COUNTERPART

Umir Nuri
Rainbow of Life
Child Survival Program, Uzbekistan

REPORT OF THE FINAL EVALUATION

***UMIR NURI (RAINBOW OF LIFE)* CHILD SURVIVAL PROGRAM**
Counterpart International / Center Perzent / Ministry of Health
Karakalpakstan, Uzbekistan

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Conclusions/Best Practices/Lessons Learned/Recommendations prepared by full team
(See Attachment 1 for names and positions).

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* Stakeholder Identified Priority Area for the evaluation.

Umir Nuri Child Survival Program – Report of the Final Evaluation

A. SUMMARY

A1. Brief Description

The *Umir Nuri* ("Rainbow of Life") Child Survival Program commenced in late 2000 in the Karakalpakstan region of Uzbekistan. *Umir Nuri* has an appropriate focus on pneumonia and diarrheal disease which are major killers of young children in the region. The program promotes exclusive and immediate breastfeeding as an important means to mitigate these killers in infants and young children. Communities in two *rayon* (districts), Nukus and Takhtapukir, were mobilized by Counterpart International (CI) and its partner NGO Perzent through the establishment of village health committees (VHCs), the work of 12 paid village health workers (VHWs) and 4 Field Officers (FOs).

Behavior change communication (BCC) strategies conveyed WHO's key community IMCI messages to mothers as key caregivers and to other critical decision-makers, principally paternal grandmothers, husbands, and peers. Complementing community level activities building knowledge, practice, and demand, *Umir Nuri* staff worked with UNICEF and the MoH to train health workers in peripheral facilities in approaches to communities and effective behavior change techniques and WHO standard case management for CDD, ARI/Pneumonia and breastfeeding, and during the last year, in IMCI, as IMCI became the accepted approach of the Karakalpakstan MoH. *Umir Nuri* also created linkages between communities and *rayon* authorities, between communities and health facilities, and between communities and external health resources.

A2. Main Accomplishments

The VHWs and their FO supervisors have worked to **mobilize** existing community structures (*makhalla)* in 18 communities scattered over the two *rayon* (see map in Attachment 5) which have in turn been assisted to establish village health committees (VHCs) and pilot community-based organizations (CBOs), e.g. breastfeeding support groups and schools of mothers. VHWs worked with the new VHCs and CBOs and directly with mothers and their families in VHC villages and in villages without VHCs, to convey key health messages. This mobilization strategy has worked very effectively to engage communities, families, and individuals in taking important steps to protect the health of infants and young children. *Hakimyat* (*rayon* government) officials expressed interest in hiring a complement of *Umir Nuri* field staff to continue these communication/liaison activities.

VHC members who were also *makhalla* committee members have been important channels for **communicating community health needs to *rayon* authorities** through program-established Child Survival Coordinating Committees (CSCC). An information flow of needs coming from communities is resulting in needed resources coming into communities, in place of a very vertical, top-down approach. Met health nets include improved water systems, extra medical personnel during public health emergencies, examination of a child death, a changed bus route, and assigning health personnel to a 24 hour/7 day a week rotation, among others.

Information about a USAID grant mechanism implemented through CPI's Healthy Communities Program has reached Takhtapukir and Nukus communities through the *Umir Nuri* network and is generating excitement at both community and *rayon* levels, with its potential for funding needed health infrastructure and activities.

CPI and its NGO partner Perzent have developed a successful **behavior change approach** which has resulted in increased knowledge and changed key practices in mothers. The BCC approach has developed unique, easy to understand written materials (and video, drama, songs, etc.) in the local language. While all the communication vehicles were well received, the written materials deserve special mention for their universal appeal: booklets and pamphlets are viewed by families as a valuable information resource and reference for illnesses in the family, and they are in professional demand by health facility staff. These attractive written materials with their essential messages, used by VHW and VHC members and health staff, have been instrumental in achieving *Umir Nuri*'s excellent coverage results, which extend beyond the immediate vicinity of VHCs.

Along with mobilizing communities, increasing knowledge and improving household practice, the program has worked with UNICEF and the Karakalpakstan MoH to **develop a cadre of health professionals** in peripheral facilities which can effectively manage serious diarrhea and ARI cases including pneumonia, and promote breastfeeding. IMCI as an approach has been introduced in both *rayon* during the last year in line with changes in MoH policy and a UNICEF pilot, which have provided an enabling environment for IMCI; the process of introducing IMCI has been valuable in further strengthening the excellent working relationship between CPI, Perzent, and the MoH. Key MoH personnel articulated to the evaluation team their realization of the value of involving the community as a partner. They seek to expand this community-driven approach in other *rayon.* They made it clear to the evaluation team that they see CPI as an important partner for upcoming IMCI expansion.

The Umir Nuri CS program was managed unusually well and has excellent leadership from HQ to the field office. The program director is supported well by the HQ program director who is very committed and provided adequate technical and administrative support. Director Health program from HQ has visited program several times and managed during crisis of absence of previous program director and death of deputy program manager and provided strong support to the Umir Nuri staff. Staff turnover is almost none.

A3. Highlights from comparison between baseline and end-of-program

Umir Nuri has documented impressive changes in knowledge and practice. Highlights of percentage change over baseline (and percentage change over target, for targets set in the DIP) from the KPC and HFA include:

Knowledge

Indicator	Baseline (%), 2001	Final (%), 2004	% Increase over Target *(if applicable*
Two danger signs (chest in-drawing, fast breathing) of ARI/pneumonia.	0.0	60.7	*26.3*
At least 2 danger signs of diarrhea.	32.0	91.3	*27.3*
Mothers who can properly prepare and know how often to give ORS.	42.3	89.0	*29.0*

Practice:

Indicator	Baseline (%), 2001	Final (%), 2004	% Increase over Target *(if applicable)*
Mothers who sought medical care for ARI/pneumonia on the same or next day.	57.1	72.7	
Mothers with children exhibiting danger signs from diarrhea who sought qualified medical care.	38.5	54.1	
Appropriate home based care of children with diarrhea and post-care:			
✓ *use of acceptable form of ORT*	0.0	75.7	
✓ *giving more or same amount of food during recovery*	0.0	32.4	
✓ *more of same amount of food during case*	20.0	63.6	
✓ *more liquids during case*	0.0	56.8	*16.8*
Appropriate handwashing	3.7	30.7	
**Exclusive breastfeeding of children under 6 months of age.*	30.5	74.5	*24.5*
Breastfeeding commenced within 1 hour of birth	48.0	80.3	*30.3*
Regarding child presenting with cough/difficult breathing, health worker:			
✓ *Counts breaths per minute*	27.6	56.7	
✓ *Checks for chest in-drawing*	31.0	76.1	
Regarding child presenting with diarrhea, health worker:			
✓ *Checks how long the child has Diarrhea*	10.3	100.0	
✓ *Checks for blood in stool*	6.9	94.4	
Observes child drinking/breastfeeding	41.4	83.3	
Pinches skin on abdomen	3.4	50.0	
Looks for sunken eyes	3.4	88.9	

** Success in this indicator generated considerable excitement at the MOH*

In addition to measured increases in health outcomes in knowledge and practice, there are new and strategic health resources in both *rayon* directly resulting from *Umir Nuri* action:

- an effective network for conveying important health messages to mothers/caregivers, which links health facilities, village leaders, and families;
- an effective link between village leaders and *rayon* health and government authorities which is resulting in additional health resources in communities;
- a working relationship between communities and the external financial resources for health of the Health Communities Project;
- two TOT (core) teams, at *rayon*-levels, experienced in training peripheral health workers. The core teams can continue to reinforce PCM, DCM, breastfeeding promotion, and IMCI, and use their training techniques and experience to teach new technical skills.

Similar results could be realistically anticipated for the other 13 *rayon* of Karakalpakstan. The MoH and government authorities at the Republic level are already positively engaged. Approaches and tools have been developed, tested, and found effective. A core training team is available to assist in initiating training.

The evaluation team heard from representative clinic staff that the management style within their clinics was improving as a result of *Umir Nuri* staff modeling. The new style is more egalitarian and less punitive. As a result of Field Officer and VHW modeling visiting nurses in clinics are also making changes in their mode of approach to mothers. Clinic staff are inspired by the new engagement with communities.

The working relationship Counterpart has built with the Karakalpakstan and *rayon* MoH and local government authorities is noteworthy. The *hakimyat* Deputy Director for Women's Affairs for Takhtapukir intends to request funding to hire three of the *Umir Nuri* field staff to continue working with VHCs and the CSCC. The Nukus *hakimyat* has similar plans. The MoH is gearing up for a large expansion of IMCI and urgently requests Counterpart's involvement.

A4. Priority Conclusions

Using as its basis a list of eight evaluation priorities generated by a large group of program stakeholders as part of the final evaluation process, after (1) review of program documents, (2) review of KPC and HFA data, (3) observations in clinics, (4) interviews/focus group discussions with key informants at *makhalla*/*hakimyat,* MoH, Perzent, other collaborator levels, (5) focus groups with mothers and grandmothers, (6) interviews with staff, and (7) discussions among the team members, the final evaluation team concluded that:

- *Umir Nuri* activities to positively change mothers/caregivers practices in breastfeeding were successful.

- *Umir Nuri* activities to positively change mothers/caregivers practices in diarrhea case management were successful.

- *Umir Nuri* activities to positively change mothers/caregivers practices in pneumonia case management were successful.

- *Umir Nuri's* VHCs, VHWs successfully impacted mother/caregiver health practices.

- *Umir Nuri* successfully mobilized communities to support important health practices.

- The role of *Umir Nuri* BCC strategies in improving mother/caregiver practices was successful.

- The role of *Umir Nuri* training in improving MoH services in peripheral health facilities and maternity homes is showing some success but has not been adequately measured through the HFA. The training process itself is well accepted by the MoH. Earlier work in WHO SCM has been superseded with initial rounds of IMCI training during the last year. Additional time is needed to further expand IMCI and evaluate the effect of IMCI on case management.

- There are many examples of successful *Umir Nuri* efforts to create sustainable activities.

In conclusion, the FE team recommends that Counterpart International utilize its experience and the excellent operating environment which exists now to replicate the program's successes in the other 13 Karakalpakstan *rayon*. Alternatively, CPI could use the existing effective infrastructure to expand into other health sectors of need such as HIV/AIDS prevention, support to the national TB control program (perhaps in partnership with MSF/Holland as well as the MoH), micro-nutrients (iodine, iron) and/or safe motherhood/newborn care.

B. ASSESSMENT OF RESULTS AND IMPACT OF THE PROGRAM

B1. Results: Summary Chart for *Umir Nuri* Program Objectives/Indicators

Objectives/Indicators/Comments	Baseline	EOP
Objective 1: Capacity Building **Counterpart has increased capacity to document and disseminate impacts/lessons learned related to child survival programs.**		
Indicators (3): • 1.a) A system for documentation is institutionalized in computerized database and in Counterpart's in house library. *Comments: Achieved. CPI has put monthly and annual reports, planning/implementation/evaluation (PIE) documents, and feedback documents, for both Umir Nuri and its CSP in India, in its in house library, and on an accessible (common drive) database.*	Activity was planned to develop as CSP progressed	Achieved. See comments
• 1.b) Lessons learned disseminated externally through regular reports to USAID and CORE, CSTS, Counterpart webpage, and publication of a series of working papers on child survival. *Comments: Achieved. Lessons learned as part of Umir Nuri implementation were documented by the staff as part of an annual*	Activity was planned to develop as CSP progressed	Achieved. See comments

review process (2002, 2003, EOP plan in place for 2004). Lessons learned were also included in Annual Reports, the MTE, and FE. CPI Director Health programs form HQ shared lessons learned at CORE venues. Umir Nuri has a website full of useful program data. Working papers were shared at a USAID/CAR conference, with CSTS, and at Global Health Councils.		
• 1.c) Lessons learned will be exchanged, shared and disseminated within MoH, NGOs, and other donors *Comments: Achieved. Umir Nuri conducted an Annual Conference in January 2003 and involved a wide range of stakeholders including the MoH, MSF, HOPE, Peace Corps. Stakeholders were convened at the MTE and FE, to provide input to the process, and discuss data. Umir Nuri staff have shared data with UNICEF, World Bank/Tashkent, JICA, USAID/Tashkent and CAR, among others.*	Activity was planned to develop as CSP progressed	Achieved. See comments
Objective 2: Capacity Building **Counterpart has improved systems in place for monitoring child survival programs.**		
Indicator (1): 2.a) Counterpart has an M&E system that has been appraised and approved by external monitoring and evaluation specialist by end of year 1. *Comments: Largely achieved. The FE team found the program's HMIS to be well-designed and utilized for program decision-making (exception: monitoring changes in health worker practice, which was not adequately measured with the HFA). The Umir Nuri HMIS evolved over the first year and beyond. During the 4th quarter of Year 1 staff from CPI's CSP in India visited Umir Nuri and advised on HMIS development. HMIS tools pre-testing continued on into the 1st quarter of Year 2.*	M&E system did not initially exist.	Largely achieved. See comments
Objective 3: Capacity Building **Build capacity in Perzent and MoH staff to implement child survival programs.**		
Indicators (3): • 3.a) # BCC activities, training, and peer education activities organized and implemented by Perzent. *Comments: No target was set for this indicator. Limited achievement. It is not apparent that Perzent as an organization has institutionalized this technical skill. Nevertheless, staff hired by Perzent using CSP funds were very involved in the BCC activities. All Umir Nuri BCC, training, and peer education activities were implemented jointly by a team of Field Officers and VHWs half of whom were hired by CPI and half hired by Perzent for the duration of Umir Nuri,, who were in turn supervised by CPI and Perzent senior staff.*	Perzent not initially engaged in BCC and peer education activities, but was already actively training.	Limited achievement. See comments
• 3.b) # of staff trained in SCM, PCM, breastfeeding, CS technologies that have conducted at least one supervised training session for each topic. *Comments: No target was set for this indicator. Achieved. The HMIS staff developed and maintained a training database which differentiates between trainings for Perzent, MoH, and community members, and lists topics, trainers, # trained, # days trained, etc. The database indicates that significant TOT took place, and this*	TOT for SCM, etc. did not exist.	Achieved. See comments

<table>
<tr><td>was verified through KII with key MoH, CPI, and Perzent staff.</td><td></td><td></td></tr>
<tr><td>• 3.c) # of joint sessions for documentation of lessons learned.

Comments: No target was set for this indicator. Achieved. Key stakeholders met three times: twice in 2003 (Annual Conference, MTE) and again in 2004(FE) during which lessons learned were discussed and documented.</td><td>A system for documenting lessons learned was not in place.</td><td>Achieved.

See comments</td></tr>
<tr><td colspan="3">Objective 4: Sustainability
Perzent and targeted SVPs improve skills and quality of care in CDD, PCM, breastfeeding and interpersonal communication.</td></tr>
<tr><td>Indicators (3):
• 4.a) Increase % of SVP and other MoH facilities with trained staff who are providing DCM and PCM services, and breastfeeding promotion.

Comments: No target was set for this indicator. Achieved. Rather than monitor % of facilities with trained staff, Umir Nuri monitored number of trained staff through a training database. Training in SCM for PCM and DCM, and BFP were provided. The HFA indicates DCM and PCM activities, which serve as proxies for SCM implementation. It does not adequately show whether SCM in its entirety is being utilized.</td><td>SCM was not initially being implemented.</td><td>Achieved.

See comments</td></tr>
<tr><td>• 4.b) Enhanced capacity of Perzent in specific child survival interventions.

Comments: Largely achieved. Individual staff hired by Perzent enhanced their capacity in specific child survival interventions. Perzent's director indicated that Perzent has benefited from the variety of training it received in standard case management. She is willing to take on direct management of CSHGP or CSP-type activities. Perzent is not now utilizing any of the specific child survival interventions for which it received training in its other ongoing programs, but it is actively programming other CS interventions. Perzent is using CSP approaches such as the KPC and TOT in its current programs. This indicator would be better served by looking at Perzent a year or two from now.</td><td>Perzent had no previous experience in SCM for CDD, ARI/pneumonia, BFP, or IMCI.</td><td>Largely achieved.

See comments</td></tr>
<tr><td>• 4.c) Increase % of staff using satisfactory and appropriate health communication and counseling during and following the clinical examination and treatment of children in SVP and MoH facilities.

Comments: No target was set for this indicator. Largely achieved. The HFA measures a number of communication and counseling activities, the vast majority of which stayed high or showed significant improvement over the LOP (exception: showed how to take medication):

<table>
<tr><td>Activity</td><td>Baseline</td><td>EOP</td></tr>
<tr><td>Provided diagnosis</td><td>93.1</td><td>93.3</td></tr>
<tr><td>Explained medication</td><td>72.4</td><td>80.0</td></tr>
<tr><td>Showed how to take medication</td><td>41.1</td><td>33.3</td></tr>
<tr><td>Counseled to continue food or</td><td>72.4</td><td>83.3</td></tr>
<tr><td colspan="3">Additional danger signs needing follow-up: 4 showed an</td></tr>
</table>
</td><td>See comments</td><td>Largely achieved.

See comments</td></tr>
</table>

decrease over baseline of 12, 25 percentage points.		
Objective 5: Sustainability **Targeted makhalla committees and VHCs have the capacity to implement local health education interventions.**		
Indicators (5): • 5.a) # of VHCs established and trained. *Comments: Target changed. Achieved. Umir Nuri established 9 VHCs in key communities (selected primarily for density of population plus some locations were in especially remote areas) in each of the two rayon, for a total of 18 VHCs, near the end of Year 1. By the MTE, it was decided that this number of VHCs could adequately accomplish program objectives, and no further VHC initiation was planned. It is unlikely that the successful KPC results would have been much higher with additional VHCs. The ability to concentrate FO and VHW time and effort on the existing VHCs likely enabled them to become more established, and increase their effectiveness in their important role of communication channel between communities and rayon-level government. Locations not included in VHC catchments were served directly by VHWs using BCC materials.*	A minimum of 40 were originally anticipated.	Target changed in Year 1. Achieved. See comments
• 5.b) # of makhalla committee members appointed/elected to VHCs. *Comments: No target was set for this indicator. Achieved. All 18 VHCs were formed specifically as sub-committees of makhalla committees, and included makhalla committee members, along with a wide range of other community members. It is the makhalla members who directly liaise with rayon authorities in CSCCs. Including makhalla members in VHCs was strategic and effective.*	VHCs did not initially exist.	Achieved. See comments
• 5.c) Quality of BCC materials. *Comments; Achieved. The quality of BCC materials is excellent as evidenced by the KPC results, comments of the MoH and mothers, and observations by the FE team. The process CPI utilized to develop BCC materials was professional and thorough.*	Existing MoH BCC materials were noted to be dense, heavy in medical terms, and having few graphics.	Achieved. See comments
• 5.d) # of BCC materials developed. *Comments: No target was set for this indicator. Achieved. Many BCC materials were developed by Umir Nuri, including leaflets, booklets, videos, songs, drama, and puppet shows, to convey key messages in all three program interventions (PCM, CDD, BF) plus additional topics.*	Activity was planned to develop as CSP progressed	Achieved. See comments
• 5.e) # of VHC members who continue to volunteer their time one year after their initial training. *Comments: No target was set for this indicator. Achieved. The HMIS did not track this indicator, however, randomly visited VHCs at the EOP had a wide spectrum of active members with substantial history with their respective VHCs indicating that any natural turn-over has not interfered with the functioning of VHCs.*	VHCs did not initially exist.	Achieved. See comments
Objective 6: Sustainability **Measurable increases in service-seeking behavior.**		
Indicators:	N/A	N/A

• Please refer to specific Intervention indicators below		
Objective 7: Sustainability **To establish lasting, local institutions capable of sustaining systems for promoting positive change in health behaviors.**		
Indicators(6): • 7.a) # of communities in the target area with trained and functioning VHCs by the end of the program. *Comments: No target was set for this indicator, although it could be inferred that at least 40 communities would have their own VHC, and a number of nearby communities would also directly benefit. This number was subsequently changed to 18. Achieved. Refer to the map in Attachment 5 for a graphic view of where VHCs were located the rayon.*	VHCs did not initially exist.	Achieved. See comments
• 7.b) # of VHC members who continue to volunteer their time one year after their initial training. *Comments: Refer to 5e). Achieved.*	VHCs did not initially exist.	Achieved. See comments for 5e).
• 7.c) # of SVP and other MoH facilities in the target area with "master" trainers in PCM, DCM, and breastfeeding promotion by the end of the program. *Comments: No target was set for this indicator. Indicator reconfigured, and achieved. Instead of looking at establishing master trainers in specific facilities (some of which have very few staff), a more practical plan of establishing a rayon-level TOT "core" team was pursued early on in the program. The core team in turn conducted extensive training for various levels of MoH staff in peripheral facilities. This was documented in a training database and verified at EOP through the HFA, and KII with key MoH, Perzent, and CPI staff. The training database indicates that 75.5% of targeted health workers were trained in PCM, 50.4% in DCM, 45% in BFP, and 75.5% in IMCI. These Umir Nuri trained workers are based and currently working in 100% of targeted facilities.*	TOT for SCM, etc. did not exist.	Indicator reconfigured. Achieved. See comments
• 7.d) # of SVP and other MoH facilities located near VPs staffed by trained village pharmacists. *Comments: The village pharmacy pilot plan was dropped after consideration of the political operating environment, after the mid-term evaluation. More discussion on this is included further in the report.*	Village Pharmacies did not initially exist.	Activity/Indicator dropped. See comments
• 7.e) Perzent will have enhanced capacity in financial, human resources, and logistics management, supervision, and monitoring and evaluation methodologies by the end of the program. *Comments: Achieved (exception: logistics capacity not assessed). Prior to preparing the DIP, CPI and Perzent discussed Perzent's capacity building needs and documented these as part of the DIP process. No formal capacity building tool was used to quantify a baseline or EOP status. Perzent's Director and Program Assistant reported on capacity changes during interviews with the FE team, along with reports from CPI Umir Nuri staff who worked with Perzent: Financial capacity: Perzent is now utilizing the QuickBooks financial software package after training from CPI's*	Baseline informally assessed and documented during the DIP process. See comments	Achieved (exception: logistics capacity not assessed). See comments

finance office. CPI's financial officer is confident in Perzent's financial accountability for CSP sub-grant funds. Human resources capacity: The Perzent director and the Program Assistant (a senior technical position) were involved in Umir Nuri activities throughout the grant period. Eight field staff (half the field staff in each rayon) were hired by Perzent using their sub-grant of Child Survival funds. Perzent indicated it is interested in hiring from among the 4 CSP FOs for other ongoing activities post-program. Perzent is currently utilizing a TOT approach based on its Umir Nuri experience in its other programs. Logistics management capacity: Not assessed. Supervision capacity: Perzent has changed its approach to management and is now going out to rayon, instead of having staff come to its office, so that all program staff can be involved in staff meetings. The Perzent Program Assistant reports that the "style" of meetings has changed positively. Monitoring and evaluation methodologies capacity: Perzent received training in KPC and HFA methodology, and in EpiInfo. Perzent has enhanced capacity in evaluation methodologies and is utilizing the KPC tool for other on-going activities in the region. Other: Perzent's Director reports that it is utilizing an integrated approach to its health, environmental and WID programming.		
• 7.f) Perzent will develop plans for expanding the CS Program into additional *rayon* in Karakalpakstan by the end of the program. *Comments: Achieved. CPI took the lead to develop an Expanded Impact CSP for all rayon in Karakalpakstan which was submitted to USAID in November 2003: it was not funded. While Perzent worked with CPI to prepare this proposal, it ultimately opted not to participate as a partner NGO. The Perzent directly expressed her interest to the FE team to work again with CPI in partnering for a second submission of this proposal.*	Perzent not previously engaged in CS-type program-ming, although it was already engaged in health program-ming (clinical, training, research).	Achieved. See comments
Objective 8: Sustainability **Alternative funding and cost-recovery systems in place to continue CS interventions beyond LOP.**		
Indicators (3): • 8.a) Perzent continues to assist the MoH in child survival interventions in the targeted region. *Achieved. Perzent remains an active NGO, and is engaged in child-survival type program and interventions including reproductive health, safe motherhood, and water/sanitation in various rayon of Karakalpakstan, with funding from multiple sources. Beyond Umir Nuri, which is still ongoing until March 2005, Perzent is not engaged in other activities involving PCM, CDD, or BFP. This indicator would be better served with a check a year or more from now.*	Activity was planned to develop as CSP progressed.	Achieved. See comments
• 8.b) Perzent will develop at least 3 proposals and submit them to donors for funding by the middle of year 4 of the programs. *Limited achievement. Perzent worked with CPI to prepare an Expanded Impact submission to the CSHGP in 2003. Perzent is engaged in other child-survival type programs including reproductive health, safe motherhood, and water/sanitation in various rayon of Karakalpakstan, with funding from multiple sources. Beyond child survival type activities it is also engaged in*	Activity was planned to develop as CSP progressed.	Limited achievement. See comments

sexual health, a women's crisis center and hotline, activities to strengthen women's roles, gender equity, women's rights, organic farming, clinical services (Perzent runs its own clinic in Nukus), and they are about to start micro-credit using a village banking model. So, technically, Perzent has developed at least 3 proposals. However, other than the CSHGP submission, these activities are not taking place as part of a deliberate plan to continue Umir Nuri-related activities in Karakalpakstan, which is the real basis for this indicator.		
• 8.c) Village Pharmacies have 70% cost recovery by the end of year 2. *Comments: During the second half of Year 3, CPI decided not to pursue the village pharmacy pilots for a number of reasons (discussed further elsewhere in this report), and dropped this activity from its workplan.*	0 village pharmacies existed at the start of the program.	Activity/indicator dropped. See comments
Objective 9: Intervention--Pneumonia Case Management **Increased percentage of mothers with children <2 would seek care promptly from an appropriate provider upon early recognition of key signs of pneumonia.**		
Indicators (3): • 9.a) 75% of mothers with children <2 years of age would be able to recognize at least two danger signs of pneumonia indicating medical treatment.	61.3%	96.0% Achieved.
• 9.b) 25% of mothers/caregivers would be able to recognize the danger signs of rapid breathing and chest-indrawing or difficult breathing.	0%	60.7% Achieved.
• 9.c) 60% of mothers with children <2 would seek medical treatment from a qualified provider on the same day that the child shows danger signs of pneumonia. *Comments: Not achieved. CPI also measured "mothers who sought medical care on the same or next day" which increased from 57.1% at baseline to 72.7%, indicating an improvement in practice but a gap in immediacy.*	32.7%	36.4% Not achieved. See comments.
Objective 10: Intervention—Pneumonia Case Management **Increased number of health workers correctly assess, treat, and counsel for pneumonia in children <5 years.**		
Indicators(3): • 10.a) 50% of children <5 years with cough/difficulty breathing would be managed by a trained health worker following protocols for SCM of pneumonia. *Comments: Proxy achieved. A proxy for SCM was measured through the HFA, which looked at health workers checking children presenting with cough/difficult breathing and performing two activities: counting breaths/minutes (baseline 27.6%) and looking for chest indrawing (baseline 31.0%). By these measures, health worker practice in managing cases of children with cough/difficulty improved, and exceeded the target of 50%. As noted under PCM in Section B2b, it would have been more useful to ascertain if the full WHO SCM for pneumonia was being utilized.*	27.6% 31.0% See comments.	56.7% 76.7% Proxy achieved. See comments.
• 10.b) 50% of children <5 years with cough/difficulty breathing will have their respiratory rate checked when visiting the health facility.	27.6%	56.7% Achieved.

• 10.c) 50% of trained health workers would receive a supervisory visit within the last 2 months that included an observation of case management of a sick child (assessment, treatment, and counseling). *Comments: Assumed unachieved. The baseline and EOP measurement status is not very useful, since the HFA does not distinguish between Umir Nuri- trained and any other trained health worker. The HFA looked only at workers trained during the last 6 months. The HFA should be configured to distinguish between trained and untrained workers, and more clearly defined aspects of the case management to be observed among those trained, to ensure that WHO's SCM was being utilized. It did not accomplish this, leaving this indicator unmeasured. The HFA did assess, through recall, if observations of case management of any type occurred in any worker. Using this measure, it did not achieve its target: results were essentially unchanged (baseline: 28.6%.; EOP 26.7%).*	29.6%	37.5% Unknown (not adequately measured). Assumed unachieved. See comments.
Objective 11: Interventions—Pneumonia Case Management **Health facilities in the targeted rayons maintain an adequate inventory and supply of cotrimoxizole.**		
Indicator (1): • 11.a) 50% of health facilities will not experience a stock-out of cotrimoxizole in the two months prior to HFA. *Comments: This indicator was inadequately measured. The HFA question used to measure this actually measured available stocks on the day of the assessment. Using this measure, the target was not met. Notes:* *1. The HFA tool for measuring inventory was utilized in September 2003 for the mid-term, and was not repeated during the EOP which came only 11 months later. MTE results are provided for the EOP.* *2. The MoH uses a variety of antibiotics for pneumonia, other than cotrimoxizole, although it and amoxocyllin (which was the only drug provided by UNICEF for the IMCI pilot) are the drugs of choice. Other drugs used include ampicillin, penicillin, eritromycin, bicyllin, chloramphenicol, benzylpenincyllin, and gentamycin. Use depends on many factors, mainly clinical, but also availability. The MTE indicated an overall improvement in general antibiotic availability: of the 4 antibiotics surveyed in the HFA ampicillin tablets/syrup increased from 0 to 16.7%; amoxicillin tablets/syrup increased from 10.7 to 43.3%; cotrimoxizole tablets/syrup essentially stayed the same (28.6 to 30.0%), and penicillin tablets, which were not measured in the baseline, were available in 43.3% of facilities.* *3. The HFA was insufficiently sensitive to ascertain the % of health facilities continually stocked with any antibiotic suitable for treating pneumonia, which would have been a more accurate measure of Umir Nuri activities relating to pharmaceuticals for pneumonia.* *4. The HFA did not look at stock-outs in the past two months; it looked only at what was available on the day of the survey.*	28.6%	MTE is 30.0%. Unknown, but most likely not achieved. See comments.
Objective 12: Interventions—Diarrhea Case Management **Increased percentage of children with diarrhea in the last two weeks would be treated with ORT.**		
Indicators (2): • 12.a) 40% of children under 24 months with diarrhea in the past	0.0%	75.7%

two weeks whose mothers report they were treated with ORT (ORS, cereal based ORT, recommended home fluids, or increased amount of fluids).		Achieved.
• 12.b) 60% of mothers would be able to demonstrate correct preparation of ORS (or substitute) and explain its use.	42.3%	89.0% Achieved.
Objective 13: Interventions—Diarrhea Case Management **Increased percentage of mothers are able to identify the signs of diarrhea requiring treatment.**		
Indicators (1): • 13.a) 65% of mothers of children less than 24 months who know at least two danger signs of diarrhea indicating medical treatment.	32.0%	91.3% Achieved.
Objective 14: Interventions—Diarrhea Case Management **Increased number of health workers are able to correctly assess, treat, and counsel caregivers regarding diarrhea management.**		
Indicators (3): • 14.a) 35% of children <5 years with diarrhea who are managed by a trained health workers following protocols for SCM of CDD. *Comments: Proxy achieved. A proxy for SCM of CDD was measured through the HFA, which looked at health workers checking children presenting with diarrhea and performing three activities: looking for blood in the stool (baseline: 6.9%), pinching skin on abdomen (baseline: 3.4%), and checking for sunken eyes (baseline: 3.4%). By these measures, health worker practice in managing cases of children with diarrhea improved, and exceeded the target of 35%. As noted under CDD in Section B2b, it would have been more useful to have measured actual use of the full WHO SCM for diarrhea.*	6.9% 3.4% 3.4%	94.4% 50.0% 88.9% Proxy achieved. See comments.
• 14.b) 50% of health workers trained in SCM of diarrheal disease in last 6 months. *Comments: Achieved. At the MTE and EOP, the HFA only measured what training had taken place in the past 6 months in facilities randomly selected, e.g. it missed a lot of the training. The HFA EOP results indicate that 29.6% of those interviewed had received IMCI training (which included SCM for diarrheal disease) in the last 6 months. Training database records indicate that 50.4% of targeted health workers (MDs, nurses, feldschers working in FAPs) were trained in IMCI in the last 6 months, which is a more accurate description of the indicator.*	18.4% See comments.	50.4% Achieved. See comments.
• 14.c) 45% of trained health workers who have received a supervision visit within the last 2 months that included an observation of case management of a sick child (assessment, treatment, and counseling). *Comments: Assumed not achieved. Refer to the comments in 10c) which also apply here.*	33.3%	26.7% Unknown (not adequately measured). Assumed not achieved. See comments.
Objective 15: Interventions—Breastfeeding **Increased percentage of newborns are breastfed within one hour of birth (at the hospital).**		
Indicators (2): • 15.a) 60% of newborns are breastfed within one hour.	48.0%	80.3%

		Achieved.
• 15.b) 50% of infants under six months are exclusively breastfed (receive no other liquids or solids).	30.5%	74.5% Achieved.

B2.Assessment of the Progress Made Towards Achievementsof Program Objectives Resultas and Technical Approach

B2a. Brief Overview

The *Umir Nuri* CSP is located in the *rayon* (districts) of Takhtakupir and Nukus in the Autonomous Republic of Karakalpakstan, Uzbekistan. As an Autonomous Republic, Karakalpakstan has its own president, parliament, and ministries, including its own Ministry of Health, while still being closely tied to the central government in Tashkent. Working successfully with the Regional authorities based in Nukus opens doors of influence for the entire Republic of Karakalpakstan and all 15 of its *rayon*.

The two target *rayon*s were selected based on need assessments in local communities, local health statistics, and discussions with the MoH, local partners, and the USAID Mission. The program has two higher goals (see below) to be achieved through successful implementation of a number of objectives/activities: please refer to Attachment 5 for the program's logframe: objectives, indicators, means of measurement, major activities by intervention.

Goal 1: To sustainably reduce the high rate of mortality in children under five in the two rayon through improved caregiver practices and increased access to quality of care.

Goal 2: To improve the capacity of its local partner, Perzent, to plan, implement, and evaluate child survival programs.

Umir Nuri has had an appropriate focus on pneumonia case management (45% effort) and diarrhea case management (35% effort) since pneumonia and diarrhea are responsible for half of the deaths of young children in the region, plus it promoted exclusive and immediate breastfeeding (20% effort) as an important means to mitigate these killers. All communities in Nukus and Takhtapukir were mobilized through establishment of village health committees (VHCs) as part of existing *makhalla* committees, and the work of 12 paid village health workers (VHWs) and 4 Field Officers, who were nearly all trained nurses or physicians, capitalizing on the availability of health professionals seen throughout the former Soviet Union.

Behavior change communication (BCC) strategies conveyed WHO's key community IMCI messages in culturally suitable and effective ways for mothers as the principle caregivers, and to mothers-in-law, husbands, and peers. Attractively prepared written materials were found to be a compelling means of communicating key messages directly to families.

Complementing community level activities building knowledge, practice, and demand, *Umir Nuri* staff worked with UNICEF and the MoH to create a core training team which in turn trained health workers in peripheral facilities first in approaches to communities and effective behavior change techniques and in WHO standard case management for diarrhea, pneumonia, and breastfeeding, and during the last year, in IMCI, as IMCI as an approach became accepted by the MoH.

Important linkages were developed between villages and *rayon*-level health and government authorities, and to external resources such as:

- MSF/Holland's TB activities: Counterpart and MSF are currently involved in a small risk reduction program which is housed at the *Umir Nuri* office and coordinates closely with *Umir Nuri;*
- Red Cross Title II activities during years 1-3: the Red Cross phased out about a year ago but has approached Counterpart to partner with it in a new CHGHP submission, which is currently under discussion;
- the Healthy Communities Program which has USAID grant funds available for community-based health programs through 2005, and perhaps beyond 2005.

Counterpart International worked closely with the local NGO Perzent for implementation and capacity building so that Perzent could sustain activities and programs after four years and further develop as a major health player in the region.

Counterpart worked closely with the Karakalpakstan Ministry of Health. The MoH was very involved in the program design during the DIP process. Activities were planned to strengthen the MoH's capacity to implement and monitor program interventions, including development of a core TOT team; extensive training of peripheral health workers in BCC and SCM and in the past year, IMCI; use of program data; and linkages to communities at local and *rayon* levels.

B2b. Progress Report by Intervention Area

The *Umir Nuri* stakeholders put a strong priority on determining the program's success in changing mothers' practices in PCM, CDM, and promotion of breastfeeding as part of the final evaluation process.

Pneumonia Case Management

i. Results and Outcomes

Please refer to the table in Section B.1 for the results and outcomes of *Umir Nuri* as measured by comparison of the baseline and final evaluation surveys. Section B.1 also includes commentary.

ii. Factors Affecting Achievements

Umir Nuri achieved large gains in increasing the knowledge of mothers about danger signs of pneumonia, and good success in getting children into medical treatment the next day.

The BCC approaches and materials developed were very effective means of teaching mothers danger signs of pneumonia. The *Umir Nuri* video showing chest in-drawing was found to be especially useful for conveying this more complex symptom.

The evaluation team reported from its FGDs inroads in mothers' understanding of ARI causes, indicating an important movement away from "evil eye", a commonly understood local explanation for respiratory illnesses which would normally call for resolution through traditional healing, and an important movement toward acceptance of medical care as the preferred treatment for respiratory illness with danger signs. This was corroborated by a growing percentage of mothers going for medical treatment the next day, although more work needs to be done to cement this understanding into more immediate, same day, practice. Mothers also reported less self-prescribing, and MoH staff interviewed reported that mothers were bringing children earlier in the course of the disease.

The Umir Nuri staff and MoH were trained by the Director Health Programs in BEHAVE framework and successfully adopted framework in to CS program. Followed by HQ BCC training in august 2001, BCC specialist and Perzent staff went to Cambodia for BEHAVE workshop in 2002 and received training. Extensive health staff training was realized through the use of a trained TOT "core team" for training for peripheral facility staff in not only clinical material but also communication techniques and approach. Overlapping of topics (e.g., reviewing previous topics as part of new topic training) is an innovative approach. Health workers report an "easier time talking to mothers". Mothers report a more supportive atmosphere in the clinics. Doctors in peripheral facilities are also reporting less use of antibiotics as a first response to just any respiratory infection.
Umir Nuri's training database indicates that 209 health workers or 75.7% of total health workers in peripheral facilities received training through a collaboration of *Umir Nuri*, UNICEF, and the MoH first on WHO Pneumonia Standard Case Management, and subsequently on IMCI, in addition to BCC approaches. This represents development of two *rayon*-level TOT teams. It also represents 100% of peripheral facilities (with an emphasis on SVAs/SVPs and FAPs) having a trained health worker, an important improvement in access to SCM.

The HFA, which included observations of case management with randomly selected health workers in 60 facilities across both *rayon,* shows progress in improved health worker practices for managing children presenting at peripheral facilities with cough/difficult breathing. While the HFA did not measure full use of the WHO SCM or IMCI, for PCM it used as a proxy the performance of two activities which are important aspects of SCM: counting breaths/minute (baseline: 27.6%, EOP: 56.7%) and looking for chest indrawing (baseline: 31.0%, EOP: 76.7%). By these measures, improved health worker practice in managing cases of children with cough/difficulty exceeded the target of 50% (noting that the number of children presenting with these symptoms at the time of the final HFA, e.g. 23, was not a large sample).

As noted in Section B.1, the MoH uses a variety of antibiotics for pneumonia case management depending on many factors both clinical and relating to availability. Umir

Nuri did work with CHAP and UNICEF during their humanitarian assistance activities in 2002, to supply key drugs including cotrimoxizol, to health facilities. UNICEF was not able to provide cotrimoxizole but did provide amoxycillin.

The HFA survey taken in September 2003 indicated an overall improvement in the current stock of antibiotic availability compared to the baseline. Of the 60 facilities randomly surveyed, and of the 4 antibiotics surveyed, ampicillin tablets/syrup availability increased from 0 to 16.7%; amoxicillin tablets/syrup from 10.7 to 43.3%; cotrimoxizole tablets/syrup essentially stayed the same (28.6 to 30.0%), and penicillin tablets, which were not measured in the baseline, were available in 43.3% of facilities.

Cross visits of India CS program visits and BCC training has helped to revise BCC materials and curriculum and adopted a new approaches such as puppet shows and street theater that has increased community outreach activities and mobilization.

iii. Contributing Factors

While *Umir Nuri* succeeded in getting children exhibiting danger signs to health facilities the day following recognition, it had less success in changing the practice of mothers/families to get children exhibiting danger signs into the medical system the same day.

Roll-out of IMCI

Because the MoH was not yet ready for full roll-out of IMCI (see below), *Umir Nuri* conducted WHO SCM training in 2001 and 2002, and began IMCI training in September 2003, less than a year before the EOP. Further consolidation of results would likely have occurred if all training had been able to focus solely on the IMCI approach over the four year period.

The roll-out of IMCI at facility levels followed the progress of a pilot conducted by UNICEF (with funding from JICA) and the MoH between 2001-2003. Nukus was included in the pilot, which was conducted in 2 Karakalpak *rayon* and two other *rayon*. The pilot focused on training physicians during its first 2 years (feldschers were added in 2003) and included a one-time supply of drugs in 2002/2003 from UNICEF and WHO which *Umir Nuri* staff report were consumed in about 3 months: the MoH is responsible for further drug supplies. HH/C-IMCI largely encompassed the role of visiting nurses. In 2003 WHO began supporting IMCI in 3 *rayon* in Karakalpakstan with health worker training.

During this same pilot period, *Umir Nuri* put the majority of its emphasis on C-IMCI, as evidenced by its training database, and the results of its KCPs. It also worked with the MoH to fill the gap in SCM by conducting training on WHO's SCM for pneumonia in peripheral facilities in 2001-2002, and preparing for a change-over to IMCI. *Umir Nuri* made this change to IMCI in 2003, having conducted needed additional training of the technical staff of CPI and Perzent, development of the TOT for Takhtapukir, and a new roll-out of training in peripheral facilities. Not quite a year passed from the time of initial IMCI training of MoH staff in Nukus and Takhtakupir until the EOP evaluation. This is insufficient time to ascertain the results of this important change-over.

Use of supervision indicator to measure utilization of SCM

While *Umir Nuri* did not focus specifically on improving supervisory skills, it chose to use health worker recall of what took place in past supervisory visits using the ongoing MoH supervision system as a means to verify that health workers were using the new methods of standard case management as part of their routine practice, in addition to the direct observations portion of the HFA. The value of using this indicator for this purpose is questioned since direct observation was already being conducted. As it turned out, the HFA data collected for this indicator proved inadequate for its measurement. The collected data looked at whether the observed health worker in the randomly selected facility reported having had a supervisory visit in the past two months which included observation of their management of a sick child. Analysis was conducted on health workers who had received training in ARI SCM and/or IMCI (which covered ARIs/CDD/TOT) in the past 6 months. Analysis did not include trained health workers, trained in SCM ARI and/or IMCI earlier than 6 months, which left out some trained workers. Final results did not change significantly during the 2 ½ year period from baseline (January 2001) to the mid-term (September 2003), at 29.6% and 37.5% respectively.

Stock-outs of cotrimoxizole

Umir Nuri anticipated that there would be fewer stock-outs of cotrimoxizole over time as a result of program interventions. This was to be accomplished by continued MoH supply at peripheral facilities, CHAP donations, and Village Pharmacies in 10 pilot locations. Stock-outs were to be measured by the HFA.

MoH supplies of cotrimoxizole were essentially the same at the point of the baseline (January 2001: 28.6%) and midterm HFA (September 2003: 30.0%). Assistance to the MoH from UNICEF only included amoxicillin. CHAP provided cotromoxizole, but this did not occur time-wise at a point when it could be picked up by the HFA. The Village Pharmacy pilots were not instituted.

The HFA did not look at stockouts, but rather what was the inventory at the time of the baseline and mid-term surveys. (The inventory portion of the HFA was not instituted again at EOP since only a year had passed since the midterm survey). In summary, the HFA did not pick up the frequency of stock-outs, nor was it timed to record the contributions of CHAP. It did indicate that at two points during the life-of-program, cotrimoxizole supplies remained constant, at inadequate levels, through the efforts of the MoH.

iv. Main Successes and Lessons Learned

A significant increase in mothers' knowledge of danger signs, and an increase in mothers' practice in bringing children exhibiting danger signs to medical care by the next day after recognition of symptoms, brought about through effective BCC materials and the work of VHWs/Field Officers and VHCs, plus a good start in changing health worker practice to WHO SCM utilizing the IMCI approach, were the major successes of the PCM intervention. Important lessons learned include:

- BCC materials were useful and effective.
- Cross visits to India to learn BCC approaches helped to design more feasible BCC activities. More cross visit would help to improve strategies for BCC and HMIS activities
- It would have been more useful to check for utilization of the full SCM protocol, rather than only two activities used as a proxy. (It is unlikely that the baseline would have been above 0 in this case).
- It would have been useful to assess all (or at least a sufficient sample) of the health workers who had been trained in either WHO SCM or IMCI, using a checklist, to ascertain their use of the new protocol.
- The HFA was insufficiently sensitive to ascertain the % of health facilities with MoH approved antibiotic in stock suitable for treating pneumonia, which would have been more in line with the approach to pharmaceuticals taken by *Umir Nuri*.
- Have a thorough understanding of the political environment prior to implementing an initiative that requires changes in infrastructure.
- Ensure that PCM medication reaches intended beneficiaries through increased monitoring of drug distribution systems.
- Village pharmacies are in demand in communities remote from the *rayon* centers and should be piloted if MoH have given permission.

A fuller discussion of findings, conclusions, lessons learned, best practices, and recommendations identified by the full final evaluation team is included in Attachment 5.

v. Special Outcomes, Unexpected Successes/Constraints

Through a special study, *Umir Nuri* documented that antibiotics are not readily available for purchase through private drug vendors outside of the two *rayon* centers. Only in the *rayon* centers do a few private drug vendors fill a critical lack in government supplies.

vi. Potential for Scale-up or Expanded Impact

As a result of *Umir Nuri* there now exists an effective network for conveying important health messages to mothers/caregivers. The network links health facilities, village leaders, and families, and it links village leaders and rayon health and government authorities. The network is also linked to external resources for health. A core TOT team is experienced in training peripheral health workers. This network and TOT core team stands ready to continue to reinforce PCM. A similar network could be established in the other 13 rayon of Karakalpakstan since the MoH and government authorities at the Republic level are already engaged very positively and are requesting Counterpart collaboration in a planned focus on IMCI in the immediate future- an excellent opportunity for Counterpart. Counterpart's CHAP program remains viable as a way to supplement irregular MoH pharmaceutical supplies, since external assistance in this area appear to remain an ongoing need, and could be utilized more often.

Control of Diarrheal Disease

i. Results and Outcomes

Please refer to the table in Section B.1 for the results and outcomes of *Umir Nuri* as measured by comparison of the baseline and final evaluation surveys. Section B.1 also includes commentary.

ii. Factors Affecting Achievements

Umir Nuri achieved large gains in both mothers' knowledge and practice regarding home based case management of diarrhea (ORT, increased feeding/fluids during the case and afterwards), referral when danger signs are present, and handwashing practices.

Written BCC materials distributed by VHWs and VHC members worked very effectively to convey key messages about diarrhea, dehydration, home based case management, and when to refer, despite requests for more video, TV, etc. which may have been even more interesting but perhaps not had as long or efficient a reach in terms of coverage. Extensive training was realized through the use of a trained TOT core team for training for peripheral facility staff in not only clinical skills building but also communication techniques and style. Health workers report an "easier time talking to mothers". Mothers report a more supportive atmosphere in the clinics. Health workers have also reported that puppets were useful communication tools to motivate mothers.

As discussed under PCM above, extensive health staff training was realized through the use of a trained TOT core team for training for peripheral facility staff in not only clinical material but also communication techniques and approach. Overlapping of topics (e.g., reviewing previous topics as part of new topic training) is an innovative approach.

Umir Nuri's training database indicates that 139 or 50.4% health workers in peripheral facilities received training through a collaboration of *Umir Nuri*, UNICEF, and the MoH first on WHO CDD Standard Case Management, and subsequently 209 or 75.5% of health workers trained in IMCI, in addition to BCC approaches. This represents development of two *rayon*-level TOT teams. It also represents 100% of peripheral facilities having a trained health worker, an important improvement in access to SCM.

The HFA shows progress in improved health worker practices for managing children presenting at peripheral facilities with diarrhea/vomiting. While the HFA did not measure full use of the WHO SCM or IMCI, for CDD it used as a proxy the performance of three activities which are important aspects of SCM: looking for blood in the stool (baseline: 6.9%; EOP: 94.4%), pinching skin on abdomen (baseline: 3.4%; EOP: 50.0%), and checking for sunken eyes (baseline: 3.4%; EOP: 88.9%). By these measures, improved health worker practice in managing cases of children with diarrhea/vomiting exceeded the target of 35% (noting that the number of children presenting with these symptoms at the time of the final HFA, e.g. 13, was not a large sample).

Collaboration with UNICEF on contribution of ORS packets resolved early supply problems. Adopting CSs materials form India CS program helped to facilitate m others understanding for diarrhea.

iii. Contributing Factors

Please refer to Section iii under Pneumonia Case Management for the discussion on roll-out of IMCI and use of the supervision indicator, which applies equally to CDD. Cross visits to India and Turkmenistan was very useful and effective to adopt CDD materials.

iv. Main Successes and Lessons Learned

A significant jump in mothers' knowledge of danger signs, an increase in mothers' practice in using ORT/home based fluids, and bringing children exhibiting danger signs to medical care, brought about through effective BCC materials and the work of VHWs/FOs and VHCs, plus a good start in changing health worker practice to WHO SCM utilizing the IMCI approach, were the major successes of the CDD intervention. Important lessons learned include:

- It would have been more useful to check for utilization of the full SCM protocol, rather than only three activities used as a proxy. (It is unlikely that the baseline would have been above 0 in this case).
- It would have been useful to assess all (or at least a sufficient sample) of the health workers who had been trained in either WHO SCM or IMCI, using a checklist, to ascertain their use of the new protocol.
- Information needs to be presented in communities, with seasonality in mind. Information from India on community bulletin board helped to inform community.
- Training also needs to be seasonal: summer for CDD, winter for PCM.
- Refresher training is worthwhile.

A fuller discussion of findings, conclusions, lessons learned, best practices, and recommendations identified by the full final evaluation team is included in Attachment 5.

v. Special Outcomes, Unexpected Successes/Constraints

While most households already had a special place for handwashing, there were important new achievements in maintaining a soap supply in the handwashing area, and in mothers' handwashing practices.

vi. Potential for Scale-up or Expanded Impact

Please refer to Section vi under PCM above, as the excellent infrastructure is identical for both interventions. The established network and TOT core team stands ready to continue to reinforce CDD activities, perhaps to introduce the "new" ORT and/or zinc supplementation, or to convey other health messages. Funding through JICA for zinc could be explored, since JICA has recently funded health facility improvements through UNICEF and has expressed interest in zinc supplementation.

Breast Feeding Promotion

i. Results and Outcomes

Please refer to the table in Section B.1 for the results and outcomes of *Umir Nuri* as measured by comparison of the baseline and final evaluation surveys. Section B.1 also includes commentary.

ii Factors Affecting Achievements

Umir Nuri was particularly effective in promoting breastfeeding, showing noteworthy achievements which have caught the attention of the Karakalpakstan MoH in both immediate and exclusive breastfeeding practices. 126 or 45% of health workers in peripheral facilities received training through a collaboration of *Umir Nuri* and the MoH on breastfeeding promotion along with BCC and communication techniques, which was later supplemented with IMCI training which supports breastfeeding promotion. Based on program data, a shift to training and supporting MoH staff working in maternity homes occurred after the MTE.

Written BCC materials distributed by VHWs and VHC members worked very effectively to convey key messages about immediately breastfeeding after delivery, and exclusively breastfeeding to six months of age.

A much larger gain noted in immediate breastfeeding noted following the MTE could be a result of the more pronounced focus of training at maternity homes during the program's final year, which was very appropriate since these sites are where most deliveries occur. Since mothers-in-law are very important for setting child care parameters and providing an enabling environment for changed child care practices, program efforts to reach this special group with BFP information has been particularly noteworthy.

iii. Contributing Factors

All objectives achieved.

iv. Main Successes and Lessons Learned

A significant gain in mothers' practice of immediate breastfeeding (within an hour of delivery), exclusive breastfeeding to six months of age, and a large increase in mothers' knowledge of demand feeding, brought about through effective BCC materials and the work of VHWs/FOs and VHCs, and concurrent training of health workers to support mothers in their breastfeeding practice, were the major successes of the BFP intervention.

An important lesson learned is that information needs to be presented "just in time" in order to influence mothers' breastfeeding behavior. Project HOPE's CSP Director, who was a member of the Stakeholders Meeting of the final evaluation, noted that their BFP KPC gains in Navoi were not as large as *Umir Nuri's,* and attributed the difference to *Umir Nuri's* strong community level components. He expressed this as a lesson learned for Project HOPE, which is working only with the MoH, not in communities.

A fuller discussion of findings, conclusions, lessons learned, best practices, and recommendations identified by the full final evaluation team is included in Attachment 5.

v. Special Outcomes, Unexpected Successes/Constraints

Pilot Breastfeeding Support Groups (an idea borrowed from Project HOPE's Child Survival Project in Navoi) and Schools of Mothers developed by 13 *makhalla*/VHC committees were effective for peer group support.

The MoH is particularly excited about the BFP results, in part because there was a recent decree from the central government regarding restricting advertisement on formula or early feeding in maternity centers, in support of BFP, which will now result in a large push for breastfeeding support activities.

vi. Potential for Scale-up or Expanded Impact

An effective system and approach exists for replicating BFP in a large scale-up throughout the Republic (refer to the PCM section for a fuller explanation). There is excellent potential for scale-up/expanded impact.

B2c. New Tools/Approaches; Operations Research/Special Studies

BCC: *Umir Nuri* developed a large array of effective BCC materials and approaches (booklets, pamphlets, posters, videos, dramas, songs, puppet shows, training curricula, etc.) which are particularly suited to Karakalpakstan. BCC materials were carefully developed and pre-tested with focus groups in the community before finalization, and this approach paid off. Refer to Section B.3 for more details on the BCC approach.

Village Pharmacy Pilot: Work in Tajikistan was studied. A Willingness to Pay study was commissioned prior to launch of the pilot, with the assistance of an external consultant. The resulting data supported the concept of initiating village pharmacies. Community residents were willing to pay for pharmaceuticals which were not available outside of *rayon* centers, and their willingness to pay increased with remoteness from the *rayon* center, and was not correlated to type of illness or whether the family had actually experienced the illness. Evaluation team members noted that mothers continue to express interest in village pharmacies. Nevertheless, the pilot was dropped from the workplan shortly after the MTE, because the MoH needed to be involved with the pharmacies, which were accessory to health facilities, and payment for services is not permitted in MoH facilities. While a suitable resolution has not been presented yet, Counterpart is committed to pursuing the concept of village pharmacies within the context of future programming.

B3. Results: Cross-Cutting Approaches

Community Mobilization

The final evaluation team was requested by *Umir Nuri* stakeholders to put a special focus on the results of community mobilization on mothers' changed practices.

i. Effectiveness of Approach

The approach taken, (1) using *makhalla* committees and forming VHCs in selected locations, (2) training and supporting *makhalla*/VHC members, (3) using VHWs and FOs to support VHCs and work directly with community members, and (4) establishing a Child Survival Coordinating Committee (CSCC) in the *hakimyat* (*rayon* level government), was found to have been very successful.

ii. Status of Objectives

No specific objective was formed around community mobilization. The DIP's planned roll-out for community mobilization was accurately forecast and implemented. The final evaluation team found the randomly selected and visited VHCs active, with full complements of members from a range of community stakeholders, including *makhalla* committee members, mothers, health facility staff, *mulla* (religious leaders), traditional healers, teachers, etc. VHWs and FOs have been meeting regularly with VHCs and the two CSCCs, with new community-based organizations such as the breastfeeding support groups and schools of mothers, with peripheral health facility staff, and with community members. The introduction of potential funding for health activities in communities through the Healthy Communities Project was generating excitement in VHCs and among *rayon* authorities.

iii. Lessons Learned

The following best practices/lessons learned were identified by the full evaluation team in reference to VHW/VHCs and mobilization activities:

- Using *makhalla* was effective.
- The role of VHWs/FOs was essential.
- Written materials were effective.
- Cross visits of CS program in India and MCH in Turkmenistan were useful and adopted successful approaches that are very effective
- Links to external resources has kept interest high.
- Use interactive learning techniques (e.g., role plays, competitions).
- Use local women as VHWs.
- Use TV/films spots as part of BCC.
- Improve the work of VHCs through incentives (small gifts which were relevant to their work, inviting them to seminars/workshops).
- Invite community elders to program activities (e.g. group health education events, FGDs, meetings, etc.).
- Use follow-up household visits to re-enforced *Umir Nuri* messages.
- Focus VHC efforts in a few key communities rather than reducing their effectiveness by establishing them throughout the region.
- Elect VHC members on voluntary basis is good practice.
- Establish links between CSCC, VHCs and the community.
- Disseminate mothers' and caretakers' knowledge and positive practices to others in the community.
- Constantly work with community members will increase the popularity and recognition of health workers in the community.

- Additional training for VHWs resulted in more effective and successful work on their part.
- Involve influential and respectful people in the VHC.
- Establish the VHC through a local mechanism, using local people.

A fuller discussion of findings, conclusions, lessons learned, best practices, and recommendations identified by the full final evaluation team is included in Attachment 5.

iv. Community Demand

The final evaluation team visited four communities in each of the two *rayon* and noted community demand. These communities were randomly selected from prepared lists of all *rayon* communities which designated a community as either located "close in" or "remote" in relation to a *rayon* center, and either "close to a VHC" or "remote from a VHC". Sub-teams conducted interviews of *makhalla* or VHC members, interviewed health facility staff in the nearby most-used peripheral facility, and conducted FGD with mothers and grandmothers. All teams reported community demand for *Umir Nuri* activities.

v. Sustainability Plan

It is anticipated that VHCs and the CSCCs will continue to meet post-program. VHCs visited by the final evaluation team have plans to continue meeting after September 2004, the expected closure date for the program (it has subsequently been given a no-cost extension until March 2005 but this was not known in communities at the time of the FE). *Hakimyat* authorities informed the final evaluation team that they intend to call CSCC meetings, to which VHC members come on a rotating basis. The Takhtapukir *hakimyat* outlined a plan to the final evaluation team to have CSCC meetings rotate to different villages, to reduce the transportation costs for VHC members. They are also submitting a request in late September 2004 to the *hakimyat* full body for funding to hire 3 of the 8 field staff (VHWs and FOs) to continue working with communities, VHCs, health facilities, and the *hakimyat*. Nukus officials have previously mentioned similar plans to *Umir Nuri* staff. Republic MoH authorities are also interested in investing in the existing VHCs and initiating new ones in new *rayon.*

vi. Assessment of Sustainability Plan

There is good evidence that communities and health authorities are assuming responsibility for important community mobilization activities initiated by *Umir Nuri*. The no-cost extension period will be an excellent opportunity to assess the strength of these efforts and provide support as needed. A few more months of financial support to key *Umir Nuri* staffing positions to provide support to the *hakimyat* and the MoH to fully operationalize these new directions would be a worthwhile investment.

Communication for Behavior Change

The final evaluation team was requested by *Umir Nuri* stakeholders to put a special focus on the results of behavior change communication (BCC) on mothers' changed practices.

i. Effectiveness of Approach

The approach, which involved development of BCC culturally acceptable materials/venues (booklets, pamphlets, posters, videos, drama, songs, puppet shows, contests, curricula, and documentation) in the Karakalpak language as needed, with excellent graphics and formatting, using a professional approach of involving focus groups, pre-testing, and re-checking, along with BCC training of all *Umir Nuri* staff, VHC members, and health workers in peripheral health facilities, was found to have been very successful.

ii. Status of Objectives

No specific objective was formed around BCC, although use of BCC materials and approaches is part of evaluating capacity building in *makhalla* committees, VHCs, and Perzent. The DIP's planned roll-out for behavior change was accurately implemented, although there were some early delays which were subsequently resolved. The KPC EOP and HFA indicate that the BCC approach (which was the major method *Umir Nuri* utilized to convey key messages) resulted in improved knowledge and changed practices in mothers. Mothers are liking and using booklets and finding them easy to understand. One grandmother preparing food at a wedding proudly announced to the evaluation team: "Our mothers know as much or more than the health workers!" This was echoed by 11 other grandmothers helping nearby. The MoH at all levels reported that *Umir Nuri* BCC materials played a key role in program achievements. MoH staff in peripheral health facilities, particularly visiting nurses, have changed their way of talking to mothers using their new BCC skills. Mothers report that they are getting better counseling in health facilities.

iii. Lessons Learned

- BCC materials should be developed in a participatory and team environment.
- BCC materials development should be responsive to community needs.
- BCC materials need to be culturally sensitive, using easy to understand language, and have engaging designs and layouts.
- Establish and open and comfortable rapport with beneficiaries.
- Presentation of health messages, including trainings, should coincide with seasonal needs.
- Pre- and post- testing of BCC materials was essential to the development process.
- BCC materials need to distributed a wider audience.
- Films can be effective for disseminating health messages (e.g. HH/C-IMCI, PBF)
- Through puppets were new concept acceptance was very high. New approaches should be adopted on trial/pilot basis and based on successes scale up activities.

A fuller discussion of findings, conclusions, lessons learned, best practices, and recommendations identified by the full final evaluation team is included in Attachment 5.

iv. Sustainability Plan

It was agreed by the FE team that it would be difficult for the MoH or other local organizations including Perzent to create new BCC materials at a caliber of as high a quality as those produced by *Umir Nuri*, without paying for technical/graphic support.

The skill to do this is available in Karakalpakstan in existing *Umir Nuri* staff and perhaps elsewhere (one new graphic arts business was identified but not assessed), if funding is available. Blue-lines of existing materials along with full instructions on conducting training sessions on the effective BCC approach have been recommended to be prepared as packets for key MoH departments and Perzent for distribution and discussion prior to *Umir Nuri* close-out.

v. Measurement of BCC Interventions

The impact of BCC interventions was measured through the KPC (increased knowledge, improved practice in mothers) and through the HFA (improved practice of peripheral health workers). This was supplemented by interviews and FGD with mothers, grandmothers, health facility staff, and *rayon* health authorities.

Capacity Building Approach: Strengthening Counterpart International

i. Effect of Umir Nuri/CSP on Counterpart International

Counterpart International has been programming Child Survival Programs since 1993. The experience of planning and implementing each program builds capacity year by year. An important resource at CPI's HQ resulting from this round of CSP funding has been the establishment of a Health Committee within the Board of Directors, which is responsible to look across the health portfolio. Committee members visited *Umir Nuri* to learn specifically about CS programming on the ground.

ii. Effect of Umir Nuri on Child Survival programming of Counterpart International

Director Health program Darshana Vyas from HQ instituted significant cross visits between its CSPs in Uzbekistan and India: CSP India staff visited Uzbekistan 3 times, and *Umir Nuri* staff visited India three times. Staff shared lessons learned as well as technical skills building in BCC and Hearth/nutrition, and managerial skills building in HIS and finance. In addition to this, Darshana Vyas, Director Health programs has sent staff to visit Turkmenistan to share lessons learned as well as BCC training. Also she sent program director and HMIS specialist to attend Hearth Asia workshop in India to participate and share their experiences. This exchange visits have helped Umir Nuri staff to try new feasible approaches and strategies for the CS program. As a result exchange system is established for other programs as well.

iii. Effect of Umir Nuri/CSP on other programming of Counterpart International

Beyond only *Umir Nuri,* the CSHGP itself has influenced the way director Health programs Darshana Vyas plans and implements its health programming. Its Food Security program in Vietnam, and its health programming in Turkmenistan, for example, Director Health programs is now using the KPC methodology. The CPI MCH program in Turkmenistan is using the CORE/CSTS Sustainability Framework, and overall, the framework is being modified for broader use within health programs. CPI's HQ was recently re-oriented so that child survival can be more fully supported. CPI health division understands the importance of child survival, and is committed to it. In addition to this, Darshana sent IMCI trainer Dr. Sarah form CS program to train project staff for

the USAID mission funded Healthy Community Project in Tajikistan to institutionalize CS approaches.

Capacity Building Approach: Strengthening Perzent and the Regional (Karakalpakstan) MoH

Perzent: Karakalpakstan has an emerging civil society and there are not many health NGOs, although the number is growing. Perzent as an institution can be characterized as a very small group of professionals, one of whom is a charismatic and articulate leader, with access to health funding which enables temporary hiring of needed expertise. The number of permanent staff is very small. Perzent's Director has many interests and responsibilities, including operation of a clinic. While she recently become a Member of Parliament in Karakalpakstan, she views Perzent as "non governmental".

Continuing organizational development would appear to depend more on the pace and interests of Perzent's leader than to be a matter of institutional policy or routine. An organization active in bringing in needed health resources merits capacity building attention. Perzent's director is very active in finding funds for health activities, to the benefit of the region. However, it is difficult (though not impossible) to build organizational capacity when the number of permanent staff is so small and so much depends on the director.

Karakalpakstan MoH: The Karakalpakstan MoH has regional responsibility for health, yet is still far from being truly decentralized. It is closely tied to the central MoH in Tashkent and largely takes its cues in response to directives/protocols coming from Tashkent, which may or may not be relevant to the unique needs of the region. A series of actions under health reforms is taking place, most notably a shift to SVPs (fully staffed clinic with a few beds), so that there is one SVP per "aul" (community, roughly equivalent to the former Soviet-conceived communal farming area). International support from JICA/UNICEF, World Bank, and the ADB for improving SVPs is underway. Other types of peripheral health facilities such as SVAs, SUBs, and FAPs are slated for closure, with the exception of some FAPs (physician assistant type worker plus midwife, no beds) which will continue in remote parts of Karakalpakstan. The MoH is underfunded. Its peripheral health facilities have deteriorating infrastructure and staff report delays in delivery of supplies. Out-migration does not appear to be affecting the availability of needed staff. Family physicians are in demand and hard to recruit.

i. Outcomes of Capacity Building Assessments

Perzent: Counterpart International and Perzent participated in an formal capacity assessment using Technical Training and Assistance Plan (TTAP) during the first few months of program implementation. Perzent's capacity building goals were documented as part of the DIP and within a Memorandum of Understanding (MoU), and were assessed as part of the mid-term evaluation. Perzent's Director and Program Assistant were interviewed about capacity changes during the final evaluation, which also included reports from CPI *Umir Nuri* staff who worked with Perzent's finance staffmember and field staff hired specifically for *Umir Nuri*. Perzent staff have acknowledge that now they are using KPC, BCC, HMIS and other community mobilization techniques into

their health programs. Perzent director also acknowledge that their financial skills are built through this partnership. In addition to ongoing joint program implementation and training, Perzent staff attended Cambodia and South Africa BEHAVE training and staff is able to train inhous training for other non CS staff within Perzent and other small new NGOs.

Karakalpakstan MoH: The MoH at the Republic (regional) and *rayon* levels is a key implementing partner of *Umir Nuri*. Roles and responsibilities were defined in an MoU. The capacity of health center staff was assessed at baseline, mid-point and end-of-program, through an HFA, which does include questions relating to supervision but does not specifically assess capacity at *rayon* and regional levels, and does not look specifically at standard case management. The FE team interviewed key Republic and *rayon* MoH staff and talked with health center directors as a means to gauge capacity change relating to *Umir Nuri* at the top MoH levels.

ii. Changes in Organizational Capacity

Perzent: The local NGO partner Perzent continues to be active in health programming, bringing in needed financial resources as grants which supplement MoH and bilateral efforts. The team found evidence that Perzent has adopted more participatory approaches to its programming, and is involving the community as a partner in another program running concurrently with *Umir Nuri*. The team also found that Perzent has adopted KPC, HMIS, IMCI and BCC tools and techniques into other health programs. Perzent expressed interest in hiring *Umir Nuri* HMIS, public relations, financial and supervisory staff members post-program.

Specific training, either formally with consultants or one-on-one with Counterpart-hired staff who were specialists in their fields, was the most influential contributor to capacity changes among its staff hired for *Umir Nuri* activities, according to Perzent's Director and Program Assistant. A major capacity building strategy utilized by CPI was having Perzent's Program Assistant (a key position) "seconded" nearly 100% to *Umir Nuri* program administration and technical support, exposing this staffmember to new ways of management and implementation over a four year period. He has subsequently transferred some of these new management approaches to new programs being implemented by Perzent. Please refer to the table in Section B1, Objective 7, indicator "e" for a description of changes in Perzent's capacity in financial accountability, human resources, logistics management, monitoring and evaluation methodologies, and other areas.

Karakalpakstan MoH: The FE team noted that the regional and *rayon* MoH authorities have excellent working relationships with *Umir Nuri* staff, and are wanting to continue their relationship with Counterpart International in their anticipated roll-out of IMCI in the near future. Organizational capacity has improved in terms of valuing community input, engaging the community for healthy change, utilization of improved BCC materials, review of program data and comparison of program data with MoH HIS data, decision-making based on data, and evaluation techniques: involvement in the KPCs, HFAs, MTE, and EOP as team members.

iii. Best Practices/Lessons Learned

Perzent: In the case of *Umir Nuri*, it is unclear at this point if the field staff hired by Perzent through their sub-grant will work with Perzent in the future to transfer knowledge, experience, and skills, even though the partnership ensured that half the field staff were hired at wage levels consistent with Perzent's wage scale and management style.

- Assessing additional transfer of field staff skills to Perzent's overall portfolio will be better gauged a year or more from now.

It has been consistent with best practices for Counterpart to guide Perzent toward becoming an organization, and to build capacity for health within the small group of its permanent staff. Counterpart has conferred with the Perzent Director from the planning period throughout the life of the program, and worked closely with the finance staffperson, and with the Program Assistant through whom improved managerial practices are being transferred to other Perzent projects.

- When working with a young NGO, select those staff members whose work is cross-cutting, for capacity building training and follow-up.

During discussions with the partner NGO Perzent, Perzent's director felt that if they were to absorb the employees from the CS program into their organization after the completion of the program, then it would be in their best financial interest to allow their employees to start at a lower salary rate, so that the staff had more room for financial advancement during the progress of the program, and it would help as the role of the international NGO became more facilitative, and the role of the NGO more implementation oriented and then transitioned into continuing on their own, and procuring funds on their own to continue the program. Therefore it was decided after careful deliberation that half of the field staff that are hired by Perzent and report to Perzent's Program Assistant, and half of the field staff hired by CPI would report to CPI's top technical staffmember. Thus, wage scales are different (CPI pays more compare to local NGOs), although job responsibilities are relatively the same. .

The proposal jointly submitted in 2003 to expand *Umir Nuri* reflected this arrangement, where Perzent was to be in a managerial position, with Counterpart staff acting as senior advisors and as a technical resource, as well as available to fill in any managerial gaps.

- Structuring *Umir Nuri* so that Perzent had more of an implementation role and CPI more of a facilitative/advisory role would likely have helped further build Perzent's capacity in child survival implementation

Karakalpakstan MoH:

- Involve key people from the start to build appreciation for capacity building activities.

- Involve MOH in the design and development of BCC materials, namely posters and booklets, early on so that sustainability can be achieved at the end of the program

Capacity Building Approach: Strengthening Health Facilities

JICA (through UNICEF), the World Bank, and the Asian Development Bank are currently equipping SVPs with excellent new equipment such as microscopes, centrifuges, complete cold chains, filing cabinets, medicine cabinets, birthing chairs, etc. as part of enhancing the role of SVPs and de-enhancing the role of FAPs/SUBs/SVAs, as part of health reform activities. However, training on the use of equipment is not included.

i. Effectiveness of Approach

The *Umir Nuri* approach toward strengthening health facilities was not focused on equipment and supplies, although CHAP donations were a component as cost share and leverageing and upgrading health facilites. Its focus was more on initiating substantive and sustainable links between health facilities and communities in VHCs and links between groups of VHCs and *rayon* MoH and *hakimyat* authorities, to better tailor health services to community demands. The approach was found to have been successful.

ii. Health Facility Assessment Tools

Umir Nuri utilized the BASICS Health Facility Assessment Tools, parts 1-4 as the primary basis for looking at changes in health facilities, but this does not capture the important linkages which form the foundation for *Umir Nuri's* work in strengthening health facilities. Of the four parts utilized, the Observation Checklist-Sick Child had the most relevance to *Umir Nuri* (see Strengthening Health Worker Performance, below). For other aspects of health facility strengthening, VHWs kept records on VHC strengthening (health facilities are linked to VHCs), activities with CBOs, visits with MoH staff and facilities, and meetings at the CSCC level. The outcomes of these activities were assessed qualitatively and through the KPC with mothers' changed practices being the final, and most meaningful, measure.

iii. Lessons Learned

- Locate VHCs outside of MoH facilities (*makhalla* buildings worked well).
- Invite outreach staff as well as MoH facility decision-makers to the VHC.
- HFA tools should be revised and adapted to reflect changes in program activities and MOH policies.

iv. Sustainability Plans

The continued work of VHCs is an important part of the *Umir Nuri* sustainability plan for this cross-cutting component. Health facilities located near to VHCs have staff members who are members of the VHC. The sustainability plan includes continuing dialogue between the community, Makhallas and the health facility for health education, and for meeting demands. Already some VHCs are becoming venues for sharing health information on a variety of subjects of wide community interests: one VHC visited reported that their health facility representative had provided training on anemia, TB and

other pulmonary diseases, allergies, skin diseases, hepatitis A and B, the relationship of sanitation and hygiene to health, arthritis, kidney diseases, and seasonality of diseases (respiratory infections and diarrhea), above the HH/C-IMCI key household messages. Several VHCs have also had members participate in Healthy Communities Program training in proposal design and writing, and have submitted concept papers for funding which are currently under review. As discussed elsewhere, VHCs are making plans to continue meeting post-program, and it is anticipated that a few VHWs/FOs will be picked up by the Takhtapukir and Nukus *hakimyat* and continue working with communities and health facilities.

v. Linkages Between Facilities and Communities

Please refer to sections i and iv for discussion of important linkages initiated between health facilities and communities.

Capacity Building Approach: Strengthening Health Worker Performance

i. Effectiveness of Approach

The *Umir Nuri* approach toward strengthening health worker performance, which involved development of a core training team in each *rayon,* and layered training for key health workers in peripheral health facilities in behavior change approaches, standard case management, and later IMCI, follow-up of training through regular visits to facilities by VHWs and Field Officers (who were themselves trained nurses and physicians), and use of BCC materials, was found to have been a sound plan. IMCI training, all of which was conducted during the past year, is too recent for this evaluation to adequately assess its effect on health worker performance. The HFA is uable to pick up changes in health worker performance in terms of deploying comprehensive SCM, although proxy measures indicate progress is being made.

ii. Status of Performance Objectives

Please refer to the table in Section B.1 for the results and outcomes of *Umir Nuri* as measured by comparison of the baseline and final evaluation surveys. Objectives 10 and 14 relate specifically to health worker performance. Section B.1 also includes commentary.

A thorough discussion of the results of *Umir Nuri* activities to strengthen health worker performance through training and support is included in the Sections above on Pneumonia Case Management and Control of Diarrheal Disease.

iii. Best Practices/Lessons Learned

- Involve supervisors in all training and field follow-up.
- Improve monitoring of trainings and ensure better follow up

Please refer to the Sections above on Pneumonia Case Management and Control of Diarrheal Disease for additional best practices/lessons learned related to training in these areas.

iv. Sustainability Plans

The key component to *Umir Nuri*'s sustainability plan for health worker performance has been the development of an experienced core training team in each *rayon*. This was a reasoned change from what was anticipated at the time of DIP preparation, when it was planned that each health facility would have a training team.

Sufficient numbers of senior MoH staff from a variety of positions within the *rayon* and within health facilities have been trained as trainers (with a focus on TOT skills), so that training teams can be formed for training in PCM, DCM, IMCI, BFP, and potentially other technical areas, as needed. The Republic MoH authorities are already planning to utilize some of these trained team members for training in other *rayon* in the Republic. While some core trainers may leave as part of natural outmigration to Kazakhstan and elsewhere, the MoH at the Republic level reports it does not anticipate a "crippling" level of turnover.

Similar to what is planned for the BCC materials and approach, *Umir Nuri* staff are preparing "packets" of training curricula (BCC, SCM, BFP, IMCI) with full explanations for distribution to key MoH departments and to Perzent. Full discussions on the packets is planned for the period prior to final *Umir Nuri* close-out.

v. Effectiveness of Measurement Tools

The period just prior to assessing the baseline (KPC) in a new program is a very busy and sensitive time which needs to include such a thorough understanding of all program components that baseline tools utilized can remain essentially untouched thereafter. Unfortunately, that thorough planning activity (DIP preparation) most often occurs after the baseline is already completed. Once a tool has been used for a baseline, substantial changes to it for the MTE and EOP would make it difficult to track changes over time. *Umir Nuri* used the BASICS HFA tool pretty much intact during its baseline, and made some assumptions about how well it would track some of its program indicators. The tool as it stands now is insufficiently sensitive to pick up the changeover from Soviet practice to WHO SCM, both in terms of health worker practice and supervision. *Umir Nuri* did not necessarily plan its training to be just within 6 months prior to HFA activities, e.g. results did not pick up all training since it only looks at what took place within a set period prior to the HFA. It did not look at drug stockouts throughout the entire program period. It would need to be modified to track these kinds of changes. Gaps were largely compensated for through identification of proxies, and the development of special tools such as the training database. And of course, much valuable information was obtained from the tool as it stands now. KPC tool was used at the baseline, mid term and final evaluation with rapit catch and is very effective to measure the progress of the program.

vi. Addressing Performance Gaps

Rather than addressing specific gaps (since *Umir Nuri* did not work directly with supervisors on supervision skills since it was not in the original Dip plan), all new training offered included a "review"/overlap with previous training, along with regular refresher training, and regular meetings between VHWs (who were physicians and

nurses) and clinic staff. Post-training testing was given several months after training to check retention. Results of the MTE HFA were shared with the MoH.

Capacity Building Approach: Training

i. Effectiveness of Strategy

Please refer to the section above on "Capacity Building Approach: Strengthening Health Worker Performance, and to the sections on Pneumonia Case Management and Control of Diarrheal Disease, which discuss the *Umir Nuri* strategy and outcomes for training of MoH health service staff, which was a major component of the training activities.

In addition to training health center staff, *Umir Nuri* also included training for *Umir Nuri* staff at all levels; *makhalla*/VHC/CSCC members; and members of Breastfeeding Support Groups/Schools of Mothers. A database of training activities was analyzed as part of the EOP. *Umir Nuri's* training approach at community levels had excellent results, as evidenced by KPC results, and through evidence of active VHCs which have been integrated into *makhalla* and *hakimyat* ongoing activities.

ii. Status of Training Objectives

Please refer to the section above on "Capacity Building Approach: Strengthening Health Worker Performance, and the table in Section B.1 which discusses the status of the two training objectives (#10and #14) relating to training MoH staff.

In addition, there are three other *Umir Nuri* objectives which include indicators relating to other levels of training: Objective 3, indicator a; Objective 5, indicator a; and Objective 7, indicator a. Please refer to the table in Section B.1 for the results for these Objectives/indicators, which were successfully achieved.

iii. Evidence of Positive Effects

The KPC results assess the overall effectiveness of training for all other trainees except MoH staff (examined previously), by looking at end-point changes in mothers knowledge/practice. The KPC provides evidence that the overall effectiveness of training activities was very positive.

iv. Best Practices/Lessons Learned

- Parallel trainings at health facilities and community levels complemented and reinforced one another.
- Selectively targeting health workers working in *Umir Nuri* program interventions ensured greater program success

v. Sustainability Plans

VHCs and the CSCCs are anticipated to continue. With the potential in place for VHWs/FOs to be hired by *hakimyat*, there also exists excellent potential for continued support, including training, for VHC and CSCC members. The FE team also reported that health facility staff were engaged in training at VHC levels, at the request of VHC members, providing another sustainable way to support VHCs.

Sustainability Strategy

i. Status of Sustainability Goals/Objectives; Sustainability Plan Evolution

The DIP articulated a well-thought through sustainability plan involving a focus on strengthening Perzent and MoH staff in peripheral health facilities for health action, mobilizing and training *makhalla* committees for health action, working with mothers-in-law and peers through *makhalla*/VHCs and through CBOs to engage mothers for health action, strengthening Perzent to obtain donor funds, and establishing largely cost-recovered village pharmacies. With the exception of dropping the pilot village pharmacy component, and the addition of a linkage to the Healthy Communities Project grant mechanism, the sustainability plan articulated in the DIP has served as an accurate guide for *Umir Nuri*'s sustainability planning. Objectives and indicators relating to sustainability (exception: village pharmacies) have been successfully met. The addition of the Healthy Community Project activities to *Umir Nuri*, which includes the potential for grants in the immediate future, is an excellent opportunity to further contribute to sustainability of activities in communities.

ii. Status of Phase-over Plan

The phase-over plan is largely on schedule, although it could use some additional months to "cement" important actions underway, particularly at the *hakimyat* level. Also, MoH staff have had training only during the past year (September 2003, May 2004) to re-organize their case management of pneumonia and diarrhea under the IMCI approach, and further follow-up is needed since this is so recent.

Makhalla committees have helped to develop VHCs which are representative of health stakeholders in communities, meet regularly, and have plans to continue meeting. VHCs and CBOs continue to meet and are at this time applying for funding from the Healthy Communities Project for health priorities of their choosing. The two *hakimyat* have discussed their plans to hire some VHWs/FOs to continue to support VHCs and communities. Perzent has proven its ability to successfully plan proposals and obtain external/donor funding. CPI has an additional 4 months no-cost extension which could be a very helpful period for solidifying its results. Additional external funding is in the pipeline.

CPI submitted a proposal for an Expanded Impact program to the CSHGP last year hat was designed jointly with MoH and Perzent, which was not funded. Counterpart intends to continue health programming in Karakalpakstan, and has re-submitted to CSHGP this November 2005. CPI recognizes the inherent value of the *Umir Nuri* staff and various effective relationships and networks now established. To keep this in place for replication/expansion over the near term will require resources for the next fiscal year while additional funding is sought. Submitted proposal to the Department of Defense funding at $300,000 for one year and are waiting for the results within this calendar year. A number of other avenues are currently under study to keep the momentum of *Umir Nuri* in place until CSHGP funding again becomes available in October 2005 (these are not in any particular order of priority):

- Some *Umir Nuri* staff to register as a local NGO, or alternatively, work through the small NGO already registered by one of the HIS staff, which could then work

directly with the Healthy Communities Project as a technical arm (among other potential work).
- Obtain funding from USAID/Tashkent or USAID/CAR.
- Engage with ADB's Water and Sanitation program which is about to be implemented.
- Explore collaboration with the new Global Fund for HIV/AIDS which has recently been started.
- Establish work under the Project HOPE consortium.
- Continue to work jointly with MSF/Holland on risk reduction. A small $7000 program is underway.

iii. Status of Building Financial Sustainability

Umir Nuri's results on building financial sustainability have been mixed. On the negative side, the cost-recovery component through the Village Pharmacies did not materialize. On the positive side, the *hakimyat* interest in absorbing key *Umir Nuri* field staff to continue supporting the emerging community health action is exciting, as is the involvement of VHCs, Breastfeeding Groups, and program-involved communities in the Healthy Communities Project, which includes training, T.A., and funding. Also, Perzent has proven its ability to successfully plan and apply for external/donor funding, indicating that Perzent was a worthwhile focal point for capacity building. Perzent is anticipating a major role in the soon-to-be announced ADB program in water/sanitation in 5 *rayon* of Karakalpakstan. They are involved in a reproductive health educational campaign in 3 *rayon.* With WHO and a Dutch funder, they are implementing safe motherhood training in 5 *rayon*, including Takhtapukir and Nukus. In addition to this WHO Europe recently accepted a case study they developed.

iv. Demand Building/Engagement of Community

Please refer to the Community Mobilization sub-section of this portion of the report for a discussion on building community demand, which has been accomplished through mobilizing *makhalla* committees, establishing VHCs and CBOs, and working directly with families and health facilities. It is still too soon to know if the community is sufficiently engaged to influence how services are delivered, however, there is positive evidence that this is underway, for example, by VHCs informing CSCCs to add extra health staff during an emergency outbreak, by having staff on rotation to provide better coverage during off hours, etc.

C. PROGRAM MANAGEMENT

C1. Planning

C1a. Planning Process

Perzent and the MoH at the Republic level were extensively by Director Heath program Darshana Vyas in the design and development of the *Umir Nur* CS program for Karkalkapstan. Both the choice of interventions and the use of *makhalla* for community action were results of this inclusive planning process. Unlike what occurs in some other countries in the FSU, CPI, Perzent and the MoH very readily developed and signed an MoU which has served the program well. A seven days participatory process followed by series of meetings with MoH Tashkent, MSF, UNICEF and MoH Karkalkapstan were

held by the Director Health programs Darshana Vyas in 1999 to solicit their views. The Umir Nuri program proposal was design in bottom participatory approach which is unusual in former Soviet management. Representatives from Makhallas, Hospital doctors, Hakims and religious leaders were involved in the planning processes.

C1b. Assessment of DIP Work Plan

This program has a well defined DIP. The director health program Darshana Vyas spent three weeks during DIP development process and facilitated DIP workshop. The DIP development process also include USAID representative, representative from Project Hope, UNICEF, MSF, SRIP and Red Cross. The DIP work plan was very realistic and practical that involved various stakeholders. USAID mission representative was also involved at all level in the planning and solicit their views. Only one activity (village pharmacies) was modified significantly. The process was felt to have given clarity to each key stakeholder, and defined the responsibilities of each important partner that is articulated well in MoU. Furthermore, Program director, Dr. Nizamuudin Ahmed came to Washington to defend DIP and spent two weeks at HQ for further training.

Perzent staff participated actively in all stages of the DIP development process and also assisted in interviews and discussions. Perzents experience with community and MoH is an important asset to the Umir Nuri program.

The program planning process continues to involve MoH and perzent staff in implementation and evaluation processes and they understand that this program is result and performance based and objectives of the program are understood by every partners(CPI, Perzent, and the MoH).

As suggestions for future DIP preparation, USAID could consider a more detailed 4 year workplan, rather than detail only for Year 1. There also needs to be more "room" up front for formative research. CPI also found that they had to educate their DIP reviewers, who were not experts in the Central Asia region.

C1c. Gaps in DIP

No gaps were identified.

C2. Staff Training

C2a. Changes in CPI/Perzent Staff Capacities

Public health remains an emerging competency throughout the FSU, particularly in remote areas such as Karakalpakstan. Both CPI and Perzent staff significantly increased their competency in program interventions (SCM in PCM, CDD, and BFP, and in IMCI), in TOT development, in KPC and HFA application, in BCC, and in team-building, as evidenced by pre- and post- KAPs and the successful training they in turn conducted. The KPC and the HFA provide evidence that key competencies were conveyed to MoH health center staff and to mothers. Perzent has utilized its KPC skills in other programs it is implementing. *Umir Nuri*'s chief trainer was invited to conduct the 11-day IMCI training in Tajikistan, and has been invited back to do more training. The MoH, Perzent, the *hakimyat*, and MSF/Holland are all interested in hiring *Umir Nuri* staff.

C2b. Assessment of Resource Allocation for Staff Training

Adequate resources were dedicated to staff training, not only direct training but also cross-border/cross-regional training at and from the Counterpart International CSP in India, Turkmenistan, Tajikistan, South Africa and Cambodia and with Project HOPE in Navoi (Uzbekistan).

Need to cite all trainings here.

C2c. Lessons Learned

- Budget for international training opportunities: there are more and more available every year.
- There is not a large cadre of trained and experienced staff in this region; staff need to be "built". Sufficient resources must be set aside to invest in building capacity of local staff.
- Staff appreciate receiving certificates indicating international level training expertise.

C3. Supervision of Program Staff

C3a. Supervision System

Supervision occurred at a number of levels:

1. HQ to Program Manager/Director: The Program Director reported that he had adequate access to his HQ level supervisor. Access was accomplished through telephone, email, and frequent visits to the field.
2. Program Director to senior staff: the FE noted the good team spirit among the *Umir Nuri* staff.
3. Senior staff to mid-level staff (FOs): As a result of gaps in quality noted at the MTE, all training of mid-level staff was consolidated under one senior level position.
4. FOs to VHWs: the 1:3 ratio was very generous, probably overly so. However, KPC results indicate excellent work accomplished at this level.
5. *Rayon* health authorities to chiefs of peripheral health units: this was not a strong focus of *Umir Nuri,* although *rayon* level staff were important members of the TOT.
6. CSCC (*hakimyat, rayon* levels) to *makhalla*, in terms of involvement with VHCs: there is good evidence of information going to CSCCs and assistance coming back to VHCs.
7. *Makhalla* to VHCs: VHWs had more of supervisory role here than originally envisioned; However, CSCC members at the *hakimyat* are taking this role very seriously as evidenced by their willingness to hire field staff to continue liaison work.
8. VHCs to CBOs (breastfeeding support groups, schools of mothers): The supervisory link was not assessed. There is a good information flow, for example, CBOs have been informed about the opportunity to apply for grants from the HCP.

C3b. Maintenance of Supervisory System

The MoH supervision system is fully institutionalized. The *makhalla* system is fully institutionalized, and is the major link with VHCs. The *rayon* anticipates assuming supervision of VHWs/FOs, e.g. the CSCC link to VHCs and health facilities is becoming institutionalized. With VHWs/FOs in place, they will in turn be able to continue supporting *makhalla* committees, VHCs, and the new CBOs, and help strengthen the health facility-community links.

C3c. Assessment of Sustainability

Some novel aspects of the supervisory system are on the way to becoming institutionalized, for example, the involvement of the *hakimyat* and *makhalla* with the VHCs. There is good potential for institutionalization.

C4. Human Resources and Staff Management

C4a. Policies and Procedures for Sustainability

All essential personnel policies, procedures and manuals both financial and personnel policies are in place for those activities, which will continue through the grant period. Darshana Vyas, Director Health program has initially consducted conflict management and team building training for the program staff followed by three days refresher counseling and team building workshop was conducted after the program director left to boost up staff morale. Secondly, Counterpart's approach is decentralized throughout and there are opportunities for staff to grow within the organization. Counterpart International shared its HR policies with Perzent as part of its capacity building activities. It appears that personnel policies and procedures are in place in Perzent.

C4b. Morale, Cohesion, Working Relationships

Umir Nuri has had its ups and downs in terms of cohesion and morale during its early days. The first Director was unsuitable, and this was rectified by HQ. An excellent team spirit developed, along with a transparent management style from HQ. The team is remarkably cohesive and motivated for success.

C4c. Staff Turnover

Early on, *Umir Nuri* had significant turnover at its most senior levels. 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 initial Program Manager joined MSF. 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 participatory management. .
b. The contribution made by the late Dr Nuriyah Elgondieva, who was trained to be program director after two years as per the original plan tragically died on Jan 2003.

Her death created void in the program, considering that a lot had been done in training her as a program director. 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 senior management 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.

Despite these early senior staff issues, the mid-term evaluation documented excellent results, not least because mid level and junior staff positions were filled with talented staff who have remained active in their positions throughout the program period --there has been little turnover in these important positions. The last two years have been much smoother.

C4d. Staff Transitions

A reasonable program exit strategy is on paper, defining a number of alternatives all of which were still under discussion at the time of the final evaluation. With the no-cost extension of the program and the new DoD funding, CPI has a bit more time to finalize its direction, which is not expected to be an "exit" for Counterpart but rather an expansion of Counterpart-initiated health activities in the region. The staff is anticipating that Counterpart can locate sufficient funding to keep them largely intact as a team over the near term while a reapplication for CSHGP funding is realized. Proposals and requests have been submitted to the Healthy Communities Program, to USAID/Tashkent and elsewhere (refer to the Sustainability Strategy, part ii) for funding during this interim period to accomplish needed health activities in Karakalpakstan using the team's expertise. The Peace Corps Volunteer remains available. The one CPI expatriate staff member has been provided with information on other potential job options within and outside CPI earlier this year, and will be extended for a bit longer. The national staff are in demand from other organizations.

C5. Financial Management

C5a. Financial Management and Accountability

The FE briefly examined the financial systems of Counterpart's field office, which appear sound.

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

There have been four visits from Counterpart International and five visits using private funds and from a Counterpart sister program in Tashkent, and a cross visit to

Counterpart's CSP in India, to assist *Umir Nuri* finance staff with setting up financial systems consistent with Counterpart's international standards. Also a two weeks formal training at the USAID mission at Almaty as well well as Counterpart regional office by the regional financial director. These standards have in turn been shared with Perzent, for their use in managing their sub-grant, which Counterpart reports has been accounted for adequately. CPI reports that there have been no amendments to the budget. There have been minor adjustments in terms of timing. A quick look at the budget drawdown/pipeline indicates that there are line items where the program has both overspent and underspent, indicating that an adjustment may be needed before closure. There are adequate budgeting skills to estimate costs and elaborate on budgets for future programming.

The 25% match has been more than met through the addition of CPI funds through the Counterpart's Humanitarian Assistant Programs (CHAP)funds. CHAP has provided about 2 million of medical supplies to the rayon hospitals, SVP and FAPS.

The cost accounting system, approved by USAID, met the test of audits, including source records, ledgers and job costs. It segregated costs between direct and indirect. Its design allows for reporting on a number of sub-levels, so Program director have access to both consolidated and detailed reporting on a variety of levels. Actual costs are captured for the reporting period, fiscal year to date and cumulative to date. Labor utilization reporting captures all direct salaries charged to a program. Finance staff has many years of relevant experience and are fully familiar with all applicable USAID regulations including A-133 and 22 CFR 226. Finance staff maintains permanent Grants and Cooperative Agreements files that contain all needed critical information from award to

C5b. Resources for Planned Sustained Activities

Counterpart has received a no-cost extension through March 2005, which will be an important time period to solidify aspects of the phase-over and sustainability plan. It is anticipated that Counterpart will obtain sufficient funding to continue operations, perhaps at a slightly more limited scale, through the next fiscal year, so that there can be seamless operation to the anticipated future funding coming from a new submission this November to the CSGHP.

C5c. Assessment of Technical Assistance

Counterpart reports that there was sufficient outside technical assistance available to develop financial plans for sustainability. A lack of technical assistance was not a reason behind the decision taken to drop the cost recovery pilot.

C6. Logistics

C6a. Impact of Logistics

Karakalpakstan is remotely located. It requires an airplane trip to reach Tashkent for much of the procurement, for meetings with other NGO HQs and with USAID, etc.

There were some initial logistical delays at the start of implementation, for example, buying computers, but these were successfully ironed out. *Umir Nuri*'s Program Director

reports that their logistician is very talented, solid, and resourceful. It has also been very useful to have other Counterpart activities based in Tashkent, where their logistics staff have been able to assist the remotely located *Umir Nuri*.

C6b. Assessment of Logistics System for Future Activities

It is not anticipated that the logistics system will be needed to support operations and activities to be sustained, although logistics help will be needed during the interim period for routine administrative tasks. Any further CHAP donations could be handled by the CHAP staff out of Tashkent.

C7. Information Management

C7a. Assessment of HIS

The HMIS staff of *Umir Nuri* put much effort into developing an HMIS which tracks the indicators included in the DIP. Most program indicators were adequately tracked, although there were a few indicators where BASICS HFA data, which was intended to capture results, did not adequately do this.

C7b. Use of Data

A reporting system with a foundation based on VHW reports included morbidity/mortality surveillance along with records of inputs and activities. Surveillance was not intended to replace government systems, but rather to bring data to a community level and serve as the basis for discussions to prompt health actions. Surveillance information was tactfully compared with MoH case reports and mortality/morbidity data, at regular meetings with chief pediatricians. Information was fed back to VHCs.

Staff report a number of interesting and practical examples of management decisions based on program data. At community levels (and *makhalla, hakimyat* levels) decisions included a change in a bus route, two health centers now having rotating duty, cleaning of a well, and new handpumps, At the *Umir Nuri* program level, the MoH compared their diarrhea data with program data, and after discussions, initiated health care worker training. Also, there is a reported increase in morbidity reporting from health facilities, increased interest in comparing MoH data with other data such as the recently officially released DHS data, and comparing of Takhtapukir and Nukus data (e.g. system strengthening). The program switched its facility-based Breastfeeding Promotion activities from strictly peripheral facilities to Maternity Houses. MTE data prompted an increased emphasis on ARI danger signs, and handwashing.

Another important result of data sharing has been support from key people, rather than hindrance.

C7c. Assessment of Program Staff Capacity for HIS

The *Umir Nuri* staff members are well trained and skilled in data collection and use of data for program revisions/strengthening. The staff conducted their mid-term HFA surveys without external technical assistance. The HMIS manager is well trained has designed HHMIS system that is unique in Karkalkapstan and MoH I snow adopted the system. MoH statisticians and MIS managers are trained by Counterpart in Nukus along

with field staff. Technical assistance in modifying the HFA for use in tracking program indicators would have been useful.

C7d. Testing New Approaches

Umir Nuri conducted pre-tests and FDG for development BCC materials, pre- and post-tests for training activities, and conducted a Willingness-to-Pay survey prior to launching the Village Pharmacy pilot. Please refer to Section B.2.c for details on this study, which provided good support for starting Village Pharmacies (these were dropped from the workplan because of a political situation within the MoH).

C7e. Strengthening Existing Data Systems

The program's HMIS was intended to complement, not duplicate, the MoH's own system. It was designed to open up a dialogue with the MoH to encourage more accurate data collection and different uses of data. Holding regular discussions with health facility staff about unusually extensive numbers of cases of diarrhea, severe diarrhea, and ARI/pneumonia found at community levels prompted staff to consider how families responded to the illness, and how they could best be involved.

Just prior to the qualitative EOP assessment, *Umir Nuri* conducted an HMIS Phase-over Workshop with the MoH, providing the MoH with information needed to continue to utilize the information systems in place in communities. This was well-received.

The MoH as an institution remains very inclusive of its data. Internationally, Uzbekistan official data has been found to under-report actual morbidity and mortality. In light of the excellent relationship which now exists, continuing to work with the MoH at the Karakalpakstan level, perhaps on a pilot basis, using WHO diagnosis categories and follow-up of all cases of infant/child (and potentially maternal) mortality at the household level, is a recommended avenue to consider for future programming.

C7f. Understanding of Program Achievements

Umir Nuri has done well in dissemination of its results-to-date (e.g. baseline, annual, MTE, and EOP results). It has announced plans for dissemination of its EOP results in a way similar to what it did with its MTE, which involved a large group of stakeholders. A wide range of stakeholders- HQ and program staff including Perzent, the MoH at all levels from regional to *rayon* to health facility, and community representatives (*makhalla,* VHC members, *hakimyat,* mothers), have been part of the stakeholder team.

C7g. Effects of Umir Nuri's Data

Umir Nuri data have been shared with the Peace Corps, MSF/Holland, UNICEF (Nukus office), Project HOPE, JICA, The World Bank in Tashkent, the Counterpart CSP in India, CPI's overall health programs via its reconfigured health department at HQ and the Health Committee within its Board of Directors, with CORE member organizations at CORE Spring and Fall Meetings, and at Global Health Council, and through documentation. Data has been published in the "Medical Express", a subscriber journal which goes to health organizations in the Central Asia region. There is an *Umir Nuri* website where KPC, HFA, MTE, and annual report data is freely available for download.

C8. Technical and Administrative Support
C8a. External Technical Assistance

Timing	Type	Source
Yr 2001, Qtr 1:	Baseline (KPC, HFA); DIP	External Consultant Julie Mobley
Yr 2003, Qtr 2	Finance	CSP India and HQ
Yr 2002, Qtr 3	HMIS	CSP India, HQ
Yr 2003, Qtr 1	BEHAVE	Darshana Vyas, HQ provided first five days training on Behave followed by BEHAVE workshop in Cambodia
Yr 2003, Qtr 4	Hearth, Nutrition	External Consultant Donna Sillan and CORE Nutrition WG/Hearth Taskforce
Yr 2003, Qtr 3	MTE	External Consultant Arvind Kasthuri
Yr 2003, Qtr 2	Finance, BCC, Sharing Lessons Learned	CSP India
Yr 2004, Qtr 4	EOP Qualitative	External Consultant Sharon Tobing

Umir Nuri staff report that technical assistance was timely and useful. Perzent's Director mentioned that training from external/international experts was especially appreciated. Furthermore staff have mentioned that technical support and training from the director health program was excellent and she provided support especially time of difficulty and stood by team.

C8b. Unmet Needs and Suggestions for Improvement
Counterpart was satisfied with the assistance it obtained, and reported that needed assistance was available.

C8c. CPI HQ and Regional Support
This program was conceived by Darshana Vyas, Director Health Programs from CPI Headquarters. Through her diligence she was able to tap her contacts in the various health departments and health institutions, and involve many government players in Uzbekistan and Karakalpakstan, as well as the local NGO Perzent, the MoH, Counterpart other divisions implementing programs in Uzbekistan and importantly the community, in the development of the program. Community mobilization is the key to this programs success. Ms. Vyas' participatory approach has allowed the program, to become a part of the community, which is vital to the sustainability of the program interventions, activities and actions. The program that was designed was a result of the highly participatory process, which allowed for all stakeholders to participate, and have input into the proposal writing process. Guidance form USAID was constant and solicited their views in the designing of the proposal.

The intense support given by Darshana Vyas, Director of Health Programs from Counterpart headquarters, who made periodic visits to the CSP conducted various training such as BCC on BEHAVE framework , Counseling, ARI, diarrhea, Conflict

management, team building and breast feeding trainings and gave valuable inputs. Her grasp of the details of the program is commendable, and this has helped even the current Program director Ramine Baharambegi to establish a pattern of participatory management. Darshana has been fully engaged in the program from start to complete.. She lent a "day-to-day" touch, without micro-managing. She deferred to the local manager (Ramine) and Dr. Nuriah while offering constant technical guidance, support and encouragement.

Counterpart's HQ filled a needed top management gap early in the program's implementation, while recruiting for a new Director was ongoing. Once adequate management was in place, the HQ role reverted to normal backstopping. Regional Counterpart support was provided in logistics and financial support. During the first 2 ½ years, HQ support was 40-50% of a full-time individual. During the remaining program period, HQ support was 40% of a full-time individual. CPI has helped supplement this cost above the CSHGP budgeted line item. Director Health provided supportive supervision and provided all needed technical assistance and facilitated trainings. Director Health program was sharing information and facilitating staff training within and out side of Uzbekistan: Turkmenistan, Kazakhstan, India, Cambodia, and Tajikistan where similar CS programs are implemented. Program staff were encouraged to participate in conferences and seminars to share lessons learned.

There is tremendous support from the headquarters' director health programs and the senior management team as well as regional office in Kazakhstan and Tashkent. . There is a tremendous amount of agency transparency keeping the organizational structure extremely horizontal, avoiding hints of vertical programming. The director health programs and organizational commitment to Child Survival program is extraordinary.

C9. Management Lessons Learned

- It is difficult to work in Karakalpakstan without bringing "something' in besides knowledge. CHAP was so useful in this regard. The *hakimyat* became acquainted with Counterpart through the CHAP program.
- Include sufficient budget for staff to take full advantage of international training opportunities, of which there are becoming more and more.
- Invest in the capacity building of local staff is key approach in this program
- HQ played an important role in maintaining program momentum during times of key staff turnover and the style of management in this program was one of openness, respect, and trust. It is fully participatory from HQ to the field in the true sense of the word
- Having a Counterpart office in Tashkent proved useful for logistics.
- Cross visits to and from the India, Turkmenistan CSP was useful.
- There are excellent opportunities for strong working relationships with other Counterpart International programs in Karakalpakstan.
- A few key people need to be involved throughout the LOP, to build relationships.
- Additional private funds which Counterpart International allocated for additional HQ Director Health Programs visits for boosting morale, technical assistance, and relationship building/building confidence were well used.

- Key staff positions need to be at I-NGO, vs. NGO, wage standards, to retain the caliber of staff needed for capacity building.
- There needs to be the right personality and commitment for collaboration and networking.
- When working in the FSU, MoH involvement at all levels strengthens the program. It would be difficult to even talk with *makhalla,* for example, without MoH support. The MoH acts as a facilitating agent with government.
- The transparent management style *Umir Nuri* now has resonates well with the MoH. Also, independence/decentralization/thinking for one's self has been a managerial approach at all levels: Field Officers make decisions, articles are published, and training is selected, all without unnecessary bureaucracy, e.g. participatory management is engaged.
- Being able to delegate to others with know-how is "tough love", and necessary.
- Sharing the program lessons outside of the program: The exposure of the program staff to sharing sessions and workshops brought presentation skills. This sharing not only benefited the those outside the program, but provided the staff with the need to reflect and share

D. OTHER ISSUES

The FE team recognized that collaboration with other organizations engaged in health and related activities has been an important aspect of *Umir Nuri* and a contributor to its success. The American Red Cross conducted Title II distribution of food commodities for TB patients and their families up until this current fiscal year, with which *Umir Nuri* assisted in its two target *rayon*. A Peace Corps Volunteer has been assigned to *Umir Nuri* for the past two years. The current PCV is a medical professional who serves more than half-time as a Technical Advisor. He has been particularly involved in BCC activities and preparing a foundation for future HIV/AIDS action through collection of a baseline. The Healthy Communities Project is closely linked with *Umir Nuri.* Counterpart is housing both programs in the same building to facilitate complementary implementation. The ability for VHCs, the Breastfeeding Support Groups, and other CBOs initiated though *Umir Nuri* to be able to independently access funds for health priorities of their own choosing is an opportunity generating tremendous excitement in communities and at *rayon* levels. While the HCP has funding, it does not have an extensive technical staff. The HCP is actively planning on ways that *Umir Nuri* could become much more closely involved in providing technical training, technical review to concept papers, and technical assistance to grantees. *Umir Nuri* has also developed close ties with MSF/Holland, which has been engaged in Karakalpakstan with work in TB including DOTS+ and multi-drug resistance, HIV/AIDS, and mitigation of environmental hazards associated with the Aral Sea disaster. Currently, Counterpart and MSF/Holland are jointly implementing a Risk Reduction Project, housed with *Umir Nuri.* Project HOPE is a very prominent health I-NGO in Central Asia including Uzbekistan where it is conducting a Child Survival Program in addition to its MCH/RH Program. CPI and Project HOPE have kept in close contact, sharing ideas (the Breastfeeding Support Group pilot is a Project HOPE idea) and their Program Directors have been members of each other's evaluations. The PCV, the HCP Director, the Project HOPE Project Director, and

two MSF/Holland staff were part of the FE team as representatives of collaborating organization stakeholders.

E. CONCLUSIONS AND RECOMMENDATIONS

E1. Status of Objectives/Outcomes; Conclusions

Refer to the table in B.1 for the EOP status for each objective, by indicator.

Umir Nuri achieved all but one of its 15 objectives. Some objectives were completely achieved as measured by all indicators: objectives 1, 2, 5, 12, 13, 15. Some objectives with multiple indicators had a majority of indicators achieved: objectives 3, 4, 7, 8, 9, 10, 14. Objective 6 was absorbed into Objectives 9-15. Objective 11 was not achieved. Translated into outcomes/results, this means that *makhalla* committees have become engaged in health, holding VHCs and instituting CBOs to inform mothers about key health actions. *Makhalla* committees are putting demands on *rayon* authorities to meet health needs, and these needs are being met. Perzent staff and the MoH have needed skills and materials for conducting effective BCC. Experienced TOT teams exist in both *rayon*, and have been used for peripheral health facility staff training. Staff in peripheral health facilities were trained to use WHO's SCM for pneumonia and diarrhea, and to promote breastfeeding, and they are moving into IMCI to complement remarkable increases in knowledge and practice of key health messages in households. More work is needed to stabilize stocks of cotrimoxizole in health facilities; overall antibiotic availability for pneumonia has shown some improvement.

Mothers are making better informed decisions regarding the health of their children. They are recognizing serious symptoms and going more quickly to nearby health facilities for suspected pneumonia. They are effectively treating routine diarrhea at home. They are recognizing and going to nearby health facilities for serious diarrhea. They are immediately breastfeeding their newborns. They are exclusively breastfeeding their infants up to six months of age.

Umir Nuri exhibited a system for monitoring its activities which provided a practical model for Perzent and the MoH for using data for health action. Perzent's staff are using new skills in evaluation/monitoring, finance, and management. Perzent has increased its activities in health in the region. Effective ways to document and disseminate impact and lessons learned have been modeled for Perzent and the MoH.

In summary, CPI, Perzent, and the MoH of Karakalpakstan are to be commended for making a significant contribution to the health of children in the two target *rayon*.

E2. Most Important Achievements, Constraints, Other Factors

Umir Nuri has developed a methodology for mobilizing communities for health action which is extremely effective. The results of the KPC indicate that mothers have experienced very significant changes in their understanding and practice of key health actions relating to pneumonia, diarrhea, and breastfeeding. *Umir Nuri* also formed important health linkages between families and local government, between communities

and health facilities, and between communities and *rayon* government and external resources, which are making positive contributions to community health.

While *Umir Nuri* chose to concentrate more extensively on impacting community and household level knowledge and behaviors and important linkages, it also worked with the existing health system so that health workers in peripheral facilities would be better able to meet the demand it was encouraging from households. Proxy measures show important improvements in the changeover from baseline practices to WHO SCM, backed by training records and MoH opinions. A further change-over to IMCI occurred during the program's final year, too soon to measure its impact, although the overall trend/direction is positive. The MoH is eager to continue to work with CPI, especially in its upcoming roll-out of IMCI. An excellent working relationship exists.

Cotrimoxizole supplies at two measurement points remained static at the two measurement points, at inadequate levels. MoH health providers would prefer to use cotrimaxazole and amoxocyllin, the drugs of choice in the treatment of pneumonia, but they resort to prescribing other antibiotics because they are the only ones available.

Perzent participated in *Umir Nuri* activities throughout the LOP and has gained a practical perspective on MCH programming. It remains a significant health player in the region.

In summary, *Umir Nuri*'s most noteable achievements have been its ability to successfully mobilize communities to engage in important health actions, change health practices in mothers for positive health impact in their children, form important linkages which meet community health demands, and build a successful working/professional relationship with the MoH.

E3. Best Practices, Lessons Learned

Best practices/lessons learned have been included at specific points in this report, as they relate to specific activities. Attachment 5 contains best practices/lessons learned identified by the full evaluation team. Using as its basis a list of eight evaluation priorities generated by the full (large) group of program stakeholders as part of the final evaluation process, highlights include:

Umir Nuri activities to positively change mothers/caregivers practices in breastfeeding/diarrhea case management/pneumonia case management (3 priorities are grouped together here): the BCC approach was effective; work through a variety of channels, including local leaders, peers, mothers-in-law, written materials; information needs to be presented "just in time" in order to influence mothers' breastfeeding behavior; BFP requires both community and facility components with a large emphasis on the community side.

Umir Nuri's VHCs, VHWs impact on mother/caregiver health practices: VHWs use of BCC was very effective; use follow-up household visits to reinforce messages; locate VHCs outside of MoH facilities.

Umir Nuri activities to mobilize communities to support important health practices: using *makhalla* was effective; the role of VHWs/FOs was essential; written materials were effective; links to external resources has helped keep interest high; use local women as VHCs; involve community elders; a few well established VHCs is more important than lots of less established VHCs; establish links between CSCC, VHCs and the community; improve the work of VHCs through non-monetary incentives.

The role of *Umir Nuri* BCC strategies in improving mother/caregiver practices: respond to community needs; focus on cultural sensitivity, easy to understand language, and engaging designs and layouts; establish an open and comfortable rapport with beneficiaries; presentation of health messages, including trainings, should coincide with seasonal needs; pre- and post- test BCC materials.

The role of *Umir Nuri* training in improving MoH services in peripheral health facilities and maternity homes: Invite outreach staff as well as MoH facility decision-makers to the VHC; involve supervisors in all training and field follow-up; parallel trainings at health facilities and community levels complemented and reinforced one another; have appropriate measurement techniques to measure progress.

Umir Nuri efforts to create sustainable activities: The linkages formed between communities and *rayon* authorities are proving an important aspect of the sustainability plan.

Other highlights:

Pharmaceuticals: align program objectives with MoH policy (or to what changes in policy the program plans to achieve); use CHAP more frequently to fill gaps; include Village Pharmacy or similar pilots upfront in MoUs.

Partnership and Capacity Building: Organization-building (beyond increasing health capacity) is needed; involve key partner staff from the start; concentrate capacity-building activities on permanent staff; use more external expertise for training events and specific capacity building; the I-NGO should take on a more advisory, facilitative role; CHAP donations helped build a successful relationship with the MoH/local government early on; assessing capacity building results would be better gauged a year from EOP; when working with a young NGO, select those staff members whose work is cross-cutting for capacity building training and follow-up; budget for international training opportunities; there is not a large cadre of trained and experienced staff in this region, e.g. staff need to be "built".

Management: The Health Department under the directorship of Ms. Darshana Vyas utilizes a transparent management style. There was significant time spent on team building activities which helped to maintain cohesiveness and develop trust that began to deteriorate due to some trying times during the beginning of the program, this time was well spent, and helped to boost field staff morale. HQ played an important role in

maintaining program momentum during times of key staff turnover. The style of management includes supervisors in all training events of staff. Also having a Counterpart office in Tashkent proved useful for logistics; cross visits to and from the India, Turkmenistan, Tajikistan CSP were useful.

E4. Recommendations for USAID/GH/CSHGP, Umir Nuri/Perzent Program Staff, MoH/Counterpart International HQ

USAID/GH/CSHGP:

- *Umir Nuri* needs more time to consolidate the progress it has made in sustaining key activities, principally those involving the MoH (potential establishment of new VHCs) and *hakimyat* authorities (transfer of VHWs/FOs), and in follow-up to IMCI training. Six months may not be adequate.
- An excellent opportunity exists for USAID to assist in IMCI roll-out on a regional scale, using effective HH/C-IMCI to build community practice and demand.
- An effective, experienced team is available now in Karakalpakstan which can conduct CSHGP activities. USAID at all levels could continue utilizing this resource that it has helped to build, for additional health activities.

Umir Nuri/Perzent Program Staff (for future work):

- Continue to use your proven approach for community mobilization, e.g. VHWs/FOs, *makhalla*, BCC approaches and materials. It works extremely well.
- Work on an advisory basis with the MoH and other future partners, rather than performing community-based/household-based/training activities yourself (or bring your partners into this role rapidly).
- Your staff should be facilitators who are experts in their fields, or who can develop needed expertise quickly with a minimum of training.
- All partner staff performing program activities should either be already hired and working for the partner, needed for only a limited period in program activities, or funded through the CSHGP for a limited period before being picked up by the partner through its own funds or through new sources/grants (which are ideally non-USAID).
- Include more follow-up training for MoH peripheral staff when introducing SCM/IMCI. In general, more sessions and more days per session should be planned for training for MoH staff when establishing SCM. Training should include documented use of the new algorithms in practice.
- The MoH supervisory system is working in Karakalpakstan: facilities visited by the EOP team are receiving regular visits. Use this resource more pro-actively. Involve MoH supervisors in all training of the staff they supervise. Support them to provide the needed oversight on operationalization of training in clinics, keeping your role facilitative. Add additional activities to strengthen supervisory support, such as use of checklists, and potentially LQAS using a modified HFA. Support meetings where results of checklists/visits/assessments are discussed on a regular basis, and recommendations are made to fill in identified gaps.

- Follow through with the Village Pharmacy initiative. Involve an external consultant who has experience with RDFs in the FSU and in cash-poor settings to help jump the high hurdles.
- Include activities which help ensure that appropriate PCM medications are continually stocked in peripheral health facilities. Include increased monitoring of drug distribution systems through regular MoH channels, and support meetings where results are discussed on a regular basis. It would be helpful to look at stock inventories/stock-outs of essential pharmaceuticals in all or at least most involved facilities on a monthly or quarterly basis (you could use a smaller sample if it is part of an LQAS sampling frame).
- Consider working on a pilot basis with the MoH to move toward international (WHO) standards for diagnosis and reporting as part of HIS strengthening.
- Be more vigorous in identifying and discussing all deaths in children under age five. Consider adding a "verbal autopsy" activity if deaths are not being reported to authorities who can provide definitive diagnosis.
- Revise the HFA so that it can adequately assess the utilization of SCM in trained health workers and other program indicators as needed. There are other tools available too which could fit your needs better.
- At the start of new activities, ensure that the HMIS is adequately tracking every indicator.

MoH:

- In light of the anticipated roll-out of IMCI in the near future, consider a session--within the next few months --to jointly study the IMCI pilot with UNICEF and *Umir Nuri* which have both been recently completed. This would be to compare approaches, findings, conclusions, lessons learned, best practices, and results of both activities as part of a pre-planning process for the roll-out. *Umir Nuri* is an example of effective implementation of IMCI component III, which used a different approach from that used in the IMCI pilot (perhaps there are ways to take the best of both for the roll-out). There are also documented successes in the *Umir Nuri* training approach (IMCI component I) from which lessons learned and materials/guides/curricula can be collected.
- The HFA documentation of inventory for cotrimoxizole, the WHO recommended antibiotic for treatment of pneumonia, showed no change (although it only measured two points in time). Consider discussing policy regarding the drug(s) of choice for pneumonia, ways to ensure a steady supply, as well as ways that NGOs can assist in this.
- A drug schedule could help start a process of regulating the availability of essential drugs before drugs needing a physician's oversight become more widely available through private sources, and potentially abused.
- There may be ways that field staff of partner NGOs can help the MoH by identifying child deaths which may not have been reported, and providing following-up with families and communities, as well as tracking and following-up serious morbidity, which could be reported directly to health facilities or *rayon* health authorities. This could become an opportunity to find ways to prevent future deaths.

- Staff members in clinics are reporting an appreciation of the relationships being built with communities through membership in VHCs. Consider following up on the regional-level MoH suggestion of establishing VHCs yourselves in new *rayon* which can work with health staff to reach out to communities and convey essential health messages and teach essential health practices.

Counterpart International HQ:

- Counterpart International needs to protect its investment of funds and time, and its repository of success and good-will in in Karakalpakstan. It is essential to establish a bridge program which would cover the period October 1-September 30 (next fiscal year) at which time new CSHGP funds are anticipated. Funding is available from the DoD, but the anticipated activities need to be fine-tuned. The program could facilitate any of the following, but certainly the first 3 or 4:
  - the remaining phase-over of activities in VHCs and CSCCs;
  - support the transfer of field staff to the *hakimyat;*
  - work with the MoH for the core training team to deliver refresher training on IMCI with an emphasis on pneumonia and diarrhea;
  - pilot training with the MoH on establishing a VHC and/or using a visiting nurse in place of a VHW;
  - commission a study on the current antibiotic supply situation in light of the upcoming IMCI expansion;
  - provide technical support services to the Healthy Communities Project (for which HCP can pay);
  - assist in developing the CSHGP proposal.

  Funding would come from the current CSHGP (for *Umir Nuri* activities only) until those funds are depleted, up through March 2005 if needed, the DoD funding, and the HCP for services may rendered. Other potential sources (which need to be explored) are:

  (1) the Republican Institute for HIV/AIDS which just signed for a traunch of Global Fund funding for HIV/AIDS. The *Umir Nuri* network and team is ideally suited for HIV/AIDS work, and a baseline and follow-up survey on HIV/AIDS knowledge and practice was included as part of the KPC.

  (2) liaison with organizations involved in the Title II monetization of soybeans for potential local currency funding.

  (3) USAID/Tashkent also suggested training opportunities with AED's START Program.

E5. CPI HQ Plan for Utilizing Best Practices/Lessons Learned

CPI HQ remains an active member of the CORE Group and utilizes this mechanism as a major means of sharing its best practices and lessons learned with the Child Survival and

wider MCH community. CPI is also an active member of the Global Health Council, and uses this venue to share its experiences. CPI HQ also utilizes its Health Committee within its Board of Directors, and information systems, as means to ensure that experiences and data/information gained in any particular program are shared throughout its global health network. CPI health director has already started promoting best practices, strategies and methods in to other non CS health programs. KPC, HFA are now used in MCH and other health programs in Turkmenistan, Tajikistan and Vietnam. CPI is also planning a regional conference in Asia and central Asia to share lessons learned from the CS program. Furthermore, CPI has already shared HMIS system with the MoH that is now being adopted in to the Karkalkapstan system. IF CPI receives funds for the expanded category, CPI will expand this approach into neighboring rayons to reduce infant mortality.

E6. Potential for Scale-Up and Expansion

The potential for scale-up of *Umir Nuri* and expansion to other health sectors is excellent. Counterpart International already recognized this with their submission of an Expanded Impact proposal to the CSHGP in 2003. It would be a most unfortunate waste of opportunity, expended resources-to-date, experience, and good-will if Counterpart International and USAID are unable to exploit the excellent operating environment which exists now, for scaling up/expanding *Umir Nuri's* successes to the remaining 13 Karakalpakstan *rayon* as part of the upcoming IMCI expansion, and/or using the existing effective infrastructure to move into other health sectors of need such as HIV/AIDS prevention, support to the national TB control program (perhaps in partnership with MSF/Holland), micro-nutrients, and/or safe motherhood/newborn care. Working with the Karkalpakstan MoH has a unique potential for introducing new and particularly effective ways of working to the entire MoH system of Uzbekistan.

F. RESULTS HIGHLIGHTS

F1. Problem Addressed

Umir Nuri addressed a low coverage of exclusively breastfed infants under six months of age.

F2. CSHGP Inputs

The CSHGP supported the development of a zero-tolerance approach which effectively mobilized communities, health staff, family members, and mothers to provide no additional liquids above breastmilk to infants from the moment of birth, delaying weaning until six months of age. This included:

- sensitization training of local government authorities in villages (*makhalla* committees);
- establishment of village health committees, breastfeeding support groups, and schools of mothers through *makhalla*, to support breastfeeding mothers;
- training and deployment of health professionals to areas with and without village health committees to sensitive community leaders and support breastfeeding mothers;
- development of excellent behavior change communication materials (pamphlets, booklets, posters, curricula, videos, TV spots, etc.);

- training of MoH health workers in behavior change communication and breastfeeding promotion at the places where they meet pregnant and delivering mothers, e.g. peripheral health facilities and maternity homes.

F3. Magnitude of Intervention

The *Umir Nuri* program covered two *rayon,* Nukus and Takhtakupir, in the autonomous Karkalpakstan Region of Uzbekistan. The programs covered a total population of 86,910 of which 23,569 women are of reproductive age. The birth in both rayons is about 22 per 1000. The number of newborns in both rayons is around 1900 a year.

F4. Quantifiable Results

At baseline, using a 30-cluster random sample KPC survey, 30.5% of infants under six months of age were exclusively breastfed, receiving no other liquids or solids. At the endpoint measurement approximately 3 ½ years later, using the same measurement tool and parameters, 74.5% of infants under six months of age were exclusively breastfed. This represents a significant increase, and an achievement significantly above the targeted 60%.

The Karakalpak MoH has noted this achievement with interest, which coincides with recent proclamations from the central MoH prohibiting the promotion of infant formulas and advertising in maternity homes. The MoH played an important role as a collaborating partner throughout the program, and verified the quality of the sampling technique during measurement.

Success is attributed to several factors: involvement of the *makhalla* and respected leaders including *mulla* in the village health committees; involvement of mothers-in-law who exercise considerable control over child rearing along with fathers; effective behavior change materials which were written in an easy-to-understand, culturally appropriate yet interest-catching manner; vigorous training of peripheral MoH health workers at all points where they meet women of child-bearing age, pregnant women, and newly delivered women so that all messages are complementary and coordinated; and receptivity of mothers to new ideas presented in written form.

Attachment 1. Evaluation Team Members

Participants in Stakeholder's Meeting, August 26, 2004

Team 1
Sharon Tobing, Independent Evaluator
Sara Utegenova, Senior Health Education Specialist/Trainer, Counterpart (CPI)
Elmira Kurbanbaeva, Member of the School of Mothers, Nukus Rayon
Sagitjan Aitjanov, Health Information Coordinator, Interpreter, CPI

Team 2
Darshana Vyas, Director of Health Programs, Counterpart International HQ
Gulzapira Abildaeva, Chief Infectiologist, District Policlinic, Nukus Rayon
Artik Kuzmin / Mels Kutlimuratov, Program Assistants, Center Perzent
Tazabay Uteuliev, Interpreter, CPI

Team 3
Ramine Bahrambegi, Program Director, Child Survival Program, CPI/Uzbekistan
Kalbaeva Raya, Chief Doctor /IMCI Trainer, Children's Policlinic, Takhtakupir Rayon
Mukhamatdin Pirnazarov, Program Coordinator's Assistant, Medicines Sans Frontieres – Holland, Nukus office
Makhset Samambetov, Interpreter, external

Team 4
John Brown, Technical Advisor, Peace Corps Volunteer
Azamat Matkarimov, Health Communications Specialist, CPI
Zubaida Sagidullaeva, Teacher, School #4, and Takhtakupir Rayon Center VHC member
Dina Ishchanova, Neonatologist /Trainer on Breastfeeding, Maternity House, Nukus City
Alpamis Babaniyazov, Interpreter, external

Team 5
Jamal Kamalov, Program Coordinator, Risk Communication Project, MSF and CPI
Yulya Miroshnichenko, Communication Officer, CPI
Natasha Rodney, Director Health Programs Assistant, Counterpart InternationalHQ

Attachment 2. Evaluation Assessment Methodology

Counterpart International developed a final evaluation process featuring participatory methods designed to accomplish the following tasks as outlined in its SOW:

- document the impact of the *Umir Nuri* program on the target population;
- assess *Umir Nuri* activities and strategies;
- highlight promising practices, new approaches, and innovative activities;
- assess Counterpart's capacity building strategies and their ability to enhance the capacity of the Ministry of Health, the local NGO partner Perzent, and community-based organizations and groups;
- assess the impact of behavior change communication (BCC) training, materials, and activities;
- identify additional lessons learned based on the full program duration.

An internally conducted 30-cluster random sample KPC survey was conducted by the *Umir Nuri* staff using the same *Umir Nuri*, Perzent, MoH, and contracted supervisors and interviewers as used for the baseline and mid-term KPCs. Other than some minor refinements to the translation of the tool into Karakalpak, the EOP tool remained the same as for the mid-term KPC. The process was observed by the MoH for compliance with principles of randomness and quality. Two days of refresher training, actual surveying in the two rayon, and data entry/initial analysis were conducted during the period of August 5-14, 2004. Results were available to the qualitative team.

An internal Health Facilities Assessment was also conducted during the period of August 16-20, 2004, using two of the four tools used in the baseline and mid-term HFA. With only a year passing from the mid-term HFA, two tools (Equipment and Supplies Checklist, Caretaker/Parents' Interview) were not included in the EOP. Data entry and analysis were not yet completed during the time of the qualitative evaluation, so were not available to the full evaluation team. Data was provided to the external facilitator after the qualitative assessment in the field, and this data and analysis by her and the *Umir Nuri* staff were incorporated into the final evaluation report.

Initial discussions involving an external facilitator, Counterpart's HQ, and *Umir Nuri* field staff (including the partner NGO Perzent and MoH) culminated in 8 days of qualitative assessment in the field during the period of August 25-September 3, 2004. Evaluation activities were initiated with a Stakeholder's Meeting on August 26 which involved key HQ and program staff from Counterpart and Perzent; MoH representatives from the regional Karakalpakstan level, *rayon*-level (polyclinic and referral hospitals), and peripheral facility-levels (SVPs, SVAs, SUBs, FAPs, etc.); community representation from the two rayon-level *hakimyat* offices and mothers involved in breastfeeding support groups and schools of mothers; and the collaborating organizations of MSF/Holland, Project HOPE's Child Survival Project in Navoi, and the Peace Corps. A day of program review including presentation and discussion of the results of the most recent KPC culminated in the selection of priority areas for the evaluation team to focus

their attention, based on the *Umir Nuri* Detailed Implementation Plan. Stakeholders worked in the following five groups to come to consensus on their priorities:

Group 1: *Umir Nuri* staff (Counterpart and Perzent)
Group 2: regional and rayon-level MoH
Group 3: MoH peripheral health facility staff
Group 4: community representatives
Group 5: collaborating organizations.

The top 3 priorities for each group were compiled, and significant overlap was observed. Eight Stakeholder Identified Priority Areas emerged:

- mothers/caregivers practices in terms of breastfeeding, control of diarrheal disease, and pneumonia case management (each intervention was considered separately);
- impact of Village Health Committees (VHCs) and village health workers (VHWs) in improving mother/caregiver health practices;
- mobilizing communities to support important health practices;
- role of *Umir Nuri's* BCC strategies in improving mother/caregiver practices
- role of *Umir Nuri* training in improving MoH services in FAPs, SVA/SVP/SUBs, and maternity homes;
- program efforts to create sustainable activities.

These priorities guided the evaluation team in the field. They were subsequently used as "filters" for organizing the team's findings, conclusions, and recommendations, which is incorporated in this report as part of Attachment 5.

An evaluation team was drawn from among the Stakeholders and included senior *Umir Nuri* staff from Counterpart and Perzent, several MoH staff, community representatives, and representation from MSF/Holland and the Peace Corps. Kindly refer to Attachment 1 for a list of names and titles of all evaluation team members.

A sub-set of the full team (referred to as the Planning Team) were tasked with:

- finalizing the draft daily team schedule of interviews and focus group discussions;
- editing and translating lists of guiding questions for focus groups and interviews, ensuring that the eight Stakeholder Identified Priority Areas were emphasized. Question guides were finalized for interviews with the MoH at all levels including facilities, local government (*hakimyat* and *makhalla*), and *Umir Nuri* staff, and for focus group discussions with VHCs, VHWs, grandmothers and mothers;
- dividing the full team into five sub-teams with representation from external groups, the MoH, and *Umir Nuri* staff. Logistics for transportation and translation were then finalized.

The five sub-teams each spent a day in Takhtapukir *rayon* and Nukus *rayon*. All communities (*aul*) in a *rayon* were divided into "close-in" or "remote" lists by field staff. Then, both lists were sub-divided into "community is close to a VHC" or "community is remote to a VHC" lists. Then, using a computerized random selection process, one

community was randomly selected from each of these four categories and randomly assigned to a sub-team. A community of the opposite characteristic was assigned to the sub-team in the second *rayon*, enabling each sub-team to observe potential differences between near and remote communities, and those adjacent to or remote from the 18 VHCs established by *Umir Nuri*.

Sub-teams interviewed *rayon* level MoH and government (*hakimyat)* representatives; interviewed community leadership in *makhalla* committees and/or VHCs; visited and observed the most utilized peripheral health facility(ies) for the community and interviewed key facility staff who formed a key target group for training; interviewed VHWs; and interviewed mothers and grandmothers who formed the key target group for BCC activities.

Over an additional two-day period, the four sub-teams also conducted interviews with various *Umir Nuri* staff (training, BCC, HMIS, supervisors, administration, finance), and local collaborating organizations (Peace Corps, MSF/Holland).

Kindly refer to Attachment 3 for a list of individuals interviewed and contacted.

The full team then spent 1.5 days discussing their findings, conclusions, and recommendations using the eight Stakeholder Identified Priority Areas as "filters". Kindly refer to Attachment 5 for a consensus paper prepared by the evaluation team on findings, conclusions, best practices, lessons learned, and recommendations by Stakeholder Identified Priority Area.

The external facilitator utilized the consensus work and paper to draft the final evaluation report, which was then reviewed by several members of the evaluation team for completeness and integrity to the process.

Attachment 3. Persons Interviewed and Contacted

Takhtakupir *Rayon* Focus Groups and Key Informant Interviews:

- Aysanem Allayarova - Deputy Hakim on Women's Issues, Takhtakupir Rayon
- Focus Group Discussion (FGD) with 9 VHC members and 2 BFSG members, Makhpalkol village
- FGD with 11 mothers, Bessari village
- FGD with 13 grandmothers, Bessari village
- Begimova Risgul, Chief Doctor of the SVP in Makhpalkol
- FGD with 2 Counterpart VHWs (Gulchekhra Pirjanova and Guljahan Allambergenova) and 2 Perzent VHWs (Svetlana Sagidullaeva and Zulfia Rametova)
- Mariyash Koshimova, Chief Doctor, Central Rayon Hospital (CRH), Takhtakupir Rayon
- Kazakov Azat, Chief Doctor, Maternity Department, CRH, Takhtakupir Rayon
- Dauranbek Berikbaev, Chief of Makhalla Committee, Mulk village, Atshabar aul.
- FGD with Mambetov Mukhan, Chief of Community Council/VHC leader, and 5 members, Atshabar
- FGD with 9 nurses, SUB, Mulik village
- FGD with 6 mothers, Mulik village
- FGD with 7 grandmothers, Mulik village
- Raya Kalbaeva, Chief Doctor, Children's Policlinic, Takhtakupir Rayon
- FGD with 4 VHC members, Tazajol village
- FGD with 4 mothers, Tazajol village
- FGD with 6 grandmothers, Tazajol village
- Jumamuratov Abat, Chief Doctor of SVP, Dawkara village
- FGD with 5 nurses, FAP, Kumetek village
- FGD with Perzent VHWs Roza Jannazarova, Sveta Sagidullaeva and Arzigul Uteeva
- Jalgasbaev Niyetbai, Chief of Community Council and VHC leader, Borshitaw
- FGD with 6 VHC members, Borshitaw
- Kaltaeva Galya, Chief Doctor of SVA, Borshitaw
- FGD with 4 mothers, Borshitaw
- FGD with 4 grandmothers, Borshitaw

Nukus *Rayon* Focus Groups and Key Informant Interviews:

- Kudyar Narbaev, Chief Doctor, Central Rayon Hospital
- Kalillaev Marat, Chief of Community Council
- FGD with 2 nurses, SVP, Kerder village
- FGD with 6 mothers, Kerder village
- FGD with 8 grandmothers, Kerder village
- Koshkarbai Sadikov, Nukus Rayon Hakim
- Hurliman Berdieva, Deputy Hakim on Women's Issues
- Begimabai Kaipanov, Assistant Hakim
- Kutlimuratov Niyetbai, Chief of Community Council, Kalmen aul, Ornek village
- FGD with 2 Nukus Rayon CSP VHWs (CI)
- FGD with 2 Nukus Rayon CSP VHWs (Perzent)

- FGD with 7 nurses, SVP, Ornek village
- FGD with 5 mothers, Ornek village
- FGD with 6 grandmothers, Ornek village
- Bekmuratova Ayjamal, Injigul Tilewova, MOH trainers
- Shukurbai Matneyazov, VHC leader, Otarbai aul
- Rosa Bekmuratova, Chief gynecologist, SVP, Shortanbai village
- FGD with 8 nurses, SVP, Shortanbai
- Gulbahar Murtazaeva, Chief Doctor of Policlinic, Nukus
- Suluwkhan Utenyazova, Chief Pediatrician, Nukus
- FGD with 4 VHC members, Darsan village
- Jaqsiliq Murtazaev, Chief of Akmangit Community Council
- FGD with 4 mothers and 1 grandmother, Akmangit.

Perzent and *Umir Nuri* Staff Key Informant Interviews:
- Oral Ataniyazova, Director, Perzent
- Mels Kutlimuratov, Program Assistant, Perzent, and *Umir Nuri* staff
- Ramine Bahrambegi, Program Director, *Umir Nuri*
- Azamat Matkarimov, HMIS Specialist, *Umir Nuri*
- Sagitjan Aitjanov, HMIS Assistant, *Umir Nuri*
- Sara Utegenova, Health Education Specialist, *Umir Nuri*
- Lilya Kim, Finance & Administration Director, *Umir Nuri*

Counterpart International Staff Key Informant Interviews:
- Darshana Vyas, Health Programs Director
- Sergei Sultanov, Coordinator, Healthy Communities Program (HCP)
- Shukhrat Aripov, Program Coordinator, Healthy Communities Program (HCP)/Tashkent
- David Smith, Program Director/Country Representative, Civic Advocacy Support Program (CASP)/Tashkent

MoH Regional/National Staff Key Informant Interviews:
- Nuriyah Aitjanova, Deputy Minister of Health, MCH, Ministry of Health
- Sveta Allambergenova, Chief Pediatrician, Ministry of Health
- Davron Ibragimov, UNICEF Coordinator on Health Care and Nutrition Projects in the Republic of Karakalpakstan and Khorezm Province in the UzMoH

Other Collaborating Organizations' Staff Key Informant Interviews:
- John Brown, Peace Corps Volunteer, Technical Advisor to *Umir Nuri*
- Jamal Kamalov, Project Coordinator, Risk Communication Project, MSF and CI

Attachment 4. CD

Enclosed with the hard copy report, please find a CD with an electronic version of the report.

Attachment 5. Special Reports (Logframe, Map, EOP Team Report)

Logical Framework for the *Umir Nuri* Child Survival Program

Capacity Building			
Objectives	**Indicators**	**Measurement**	**Major Activities**
Counterpart has increased capacity to document and disseminate impacts/lessons learned related to child survival programs	• A system for documentation is institutionalized in computerized database and in Counterpart's in house library • Lessons learned disseminated externally through regular reports to USAID and CORE, CSTS, Counterpart web page, and publication of a series of working papers on child survival • Lessons learned will be exchanged, shared and disseminated within MOH, NGOs, and other donors	• Final lessons learned document produced • Program staff aware of lessons learned process and implications • Web page updated regularly, and links to CS reports added • Regular reports • Working papers • MOH, NGOs, community and donors participated in lessons learned	• Set up management process to review and document lessons learned • Develop and disseminate reports on annual (or other appropriate) basis • Update web page, including links to reports on lessons learned and other CS sites • Establishment of Health Committee within Board of Directors • Publish working papers • Dissemination workshops
Counterpart has improved systems in place for monitoring child survival programs	• Counterpart has an M&E system that has been appraised and approved by external monitoring and evaluation specialist by end of year 1.	• M&E reports produced every six months by in-house staff with the assistance of technical consultant and later independently by Counterpart staff	• Design M&E system • Train Counterpart staff in use of M&E • Produce M&E reports every six months • Hire independent outside technical consultant to evaluate the system
Build capacity in *Perzent* and MOH staff to implement child survival programs	• # of BCC activities, training, and peer education activities organized and implemented by *Perzent.* • # of staff trained in SCM, PCM, breast-feeding, CS technologies that have conducted at least one supervised training session for each topic • # of joint sessions for documentation of lessons learned.	• Continued achievement of all program objectives • Training records • Skill checklists • TTAP • Quarterly reports • Evaluations • Program HMIS reports	• Training in SCM, PCM and breast-feeding interventions and BCC • Monitoring and supervision of training and implementation • Broad participation in the organization and implementation of the baseline survey, midterm and final evaluations • Workshops for data analysis and sharing information • Program review on a quarterly basis

Sustainability			
Objectives	**Indicators**	**Measurement**	**Major Activities**
Perzent and targeted SVPs improve skills and quality of care in CDD, PCM, breast-feeding and interpersonal communication	By the end of the program: • Increase % of SVP and other MOH facilities with trained staff who are providing DCM and PCM services, and breastfeeding promotion. • Enhanced capacity of *Perzent* in specific child survival interventions. • Increase % of staff using satisfactory and appropriate health communication and counseling during and following the clinical examination and treatment of children in SVP and MOH facilities.	• MOH data • HMIS data • Ongoing monitoring and supervision records • Final evaluations • HFA and health worker competency questionnaire • MOST • COPE	• Conduct skills training in CDD, PCM, breast-feeding, HIV/AIDS, data collection and communication • Design and maintain HMIS • Conduct training in maintenance and use of HMIS and other records • Develop supervision checklist • HFA at midterm and endline
Targeted makhalla committees and VHCs have the capacity to implement local health education interventions	• # of VHCs established and trained • # of makhalla committee members appointed/elected to VHCs • Quality of BCC materials • # of BCC materials developed • # of VHC members who continue to volunteer their time one year after their initial training	• Ongoing monitoring and supervision records and other program records • Training records • Baseline, final evaluations • BCC materials	• Conduct workshops for makhalla committees and VHCs in CDD, PCM, breast-feeding interventions, HIV/AIDS and communication • Develop and implement BCC strategies • Facilitate election/appointment of makhalla committee members to VHCs
Measurable increases in service-seeking behavior	• See Intervention Indicators	• See Intervention Indicators	• See Intervention Indicators
To establish lasting, local institutions capable of sustaining systems for promoting positive change in health behaviors.	• # of communities in the target area with trained and functioning VHCs by the end of the program. • # of VHC members who continue to volunteer their time one year after their initial training. • # of SVP and other MOH facilities in the target area with "master" trainers in PCM, DCM, and breastfeeding promotion by the end of the program. • # of SVP and other MOH facilities located near VPs staffed by trained village pharmacists. • *Perzent* will have enhanced capacity in financial, human resources, and logistics management,	• Ongoing monitoring and supervision records and other program records • Training records • HFA • Organizational assessment for *Perzent* • MOST, TTAP • Existence of strategic plans for expansion • Minutes of VHC meetings • Intervention and capacity building indicator matrices.	• Facilitate election/appointment of makhalla committee members to VHCs • Conduct HFA. • Conduct organizational assessment of *Perzent*. • TOT for MOH staff. • Training of village pharmacists. • Establish village pharmacies. • Training of *Perzent*, SVP/MOH staff, VHCs and makhalla committees in technical interventions, management skills and BCC, interpersonal communication, community

	supervision, and monitoring and evaluation methodologies by the end of the program. • *Perzent* will develop plans for expanding the CS Program into additional rayons in Karakalpakstan by the end of the Program.		data collection, etc. • Joint activity planning and implementation with partners at SVP and community level. • Review and promote positive changes in regular CSCC meetings.
Alternative funding and cost-recovery systems in place to continue CS interventions beyond LOP	• *Perzent* continues to assist the MOH in child survival interventions in the targeted region • *Perzent* will develop at least 3 proposals and submit them to donors for funding by the middle of year 4 of the program. • Village Pharmacies have 70% cost recovery by the end of year 2.	• Final evaluation • TTAP • Final sustainability conference at the end of the program • Quarterly reports • Pharmacy inventory reports, financial reports, CORE assessments • Number of submitted proposals by *Perzent*	• Capacity building • Training in fundraising • Outside consultant to assist with set-up of pharmacies and assessment of cost-recovery mechanisms • Consult with stakeholders in preparation of sustainability plan

Intervention: Pneumonia Case Management			
Objectives	**Indicators**	**Measurement**	**Major Activities**
Increased percentage of mothers with children < 2 would seek care promptly from an appropriate provider upon early recognition of key signs of pneumonia	• 75% of mothers with children < 2 years of age would be able to recognize at least two danger signs of pneumonia indicating medical treatment (baseline: 61.3%) • 25% of mothers/caretakers would be able to recognize the danger signs of rapid breathing and chest- indrawing or difficult breathing (baseline: 0%). • 60% of mothers with children < 2 would seek medical treatment from a qualified provider on the same day that the child shows danger signs of pneumonia (baseline: 42.9%)	• Surveys (KPC and HFA) • Training post-test records, other program records • Quarterly reports • Program HMIS reports • LQAS	• Ethnographic/formative research to develop a comprehensive BCC strategy taking account of community beliefs and care-seeking behaviors • Organize community health education to teach mothers and caretakers the early signs and symptoms of pneumonia and when and where to seek care. BCC will include local life drama, community mobilization, and media activities, and will target mothers-in-law and other caretakers. • Develop and use BCC materials (posters, leaflets, pamphlets, TV spot) for group education, mass media and campaigns. • Increase outreach by SVP doctors and nurses through community clinics and home visits, and increase the times and opportunities for health education during fixed clinic sessions and immunization days
Increased number of health workers correctly assess, treat and counsel for pneumonia in children < 5 years	• 50% of children <5 years with cough/difficult breathing would be managed by a trained health worker following protocols for SCM of pneumonia (baseline: 31.0%) • 50% of children < 5 years with cough/difficult breathing will have their respiratory rate checked when visiting the health facility (baseline: 27.6%)	• Baseline, final evaluations • Health facility assessments • HMIS reports • MOH reports • Village pharmacy inventory records	• Ensure the availability of SCM antibiotics in SVPs, village based pharmacies (VPs) • Ensure the availability of WHO protocols of pneumonia for use. • Organize regular meetings of VHCs with and MOH staff to discuss problems of service delivery and potential solutions • Facilitate QOC by MOH through core trainers providing training and supportive supervision to MOH staff, who supervise SVP doctors and nurses; training SVP doctors and nurses and other health workers in SCM; MOH community surveillance for pneumonia deaths

Health facilities in the targeted rayons maintain an adequate inventory and supply of cotrimoxizole.	• 50% of trained health workers would receive a supervision visit within the last 2 months that included an observation of case management of a sick child. (assessment, treatment and counseling) (baseline: 28.6%) • 50% of health facilities will not experience a stock-out of cotrimoxizole in the two months prior to HFA (baseline: 28.6%)	• Supervision checklists • COPE	SCM; MOH community surveillance for pneumonia deaths, problems/complications, problem solving, review and feedback • Training of MOH health workers on selected interventions • Monitoring and supervision visits to program sites • Regular meeting with MOH to review essential drugs supply situation. • Develop linkages with UN, Int'l PVOs such as Project Hope and NGOs for assisting MOH for supply of drugs.

Intervention: Diarrhea Case Management			
Objectives	**Indicators**	**Measurement**	**Major Activities**
Increased percentage of children with diarrhea in the last two weeks would be treated with ORT	• 40% of children under 24 months with diarrhea in the past two weeks whose mothers report they were treated with ORT (ORS, cereal based ORT, recommended home fluids, or increased amount of fluids) (baseline: 9.1%) • 60% of mothers would be able to demonstrate correct preparation of ORS (or substitute) and explain its use (baseline: 42.3%)	• Surveys (KPC and HFA); • Training; pre/post test records and other program records • HMIS and other program reports • LQAS	• Health education activities at community level and organize campaigns annually. • Ethnographic/formative research to develop a comprehensive BCC strategy based on ethnographic research of community beliefs and care-seeking behaviors • VHWs, with the help of VHCs, will educate mothers and caretakers about diarrhea: its prevention, recognition, early home treatment and appropriate care seeking • Other BCC activities will include programs for womens' groups, programs targeting mothers-in-law, and community-based initiatives to improve sanitation and hygiene. • Develop relevant BCC materials to target multi-channel dissemination at the rayon and community level.
Increased percentage of mothers are able to identify the signs of diarrhea requiring treatment	• 65% of mothers of children less than 24 months who know at least two danger signs of diarrhea indicating medical treatment. (baseline: 47.3%)		
Increased number of health workers are able to correctly assess, treat, and counsel caretakers regarding diarrhea	• 35% of children <5 years with diarrhea who are managed by a trained health worker following protocols for SCM of CDD (baseline: 3.4%) • 50% of health workers trained in SCM of diarrheal disease in last 6 months (baseline: 18.4%)	• Ongoing monitoring and supervision records	• Training of SVP doctors and nurses and FAP personnel on WHO protocols for SCM • Monitoring and supervision visits • Increasing outreach by SVPs through community clinics and home visits

management	• 45% of trained health workers who have received a supervision visit within the last 2 months that included an observation of case management of a sick child. (assessment, treatment and counseling) (baseline: 28.6%)	• Surveys; HFA; KPC • MOH reports • COPE	• Facilitate establishment and training of Village Pharmacies & staff • Encourage MOH to ensure supply of ORS packets to SVAs, SUBs, SVPs and VPs. • Organize meetings of VHCs with SVP nurses to discuss problems of service delivery and potential solutions

Intervention: Breastfeeding			
Objectives	**Indicators**	**Measurement**	**Major Activities**
Increased percentage of newborns are breastfed within one hour of birth (at the hospital)	• 60% of newborns that are breastfed within one hour (baseline: 44.0%) • 50% of infants under six months are exclusively breastfed and receive no other liquids or solids (baseline 31.9%).	• KPC surveys • Quarterly reports • Program HMIS reports • Special survey or monitoring reports • LQAS	• Train OB/GYNs, SRIP, SVP doctors and nurses in lactation counseling and breastfeeding promotion. • Assist maternity hospitals in program area to establish baby-friendly procedures • Promote the development of breastfeeding support groups • Use of informal womens' groups (*gashtegs*) to communicate the messages • Conduct qualitative research or barriers to exclusive breast-feeding during the first months • Promote exclusive breastfeeding through community-based BCC activities, including BCC programs for mothers-in-law • Conduct special programs, including radio/TV and print media. Develop and distribute other BCC materials to the community.

Top Priority Points from Stakeholders' Meeting and Feedback from Final Evaluation Sub-team Members

1. Mothers/caregivers practices in terms of BF, CDD, PCM is a priority

FINDINGS:

Breastfeeding (BF):

- Mothers know about proper breastfeeding practices for themselves and to their children
- The behavior of mothers-in-law toward daughters-in-law has improved.
- Mothers' health has improved with less mastitis, fever, bleeding observed after birth.
- According to latest MOH figures, child mortality and morbidity including hospital infections has decreased.

Control of Diarrheal Diseases (CDD):

- Knowledge of proper ORS preparation has increased
- Danger signs of child illnesses are recognized by mothers and caretakers
- Referrals and visits to health facilities has increased
- Proper feeding practices and intake of fluids during bouts of diarrhea has increased
- Knowledge of diarrhea prevention has increased
- Knowledge of health workers has increased
- Religious leaders (Mullahs) and local healers treat cases of diarrhea more carefully
- Diarrhea cases among children have decreased

Pneumonia Case Management (PCM):

- Women are referring their children to health facilities before symptoms worsen
- Mothers hesitate to give anything other than Paracetamol without first consulting with a health care professional
- The best treatment for 'Evil Eye' is to go to a health facility (doctors can treat evil eye!)
- Doctors are dispensing less antibiotics due to better understanding of supportive care
- Health facility workers have better rapport with mothers as a result of their increased knowledge
- Mothers have more knowledge on how to treat their child while awaiting advice qualified medical personnel (first aid)
- The availability of pneumonia medication has not changed significantly

CONCLUSIONS

BF:

- Very good

CDD:

- Approach to training mothers on CDD was very good but things improved once linkages with such organizations as UNICEF were established and training programs on ORS preparation at health facilities were implemented

PCM:

- Very successful at the community level but drug availability remains a problem.

BEST PRACTICES

BF:

- Breastfeeding Support Groups (BFSGs) for young mothers
- Trainings for mothers on peer-education
- Trainings among mothers, caretakers and health workers
- Use of BCC materials in trainings
- Linkages between maternity houses and BFSGs
- Training programs for mothers in maternity houses and after discharge at home
- Counseling mothers in informal gatherings (e.g., party, wedding-parties)

CDD:

- Joint activities with other MOH and other organizations including WHO, UNICEF, and local NGO Perzent
- Established VHCs and collaboration with VHWs
- Trainings in the use BCC materials and methods for health workers, mothers and caretakers
- Involvement of mullah and local healers in training activities
- Joint activities between CSP and MOH health workers

PCM:

LESSONS LEARNED

BF:

- BF Information presented on time have a positive influence on young mothers

CDD:

- Seasonality of information
- Seasonality of trainings
- Training of health workers
- Refresher training

PCM:

- A thorough understanding of the political environment prior to implementing an initiative, particularly when it requires changes in infrastructure, is essential
- Ensure that pneumonia medication reaches intended beneficiaries through increased monitoring of drug distribution systems
- BCC materials were useful and effective
- Responding to the needs of communities

RECOMMENDATIONS

BF:

- Develop documentary film using local people and locations (e.g., health facilities).
- Translate documentary on BF into local language.
- Disseminate BF information on TV/radio and mass media
- Increase the number of BFSGs
- Continue BCC among mothers-in-law and husbands and include information of domestic violence and housework.
- Continue linkages between MOH (e.g., community health workers, maternity house health workers) and BFSGs

CDD:

- Give list of donors to CSCC to find funding for further trainings
- Involve local Hakimyats in finding funding
- Mobilize local initiative groups for program development
- Establish training centers in each rayon and provide them with equipment
- Involve international organizations (e.g. WHO, MSF, UNICEF) in the monitoring process

PCM:

- Ensure that PCM medication reaches intended beneficiaries through increased monitoring of drug distribution systems
- Follow through with village pharmacy initiative
- Recommend that the MOH establish a drug schedule to regulate the availability of essential drugs (i.e., distinguish between prescription and OTC drugs)

SUSTAINABILITY

BF:

- BFSGs should continue disseminating information
- Continued use of BCC materials by trained health workers
- Trained mothers-in-law continue to support their daughters-in-law on BF

CDD:

- Continue trainings and distribute BCC materials by trained health workers and VHCs
- Trained mothers-in-law continue support their daughters-in-law towards diarrhea
- Ask MOH to invite international organizations to conduct monitoring

PCM:

- *See comments for BF and CDD*

SCALE-UP AND EXPANSION

BF:

- Make use of trained VHCs and BCC materials to train health workers in other regions

CDD:

- MOH plans to conduct IMCI trainings and use BCC and TOT methods
- Use the trained potential (VHWs, BCC materials) to train health workers in other rayons

PCM:

- *See comments for BF and CDD*

2. The impact of VHCs, VHWs in improving mother/caregiver health practices is a priority.

FINDINGS:

- Quote from a mother from a community *"My children are healthier following the advice and suggestions of Umir Nuri VHWs and VHCs."*

(Many mothers in Umir Nuri program areas echoed these sentiments and felt that the overall status of children in their communities was better now compared to before the program began.)

- Hospital and clinic staff report that VHWs and VHCs are helping to identify sick children, find hidden cases and refer them to health facilities. Many VHCs are facilitating the transportation of sick children to health facilities.
- VHWs are the main disseminators of *Umir Nuri* health messages in communities. They also received assistance from VHCs and local government in public outreach activities.

- VHCs work with Hakimyat in facilitating community problems relevant to *Umir Nuri* program activities (e.g social problems, water shortages, gas/electricity, etc.). For example, water & sanitation issues have been discussed and resolved between VHCs and Local government officials.
- Caregivers and HF staff appreciate the work of VHWs and VHCs.
- Mothers are bringing their children earlier to health facilities as a result of VHWs and VHCs.
- Mothers and grandmothers cite that household visits, competition of mothers ('infotainment') as being the most effective way of learning about *Umir Nuri* messages.
- Visual aids (BCC), and other activities were considered the most important activity of VHWs
- Mothers and grandmothers reported that they preferred the approach of VHWs over the work of MOH workers because of better communication skills and better rapport
- Grandmothers reported changes in practices (e.g. BF) because of the work of VHWs and VHCs.
- BCC materials helped the work of VHWs and VHCs tremendously
- VHWs have helped mothers to become as knowledgeable as health staff regarding *Umir Nuri* messages

CONCLUSIONS:

- The work of VHWs and VHCs have been extremely successful

BEST PRACTICES:

- Interactive learning techniques (e.g., Role plays, competitions) worked well in the program
- Using local women as VHWs were well accepted in communities.
- TV/films spots were very effective (BCC)
- Improving the work of VHCs through incentives, small gifts (relevant to work), inviting them to seminars/workshops is a good program strategy
- Inviting community elders in program activities (e.g. GHEs, FGDs, meetings, etc.)
- Follow-up household visits re-enforced *Umir Nuri* messages

LESSONS LEARNED:

- Focus VHC efforts in a few key *auls* rather than reducing their effectiveness by establishing them throughout the region.
- Electing VHC members on voluntary basis is good practice

RECOMMENDATIONS:

- *Umir Nuri* staff should continue to assist VHC members and other community leaders in submitting viable concept papers and proposal for the Healthy Communities Grants Programs (HCGP)
- VHCs are working closely with *Makhalla* committees but they would need additional room/facilities to hold their own meetings and trainings
- Follow up with CSCC recommendations that their members should participate in VHCs meetings
- Provide VHCs and community leaders with a list of potential donors and establish a mechanism whereby they could receive funding announcements
- Invite representatives from donors to distribute resources to VHCs (e.g., NGO fairs) so that they can apply for funding.
- Consider addressing other health problems -- TB, HIV/AIDS, iodine deficiency, anemia, and other micronutrient deficiencies -- affecting the people in the region

SUSTAINABILITY:

- Many VHCs requested *Umir Nuri* resources that would help them continue their work after LOP
- VHC members and community leaders should receive more trainings in program design and proposal writing so that they receive funding on their own.
- Representatives from local government trained by *Umir Nuri* could serve as trainers of trainers (TOT) (Refer to HCGP)

SCALE-UP AND EXPANSION:

- If funding were available, replicating VHCs in other regions can be easily accomplished and would be highly successful
- Current VHWs have the required knowledge to train MOH and/or other new village health workers (i.e., community health promoters from MOH) in *Umir Nuri* interventions, community mobilization, and other relevant health topics.

3. Mobilizing communities to support important health practices is a priority.

FINDINGS:

- VHWs and VHCs increased the knowledge of mothers and caretakers
- BFSGs and Schools of Mothers were effective initiative groups in the community
- CSCCs were effective
- Children's Day activities, Competition of Mothers, puppet shows and live theatre were effective community activities
- Development and distribution BCC materials with the help of community was important
- Dissemination of information during parties and other gatherings was useful

CONCLUSIONS:

- The approach to community mobilization was effective due to regular meetings, trainings, informal meetings and distribution of BCC materials
- People responded to the people from their own community better than to outsiders

BEST PRACTICES:

- Establishing linkages between CSCC, VHCs and the community.
- Disseminating mothers' and caretakers' knowledge and positive practices with others in the community
- Trainings and BCC among the community

LESSONS LEARNED:

- Work with communities increased the popularity and recognition of health workers among community.
- After receiving VHWs different kinds of trainings the work became more effective and successful
- Involvement of influential and respectful people in VHCs
- Establishment of VHCs involving local people

RECOMMENDATIONS:

- Conduct trainings, workshops and other activities to mobilize community (refresher trainings needed)
- MoH workers trained by CSP (TOT) should lead sessions.
- Provide technical training from donor agencies for initiative groups on proposal writing (e.g. HCGP).
- Established VHCs and VHWs workers from Perzent can share experience with MOH and Hakimyat on how to establis new VHCs.

SUSTAINABILITY

- Trained mothers, caretakers, VHC members and BFSG, local health workers will continue work at community level.

SCALE-UP AND EXPANSION

- To recommend MOH to conduct trainings on community mobilization in other rayons.

4. **The role of the program BCC strategies in improving mother/caregivers practices is a priority**

FINDINGS:

- At the regional/local level, BCC materials played a key role in changing behaviors
- Most of the mothers mentioned that using the BCC materials was a great help and they understood health message better. Puppet shows, training films were also very helpful
- BCC materials contributed to the reduction of child mortality in the region
- Program communication strategies helped health workers to communicate more effectively with mothers in contrast with the traditional approach used by the MoH.
- Other *Umir Nuri* beneficiaries (e.g., grandmothers, husbands, etc.) benefited from the BCC materials
- Mothers' referral to health facilities increased as a result of better trained health workers
- Mothers feel that *Umir Nuri* BCC materials are easier to understand and more effective
- Booklets were very impressive and training films were very well received
- Competition of mothers, BCC trainings were also effective
- Community members became more involved in BCC activities (e.g. live theatre, competition of mothers)
- ORS packages are being used more frequently as a result of increased mothers' knowledge

CONCLUSIONS:

- BCC strategies were considered successful by all *Umir Nuri* beneficiaries
- Health workers learned to communicate more effectively with mothers and other beneficiaries.
- Mothers have changed their practices.

BEST PRACTICES

- Effective training films (e.g. c-IMCI, BF) to disseminate health messages
- Culturally sensitive and easy to understand language, engaging design, and layout of BCC materials.
- Establishing open and comfortable rapport with beneficiaries

LESSONS LEARNED

- BCC materials should be developed in a participatory and team environment
- BCC materials need to distributed a wider audience
- Presentation of health messages, including trainings should coincide with seasonal needs
- Pre- and post- testing of BCC materials was essential to the development process.
- BCC materials development should be responsive to community needs

RECOMMENDATIONS

- Training films need to use more locals
- The MOH should incorporate *Umir Nuri* BCC strategies and approaches in its own training activities
- Share electronic copies of *Umir Nuri* BCC materials (e.g., posters, booklets, etc.)
- Create field guidelines/manuals on how to conduct interactive community activities such as competition of mothers, role plays, etc.
- Help MOH to generate funds for BCC materials, trainings, and community health activities
- Develop personnel with relevant technical skills (e.g. computers, software, graphics, etc.) to develop BCC materials
- Help *Hakimyat* to generate funds to create BCC materials
- Establish a monitoring team from within the community (e.g. local government, VHCs) to monitor the development of BCC materials

SUSTAINABILITY

- Trained trainers on BCC messages including members from the community (e.g. VHCs, Breastfeeding Support Groups)

SCALE-UP AND EXPANSION

- Expansion would be feasible since many of the BCC materials have already been developed

5. The role of program training in improving MoH services in FAPs, SVA/SVP/SUBs, maternity homes is a priority.

FINDINGS:

- Increased number of trainings at the health facility level
- Increased emphasis on supportive care for children at health facilities
- Improvement of training in other relevant areas
- Substantial amount of follow up in training activities
- An established cadre of trainers at bother rayons available for training activities
- Most trainings a the health facilities are observed by CSP staff
- Pre- and post testing of trainings
- Follow up trainings were based on deficiencies in post testing
- Training activities were not duplicated due to collaboration among NGOs/agencies (e.g. UNICEF, WHO).

CONCLUSIONS:

- Having local trainers train other doctors in their own communities is effective.

BEST PRACTICES:

- Pre- and post testing of trainings are effective
- Refresher trainings
- Sequential training to allow material and knowledge to build upon the previous trainings.

LESSONS LEARNED:

- Parallel trainings at health facilities and community levels complimented and re enforced one another

RECOMMENDATIONS:

- Create a database of trainers in program interventions (BF, CDD, PCM, BCC) who can be used by the MOH
- Share database with other NGOs/agencies working with MOH on training activities.
- Encourage the MOH to use the database.
- Ensure that relevant *Umir Nuri* resources are passed on to the MOH and trainers.
- Include a BCC component in all training modules.

SUSTAINABILITY:

- The structure of trainings is based on trainers of trainers. As such, they fully involve health facility staff who are motivated to continue training beyond LOP.
- Modules and manuals have been developed and are being used by health workers

SCALE-UP AND EXPANSION:

- Local trainings have the potential for scale up and replication in surrounding regions because of training modules and manuals that have already been developed (e.g., successful training implemented by CSP staff in Tajikstan)

6. Program effort's to create sustainable activities is a priority.

Factors that encourage sustainability

- Mothers with changed practices will improve children's health status
- Training resources (materials and personnel) at the MoH and elsewhere
- Greater linkages between local government and the community
- BCC materials in all program interventions are available to interested parties

- BCC strategies developed by the program have been adapted by community members on their own initiative to other health topics (e.g., anemia, water & sanitation)

Factors that Restrict Sustainability

- Lack of funds at the MOH at the community level
- Lack of local personnel with professional expertise in graphic design and IT
- Language obstacles (Cyrillic v. Latin alphabet, Russian v. Uzbek v. Karakalpak language)
- Lack of centralized responsibility to continue program activities
- Ensuring that VHCs continue their work make up for fewer CSCCs
- Turnover at the government level
- A non-responsive donor

Attachment 6. Program Data Sheet Form, updated version