon were more aware of the methods to be used in reaching messages to the community than workers from other non program rayons during a meeting of MoH doctors organized by the MoH.

17. Organizational Capacity - Perzent

An important goal of the CSP is to build the capacity of the partner organizations to enable them to independently plan, implement and evaluate a Child survival program.

The staff of Perzent who are with the CSP have had the training, the experience and the first-hand acquaintance of the project. Training has been imparted to Perzent staff at Karakalpakstan and by means of deputing them to international training programs. At the end of the CSP, Perzent will therefore have human resource who are technically competent to actually deliver a program directed towards child survival. The Field officers, the Village Health workers and the supervisory level staff member, Mels Kutlimuratov, have expressed confidence in their ability to carry out the interventions and strategies of the CSP.

The measurement of capacity of an organization would probably be based on considerations which include the following:

a. *The ability to independently attract funds by making proposals*
b. *The ability to retain staff who are technically competent*
c. *The presence of Enthused, willing, motivated staff*
d. *The New projects which the organization has developed*
e. *The ability of the organization to expand the scope of its existing activity*
f. *The Presence, within the organization, of trained staff and trainers*

Perzent is currently involved in 8 rayons in Karakalpakstan, and the organization is committed to work in the areas of women's/ reproductive health and the environment. The CSP has given it an orientation to work in the area of child survival, and the partnership has ensured that in addition to the intent, the ability is also present. Perzent has moved to a new and larger office in Nukus, and appears to have the physical infrastructure to be able to handle a program of this nature

18. Organizational Capacity - Ministry of Health

The capacity of the MoH is difficult to measure, in the absence of a formal HFA study. The documentation of the HFA study being commissioned by the Umir Nuri CSP will aid in this regard. However, discussions had with personnel at the Health facilities would seem to suggest that the capacity of the health facilities in the 2 program rayons with respect to the program interventions has indeed shown a trend for the better. Specific examples cited were:

a. *Facilities were supplied with drugs (Co trimoxazole) and equipment. This was facilitated by the CSP involving UNICEF and the Counterpart Humanitarian Assistance Program (CHAP)*
b. *The process of filling in health related information in cards during house visits by health personnel has become a more intensive activity, probably because of better communication skills acquired during BCC training.*
c. *Health workers at the facilities now compete with Village Health workers of the project in their community based activities*

The BCC materials and methods used at the health facilities have improved considerably since the start of the project. BCC material relating to the program interventions were found at almost all the facilities. While this was encouraging to note, true empowerment of the MoH facilities will be in evidence when the MoH creates its own BCC materials which are attractive and educational. Even if funds and resources within the MoH are needed for this to happen, the CSP has shown a direction for its partner to take.

E. Networking and Advocacy

19. Networking and advocacy strategy - basis

The Networking and advocacy strategy of the CSP is founded on the following principles

a. *Regular interagency and intersectoral meetings help in getting like- minded organizations together, and in giving them a forum to interact with the Ministry of Health.*
b. *Excellent public relations, especially with the current Program Director, Ramine Behrambegi, helps in getting people together, and in getting them to articulate their views on issues of common interest*
c. *Finding common areas of interest and assisting in whatever way possible (for example – World TB day) is a good way of making and keeping friends.*

20. Networking and advocacy - benefits

Networking and advocacy helps the CSP and Counterpart in the following ways

a. *Deciding and marking out geographic territories of involvement*
b. *Enhancing the visibility of the program and the organization Counterpart in the area and the development community in the region*
c. *Avoiding of duplication of efforts directed at a common purpose by discussing plans and strategies at interagency and intersectoral meetings*
d. *Discovering potential areas of collaboration and partnerships between organizations*
   MSF has discussed possibilities for collaborative research in the future on areas like
   - *Persistent organic pollutants and risk communication*
   - *Anemia, especially in women and children*
   - *Building of capacity of educational institutions in doing research on issues related to environmental health*
e. *Learning from each others experiences which are shared at interagency and intersectoral meetings*
f. *Advocacy for issues of common interest by presenting a stronger voice to policy makers*

21. Donor visibility

The visibility of the donor – USAID – has also been enhanced in the Karakalpak region because of the CSP program, which is the only health program supported by USAID in the region. The CSP enjoys an excellent relationship with the USAID mission at Tashkent.

The US ambassador to Uzbekistan visited the CSP office in May 2003.

22. Support from headquarters

Counterpart Headquarters has also been very supportive to the program, especially through its Director, Health Programs, Darshana Vyas. Specific areas of support and facilitation by Ms Vyas include:

a. *Three training programs were conducted by her, on BCC, ARI and HMIS*
b. *The ensuring of participation in international training programs and seminars to enable upgradation of skills*
c. *The Design of BCC strategy and materials*
d. *The periodic feedback on reports and information sent to Headquarters*
e. *The incentives provided as part of the staff retention strategy*
f. *A two day retreat and training on team building and conflict resolution*

The CSTS unit has helped with technical information and advice when sought.

F. Sustainability

Evidence that the program objectives related to sustainability are being fulfilled at the mid term includes:

23. Health Facility/ MoH

Expressions of confidence among personnel at the health facilities met as part of the MTE that they are capable of delivering care in the program intervention areas to mothers in the community. This feeling was also echoed by the members of the Ministry of Health who were met who said that their facilities have benefited from the inputs given by the program and that they are better equipped to deliver intervention-related care

24. Village Health committees

Village Health Committee leaders and members who were met as part of the MTE expressed their satisfaction at the program and expressed willingness and confidence in their ability to talk to mothers in their communities regarding program interventions

In addition to this VHCs have been exposed to the unique Community Grants program, where training was imparted to some of them on the development of project proposals aimed at improving the situation in their communities by means of some development initiative.

VHCs who attended this program have prepared some project proposals directed at common health issues like anemia, breastfeeding promotion and fortification of commonly consumed foods with iron.

This skill imparted to the VHCs will enable them to independently secure funds for their own development, which will pave the way for their independence and empowerment.

25. Care seeking behavior

The KPC indicators which measure care-seeking behavior in diarrhea and in ARI have improved since the baseline. Though the indicator which measured immediate care seeking was estimated at a level less than baseline in the case of ARI, the indicators of seeking care form a qualified health care provider were estimated at levels higher than baseline for both diarrheal disease and ARI

RECOMMENDATIONS

A. Technical Interventions

1. ARI Practice

Quick research aimed at eliciting the reason for the low level of practice relating to taking a symptomatic child immediately for treatment, by meeting groups of mothers and other key individuals can provide clues as to the reasons behind this. An appropriate strategy can then be planned to improve the indicator

2. Revision of targets

The **targets** for indicators of knowledge and practice related to the interventions indicated in the DIP must be **appropriately revised** since most current estimates exceed target levels. This needs to be done as a joint exercise between the partners, including the inputs of field level staff.

3. ORS Corners

ORS corners at Health facilities are popular with Health workers and Village Health workers. These could be promoted to a greater extent, since the Health facility personnel appear to be comfortable with the concept of ORS corner, have the time and the knowledge to educate mothers and provide them with the right messages, at the ORS corner.

4. Messages – feeding during diarrhea

The **messages relating to** continued feeding, continued administration of liquids, and the feeding of children recovering from diarrhea could be emphasized since the indicators of these practices show that about half the mothers whose children had diarrhea in the 2 weeks preceding survey did not practice the same.

5. Handwashing practice

The estimated level of the indicator of **appropriate handwashing practice** is still low (15.3%), even if it is higher than baseline (3.7%). The project needs to emphasize the prevention of diarrhea in its messages related to diarrhea management. With the high literacy level, it should be possible for mothers to read posters, leaflets and other material on hygiene. The Poster on hygiene is a good step in this direction – it needs to be built upon.

6. Breastfeeding practice

The indicators of early initiation of **breastfeeding** and exclusive breastfeeding practice show that there are still mothers who do not practice these key interventions. The program has emphasized the

importance of correct breastfeeding practice, but needs to do more to ensure that ALL mothers practice these behaviors.

Since the place of delivery is usually the maternity home, intensive training and support could be provided to staff at maternity homes, specifically on early initiation of breastfeeding.

7. Breastfeeding support groups

The **Breastfeeding support group** initiative was not a part of the Umir Nuri CSP's DIP. The experience of the CS program at Navoi, coupled with the Community's response to the BCC on breastfeeding encouraged the establishment of the BFSGs. There are currently 6 breastfeeding support groups, 3 at each rayon. These could be promoted further, and extended to cover a wider area. Some members of BFSGs are potential trainers themselves and could be included in training of trainers' programs planned for the future.

B. Community Mobilization

8. Inactive VHCs

It has been reported that there are some VHCs which are not as active as others. The CSP should focus on these poor performers and find out the reasons for poor performance. Attention should be focused on them, in order to build them up to the level of the better performing committees.

9. VHCs – target number

The target for the end of the project is 40 VHCs. In order to ensure quality, it may perhaps be better to identify those areas where committed persons are willing to work for their own communities, and facilitate formation of VHCs in such areas, even if the total number is less than 40.

10. Traditional healers and religious heads

Traditional healers and mullahs (religious heads) play an important role in some communities. While some VHCs have incorporated these individuals in their membership, others have not. It would be useful to identify all traditional healers in the area, and ensure that they are reached with the messages of the CSP. This could be done by

- organizing a training program for traditional healers on key messages and try to get them involved in BCC
- encouraging their membership at VHCs so that they may be reached through the VHC

11. Breastfeeding support groups and School of Mothers

The Breastfeeding support groups and the School of Mothers are useful initiatives. If they grow to the level of community based women's groups, who are not just involved with health, but also social and economic developmental activity like small savings and home based income-generating activity like tailoring, they could be powerful instruments of social change.

A group of women which meets regularly, saves money, and is involved with acquisition of skills among its members which will increase their income, is a group which can sustain itself. It can also serve as an entry point into the community for messages directed at child health, and reproductive health.

The CSP can consider the formation of such groups.

C. BCC

12. BCC material preparation

The production of BCC materials by the CSP, as mentioned above, can be rated as one of its most major accomplishments, and the BCC strategy as being successful. Each step in preparation of BCC materials, from the stage of conception of a message, to developing a draft form, pretesting it with the community, and finalizing it, has been given the importance it deserves by the CSP. The production of materials – design and printing – is not an easy task in Karakalpakstan, and the CSP has done well in this regard.

There has been delay however, in the case of certain materials, and such delays must be avoided in future.

13. BCC Messages

One of the issues repeatedly encountered during discussions at the community level was that messages must be simple and easy to understand by mothers, without sounding too technical, if they had to be effective. The messages given by workers at Health Facilities in the past were cited as examples of complicated messages, while the messages given by the CSP were simple and straightforward, in the language that mothers would understand. Leaflets and booklets were accepted very well in the community, and mothers pointed to the simplicity of the language used as a major reason for such enthusiastic acceptance.

The messages of the CSP must continue to retain their simplicity while not compromising on technical content. This presents a challenge to a communicator.

14. BCC Methods

The methods most preferred by most members of the community who were met as part of the MTE were dynamic visual media like Video, Television and Film. The CSP could explore the possibility of

- creating educational video films based on local culture, with the key messages built in
- Creating television spots, which could be aired at appropriate times, to ensure maximal viewing by members of the target group
- Even leaflets and booklets must have an increased visual rather than textual content in order to be more attractive and appealing.

Other methods which were perceived as being useful were:

- Models, especially the breast model which was used to demonstrate correct breastfeeding technique
- Booklets, which were received enthusiastically by the community. Since literacy levels in the population are very high (above 90%), written material is well received and utilized.

The leaflets were received with a mixed response, with some saying that they were not so useful, and tended to be used as paper containers. Even so, they were on display at almost all the facilities visited as part of the evaluation.

15. BCC to special groups

BCC could be directed towards traditional healers, which is an important group in the context of the CSP. While it is good to involve them as part of the Community Mobilization strategy by facilitating their membership at VHCs, BCC could also be designed and directed towards this important group.

The other groups which could be focused upon in the BCC strategy are those who are decision makers in child health issues: These include

- Mothers-in-law and other older women
- Fathers and other men

The CSP has succeeded in making contacts with these groups. These are not easy groups to reach and communicate with, but considering the rapport the VHWs of the CSP enjoy at the community level, it could be tried at this stage in the project.

16. Reinforcement and Follow-up

For communication in terms of distributed materials to be effective, it must be followed up by interaction and reinforcement. The VHWs of the CSP have been reinforcing and interacting with the community at every stage, and this is what probably sets them apart from the

workers at the health facilities, who were perceived as distributing materials in a more passive manner. This strength of the CSP is an important one, and must be carried forward to the next stage.

The challenge is to be able to get the members of VHCs and the health workers of the MoH to adopt this approach, since it is they who will be there when the project comes to an end. Attempts must be made to inculcate this value into the workers of the Health facilities and to the members of the VHCs

D. Organizational Capacity

17. Health Management Information system (HMIS)

The HMIS could be developed further to make it a sensitive mechanism for detecting areas of need, both in terms of training and in terms of program interventions and activities.

The HMIS was collecting information pertaining to indicators of knowledge and practice at a monthly frequency. This proved to be a time-consuming laborious exercise, which took time of the VHW away from important, BCC related activity. Following a review of this mechanism, the amount of information collected was reduced and the frequency made once six-monthly, which is a more reasonable frequency for indicator-related information. Process-related information is still collected monthly, as it should be.

The HMIS staff have developed most of the instruments used themselves, which is commendable. But there is a need for formal training of the HMIS staff on methods designed to make the collection and use of data a more useful and active exercise. Training of the MoH staff on HMIS would further build capacity.

18. Refresher training

The system of periodic assessment of VHW performance by the Health Education specialist is a good basis for designing refresher training. The Rapid assessments which are done by the HMIS staff of the CSP should help identify need for refresher training for the Health facilities as well.

Motivation and communication skills are two additional areas of need for training of MoH staff.

Newly recruited staff should receive some form of orientation training so as to make them feel one with the rest of their peers.

19. Capacity of Perzent

Discussions with Dr Oral Ataniyazova, Director, Perzent, would appear to indicate that her organization is expressing confidence in their ability to handle a program of a similar nature. She suggested that in the future, Counterparts role could be more facilitatory and supportive, with Perzent being involved in the actual grassroot level implementation.

Additional areas where there was a need felt for capacity building in Perzent were the following:

a. Lobbying / advocacy, where skills were required in trying to secure support for issues which need to be addressed
b. Documentation
c. Dissemination of information relating to programs and activities
d. Health Management Information systems

E. Networking and Advocacy

20. Scientific Conference

The CSP has already taken the lead in organizing interagency and intersectoral meetings on a regular basis. A further step towards emphasizing the identity of the program would be to organize a scientific conference, or seminar, or symposium centered around Child Survival issues of relevance to the region. Besides contributing to the knowledge base on Child survival in the region, it would serve as an excellent platform for all stakeholders – donors, policy makers and communities to come together on a scientific platform and exchange information and views relating to child survival. The achievements of the program could also be presented to the group and their suggestions on future directions be solicited.

F. Sustainability

21. Local institutions – womens organizations

The VHCs are strong community based organizations which have been created by the CSP. Being voluntary bodies, who are not being paid by the program, VHCs will play a key role in the future of the program.

BFSGs, School of mothers and the Village health workers of the CSP who reside in the community can be the starting points to establish solid community based institutions which will continue to exist beyond the LOP. Ideally, organizations of women will be the best source of health related knowledge for newly weds and young mothers. They may be a better source than a VHC, which has an

"official" nature as compared to the "woman next door" nature of local women organizations.

The CSP must aim to establish women's groups through the VHCs, BFSGs and Schools of mothers. These groups must receive training from the CSP on the interventions of the program and on social issues, since they will also be social organizations where women can join and discuss social issues of common interest, maybe even start a small savings program. This can be the source of a revolving fund through which items necessary for women and children at the village such as ORS and drugs can be purchased.

22. Village Pharmacies

The groundwork for the Village pharmacy initiative has been done in the shape of the Willingness to pay study, though this is an initiative which should be accelerated.

The Village pharmacy promise to be a good legacy to leave behind after the LOP. Since the initiative is based upon solid research, the chances of success are high. In this initiative, it is proposed to establish village pharmacies, which will receive an initial stock of drugs as a grant. Sale of these drugs will lead to the creation of a revolving fund, which will then be used to get more drugs. The management of the pharmacy will be in the hands of the local community. The VHCs could play a role in this, thereby ensuring their continued existence.

23. Health Facilities

The support required for the HF in the remaining part of the program will relate to the following areas:

- Support with BCC materials and educational aids, and, more importantly, training to enable the MoH to produce and use innovative materials
- Training for the newly recruited staff and refreshers for the existing staff
- Creating cadres of trainers by organizing more training of trainers programs..

G. The Future

The Future of the CSP, if it continues to be supported in Karakalpakstan, could be in one of two broad directions:

I. **Expanding** the scope of the activity and consolidating the presence of the program in the same rayons.

In this scenario, the program will continue o work in Nukus and Takhtakupir rayons, but will expand the scope of activity to include such issues as

a. Other Child health issues like Nutrition, Iodine deficiency disorders
b. Reproductive Health issues, particularly anemia
c. HIV/AIDS, which has been reported as being a "silent" crisis in the region
d. The building of the capacity of schools and educational institutions, the use of school teachers as potential trainers in the community

II. **Replicating** the successes of the CSP in other rayons, by initiating similar programs

This is the scenario which the MoH would like to see, so that as much of Karakalpakstan, if not the whole of it, receives the benefits of the program interventions.

Either of the possibilities can be actually implemented by Perzent, with Counterpart playing a technical advisory role. Perzent has indicated its willingness and ability to be involved with the grassroot level functioning of any future child survival initiative, with Counterpart providing technical support. The resources of Perzent, in the form of its new office and trained manpower could be used to share costs with the organization in the next phase.

The excellent networking skills of the CSP will result in possible areas of collaborations and areas of cost sharing with other international organizations. MSF has indicated potential areas of collaboration.

The Umir Nuri Child Survival program is a working model which has the potential to improve health status, while empowering local communities at the same time. In the period upto December 2004, the program must consolidate, refocus and plan for the future, which has exciting possibilities.